S. HRG. 112–508

VA MENTAL HEALTH CARE: EVALUATING ACCESS AND ASSESSING CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

APRIL 25, 2012

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PRINTING OFFICE

74–334 PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

PATTY MURRAY, Washington, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
DANIEL K. AKAKA, Hawaii
BERNARD SANDERS, (I) Vermont
SHERROD BROWN, Ohio
JIM WEBB, Virginia
JON TESTER, Montana
MARK BEGICH, Alaska

RICHARD BURR, North Carolina, *Ranking Member*
JOHNNY ISAKSON, Georgia
ROGER F. WICKER, Mississippi
MIKE JOHANNS, Nebraska
SCOTT P. BROWN, Massachusetts
JERRY MORAN, Kansas
JOHN BOOZMAN, Arkansas

KIM LIPSKY, *Staff Director*
LUPE WISSEL, *Republican Staff Director*

C O N T E N T S

APRIL 25, 2012

SENATORS

WITNESSES

APPENDIX

VA MENTAL HEALTH CARE: EVALUATING ACCESS AND ASSESSING CARE

WEDNESDAY, APRIL 25, 2012

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:35 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Tester, Brown, and Moran.

STATEMENT OF HON. PATTY MURRAY, CHAIRMAN, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning. This hearing will come to order. I would like to welcome all of you to today's hearing to evaluate VA access to mental health care services.

Today's hearing builds upon two hearings held last year. At each of the previous hearings, the Committee heard from the VA how accessible mental health care services were. This was inconsistent with what we heard from veterans and the VA mental health care providers. So last year, following the July hearing, I asked the Department to survey its own mental health care providers to get a better assessment of the situation.

The results, as we all now know, were less than satisfactory. Among the findings, we learned that nearly 40 percent of providers surveyed could not schedule an appointment in their own clinic for a new patient within the VA-mandated 14-day window; and 70 percent reported inadequate staffing or space to meet mental health care needs.

The second hearing, held in November, looked at the discrepancy between what the VA was telling us and what the providers were saying. We heard from a VA provider and other experts about the critical importance of access to the right type of care, delivered timely by qualified mental health professionals.

At last November's hearing, I announced that I would be asking VA's Office of Inspector General to investigate the true availability of mental health care services at VA facilities. I want to thank the IG for their tremendous effort in addressing such an enormous request. The findings of this first phase of the investigation are substantial and troubling. We have heard frequently about how long it takes for veterans to get into treatment, and I am glad the IG has brought those concerns to light.

The IG will also discuss an entirely different and more useful way of understanding access to care. This model would give more

reliable data and reduce the rampant gaming of the system that we have seen thus far. The IG has also found the existing scheduling system is hopelessly insufficient and needs to be replaced.

VA has struggled with developing a new scheduling system. I understand VA is working to get a replacement system in place. I would like the Department's commitment that they will work to get this done right and get it done soon.

The IG findings also show some serious discrepancies in what VA has been telling this Committee and veterans. VA stated that 95 percent of veterans received mental health evaluation within 14 days. In reality, it was only about 50 percent. VHA data reported that after the evaluation was completed, 95 percent of veterans received a treatment appointment within 14 days. In reality, it was only 64 percent. For those in treatment, 12 percent were scheduled beyond the 14-day follow up appointment window, with providers telling the IG that they were delaying follow up for months, not because of the veterans' needs, but because their schedules were too full.

VA is failing to meet its own mandates for timeliness and instead is finding ways to make the data look like they are complying. VA can and must do much better. Important steps have been taken in the right direction by the Department. Last week, VA announced the addition of 1,600 mental health providers. And late last year, VA announced an increase in staffing levels at the Veterans Crisis Line.

As we will see today, the hard work remains in front of us at a time when veterans are dying by suicide at an alarming rate. We know that the sooner a veteran can get a mental health care appointment after they request it, the more likely they are to follow through with care.

We cannot afford to leave them discouraged when trying to access care, and when in care, we must be getting veterans their next appointment in a clinically appropriate time. We need to be sure there are enough resources so providers do not have to delay treatment because their schedules are too full.

While I commend VA for the decision to hire another 1,600 mental health providers, there is still no reliable staffing model to determine where these individuals are needed. Without that model, VA needs to explain how they will know where to place these additional providers.

There are other challenges with getting the best providers into the system. I understand that nationally there are shortages of mental health providers, and it is even harder for VA because they cannot always pay the highest salaries in the community. There are still a large number of vacancies in VA's mental health ranks.

I want to hear from the Department how they will fill the existing gaps and ensure the new positions they have announced do not become 1,600 empty offices. Ultimately, what really matters is how long it takes for a veteran to start that first treatment session. What really matters is not abandoning that veteran.

I recently saw Andrea Sawyer whose husband Lloyd suffers from PTSD and depression. Andrea bravely testified before this Committee last July about the tremendous difficulties she and her husband faced in getting him into care. Lloyd still faces challenges, but

he is now getting the care he needs. That is what matters. We cannot let our veterans down, especially when they have shown the courage to stand up and ask for help.

I look forward to hearing from VA how they intend to address the issues the IG has found. Now more than ever is the time for action and for VA to show effective leadership. Let the hearing today serve as an unequivocal call to action. The Department must get this right.

In closing, I do want to be clear that while we have discussed a number of problems with the system at large, none of this reflects poorly on VA's providers. I believe I can speak for all of us in thanking VA's many mental health providers for the incredible job that they do. Let there be no mistake, these individuals are incredibly dedicated to their mission. They choose to work harder than most of their peers, often for less lucrative benefits, all because they believe in what they do and because they have a deep and unshaking commitment to our veterans.

To all of VA's psychiatrists, psychologists, social workers, and other providers, and to all the administrative staff who support them, thank you so much for the good job, and keep up the good work.

With that, I want to turn it over to Senator Brown who is standing in for Senator Burr today.

STATEMENT OF HON. SCOTT P. BROWN,
U.S. SENATOR FROM MASSACHUSETTS

Senator BROWN. Thank you, Madam Chair. It is good to be here as the Ranking Member in place of Senator Burr. It is good to be back on the Committee serving with you. I want to thank you for holding this very important hearing.

Some of these I am still serving, I see and hear of these types of situations regularly. $5.9 billion, that is the increase that VA got. And out of that, do you think we could hire some more people to address these very real concerns? $5.9 billion.

To read some of the things that we have been reading about the suicidal veteran calling for help, gone unanswered, one more person killing themselves, and the veteran's mental health care is delayed—put out by the Washington Post, actually yesterday, talking about how the system is being gamed by the VA, and not actually scheduling and following through with scheduling and providing a good opportunity for these soldiers to get the care and coverage that they need—it is mind boggling.

I mean, I understand the delay. I understand that there are problems. I understand that claims go over a year. But for somebody who calls and says, "Hi, I'm thinking of killing myself."

"Well, do you feel that way right now?"

"Well, not right in this moment. But I tried to hang myself yesterday. Does that count?" And then to be blown off; it just makes absolutely no sense to me at all.

So I am glad you are holding this hearing. I want to continue to look into mental health services. Your insights in this Committee help perform the oversight to ensure that veterans get the services they need, and that is a good thing.

As you know, one of the several hearings regarding mental health services—this is another one—last year, I remember we did learn about the various serious mental health services that were needed and, quite frankly, lacking. I want to just say that today's hearing will focus on evaluating the availability of these services and accessing the care that is delivered.

The testimony we hear today will be from VA's Inspector General, as well as Iraq veteran and former VA mental health officer, Nick Tolentino, who feels there is an ongoing cultural problem at the VA.

Nick, I want to thank you for your testimony and pointing out where the loopholes are sought and openly shared to hide the fact that the facilities are not meeting their performance metrics. And I have got to tell you, it is unacceptable, as I said, for some of you who still serve and see and speak regularly with people that are affected by these various serious ailments.

The gaming of the system has to stop. The IG found in their audit, and Nick confirmed in his testimony, that our veterans are not given the opportunity to actually offer a desired date for their next appointment. They were simply told when and where to show up and no consideration or compassion to address the very real concerns that they have.

The scheduling system is not the only problem with delivering mental health care. Even though the VA has increased the staffing by 48 percent between 2006 and 2010, both the IG and Nick point out that it is understaffed and lacks a methodology to assess their staffing needs. And it is no surprise that just 1 week after this hearing, VA announced they are hiring 1,900 additional mental health staffers.

Well, that is great. It is a good start. But, man, what have we been doing up to this point? We need to do it better. We have people's lives depending on these decisions that we are making. And it is a good step, as I said, but how long will it take to actually fill these positions? And what happens to that soldier who calls, as been happening with Jacob Manning and others.

We will hear today from community groups that are helping, General Tom Jones, founder of Semper Fi Odyssey, to help veterans from the current conflicts manage their mental health. And I want to thank you, sir, for that effort, going above and beyond. It will help veterans volunteer their time to help fellow soldiers cope with those invisible wounds of war, which we all know about. It is a great example of the community coming forward and addressing needs not currently being met. So thank you for that.

In the end, simply hiring more staff and fixing VA's broken scheduling system will not cure all the issues, but it will certainly take a combination of changes at the facility level and the VA office level. And the VA will use all available resources, including fee bases, care, staffing increases, and developing better performance metrics to fix a severely broken system.

I concur with you that the individual people that are there, they are doing yeoman's work, but it is still not enough. Is it you need more people? You need more computers? What is it? $5.9 billion should go a long way to addressing those issues.

Madam Chair, as I reference, I am heading upstairs just to give HSGAC a quorum, then I will be right back down. So I look forward to everybody's testimony. Thank you.

Chairman MURRAY. At this time, I would like to introduce the first panel. Representing the VA is Mr. Bill Schoenhard, VA's Deputy Under Secretary for Health, Operations and Management. He is accompanied today by Dr. Antonette Zeiss, Chief Consultant for the Office of Mental Health Services, and Dr. Mary Schohn, Director of Mental Health Operations with the Veterans Health Administration at the Department of Veterans Affairs.

From the Office of Inspector General, we have Dr. David Daigh, Assistant Inspector General for Healthcare Inspections, accompanied by Dr. Michael Shepherd, senior physician in the IG's Office of Healthcare Inspections. Also from the Office of Inspector General, we have Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations, accompanied by Mr. Larry Reinkemeyer.

Next, we will hear from Nick Tolentino. He is a Navy veteran of the Iraq War and a former mental health administrative officer in the VA.

Finally, we will hear from the founder and executive director of Outdoor Odyssey, retired U.S. Marine Corps, Major General Thomas Jones.

So, Mr. Schoenhard, we will begin with your testimony. We have a lot of answers we need from you, so please begin.

STATEMENT OF WILLIAM SCHOENHARD, FACHE, DEPUTY UNDER SECRETARY, HEALTH, OPERATIONS AND MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ANTONETTE ZEISS, PH.D., CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES; AND MARY SCHOHN, PH.D., DIRECTOR, OFFICE OF MENTAL HEALTH OPERATIONS

Mr. SCHOENHARD. Thank you.

Chairman Murray, we appreciate the opportunity today to address the access to and the quality of mental health care services to our Nation's veterans. And we appreciate so much discussion of a topic that is integral to the well being and full living out of a fulfilled life of our Nation's veterans.

Mental health is integral to the overall well being and physical health of a veteran. It is important, if there is underlying depression, problem drinking, or substance abuse, or other medical mental ailment, that this be diagnosed in order to ensure that those who have served our country have the full treatment of something that is so core to their overall well being and to their ability to also implement the physical health aspects of medication management, staying employed and the rest, which is so important to the quality-of-life of a veteran who has served this country.

It is the sacred mission of VA to ensure that this very integral part of our care is well delivered.

I appreciate so much your comments regarding the 20,500 providers who on the ground work so hard every day to serve our Nation's veterans in this important mission.

In the written statement, I have outlined three areas of improvement and concern, but I would like to first mention that we appre-

ciate so much your leadership, the Committee's review, and the Inspector General's review. This is an important aspect of care, and we appreciate all of the assistance.

We will be working very closely with the Inspector General as we go forward with their report as it relates to the first recommendation that I would like to address. And that is that we agree with the Inspector General that our appointment measurement system should be revised to include a combination of measures that better capture the overall efforts throughout a course of treatment for a veteran, while maintaining flexibility to accommodate a veteran's unique condition and phase of treatment.

We must also continue our efforts to strengthen mental health integration into our primary care in order to ensure in the primary care settings that we are assessing mental health needs of our Nation's veterans and also be able to address the stigma that is often associated with this, that can be discussed in a primary-care setting.

The second point I would like to make, as announced by Secretary Shinseki last week, we are increasing staff to enhance both the access to and the quality of mental health care by hiring 1,900 additional staff, more than 1,600 of those who are mental health clinicians. As I mentioned, this will augment the current complement of 20,500 mental health employees in our system and is designed to provide additional staff in our facilities.

It is also designed to increase our staffing of our crisis line, which is so integral to the identification and treatment of people who are in crisis, as Senator Brown spoke of so eloquently. And it is also an important aspect of increase in that we will be adding additional examiners for compensation and pension examinations.

It is an important transition from active duty to veteran status for those who are currently on active duty and for those who present with new conditions. We have a solemn responsibility to ensure that we increase our staff to ensure that we can handle this volume in a timely fashion, and that we can do this in a way that does not erode our capacity to serve our existing patients.

I want to emphasize that this additional staffing will continue to be evaluating and assess data and refine the staffing model. We are currently piloting this in three VISNs, and this is a work in progress that will be continually improved as part of our comprehensive approach to ensuring that our facilities have the resources to ensure that we accomplish this mission.

The third point I would like to make is that deploying evidence-based therapies to ensure veterans have access to the most effective methods for PTSD and other mental health ailments, we are making more widespread and improving our training for those who are receiving care and delivering care of evidence based treatments. We are shifting from a more traditional approach to one with newer treatments.

We would acknowledge that we have not always communicated these changes as clearly as we might to our Nation's veterans, so we are redoubling our efforts to improve communication not only to our providers but to our veterans to ensure that these evidence based therapies are implemented in a way that can be supported

by the veteran, and fully educated and trained personnel assuring that that is delivered.

In summary, we just thank you again for your encouragement, for your support. This is an important part of care that is fundamental to the well being of our Nation's veterans. We look forward to answering your questions and those of the Committee.

[The prepared statement of Mr. Schoenhard follows:]

PREPARED STATEMENT OF WILLIAM SCHOENHARD, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION (VHA), DEPARTMENT OF VETERANS AFFAIRS (VA)

Chairman Murray, Ranking Member Burr, and Members of the Committee, I appreciate the opportunity to address access to, and quality of, VA's mental health care. I am accompanied today by Mary Schohn, Ph.D., Director, Office of Mental Health Operations and Antonette Zeiss, Ph.D., Chief Consultant, Office of Mental Health Services.

VA has testified twice within the past 12 months on its mental health programs, and values the feedback received from those hearings. From these hearings and subsequent field visits, VA has learned a great deal about the strengths of our mental health care system, as well as areas that need improvement. VA's Office of Inspector General (OIG) also recently completed a review of VA's mental health programs and offered four recommendations. The OIG cited a need for improvement in our wait time measurements, improvement in patient experience metrics, development of a staffing model, and provision of data to improve clinic management. VA is using the OIG results in concert with our internal reviews to plan important enhancements to VA mental health care. VA constantly strives to improve, and we will use any data and assessments—positive or negative—to help us enhance the services provided to our Veterans.

Reviews have confirmed that Veterans seeking an initial appointment for a mental health evaluation generally receive the required rapid triage evaluation in a timely manner; this was confirmed by the OIG report on mental health access. While a mental health evaluation within 14 days of the triage referral generally occurs, we were concerned to learn from the OIG report that those evaluations do not always result in the full diagnostic and treatment evaluation required by VA policies. Further, Veterans seeking follow up appointments may experience waits of longer than 14 days, especially for some intensive services such as beginning a course of evidence-based psychotherapy. While the explanations for these findings are varied, none are satisfactory—we must do more to deliver the mental health services that Veterans need. My written statement will describe how we have traditionally evaluated access to mental health care and how we propose to evaluate access in the future. It will then explain how we assess the quality of care delivered and potential new considerations on this topic. Both sections will address the need for increased staffing and better data collection.

ACCESS TO CARE

Ensuring access to appropriate care is essential to helping Veterans recover from the injuries or illnesses they incurred during their military service. Over the last several years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that services can be more readily accessed by Veterans. Mental health care must constantly evolve and improve as new research knowledge becomes available, as more Veterans access our services, and as we recognize the unique needs of Veterans—and their families—many who have served multiple, lengthy deployments. In addition, enhanced screening and sensitivity to issues raised by Veterans are also identified as areas for improvement.

In an effort to increase access to mental health care and reduce the stigma of seeking such care, VA has integrated mental health into primary care settings. The ongoing transfer of VA primary care to Patient Aligned Care Teams will facilitate the delivery of an unprecedented level of mental health services. Systematic screening of Veterans for conditions such as depression, Post Traumatic Stress Disorder (PTSD), problem drinking, and military sexual trauma has helped us identify more Veterans at risk for these conditions and provided opportunities to refer them to specially trained experts. Research on this integration shows that VA is seeing many Veterans for mental health care who would not otherwise be likely to accept referrals to separate specialty mental health care. These are important advances, particularly given the rising numbers of Veterans seeking mental health care. In an

informal Mental Health Query administered by VA in August 2011, VA learned that many of its providers in the sites queried believe that Veterans' ability to schedule timely appointments may not match data gathered by VA's performance management system. These providers also identified other constraints on their ability to best serve Veterans, including inadequate staffing, space shortages, limited hours of operation, and competing demands for other types of appointments, particularly for compensation and pension or disability evaluations. In response to this query, VA took two major actions. First, VA developed a comprehensive action plan aimed at enhancing mental health care and addressing the concerns raised by its staff. Second, VA conducted external focus groups to better understand the issues raised by front-line providers. As part of this action, VA is visiting every VA facility this year to conduct a first-hand review of its mental health program. As of April 25, 2012, 63 of 140 (45 percent) site visits have been completed, one to each VA health care system, with the remainder scheduled to be completed by the end of the fiscal year.

As part of this ongoing review of mental health operations, Secretary Shinseki recently announced that VA will be adding approximately 1,600 mental health clinicians—including nurses, psychiatrists, psychologists, social workers, marriage and family therapists and licensed mental health professional counselors—as well as 300 support staff to its existing workforce of 20,590 mental health staff. This addition was based on VA's model for team delivery of outpatient mental health services, and as these increases are implemented, VA will continue to assess staffing levels. Further, as part of VA's efforts to implement section 304 of Public Law 111–163 (Caregivers and Veterans Omnibus Health Services Act of 2010), VA is increasing the number of peer specialists working in our medical centers to support Veterans seeking mental health care. These additional staff will increase access by allowing more providers to schedule more appointments with Veterans. VA began collecting monthly vacancy data in January 2012 to assess the impact of vacancies on operations and to develop recommendations for further improvement. In addition, VA is ensuring that accurate projections for future needs for mental health services are generated. Finally, VA is planning proactively for the expected needs of Veterans who will separate soon from the Department of Defense (DOD) as they return from Afghanistan. We track this population to estimate the number of such Veterans, how many are anticipated to seek VA care, and how many who seek care are anticipated to need mental health evaluation and treatment services. These processes will continue, with special attention to whether patterns established up to this point may change with the expected increase in separations from active duty military.

