CHAPTER ONE

Introduction

It is well established for civilian populations that persons farther away from medical care are less likely than others to seek or use health care services, including behavioral health care services (White, 1986; Beardsley et al., 2003)—that is, treatment for mental, behavioral, or addictive disorders. The same is true of veterans (Fortney et al., 1998; Schmitt, Phibbs, and Piette, 2003; McCarthy et al., 2007; Pfeiffer et al., 2011). For example, sharp reductions in care-seeking are evident at a distance of five miles or more from providers (U.S. Government Accountability Office, 2011). The response of the Department of Veterans Affairs (VA) to concern over health care access for geographically remote veterans has resulted in a variety of policy responses, including (1) the implementation of continuous geospatial monitoring of veterans' access to care; (2) a VA policy that 70 percent of veterans should live within a 30-minute drive of care;[1] (3) the development and extensive testing of telehealth capabilities for providing behavioral health care; (4) the deployment of Vet Centers across the United States to provide greater access to counseling services, including mobile Vet Centers for veterans in remote locations; and (5) the establishment of community-based outpatient clinics that are satellites of VA medical centers to treat more remote populations.

Although it is a well-recognized problem in civilian and veteran populations, geographic remoteness from care among service members and their dependents has not, until recently, received the same atten-

[1] Except for populations defined as *highly rural*, where the standard is a 60-minute drive (Mengeling and Charlton, 2012).

tion. With many service members now returning to the United States from the recent conflicts in Iraq and Afghanistan, concern over adequate access to behavioral health care has grown. Anecdotal reports from news and other sources describe barriers for some service members seeking behavioral health care, as well as difficulties faced by families of reintegrating service members who do not receive adequate behavioral health care (Lazare, 2013). Yet little is known about how many service members and dependents reside in locations remote from behavioral health providers and how this affects their access to care. Little is also known about the effectiveness of existing policies and other efforts to improve access to services among this population. This report seeks to fill that gap, focusing on three primary research aims and associated research questions.

Aim 1: How many service members and dependents are remote from behavioral health care? We analyzed geographic information (geospatial analysis) using three main data sources: (1) the residential location of service members and dependents, (2) the location of behavioral health care services, and (3) information regarding insurance coverage and regulations surrounding access to these services for different military subpopulations. We also conducted a literature search to help develop the appropriate driving-distance guidelines for our working definition of remoteness. Finally, we examined demographic characteristics of the military population residing in remote locations. We discuss these results in Chapter Three.

Aim 2: How does remoteness affect access to and use of behavioral health care? We first reviewed evidence for veteran and civilian populations of the impact of geographic remoteness on care-seeking and patterns of health care use, discussed in Chapter Three. There is no extant systematic analysis on whether (and how) remoteness affects military service members and dependents. We therefore used our geographic definition of remoteness from Aim 1 to analyze medical claims data from TRICARE (both direct care received at military treatment facilities [MTFs] and purchased care claims). We analyzed longitudinal data regarding the impact of living in a remote area on use of care, as we discuss in Chapter Four.

Aim 3: What are current gaps in policy and practice for improving access to care among remote service members and dependents, as well as some promising solutions? Despite the current lack of systematic evidence about geographic remoteness from behavioral health care among military populations (and its impact on care), there is a general awareness that this is a problem. The Department of Defense (DoD) has implemented initiatives and policies for improving access to care, some of which are specifically targeted at remote service members and dependents. Drawing on academic literature, white papers, and reports, we identified best practices for improving access to behavioral health care among military, veteran, and civilian populations. We also examined existing programs and policies for addressing access to care among service members and dependents, using both a comprehensive policy search and conversations with experts to gather data. Finally, we identified critical gaps in existing policies and programs and made recommendations to address those gaps through research, practice, and policy. We discuss Aim 3 analyses in Chapters Five, Six, and Seven.

Summary of Findings

Our geospatial analysis identified roughly 1.3 million military service members and dependents as geographically remote from behavioral health care (approximately 1 million dependents and 300,000 service members). In our longitudinal analysis, we found that 27 percent of service members experience remoteness from behavioral health care over a five-year period.

Our longitudinal analysis of claims data also indicated that *geographic remoteness is associated with lower likelihood of specialty behavioral health care (both therapy and drug treatment) among those with an existing behavioral health diagnosis*. Because of limits on data availability, we could not analyze the quality of care that was delivered or assess unmet need for service members and dependents who need behavioral health care but never seek treatment.

In our review of existing policies and programs, *we discovered guidelines for access to care, but no evidence of systematic monitoring*

of adherence to those guidelines. We recommend that DoD develop a system for monitoring drive time to specialty behavioral health care among service members and dependents, along with clear benchmarks for system performance (and consequences for not meeting those benchmarks). Finally, we identify two promising pathways for improving access to care among remote military populations: (1) telehealth and (2) collaborative care that integrates primary care with specialty behavioral health care. In both cases, we indicate areas where there is need for better evidence and assessment, barriers in existing policies and practices, and suggested solutions.