The Impact of TRICARE and Its Influences on Social Change within a Behavioral Health Department

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Introduction

One hallmark of a modern civilized society is its commitment to healthcare for every citizen. Although the United States has made remarkable advances in the quality of its medicine as well as its medical delivery system, at the end of the 20th century, the future of healthcare delivery was still ambiguous. Today, millions of Americans, including children, are still without either health insurance or the financial resources to carry them through even minor health problems. "Health coverage is continuing to decline and the number of uninsured persons is rising at the rate of more than one million persons each year" (Andersen, Rice and Kominski, 1996, p. 41).

The following are some of the problems with contemporary healthcare: (1) many Americans cannot afford to buy health insurance, yet they cannot afford to be without it; (2) the redesign of healthcare delivery practices is the next evolution of the on-going effort to help healthcare agencies fulfill their mission in society; (3) the progress of society and healthcare has not meet societal needs, and an increased awareness of the planning dilemma confronting the world makes it necessary to assess the role of healthcare and how it affects society today; and (4) there is a need for communication, cooperation, and collaboration within the healthcare delivery industry.

In addition, there needs to be a redefinition of the consumers' expectations of health professionals' roles, the healthcare needs of any community, the influence of social and economic class on the receipt and utilization of services, and the evaluation of types of organizations designed to deliver health services. These are of central importance in practicing healthcare services.

This paper discusses social and cultural change to present new ideas that may create effective ways to cope with change and help reshape the healthcare delivery system. In particular, it specifically recounts observations of behavioral health services under TRICARE, a regionally managed health plan program for active duty and retired members of the uniformed services, their families, and survivors, and how a military treatment facility behavioral health department in the National Capitol Area uses management controls and performance indicators to help ensure that behavioral health services are delivered effectively and efficiently.

An operational definition of healthcare delivery.

"The World Health Organization (WHO) defines health as a state of physical, mental, and social well-being and not merely the absence of disease or infirmity" (Duhl, 1986, p. 35). Western society recognizes "medicine" in the context of developments that introduce a view of illness that sees its origins and treatments as physical and explicable in scientific terms. According to Katz (1998) "change is now the mainstay of American medicine" (p. 381). Medicine functions at a personal level by reassuring individuals and delaying their anxiety when they turn to physicians to cure and prevent disease. It provides for the proper organization and development of health services at the sociological level (Katz, 1998).

According to Schaffner, Allenman, Ludwig-Beymer, Muzynski, King, and Pacura (1999), measurements of the quality of care and the impact of care on cost, clinical outcomes, patient satisfaction, and patient quality of life are critical for the delivery of healthcare. One of the major features in the development of modern healthcare delivery is the application of science to medical diagnosis and cure.

Consumer expectations of health services.

An often-expressed desire by consumers is to increase the efficiency and availability of both the physician and the organization of health services. Consumers want to be more involved in their own healthcare, and would like to be armed with more medical information. They presently feel alienated by their medical providers, including physicians who spend less time with them. Consumers want their physicians to listen to them, and they want to develop a relationship of trust (Corey, 1972).

To add to their dissatisfaction, consumers believe they are paying a bigger share of their medical tab. Healthcare costs have increased more than the increase in the cost of living. The average consumer does not have a clear understanding of the factors at play in the health market place. According to Ulrich (1997), the consumer is overwhelmed by the jargon and buzzwords associated with design and consider healthcare "to be like clues to an unsolved mystery" (p. 23). It seems clear that healthcare is a 43 billion dollar industry that may fail to meet the psychological and social needs of the consumer.

Current healthcare problems.

The association between socioeconomic factors and healthcare delivery is well established, though the precise mechanism by which these factors influence health services is not fully understood. In spite of incredible scientific progress that would have seemed a fantasy even 50 years ago and despite tremendous economic resources, one could argue that the United States has not fully applied its technological capabilities and material resources to this significant domestic issue.

Science, technology, and society influence each other. Technological innovation affects social life. According to Starr (1982), the structure of advances in technology and medicine is explained as a mirror of the development of capitalism. The competition for money has made physicians more dependent on organization to maximize profit in order to gain access to the latest technology in modern medicine.

The basic cause of healthcare crisis.

The delivery of healthcare is not without social constraints. While healthcare influences social change, it does not determine it. According to Kuehl, Lobb, and Ward (1998), "The current

health care system has deep roots in research, and the system has searched for miracle cures and silver bullets" (p. 1132). With outstanding advances in medical research, a large part of society's healthcare system -- the delivery of healthcare-- has been buried. Katz (1998) said that the major flaws within the existing system are found in the areas of access and affordability.

The role of private health insurance.