Historically, VA has measured access to mental health services through several data streams. First, VA defined what services should be available in VA facilities in the 2008 Uniform Mental Health Services in VA medical centers and Clinics Handbook and tracks the availability of these services throughout the system. Moreover, VA has added a five-part mental health measure in the performance contracts for VHA leadership, effective starting in fiscal year (FY) 2012. The new performance contract measure holds leadership accountable for:

- The percentage of new patients who have had a full assessment and begun treatment within 14 days of the first mental health appointment;
- The proportion of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans with newly diagnosed PTSD who receive at least eight sessions of psychotherapy within 14 weeks;
- Proactive follow-up within 7 days by a mental health professional for any patient who is discharged from an inpatient mental health unit at a VA facility;
- Proactive delivery of at least four mental health follow-up visits within 30 days for any patient flagged as a high suicide risk; and
- The percentage of current mental health patients who receive a new diagnosis of PTSD and are able to access care specifically for PTSD within 14 days of referral for PTSD services.

VA policies require that for established patients, subsequent mental health appointments be scheduled within 14 days of the date desired by the Veteran. This has been a complicated indicator, as the desired date can be influenced by several factors, including:

- The Veteran's desire to delay or expedite treatment for personal reasons;
- The recommendation of the provider; and
- Variance in how schedulers process requests for appointments from Veterans.

VA understands virtually every health care system in the country faces similar challenges in scheduling appointments, but as a leader in the industry, and as the only health care system with the obligation and honor of treating America's Veterans, we are committed to delivering the very best service possible. As a result,

VA has decided to modify the current appointment performance measurement system to include a combination of measures that better captures overall efforts throughout all phases of treatment. VA will ensure this system is sufficiently flexible to accommodate a Veteran's unique condition and the phase of treatment. Some Veterans may need to be seen more frequently than within 14 days (for example, if they need weekly sessions as part of a course of evidence-based psychotherapy), while others may not (for example, if they are doing well after intensive treatment and will benefit most from a well-designed maintenance plan with far less frequent meetings). A thoughtful, individualized treatment plan will be developed for each Veteran to inform the timing of appointments.

VA has formed a work group to examine how best to measure Veterans' wait time experiences and how to improve scheduling processes to define how our facilities should respond to Veterans' needs. In the interim, the work group has recommended a return to the use of the "create date" metric, which will minimize the complexity of the current scheduling process. The "create date" refers to the date on which a Veteran requested an appointment, and the wait time will be measured as the numbers of days between the create date and the visit with a mental health professional. The work group is currently developing an action plan to be reviewed by the Under Secretary for Health by June 1, 2012. Performance measurement and accountability will remain the cornerstones of our program to ensure that resources are being devoted where they need to go and being used to the benefit of Veterans. Our priority is leading the Nation in patient satisfaction with the quality and timeliness of their appointments.

Decisions concerning staffing and programs were determined historically at the facility level to allow flexibility based on local resources and needs. However, as evidence accumulates, it is clear that sites can benefit from more central guidance on best practices in determining needed mental health staff. Therefore, we recently developed a prototype staffing model for general mental health outpatient care using a methodology that considered findings in the academic literature, consultation with other health care systems, and productivity data. We are using these results to pilot this staffing model in Veterans Integrated Service Networks (VISN) 1, 4, and 22, and we anticipate national implementation of this new model by the end of the fiscal year. While the model may be refined as a result of the pilot testing, it provides a clear basis for assessing staffing for mental health services, and shows that currently there are shortfalls at some sites nationally.

By adding staff, offering better guidance on appointment scheduling processes, and enhancing our emphasis on patient and provider experiences, we are confident we are building a more accessible system that will be responsive to the needs of our Veterans while being responsible with the resources appropriated by Congress.

QUALITY OF CARE

VA has made deployment of evidence-based therapies a critical element of its approach to mental health care. Mental health professionals across the system must provide the most effective treatments for PTSD and other mental health conditions. We have instituted national training programs to educate therapists in two particularly effective exposure-based psycho-therapies for PTSD: cognitive processing therapy and prolonged exposure therapy. The Institute of Medicine and the Clinical Practice Guidelines developed jointly by VA and the DOD have consistently concluded the efficacy of these treatment approaches.

Not everyone with PTSD who receives evidence-based treatment may have a favorable response. Although VA uses the most effective treatments available, some Veterans will need lifetime care for their mental health problems and may see slow initial improvement. Almost everyone can improve, but some wounds are deep and require a close, consistent relationship between VA and the Veteran to find the most effective individualized approaches over time. Veterans and their families should not expect "quick fixes," but they should expect an ongoing commitment to intensive efforts at care for any problems.

A recent analysis of data from VA's large Cooperative Study (CSP# 494), a study on prolonged exposure to the stress factors associated with and contributing to PTSD symptoms among female Veterans and active duty Servicewomen, identified those factors that predict poor treatment outcome. This is the largest randomized clinical trial of prolonged exposure treatment ever conducted (284 participants), and the first one focusing solely on Veterans and military personnel. VA staff would be pleased to brief you in greater detail on the methodology and results of this study. Our analysis shows that Veterans with the most severe PTSD are least likely to benefit from a standard course of treatment and to achieve remission. Other factors that predicted poor response were unemployment, co-morbid mood disorder, and

lower education. In other words, those with the worst PTSD are least likely to achieve remission, as is true with any other medical problem.

Even when Veterans are able to begin and sustain participation in treatment, timing, parenting, social, and community factors all matter a great deal. Treatment, especially treatment of severe PTSD, may take a long time. During this period, Veterans with PTSD are at risk for many severe problems including family and parenting issues, inability to hold a job or stay in school, and social and community function. Further, evidence also shows that whereas a positive response to treatment may reduce symptom severity and increase functional status among severely affected Veterans, the magnitude of improvement may not always be enough to achieve full clinical remission. This is no different than what is found with other severe and chronic medical disorders (such as diabetes or heart disease) where effective treatment may make a substantial and very important difference in quality of life without eradicating the disease itself. Thus, providing the best treatments with the strongest evidence base is crucial to care, but that must be placed within an ongoing commitment to recognize that initial care may need to be followed by ongoing rehabilitative care, for the major diagnostic problem, for other co-occurring mental health problems, and for the host of psychosocial problems that may accompany the diagnosis (or diagnoses).

Outcome evidence generated from cases involving Veterans who are receiving these therapies in VA substantiate that they are effective for Veterans participating in ongoing clinical care not associated with research projects. Based on ongoing surveys, we know that all VA facilities have staff trained at least in either prolonged exposure or cognitive processing therapy, and usually both. In addition, one of the preliminary results of our site visits found that many facilities have a strong practice of training more staff in these and other evidence-based therapies for a wide array of mental health problems.

As more providers are trained in these approaches to care, facilities are shifting from their more traditional counseling approach to these newer treatments. We have not always communicated well enough to Veterans the nature or reason behind these changes. These new programs emphasize a recovery model, which is strengths-based, individualized, and Veteran-centered. A recovery-oriented model does not focus exclusively on symptom reduction, but has as its goal helping Veterans achieve personal life goals that will improve functioning while managing symptoms. These efforts have been recognized as successful in the academic literature and through a Government Performance and Results Act review conducted by RAND/Altarum, which concluded that VA mental health care was superior to other mental health care offered in the United States in almost every dimension evaluated.

Before the development of these evidence-based approaches, VA made every effort to offer clinical services for PTSD based on clinical experience and innovation. Some of these approaches have developed into the evidence-based approaches we have now, while others have not been shown to offer the help that was expected. Even those therapies that did not help in truly alleviating PTSD could come to feel like "lifelines" to those receiving them. For example, some sites hold group educational sessions to help Veterans understand PTSD symptoms and causes, and these sometimes developed into ongoing groups. While group therapy for PTSD can be effective and is cited in the VA/DOD Clinical Practice guidelines, group therapy is understood (and validated) as possible only in fairly small groups—usually fewer than 10 participants. Educational groups often have far more members, sometimes up to 50 or more; while this can be an effective way to conduct psycho-education, it cannot be considered "group therapy."

Veterans who have used some of the PTSD services previously adopted by VA may not be familiar or comfortable with newer approaches, and we must continuously educate Veterans and others about what treatments are most likely to be effective and how Veterans can access them. Some of our own providers have not understood these changes. The National Center for PTSD has been providing guidance through the PTSD mentoring program to help facilities collaborate with providers and Veterans in the transition. We have developed educational processes to help clarify the need for and rationale behind efforts to change clinical practice patterns to ensure best possible care for VA.

The Under Secretary for Health's realignment of the Veterans Health Administration last year created an Office of Mental Health Operations with oversight of mental health programs across the country. This has aligned data collection efforts with operational needs and connected resources across the agency to bring the full picture of VA's mental health system into focus. In fiscal year 2011, VA developed a comprehensive mental health information system that is available to all staff to support management decisions and quality improvement efforts. This year, a collabo-

rative effort between VA Central Office and field staff is underway to review mental health operations throughout the system and to develop quality improvement plans to address opportunities for improvement through dissemination of strong practices across the country.

CONCLUSION

VA remains fully committed to delivering high quality, timely mental health care. VA defined this commitment in 2004 with the Comprehensive Mental Health Strategic Plan, which was fully implemented and evolved into the Uniform Mental Health Services Handbook in 2008. Efforts to implement the Handbook have been largely successful, but more effort is needed to ensure full implementation at every appropriate VA facility. In addition, new challenges and opportunities continuously require response. For example, OEF/OIF/OND Veterans have faced more and longer deployments than previous generations of Servicemembers, and their families have shared these challenges. Many of these Veterans also have survived battlefield injuries that previously would have been fatal. Other challenges are presented by Vietnam era Veterans who seek mental health care at far higher levels than prior generations of older adults. In part, that is because we did not have the effective treatments for them when they returned from service more than 40 years ago. We know that the therapies discussed previously are effective for this population, and we welcome their search for mental health care. As VA reaches out to serve all generations, and as our intensive, effective outreach programs bring in greater numbers of Veterans to VA's health care system, we must constantly find ways to keep pace with the need for expanded capacity for mental health services and for those services to be based on the best possible known treatments. Secretary Shinseki's recent announcement that VA will add approximately 1,600 mental health clinicians and 300 support staff reflects VA's continuing commitment to meet the needs of Veterans. As these increases are implemented, VA will continue to assess staffing levels.

New technologies, staff, training, approaches to care, and data measurement will provide VA the mechanisms it needs to deliver the necessary quality and timely mental health care. VA is developing solutions in each of these areas or is currently implementing new efforts to offer better access to and quality of mental health care.

Madam Chairman, we know our work to improve the delivery of mental health care to Veterans will never be done. We appreciate your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. This concludes my prepared statement. My colleagues and I are prepared to respond to any questions you may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

HEALTH CARE

Question 1. The Department has conducted several site visits to medical facilities across the country to get a better sense of what is happening at various points of access to mental health care. Please provide the Department's assessment of the findings from these site evaluations.

Response. Site visit teams review the implementation of the Uniform Mental Health Services Handbook (UMHSH) across 18 domains; these domains capture all components of the mental health program that are to be implemented nationally. The team identifies strengths and opportunities for growth in each of these domains based on facility data submitted as pre-work, data from the Mental Health Information System, information gathered at the site through interviews with facility and mental health leadership; information gathered during interviews with front-line staff; and finally information gathered from Veterans, Veterans' family and friends and community stakeholders. Prior to the facility debrief at the end of the visit, the site visit team determines the top five strengths and opportunities for growth at the facility. Strengths are determined by the team as practices which exceed the UMHSH guidance in any of the 18 areas, while opportunities for growth are areas in which the facility would benefit from targeted approaches for improvement.

An analysis of the initial 55 site visits completed through March 31, 2012, has been completed based on the summaries of the top five strengths and top five growth areas aggregated across facilities.

Common Strengths:

• Identification of the mental health staff as hard working, mission-oriented individuals focused on the care of Veterans.
• Numbers of staff trained in Evidence-Based Psychotherapy and supported by mental health leadership to complete all necessary training requirements.
• Suicide prevention services, including providing education to staff on suicide prevention while simultaneously providing continuity of care services for Veterans at high risk for suicide.
• Substance Use Disorder treatment.
• Provision of services to Veterans who are homeless.
• Development of excellent community partnerships to assist in providing the best care for Veterans.

Common Opportunities for Growth:

Identification of opportunities for growth does not mean it is not present at a facility, but rather that this area is in need of further development. The most common opportunities for growth identified were:

• Expansion of recovery-oriented programming, especially in inpatient settings, and further developing Psychosocial Rehabilitation and Recovery Centers (PRRCs) while increasing the presence and role of Local Recovery Coordinators.
• Expansion of peer support services.
• Need to fill vacancies and/or address concerns related to staff members covering multiple roles related to covering for staff vacancies.
• Need to expand the Primary Care-Mental Health Integration program to include both co-located collaborative care providers and care management services within primary care.
• Need to continue to improve transitioning of Veterans between different levels of care, including tracking and follow-up of Veterans as care is transferred from various settings such as inpatient to residential, residential to outpatient, and outpatient to inpatient.
• Need to improve wait times, access, and scheduling of appointments for Veterans.

Question 2. OIG found VA's performance measures do not accurately convey whether patients are being provided timely access to mental health care. How will VA ensure medical centers are reliably and accurately reporting whether they are providing patients timely access to mental health care service, as well as verify those reports?

Response. The Department of Veterans Affairs (VA) has formed a workgroup, including leadership from VHA clinical operations, mental health operations, systems redesign, and field representation, to make recommendations on methods to measure Veterans' wait time experiences and to improve scheduling processes based on Veterans' needs. The Veterans Health Administration (VHA) has piloted the use of metrics that will simplify the interactions required between a scheduler and a Veteran as well as increase the number of measurement points to include the full continuum of care. In the interim, the workgroup has recommended using the "create date" metric for new patients, which minimizes the complexity of the current scheduling process. The "create date" is captured "automatically" by the computer when an appointment is made. VHA has also developed and successfully piloted a proposed standard process to more reliably capture "desired date" for established patients. The work group recommendations were accepted by the Under Secretary for Health (USH) on July 1, 2012. To support implementation of the new metrics, VHA has established a workgroup to develop training materials and processes to educate clinicians and schedulers about the new requirements. As part of implementation, an auditing process will be developed to assess reliability and accuracy with the new reporting requirements. In addition, VHA will continue to use the site visit methodology to verify the process. Full implementation of the new metrics is anticipated by the start of fiscal year (FY) 2014.

Question 3. OIG indicated VA's mental health care measures for evidence based therapies are not valid. How will VA hold medical centers accountable to ensure evidence based therapies are being provided as treatment guidelines state?

Response. The measure evaluated by the VA Office of Inspector General (OIG) as the evidence-based psychotherapy measure was still in draft form at the time of the audit. This measure is not directly a measure of evidence-based practice, but is a proxy measure to assess the percent of patients receiving an intensity of treatment (eight sessions in fourteen weeks) deemed as adequate for effective provision of psychotherapy. A software development project is underway to develop templated progress notes that will more directly measure implementation of evidenced-based

therapies. These templates provide a mechanism of tracking utilization of evidence-based psychotherapies (EBP), currently not available in our system, and will be required for use whenever EBPs are employed. Once these become available, Veterans Integrated Service Network (VISN), facility and VA Central Office Leadership will be able to review the data to follow-up on practices that do not meet the treatment guidelines.

Question 4. How will OMHS ensure a non-clinical encounter with veterans related to the mental health care services is not recorded as a session of treatment for performance measure purposes?

Response. Encounters which are entered in the Electronic Health Record (EHR), include information about the clinic where a visit occurred (documented with a stop code), the provider who met with the Veteran, and a Current Procedural Terminology (CPT) code. CPT codes describe what medical and diagnostic services occurred during a particular visit. Certain CPT codes are used to reflect the delivery of mental health treatment. If an encounter is non-clinical in nature, it would be reflected in the CPT code utilized, and it would not include a CPT code that is reflective of treatment. Based on the logic of the mental health metrics, non-clinical encounters would not be recorded with treatment CPT codes, and thus would not be recorded as a session of treatment for performance measure purposes.

Question 5. Psychotherapy session note templates were proposed by VA's Office of Patient Care Services, Mental Health Services to help clinicians consistently document use of evidence-based psychotherapies and accurately track use of these treatments, as well as allow program evaluators to monitor treatment outcomes. Please provide the Committee with the status of the implementation of these session note templates.

Response. Mental Health Services has developed session-by-session documentation templates for evidence-based psychotherapies being nationally implemented in VHA. The first set of evidence-based psychotherapy documentation templates is on the current Work Plan of the Office of Information and Technology for planned distribution to the field by the end of fiscal year (FY) 2013.

Question 6. Please describe the methodology used to allocate special funding for mental health initiatives. What steps is VA taking to hold recipients of such funding accountable for its targeted use and to prevent recipients from reallocating the funds to be used for other priorities set forth by VISN or medical center leadership?

Response. VHA, through the offices of Workforce Management and Consulting (WMC) and the Office of Mental Health Operations (OMHO) is closely tracking the hiring of the additional staff recently funded as well as the filling of existing vacancies to ensure the monies are being spent for mental health staff. WMC and OMHO are providing biweekly reports and as needed to VHA senior leadership on the hiring status.

Question 7. After the Department concludes its site visit reviews of mental health care services, how will VA ensure systematic surveillance efforts are carried out to better understand care trends, links between care processes and treatment outcomes, and facility-by-facility differences in performance?

Response. OMHO is currently completing site visits at all 140 VHA facilities this fiscal year. Upon receipt of the site visit report, the facility schedules a meeting with Director of OMHO, the OMHO technical assistance specialist, facility leadership, facility mental health leadership, and VISN mental health leadership. On this call, the findings are reviewed and the facility is asked to submit an action plan to address the recommendations. OMHO provides ongoing consultation, at a minimum on a quarterly basis, with the facility to ensure implementation of the action plan. VHA is aggregating the data across facilities to look for systemic areas that require improvement across the system.

Question 8. In 2005, and again in 2007, OIG released reports highlighting problems with VA's patient scheduling system, including the calculation of wait times and inconsistent practices used by schedulers to capture appointment information. Despite the identification of these issues nearly seven years ago, the most recent IG report again identified these same issues as significant challenges. Please explain how recommendations issued by OIG and concurred with by the Under Secretary for Health remain unresolved for so long, and discuss the lessons learned.

