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# Improving Behavioral Health Care in the Military Health System

## Challenges, Promising Strategies, and Research Directions

**E**nsuring that service members have timely access to high-quality behavioral health (BH) care is a priority for the U.S. Department of Defense (DoD) and essential to ensuring the health and readiness of the force. The Military Health System (MHS) provides health care to service members, their dependents, and military retirees, and the Defense Health Agency (DHA) oversees health care delivery. To support the MHS in its mission, in this paper, we highlight opportunities to improve the quality, access, and equity of BH care delivery.

Military health care is delivered in two ways: as *direct care* provided at military treatment facilities (MTFs) and as *private-sector care* provided by TRICARE-contracted civilian health care facilities and providers in the community.<sup>1</sup> Private-sector care extends access to care for patients who are unable to access timely care or specific specialty care from an MTF. Active-duty service members receive most of their care from MTFs, whereas their dependents and other beneficiaries receive most of their care from private-sector providers (Bond and Schwab, 2019; Tanielian and Farmer, 2019). In fiscal year (FY) 2021, private-sector care accounted

## Abbreviations

BH	behavioral health
BHDP	Behavioral Health Data Portal
BHT	behavioral health technician
COVID-19	coronavirus disease 2019
CPG	clinical practice guideline
DHA	Defense Health Agency
DoD	U.S. Department of Defense
FY	fiscal year
GAO	U.S. Government Accountability Office
HEDIS	Healthcare Effectiveness Data and Information Set
HMO	health maintenance organization
MHS	Military Health System
MTF	military treatment facility
NDAA	National Defense Authorization Act
PTSD	posttraumatic stress disorder
VA	U.S. Department of Veterans Affairs
VBH	virtual behavioral health

for 12.6 percent of primary care and 15.1 percent of specialty care visits covered by TRICARE (DHA, 2022). Much of this private-sector specialty care, both inpatient and outpatient, was for BH care. In FY 2021, there were about 1.2 million encounters each for two common BH diagnosis groups (depressive disorders and anxiety disorders) in private-sector care, compared with just under 300,000 encounters for each diagnosis group in direct care (DHA,

2022).<sup>2</sup> An older report indicated that, in FY 2014, active-duty service members received 24 percent of their outpatient BH care and 69 percent of their inpatient BH care in the private sector (Williamson, 2016).

In this paper, we highlight four potential priority areas for improving the quality of BH care for service members: increasing access to BH care, ensuring effective integration of virtual BH care, focusing on the quality of BH care delivered by private-sector providers, and prioritizing racial and ethnic equity in BH care.<sup>3</sup> For each area, we first characterize the challenges that the MHS faces in delivering BH care, drawing on the relevant literature. We then describe potential strategies to extend MHS's ongoing efforts to further address the challenges. Finally, we describe directions for future research that could inform how the MHS focuses its improvement efforts in the future.

## Increase Access to Behavioral Health Care

Timely access to BH care that meets the needs of service members is necessary for ensuring the readiness of the force. We explored challenges to providing timely access to BH care, identified potential strategies for improvement, and used these strategies to generate potential research priorities. Although service members differ as a population and how they access health care when compared with civilians, we include information from civilians when data on service members are lacking.

## **Demand for Behavioral Health Care Among Service Members Likely Increased Following the Onset of the COVID-19 Pandemic, but Access Barriers Remained**

Access to BH care has been a long-standing challenge across the U.S. health care system. Among the civilian population, demand for BH care nationwide has increased with little or no gains in the number of available providers (Health Resources and Services Administration, undated). Legislative efforts have tried to address the gap between the demand for care and the supply of providers, but the coronavirus disease 2019 (COVID-19) pandemic exacerbated an already taxed BH care system. BH care visits initially dropped early in the pandemic because of facility closures, but the increased stressors from the pandemic and the expansion of telehealth services led to an overall increase in the number of adults reporting BH conditions and trying to access care for the first time (American Hospital Association, 2022; Kaiser Family Foundation, 2022; McBain et al., 2023).

There is a paucity of literature on the pandemic's impact on the military, but it is likely that there was an increase similar to that in the civilian population in the need for BH care. According to a 2020 survey, 23 percent of service members and their family members reported new symptoms of depression and anxiety during the pandemic, and one-quarter of respondents reported that their mental health needs were not being met (Booz Allen Hamilton, 2022). A 2019 survey of military millennials reported that 19 percent of respondents stated they needed mental health treatment or counseling, and just 50 percent

of those respondents stated they had no problem accessing that care (Baker, Gehrke, and Clusen, 2020).

Stigma associated with receiving BH care has been a prominent barrier historically, but decreasing stigma could lead to increased demand for BH care among service members. There is some evidence that there has been a reduction in stigma in the general U.S. population related to seeking BH care; diagnoses and treatment of depression have increased (Goodwin et al., 2022), and a younger generation (those 18 to 25 years old) is less likely to have negative views on treatment than older cohorts (Anxiety & Depression Association of America, undated). Nonetheless, a 2017 qualitative RAND Corporation study of patients, providers, and care managers at 18 U.S. Army primary care clinics identified a variety of barriers to accessing care for posttraumatic stress disorder (PTSD) and depression, including attitudinal and cultural concerns—for example, military leaders' negative perceptions of soldiers who seek BH care and the possibility of career repercussions (Tanielian et al., 2016). While stigma is an important factor in service members' access to care, the relationship between perceived stigma and care-seeking is not clear and requires additional research (Acosta et al., 2014; Acosta et al., 2018; Russell, Russell, and Hill, 2022; Sharp et al., 2015).

DoD is working to change military culture by destigmatizing BH care. Efforts include incorporating access to BH treatment as a core tenet of readiness. To facilitate access, many units have embedded BH providers to identify BH issues early, provide treatment when needed, and hold real-time consultations with unit leaders (DoD, 2022b). In addition, a recently initiated self-referral process for BH care is aimed at facilitating service member access

to BH care (Cisneros, 2023). Several senior military officers have shared their own experiences with BH treatment to help dispel fears of career impact (DoD, 2022b). The combination of the effects of the pandemic and decreasing stigma might lead to an increased demand for BH care among service members.

## The Military Health System May Not Have Enough Behavioral Health Providers to Meet Demand

An adequate BH workforce is necessary to meet the existing and potentially growing demand for BH care among service members. A 2022 report by the GAO identified more than 6,300 areas of the country with a shortage of BH providers, particularly psychiatrists and those who provide substance use disorder treatment across the country (Hundrop, 2022). These shortages are expected to extend into the future because reimbursement rates and distributional issues continue to limit provider recruitment and retention.

Service members and their dependents might face difficulty finding a BH provider, whether they seek care at MTFs or from the private sector. In the MHS, an analysis of FY 2019 direct care data revealed a shortage of 1,050 BH providers (i.e., the number of providers versus the number authorized) (DoD, 2022b). The nationwide shortage of providers, competition for these few providers from the private and commercial health sectors, lower pay from DoD, and issues related to deployment and location that are unique to the military all present additional challenges to direct care BH provider recruitment in the MHS (DoD, 2020). Although BH provider shortages vary across the service branches, 35 percent of service members and their

beneficiaries live in shortage areas and 6 percent live in areas with no access to psychiatric care (Bacolod, Heisel, and Shen, 2023). Access to other types of providers, such as psychologists, social workers, and BH technicians (BHTs), is harder to quantify because these provider types are not tracked in a similar fashion by the federal government. This challenge could be most acute for those located far from an MTF or in rural areas with a lower density of private-sector BH care providers. A RAND study of access to BH care for service members who were located remotely from their assigned MTF revealed that remote service members received fewer BH services, including specialty care and psychotherapy, than their nonremote counterparts (Brown et al., 2015).

Estimating the number and types of MHS BH providers that are needed to meet demand is an ongoing challenge. DoD does not have an MHS-wide staffing model for direct and private-sector care (DoD Inspector General, 2020). In 2015, DoD selected the Psychological Health Risk Adjusted Model for Staffing to estimate the need for providers. However, that model did not meet the military services' needs and was discontinued (DoD Inspector General, 2020). A DoD report on BH care requirements for FY 2021 based its estimates on prepandemic staffing levels, which it claimed were representative of "normal" demand, although it acknowledged that demand for BH care had likely increased since then (DoD, 2022b). Estimates for direct care BH providers were based on the anticipated need for prescribers and therapists and associated numbers of visits (i.e., one visit every 24 days for six visits when medication is prescribed and one visit per week for eight weeks for therapy). For private-sector care, proprietary formulas are used to determine the number of BH providers needed to

support demand. TRICARE assesses the adequacy of these provider networks monthly using referral, claims, and care access data (DoD, 2022b). The lack of an MHS-wide staffing model for direct and private-sector care could have implications for BH care access and quality (DoD Inspector General, 2020). In response, the National Defense Authorization Act (NDAA) for FY 2023 included a requirement for the MHS to audit the accuracy of its TRICARE directory of private-sector BH providers and describe its efforts to recruit, retain, and improve the availability of these providers (H.R. 7900, 2022a). Congress also asked for a report on the direct care BH workforce on the number of authorized providers relative to positions filled (H.R. 7900, 2022a).

Other efforts to address BH staffing shortages in the MHS have focused on maximizing the use of licensed mental health counselors and psychiatric physician assistants. However, these providers have different educational requirements and pay levels, and their geographic distribution might not align well with the military's needs (DoD, 2022b). A recent series of RAND reports explored the use of BHTs, sometimes referred to as *care extenders*, to support BH care delivery and improve access to care (Hepner, Brooks Holliday et al., 2022; Brooks Holliday et al., 2019). BHTs already performed many BH care functions, including screening and assessment, psychosocial interventions, treatment planning and monitoring, and outreach. However, according to licensed BH providers at MTFs, insufficient training and supervision limited potential effectiveness (Hepner, Brooks Holliday, et al., 2022). These providers were open to engaging with BHTs but required more training on how best to integrate those individuals into clinical care.

