BRIEF

SUPPORTING READINESS

Assessing the Quality of PTSD and Depression Care for Service Members

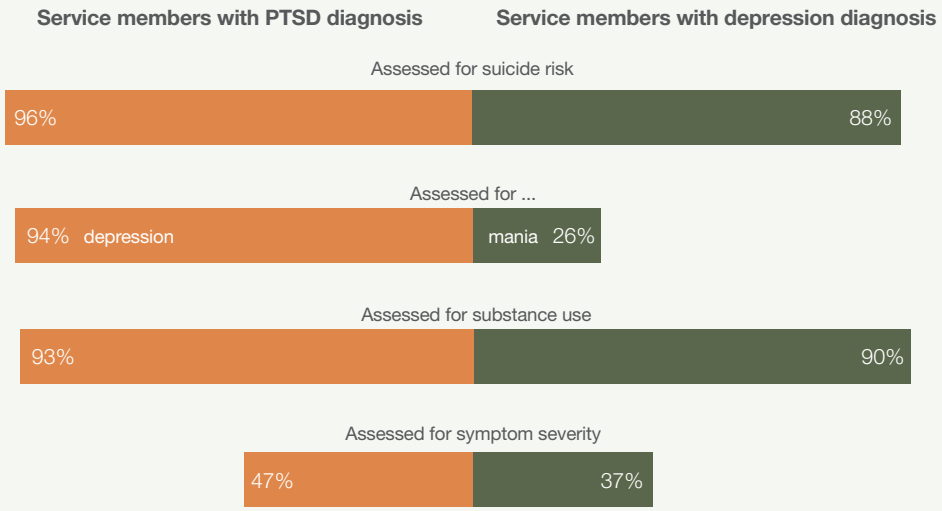
A healthy, mission-ready force depends on the physical and psychological readiness of every service member. Left untreated, posttraumatic stress disorder (PTSD) and depression can have a significant impact on force readiness. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, part of the U.S. Department of Defense's Defense Health Agency, asked the RAND Corporation to conduct a multiyear study of the care provided to service members diagnosed with these conditions and to recommend strategies to continuously improve the quality of psychological care provided to service members in the Military Health System (MHS). One of the largest studies of military mental health care ever conducted, this study offers the most complete picture to date of the characteristics of service members diagnosed with PTSD or depression, the quality of care they receive, and variations in care across the MHS.

RAND CORPORATION

The MHS excelled at ensuring that service members with PTSD or depression were appropriately assessed for suicide risk and co-occurring psychiatric conditions

The RAND study found that most service members with PTSD or depression received appropriate assessment when they started a new episode of treatment. More than 90 percent of service members with PTSD were assessed for suicide risk and co-occurring depression or substance use. Rates of appropriate assessment were also high for service members with depression. Nearly 90 percent were assessed for suicide risk, and 90 percent were assessed for recent substance use. However, only around one-quarter of service members who were diagnosed with depression were assessed for manic symptoms, suggesting that this is an area for improvement. The study found that fewer than half of service members with PTSD or depression were assessed for the severity of their symptoms using a standardized measure—a key strategy in tracking whether service members are getting better.

MOST SERVICE MEMBERS WITH PTSD OR DEPRESSION RECEIVED RECOMMENDED ASSESSMENTS, BUT FEWER WERE ASSESSED FOR SEVERITY OF SYMPTOMS



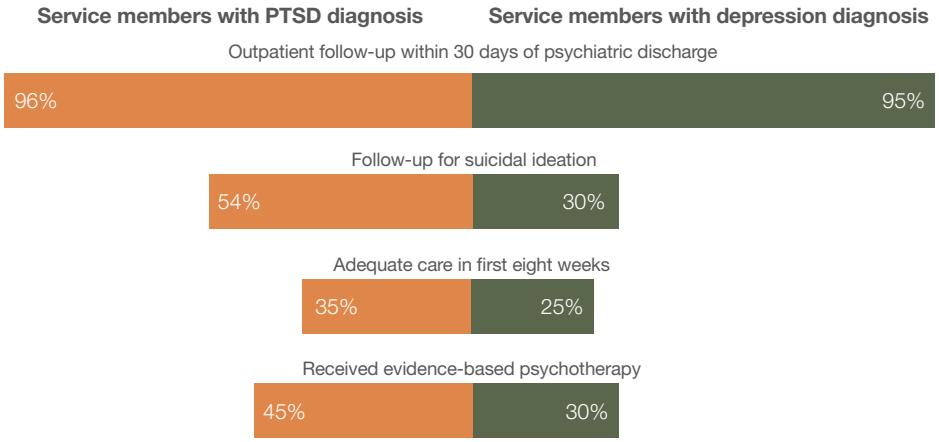
ASSESSING CARE QUALITY

Clinical practice guidelines describe how to treat patients with a given condition. These guidelines are based on the best available evidence, such as clinical trials, combined with expert judgment. Practice guidelines for PTSD and depression specify how patients should be assessed when starting treatment and how they should be treated during different phases of care, including recommending certain types of psychotherapy and medication. Quality measures are used to determine what percentages of patients received recommended care. They are an essential tool to understand how appropriately providers are caring for patients, and they can show which aspects of care need improvement. The study assessed the quality of care provided by the MHS between 2012 and 2014 using 30 quality measures designed to align with clinical practice guidelines, using data from administrative records, medical records, and symptom questionnaires.