Response. In response to problems identified by OIG in 2005 and again in 2007, VHA stepped up its efforts to systematically train schedulers on correct scheduling practices and to audit their performance. These requirements were outlined in VHA policies published in 2008 and 2009. Internal VHA surveys show that compliance with VHA policy, especially in the area of entering desired date correctly has improved from the 60 percent range when OIG first studied the problem to the current 90 percent range in Mental Health. Because of the large number of employees

scheduling appointments (50,000+) and the large number of appointments made each year (over 80 million), even a small rate of error will result in a large absolute number of desired date inaccuracies. While the problem is not completely solved, performance has improved. VHA has learned that training alone will not solve the problem, and is working to improve the reliability of Desired Date entry again by piloting efforts to standardize communication processes and electronically audit desired date accuracy.

Additional Information:

VHA has, over the years, attempted to improve and strengthen the policy direction, measure, display, and report waiting times, and respond to all known issues. Appendix 1 and 2 provide detailed timelines of significant activities. The following table is a brief summary of major events:

Events		VHA Responses	
Timeline	GAO/IG Report Findings	VHA Waiting Time Metric	Directives
1999		Third Next Available	
2000-2004		Next Available	2002-028
Jan-03	Audit of Veterans Health Administration's Reported Medical Care Waiting Lists	Electronic Waiting List	
Jan-04		Beginning of Time Stamp Measures	
		Create Date for New Patients	
		Desired Date for Established Patients	
2005	Audit of Outpatient Scheduling Procedures		
2007	Audit of the Veterans Health Administration's Outpatient Waiting Times	Access List	
2008	Audit of Efforts to Reduce Unused Appointments	Consult Wait Time Measures Started	2008-056
	Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3		
	Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System		2009-070
2009		Recall Scheduling System	
Oct 1 2009 (FY 2010)	Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center	Desired Date for New and Established Patients	2010-027
	Audit of VA's Efforts To Provide Timely Compensation and Pension Medical Examinations		
2012	Review of Veterans' Access to Mental Health Care		

Specific Explanation of Issues:

• Appointment waiting times are a negotiation between patients, providers, and the schedule capacity considering a number of factors. Experience has taught that there is no one perfect way or "solution" to the measurement of waiting times.

• Private sector waiting time methods focus on capacity measures such as time to the third next available open appointment slot. VHA possesses and uses third next (and first next available) capacity measures and has since 1999.

• Because of the weaknesses in capacity measures to show the individual patient experience, beginning in 2004, VHA went well beyond other healthcare systems to measure 4 time stamps for every one of the approximately 80 million appointments per year.
• Each one of the time stamp points (Desired Date, Create Date, Scheduled (future) Appointment and Completed Appointment) has its strengths and weaknesses. Appendix 4 provides a comprehensive explanation of these strengths and weaknesses. The challenges in measuring waiting times exist for every healthcare system, not just VHA.
• Based on VA commissioned research studies that have just recently become available, VHA has new information on which measures are best associated with patient satisfaction and patient outcomes. VHA has learned:
  – Create Date has the strongest association with New Patient Satisfaction and outcomes
  – Desired Date (prospective) has the strongest association with Established Patient Satisfaction and outcomes
• Limitations of the Desired Date (DD) measure include reliance on schedulers to accurately determine Desired Dates. Multiple OIG reports since 2005 found the DD was not entered correctly in some cases. Internal audits of VA's scheduler performance in 2005 found DD correctly entered about 60 percent of the time. VHA agreed with the OIG finding and undertook mandatory scheduler training, yearly scheduler audits and feedback, facility certification of scheduling directive compliance, nationally hosted educational sessions, etc. The most recent audit of 43,643 appointments, done about 54 months ago, indicated that Mental Health Schedulers correctly entered the DD 91.61 percent of the time.
• It should be pointed out that there is yet another approach to measure wait times and that is from one completed appointment to another completed appointment. This is the method used in the widely debated Mental Health access performance measure looked at by the OIG recently where the time from completion of initial evaluation to completion of final evaluation was used. This method attempted to "zero in" on the experience of these specific mental health patients, required complex programming of the system, and does not measure the entire waiting time experience of the patient. The OIG attempted to combine the wait time methods of measuring one completed appointment to another completed appointment combined with DD wait times. The system was not designed to make this connection limiting the ability of the system to see the patient experience accurately.
• As stated earlier, wait time measurements are only one piece of information that a clinic needs in order to manage their clinic operations. In addition to wait time, the clinic needs to know at a minimum, the panel size (or case load), the appointment demand, supply and activity, the no-shows, the cancel and reschedule rate, and the appointment continuity. This information is used to manage day-to-day clinic flow to optimize access.

Lessons Learned:

(1) There is no perfect measure of waiting times in the VA, or probably in private sector for that matter.
(2) With more than 50,000 people making appointments in VHA, many of whom are entry level employees and with the high turnover in that job, it is probably unrealistic to expect DD will be entered correctly in every case.
(3) VHA should use different methods for measuring wait times in different subpopulations of patients (see appendix 4 and above). This is the best information on the "correct" methods to measure wait times that is known to exist at this point.
(4) It is important to clearly understand the method used to measure wait times when interpreting actual patient experience. For example, Mental Health measure reflects only a portion of the entire patients wait time, but was reported as reflecting the entire patient wait time.
(5) Management of wait times would be enhanced by a better scheduling system.

Question 9. Following the November 30, 2011, hearing on mental health care, VA indicated in questions for the record that off-hours care for mental health is available widely available. Based on completed site visits, has VA found discrepancies with what facilities have reported and what the site visits discovered regarding off-hours availability? Are facilities meeting the Extended Hours Access for Patients policy requirements?

Response. The Mental Health After Hours Report was reviewed through the second quarter of FY 2012. All medical centers visited through April 2012 have confirmed mental health clinic activity in off-hours as confirmed by medical record encounters. However, the site visits have identified three large CBOCs that had no

confirmed off-hours services in the first two quarters of FY 2012. These CBOCs are associated with two medical centers visited by OMHO through April 2012. Final site visits reports for these facilities have not yet been generated. However, overall, there does not appear to be a discrepancy between the Mental Health After Hours Report and what has been found on the site visits to date. As part of the site visit feedback, some facilities have been encouraged to expand the utilization of extended hours to assist with increasing access and reaching out to meet particular needs of Veterans.

Question 10. An OIG report identified that VA does not have a scheduling system that works. VA is replacing the medical scheduling software but will not be available for full implementation until 2014 at the earliest. Given VA has a scheduling system that is simply insufficient, what steps is the Department taking to expedite the replacement of this system so that veterans who need access to mental health care services can be scheduled for appointments in a timely and reliable way?

a. What steps is the Department taking to expedite the replacement of this system?

Response. In February 2009, the previous effort to replace VHA's 25-year-old scheduling system was ended without success. Work to examine the reasons for failure, including a comprehensive risk assessment concluded in 2010. At that point, VA reactivated the project with a decision to pursue a Commercial Off-The-Shelf software package to replace VistA Scheduling and be compatible with the current open source version of VistA.

In December 2011, VA published a Request for Information about scheduling software and received 35 responses from a broad range of industry sources. These responses validated the assumption that commercial products can meet most of our needs.

VA is in the process of designing a contest under the America Competes Act to address the most difficult component of the scheduling module: the ability to schedule across all facilities in the system.

In April 2012, Information Technology leadership led a joint VHA/OIT/CTO workgroup which defined the projected outcomes from conducting a contest under the America Competes Act. A draft integrated project team (IPT) charter was completed and an OIT project manager was assigned full-time to the project in May 2012.

b. What is VA doing now to make immediate access improvements for Veterans?

Response. In the interim, VA is contracting to develop two near term improvements to the current scheduling system. The first is a Veteran-facing application intended to reside on handheld devices that would allow a Veteran to request an appointment within a Veteran-specified date range. The second is a scheduler-facing application which would change the scheduler's view from the current blue-screen roll-and-scroll to a more user friendly calendar view of the schedule. Both of these short term improvements would provide significant improvements as the Veteran would be able to express their desired appointment date (improving the reliability of wait time measurement) and the scheduler would be able to much more efficiently find an available clinic slot. These improvements are being pursued along with the ultimate solution of replacing the scheduling system.

In addition to software efforts, VA continues to train key staff in "Advanced Clinic Access" principles through multiple internal venues. An initiative focused on improvements in Specialty Care, including access improvements was piloted in every network in 2012. This initiative will expand in 2013. VA is also working to decrease the rate of no-shows through system-wide initiatives including network and facility collaborations, virtual phone educational sessions, change strategies customized to individual facility problems. These initiatives are working to enhance the information available to local managers to pinpoint problematic clinics.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. As of today, how confident are you that schedulers are fully complying with the 2008 Uniform Mental Health Services in VA medical centers and Clinics Handbook with regard to performance compliance standards?

Response. We are confident that schedulers correctly establish Desired Date more than 90 percent of the time. In the first quarter of FY 2012, VA conducted an internal audit of a sample of mental health schedulers at each VA facility and the results

demonstrated that schedulers were accurately capturing the Veteran's Desired Date 91.61 percent of the time.

Question 2. Can you explain why the performance compliance standards could be so universally "misunderstood" or "misinterpreted" throughout the VA health care system?

Response. We believe the question refers to the performance standard regarding scheduler entry of Desired Date. Desired Date is a time-stamp used to measure waiting times. VA has the experience of many approaches to the measurement of wait times. The table below shows the high level timeline of these events and measures for the past 11 years. In response to congressional and oversight bodies, VHA has gone well beyond other healthcare systems (that measure access at the "clinic" level) in implementing a measurement of "Desired Date" in order to understand access at the individual patient level. "Desired Date" means the date which the patient or provider wants the patient to be seen. The definition is necessarily broad in order to accommodate all scheduling situations. For example an established patient scheduling an agreed-upon future appointment with their provider is very different than a new or established patient requesting an out-of-cycle appointment for a new problem. Training 50,000 people who schedule appointments to enter Desired Date correctly for each situation for over 84 million appointments per year is a daunting task. The turnover of schedulers alone requires constant vigilance and training. However, internal VHA reviews show the performance has improved from correct entry about 60 percent of the time (in 2005) to more than 90 percent currently. VHA is currently taking steps to improve the reliability of Desired Date entry by piloting standard communication and electronic audit processes. The aim of these efforts is to improve the reliability of Desired Date information even more.

Question 3. Were any schedulers reprimanded or fired because they were accurately reporting lower percentages in performance compliance standards than their counterparts who deviated from the VA Directives?

Response. Although VHA's Office of Workforce Services maintains data regarding adverse employee actions for senior staff, they do not have data regarding whether schedulers were reprimanded or fired due to inaccurate reporting of lower percentages in performance compliance standards.

Question 4. Do you have any idea how many veterans decided not to participate in VA Mental Health Care programs because they didn't want to wait beyond 14 days to be evaluated or have an appointment? Would the veteran's decision be documented as "resistant to treatment" or "denied treatment" or "no show" in his or her medical record?

Response. VHA does not currently collect data on Veterans who have decided that they did not wish to be evaluated due to having to wait beyond 14 days for a full evaluation appointment. If a Veteran decided that they did not wish to engage in VA mental health programs, the clinician who met with the Veteran should document an accurate reflection of the interaction with the Veteran. In the situation described in your question, such a statement might be "Veteran did not wish to engage in mental health care programs due to an extensive wait for an appointment." Such electronic health record entries cannot be readily pulled at a national level.

If a Veteran had an appointment scheduled and did not attend, they would be identified as a "no show" and attempts would be made to reschedule the appointment. The requirement is to attempt at least three times to reach the patient to reschedule or determine that they no longer are requesting services. There would never be a presumption of "resistance to treatment."

Question 5. Who is responsible for quality control assurance of the Performance and Accountability Report (PAR)? Knowing that clinical scheduling has been identified as a problem by VA's Office of Inspector General since 2005, how did the flawed data get past quality control reviews?

Response. There is no recognized "gold standard" in the health care industry for calculating appointment timeliness, and no best way to capture the needs of patients and clinicians in a single access number. The metrics used in the Performance Accountability Report were developed with the input of subject matter experts and approved by senior agency leadership. VA made the decision to calculate waiting times using the "Desired Date" methodology after several options were assessed by an internal working group. At the time, we believed this approach, while imperfect, would provide the most patient-centered perspective possible within our decades-old scheduling system, and that the improvement trends in the metrics, rather than their absolute values, would help gauge VA efforts at improving access.

Although the metrics themselves were calculated electronically from automated data systems, we were aware that over 50,000 staff across VA had the capability of scheduling appointments and that their individual actions would impact the va-

lidity of the data. Taking that into account, we thoughtfully designed staff education and a process of periodic auditing to assure our numbers were as accurate as humanly possible. Seven years ago, compliance with policy was assessed at approximately 60 percent; a level of performance that we recognized was insufficient. As a result of continued education and feedback, the most recent audits of mental health scheduling have indicated over 90 percent compliance with the capture of "Desired Date" as dictated by VA policy.

In order to eliminate any ambiguity about our intent or our performance, we will report to Congress from this point forward appointment times calculated using the "create date" entered into our scheduling package, while continuing to internally track waiting times based on Desired Date of appointment as well. We now have evidence from internal research that, for Veterans seeing us for the first time, waiting times calculated using "create date" may be overall more predictive of patient satisfaction. The same research also suggests that for established patients, waiting times calculated using "Desired Date" is the better predictor of satisfaction.

It is important to point out, however, that we capture only an incomplete picture of access with such measured waiting times. Holistic mental health care requires the engagement of a team of professionals, including psychiatrists, psychologists, social workers, advanced practice nurses, and primary care providers to assure access to appropriate evaluation and treatment. VA has done considerable work over the past decade to integrate mental health evaluation and treatment into team-driven primary care settings, including collaborative care models and the extensive use of telemedicine. These modalities assure that Veterans experiencing emotional distress can be seen immediately, without the additional step of scheduling a separate consultation or appointment and waiting for a response. While such approaches are truly Veteran-centered and appreciated by patients and clinicians, ironically, they are not captured in our scheduling system, which was designed decades before such approaches were made part of our clinical routine.

Question 6. If an active-duty servicemember is diagnosed with PTSD by a military behavioral health care professional and is subsequently medically discharged from the Armed Forces, is there a formal process between the Military Health Care System and VA to make sure the veteran's treatment plan is successfully transferred between the two Federal agencies?

Response. VA has a formal process in place to transition ill and/or injured Servicemembers from DOD to VA. VA has 33 VA Liaisons for Healthcare, registered nurses or licensed social workers, stationed at 18 Military Treatment Facilities (MTFs) with concentrations of recovering Servicemembers returning from Iraq and Afghanistan. These staff transition ill and/or injured Servicemembers from DOD to the VA system of care. VA Liaisons are co-located with the DOD case managers at the MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. Each referral from the DOD treatment team, including referrals for Servicemembers being medically discharged with PTSD, utilizes a standardized referral form completed by the DOD Nurse Case Manager identifying the ongoing treatment needs. In addition, each referral to a VA medical center (VAMC) includes supporting medical documentation such as progress notes and narrative summaries. At MTFs without an onsite VA Liaison, DOD Case Managers can refer Servicemembers directly to the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Program Manager at the Servicemember's home VAMC. These referrals also utilize the standardized referral form identifying the ongoing treatment needs as well as the supporting medical documentation. As part of this process, a Servicemember's treatment plan is transferred from DOD to VA, though the Servicemember/Veteran has a choice whether or not to enroll and participate in the VA health care system.

Question 7. Did the VA pay any bonuses to employees based on the 95 percent compliance rate for new patients receiving an evaluation within 14 days or appointments within 14 days of their desired date?

Response. This information is local information that is not available centrally.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The OIG has reported several times on inappropriate and inconsistent scheduling practices in 2005, 2007, and now again in 2012. VHA has taken steps to address these issues, however, the problem persists.

(a) Why does this continue to be an issue and what is contributing to the inappropriate practices?

Response. Establishment of Desired Date (DD) requires knowledge of the patient and provider negotiation (for return appointments) and an understanding of what the patient wants under IDEAL circumstances (for new appointments, or for established patients who request a new appointment). Schedulers must enter the correct date in a roll-and-scroll line in the middle of a complex computer appointing process. If they are pressed with other duties (checking in, checking out, answering phones and questions from staff and patients), it is easy for the scheduler to be expedient and accept the default on the DD question.

(b) Is it simply a lack of training for schedulers?

Response. Not entirely. The process of establishing DD can be difficult. VHA is pushing to simplify and standardize the parts of the communication between the provider and patient so the establishment of DD in that situation (which is the majority of the cases) should be simpler and more reliable.

(c) Are the schedulers receiving the required annual trainings and taking the annual tests to ensure they are properly carrying out VHA directives?

Response. The schedulers are required to successfully complete the scheduler modules and Soft Skills training at the time they are hired. The scheduler supervisors are responsible for conducting a yearly audit on their performance, and addressing performance gaps. Additional training is available and should be undertaken by those schedulers who are uncomfortable with the scheduling protocols.

Question 2. According to the OIG, this is leading to skewed data that is not helpful to key decisionmakers from the managerial level to the administrative level to Congress.

(a) Do these inconsistencies occur in all the VISNs, or some performing better than others?

Response. The inconsistencies in question are the correct entry of the Desired Date (DD) into the VistA scheduling system. The latest VHA self-study on entry of DD, completed December 23, 2011, looked at 43,643 mental health records from the five busiest Mental Health Clinics in all VISN's. Overall, VHA found DD was entered accurately 91.67 percent of the time. Since most appointments made are for established patients rather than new patients, this study is thought to include predominately established patients; therefore, VHA is less certain about the accuracy of DD for new patients.

No VISN enters DD correctly all of the time. This is because of several factors, including: the difficulty associated with determining the DD (as noted in the examples below); reliance on humans who may make mistakes to enter the DD; variation in systems and processes within and between clinics; and high turnover rates of scheduling clerks, resulting in less experienced staff performing the task at times.

Some examples of different approaches to determining the Desired Date follow:

- If the patient has an established relationship with the provider and agrees to return for a future appointment, the date the patient and provider agree upon as the desired return date is the DD. This situation is often called "internal demand" in the Advanced Access literature and comprises the majority of appointments in VHA. For example, a patient with diabetes may be due for a return visit in 6 months, in which case the Desired Date for the follow-up appointment would be the date 6 months from the present appointment, regardless of when the follow- up appointment is ultimately scheduled.
- Alternatively, if an established patient requests a previously unanticipated appointment, or a new patient requests their first appointment, the scheduling clerk is instructed to ask the patient when they would like to be seen (regardless of when they are able to be seen in an open slot). The answer to this question establishes the DD for this "external demand" situation. For example, if a Veteran calls on a Monday requesting an appointment right away and says Thursdays are good, the following Thursday (e.g., 3 days from the appointment request) is entered as the Desired Date. The appointment is then negotiated and created without changing the Desired Date, even if there is no appointment availability on the date the patient initially requested.