To address the BH provider shortage, the MHS is also exploring the feasibility and advisability of establishing a graduate program in counseling and social work at the Uniformed Services University of the Health Sciences and expanding the clinical psychology program. The MHS is also considering a pilot program to cover tuition and fees for a graduate degree in clinical psychology, social work, counseling, or a related field in exchange for a commitment to work for the MHS (H.R. 7900, 2022a).

## Measuring and Monitoring Access to Care Is Complicated

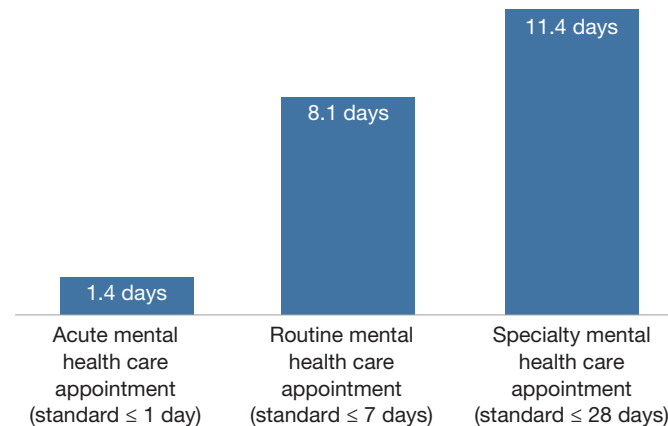
Monitoring access to care is essential to identifying access barriers and informing targeted improvement efforts (DoD Inspector General, 2020). The MHS has established standards and associated quality measures (also referred to as *quality metrics*) that it uses to monitor access to care. For example, there are standards for maximum wait times for appointments (i.e., one day for an urgent or acute visit,

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seven days for a routine visit, and 28 days for an initial referral to specialty care [including BH care]) and the availability of providers within a reasonable driving distance (i.e., routine care within 30 minutes' drive time from the beneficiary's residence and within 60 minutes for specialty care) (TRICARE, undated). A U.S. Government Accountability Office (GAO) analysis of MTF data from April 2014 to August 2015 indicated that active-duty service members were able to get mental health appointments within the specified wait times more than 90 percent of the time, but the MHS fell short when it came to scheduling routine care appointments within seven days; only 59 percent of appointments met this standard, and the average was 11.6 days (Williamson, 2016). Comparable data were not available for private-sector care. The GAO report noted that most visits (59 percent) were follow-up appointments, for which there is no wait-time standard (Williamson, 2016). RAND research evaluated access to BH care in 2016 and 2017 for active component and National Guard or reserve service members with PTSD, depression, or substance use disorder. Average time to appointments at MTFs for urgent care (1.4 days) and routine care (8.1 days) exceeded MHS standards (Hepner, Brown, et al., 2021) of one day and seven days, respectively (see Figure 1). However, the MTFs met the average wait-time standard for specialty care (no more than 28 days). A more recent six-month audit of 13 MTFs and their supporting private-sector care networks in 2019 revealed that more than half of the MTFs or their supporting networks did not meet specialty BH access to care standards every month and that MTFs interpreted the standard differently—specifically in whether they counted referral approval times against appointment wait times (DoD Inspector General, 2020).

FIGURE 1  
Average Wait Times for a Mental Health Appointment at a Military Treatment Facility, 2016–2017



SOURCE: Hepner, Brown, et al., 2021.

NOTE: The figure shows average wait times for active component and National Guard or reserve service members with a diagnosis of PTSD, depression, or substance use disorder.

The MHS also evaluates access through routine surveys of patients' satisfaction with their access to care. One of these surveys asks about care received from private-sector providers and allows the MHS to compare patients' experiences with both direct and private-sector care and to compare these results with civilian benchmarks (MHS, 2022a). Satisfaction with access to care has consistently been higher among TRICARE beneficiaries who use private-sector care. When asked to rate their overall care on a scale from 0 to 10, 71.8 percent of private-sector care users surveyed in FY 2021 rated their care a 9 or 10, compared with 45.4 percent of direct care users (DHA, 2022).



The gap was similar for satisfaction with the timeliness of care; 87.6 percent who received private-sector care reported that they were satisfied versus just 69.5 percent of those who received direct care (DHA, 2022).

Measuring and monitoring access to care is complicated, and this is particularly true for the MHS, with its dual system of direct and private-sector care providers. Although the same access standards apply to both sources of care, there has been some confusion in how to apply them (DoD Inspector General, 2020). Evaluations of appointment wait times include only those who received care, so information about patients who needed care but did not receive it is lacking (DoD Inspector General, 2020). While the standard for access to specialty care is 28 days, the 2022 TRICARE report indicated a goal of specialty referrals being processed within one business day and access to specialty care occurring within 15 days. In FY 2021, 87 percent of referrals met the one-day processing metric and nearly met the standard for specialty care appointments: the average number days to a scheduled specialty appointment in direct care was 15.8 days, with a range of 0.6 to 23.7 days (DHA, 2022). DHA agreed to add a reporting requirement for these data to TRICARE managed care contracts with private-sector care providers (DoD Inspector General, 2020). In addition, provisions within the FY 2023 NDAA request updated MHS access standards for BH care, taking into account the time between patient referral and the initiation of BH care and the frequency of regular follow-up appointments subsequent to the first appointment (H.R. 7900, 2022a).

Access affects timeliness of care, which is linked to quality of care—and quality measures can shed light on access barriers. For example, a RAND study of service

members with PTSD, depression, or substance use disorder found that remote service members were more likely to receive their BH care in the private sector and from primary care providers (rather than BH specialty care providers), and they were less likely to receive psychotherapy. And after initiating medication treatment for these conditions, remote service members had lower rates of follow-up appointments than their nonremote counterparts (Hepner, Brown, et al., 2021). However, for all service members, receipt of at least a minimally adequate amount of initial care (defined by RAND as four psychotherapy visits or two medication management visits within eight weeks) when starting a new episode of treatment for PTSD or depression was low: 22 percent for PTSD and 27 percent for depression. These findings suggest a great deal of variability in service members' timely access to recommended BH care, so monitoring both access and quality should remain an ongoing priority for the MHS.

## Strategies to Address the Challenge

We identified three potential strategies to extend existing efforts in the MHS to enhance access to BH care for service members.

### Clarify Access Standards and Guidance

The MHS has standards for wait times for urgent, routine, and specialty care appointments, but there is a lack of clarity in how MTFs interpret these standards, according to an audit (e.g., when the routine nonurgent standard of seven days applies versus the referral standard of 28 days) (DoD Inspector General, 2020). There are inconsistencies in how these standards are applied in direct versus private-sector

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care settings (e.g., whether wait time starts with the referral request or after the referral's approval). The MHS is striving for a maximum 15-day wait time for specialty care appointments, although the standard is still 28 days (DHA, 2022). Clarifying the timeliness standards and implementing this 15-day maximum wait time for specialty appointments would help the MHS better meet service members' needs for timely access to BH care. This change would put the MHS on track to address a request from Congress in the FY 2023 NDAA to account for referrals in BH appointment wait-time standards for initial care and the frequency of follow-up BH appointments (H.R. 7900, 2022a).

### Monitor and Report Access Separately for Behavioral Health and Non-Behavioral Health Care, Direct and Private-Sector Care, and at the Military Treatment Facility Level

The MHS reports standard wait times for appointments for scheduled specialty care as an average across all

types of specialty care (DHA, 2022). Decoupling BH and non-BH care in these reports would provide more clarity on how access to BH care compares with access to other specialty care. Reporting these measures (including median and mode of average days wait time) separately for direct and private-sector care and for individual MTFs would increase transparency and could provide additional insights into where access issues persist, supporting targeted efforts to improve service members' care. Although the average wait time for care at given facility might fall within the specified standard, there might be considerable variation across facilities. The U.S. Department of Veterans Affairs (VA) posts average clinic appointment wait times for new and established patients by specialty, and these results demonstrate the high variation within the VA among clinics (VA, undated).

### Monitor Additional Measures of Minimal Initial Care

The MHS monitors and publicly reports (for direct care only) whether patients who have been newly diagnosed with PTSD or depression receive at least three BH follow-up visits within 90 days of diagnosis (DHA, 2022). A primary limitation of this metric is that it sets a threshold that is inadequate for most patients starting treatment for PTSD or depression—about one BH visit per month. A higher standard would align more closely with treatment recommendations for these conditions. RAND has reported MHS performance on a “minimal initial care” measure that assessed whether a patient newly diagnosed with PTSD or depression received at least four psychotherapy visits or two medication management visits within eight weeks (Hepner, Brown, et al., 2021). Such a measure could provide a better estimate of the adequacy of initial care for patients



with a new diagnosis of PTSD or depression and should be reported for both direct and private-sector care and at the MTF level.

## Research to Inform Solutions

We identified three promising areas in which research could support the MHS in ensuring timely access to high-quality BH care for service members.

### Identify Predictors of Timely Access to Care and Share Best Practices from High-Performing Military Treatment Facilities

MTFs vary in their performance on measures of access to care, potentially leading to disparities in the quality of care that service members receive across the MHS. Analyses could identify what factors predict timeliness of care. For example, structured interviews and surveys of leadership and frontline staff at high-performing MTFs (those that provide better access to care) and low-performing MTFs (those that struggle the most to provide timely care) could identify factors that are common among high performers and factors that might hinder timely access to care. Interviews could also be used to investigate how MTFs have implemented care processes or staffing models (e.g., integrating BHTs) that have resulted in improvements and where the deficiencies remain for MTFs that are struggling. This information could be combined to identify key areas for struggling MTFs to target, generate strategies to improve the timeliness of care at these locations, and establish connections with staff at high-performing MTFs who can share their experiences and best practices.