Katz (1998) states that managed care was one response to runaway prices and other oversights. For the consumer, healthcare provided by companies, but often paid by employers, have made health services financially accessible. Advocates have argued that private health insurance created a stable base of revenues for hospitals, physicians and healthcare providers. However, at the same time, critics suggest the private health insurance industry failed to control cost and ensure quality in the delivery of health services.

The need to expand health coverage.

The White House Domestic Policy Council (1993) said, " moved by stories of families barely hanging on financially and emotionally because of a health crisis and skyrocketing insurance costs, society must focus on … people, their health care, and their peace of mind" (p. xvii). It is not efficient for our society to expend billions of dollars in a system that functions suboptimally and which wastes human and financial resources without finding satisfactory answers to unresolved questions.

Schaffner et al. (1999) state that healthcare professionals need to act as an advisory body for consultation, advice, communication, or discussion regarding patient care issues, patient care delivery, and quality improvements. This concept is a value-driven cultural change that has greater depth and reach in redesigning healthcare. This issue of healthcare redesign is too critical for professionals to ignore. They must demonstrate the willingness and commitment to hold policymakers more accountable for health issues. "The organization can no longer afford to carry those who do not or cannot support the necessary redesign which improves a health facility's service and cost framework for a changing marketplace" (Porter-O'Grady, 1996, p. 48).

Department of Defense (DoD) and TRICARE.

The Department of Defense, concern with military healthcare cost, quality, and access prompted dramatic reform and initiated a managed care program called TRICARE. A regionally managed healthcare program, TRICARE is designed for active duty and retirees of the uniformed services as well as their family members, and survivors. TRICARE is a healthcare system delivery in which military healthcare providers are partnered with civilian networks of healthcare providers to complement the military resources providing better access and quality care. The goal of TRICARE is not only to provide beneficiaries improved, convenient, and efficient access to healthcare but also to provide beneficiaries with choices for healthcare while controlling cost.

Delivery of behavioral healthcare services.

The delivery of behavioral health (BH) treatment and its associated costs presents special challenges. Increased complexity and stress with deployment of service members overseas have resulted in increased instances and manifestations of various psychosocial symptoms. In recent years, advances in medication and psychological therapeutic techniques have successfully promoted more effective treatments for many common disorders.

Any managed care organization (MCO) venturing into management of BH care faces the dilemma of how to address potentially large treatment needs that place demands on scarce resources and how to compete for limited BH resources. The concept of medical necessity begins to blur when the causes of a disorder encompass social, personality, and biological factors and when necessary services must address stabilization of social supports.

This behavioral health department is one of two U.S. Army multidisciplinary behavioral health departments in the military healthcare system (MHS) worldwide. It is composed of social work services, psychology services, psychiatry services, family advocacy program, child and adolescent program services, adolescent partial hospitalization program, and alcohol and drug abuse prevention and control program. The department provides behavioral health services to 100,000 beneficiaries in the Northern Virginia area, with the goal of providing comprehensive outpatient mental health care that includes diagnostic evaluations of mental illnesses, treatment planning, medication management and follow-up treatment within the capabilities and resources of the department.

The department's staff consists of multidisciplinary teams of mental health providers to include: licensed psychiatrists, psychologists, social workers, nurses, and others. It accepts referrals from all sources, including self-referrals, DoD, and civilian provider.

The treatment goal of the department is to improve the behavioral health of a defined population. To accomplish the goal, treatment systems have been implemented to reduce suicide and homicide rates, substance abuse-related impairments, and mortality and morbidity from accidents related to substance abuse or mental disorders.

Ultimately, the hospital commander is accountable for healthcare costs, and the quality and accessibility of care in the Northern Virginia military hospital for all beneficiaries. With the help of the Army Audit Agency (1997), this hospital implemented an active program to reduce and control fraud, waste and abuse. The hospital put into practice programs that made significant progress toward reducing costs while ensuring that patients received the proper care. This accountability encompasses both civilian healthcare networks and the military health system.

Before the implementation of management control programs, one problem that the military treatment facility encountered in an effort to contain behavioral health cost was the need to gain access to behavioral health patient treatment records from civilian providers. Because the hospital commander did not have additional authority to gain access to these treatment records from civilian providers, the propriety of payments would not ensured. The hospital commander having the authority to gain access to treatment records of civilian providers could also help to ensure that patients received adequate psychosocial healthcare. However, the inability to review the care that civilian providers have given patients resulted in payment for services not rendered and, in some instances, inadequate treatment. This resulted in the issuance of nonavailability statements.

Nonavailability statements.

Military hospitals issue nonavailability statements when a hospital cannot provide specific medical care to patients. This statement is not required for certain outpatient services and in a true medical emergency.

According to policies enacted by TRICARE, for certain services, a claim for reimbursement of expenses for medical care could be denied if the proper authorization, a nonavailability statement, from a military hospital, was not issued prior to the patient receiving medical care at a civilian hospital or other medical facility.