(b) What is VHA doing to correct this problem?

Response. VHA chartered a workgroup to make recommendations to the USH on developing new metrics to better measure the Veteran waiting experience. The workgroup made a number of recommendations that were accepted by the USH on July 1, 2012. These recommendations are in the process of being implemented.

Question 3. In the discussion on metrics, VHA mentioned that the work group recommended they return to using the "create date" metric to help give a better picture of veterans' waiting times.

(a) When the use of this was metric abandoned?

Response. VHA still collects the data on Create Date (CD), but stopped using it as a performance measure in 2010.

(b) Why did VHA stop using it?

Response. VHA stopped using it because field facilities indicated there were multiple case of patients who wanted to make appointments earlier than 14 or 30 days from the time they wanted the appointment to occur. It was an attempt to make the waiting time measure more patient-centric.

Question 4. In light of Sec. Shinseki's announcement of the addition of 1600 mental health clinicians and 300 support positions, how will these positions be distributed amongst the VISNs?

(a) How did VHA determine the numbers of needed clinicians and support staff?

Response. VHA is piloting a staffing model to ensure consistent staffing patterns for outpatient mental health services based on numbers of patients served, the range of services available at a facility, characteristics of the facility, and complexity of services. A projection for national implementation of the model showed that many sites would need additional staff. This need was also suggested by data from site visits, providers and Veterans. The initial projection was then modified in conjunction with VISNs/facilities to correct for local practices such as the use of tele-mental health or contracting.

(b) Is this number an appropriate reflection of the need for mental health providers throughout the VA system?

Response. VHA is piloting the staffing model, which is based on Veteran population in the service area, mental health needs of Veterans in that population, and range and complexity of mental health services provided in the service area. VHA will be assessing the adequacy of the model based on access, Veteran and provider satisfaction, use of evidence-based psychotherapy among other therapies, and will continue to adjust staffing as needed to meet the mental health needs of Veterans.

(c) What will VHA do in the interim to help veterans receive timely mental health services?

Response. As part of the site visit process, VHA is working with facilities to reduce barriers to access as they are identified. In FY 2012, VHA provided $12 million in funding to expand the use of tele-mental health for PTSD and is continuing to work with sites to identify opportunities to use this technology to provide expanded services. VHA is also expanding the implementation of mental health in primary care which allows Veterans to have access to mental health services within the primary care setting. Sites are also able to use fee and/or contract services to provide timely services.

Question 5. The VHA Action Plan states that the work group will provide the Under Secretary for Health with an action plan to create new metrics no later than July 1, 2012.

(a) How long will the review process take?

Response. The review process began with the July action plan deadline and will continue, with expected refinements, and initial piloting of the new metrics by the first quarter of FY 2013.

(b) What is the timeframe for implementation of the work group's action plan?

Response. It is anticipated that the action plan will be implemented by December 31, 2012.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. ROGER F. WICKER TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

POST-TRAUMATIC STRESS DISORDER

Over the years, the public has seen an increase in Veterans who suffer from PTSD. With the recent withdrawal of U.S. combat forces from Iraq and the administrations announcement to end combat operations in 2014 in Afghanistan, I expect that there will be an increasing number of veterans that will be diagnosed with PTSD. I am concerned about the process to determine how benefits are given to those who suffer from PTSD amid this backlog.

Question 1. My office has received complaints about doctors at VA hospitals in Mississippi who are skeptical of accepted science regarding PTSD. What actions will be taken to ensure that certain doctors, who receive a large number of complaints, over an extended period of time, will be properly vetted by the VA and that appropriate action will be taken?

Response. VHA is invested in ensuring that Veterans receive evidence-based care for PTSD and appreciates being informed when concerns are identified about PTSD treatment. Complaints about any provider that are reported to the patient advocates locally are recorded in a complaint tracking file. Supervisors are notified when a complaint is made and the supervisor follows up with the concern at that time. Additionally, all VA credentialed and privileged providers are required to be reviewed on a variety of performance standards twice a year through the Ongoing Professional Practice Evaluation (OPPE). Quality monitors are reviewed with providers by their supervisor. If there is a continued pattern of complaints regarding a provider, this would be reviewed at that time as well as with the mid-year performance and end-of-year performance evaluations. If improvements are not made, the supervisor may pursue disciplinary actions and/or dismissal if no progress is made on written goals.

Question 2. What is the number of denials for PTSD claims at the Jackson Regional Office based on the doctor's recommendations? Additionally, what is the number of claims which were initially denied, but later reversed on appeal?

Response. VBA does not track claims by physician. In FY 2011, service-connection for PTSD was granted on approximately 11,500 appeals nationally. Of these, 1,573 were granted by the Board of Veterans' Appeals.

Question 3. Can you please provide the statistical data on the denial rate at the Jackson VA Regional Office in comparison to other VA Regional Offices?

Response. In FY 2011, the average percentage of claims denied nationwide was 23.2 percent for claims for PTSD, to include original claims, claims for increase, and claims that were previously denied. The Jackson Regional Office's (RO) denial rate was 33.4 percent.

In 2006 and 2009, the Institute for Defense Analyses (IDA) conducted studies to determine factors that contribute to differences in disability compensation awards. One factor they found was that claims approval rates vary significantly based on the population served. For example, ROs processing high volumes of pre-discharge claims and claims from recently separated Servicemembers have higher grant rates. Pre-discharge claims and claims from recently separated Servicemembers usually have service treatment records readily available and up-to-date medical information and have a higher number of issues claimed. IDA also found that other factors that contribute to the differences include median family income, percentage of the general population with a mental disability, length of service, and population density (urban, rural, and highly rural). In areas experiencing difficult economic conditions, Veterans are more likely to submit first-time claims, claims for an increase in benefits, and to resubmit claims that were previously denied, also impacting grant and denial percentages.

Question 4. Why is the VA Form 9 processed at Regional Offices before they reach the Board of Veteran Appeals?

Response. VA Form 9s are processed at ROs prior to going to the BVA because it provides additional opportunities to resolve the appeal at the lowest possible level. ROs must ensure the following actions take place after a VA Form 9 is filed:

- Determine if the VA Form 9 was timely filed
- Obtain clarification of appealed issues if VA Form 9 is incomplete
- Consider additional evidence submitted by the appellant
- Accommodate appellant requests for a local hearing at the RO
- Consider any new issues raised by the appellant

These prerequisite steps to certifying an appeal are in place to ensure ROs have done everything possible to resolve the appeal prior to sending the claim to the Board of Veterans' Appeals.

Question 5. Describe how the VA conducts quality control of PTSD, C&P Exam Results, and C&P Examiner Performances?

Response. The Systematic Technical Accuracy Review (STAR) program assesses the accuracy of disability benefit determinations and is administered by VBA's Compensation Service. It utilizes employees well-versed in the claims adjudication process to review and analyze claims data nationwide. Although there is no special review for PTSD claims, a percentage of them are reviewed along with other categories of claims. The STAR reviews focus on nationwide rating consistency by reviewing RO rating decision variance across frequently rated medical diagnostic codes, including those for PTSD and other mental disorders. In addition, earlier this year VBA implemented the Quality Review Team's transformation initiative that will result in improvements in the service VBA provides. Dedicated teams of quality review specialists at each RO evaluate decision accuracy at both the RO and individual employee level, and perform in-process review to eliminate errors at the ear-

liest possible stage in the claims process. The teams are comprised of personnel trained by our national quality assurance review staff to assure local reviews are consistently conducted according to national standards.

VHA's Office of Disability and Medical Assessment (DMA) conducts quality reviews of VA Compensation and Pension (C&P) examination requests made by VBA and examinations completed by VHA clinicians. The Quality Management section, an integral component of DMA's quality and timeliness mission, is responsible for the collection and evaluation of VA disability examination data to support recommendations for improvement throughout the VHA and VBA examination process. The quality review program incorporates a three-dimensional approach consisting of an audit review process to assess medical-legal completeness, performance measures, and a review process to assess clinical examination reporting competence.

A mix of staff knowledgeable in both the clinical protocol/practices of the C&P examination process and staff with VBA rating experience perform the reviews. This monthly random sample can include all potential exam types. This quality review process started in October 2011, replacing the former C&P Examination Program that was discontinued in October 2010. Ongoing enhancements to data collection will provide VBA and VHA with detail data to support process improvement.

DMA is charged with improving the disability examination process by monitoring the quality of examinations conducted. Quality is monitored monthly using an audit review tool and the results are reported on a quarterly basis. This intense audit is conducted on all types of disability examinations, assessing consistency between the medical evidence and the examination report.

DMA monitors disability examiner registration and certification and designs and conducts continuous education and training. DMA, in conjunction with the Employee Education System, oversees the program for mandatory registration and certification as outlined by VHA Directive 2008–05, "Certification of Clinicians Performing Compensation and Pension Examinations," (below). This program provides all compensation and pension (C&P) clinicians with a common resource of essential knowledge about the C&P process and ensures that all Veterans' disability examinations are performed by clinicians who are specially trained to conduct C&P examinations.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2008-005

January 29, 2008

CERTIFICATION OF CLINICIANS PERFORMING COMPENSATION AND PENSION EXAMINATIONS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy for the implementation of an education and certification program for clinicians who perform compensation and pension (C&P) examinations.

2. BACKGROUND

a. VHA performs over 700,000 C&P examinations yearly. As part of the ongoing quality assurance program operated by the office of Compensation and Pension Examination Program (CPEP), and from reports issued by the office of the Department of Veterans Affairs (VA) Inspector General, it has been concluded that there is observed variation in the performance and quality of C&P examination reports between Veterans Integrated Service Networks (VISNs).

b. As health care providers traditionally approach examinations in the purely clinical domain, training is critical to ensure that they have an understanding of the legal ramifications of the examinations, and what elements are required by the Veterans Benefit Administration (VBA) in order to make a valid determination. Given the importance of a thorough examination to the veteran in terms of eligibility for future benefits and compensation, it is critical that standards are consistently enforced and applied fairly across all VISNs. As a result, VHA and VBA have determined the need for a training and certification program established for all clinicians performing C&P examinations, no matter where they are performed. These courses are available on VA Learning Management System (LMS) http://www.lms.va.gov to meet the requirements identified below (search for keyword "CPEP").

c. After completion of the certification process, employees who have demonstrated increased performance in the efficiency of claims processing, customer satisfaction, and improved quality of examinations being performed may be acknowledged. In recognition of this increased performance, VHA physicians and other clinicians who are "certified C&P examiners" on a prorated basis may receive a one-time incentive award up to $1,000 from their local health facility. ***NOTE:*** *Any VHA clinician may take the certification training and receive continuing medical education (CME) for course completion, but only clinicians designated to perform C&P examinations are eligible to receive the cash award. Residents and interns assisting with C&P examinations, as part of their graduate training curriculum under the supervision of a VHA certified C&P examiner, are encouraged to complete the training modules that are appropriate to their courses of training, but are not eligible for the cash awards.*

3. POLICY: It is VHA policy that all clinicians designated to conduct C&P examinations must complete the required training modules and post-tests and become certified by CPEP; new clinicians must be certified prior to being allowed to perform any C&P examination; clinicians already performing C&P examinations have until July 1, 2008, to be certified; however, they may still perform C&P examinations during the interim period.

THIS VHA DIRECTIVE EXPIRES ON JANUARY 31, 2013

4. ACTION

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for joint oversight of CPEP.

b. **Compensation and Pension Examination Program (CPEP) Office.** The CPEP Office is directly responsible for:

(1) The development, evolution, management and implementation of the ongoing clinician certification program.

(2) Working collaboratively with the Employee Education System (EES) to:

(a) Produce the certification training modules, and

(b) Document and track clinicians who have successfully completed the required training.

(3) Coordinating the certification process and providing a list of certified clinicians to the appropriate field facility.

(4) Monitoring field facilities for compliance with this Directive.

(5) Establishing and chairing the C&P Examiner Certification Review Board (ECRB). Membership on the board shall include representation from Patient Care Services (PCS), Employee Education System (EES), C&P Service, Office of Nursing Services, Mental Health Services, and a field representative from a Medical Center C&P Program Office.
The ECRB shall be responsible for the identification and oversight of all future modules and updates to existing modules which will be used as content requirements for maintaining certification. The ECRB will serve in an advisory capacity to the CPEP office which has overall responsibility for the clinician certification program.

c. **EES Office in Northport, NY.** The EES Office in Northport, NY, is responsible for the:

(1) Production of C&P training modules in direct collaboration with CPEP and field-based subject matter experts who perform C&P examinations.

(2) Development and maintenance of the web-based training and testing sites.

(3) Access to course completion and testing data.

d. **VISN Director.** Each VISN Director is responsible for ensuring:

(1) Certification of all clinicians performing C&P examinations (including fee-for-service physicians) within their areas of responsibility.

(2) The VISN C&P Contact Person compiles and maintains a list of providers who perform C&P examinations at each facility, and submits the list to CPEP Office.

(3) Additional instructions provided by CPEP on the certification process are distributed to the VISN facilities.

e. **Facility Director.** Each facility Director is responsible for ensuring:

(1) Certification of all clinicians performing C&P examinations (including fee-for-service physicians) within their area of responsibility.

(2) Consideration of cash awards acknowledging successful completion of certification.

(3) Local record keeping strategies are developed and implemented to track employees' completion of C&P certification training.

(4) All clinicians who perform VA C&P examinations (for VHA this means all employee and Fee-For-Service Providers) complete the interactive video module on "CPEP General Certification Course."

(5) All clinicians who perform VA C&P examinations (for VHA this means all employee and Fee-For-Service Providers) successfully complete the post-test examination.

(6) Requirements are met for certain special examinations. In addition to completing the interactive video module on "CPEP General Certification Course," and successfully completing the post-test examination, those:

(a) Clinicians performing joint, feet, and spine examinations, must complete the module on the "Musculoskeletal Examination," and successfully complete the post-test.

(b) Psychiatrists and clinical psychologists performing initial mental disorders examinations, must complete the "Mental Disorders Initial Examination" module, and successfully complete the post-test.

(c) Psychiatrists and clinical psychologists performing initial Post Traumatic Stress Disorder (PTSD) examinations must complete the "Initial PTSD Examination" module and successfully complete the post-test.

(d) Clinicians who perform mental disorder review examinations (including nurse practitioners, physician assistants, and licensed social workers) must complete the module for "Mental Disorders Review Examinations," and successfully complete the post-test.

(e) Clinicians who perform Post-traumatic Stress Disorder (PTSD) review and/or increase examinations, (including nurse practitioners, physician assistants and licensed social workers) must complete the module for "PTSD Review and/or Increase Examinations," and successfully complete the post-test.

(7) Timely completion of updates to existing modules and any new module requirements that may be added in the future for enhancing the efficacy of the clinician certification program.

(8) The completion of the certification process is linked to increased performance in the efficiency of claims processing, customer satisfaction, and improved quality of examinations being performed. In recognition of this increased performance, VHA physicians and other clinicians who become "certified" C&P examiners, and are involved in the actual performance of C&P examinations, may receive a one-time incentive cash award up to $1000. The decision to grant any cash award is the responsibility of the facility Director, as is the determination of the actual amount of the award that each clinician may be eligible to receive. ***NOTE:*** *Any VHA clinician may take the certification training and receive continuing medical education (CME) for course completion, but only clinicians designated to perform C&P examinations are eligible to receive the cash award. Residents and interns assisting with C&P examinations as part of their graduate training curriculum under the supervision of a VHA certified C&P examiner, are encouraged to complete the training modules that are appropriate to their courses of training, but are not eligible for the cash awards.*

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBLITIES: The Office of Department of Defense (DOD) Coordination (10D) is responsible for the contents of this Directive. Questions may be addressed to the Office of DOD Coordination at (202) 461-6082.

7. RESCISSIONS: None. This VHA Directive expires on January 31, 2013.

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 1/30/08
FLD: VISN, MA, DO, OC, OCRO and 200 – E-mailed 1/30/08

4

Chairman MURRAY. Thank you very much.
Ms. Halliday?

STATEMENT OF LINDA HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LARRY REINKEMEYER, DIRECTOR, KANSAS CITY OFFICE OF AUDITS AND EVALUATIONS

Ms. HALLIDAY. Madam Chairman, Members of the Committee, thank you for the opportunity to discuss the results of our recent report on veterans access to mental health care services in VA facilities. We conducted the review at the request of the Committee, the VA Secretary, and the House of Veterans' Affairs Committee.

Today I will discuss our efforts to determine how accurately the VHA reports wait times in mental health services to both new and established patient appointments. Dr. Daigh, the assistant Inspector General for the Office of Healthcare Inspections, will address whether the wait times data VHA collects is an accurate depiction of the veterans' ability to access those services.

We are accompanied today by Dr. Michael Shepherd, a senior physician in the Office of Healthcare Inspections, and Mr. Larry Reinkemeyer, the Director of the Kansas City Office of Audits.

Our review found that inaccuracies in data and inconsistent scheduling practices diminished the usability of information needed to fully assess current capacity, resource distribution, and productivity across the VA system. In VA's Fiscal Year 2011, in the performance accountability report, VHA reported 95 percent of first time patients received a full mental health evaluation within 14 days. However, we concluded that that 14-day reported measure has no real value as an access to care measure because VHA measured how long it took to conduct the mental health evaluation, not how long the patient waited to receive that evaluation.

We calculated the number of days between the first time patient's initial contact with mental health and the completion of their evaluation. We projected that VHA provided only 49 percent or approximately 184,000 of these evaluations, within 14 days of either the veterans' request or referral for mental health care. On average, it took VHA about 50 days to provide the remaining patients their full evaluation.

Once VHA provides the patient with their evaluation, VHA schedules the patient for an appointment to begin treatment. In Fiscal Year 2011, we determined that VHA completed approximately 168,000 or 64 percent new patient appointments for treatment within 14 days of their desired date. Thus, approximately 94,000 or 36 percent of the appointments nationwide exceeded 14 days.

In comparison, VHA data showed that 95 percent received timely care. We also projected that VHA completed approximately 8.8 million or 88 percent of the follow up appointments for treatment in 14 days. Thus, approximately 1.2 million or 12 percent of the appointments nationwide exceeded 14 days. In contrast, VHA reported 98 percent received timely care for treatment.

We based our analysis on the dates documented in VHA's medical records. However, we have concerns regarding the integrity of the date information because providers told us they used the desired date of care based on their schedule availability.

I want to point out that we reported concerns with VHA's calculated wait time data in our audits of outpatient scheduling procedures in 2005 and outpatient wait times in 2007. During both audits, we found schedulers were entering an incorrect desired date, and our current review show these practices continue. For new patient appointments, the schedulers frequently stated they used the next available appointment slot as the desired date of appointment for new patients. This practice greatly distorts the actual waiting time for appointments.