### Identify and Evaluate Mechanisms to Retain Providers

Several factors can contribute to BH providers' decisions to continue serving in the MHS as a uniformed provider, government civilian, or contracted provider working at an MTF. RAND research has explored special and incentive pay models that can support retention of uniformed providers (Mattock and Arkes, 2007), but other factors could play a similarly important role. For example, there are various models that could be used to improve provider retention in underserved areas, including rural and remote locations (Abelsen et al., 2020; MacQueen et al., 2018; Russell et al., 2021). These models can help the MHS forecast and project its need for providers in particular geographic areas, train providers and staff to address the needs of patient populations in underserved areas, recruit providers and staff with ties to the area or similar areas, and support efforts to integrate providers into the community to familiarize them with their patients' experiences. Several research approaches can shed light on the motivations for BH providers' career decisions and guide MHS retention strategies. Qualitative interviews or surveys of providers could identify the factors that are most important in increasing retention and job satisfaction and explain variations in retention among those who have been practicing in the MHS for longer periods, newly hired providers, and providers who have recently left the MHS. Such research could also evaluate novel factors that have not been considered, including whether the flexibility afforded by delivering BH care virtually while working from home could support retention.

## Develop a Military Health System–Wide Model for Determining the Optimal Number and Mix of Behavioral Health Providers

Access to BH care varies by MTF and type of service. Many types of providers in the MHS address BH conditions. It would benefit the MHS to conduct an audit of the availability of providers and their locations, the types of care they can deliver, and where there are deficits across MTFs. Surveys of service members could be used to assess whether there is demand for BH services that is not being met, while analyses of health care utilization could determine how demand for particular types of BH care has changed over time and MTFs' capacity to deliver that care. A better understanding of deficits in meeting service member demand with the existing supply of providers could help the MHS better target recruitment efforts and achieve a more optimal balance between supply and demand.

## Ensure Effective Integration of Virtual Behavioral Health Care

Virtual health care (or telehealth) relies on technology to connect patients and their providers and has the potential to increase access to BH care. These interactions can be synchronous (i.e., live, real-time exchanges) or asynchronous (i.e., one-way sharing of information, such as through electronic messaging) (Reynolds, 2022).<sup>4</sup> When digital means, such as a computer or smartphone, are used to access BH care, it is referred to as *virtual behavioral health* (VBH) (Reynolds, 2022).

## The Effectiveness of Virtual Behavioral Health Care May Be Comparable with In-Person Care

VBH has long been used to deliver BH care in civilian settings (Dongier et al., 1986; Shore, 2015; Wittson, Affleck, and Johnson, 1961). In fact, much of the early evidence base on the effectiveness of synchronous virtual health care focused on VBH care for patients in remote areas with few BH providers (Field, 1996). Prior to the COVID-19 pandemic, the evidence suggested that VBH was as effective as in-person care for assessment, diagnosis, and treatment of many BH conditions (Ekeland, Bowes, and Flottorp, 2010; Hilty et al., 2013; Langarizadeh et al., 2017; Liu et al., 2020). These studies were not without limitations; there were relatively few large randomized clinical trials, and there was variation in the interventions (e.g., audio versus video visits, individual or group psychotherapy versus medication treatment) and patient populations (e.g., different acuity levels and BH conditions) studied (Hilty et al., 2013; Hubley et al., 2016; Lin et al., 2019; McLean et al., 2013; Shigekawa et al., 2018). Studies comparing VBH and in-person BH also care tended to have short follow-up windows, making it difficult to evaluate differences in outcomes (Hilty et al., 2013; Hubley et al., 2016; Lin et al., 2019; McLean et al., 2013; Shigekawa et al., 2018).

Similar to other health care systems, the MHS rapidly expanded its VBH services at the start of the COVID-19 pandemic. Reviews in the past few years have largely confirmed earlier findings that VBH is effective for treating a broad variety of BH conditions (Barnett et al., 2021; Batastini et al., 2021; Bellanti et al., 2022; Connolly, Hogan, et al., 2022; Greenwood et al., 2022; Liu et al.,

2020). However, the evidence is still lacking for certain BH conditions (e.g., psychotic disorders) and treatments (e.g., group psychotherapy) (Sugarman and Busch, 2023). There has also been a rise in the use of hybrid models of care in which a patient receives a mix of video or audio visits and in-person BH appointments (Mishkind, Shore, and Schneck, 2021; Uscher-Pines et al., 2022). Additional research is needed to determine the optimal combination of video, audio, and in-person BH visits for patients with different circumstances (Mark et al., 2022).

### **Virtual Behavioral Health Care Could Exacerbate Existing Inequities If It Is Not Implemented Thoughtfully**

Equity should be a key consideration in assessing the overall effectiveness of any approach to health care delivery, and VBH is no different. Video and audio visits require digital literacy and access to technology and privacy, which could limit access for some patient populations. We were unable to identify research on the equity implications of VBH in military populations, but there is much to be learned from studying veterans and other civilian populations. For example, research suggests that Black and Hispanic patients were less likely to have VBH visits and less likely to receive BH care in general during the COVID-19 pandemic than White patients (Busch et al., 2022; Rodriguez, Betancourt, et al., 2021; Yang et al., 2020); video visits presented the greatest barriers (Eberly et al., 2020). Low-income populations are less likely to receive VBH visits than those with higher incomes (Busch et al., 2022; Connolly, Stolzmann, et al., 2022; Patel et al., 2021; Yang et al., 2020). Older adults and patients who receive

BH care in languages other than English also face greater barriers to accessing VBH (Connolly, Stolzmann, et al., 2022; Rodriguez, Betancourt, et al., 2021; Rodriguez, Saadi, et al., 2021). Furthermore, evidence suggests that patients with BH conditions have been disproportionately affected by digital literacy barriers relative to patients with other health conditions (Degan et al., 2021; Robotham et al., 2016; Saeed and Masters, 2021). These and other disparities in access to VBH might widen existing disparities in health outcomes for some patients.

### **Patient Experiences with Virtual Behavioral Health Are Generally Positive**

VBH is associated with increased convenience and access to care (Barnett et al., 2021; Jenkins-Guarnieri et al., 2015; Polinski et al., 2016). VBH can reduce the amount of time spent away from work or need for child care (Guinart et al., 2020). Patients have cited the lack of a commute—and the associated savings in time and transportation costs—as being among the advantages of VBH (Guinart et al., 2020).

Patient satisfaction with VBH is high, and it appears to be comparable with that of in-person BH care (Chen et al., 2022; Gotthardt et al., 2023; Lin et al., 2019; Mazziotti and Rutigliano, 2021). Furthermore, patient satisfaction and comfort with VBH increase as patients gain more experience receiving VBH (Fischer et al., 2022; Waite, Diab, and Adefisoye, 2022). However, some patients still prefer in-person care (Stahl and Dixon, 2010), and there is evidence suggesting that patients might perceive in-person care as more valuable than VBH (Predmore et al., 2021). Among those who use VBH, some patients might prefer video visits over audio visits (Chen et al.,

2021). Although in-person BH care might be seen as the preferred modality or gold standard for some, certain patients might be equally satisfied with a video or audio visit—particularly if they face barriers to accessing in-person care (Berry et al., 2022; Courtemanche et al., 2023; Juarez-Reyes et al., 2021; Moeller et al., 2022). In short, patients might prefer to receive their BH care through a mix of video, audio, and in-person visits, depending on their individual circumstances (Tse et al., 2021).

We were unable to identify any studies on patient satisfaction with VBH that included military populations. However, a retrospective analysis of anonymous patient surveys completed in 2015 by soldiers who received virtual health visits in 31 different specialties in Europe found that rates of satisfaction were high, and nearly all respondents expressed an interest in using virtual health in the future (Waibel et al., 2017).

## The Use of Virtual Behavioral Health Care Increased Following the Onset of the COVID-19 Pandemic

Use of VBH prior to the pandemic was limited in the MHS, accounting for less than 3 percent of BH visits for service members with PTSD, depression, and substance use disorders (Hepner, Brown, et al., 2021; Madsen, Banaag, and Koehlmoos, 2021). It was primarily restricted to home-based VBH pilot programs and as part of routine care offered for some patients at remote MTFs (Hepner, Sousa, et al., 2021; Madsen, Banaag, and Koehlmoos, 2021; Mishkind et al., 2012). Although a 2016 DoD memo permitted VBH to be used to deliver care to patients in their homes, it was relatively uncommon prior to 2020 (Hepner,

Sousa, et al., 2021; Madsen, Banaag, and Koehlmoos, 2021; Woodson, 2016). This changed with the onset of the COVID-19 pandemic. Regulatory changes in response to the public health emergency led to expanded VBH use in civilian and military care settings alike.

RAND researchers interviewed military BH providers about experiences with VBH from July through October 2020. These providers reported a dramatic shift away from in-person BH care; nearly all offered their patients audio visits early in the pandemic, and more than half integrated mobile apps into their practice (Hepner, Sousa, et al., 2021). Few providers reported using video visits—the majority stated that they faced technological and administrative barriers to doing so, including insufficient internet bandwidth or equipment, concerns about data security, and a lack of clear policy guidance (Hepner, Sousa, et al., 2021). Furthermore, use of audio visits varied widely, both within and across MTFs. Some military providers described using audio visits for check-ins for a short period until in-person BH care could be resumed, while others used audio visits to deliver psychotherapy or medication management to some or all of their patients (Hepner, Sousa, et al., 2021). Few were comfortable using VBH with high-risk patients or those with high symptom severity, and half reported that they were returning to providing mostly in-person care at the time of the interviews (Hepner, Sousa, et al., 2021). Administrative data on direct and private-sector care showed that, as of spring 2020, video or audio VBH accounted for three-quarters of medication management visits and more than half of individual psychotherapy visits for active-duty service members with PTSD, depression, or substance use disorder (Figure 2) (Hepner et al., 2023). Notably, during this period of increased VBH use, evidence

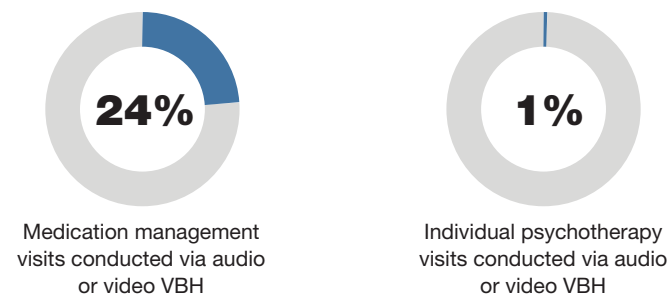
suggests that the quality of BH care for PTSD, depression, or substance use disorder based on process of care measures was largely sustained or improved following the onset of the pandemic, although fewer service members were seen for BH treatment for these conditions in 2020 than in the prepandemic period in 2019 (Hepner et al., 2023).