Within the mental health treatment field, nonavailability statements are required for inpatient and certain outpatient treatments. The behavioral health department case manager must approve all nonavailability statements for mental health treatment of five psychotherapy sessions a week, or more than two psychotherapy a week as an outpatient in a nonmilitary treatment facility. The case manager must review the medical necessity for the care. Within the department, the organizational case manager makes the initial recommendation for approval or disapproval of the nonavailability statement to the department chief, assesses the patient's need for treatment, and develops the treatment plan. It is at that point that the military treatment facility can implement some form of management control.

Prior to the implementation the practice of requiring nonavailability statements for inpatient psychiatric care; hospital personnel did not attempt to locate a treatment bed in a military facility at the lowest possible cost. Following implementation of the statements, however, payment was denied for lack of a nonavailability statement before admission in many cases. This management control measure was implemented to ensure that patients were treated at military facilities whenever possible to save the military money.

Use of healthcare database reports.

The mission of a hospital is to provide the necessary medical care required by patients in the most cost- effective manner possible. Management performance indicators are a good tool for objectively measuring standards of care provided to beneficiaries. The indicators describe the quality of care and the basis for some measurements may be applied to providers to make an initial assessment of the overall quality of care they give to beneficiaries. When indicators are used in conjunction with databases, managers can set thresholds or non-acceptable. Management performance indicators also report trends in transactions through analysis of current and historical medical services. Periodic reviews would help identify inefficient use of TRICARE funds and help hospital personnel ensure that patients receive the appropriate level of care in a cost effective manner.

However, the hospital also needs to ensure its personnel have the necessary tools and authority to implement organizational case management. To achieve this two things need to occur:(1) the behavioral health department needs to establish a program that uses transactional analysis to identify potential problem cases and providers, and (2) the department needs to develop and implement a written policy on production, review and use of medical database information.

Review and analysis.

> The Army Audit Agency (1997) states:
> Review and analysis is another management performance indicator tool that helps to ensure the propriety of claims and payment, to provide the proper administration and operation of the program, and to give the hospital commander some assurance that patients are receiving appropriate levels and quality of care (23).

This military treatment facility implemented a monthly review and analysis (R & A), program that tracked information retrieved from the medical databases. The data tracked was "available provider appointments": new, follow-up, same day, tel-cons, walk-ins, medication refill, and group counseling (Table 1). The available provider appointments were compared to actual scheduled patients seen. Tracking this information and presenting it monthly to the hospital

commander effectively gives the commander, as well as mental healthcare staff members, indicators of performance. The analysis helps personnel identify priorities for allocation of case management resources.

Table 1. Definition of Appointment Types

New	**60 minutes** appointment for all first time patients to the clinic. Patient has to arrive **15 minutes** early before scheduled appointment to fill out an intake package on patient's psychosocial history.
Follow-up	**30 minutes** appointment that is scheduled after the patient has an initial (new) appointment; provider and patient develop a treatment plans and treatment goals
Same Day/ Walk-in	**24 hours** appointment for patients that feel suicidal or homicidal during clinic hours can walk-in as an emergency appointments
Tel-cons	**10 – 20 minutes** phone conversation where providers call high-risk patients when they do not show up for their appointments. Providers also return patients calls and consult with other mental health professionals to discuss patients' treatment.
Group Therapy	**60 minutes** group counseling classes, i.e. anger management and substance abuse management, stress management, and etc.
Medication Refill	**10-15 minutes** appointment for patients who are stable with psycho-tropical medications are seen to adjust medication of need and refill prescription.

Conclusion:

Social change is continuous. Given societal needs, the changes in healthcare delivery and the increasing complexity of patient care, the most important and successful healthcare delivery models will be those that incorporate clinical, political, and economic elements into redesign.

Therefore, it is imperative that society remains abreast of progress in the delivery of healthcare and is offered a realistic role in helping to shape it. How can society better communicate, cooperate and collaborate within the scope of healthcare delivery? How can steps be taken in a clinical setting to influence healthcare delivery? How can knowledge about healthcare delivery be used to improve care for the consumer? The answers to these questions can help create a strong alliance between healthcare professionals and policy makers to identify, develop and implement cost-effective quality healthcare programs and services.

This approach is true for the delivery of behavioral health services under the TRICARE program. Under the military medical system and military treatment facilities, there is

responsibility for providing psychosocial care to soldiers, their families, retirees, and their family members. However, the treatment facilities do not have enough capacity to provide services to all those eligible for care. When the military treatment facilities grow to provide treatment for all eligible for its services, it will be seen as a model that can be emulated in the private sector. Until that time however, behavioral health departments must continue to adopt strategic management approaches patient care issues, patient delivery, and quality improvements.

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