To illustrate, VHA showed 81 percent or approximately 211,000 new patients received their appointments on their desired appointment date. We found the veteran could still have waited two to 3 months for an appointment, and VHA's data would show a zero day wait time.

Based on discussions with medical center staff and our review of the data, we contend it is not plausible to have that many appointments scheduled on the exact day the patients' desired.

I offer the rest of my time to Dr. Daigh, who will provide the overall OIG conclusion.

[The prepared joint statement of Ms. Halliday and Dr. Daigh follows:]

PREPARED STATEMENT OF THE OFFICE OF INSPECTOR GENERAL,
U.S. DEPARTMENT OF VETERANS AFFAIRS

INTRODUCTION

Madam Chairman and Members of the Committee, thank you for the opportunity to discuss the results of a recent Office of Inspector General (OIG) report, *Veterans Health Administration—Review of Veterans' Access to Mental Health Care*, on veteran access to mental health care services at VA facilities. We conducted the review at the request of the Committee, the VA Secretary, and the House Veterans' Affairs Committee. The OIG is represented by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections; Dr. Michael Shepherd, Senior Physician in the OIG's Office of Healthcare Inspections; and Mr. Larry Reinkemeyer, Director of the OIG's Kansas City Office of Audits and Evaluations.

BACKGROUND

Based on concerns that veterans may not be able to access the mental health care they need in a timely manner, the OIG was asked to determine how accurately the Veterans Health Administration (VHA) records wait times for mental health services for both initial (new patients) and follow-up (established patients) visits and if the wait time data VA collects is an accurate depiction of veterans' ability to access those services.

VHA policy requires all first-time patients referred to or requesting mental health services receive an initial evaluation within 24 hours and a more comprehensive mental health diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs and to trigger hospitalization or the immediate initiation of outpatient care when needed. Primary care providers, mental health providers, other referring licensed independent providers, or licensed independent mental health providers can conduct the initial 24-hour evaluation.

VHA uses two principal measures to monitor access to mental health care. One measure looks at the percentage of comprehensive patient evaluations completed within 14 days of an initial encounter for patients new to mental health services. Another method VHA uses is to calculate patient waiting times by measuring the elapsed days from the desired dates[1] of care to the dates of the treatment appointments. Medical facility schedulers must enter the correct desired dates of care in

[1] The desired date of care is defined as the earliest date that the patient or clinician specifies the patient needs to be seen.

the system to ensure the accuracy of this measurement. VHA's goal is to see patients within 14 days of the desired dates of care.

REVIEW RESULTS

Our review focused on how accurately VHA records wait times for mental health services for initial and follow-up visits and if the wait time data VA collects is an accurate depiction of the veterans' ability to access those services. We found:

- VHA's mental health performance data is not accurate or reliable.
- VHA's measures do not adequately reflect critical dimensions of mental health care access.

Although VHA collects and reports mental health staffing and productivity data, the inaccuracies in some of the data sources presently hinder the usability of information by VHA decisionmakers to fully assess current capacity, determine optimal resource distribution, evaluate productivity across the system, and establish mental health staffing and productivity standards.

VHA's Performance Data Is Not Accurate or Reliable

In VA's fiscal year (FY) 2011 *Performance and Accountability Report* (PAR), VHA reported 95 percent of first-time patients received a full mental health evaluation within 14 days. However, the 14-day measure has no real value as VHA measured how long it took VHA to conduct the evaluation, not how long the patient waited to receive an evaluation. VHA's measurement differed from the measure's objective that veterans should have further evaluation and initiation of mental health care in 14 days of a trigger encounter. VHA defined the trigger encounter as the veteran's contact with the mental health clinic or the veteran's referral to the mental health service from another provider.

Using the same data VHA used to calculate the 95 percent success rate shown in the FY 2011 PAR, we conducted an independent assessment to identify the exact date of the trigger encounter (the date the patient initially contacted mental health seeking services, or when another provider referred the patient to mental health). We then determined when the full evaluation containing a patient history, diagnosis, and treatment plan was completed. Based on our analysis of that information, we calculated the number of days between a first-time patient's initial contact in mental health and their full mental health evaluation. Our analysis projected that VHA provided only 49 percent (approximately 184,000) of first-time patients their evaluation within 14 days.

VHA does not consider the full mental health evaluation as an appointment for treatment, but rather the evaluation is the prerequisite for VHA to develop a patient-appropriate treatment plan. Once VHA provides the patient with a full mental health evaluation, VHA schedules the patient for an appointment to begin treatment. We found that VHA did not always provide both new and established patients their treatment appointments within 14 days of the patients' desired date. We reviewed patient records to identify the desired date (generally located in the physician's note as the date the patient needed to return to the clinic or shown as a referral from another provider) and calculated the elapsed days to the date of the patient's completed treatment appointment date.

We projected nationwide that in FY 2011, VHA:

- Completed approximately 168,000 (64 percent) new patient appointments for treatment within 14 days of their desired date; thus, approximately 94,000 (36 percent) appointments nationwide exceeded 14 days. VHA data reported in the PAR showed that 95 percent received timely care.
- Completed approximately 8.8 million (88 percent) follow-up appointments for treatment within 14 days of the desired date; thus, approximately 1.2 million (12 percent) appointments nationwide exceeded 14 days. VHA data reported in the PAR showed that 98 percent received timely care for treatment. Although we based our analysis on dates documented in VHA's medical records, we have less confidence in the integrity of this date information because providers at three of the four medical centers we visited told us they requested a desired date of care based on their schedule availability.

Scheduling Process

Generally, VHA schedulers were not following procedures outlined in VHA directives and, as a result, data was not accurate or reliable. For new patients, the scheduling clerks frequently stated they used the next available appointment slot as the desired appointment date for new patients. Even though a consult referral, or contact from the veteran requesting care, may have been submitted weeks or months earlier than the patient's appointment date, the desired appointment date

was determined by and recorded as the next available appointment date. For established patients, medical providers told us they frequently scheduled the return to clinic date based on their known availability rather than the patient's clinical need. Providers may not have availability for 2–3 months, so they specify their availability as the return to clinic timeframe.

OIG first reported concerns with VHA's calculated wait time data in our *Audit of VHA's Outpatient Scheduling Procedures* (July 8, 2005) and *Audit of VHA's Outpatient Wait Times* (September 10, 2007). During both audits, OIG found that schedulers were entering an incorrect desired date. Nearly 7 years later, we still find that the patient scheduling system is broken, the appointment data is inaccurate, and schedulers implement inconsistent practices capturing appointment information.

Workload and Staffing

According to VHA, from 2005 to 2010, mental health services increased their staff by 46 percent and treated 39 percent more patients. Despite the increase in mental health care providers, VHA's mental health care service staff still do not believe they have enough staff to handle the increased workload and to consistently see patients within 14 days of the desired dates. In July 2011, the Senate Committee on Veterans' Affairs requested VA to conduct a survey that among other questions asked mental health professionals whether their medical center had adequate mental health staff to meet current veteran demands for care; 71 percent responded their medical center did not have adequate numbers of mental health staff.

Based on our interviews at four VA medical centers (Denver, Colorado; Spokane, Washington; Milwaukee, Wisconsin; and Salisbury, North Carolina), staff in charge of mental health services reported VHA's greatest challenge has been to hire and retain psychiatrists. We analyzed access to psychiatrists at the four visited medical centers by determining how long a patient would have to wait for the physician's third next available appointment. Calculating the wait time to the third next available appointment is a common practice for assessing a provider's ability to see patients in a timely manner. On average at the four VA medical centers we visited, a patient had to wait 41 days.

VHA's Measures Do Not Adequately Reflect Critical Dimensions of Mental Health Care Access

The data and measures needed by decisionmakers for effective planning and service provision may differ at the national, Veterans Integrated Service Network, and facility level. No measure of access is perfect or provides a complete picture. Meaningful analysis and decisionmaking requires reliable data, on not only the timeliness of access but also on trends in demand for mental health services, treatments, and providers; the availability and mix of mental health staffing; provider productivity; and treatment capacity. These demand and supply variables in turn feed back upon a system's ability to provide treatment that is patient centered and timely.

Decision makers need measures that:

- Are derived from data that is reliable and has been consistently determined system-wide.
- Are based on reasonable assumptions and anchored by a reasonable and consistent set of business rules.
- Are measurable in practice given existing infrastructure.
- Are clinically or administratively relevant.
- Provide complementary or competing information to other measures used by decisionmakers.
- Measure what they intend to measure.

Measuring Access to VHA Mental Health Care

Included in the FY 2012 Network Director Performance Plan are the following measures: the percentage of eligible patient evaluations documented within 14 days of a new mental health patient initial encounter; a metric requiring a follow-up encounter within 7 days of discharge from inpatient hospitalization; a measure requiring four follow-up encounters within 4 weeks of discharge from inpatient treatment for high risk patients; and a measure of the percentage of new Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans receiving eight psychotherapy sessions within a 14-week period during one year period.

VHA's 14-day measure calculates the percentage of comprehensive patient evaluations documented within 14 days of an initial encounter for patients new to mental health services. In practice, the 14-day measure is usually not triggered until the veteran is actually seen in a mental health clinic and a comprehensive mental health evaluation is initiated. For example, a new-to-VHA veteran presents to a primary care clinic, screens positive for depression, and the primary care provider re-

fers the veteran for further evaluation by a mental health provider. The "clock" for the 14-day follow-up measure will start when the veteran is actually seen in a mental health clinic and a comprehensive mental health evaluation is initiated, not at the time of the primary care appointment. Consequently, the data underlying this measure only provides information about the timeliness within which comprehensive new patient evaluations are completed but not necessarily the timeliness between referral or consult to evaluation.

Veterans access VHA care through various routes, such as VA medical center emergency departments, primary and specialty care clinics, women's clinics, or mental health walk-in clinics. Alternatively, they may seek services at community based outpatient clinics or Vet Centers in their communities. They may also initiate mental health services with private providers and later come to VA seeking more comprehensive services. The 14-day measure does not apply to veterans who access services through Vet Centers or non-VA-based fee basis providers.

A series of complementary and competing timeliness and treatment engagement measures that better reflect the various dimensions of access would provide decisionmakers with a more comprehensive view of the ability with which new patients can access mental health treatment.

The timeframe immediately following inpatient discharge is a period of high risk. The 7-day post-hospitalization and the four follow-up appointments in 4 weeks for high-risk patient measures are clinically relevant. The eight psychotherapy session in 14 weeks measure attempts to be a proxy for whether OEF/OIF patients are receiving evidence-based psychotherapy. The measure is clinically relevant but the utility is presently marred by inaccurate data or unreliable methodology.

Beyond measures of timeliness (or delay) to mental health care, user friendly measures that incorporate aspects of patient demand, availability and mix of mental health clinical staffing, provider productivity, and treatment capacity, anchored by a consistent set of business rules, might provide VHA decisionmakers with more information from which to assess and timely respond to changes in access parameters.

Recommendations

Our report contained four recommendations for the Under Secretary for Health:

- Revise the current full mental health evaluation measurement to ensure the measurement is calculated from the veterans contact with the mental health clinic or the veteran's referral to the mental health service from another provider to the completion of the evaluation.
- Reevaluate alternative measures or combinations of measure that could effectively and accurately reflect the patient experience of access to mental health appointments.
- Conduct a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the Veterans Health Administration's ability to meet mental health timeliness goals, and if so, develop an action plan to correct the impediments.
- Ensure that data collection efforts related to mental health access are aligned with the operational needs of relevant decisionmakers throughout the organization.

The Under Secretary for Health concurred with our recommendations and presented an action plan. We will follow-up as appropriate.

CONCLUSION

VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services. VHA did not provide first-time patients with timely mental health evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. As a result, performance measures used to report patient's access to mental health care do not depict the true picture of a patient's waiting time to see a mental health provider.

While no measure will be complete, meaningful analysis and decisionmaking requires reliable data. A series of paired timeliness and treatment engagement measures might provide decisionmakers with a more comprehensive view of the ability with which new patients can access mental health treatment.

Madam Chairman, thank you for the opportunity to discuss our work. We would be pleased to answer any questions that you or other Members of the Committee may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO THE OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. Linda Halliday

Question 1. During your investigation, did you observe any obvious trends, such as an influx of National Guard servicemembers recently discharged from active-duty that helps explain why some veterans are scheduled appointments within the performance standards while others are not?

Response. We did not identify any trends specific to particular groups of veterans. As part of our review, we interviewed key personnel involved in the scheduling process at four VA medical centers located in Spokane, Washington; Milwaukee, Wisconsin; Salisbury, North Carolina; and Denver, Colorado. None of the personnel interviewed stated that a recent influx of National Guard servicemembers recently discharged from active-duty caused any of their access issues.

Question 2. Did any scheduler or scheduler's supervisor explain why there was such a deviation from VA Directives with regards to mental health appointments?

Response. The schedulers that we interviewed received the required annual training that clearly shows how the appointments should be scheduled. However, at two of the locations (Salisbury and Denver), schedulers indicated that supervisors told them not to follow the Directive. Instead, schedulers access the software to see when the next appointment is available. The scheduler then backs out of the scheduling package and goes back in to enter the date of the available appointment as the desired date. An audit trail is not created in Veterans Health Administration's (VHA) records that documents and captures these actions.

Dr. John Daigh

Question 1. Would you consider group therapy for "high risk" mental health patients as "clinically inappropriate" if it is not, at minimum, done in concert with individual therapy?

Response. "High risk" is a term that can have a variety of meanings. Patients may over a short period of time transition from "high risk" to "low risk" and back to "high risk." Mental health providers need to consider all forms and combinations of therapy when constructing a treatment plan. A more specific answer requires the facts and circumstances of a specific patient.

Question 2. During your investigation, did you discover any group therapy for "high risk" mental health patients who were not at the same time receiving individual therapy? If so, how frequently was this group therapy done in lieu of a more individuated or comprehensive plan of therapy?

Response. The scope of our review did not include this issue.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The OIG has reported several times on inappropriate and inconsistent scheduling practices in 2005, 2007, and now again in 2012. VHA has taken steps to address these issues, however, the problem persists.

A. Why does this continue to be an issue and what is contributing to the inappropriate practices?

Response. The required management oversight is not effective. Schedulers told us that supervisors focused their attention on the appointments where schedulers were not able to schedule the patient within 14 days of the desired date of care rather than the integrity/accuracy of the appointments they were able to schedule within 14 days.

B. Is it simply a lack of training for schedulers? Are the schedulers receiving the required annual trainings and taking the annual tests to ensure they are properly carrying out VHA directives?

Response. We do not think it is lack of training, but more that the oversight is not effective and the lack of focus on ensuring the data integrity of the scheduling information. At the sites we visited, the training and competency records were up to date and schedulers stated they were receiving training on proper scheduling procedures. Scheduling supervisors also stated they evaluated schedulers' competency annually, as required. The training provided to schedulers aligns with VA's Directives.

Question 2. According to the OIG, this is leading to skewed data that is not helpful to key decisionmakers from the managerial level to the administrative level to Congress.

A. Do these inconsistencies occur in all the Veterans Integrated Service Networks (VISNs), or are some performing better than others?

Response. For our review, we visited four VA medical centers located in four different VISNS, and confirmed inappropriate scheduling practices occurred at three of the four centers. Our analysis did not attempt to draw a conclusion between VISN performance so we cannot offer an opinion in this area.

B. What is VHA doing to correct this problem?

Response. VHA has indicated they are changing the way new patient appointment timeliness will be evaluated by using the "appointment create date" instead of the "desired date" to evaluate appointment timeliness. VHA agreed with our concerns that the "desired date" is ambiguous and that a simpler methodology will improve the reliability of scheduling data.

Chairman MURRAY. Dr. Daigh.

STATEMENT OF JOHN DAIGH, M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL SHEPHERD, M.D., SENIOR PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS

Dr. DAIGH. Madam Chairman, Ranking Member, and Members of the Committee, it is an honor to testify before you today. I and my staff from the Office of Health Care Inspections on a daily basis deal with clinical care issues in VA, and we know that both the employees and leadership within VA strive to provide the highest quality care. And despite the subject of this meeting, I do believe VA provides very high quality health care to its veterans. In fact, with respect to quality metrics, I believe VA leads the Nation with respect to both the use of data and the publication of that data on the Web site.

With respect to access to care metrics, I believe it is quite a different story. I believe those metrics are flawed. I believe, as our report indicates, Dr. Petzel has indicated that he will put together a group to try to resolve the issue and get the access to care metrics in line so that they do accurately reflect the business processes that are ongoing at VA.

I plan to talk about some of the access to care metrics in the private sector, but I think what I would like to make are two different statements after hearing your opening statement, ma'am.

The first would be I think VA has a number of missions. They have a mission to provide health care. They have a mission to do research. They have a mission to train individuals who will work in the United States and elsewhere in the health care industry. They have a mission to be available in times of national disaster. And I think as individuals out there in hospitals they decide how they are going to spend their time, those missions are generally accepted as being equal—there is not a directive that says the primary mission is the delivery of health care, and we will address those requirements first as professionals schedule their time or allocate their time.

So, I think when we have a crisis like we have, that a prioritization of mission, again, stated clearly from top to bottom, would allow individuals across the system to rethink how they are spending their time.

The second issue I think is important is to set a standard of productivity. I realize that health care cannot be numbers driven. I realize it is a personal interaction between a patient and a provider.

But at the same time, there has to be some method to determine that you are getting enough work or productivity from the people that are working for you.

So, I think although VA has worked on these issues for a while, that there just has to be a clear, measurable, and in my view, productivity standard that is easily relatable to the work done in the private sector by a similar provider, so that one can decide whether the money spent is actually being effectively used. The other issues that are brought forward in terms of the kind of access to care standards we could use, I think that Mr. Schoenhard and others well understand those, and I think we can work with them in order to improve the standards that they currently have in place.

With that, I will end my comments and be happy to answer any questions.

Chairman MURRAY. Thank you very much.

Mr. Tolentino.

STATEMENT OF NICHOLAS TOLENTINO, OIF VETERAN AND FORMER VA MENTAL HEALTH OFFICER

Mr. TOLENTINO. Madam Chairman, Senator Brown, Members of the Committee, as and OEF/OIF combat veteran, I am honored to appear here today to share deep concerns about the administration of VA's mental health care system.

My testimony is based on my experience as a VA mental health administrative officer, as well as service on a VA network executive committee, membership on several VA national work groups, and a background in quality management that led to an MBA degree. Deep concerns about the Manchester, NH, VA medical center's failure to provide needed care ultimately led to my resignation last December.

I want to commend this Committee for your vigilant oversight of VA mental health care. Let me also acknowledge the VA's recent announcement and plans to add positions to its mental health workforce and address problems you have helped to uncover. But I want to emphasize that additional staffing alone will not remedy the systemic problems in the VA management of mental health care.