The increase in VBH use was even greater in the civilian sector (Mehrotra et al., 2021; Patel et al., 2021), and this change affected service members who saw private-sector care providers. Analyses of MHS administrative data showed that the majority of these VBH visits for active-duty service members with PTSD, depression, and substance use disorder were coded as video visits (Hepner et al., 2023), in contrast with the higher prevalence of audio visits in direct care. However, inconsistencies in how VBH visits were coded made it difficult to discern the actual proportion of video versus audio visits among TRICARE-contracted private-sector care providers (Hepner et al., 2023). Although more research is needed to parse trends in video and audio visits, indications from the literature on civilian health care settings suggest that VBH will continue to be used to deliver BH care in the future (Connolly, Miller, et al., 2022; Zhu et al., 2022).

Recent trends suggest a return to predominantly in-person care, particularly in direct care settings (Hepner, Sousa, et al., 2021; DoD, 2022c). Analyses of MHS administrative data showed an increase in in-person BH care and a corresponding decrease in VBH utilization beginning in July 2020 (Hepner et al., 2023; Reynolds, 2022). However, the MHS is continuing to build its infrastructure to facilitate the use of VBH in the future. In a 2022 report to Congress, DoD identified VBH as one of several key priorities for leveraging virtual health and noted that the MHS

FIGURE 2  
Virtual Behavioral Health as a Share of Military Health System Behavioral Health Appointments Before and After the Onset of the COVID-19 Pandemic

**VBH as a share of BH appointments prior to the onset of the COVID-19 pandemic**



**VBH as a share of BH appointments immediately following the onset of the COVID-19 pandemic**



SOURCE: Hepner, Sousa, et al., 2021.

NOTE: The figure shows rates of VBH use across direct care and private-sector care among service members with PTSD, depression, or substance use disorder in September 2019 and in April 2020 (immediately following the onset of the COVID-19 pandemic).

had rolled out a new systemwide commercial platform for video visits, MHS Video Connect, to all MTFs in June 2022 (DoD, 2022c). This platform was designed to be integrated into MHS GENESIS, a new electronic health record system, which is also being deployed to MTFs (Reynolds, 2022; Sanchez Bustamante, 2022). The report also included a discussion of MHS efforts to develop standardized workflows and training in virtual health care delivery and guidance on what health conditions are appropriate to treat using virtual health (DoD, 2022c). It outlined several initiatives to expand the use of VBH, including the Virtual Medical Center, which provides operational support for VBH and Telebehavioral Health Hubs staffed by providers who are available for VBH visits (DoD, 2022c).

In summary, the available evidence suggests that VBH is an effective means of delivering BH care for most conditions and patient populations. Patient experiences with VBH are generally positive. However, there is still work to be done to ensure that increased VBH use does not exacer-

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There is still work to be done to ensure that increased virtual behavioral health use does not exacerbate existing disparities.

bate existing disparities. The increased use of VBH is likely to remain a fixture of BH care delivery in civilian settings, and there is much potential for VBH use to be expanded within the MHS.

## Strategies to Address the Challenge

The MHS has dramatically expanded the delivery of VBH since the onset of the pandemic. We describe two potential strategies related to VBH to improve BH care.

### Develop an Implementation Plan and Training Strategy for Virtual Behavioral Health in Direct Care

Given evidence that video visits comprise a smaller proportion of coded VBH visits in direct care relative to private-sector care settings (Hepner, Sousa, et al., 2021), it could be useful to develop a specific implementation plan and training strategy to support VBH use in direct care settings. DoD published a strategic plan for enhancing the use of virtual health care in direct and private-sector settings in 2017 (DoD, 2022d). The plan included expansion of VBH in direct and private-sector care settings by offering VBH appointments that service members could attend from home—a particular benefit to those in underserved areas far from MTFs (DoD, 2022d). More recently, DoD identified VBH as a priority for the MHS that would spur an expansion of its virtual health capabilities and potentially help address geographic BH provider shortages (DoD, 2022b; DoD, 2022c). This is consistent with the provision in the FY 2023 NDAA “to expand access to behavioral health care under the military health system using telehealth” (H.R. 7900, 2022b). To further support the expanded use of VBH, the MHS might consider developing an implemen-



tation plan and training strategy that is specific to VBH. Such a plan could build on and serve as a unifying document for existing efforts while identifying goals and a strategic vision for VBH. In this way, it could help ensure that MTF leadership and BH administrators and providers are prepared to integrate VBH into care delivery.

A comprehensive VBH implementation plan would address the technical and administrative aspects of VBH, workforce training, and guidelines for clinical practice. It would ideally specify minimum requirements for equipment (e.g., computer and webcam) and infrastructure (e.g., broadband capacity) alongside recommended software platforms (e.g., MHS Connect). The plan could also outline which segments of the BH workforce should receive equipment and training and stipulate required competencies for different roles. To ensure consistent implementation, it is important to document clear policies with respect to the clinical management of VBH (Turvey et al., 2013). Thus, a VBH implementation plan could outline processes for verifying and documenting a patient's location during a visit, give guidance for obtaining informed consent (e.g., discussing risks and limitations), and offer guidelines for determining the clinical appropriateness of VBH. It could also include protocols for emergency management and workflows for communication and care coordination (Hepner, Sousa, et al., 2021; Shore et al., 2018; Turvey et al., 2013). Guidance to address risk mitigation for specific clinical issues could be part of a DHA procedural instruction or other formal guidance document. Guidelines for licensure, credentialing, and the provision of VBH across state lines should be clearly stipulated (Heyworth et al., 2020; Shore et al., 2018). This material could also be incorporated into the VBH clinical training curriculum. Implementation

guidance might also indicate the variety of care models involving VBH that might be used (e.g., VBH provided to service members located in their homes or while deployed, existing models in which VBH connects providers at one MTF to a service member at another MTF) and the available infrastructure for each type. Finally, although this strategy focuses on direct care BH providers, it could also be useful in developing a comprehensive VBH implementation plan for private-sector BH care.

### Clarify Coding Guidance to Improve Coding Practices for Video and Audio Visits

Continued assessment of VBH requires accurate measurement of video and audio visit use in direct and private-sector settings, which is not possible if these types of visits cannot be distinguished in MHS administrative data. Given evidence of possible differences in patient experiences with different modalities, it will be important to accurately track video and audio visits to assess patient experiences with VBH. Accurate visit data are also a prerequisite for monitoring quality and BH outcomes.

Previous RAND research identified inconsistencies in MHS and TRICARE provider guidance on VBH, including how synchronous virtual health was defined and how visits were coded in direct and private-sector care settings (Hepner et al., 2023). The term *synchronous* as used most often in MHS guidance required both audio and visual telecommunication, and visits were to be documented with specific modifiers added to the code describing the modality used for the visit. There was separate coding guidance for documenting audio (telephone) visits. However, in some TRICARE documentation, the term *synchronous* was defined more broadly as “two-way

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Efforts to standardize coding practices should start with the provision of clear guidance to direct and private-sector providers on how to code virtual behavioral health visits.

communication in real-time,” without reference to a video requirement, but used the same synchronous virtual health code modifiers (i.e., modifiers specified for video visits in MHS guidance) (Hepner et al., 2023). TRICARE guidance on coding for telephone visits was not consistently provided. As a result, it is unclear how frequently each VBH modality was used in direct and private-sector care settings (Hepner et al., 2023).

Efforts to standardize coding practices should start with the provision of clear guidance to direct and private-sector providers on how to code VBH visits (Hepner et al., 2023). Such guidance should establish definitions and codes for distinguishing between video and audio visits that are consistent across direct care and private-sector settings. In response to the increased use of VBH since the

onset of the pandemic, the Centers for Medicare & Medicaid Services added to two virtual health code modifiers to identify the use of audio visits starting in January 2023 (American Psychological Association, 2022).<sup>5</sup> The MHS might want to incorporate the use of these modifiers into its coding for VBH services. Providers might also benefit from training or additional resources to help them apply this updated coding guidance. The dissemination of clarified coding guidance might also result in improved data quality and standardization across the MHS.

## Research to Inform Solutions

In this section, we highlight three potential areas for future research on the use of VBH in the MHS.

### Assess Technology and Clinical Training Needs for Delivering Video Visits

Evidence suggests that video visits might be underused in direct care and that most VBH delivered in direct care settings has consisted of audio visits (DoD, 2022d). Assessing the reasons for this could help the MHS better integrate VBH into care delivery. Preliminary evidence suggests that military BH providers lack the equipment, technology (software), and technical support to provide video visits (Hepner, Sousa, et al., 2021). Providers also described a need for clinical training on VBH use. There has not been a thorough examination of the barriers that military BH providers face in delivering video VBH. A survey of direct care BH providers across service branches could document the scope of technology and training needs, along with other barriers that have prevented broad, sustained implementation of VBH. Such a survey might also assess

providers' willingness or comfort in delivering video visits and inform the development of training materials or additional guidance to address provider concerns. Survey implementation could also be paired with a request to MTF leadership to identify BH providers in need of equipment for video visits to help inform resource allocation.

