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Innovation Fund Project on Mental Illness (RECOVER)

Staged, evidence-based, integrated care

Germany, like many other countries, is affected by the high and steadily increasing health and economic burden of mental illness. In 2015, the reference year of the RECOVER study, mental illnesses in Germany caused annual societal costs of 146 billion euros, 4.8% of the gross domestic product, and the trend is rising. (1) Of these, 44.4 billion euros were direct health costs, including 24.9 billion euros in hospital costs. (2) According tothe Organisation for Economic Co-operation and Development (OECD), the insufficient establishment of evidence-based care models in Germany plays a role here, especially for people with severe mental illnesses. (3).

>> Based on this health policy starting point, the RECOVER model* was developed 3. From 2017 to 2021, its testing was funded by the Innovation Committee at the Federal Joint Committee (G-BA) (funding reference: 01NVF16018). The three main objectives of the RECO-VER trial were the reduction of societal costs, greater effectiveness and better cost efficiency compared to standard care in Germany. (3)

The RECOVER care model is based on a comprehensive evidence review of the effectiveness and efficiency of managed care, care models and treatments for mental illness. (3) Accordingly,the RECOVER model only integrates care components with (partly international) evidence. In the sense of cross-sectoral tiered managed care models, the basic rules of the model include evidence-based, coordinated and integrated cooperation between service providers and starting with the most effective and resource-efficient treatment. It defines four severity levels, which are constituted by the severity of the disease and the psychosocial functioning level. In addition, the disorder-specific lifetime risk for severe mental illness (e.g. schizophrenia in level 4 with 90% risk) was taken into account.

The core components of the model were
(a) an interdisciplinary and cross-sectoral managed care network with a care control centre involving hospitals and registered doctors and psychotherapists in the care sector,
(b) a clearly structured/defined access to care,
(c) a multiprofessional and interdisciplinary initial examination, treatment planning and organisation in the sense of a liaison outpatient clinic,
(d) a multiprofessional and interdisciplinary crisis intervention team to prevent or reduce inpatient/partial inpatient treatmentreduction of inpatient/partial inpatient acute treatment according to the evidence-based model of the Crisis Resolution Team (CRT),
(e) accompanied digital therapy through an e-mental platform (eRECOVER; www.erecover.de),
(f) stepped individual psychotherapy and/or group therapy,
(g) case management for people with general severe mental illness (level 3),
(g) Assertive Community Treatment (ACT) teams for people with persistent severe mental illness (level 4) as well as
(h) social work, supported employment and recovery support. In terms of cross-sectoral quality assurance and transfer to other regions, 12 quality assurance manuals were prepared for all components and processes.

Effectiveness and efficiency of the model were evaluated in a 12-month, two-arm randomised controlled trial in an extended care sector of the UKE. Participants aged 16 to 79 years with all mental health conditions were assigned to either RECOVER or Treatment-AS-Usual (TAU). A total of 891 patients were included (n = 477 in the RECOVER intervention, n = 444 in TAU).

The results showed significant and substantial reductions in annual societal and statutory health insurance costs. The reduction in hospital costs and the cost reduction in the group of persistent severe mental illnesses (level 4) were particularly pronounced. The latter result is of particular importance against the background of very high indirect and direct costs: patients in stage 4 caused total costs of 31,883 euros in the 6 months before inclusion, of which 10,485 euros were direct costs with a hospital cost share of over 90%. (5) Thishigh share of hospital costs in the direct costs (88%) was also evident in the general severe mental illnesses (level 3). 5Inboth groups (level 3 and 4), application psychotherapy did not play a role as a cost factor.

The overall RECOVER model was shown to be highly cost-effective compared to standard care. The results of cost reduction and cost-effectiveness were also accompanied by significantly better treatment outcomes and improved quality of care (primary endpoint calculated from clinical external and self-assessment). Subgroup analyses also showed that before the Corona pandemic, significant differences in the primary effectiveness parameter in favour of RECOVER were also detectable with exclusive presence study evaluation. An improved quality of care was also shown in several secondary endpoints, especially with regard to the participation of patients in the treatment process. As part of a strategic test of the transferability of the RECOVER model, the complete care model was transferred to another (rural) care region (Steinburg district, Itzehoe hospital) with adaptation to local care structures and resources and successfully implemented there.

Corresponding reports were finalised at the beginning of 2023 and sent to the Innovation Committee at the Federal Joint Committee (G-BA) for evaluation. A continuation of the RECOVER model and its care components in a future standard care is currently the subject of examination within the expert committees of the G-BA.A.

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* www.recover-hamburg.de