Let me be clear. I do not wish to discredit the VA or its mental health staff who work diligently to help veterans. But for all it strives to do, the VA's mental health system is deeply flawed. The system is too open to putting numerical performance goals ahead of veterans' mental health care needs. It is too susceptible to gaming practices and making the facilities look good and too little focus on overseeing the effectiveness of care it promises to provide. These systemic problems compromise the work of a dedicated mental health staff and fail our veterans.

Like many VA medical centers, the overriding objective at our facility, from top management on down, was to meet our numbers, meaning to meet our performance measures. The goal was to see as many veterans as possible, but not necessarily to provide them the treatment they needed. Performance measures are well intended, but they are linked to executive pay and bonuses, and as a result, create incentive to find loopholes that allow the facility to meet its numbers without actually providing the services. Far too

often, the priority is to meet a measure rather than meet the needs of the veteran.

Many factors, including understaffing, make it very difficult to meet performance requirements. But administrators do not feel that they can acknowledge that. Instead, as soon as new performance management program manuals were published each year, network and facility leadership began planning how to meet those measures. That led to brainstorming, even with colleagues of mine across the country, to find loopholes to game requirements that could not be met.

While I have detailed multiple examples in my full statement, I would like to share two of them now.

Several performance measures mandate that veterans in mental health treatment be seen within certain timeframes. At Manchester, where demand for mental health was great and staffing very limited, the facility director demanded a plan to get better and seen at any cost. We got the order: focus only on the veteran's immediate problem. Treat it quickly in that appointment, usually with medication, and do not ask further questions about needs because, "We don't want to know, or we'll have to treat it."

Another directive requires that a patient who is actively suicidal or high risk for suicide should be seen at least once per week for 4 weeks after an inpatient discharge. This is to ensure the veteran's receiving the intensity of care needed to reduce the risk of readmission and to increase the success of treatment.

Instead of providing these high-risk patients individual therapy, Manchester instead created a group for them, a step that was both clinically inappropriate and contrary to the directive's intent. Veterans who refuse to join the group were often labeled resistant to treatment.

The idea that group therapy could be substituted for individual psychotherapy spread throughout the network. In fact, the network mental health executive committee actually promoted this idea as a so called best practice. Even though it was not at all good clinical practice, it was seen as a good way to meet performance measures.

I believe that most VA facilities have an understaffed mental health service because the VA lacks a methodology to determine what mental health staffing is needed at an individual facility. In a misguided attempt to justify more mental health staff at Manchester, the head of our mental health service stated that the priority needed to be quantity rather than quality. She said, and I quote, "Have contact with as many veterans as we can, even if we aren't able to help them."

The outcome was that the facility continued to enroll a growing number of veterans, far more than our mental health clinicians could handle. And as a result, veterans fell through the cracks. Tragically, there was no effective oversight, even to detect those deep systemic problems we faced.

For example, every year, the medical center would complete a mandatory central office survey to assess facility compliance with the VA's mandate to provide uniform mental health services, but each year our network told us we were never to answer that services were not provided. Many of our answers were actually changed

to say that required services were being provided when they in fact were not.

During my years at Manchester, other members of the mental health staff and I repeatedly raised concerns with both facility and network leadership regarding practices we believed were unethical or violated VA policy. Those concerns largely fell on deaf ears. Our staff also repeatedly brought the concerns to our facility's ethics committee. And to our great frustration, however, the ethics committee consistently declined to take up these issues because they felt they were clinical matters.

For me, the final straw was the medical center's failure to take meaningful action upon discovery that a mental health clinician was visibly intoxicated while providing care to our veterans. Ultimately, I could not continue to work at a facility where veterans' well being seemed secondary to making the numbers look good.

I very much hope the VA will make real changes to address the systemic problems I have described. I believe that there are steps the VA can take beyond adding staff. I humbly offer these suggestions.

First, the VA should stop monetarily rewarding leadership for meeting numerical and process requirements that are not real measures of effective mental health care.

Second, the VA should institute a much more extensive oversight into how care is actually being provided and how program funding is deployed to ensure the funds actually go to the programs they are intended to supplement.

Finally, I would urge this Committee to press the VA to develop and implement a very long overdue empirically supported mental health methodology so that it is no longer necessary to guess whether 1,900 more mental health staff will be enough.

In closing, I am honored to have had the opportunity to share both my experience and assessment of problems that I hope you can help to resolve. I would be very pleased to answer any questions you may have. Thank you.

[The prepared statement of Mr. Tolentino follows:]

PREPARED STATEMENT OF NICHOLAS TOLENTINO, OIF VETERAN AND FORMER VA MENTAL HEALTH ADMINISTRATIVE OFFICER

Chairman Murray, Ranking Member Burr and Members of the Committee: I am honored to appear before you today to share my experience, perspective and resultant concerns about the delivery of timely, effective mental health care in the VA system. I want to begin by sharing with you that I am myself an OIF/OEF combat veteran, medically retired after nearly 14 years of service in the United States Navy.

In April 2009 I took a position as the Mental Health Administrative Officer of the Mental Health Service Line at the Manchester VA Medical Center (VAMC) in Manchester, NH. While working in the Navy as an Independent Duty Hospital Corpsman, I earned my MBA and developed a deep interest in the quality-management of medical facilities. An opportunity to support VA efforts to aid my brothers and sisters, was for me, an ideal transition into civilian work and service. As the Mental Health Administrative Officer I was responsible for a vast number of the administrative functions of the Mental Health Service Line. In addition to those duties and responsibilities, I served as a member of the VISN 1 Mental Health Executive Committee which worked to address network-wide mental health service issues, and also as chairman of the Manchester VAMC Mental Health Systems Redesign Team, which worked to address local issues specific to the function and design of our mental health services. Deep concerns about needed care we were NOT providing at Manchester ultimately led me to resign last December.

ADDITIONAL MENTAL HEALTH STAFFING ALONE IS NO PANACEA

As a combat veteran, I want to commend this Committee for your vigilant oversight into VA mental health care. Let me also acknowledge Secretary Shinseki's announcement of plans for additional staff to supplement VA's over-stretched mental-health work force and address the problems your oversight helped uncover. But additional staffing alone will not remedy fundamental national problems in VA's administration and management of mental health care. The problems I will highlight in this testimony—problems I have seen at the medical center, VISN level, and on multiple national work groups—are significant enough to derail and undermine the Secretary's well-intentioned effort.

HOW VACO MENTAL-HEALTH PERFORMANCE MEASURES DISTORT CARE DELIVERY

It is important for me to make clear that in sharing these concerns, I do not intend to discredit the VA, an organization with a critical role. I know from experience that many VA mental health staff—clinical and administrative—work tirelessly to help the veterans they serve. But I also know from experience that that system is deeply flawed. The system is too open to putting numerical performance goals ahead of veterans' mental health care needs—too susceptible to "gaming" practices to make facilities "look good"—and too little focused on overseeing the effectiveness of the mental health care it promises to provide. I have seen just how easily these systemic problems can compromise the important work of dedicated VA mental health staff, and fail our veterans.

By way of context, the Manchester VAMC serves some 12,000 veterans in the state of New Hampshire. We are the only VA in New Hampshire and we are a small facility with no inpatient services. The mental health service line staffing has itself grown exponentially over the past five years with increased national attention and funding for mental health, and is now comparable in size to many of the other services provided on site; however demand for mental health care has grown faster.

Historically, but even more so during the almost four years that I worked at Manchester, the overriding medical center objective—from top management on down was to "meet our numbers," that is, to meet performance measures and to see as many veterans as possible. Performance measures play a significant but troubling role in VA mental health care. While it is not unreasonable to expect a facility to want to meet numerical performance objectives and provide needed care to as many veterans as possible, VA Central Office's well-intentioned performance requirements often prove antithetical to providing appropriate care.

First and foremost, the achievement of performance measures is linked to pay and bonuses for Executive Career Field (ECF) employees, most commonly, upper management (myself included). The financial incentive to meet these measures too easily creates a perverse administrative incentive to find and exploit loopholes in the measures that will allow the facility to meet its numbers without actually providing the services or meeting the expectation the measure dictates. The upshot of these all too widespread practices is that meeting a performance target, rather than meeting the needs of the veteran, becomes the overriding priority in providing care.

You might ask: Why not provide the services the way the measure dictates and simply "make the numbers" in that way, why employ loopholes? While most performance measures are intended to ensure that care is provided in ways that are effective (based on empirical research), timely, and relevant to the needs of the population, they do not necessarily take the following operational realities into account:

1. *Staffing:* Most facilities' mental health services are understaffed, and mine was no exception. Without solid means to measure the relative needs of each facility, given its size, population served, etc., staffing levels are haphazard. (For example, White River Junction VAMC in Vermont, our neighboring facility, serves half the number of veterans in their mental health service, but has double the staff). Performance measures, rightfully, are not flexible as they relate to VA facility capabilities, as a veteran does not deserve lesser treatment because his local facility is small. However, the expectations reflected in VA's performance measures often far exceed the capabilities of the staff that must meet them. In my experience, it was a routine matter for facility and VISN administrators to find and use loopholes to "meet their numbers" whenever they were confronted with a gap between a performance requirement and a facility's limited capabilities that had adverse implications for their paychecks. Tragically, though, this kind of "gaming" of the system meant that veterans too often weren't getting needed mental health services.

2. *Mandated services are not always relevant to a facility:* By way of example, in a well-intentioned effort to improve rural veterans' access to mental health care, VA Central Office set mandates, and accompanying performance requirements, that called for providing certain percentages of veterans with telehealth services. How-

ever, not all facilities have this need. While our facility in particular, did not have much demand for this service, the requirement led us to place many veterans in telehealth treatment whether they wanted it or not, and in circumstances where it was not clinically relevant or of any use to the veteran. Additionally, group therapy and other services not otherwise needed or indicated for such technology were forced to adapt their treatments to fit this new initiative. The upshot was that precious staff time was devoted to a mode of treatment that veterans neither needed nor wanted.

One might think that administrators whose facilities are truly incapable of meeting a performance requirement would simply acknowledge that they cannot meet a target and request additional staff or other needed support. Unfortunately the system does not encourage that behavior, and facility administrators generally don't wish to "look bad." Moreover "failing to meet" a performance measure has adverse implications:

1. The first and most obvious is that failing to meet a performance measure has a direct impact on administrators' personal paychecks.
2. When a facility fails a measure, it must take on a significant amount of administrative work. Action reports must be generated and submitted to the VISN, data must be tracked and analyzed and a tremendous amount of attention is brought onto the administration. No one likes that. (The irony is that there are loopholes around even this administrative requirement.)
3. And finally, unlike the VA Primary Care Service Lines, for example, that have a well-defined staffing methodology, VA lacks a good method for establishing individual facility mental health staffing needs. While on paper a facility can appear "fully staffed" based on VACO's determination for that region, in reality the veteran workload and needs far exceed the man hours available to serve them. In my experience, when a service line manager does submit a request for additional staff, often the request doesn't make it past the facility director because he or she will want data to support the need before taking it higher up the chain. Gathering data takes a great deal of work, and the data gathered rarely depicts the demand in a way that translates into man hours needed. This takes us back to why even VACO has difficulty establishing a good method for establishing staffing needs for individual facilities.

Manchester offers a troubling case in point. Failure to meet a performance measure has not historically resulted in staffing needs being addressed. Instead, failure has resulted in more work for an already stretched staff, and a leadership response that has insisted that "we are already fully staffed," and therefore any failure to meet measures must be an indication of inefficient use of resources, not a lack of resources. The mental health service line manager translated the call for "improved efficiency" to mean "find more loopholes."

GAMING THE SYSTEM

I know from my experience on the VISN 1 Executive Committee and on various national VA workgroups that these problems are not unique to Manchester VAMC. Unfortunately, most VA facilities struggle to fit into the highly uniform expectations of VA performance measures. While the goal of expecting all facilities to provide uniform quality care is laudatory, the rigid one-size-fits-all approach contributes to systemic problems.

As soon as the new ECF Performance Management Program manual and performance measure technical manuals are published each year, even in draft form, planning among VISN leaders, facility leaders, Quality Management staff, and Service Line staff begins regarding how to meet the measures for that year. Staff analyze those measures that are determined not likely to be met by a facility due to either low demand, lack of resources, etc., and the group brainstorms to find loopholes that can be exploited to game the requirement. The group will also ask other facilities in the region and nationally for their "solutions" to similar problems. Let me offer some examples:

Desired Date of Appointment: VACO's performance measures include a requirement that a veteran treated by the mental health service is to be scheduled for a mental health appointment within 14 days of his or her "desired date" for service.

At Manchester, despite the fact that effective treatment requires a level of intensity and frequency determined by the veteran's symptoms, limited staffing (and other problems) made it impossible to offer veterans the frequency of psychotherapy appointments to meet their clinical needs. While a veteran and his or her clinician might agree that the veteran should return next week to con-

tinue his progress, the appointment availability was simply not there. Nevertheless our service "met" this measure by simply eliminating the opportunity for the veteran to give us a desired appointment date. Instead, the veteran was told when the next appointment with his provider was available and that appointment (often weeks, even months away) was entered as his "desired" date, thus "meeting" the measure.

(Veterans who are unable to be scheduled for their actual desired date should be placed on an Electronic Wait List (EWL) developed for this purpose and meant to track the demand versus the availability of services. (But facility leadership "unofficially ordered" that the EWL was NOT to be used under any circumstances.)

Meeting frequency measures for clinical contact: Several different performance measures mandate that veterans in mental health treatment be seen within certain timeframes and frequencies based on such classifications as whether the veteran was new to treatment, a high risk for suicide, etc. At Manchester, where demand for mental health care was great and the resources were very limited, the facility director pressed the mental health service line manager to develop a plan to "get the veterans seen" at any cost. The plan that was ultimately developed "gamed" the system so that the facility "met" performance requirements but utterly failed our veterans. Specifically, instead of conducting an assessment of veterans' mental health needs and scheduling and providing the appropriate intensity and frequency of services, the plan called for providing only the most limited mental health services (such as medication management or a mental health check-in from time to time) through the facility's primary mental health clinic. The service line manager's order was to focus only on the immediate problem with which the veteran presented in that moment, treat that quickly in that appointment (this meant only medication) and not to ask further questions about needs because, "we don't want to know or we'll have to treat it."

This perverse approach reduced the need to schedule appointments in an already backlogged scheduling system. (When appointments aren't scheduled there is no evidence that the facility is NOT getting the veterans in for appointments in a timely way that meets the measures. Thus, the facility succeeds in appearing to meet the measure.) Veterans were encouraged and often required to make use of the walk-in service, despite clinical contraindications. This fundamentally unethical approach meant that veterans who needed much more intense care made no progress toward symptom remission and achieving treatment goals.

High Risk Patients: By VHA directive, a patient who is actively suicidal or identified to be at high risk for completing suicide should be seen, at minimum, on a once-weekly basis for four weeks after being discharged from an inpatient unit. This is to ensure the veteran is receiving the intensity of care necessary to reduce the likelihood of readmission to the inpatient ward and to increase the success of the treatment provided. Manchester's response to this requirement was to create a group for these high-risk veterans to attend, instead of providing individual therapy. Not only was this clinically inappropriate and in direct conflict with the intent of the directive, but if a veteran refused to be in a group, that veteran was often labeled "resistant to treatment."

Group therapy to meet intense-therapy requirement: Another performance requirement mandates that a certain percentage of OEF/OIF veterans who have a primary diagnosis of PTSD are to receive a minimum of 8 psychotherapy sessions within a 14-week period. While the clear intent of that measure is based on research that emphasized immediate, intense individual psychotherapy as the best clinical approach to combating PTSD, the technical wording of the measure did not effectively restrict the nature of appointments to the clinically indicated individual psychotherapy. Manchester took advantage of that lack of "guidance" in the technical wording and once again used group therapy sessions as a means to meet the measure. And once again, veterans who refused to attend group therapy were labeled as non-compliant with treatment. So while the facility looked "on paper" as though it had met this VA performance measure, the vast majority of the patients in fact were not getting the intensity of care that the measure intended.

Group therapy as "best practice:" Despite clinical contraindications, the idea that group therapy could be substituted for individual psychotherapy spread throughout the VISN. Manchester was certainly not the first facility to use this strategy. In fact, the VISN Mental Health Executive Committee, which met annually to discuss how individual facilities were meeting performance measures, actually fostered this idea as a so-called "best practice." While the idea of sub-

stituting group therapy for individual therapy for any and all patients is not at all good clinical practice, it was looked on as a good way to meet requirements. The VISN actually brought that so-called "best practice" to a national level, promoting this practice at a national VA mental health conference.

(While I am not a clinician, I am aware of the various methodologies for treating many mental health disorders and symptoms relevant to the veteran population. Group therapy is a very effective and important aspect of mental health service. The problem with its use in these instances is the lack of choice and intensity in the treatment. Group therapy is by its nature a less intense form of psychotherapy, generally speaking. In addition, the veterans were given no choice over whether they would receive individual therapy or group therapy. Instead, at many facilities they are directed into a mode of care many do not want, need, or with which they are uncomfortable, because the facilities' need to meet the associated performance measure is the overriding priority.)

Targeted populations: Some performance measures identify target populations, and result in assigning certain classes of patients' priority and access to preferred treatment modalities. The obvious result is that veterans of other eras or demographics may receive less than desirable or not-so-clinically indicated treatments to create space for the preferred population. Under these circumstances the individual's clinical needs are not considered. A Vietnam veteran in crisis with significant symptoms would be passed over for that all-too-rare appointment spot with a psychotherapist, if an OIF veteran also seeks that appointment. The fact that the OIF veteran may not be in urgent need for services is not considered. He would get the appointment because a performance measure dictates that he get a more timely appointment than all others. While the intent of fostering early intervention is a good one, the drive to meet the measure impedes exercise of good clinical judgment.

BUDGET GAMING CONFOUNDS PROVISION OF GOOD MENTAL HEALTH CARE

I'm well aware that this Committee has been instrumental in increasing VA mental health care funding over the years. But "disconnects" between VA Central Office and VA medical facilities have in some instances stood in the way of special funding (to enhance mental health services) actually reaching the veterans. (Such "special funding" was intended to support the implementation of the Uniform Mental Health Services policy in VA medical centers and Clinics (VHA Handbook 116.01), which aims to ensure that a uniform set of mental health services would be accessible to veterans across the country.) Despite a clear directive, Manchester did not actually use special funding as intended or fully implement the Uniform Services Package (the "USP").