### Evaluate the Effectiveness of Virtual Behavioral Health in the Military Health System

While available evidence provides support for VBH, there have been few large-scale studies with military populations. Furthermore, studies have typically focused on comparing VBH with in-person care. Although these studies were helpful in clarifying the effectiveness of VBH, they do not adequately capture the hybrid model that many patients will receive in the future (i.e., a mix of VBH and in-person BH care). Thus, additional research is needed to evaluate the long-term effectiveness of VBH, including BH care quality and patient outcomes, for service members. Comparisons of service members who receive in-person care only, VBH only, or a mix of VBH and in-person care could help the MHS determine whether these models of care delivery offer equivalent levels of quality and promote positive outcomes. Given that audio visits are the dominant modality in direct care settings, research could evaluate the comparative effectiveness of audio versus video or in-person BH care visits for delivering different types of treatment (e.g., psychotherapy and medication management). The use of administrative treatment data for audio versus video visit comparisons depends on accurate coding of the modality used, which depends on the development and dissemination of updated coding guidance to all MHS providers.

### Evaluate the Role of Virtual Behavioral Health in Supporting Continuity of Care for Service Members Who Transfer to a New Location

VBH might have the potential to support care continuity for service members who relocate for a permanent change of station or deployment. With each relocation, service members who receive BH care need to reestablish care with a new BH provider or go without care. This process can be time consuming and might result in disruptions in care if not completed promptly. It might also be costly or inefficient for the MHS to facilitate the transition of BH care from one direct care treatment setting to another, particularly if the service member is nearing completion of a time-limited course of treatment (e.g., an eight-week course of psychotherapy). Future research could examine how VBH could support continuity of care for these service members. Qualitative interviews with military BH leaders could identify how VBH has been leveraged to support continuity of care at individual MTFs and be used to assess the feasibility of an expansion of those programs. A pilot study could involve evaluating the use of VBH to provide continuing care for a time-limited period (e.g., up to six months) to service members undergoing a transition, assigning a cohort of service members to receive either transitional VBH care or usual care (e.g., providing guidance to a service member on how to reestablish care at their new location). The evaluation could assess utilization and costs and compare process and outcome measures for the two groups.

## **Focus on Quality of Behavioral Health Care Delivered by Private-Sector Providers**

The MHS carefully monitors the quality of BH care at MTFs; however, less is known about the quality of care that is delivered by TRICARE-contracted providers. In this section, we review the increasing use and costs of private-sector BH care in the MHS, evidence of variations in the quality of direct versus private-sector care, the need to monitor the quality of both sources of care, and some challenges related to the effort to do so.

### **The Use of Private-Sector Behavioral Health Care and Its Associated Costs Have Been Increasing**

Private-sector care now accounts for a majority of MHS costs, and that share continues to increase. Over just three years (FY 2019–FY 2021), the proportion of total MHS health care expenditures attributable to private-sector care increased from 56 percent to 59 percent. Direct care outpatient encounters during the same period decreased by 4 percent, compared with a 3 percent increase for private-sector care (excluding care for retirees) (DHA, 2022). Most costs for TRICARE enrollees with an MTF-based primary care manager (that is, those who received primary care from an MTF) were associated with private-sector specialty care. A significant proportion of this private-sector care was BH specialty care. Among all TRICARE Prime beneficiaries in FY 2021,<sup>6</sup> the average number of annual outpatient BH encounters per enrollee was 1.78 in the MHS, compared with just 1.46 for civilians enrolled in employer-

sponsored health maintenance organization (HMO) plans (DHA, 2022). Following this pattern, a significant proportion of BH care for active-duty service members is private-sector care. For depressive and anxiety disorders, the ratio of encounters in private-sector to direct care was 4.3:1 and 3.9:1, respectively (DHA, 2022).

### **The Quality of Behavioral Health Care Delivered by Private-Sector Providers May Be Lower**

The MHS seeks to provide service members with high-quality care that is safe, timely, effective, efficient, equitable, and patient- and provider-centered (DHA Procedural Instruction 6025.13, 2019). To this end, it employs an integrated framework to objectively define, measure, assess, and report the quality of care delivered (DHA Procedural Instruction 6025.13, 2019). As a part of this effort, VA and DoD have created a set of evidence-based clinical practice guidelines (CPGs) to assess and manage chronic diseases, women's health conditions, pain, BH, and other common conditions. The BH CPGs specifically address the risk of suicide, PTSD, depression, and substance use disorder (VA, 2023). Although there is mandated monitoring adherence to CPGs (Pub. L. 114-328, 2016), a 2021 GAO report noted that the MHS lacked a systematic process to monitor MTFs' implementation of CPGs (Draper, 2021).

The MHS can use quality measures to monitor providers' use of CPGs and verify that they deliver care that is concordant with what the CPGs recommend. However, there is no common set of quality measures to assess both direct and private-sector care. A 2018 GAO review found little overlap in the quality measures used to assess direct

and private-sector care, and only one measure assessed BH care. In response, the GAO recommended prioritizing one set of quality measures that was appropriate for both care settings, along with a common set of performance standards and corrective action requirements (Silas, 2018). That same year, DHA implemented a strategy to monitor BH treatment and outcomes, particularly for PTSD, depression, and substance use disorder (DHA Procedural Instruction 6490.02, 2018). Relevant measures focused on the proportion of patients with newly diagnosed PTSD or depression who receive three or more follow-up visits within three months and the regular use of standardized tools to assess patient-reported symptom severity (DHA, 2022; DHA Procedural Instruction 6490.02, 2018). In a subsequent procedures manual, DHA emphasized that the MHS's clinical quality management effort applied to the entire MHS, including MTFs and all other health care provided by the MHS (DHA Procedural Instruction 6025.13, 2019).

Little data exist on the quality of BH care provided by TRICARE-contracted private-sector care providers. Using FY 2021 TRICARE data, the MHS reported that for a measure of follow-up within 30 days of a mental health hospitalization, rates for the MHS overall (combined direct and private-sector care) and for MTFs specifically (direct care) were 83.1 percent and 89.2 percent, respectively. Although those rates exceeded the national 90th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS), it is clear that private-sector care is pulling down the MHS average.<sup>7</sup> Specifically, the rate for private-sector care was only 63.2 percent, below the HEDIS 50th percentile; as Figure 3 shows, this represents an improvement over recent years (DHA, 2022). In contrast, the rate for civilian

HMOs in 2020 was 70.2 percent (National Committee for Quality Assurance, undated).

Analyses of care provided at VA facilities show a similar pattern of higher quality in government-operated settings. A 2016 study of the quality of medication treatment for mental health disorders, assessed across seven quality measures, showed that VA performance was superior to the private sector by more than 30 percent (Watkins et al., 2016). A review of published studies comparing the quality of VA care and non-VA care (not distinguishing between BH and non-BH care) found that VA outpatient care quality was better on almost all quality measures, and quality performance was better on average when compared with commercial, Medicare, and Medicaid HMOs. However, comparison of access, cost and efficiency, and patient experience between the two systems of care has been less well studied (Apaydin et al., 2023).

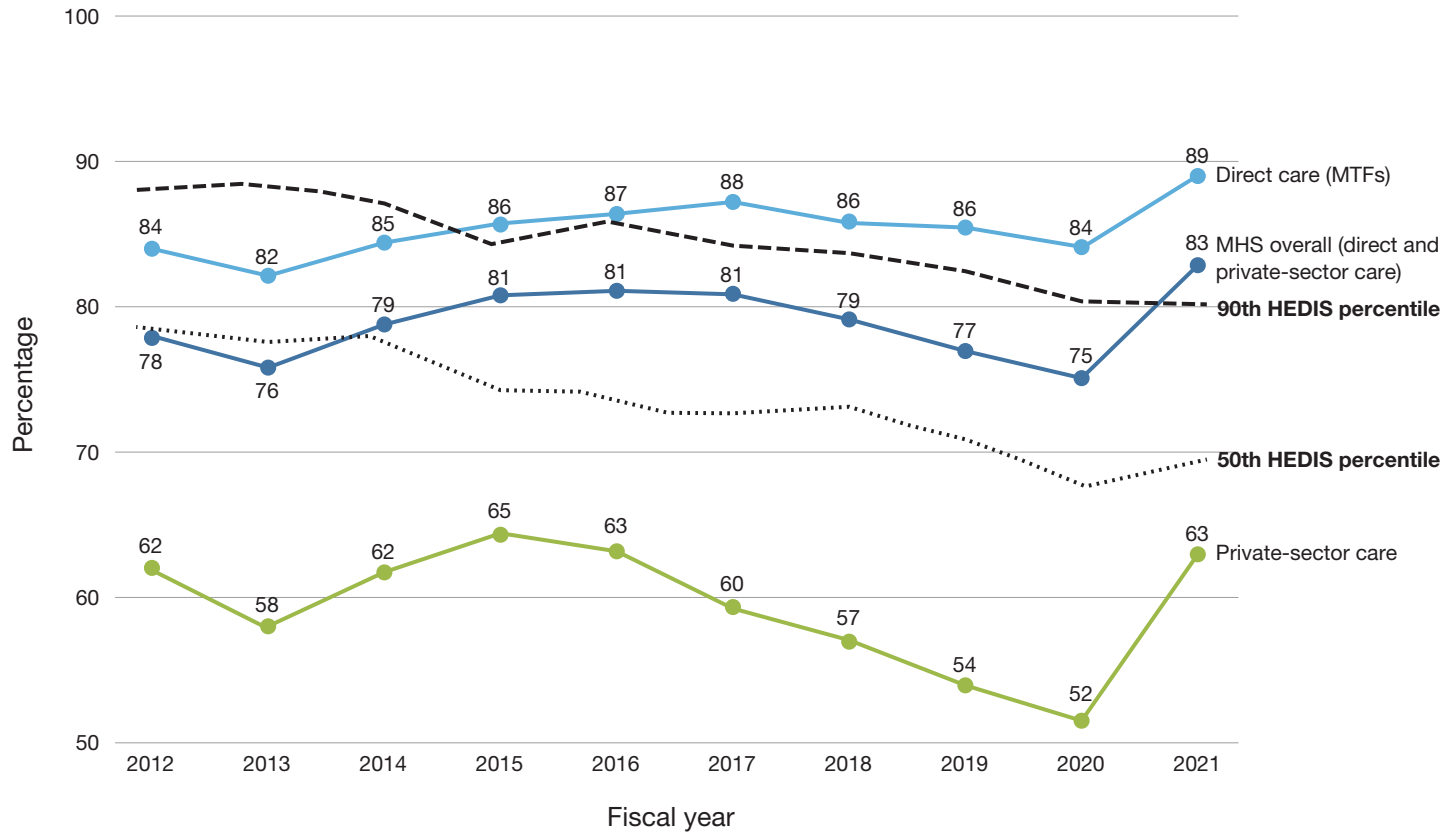
Although there are limited data and few relevant comparisons to evaluate the quality of care delivered by private-sector providers, these data suggest that private-sector providers might be less likely to deliver care consistent with CPGs. They also indicate the need to more diligently monitor the quality of care provided to TRICARE beneficiaries in the private sector.