The MHS can improve in providing recommended treatment for PTSD and depression

The MHS remains a leader in providing timely outpatient follow-up to service members who are discharged from a psychiatric hospitalization. More than 95 percent of service members with PTSD or depression received an outpatient follow-up visit within 30 days of discharge. However, the study also identified several key areas for improvement. While the MHS ensured that most service members who started a new episode of treatment for PTSD or depression were assessed for suicide risk, fewer received appropriate follow-up care when suicide risk was identified (54 percent and 30 percent among PTSD and depression patients, respectively). Further, fewer patients who were newly diagnosed with PTSD or depression received an adequate amount of initial care in the eight weeks following their diagnosis, defined as at least four psychotherapy visits or two medication management visits (36 percent and 25 percent for PTSD and depression, respectively). Among patients with PTSD who received psychotherapy, 45 percent received *evidence-based* psychotherapy. For patients with depression who received psychotherapy, 30 percent received cognitive behavioral therapy, an evidence-based technique shown to be effective for patients with depression.

NOT ALL SERVICE MEMBERS WITH PTSD OR DEPRESSION RECEIVED RECOMMENDED INITIAL AND FOLLOW-UP TREATMENT



The results suggest that, in general, care for PTSD is often better than care for depression in the MHS. However, the MHS improved slightly from 2012–2013 to 2013–2014 on most aspects of care that were measured. Although the study found no significant associations between receiving recommended care and improvements in patient symptoms over a period of six months for either PTSD or depression, more research is needed to explore the best approaches to improve patient outcomes. The largest variations in quality measure scores occurred by branch of service, region, pay grade, and age. For example, for both PTSD and depression, follow-up within seven days after a mental health hospitalization varied by around 15 percent across service branches. There was a 12-percent difference across regions in receiving a follow-up visit within 30 days after starting new medication treatment for PTSD. There was also significant variation by race/ethnicity and pay grade in whether patients received medication treatment for PTSD or depression for an adequate period of time.

It matters a great deal to me that we take care of wounded warriors. And the mental wounds are very real. We keep learning more about how to deal with this kind of illness, we're going to learn more, and we need to do more as we learn more. We owe it to these people.

—ASHTON CARTER
Secretary of Defense, in a January 2017 appearance on *Meet the Press*

RAND'S APPROACH

Data were drawn from three sources: administrative health care records of 38,828 active-duty service members who had a diagnosis of PTSD or depression in 2013; a random sample of medical records of service members who received treatment for these conditions from military treatment facilities; and symptom questionnaires completed by service members. RAND followed the care of the service members with a PTSD or depression diagnosis for a year, assessing the quality of the care they received and whether there were any disparities in care quality by branch of service, geographic region, or service member characteristics.

THIS BRIEF describes work done in the RAND National Defense Research Institute and documented in Quality of Care for PTSD and Depression in the Military Health System: Final Report, by Kimberly A. Hepner, Carol P. Roth, Elizabeth M. Sloss, Susan M. Paddock, Praise Iyiewuare, Martha J. Timmer, and Harold Alan Pincus, RR-1542-OSD (available at www.rand.org/t/RR1542), 2017. This research was sponsored by Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury within the U.S. Department of Defense.To view this brief online, visit www.rand.org/t/RB9946. The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND® is a registered trademark.

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RB-9946-OSD (2017)

The DoD is positioned to be a leader in providing high-quality, evidence-based care for PTSD and depression.

RECOMMENDATIONS

Ensuring that service members are properly assessed for symptoms of PTSD and depression—and that they receive recommended treatment—is essential to the health of the force. The study findings point to four focus areas for DoD efforts going forward.

1

FOCUS first on the areas most in need of improvement. While the study examined 30 aspects of care to identify key strengths and areas for improvement, quality improvement efforts will be most successful if specific, high-priority aspects of care are targeted for improvement.

2

EXPAND efforts to routinely assess and report on quality. This could be achieved by establishing an MHS-wide system for monitoring quality of psychological health care. Routine reporting on quality—on both MHS providers and other providers who treat service members—would increase transparency and incentivize quality improvement.

3

MONITOR treatment outcomes for service members with psychological health conditions. Tracking treatment outcomes is an essential component of measurement-based care. Implementing strategies to monitor patient outcomes across all facilities and providers and ensuring that providers are trained to integrate outcome information into their clinical practice should be top priorities.

4

INVESTIGATE the reasons for variations in care quality. It is important that health care is equitable across the U.S. military. However, the study showed variations in the quality of care received by service branch, region, and service member characteristics. Examining the reasons for these disparities would inform efforts to eliminate them.