On numerous occasions, VA Central Office would establish a new initiative related to the USP, and provide special funding for a particular mental health staff position to carry out that initiative. Most times a VHA or VACO Memorandum would be sent out to the facilities stating that the posting and hiring of the position was mandated and to be done "ASAP." However, Manchester's leadership would mandate that the position go through various administrative approval boards (despite the Memorandum having specifically stated that the position is not to be subjected to such processes). This process would greatly increase the amount of time taken to post and hire for the position. During this time—often 3–6 months in duration—the position would be caught up in meetings awaiting "approval" and the salary dollars received by the facility would go unspent, creating a substantial excess (often referred to as lag funds). At the end of the fiscal year, these lag funds would be converted to cover salary expenses of regular staff or converted into facility General Purpose (GP) funds to reduce overall facility debt accrued over the course of the year. I can recall many instances, across several fiscal years, where Manchester acquired hundreds of thousands of dollars of special mental health funding without fulfilling the actual intent of the funding.

In FY 2011, for example, approximately $500 thousand in mental health funds were converted to general operating funds. As a result, we were not able to hire the specialty mental health staff we needed or provide the initiative-programs with the tools required to perform effectively. But because VA Central Office directed all medical centers to carry out a number of new initiatives, including expansion of Geriatric Psychiatry services, substance abuse services and expansion of homeless programs, for example, clinicians at the facility were forced to take those titles on as a collateral duty, or the services were simply not offered. While concerns over the situation were raised at both the facility and VISN level, they received only minimal attention for a short time, without resultant change.

(By assigning collateral duties to clinicians who already held important titles and functions, Manchester was able to appear fully staffed without having to hire additional clinicians. On paper we were able to say that we had an "Military Sexual Trauma (MST) Coordinator," for example, despite the fact that that clinician was also carrying other mandated titles and responsibilities. This gamesmanship impacted appointment availability and further stretched limited resources. Moreover, most titled positions come with many administrative duties (weekly or monthly conference calls, data tracking, etc.). So when a clinician carries several titles, much of his or her time is consumed by those administrative tasks, resulting in less appointment availability for veterans).

Good mental health care, of course, requires that we provide veterans privacy, and the necessary office space to make that possible. We had a need for additional mental-health-service space at Manchester, and a project was submitted to VACO to remodel a storage area so that we could co-locate multiple mental health offices with primary care. VACO provided us mental health special funds to perform the work. But after the work was completed, the facility leadership decided that the space would not in fact be used for mental health offices, but would instead be used to expand Primary Care. Mental health received no additional space and was informed that the facility priority was now Primary Care, given the identification of the upcoming Primary Care expansion. This scenario was repeated with the submission of a project to add an additional wing to the medical center specifically for the expansion of mental health. After the project received initial VACO approval, the facility leadership once again chose to use it for Primary Care, though not altering the project-intent statements to reflect this fact.

MENTAL HEALTH BUDGET: DISTORTIONS IN PROVIDING CARE

Manchester's Mental Health Service Line Manager's response to our staffing dilemma was made clear to us in a meeting in which she emphasized that the service line priority needed to be "quantity" rather than "quality." By that she meant to "have contact with as many veterans as we can, even if we aren't able to help them." The strategy was an attempt to show workload numbers as a way to justify requests for adequate resources. The upshot, though, was that the facility was enrolling growing numbers of veterans with very real mental health needs, but the mental health clinicians were reporting "we already have more patients than we can handle." As a result, veterans began to fall through the cracks.

Under such circumstances where demand for needed treatment far exceeds the services available, VHA's Uniform Mental Health Services Handbook dictates that mental health services "must be made accessible when clinically needed" either in-house or under contract arrangements. But despite that mandatory language, the VISN's Mental Health Service Line Manager took the position that "these are more guidelines than rules." There was, in theory, a process through which to get fee-basis care authorized—that required going through the service-line manager to get approval from the chief of staff—but I was told requests for approving fee-basis mental health care were very rarely approved. And even if they were approved, the facility lacked any effective means to case-manage these patients, as required under the directives regarding fee-services. Similarly, it was often a battle to even send a patient to another facility for needed care.

Let me share just one horrific example to illustrate how the mindset at Manchester turned good patient care on its head. A psychiatrist assigned to the Substance Abuse Treatment Team, on more than one occasion was faced with a veteran seeking treatment to end his opioid addiction. Because the psychiatrist believed that he didn't have time to assist the patient, he prescribed the very opioids to which the veteran was addicted. He tried to justify this by stating that he needed to "hold the patient over," and went on to schedule him an appointment to return sometime in the future. The psychiatrist said "they are going to get the drugs from somewhere so we might as well just go ahead and give them to them."

LACK OF EFFECTIVE OVERSIGHT

It is heartbreaking to reflect on the many, many barriers staff encountered to getting patients the mental health care they needed and deserved. While patients truly fell through the cracks, there was no effective oversight to detect that and to address the deep systemic problems we faced. Every year our medical center took part in a Central Office survey to assess medical facilities' compliance with the Uniform Mental Health Services Handbook; as part of that surveying we were asked to delineate the services we provided. Each year, however, the VISN Mental Health Office gave the facilities the guidance that we were never to answer that services were not provided. Many of the answers were changed to say that specific (required) serv-

ices WERE being provided when they weren't. Specifically, we were instructed that the "fallback" answer was that the services were provided by fee-service, although this was never actually the case.

During my years at Manchester, other members of the mental health staff and I repeatedly raised concerns with facility leadership as well as at the VISN level regarding practices and decisions which were either frankly unethical or violated VA policy. Those concerns largely fell on deaf ears.

Internally, our medical center has an ethics committee, and staff often brought concerns regarding the compromises to mental health care to that committee. To our great frustration, however, the ethics committee consistently declined to take up these issues on the basis that they were "clinical matters" beyond its purview.

Manchester is located in relatively close proximity to the National Center for PTSD headquartered at the VA Medical Center in White River Junction, Vermont. The National Center is not an oversight body, but its director, Dr. Matt Friedman, did visit Manchester on one occasion during my tenure and advised on various requirements the facility needed to meet. He was simply told, "we don't have the staff" to meet those requirements, and was not invited back.

UNETHICAL PRACTICES: THE LAST STRAW

I could detail other instances of unethical practice at the Manchester VAMC that contributed to my decision to resign, but the final straw occurred when the medical center failed to take meaningful action in response to the discovery that a VA clinical psychopharmacologist was intoxicated while providing patient care. On October 31st, 2011 the Mental Health Service Line Manager discovered that a psychopharmacologist at our facility was noticeably intoxicated and slurring his speech. The Service Line Manager became aware of this situation when a veteran reported that the clinician had failed to appear for an appointment. Looking into the matter, I discovered that he had written numerous prescriptions during that day, presumably during the period of his intoxication. The very next day, while the clinician was again treating patients, a water bottle was found hidden in that clinician's personal office refrigerator that was filled with a brown fluid clearly smelling of alcohol. An internal panel was convened, but the panel seemed to be more of a formality than an actual investigatory board. I was disturbed to learn that the incident did not lead to the clinician's removal, and instead he was simply transferred to work in the pharmacy. To make matters worse, the service line manager's response to my protest regarding the lack of action was to imply that, as a combat veteran, I was likely also vulnerable to substance-abuse. That implication, notwithstanding my impeccable employment history, was not only personally insulting, but unfathomable coming from a psychiatrist responsible for the facility's mental health service. A similar attempt to imply that my combat veteran status is a personal liability was made after my resignation, when I provided voluntary testimony to an internal investigative board. The board attempted to discredit my testimony by stating that my responses to incidents I'd reported were simply magnified by my combat experiences and resulting emotional instability.

RECOMMENDATIONS

Ultimately, I could not continue to work at a facility where the well-being of our patients seemed secondary to making the numbers look good. I do care deeply that the VA health care system not only makes our veterans' mental health a real priority, but that it institutes the kinds of changes needed to make VA mental health care timely and effective. I believe there are steps that can be taken—beyond adding additional staff—to make this happen. Let me offer three recommendations:

1. VA must stop measuring and monetarily rewarding administrators for meeting numerical and process requirements that are simply not sound proxies for effective mental health care.

2. VA must institute much more extensive oversight into how care is actually provided and how program funding is deployed to ensure the funds actually go to the programs that they are intended to supplement.

3. Finally, I would urge that this Committee press the VA to develop and implement a very long overdue mental health staffing methodology, so that it is no longer necessary to guess whether, for example, 1900 more mental health staff will be enough.

In closing, I'm honored to have had the opportunity to share with you my "on the ground" experience and assessment of problems that I hope you can help resolve. I'd be pleased to answer any questions you may have.

Chairman MURRAY. Thank you very much.

Major General Jones.

STATEMENT OF T.S. JONES, MAJGEN, USMC (RET.), FOUNDER AND EXECUTIVE DIRECTOR, OUTDOOR ODYSSEY YOUTH DEVELOPMENT AND LEADERSHIP ACADEMY

General JONES. I am Tom Jones, retired Marine, founder and director of Outdoor Odyssey, which is a camp for at-risk youth. I do not have any expertise in mental health. I have a lot of experience dealing with those who have mental health issues.

I have been visiting Walter Reed in Bethesda every week since the start of the war in Afghanistan in 2001. I have met thousands of folks. I have been privileged to be on the board of the Semper Fi Fund, started by wives, run by wives, that deals with families of the wounded.

I also started Semper Fi Odyssey as an outgrowth of Outdoor Odyssey. While it started as a normal transition course, I met a Marine Corps captain in Bethesda who was grievously wounded, visited him many times over the next year. And while he is in therapy, he asked me to help him to start a 501(c)(3), since I had already done so, a nonprofit.

We originally started as a normal transition course, however, it was patently obvious after a while that the mental health issues were such that we really got into the whole issue of dealing with mental health. Because of my medical background, I was able to bring a lot of folks in from the outside. I noted Navy psychiatrist, Dr. Bill Nash. And he was so moved by the experience that he had me be involved in a number of gatherings of mental health professionals. From that, I was able to—because I am an adjunct at the Institute for Defense Analysis here in D.C., I was able to start a project looking at best practices on mental health.

What we have done, we have run 30 sessions now, week long sessions, of Outdoor Odyssey. I chiefly used Outdoor Odyssey because I had the facilities. What we have done is build on a volunteer strategy with team leaders. And almost all the people involved are in voluntary category.

What has transpired is this whole issue of trust, cohesion and bonding, which works in the military when you are dealing with veterans. Of our cohort, 30 sessions, 35 or so, we attend each time. Just had one last week. So we have dealt with over a thousand not only veterans but those soon to be discharged from the military.

We work in conjunction with the Wounded Warrior Regiment, so it gives us a pretty good index not only of the problems we are having in the military, but also, most strikingly, the problems we are having in the veteran community. And what we have found is that many, if not most, of the people who are undergoing clinician's care have not divulged even the source of the main stressor that has created the problem.

I agree with several of the panelists here. I do not think the numbers of additional mental health coordinators is solely going to solve the problem. I think the mental health coordinator has to have a better understanding of what the demands are of the individual warrior. I think the one thing that we have learned through our experience with bringing mental health professionals to these

experiences is that many of them can get a better perspective of what these individuals are facing through interaction with them.

So I would encourage other folks here, even my panel members, if we are so inclined to be involved, I think the insights and the site picture provided to you is absolutely illuminating. What we have learned—I call them salient outcomes. We can see the same things you get in a normal transition course, and we are getting breakthroughs where people are actually coming forward and talking about demons that they heretofore have never talked about before. We build a network of trust that is lasting, not just a network in the sense of a transition course, but a network that will follow them after they leave the experience.

Most importantly what we have learned is the fact that a large percentage and a growing percentage of folks are having mental health issues. And I would say—it is an opinion, but I think it is a pretty well-founded opinion—that the numbers are going to be growing in the future. I would think that we need experiences where folks that do deal in the setting of a clinician have a better understanding of what the issues are that they are dealing with.

I am very honored to be here. I thank you very much. I will answer any questions, and I will certainly encourage any members of your staff to visit. We have got plenty of chow and a place to put you down. Thank you very much.

[The prepared statement of General Jones follows:]

PREPARED STATEMENT OF T.S. JONES, MAJGEN, USMC (RET.), FOUNDER/EXECUTIVE DIRECTOR, OUTDOOR ODYSSEY YOUTH DEVELOPMENT AND LEADERSHIP ACADEMY

Dear Chairman Murray and Members of the Senate Committee on Veterans' Affairs: Good morning. My name is Tom Jones, and I serve as the Executive Director of Outdoor Odyssey as well as an Adjunct Staff Member of the Institute for Defense Analyses (IDA). In 1998, I founded Outdoor Odyssey and have served as its Executive Director in a voluntary capacity since that time. I am very pleased to have the opportunity to appear before the Committee this morning on this very critical subject. Although, unlike other speakers this morning, I have no certified expertise in mental health, I have been privileged to gain a great deal of experience in dealing with servicemembers who continue to struggle with mental health issues and have witnessed countless examples of success, attributed in no small measure to the power of the team, cohesion and one-on-one genuine concern. My experiences are the by-product of my involvement with wounded warriors as an active-duty officer, reinforced after my retirement through my role as a Board Member of the Semper Fi Fund and the fact that I founded and oversee the activities of Outdoor Odyssey. I will briefly outline my perspectives on the issue at hand in the following sections: Background; Semper Fi Odyssey; Cadre of Support; Salient Outcome, Lessons Learned and Opinions.

BACKGROUND

Although I have visited wounded Marines and Sailors weekly since the initiation of combat action soon after 9/11, and have certainly gained key perspectives from those same visits, my insights have been honed in large measure by the approximately thirty (30) weeklong sessions I have hosted at Outdoor Odyssey designed to assist wounded warriors make the transition from the military to the civilian sector. These sessions, now known as Semper Fi Odyssey, represent the collaborative efforts of two nonprofits, working with the Wounded Warrior Regiment of the United States Marine Corps.

As mentioned above, I founded Outdoor Odyssey in 1998, geared to identify and impact at-risk youth; at-risk in this context are those elementary-age youth identified by educators as those who face significant challenges to successful achievement in school. The focus of Outdoor Odyssey identifies strong, potential leaders among high school juniors and seniors and prepares these youth through a Leadership Academy to engage, bond with and then provide follow-on care to at-risk youth from their own community through an aggressive mentoring program. These high school

mentors are themselves mentored by community leaders, serving as Umbrella Mentors. Leveraging the success of this program with 38 school districts in western Pennsylvania, programs have been created over the past 14 years to engage countless other educational institutions to provide leadership development and team building opportunities. At the risk of appearing arrogant, I have been blessed at Outdoor Odyssey, as the success of these programs has allowed Outdoor Odyssey to expand both facilities and programs to become a high adventure leadership academy rivaled by few and surpassed by no other similar organization that I have had the opportunity to visit. I offer this information, as programs incorporated at Outdoor Odyssey associated with mentoring, bonding, goal setting, etc., represent the by-products of my lengthy Marine Corps experience and set the stage for development of the Semper Fi Odyssey experience.

Due to my involvement with Outdoor Odyssey, I was able to assist a wounded Marine Corps' Captain pursue his dream of building a transition program for wounded warriors who could not remain in the military. I met this young man during my visits to what was then known as Bethesda Naval Hospital and discussed his dream with him on numerous follow-on visits. Due to my experience with starting a 501(c)3 nonprofit, I helped him create a nonprofit and agreed to host the first session at Outdoor Odyssey and later assisted him by traveling to other sites in the United States to hold follow-on sessions. The original concept was to have quarterly sessions in different regions of the country; follow-on sessions were held in Vail, Colorado; Tampa, Florida and New York City. While the plan was conceptually sound, it precluded development of continuity of effort and the creation of a cadre of volunteer support; moreover, it soon became apparent that the costs associated with such a concept were staggering and, therefore, prohibitive to success. Due to the potential that I saw in the program and the obvious and compelling need of the wounded warriors, I went to my fellow board members of the Semper Fi Fund to assist with certain of the financial requirements. In an effort to significantly reduce financial demands, I offered to host the next four sessions at Outdoor Odyssey. The initial weeklong program, then known as COMPASS, gained immediate traction with those who oversaw the Wounded Warrior Regiment and visiting mental health professionals. I was able to recruit significant help from associates within the Washington, DC, and Pittsburgh regions, and the weeklong programs evolved from one solely oriented on transition from the military into one providing the participant bona fide skill sets in all aspects of his/her life. Most important, the sessions became a vehicle to identify and deal with a growing number who were struggling with mental health issues. A noted Psychiatrist, Dr. William Nash, along other mental health professionals, visited the sessions regularly and requested my support in sharing the power of these sessions with others at major mental health gatherings; the aforesaid led to my involvement in a major project sponsored by OSD (P&R) and connected to the Institute for Defense Analyses (IDA).

Unfortunately, the nonprofit inspired by the young Marine Corps Captain did not survive for a variety of his (Captain) professional and personal reasons. Key lessons acquired during the weeklong sessions, however, provided ample evidence of significant success, and the Semper Fi Fund and Outdoor Odyssey collaborated to form Semper Fi Odyssey, with approximately thirty (30) sessions now having been held. To remove even a hint of any conflict of interest, I stepped down from the Board of Directors of the Semper Fi Fund and am now on the Board of Advisors of the Fund and maintain an Emeritus Status on the Board of Directors.

SEMPER FI ODYSSEY

As mentioned above, Outdoor Odyssey and the Semper Fi Fund, have collaborated to develop Semper Fi Odyssey, working in conjunction with the Wounded Warrior Regiment for the identification of the majority of the participants. The vast majority of the participants are combat wounded, with a few struggling with illnesses such as cancer or undergoing recovery from injuries sustained in activities other than combat. With the exception of staff members of the Wounded Warrior Regiment who routinely participate, all of the participants will soon be medically discharged from the Marine Corps. Additionally, a growing number of veterans have been identified for involvement by case workers of the Semper Fi Fund; this cohort is exclusively comprised of those struggling to overcome mental health issues. Most of this later group have been clinically diagnosed with PTSD and/or TBI, and almost ALL diagnosed with PTSD are currently under a clinician's care. Moreover, and of significance, many of the participants who have been diagnosed with PTSD have not shared with the clinician the source of the stressor that ultimately led to the PTSD. For a variety of reasons, many struggling with PTSD have a very difficult time of developing a covenant of trust with the mental health provider.

Albeit it's virtually impossible to briefly describe Semper Fi Odyssey, suffice it to say that the weeklong session is a holistic approach to engage the Marine and through a covenant of trust help him/her build a realistic plan for the future. Rest assured, my use of holistic approach does NOT connote esoteric pabulum laced with lofty phrases but one-on-one, eye-ball level leadership, inspiring the participant to come to grips with the mental, emotional, physical and spiritual aspects of his/her life. Participants form teams and are led by very successful, volunteer veterans who are assisted by active-duty officers and senior noncommissioned officers who themselves have fought alongside the participants in Iraq and/or Afghanistan. The imperative to include the active-duty component became patently obvious as the evidence of operational stress grew in significance. All of the veterans who serve as Team Leaders have made a successful transition into the civilian sector, with the majority of this cohort having entered the business world; moreover, a sizable percentage of these veterans have experienced combat.