### **It Is Difficult to Monitor the Quality of Behavioral Health Care Provided in Private-Sector Care**

Private-sector care continues to be a significant source of BH care for service members and other TRICARE beneficiaries. However, the MHS faces several challenges in monitoring the quality of care provided in these settings.

FIGURE 3

Compliance with 30-Day Follow-Up Care Guidance After a Mental Health Hospitalization, by Care Setting



SOURCE: Adapted from DHA, 2022, p. 126.



## Available Data on Direct and Private-Sector Care Are Not the Same

DHA has been expanding the use of the Behavioral Health Data Portal (BHDP) at MTFs, allowing it to collect patient-reported BH symptom data and monitor patient outcomes (DHA Procedural Instruction 6490.02, 2018). There is no comparable outcome-monitoring program for private-sector providers, and data reporting requirements are not consistent between direct and private-sector care. For example, for patients with PTSD or major depressive disorder, DHA policy directs MTF providers to monitor patient outcomes using specific questionnaires at the baseline and every four weeks. TRICARE policy requires private-sector providers to document those same outcomes at baseline, every 60 days, and at discharge (DHA Procedural Instruction 6490.02, 2018; DoD Inspector General, 2020; MHS, 2022b). Managed care support contractors oversee the private-sector contracts and the contracted providers. It is unclear how to balance reporting contract requirements against the added perceived burdens of quality reporting.

### Data Sources Have Limitations

While quality measures based on administrative data are highly feasible to monitor routinely and are available for both MTF and private-sector providers, these data might have coding errors or not include all of the information of interest (e.g., the type of psychotherapy received). Quality measures can also be computed using care quality review of unstructured notes contained in the medical record; however, these data are accessible only for care delivered at MTFs. When RAND researchers studying service members

with PTSD or depression examined MTF administrative data, they found that 56 percent and 74 percent of patients beginning a new treatment episode for depression and PTSD, respectively, received at least some psychotherapy within four months. However, a review of the notes in patients' medical records revealed that only 30 percent and 45 percent, respectively, received evidence-based psychotherapy. The review also provided data about suicide risk assessments and appropriate follow-up (Hepner et al., 2017). Similarly detailed information is not available for private-sector care.

### Behavioral Health Care May Involve Multiple Sources of Care

Depending on the BH condition and time span of treatment, a service member might receive care from both direct and private-sector care providers. This can complicate transparency and accountability when it comes to the overall quality of the care provided. A service member might see providers at an MTF and in private-sector care settings over a period of weeks or months, increasing the complexity of assessing the quality of the care received. There is no way for the MHS to easily monitor care received across multiple settings that do not share a common medical record.

### Data on Access to Private-Sector Care Are Incomplete

MTFs use a centralized appointment system that makes it easier to assess measures of access to care (e.g., average appointment wait times). There is no comparable means of directly assessing access to private-sector care. It is also

unclear whether providers are taking referral times into account when measuring appointment wait times. It is much easier to enforce a standard at MTFs than across the vast MHS private-sector provider network (DoD Inspector General, 2020).

Some measures, such as patient satisfaction with access to MTF care, are reported publicly on the MHS website. However, maintaining updated directories of private-sector providers and tracking their compliance with contract requirements, including accreditation and efficient claims processing, is challenging. The MHS maintains several dashboards to update leadership and providers on selected performance measures related to strategic goals addressing efficiency, readiness, quality, safety, and other topics (DHA, 2022). There are plans to update the private-sector care dashboard with improved design and automation; the goal is to make existing clinical data measures available to better monitor care quality across the MHS (DHA, 2022). A Clinical Measure Data Improvement Integrated Product Team has been charged with improving the accuracy and completeness of data on the quality of care delivered by both direct and private-sector care providers. The team's work should increase transparency and make data collection and processing more efficient (DHA, 2022). However, this initiative is not specific to BH care.

### **It Is Difficult to Apply Military Health System Behavioral Health Quality Measures to Private-Sector Care**

The MHS is implementing the BHDP across MTFs to facilitate monitoring of BH outcomes, and TRICARE reports annually on PTSD and major depressive disorder symptom improvement or remission for direct care (DHA,

2022). These and other variations in data collection on direct versus private-sector care emphasize the need to align outcome-monitoring requirements using standardized tools across settings to facilitate public reporting of these data (DoD Inspector General, 2020). The MHS is taking steps to write new data reporting requirements in its contracts with private-sector care providers. For example, it began requiring these providers to more systematically monitor patients with depression who have been prescribed antidepressants beginning in 2023 (DoD Inspector General, 2020). BH-related measures that use a common data source that could be reported separately by source for direct and private-sector care include high daily dose opioid prescriptions, dual prescriptions for an opioid and benzodiazepine, the number of beneficiaries on long-term opioid therapy, and high-risk patients who have been prescribed opioids and the emergency overdose reversal agent naloxone (DoD, 2021).

## **Strategies to Address the Challenge**

### **Report Behavioral Health Quality Measures Separately for Direct and Private-Sector Care**

The MHS publicly reports performance results for some BH care quality measures for direct care and some for both direct and private-sector care combined. Stratifying this public reporting by source of care could increase transparency and help the MHS identify areas for improvement. Candidate measures for stratified reporting include additional HEDIS BH measures, treatment dosage, and opioid prescribing. As noted, DHA agreed to add new reporting requirements to its TRICARE network contracts starting in 2023, including ensuring that its contracted private-sector

care providers adhere to the same standards as direct care providers when it comes to antidepressant medication management for patients with depression. Going forward, the MHS should strengthen its efforts to monitor BH care quality by reporting results for this measure separately for direct and private-sector care and additionally by beneficiary category.

As of this writing, DHA reports for MTFs the percentage of patients with a new diagnosis of PTSD or depression who receive at least three follow-up appointments within 90 days. Although this level of care is not considered optimal by CPGs for these conditions, this frequency of follow-up visits has been associated with better outcomes in Army studies compared with fewer than three visits (DHA, 2022). The recommended treatment for a new diagnosis of PTSD or depression would likely involve weekly therapy visits or monthly medication management visits (DHA, 2022; DoD Inspector General, 2020), and four psychotherapy visits or two medication management visits within eight weeks would be in line with the CPGs and prior RAND study findings (Hepner et al., 2017; Hepner, Brown, et al., 2021). Collecting and reporting equivalent data on visit frequency for both direct and private-sector care would facilitate an assessment of the quality of follow-up care across the MHS for service members who initiate care for a new PTSD or depression diagnosis, and these data could inform changes to clinical practice.

Similarly, the MHS monitors several measures related to opioid prescribing. Prior RAND analyses of MHS data identified some potential differences between direct care and private-sector providers in postprocedure opioid prescribing practices (Hepner, Roth, et al., 2022). Stratifying opioid prescribing measures by direct and private-sector

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Stratifying opioid prescribing measures by direct and private-sector care could help the Military Health System identify opportunities to standardize these practices.

care could help the MHS identify opportunities to standardize these practices.

### Evaluate Outcome Data from Private-Sector Providers as a Source for Quality Measurement

The MHS reports measures of improvement or remission for patients with PTSD or depression who are treated at MTFs using patient symptom data from the BHDP (DHA, 2022). There is no similar centralized system for collecting and reporting symptom data for MHS beneficiaries who receive private-sector care, although these TRICARE-contracted providers are required to document standardized outcome measures for PTSD and depression at the baseline, every 60 days, and at discharge (DoD Inspector General, 2020). The MHS could examine the complete-

ness and quality of these data to determine their utility for reporting treatment outcomes. For example, are all providers reporting outcome measures at the required intervals? Are outcomes reported only as total scores, or are providers reporting responses to each item? If the MHS encounters challenges acquiring the data it needs to assess patients' treatment outcomes, DHA could add requirements for improved data documentation to its private-sector provider contracts. The ability to consistently track outcomes for service members with PTSD and depression across both direct and private-sector care settings would greatly enhance the evaluations of BH care quality.

## Research to Inform Solutions

Several questions remain when it comes to the best strategies to ensure that private-sector providers deliver high-quality BH care to service members. We identified three promising areas of research that could inform longer-term MHS efforts to monitor care quality and identify areas for improvement.

### Identify Practices and Preferences of Private-Sector Behavioral Health Providers

In the MHS, direct care providers function within a large, integrated system of care. This structure provides some support that is not necessarily available in the private sector, such as a process for disseminating evidence-based CPGs for commonly treated conditions, a central electronic health record system, provider decision support tools, and standardized provider training to help ensure that providers deliver high-quality care. It is possible that private-sector providers have less of this type of support, and they

might also be less familiar than providers at MTFs with the needs of service members and their dependents. A survey of TRICARE network providers could provide insight into their approaches to treating BH conditions, their use of evidence-based treatment, and their awareness of issues related to military culture. It could also identify challenges they encounter in sharing data with direct care providers and ensuring continuity of care for patients who see both provider types. Finally, such a survey could give the MHS a clearer picture of providers' perceptions of their contract relationship with TRICARE as a means to better understand what levers might be used to support providers in improving care while also minimizing reporting burden to support their willingness to contract with TRICARE.

### Assess Private-Sector Care Appointment Availability

It could be useful to assess the availability of BH appointments in private-sector settings using a secret-shopper approach or an audit study evaluating differences in reported and actual appointment availability. Also referred to as *simulated patient* or *standardized patient studies*, audit studies are a method of systematic data collection by direct observation. Members of a research team receive training in a standardized patient protocol so that they can systematically pose as patients seeking health care or other services and record the outcome of each interaction. Audit programs have long been used in retail settings to evaluate customer experience or to assess competition (GreenBook Directory, undated; Heskett et al., 2008). In health care, this methodology has been used to evaluate access to services by veterans facing homelessness (Weiner et al., 2022), the availability of appointments for Medicaid beneficiaries

(Hsiang et al., 2019), the quality of patient-centered care (Zabar et al., 2014), and the accuracy of visit documentation in primary care settings (Weiner and Schwartz, 2014). With respect to BH, audit studies have been used to assess opioid use disorder treatment access (Beetham et al., 2019; Wong et al., 2021) and the availability of new patient BH appointments (Tenner, Reddy, and Block, 2023). One of the advantages of audit studies is that they can be designed to reveal differences in access or quality for different patient populations—differences that might be difficult to detect through other data sources (Rankin et al., 2022; Rhodes and Miller, 2012). Such a study would have many benefits, such as helping the MHS identify access barriers for service members and other TRICARE beneficiaries who are referred to private-sector BH care.

### **Examine the Distribution of Behavioral Health Care by Source of Care and Quality to Inform Quality Improvement and Optimal Care Coordination**

BH treatment can span multiple providers and sources of care, making it difficult to attribute accountability for the quality of the care provided. Given existing evidence of differences in the quality of care in direct versus private-sector care settings, the MHS would benefit from a clearer understanding of how BH care is delivered by these two sources. Understanding the patterns of care for BH conditions could shed light on how TRICARE BH care is distributed and how this distribution affects the need for shared data and coordination of care. This analysis could also identify quality issues associated with the source of care in cases in which care came primarily from a single source that could inform future quality improvement efforts.

## **Prioritize Racial and Ethnic Equity in Behavioral Health Care**

Ensuring racial and ethnic equity in BH care delivery and outcomes is a policy priority (Biden, 2021; Centers for Medicare & Medicaid Services, 2023), and DoD has made a commitment to ensuring racial and ethnic equity in care (DoD, 2022a). Research on differences in care experiences and outcomes by race and ethnicity can expose how bias, racism, and inequity play out among populations (Flanagin et al., 2021). Existing models, such as those disseminated by the VA Office of Health Equity (VA, 2023), include best practices to promote equitable care through transparency and improved communication.

Decades of literature have demonstrated pervasive racial and ethnic disparities in BH care access and outcomes (Alegría et al., 2016; Cummings et al., 2014; Smedley, Stith, and Nelson, 2003; Lê Cook et al., 2017). The limited improvement in reducing disparities over time highlights

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Decades of literature have demonstrated pervasive racial and ethnic disparities in behavioral health care access and outcomes.

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Research has revealed disparities in the quality of health care that racial and ethnic minority patients receive in civilian settings, as well as in their treatment outcomes.

the need for innovative, evidence-based solutions (Alegría et al., 2016). Issues related to poor access to care (Agency for Healthcare Research and Quality, 2015), including workforce shortages (Erikson et al., 2022; Jackson and Gracia, 2014; Kaiser Family Foundation, 2022), stigma (Quartana et al., 2014; Rao, Feinglass, and Corrigan, 2007), and concerns around trust and privacy (Campbell and Long, 2014; Hwang et al., 2008), have contributed to disparities in care and potentially poorer outcomes for racial and ethnic minority patients in both the civilian and military contexts. Poor outcomes in BH care have spillover impacts on other aspects of health and well-being, including negative impacts on physical health, well-being, and military readiness and retention (Hepner, Roth, et al., 2021).

## **Racial and Ethnic Minority Service Members Make Up a Significant Share of the Military**

Racial and ethnic minority group service members represent a significant and growing share of the U.S. military population (43 percent in 2017) (Barroso, 2019). Compared with the U.S. population, White service members are overrepresented in all branches besides the U.S. Navy (Council on Foreign Relations, 2020). Black service members in the Army and Hispanic service members in the Marines are overrepresented among all service members in the branch (Council on Foreign Relations, 2020). Research has revealed disparities in the quality of health care that racial and ethnic minority patients receive in civilian settings, as well as in their treatment outcomes. It is important to determine whether there are similar trends in the MHS and, if there are, to address them swiftly. Black and Hispanic service members are overrepresented in lower enlisted ranks, while officers are more likely to be White and male (Council on Foreign Relations, 2020). This could have implications for racial and ethnic differences in BH care access and quality. For example, enlisted service members tend to be younger and might be more likely to deploy than officers; this could mean that they face greater barriers to accessing BH care.

Racial and ethnic minority group service members also face a greater lifetime risk of exposure to trauma, racism, and discrimination (Kessler, Mickelson, and Williams, 1999; Roberts et al., 2011; Williams et al., 1997). Extensive literature has implicated these risk factors in the development of BH conditions in civilian populations (Center for Substance Abuse Treatment, 2014; Kleber,



2019). Research further suggests that population-level differences in the accumulation of stressors might result in differences in the risk of experiencing a BH condition after an individual leaves military service (McClendon et al., 2019; Nichter et al., 2020; Roberts et al., 2011). For example, a study of recently separated veterans who served in Iraq and Afghanistan found higher rates of PTSD among Black, Hispanic, and multiracial veterans than among White veterans (McClendon et al., 2019). The accumulations of these stressors and the introduction of new stressors for those exposed to combat could exacerbate the existing mental and physical health burdens of military service for racial and ethnic minorities.

### **Service Members from Racial and Ethnic Minority Backgrounds May Face Unique Barriers to Accessing Behavioral Health Care**

In some respects, service members face fewer barriers to accessing BH care than civilians. Service members receive health care coverage through the military and, because of this coverage, tend to face fewer access challenges related to cost. This difference might be particularly important for racial and ethnic minority service members, who are more likely to have a lower socioeconomic status than their White counterparts prior to joining the military (Lee, Liang, and Shi, 2021). Previous literature notes that service members of all races and ethnicities report similar access to most forms of routine medical care (Bagchi et al., 2009; Changoor et al., 2018).

However, there is still a need to assess whether there are racial and ethnic differences in access to BH care in the

MHS, including in private-sector care. Research involving service members is limited, but studies of civilian populations indicate that patients from racial and ethnic minority groups might prefer providers with similar experiences and backgrounds (Malat and Hamilton, 2006) because they perceive these providers as having a better understanding of their needs and a greater ability to provide culturally competent care. Race concordance might also be associated with improved patient-provider communication (Shen et al., 2018). The relative lack of diversity in BH providers exacerbates challenges in accessing care in civilian populations, given that there is already a shortage of BH providers. An inability to access providers who can provide culturally competent care might lead patients to discontinue recommended care or not seek care to begin with.

Other research in civilian settings has shown that patients from racial and ethnic minority backgrounds might also be less likely than White patients to receive care that aligns with their preferences. For example, Black and Hispanic patients are more likely to prefer psychotherapy over medication (Cooper et al., 2003). Although both psychotherapy and medication treatment are often recommended as first-line treatment options, accessing psychotherapy is typically more difficult than accessing medication treatment, given that psychotherapy is considered specialty BH care. Racial and ethnic minority patients also report being discouraged from accessing BH care more often than their White peers. For example, civilian Black women seeking BH care reported concerns about provider professionalism (Thompson et al., 2011) and fear of harming the relationship with their provider (Poleshuck et al., 2013). Mistrust and concerns about disclosing health information outside close peer groups can further limit access to

services even when providers are available, highlighting a need for strategies to engage patient subpopulations in care beyond just making care available (Alang, 2019; DeCarlo Santiago and Miranda, 2014; Malat and Hamilton, 2006).

Measures of access to care, such as appointment wait times, can mask differences and inequities in seeking and receiving BH care. These measures do not capture unique barriers that discourage care-seeking or limit access, such as a lack of providers of similar backgrounds or who are culturally competent. These factors could reduce access and have a detrimental effect on BH outcomes among service members of racial and ethnic minority backgrounds.

### **Stigma May Be a More Prominent Barrier for Service Members from Racial and Ethnic Minority Backgrounds**

It is also important to identify and address racial and ethnic differences in perceived stigma among service members when it comes to BH care. In general, civilian literature has demonstrated that perceptions of stigma related to seeking BH care were higher among racial and ethnic minority populations than those of racial and ethnic majorities (Eylem et al., 2020) and might influence decisions to seek care. A 2016 GAO report found that 37 percent of service members felt that seeking mental health care would damage their careers, and that DoD is not well positioned to address issues with mental health care stigma (Farrell, 2016). In response, the Directive-type Memorandum 23-005 and Brandon Act have begun to codify a new process to reduce the stigma in mental health care-seeking among service members (Cisneros, 2023; MHS, 2023).

Hispanic and Latino patients in civilian settings have reported higher levels of self-stigma (the internalization of negative attitudes and perceptions of BH care or people who need BH care) and embarrassment about their mental health issues than patients of other racial and ethnic backgrounds (Wong et al., 2016). Among civilians, stigma has been shown to negatively affect all aspects of care—from care-seeking to choice of treatment options and treatment adherence (Knaak, Mantler, and Szeto, 2017). Stigmatization can exacerbate challenges that disproportionately affect populations from disadvantaged socioeconomic backgrounds, which include the cost of care, the knowledge necessary to find care, and the positive social connections that promote treatment adherence and better outcomes. Combined, these factors could pose significant barriers to access by reducing the desire to seek care or the willingness to continue care (Hatzenbuehler, Phelan, and Link, 2013). Similar effects can be seen in care delivery: An increase in stress related to stigma can also lead to poor care choices and negative behaviors to cope with BH conditions. Because there is so much variation in sources of stigma and their impact on care-seeking and care acceptance, it is difficult to take a one-size-fits-all approach to addressing and tackling these inequities.

Prior RAND research connected sources of stigma in the military to service members' BH outcomes, well-being, and readiness (Acosta et al., 2014). This study showed a decline in stigma over time, but service members who sought care still perceived higher levels of stigma. For service members, sources of stigma include military cultural attitudes toward seeking care, a lack of confidentiality for those who receive care, concerns about career prospects, and a belief that needing BH care is a sign of lower char-

acter strength (Kaplan, 2019). These concerns varied by rank, years of service, and service characteristics. Differences along these dimensions, particularly around rank, are unique to the military health context and should be considered a key source of potential disparities (Naifeh et al., 2016).

Although it has not been studied, the overrepresentation of Black and Hispanic service members among enlisted personnel (relative to officers) might mean that these service members face a greater risk of negative impacts on career progression associated with disclosing their BH treatment. There is a need for ongoing research on the implications of stigma for racial and ethnic minority service members' BH care and outcomes that are both shared with their civilian counterparts and unique to military service.

### **Racial and Ethnic Minority Service Members May Be at Risk of Receiving Poorer-Quality Behavioral Health Care**

Despite the extensive literature on race disparities in civilian BH health care settings, little attention has been focused on equity of access to BH care in the MHS. There is also limited research on the differences in BH treatment quality in the MHS by race and ethnicity. In one of the few such studies, RAND researchers used MHS data from 2013–2014 to generate stratified estimates of quality measures to assess differences in BH care access and quality by race and ethnicity (Hepner et al., 2017). Among those with PTSD or depression, Black and Hispanic service members were less likely to receive the recommended medication treatment than their White counterparts. A more recent

review of the literature similarly found some indication that treatment initiation and retention for PTSD among racial and ethnic minority populations is lower than that of White populations (McClendon, Dean, and Galovski, 2020). Black and Hispanic service members with depression were less likely to receive a short-term (12-week) or long-term (six-month) course of medication treatment. This finding was consistent with results from the civilian population, which revealed lower rates of short-term prescriptions and adherence to antidepressants among most

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There is a need for ongoing research on the implications of stigma for racial and ethnic minority service members' behavioral health care and outcomes that are both shared with their civilian counterparts and unique to military service.

non-White populations (Rossom et al., 2016; Waitzfelder et al., 2018).

The expanded use of VBH could have implications for the quality of BH care for service members from racial and ethnic minority backgrounds. For example, a study of care provided to civilians in New York found that higher social vulnerability was associated with more audio (and less video) virtual health care and more barriers to treatment. Among civilians, disparities in access to virtual health care by income, rurality, and English proficiency remain (Dixit et al., 2022). If racial and ethnic minority group service members are found to face greater barriers to accessing video visits compared with audio visits, this could have implications for the quality of care they receive and their experiences with VBH care.

In summary, there is a lack of literature on how inequities manifest in BH care among service members. Similar to the civilian population, racial and ethnic minority service members might face a greater risk of developing a behavioral health condition and might face greater barriers to accessing BH care than White service members. They might be more likely to perceive stigma in having a BH condition or seeking care for it, and they might have limited access to their preferred providers and types of care. Evidence of racial and ethnic differences in BH care quality is limited but suggests that racial and ethnic minority service members might be at risk of receiving lower-quality BH care.

## Strategies to Address the Challenge

A major limitation to addressing inequities is the lack of data on disparities in the military context. To that end, sev-

eral organizational models and frameworks can be applied to the MHS to improve understanding of potential disparities and begin developing metrics and standards to address them. The Centers for Medicare & Medicaid Services and the VA have both implemented models and frameworks to assess and address inequities in care. The framework in use for Medicare and Medicaid beneficiaries consists of a step-by-step process to tackle inequities by assessing data, applying performance measures, and targeting interventions (Centers for Medicare & Medicaid Services, 2023). Such a model could be adopted by the MHS, which has already developed standards for ensuring timely access to care and assessing care quality. Analyses using these same standards could help ensure that BH care in the MHS is consistently meeting access and quality standards across all racial and ethnic groups. In addition, we identified potential strategies that the MHS could consider to extend its efforts to ensure equity BH care delivery.

### Stratify Reporting by Race and Ethnicity

The MHS already tracks measures of BH care access and quality, and it could continue to support equity by using stratified approaches to assess how these measures differ across subpopulations of service members. Given the limited literature on how these factors interact with military service characteristics, including service branch, rank, and remote location, data should be stratified in these ways—as well as by race and ethnicity—to provide a clearer picture of where inequities might emerge.

Once data are available and measures are calculated in a stratified manner, it is important to develop performance measures that are specific to equity. These measures can be operationalized to evaluate differences across groups,

developing what would be minimum standards for acceptable differences or ensuring that all groups meet existing standards. Stratified analyses can help identify when a benchmark or standard is not achieved for particular groups that might be hidden when studying the service member population as a whole. Similarly, even if standards are being met, identifying differences between groups could help determine where certain groups struggle more than others and whether targeted efforts are needed to support those groups.

### Evaluate Where Differences Exist and Prioritize Areas of Improvement

Once data are stratified and differences are examined overall and between groups, including between direct and private-sector care, a formal prioritization process would help prioritize and target areas for improvement. Given the potential for multiple types of access and outcome inequities in BH care in the MHS, targeted efforts in areas where disparities are greatest or with the greatest potential impact on patient outcomes could lead to major gains in equitable care delivery. With systematic data collection and relevant measures in place to assess performance, the MHS could roll out interventions and policies to promote improvement, such as providing cultural competency training to help providers better engage minority patients in care.

### Research to Inform Solutions

Given the importance of supporting equitable BH care, the MHS would benefit from approaches that integrate principles of equity into research on military populations and their health care.

### Examine the Quality of Race and Ethnicity Data in the Military Health System

When studying equity issues, it is important to begin by assessing the quality of the data available on race and ethnicity. Concerns have been raised about the quality of race and ethnicity data available in the Defense Enrollment Eligibility Reporting System, the primary data system to track service member and other beneficiary information, and users cannot easily correct their race and ethnicity information. Without accurate and consistent data, it is not possible to assess the appropriateness of policies and differences in patient outcomes. Data should be assessed for completeness, ensuring that there are no gaps. If there are missing data, these omissions should not skew the dataset's representativeness of any specific race or ethnic group. Data should also be assessed for accuracy and—when combining multiple data sources—for consistency. If the data quality is poor, such tools as the RAND Bayesian Improved Surname and Geocoding approach could be used to impute race and ethnicity (RAND Corporation, undated).

### Fund Research on Equity in Behavioral Health Care Access, Quality, and Outcomes

Analyses of BH care access should include subgroup analyses that interrogate whether standards, quality, and other metrics of performance vary by racial and ethnic minority status. In some cases, subgroup analyses can identify hidden deficits even when standards are being met overall. These findings can be used for targeted interventions and ongoing studies of inequities to identify root causes.

## Assess the Need for Culturally Competent Care

One strategy that has been shown to be effective in providing equitable care through better patient population engagement is delivering culturally competent care (Institute of Medicine, 2010; Uniformed Services University, undated). Whether service members feel that the care they receive is culturally competent, and whether they experience barriers to accessing high-quality care or differences in outcomes because of a lack of culturally competent care, remain open questions. A survey of service members with a BH diagnosis or who receive BH care in the MHS could assess whether members perceive their source of care as culturally competent and whether that affects their ability to access care, their experiences once they receive care, and their desire to continue engaging with care. Such surveys could be supplemented by qualitative interviews with service members who have reported high and low levels of culturally competent care to examine potential differences and identify potential areas for improvement. These findings could inform the development of care standards from an equity-based perspective, the content of provider training on culturally competent practice, and BH provider recruitment.

## Conclusions

Meeting the BH needs of service members is essential to both the readiness of the force and individual well-being. There are significant opportunities to enhance BH care

in the MHS and expand the existing body of knowledge in four priority areas: access to BH care, the effective integration of VBH, the quality of BH care delivered by TRICARE-contracted private-sector care providers, and racial and ethnic equity in BH care. Addressing current research gaps and pursuing new lines of innovative, evidence-based research would provide the clarity that the MHS needs to inform and strengthen ongoing initiatives to improve BH care access and quality for service members and their dependents across care settings.

## Notes

- <sup>1</sup> TRICARE is DoD's health care program for service members, retirees, and their families.
- <sup>2</sup> *Encounters* represent receipt of such care as outpatient visits or inpatient stays. A single patient might account for multiple encounters.
- <sup>3</sup> The focus of this paper is on care delivered at MTFs and by private-sector providers; we do not discuss care in deployed environments or by embedded BH providers.
- <sup>4</sup> Although the term *synchronous* is often defined in MHS guidance as requiring both audio and visual communication, we use it more broadly to refer to any real-time communication between a provider and patient.
- <sup>5</sup> Code modifier 93 = synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system; code modifier FQ = audio-only services rendered in rural health clinics or federally qualified health centers.
- <sup>6</sup> TRICARE Prime is a type of TRICARE insurance plan; enrollment in this plan is required for active-duty service members (although other beneficiaries can enroll as well).
- <sup>7</sup> The HEDIS is a tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service.



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## About This Paper

Ensuring that service members have timely access to high-quality behavioral health (BH) care is a priority for the U.S. Department of Defense and essential to ensuring the health and readiness of the force. The Military Health System (MHS) provides health care to service members, their dependents, and military retirees, and the Defense Health Agency oversees health care delivery. To support the MHS in its mission, we highlight opportunities to improve the quality, access, and equity of BH care delivery: increasing access to BH care, ensuring the effective integration of virtual BH care, focusing on the quality of BH care delivered by private-sector providers, and prioritizing racial and ethnic equity in BH care.

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