While the syllabus of Semper Fi Odyssey ranks as taxing and quite challenging, the underlying objective is the development of both professional and personal goals, supported by definitive, understandable and usable tools to reach these goals. Participants are LED to examine themselves VERY closely and are invariably inspired to share innermost thoughts and "demons." In general, participants arrive skeptical and somewhat tentative; however, the genuine concern of the Team Leader invariably "breaks the ice," leading to team cohesion and trust among team members.

While the course includes the obvious pieces of any typical transition course, the focus of effort is to provide the participant the ability to know and talk about himself/herself, without falling victim to the commonly-known habit of building a resume that doesn't reflect in ANY manner the individual described. Without question, by the final day of the Semper Fi Odyssey session, the participant has grown immeasurably in his/her ability to understand and share insights about his/her strengths, while being armed with the ability and assistance to tackle weaknesses and challenges. More important, the participant leaves the experience with the skills to build and follow a plan to succeed, reinforced by the knowledge that he/she now has a cadre of supporters (read network) for the future.

I simply couldn't adequately outline all of the elements of the week's experience but will now offer but one vignette from our most recent weeklong event which concluded this past Saturday, the 21st of April 2012. We reinforce the classroom work and Team Leader time with physical activities to the degree possible, based on the physical challenges of the participants. As noted above, Outdoor Odyssey offers a wide variety of high adventure activities and facilities that enable sessions in activities such as yoga and physical fitness, using equipment usable to those with physical challenges. The participants thrive on events such as the zip line, high ropes course and climbing, obviously tempered by physical limitations. This past week, two Marines, having but one leg between them, executed the long staircase of our indoor facility, with the Marine with an artificial leg carrying the Marine with NO legs up to the high ropes course on his back. These two Marines then negotiated a VERY tough and rigorous ropes course in tandem; there was not ONE dry eye in the building. A Senior Staff Non-commissioned Officer, deathly afraid of heights and heretofore declining to undertake the high ropes course, was SO inspired by the experience that he scaled the stairs and negotiated the course. Without exaggeration or any sort of hyperbole, the Marine without legs felt ten-feet tall and bullet proof upon completion of the experience. Everyone (and I mean everyone) saw a stark example of the power of the mind—regardless of the body. This particular event will impact not only those involved last week but many others as well in the days ahead, as it was chronicled by camera in the form of pictures and film.

The final, collective event of the week is the visit to the crash site of Flight 93 that came down in a western Pennsylvania farm field, roughly a 20-minute drive from Outdoor Odyssey. Without question, the emotional release ranks as palpable; Marines, most for the first time, are able to come face-to-face with the reality of 9/11. As the VAST majority of these young folks joined the military in large part due to the events of that fateful day, the experience reinforces key messages shared relative to survivor's guilt and other stressors associated with the trauma of combat.

CADRE OF SUPPORTERS

It would be virtually impossible to accurately chronicle all of the volunteer support that goes into the weeklong Semper Fi Odyssey session. However, it is critical to note that the word volunteer ranks as KEY to any and all success of the sessions held thus far at Outdoor Odyssey. Folks routinely arrive skeptical of the worth of the experience, as many, if not MOST, have listened to many folks offer assistance that has eventually fallen short of advertised pedigree. Without question, though,

the power of the week rests on the two most important words in leadership: genuine concern. The one-on-one sessions and interpersonal dynamics with those who freely give of themselves and their time set the experience aside from all others the participant has encountered. Moreover, and critical from my perspective, the nature of the volunteer, able to convey genuine concern, truly sets the stage for the covenant of trust that is developed; this can NOT be overemphasized!! To provide an illustration of the utility of the volunteer, I will use the most recent Semper Fi Odyssey as an example; this event was conducted last week, concluding this past Saturday, the 21st of April. While not all-inclusive, I'll show certain positions that played integral roles in the weeklong session, coupled with examples of the various backgrounds of those filling the respective roles:

• *Team Leader:* clearly the key to the success of Semper Fi Odyssey; most Team Leaders (TLs) volunteer for the entire week, with a small percentage sharing the responsibility, changing at midweek; eleven teams were used during the recent session, with TLs coming from such locations as Oregon, Wyoming, New York, Virginia and, of course, Pennsylvania. The TLs from Oregon, Wyoming and New York were all Vietnam veterans; the gent from Oregon was an infantry officer in the USMC, followed by a stint as a F–4 pilot in the Corps; he is now CEO of his own company; he has traveled to Outdoor Odyssey six times to serve as a Team Leader; his brother was a company commander killed in Viet Nam in an epic battle experienced by one of our local Team Leaders from Pittsburgh who has now served in that capacity for 20 weeklong sessions. The gent from Wyoming is an Orthopedic Surgeon, who served in Vietnam as a Battalion Surgeon of the same battalion as the brother of the gent from Oregon and the aforementioned TL from Pittsburgh. Several of the Team Leaders hail from Pennsylvania—all former Marine Officers and/or Senior Non-commissioned Officers and serving in leadership positions in various businesses. Additionally, two retired Colonels from the DC area served as TLs during this recent session: both retired Colonels and CEOs of their own companies (one from the Air Force and one female retired from the Army—both having served multiple times as TLs). During this recent session, we were blessed with the support of several active-duty Marines to serve as TL or Assistant TL: two Majors, two Captains and two Gunnery Sergeants—all with multiple combat deployments to Iraq and Afghanistan. Previous sessions have seen TLs from Texas (Professor at Texas A&M and former Marine), Alabama (former enlisted squad leader in Viet Nam and successful businessman) and Florida (former Navy SEAL and financial advisor). Team Leaders coming from the Washington D.C. area are simply too numerous to list, with the vast majority being retired Colonels, LtCols and Senior Non-commissioned Officers—most with combat experience.

• *Mental Health Professional:* During this session, we were supported by a psychiatrist (retired Navy Captain) who had served as the 1st Marine Division Psychiatrist in Iraq and, upon his retirement, played a key role in the development of the Marine Corps' program of record for dealing with mental health injuries known as OSCAR (Operational Stress Control and Readiness). We vigorously follow the tenets of OSCAR, working hard to identify those struggling to overcome stress injuries, while working to support the mental health professional for those clinically diagnosed to be struggling with illnesses. This particular psychiatrist has been with us many times and strongly endorses our work, while providing significant reinforcement to the Team Leader. During this recent session, we were also supported by a psychologist from a prominent university, located in Pittsburgh; this gent had learned of Semper Fi Odyssey from a fellow mental health professional and actively sought the opportunity to partake and assist. I am confident that we will benefit from his services for many sessions in the days ahead.

• *Representatives from the University of Pittsburgh and Penn State:* One of the most popular, and I would state most successful, presentations of the week has routinely been one oriented on dealing with stress management. Clearly, the sessions at Semper Fi Odyssey have identified that day-to-day stressors significantly exacerbate the incidence of operational stress or post-traumatic stress that many, if not most, servicemembers face after a combat deployment. We have been blessed for approximately twenty (20) sessions with a representative from the University of Pittsburgh who provides a striking and most stimulating presentation that includes tools that can be immediately implemented to address stress levels and improve sleep habits. Many participants have offered compelling testimony relative to the power of this two-hour block of instruction. Additionally, during this most recent weeklong session, we had seven representatives from Penn State and the University of Pittsburgh form a panel to address any and all questions posed by the participants, focusing on post-secondary education, veteran benefits, Vocational Rehab and any area related to education and training sought and/or required following departure from the military. This group consisted of college professors, specialists in veterans

programs and benefits, department heads and overseers of various programs associated with the matriculation to higher learning. As many of the participants face some level of physical challenge upon departure from the military, this session has proved to be MOST beneficial, providing insights into learning aids available to the veteran. The session takes approximately two hours, with panel members but rarely unable to answer the specific questions proffered by the participants; however, for those queries that stymy the group, an answer is invariably provided by one of the representatives later in the week.

• *Yoga Instruction:* Semper Fi Odyssey has been supported by the nonprofit Exalted Warrior for approximately the last twenty (20) sessions. The key instructor hails from Tampa, Florida, and routinely spends the entire week at Outdoor Odyssey. Sessions are incorporated into the daily routine during at least four days of the weeklong schedule, with voluntary sessions held each evening after completion of scheduled events. This recent session was supported by two instructors, one of whom a Navy Admiral (retired career SEAL) who was instrumental in the founding of the Exalted Warrior nonprofit organization. Instruction is modulated according to the physical capabilities of the participants, and MANY extol the virtues of these sessions to assist in relaxation and meditation, while helping to address problems with sleep.

• *Fitness Instruction:* For the last three plus years, we have been supported by the Fitness Anywhere Corporation via the involvement of a former Navy SEAL who is an exercise physiologist, chiropractor and bona fide fitness expert of the first order. Instruction orients on the use of a device known as the TRX, and, simply put, it can be used by virtually anyone regardless of physical challenge. The addition of several periods of this instruction into the weeklong syllabus has been HUGELY popular, with every session having one or more participant opining that use of the TRX was the first time the participant felt like a warrior since being wounded. The Fitness Anywhere Corporation, founded by a retired Navy SEAL, offers a TRX free to every participant, based on the recommendation of those overseeing the Semper Fi Odyssey.

• *Professional Assessment:* A company owned by the father of a wounded Marine Captain offers his company's service during each session of Semper Fi Odyssey to conduct a computerized assessment of each participant in the manner of the Meyers Briggs personality assessment. The evaluation provides the participant insight into his/her personal makeup, principally focused on elements of the individual's personality, strengths and orientation relative to occupational fields. Fortunately, during this recent session, the Marine Corps' Captain, an above-the-knee amputee from combat in Iraq and a recent returnee from Afghanistan where he served as a company commander, represented his father for the presentation of the assessment results.

• *Numerous Instructors:* Quite a variety of other professionals, too numerous to list, visit Semper Fi Odyssey during the weeklong session to provide various periods of instruction. Many of these individuals are former military; however, we work hard to recruit, train and incorporate talent without military experience, as it serves to better educate the populace of the staggering sacrifices borne by today's servicemember. Moreover, involvement by those without military experience provides the participant the opportunity to learn more from those he/she will likely encounter after departure from the military. Many of the instructors utilized for the weeklong sessions, be they former military or not, have been responsible for the creation of actual job opportunities for a number of the participants. An example of the periods of instruction provided by these instructors are as follows: goal setting; operational planning skills; resume building; interview skills and techniques; opportunities in the Federal Government; business 101 perspectives; STAR techniques for articulating accomplishments, etc. Of additional note, EVERY weeklong session has included presentations oriented on bona fide job opportunities; several sessions have had participants linked to his/her future employer.

• *Interviewers:* Our most seasoned Team Leader, a former Marine Corps Infantry Officer with considerable combat experience, hails from Pittsburgh. This gent trains the new Team Leaders and plays an integral role in virtually anything and everything that goes on at Semper Fi Odyssey. He owned his own computer company for over three decades in Pittsburgh and knows virtually everyone in the city. He has built an inventory of over seventy potential interviewers, and personally coordinates the involvement for approximately 15–20 interviewers for the final day of instruction for each session of Semper Fi Odyssey. Each interviewer ranks as a leader in his/her field, and the variety of fields represented covers virtually any occupation one could pursue. The interview session provides each participant the opportunity to undergo at least three or more mock interviewers by folks they have never met, instilling a level of stress and offering an opportunity to evaluate the participant's

ability to talk about his/her skills, experiences and passion to serve. A number of the interviewers are military veterans; many, if not most, routinely hold interviews for actual positions within their respective organizations. Without question, those interviewers recruited for this experience are passionate about the unique opportunity that they themselves have in helping the participant transition into the civilian sector. It is NOT uncommon for an interviewer to become a mentor for one of the participants he/she has had the privilege of interviewing. This particular session ranks as one of the most, if not the most, popular of the week, greatly instilling confidence in virtually every participant. The following is a snapshot of the interviewers from the most recent session: former Vietnam Army Officer and former CEO of largest Electrical Construction Company in US; President of manufacturing firm; Human Resource Manager of major bank; Senior Franklin Covey Facilitator; West Point Grad and Vietnam Infantry Officer and President and CEO of major construction company; President of Performance Consulting; President of company that provides host of services to small businesses; Director of Systems Engineering of KEYW Corporation; lawyer and owner of Law Office; former Marine Sergeant in Vietnam and owner of nine restaurants in Pittsburgh; President and CEO of prominent technology company in Pittsburgh; Superintendent of one of Pittsburgh's School Districts; former Marine enlisted infantryman in Vietnam and high level labor negotiator; Director of three assisted living homes; former infantry Sergeant with experience in Iraq who owns a major construction company; former Army Engineer with service in Vietnam who is now a TV and radio talk show host in Pittsburgh; Orthopedic Surgeon in Pittsburgh who served as a battalion surgeon supporting Marines in Vietnam; Assistant VP of Federal Reserve Bank in Cleveland; Manager of Recruitment at the University of Pittsburgh Medical Center.

Salient Outcomes, Lessons Learned, and Opinions: As I pen this written testimony, we have now been privileged to engage approximately 30–35 participants for 30 weeklong sessions. Without any exaggeration, trust, cohesion and team building represent the major by-products of the Semper Fi Odyssey experience, helping the participant share, learn and grow during the week while setting the stage for future success. Participants build relationships that are lasting and depart with the assurance that they are armed with connecting files to people who will indeed follow up with them in the days ahead. Obviously, those who choose to break contact can; however, those who elect to remain connected and gain follow-on support have a vehicle to do so. FORTUNATELY, the vast majority of past participants remain connected. I offer the following insights from the Semper Fi Odyssey experiences:

Salient Outcomes:

- Conduct self assessment and built definitive plan for improvement
- Gain bona fide skills in application of life-planning tools
- Identify and connect to people in their lives that they can count on and trust
- Build a honest network of support among fellow participants and volunteer support
- Make commitments that lead to accountability and likelihood of noble pursuits
- Experience trust and cohesion, inspiring participants to share "demons"
- Made significant breakthroughs relative to mental health issues that pave the way to improve follow-on care
- Develop SMART (specific; measurable; attainable; realistic; time bound) Goals
- Hone interview skills and STAR techniques that reinforce a TRUE resume
- Build a tentative network of support in the eventual geographical location of residence
- Enjoy being treated as a warrior and inspired by useful, workable skills
- Learn that others with similar experiences have grown and prospered greatly

Lessons Learned:

- Vast majority of wounded warriors require some level of assistance in preparation for transition
- A growing % of wounded warriors struggle with operational stress issues, and a growing number are being diagnosed with PTSD and/or TBI
- Trust, team building and cohesion pay REMARKABLE dividends in preparing Marines for eventual departure
- Many, many programs, based on sound concepts and procedures, simply DO NOT connect to the individual warrior, lacking one-on-one, eye-ball level leadership and understanding
- Many diagnosed and under a clinician's care do NOT disclose stressor at root of the problem
- Team building and cohesion led to significant number of breakthroughs among those diagnosed with PTSD but heretofore unable to disclose nature of stressor

• Experiences at Semper Fi Odyssey paid huge dividends in project sponsored by OSD designed to identify best practices; OSCAR is truly a winner if presented correctly
• Individuals who care and possess genuine concern for the wounded warrior are essential
• Key personnel within OSD are working to provide a grant that would enable support to be provided to members of any branch of the service

Opinions:

• Any cohort of combat veterans who have served in Iraq and/or Afghanistan would provide indications of stress levels roughly equivalent to those observed in wounded Marines
• A very large percentage of mental health professionals DO NOT remotely connect to combat vets and are presently unable to establish the necessary covenant of trust
• Semper Fi Odyssey could easily serve as a prototype for programs within the active-duty services
• Many, many veterans will be identified to be struggling with combat stress issues in the near future—and for many, many months to follow
• There exist too many disparate programs that DO NOT connect to the individual servicemember
• The Semper Fi Odyssey model stands to greatly assist mental health professionals engage veterans with mental health issues
• We need to build a mechanism of support that would permit the inclusion of members from any branch of the service

Very Warm Regards and Semper Fi.

Chairman MURRAY. Thank you very much.

Mr. Schoenhard, first let me say that I am very happy to hear that the VA is finally acknowledging there is a problem. When the Department is saying there is near perfect compliance, but every other indication is that there are major problems, I think it is an incredible failure of leadership that no one was looking into this. In fact, when you sit at that table before this Committee, we expect you to take seriously the issues that are raised here. It should not take multiple hearings, and surveys, and letters, and ultimately an IG investigation to get you to act.

I also would like to suggest that if the reality on the ground could be so far off from what Central Office thought was happening as it relates to mental health, then you better take a very hard look at some of the other areas of care for similar disconnects.

Now, what we have heard from the IG is very, very troubling. For months now, we have been questioning whether Central Office had a full understanding of the situation out in the field, and I believe the IG report has very clearly shown you do not. So I want to start by asking you today, after hearing from this Committee, from veterans, from providers, and from outside experts, why you were not proactive about this problem months ago?

Mr. SCHOENHARD. Chairman Murray, we have been looking at mental health for many years. As you know, with the support of the Congress, we increased our capacity and hired about 8,000 new providers between 2007 and 2011. We relied primarily on a uniform mental health handbook that would be the source of the way in which we would deliver care to our Nation's veterans. That has been the focus of the Department, to ensure that we are getting evidence based therapies and a staffing model that was largely based on the handbook put out in 2009.

I think what we have learned in this journey, and we have been wanting to work very closely with our providers, is a number of things. As I mentioned in my opening statement, the way in which

we measure these performance measures is not a good measure of wait time. We want to work very closely with the IG and with any other resources that are available to assist us in ensuring that we provide Vet Centered performance measures going forward.

Chairman MURRAY. Mr. Schoenhard, with all due respect, I think back in 2005, the IG said this information was there. So that is a long time with a lot of veterans in between. So my question is, how are you going to address that growing gap that we have seen, what Central Office believes, and what is actually happening in the field?

Mr. SCHOENHARD. As Dr. Daigh described in our response to the IG report, we have a number of things going on. One is first we have a working group that will report this summer on a new set of performance measures that includes providers on the ground assisting us with ensuring that we have developed measures in conjunction with support from the IG that are really Vet Centered, that are centered on the veterans' individual condition, and one in which we can revamp and go forward.

We fully embrace that our performance measurement system needs to be revised, and we will be doing that with the work of people on the front lines to assist us. We have the benefit of these mental health site visits that are assisting us. We are learning as we go on other issues having to do with scheduling. And all of this effort is assisting us in not just having people at Central Office develop proposed solutions, but to engage the field in a way that we need to in order to ensure we are Vet Centered and we are able to support our providers in delivering this care.

Chairman MURRAY. I appreciate that, but it is very troubling to me that this did not happen five, 10 years ago; that we are just now—after months of this, years of this, that that disconnect is there. But we will go back to that, because I want to ask Mr. Tolentino—and I really appreciate your willingness to come forward today. And I believe your testimony is going to be very helpful to addressing many of the changes that are needed in a timely fashion.

In your testimony, you suggested that VA institute more extensive oversight into how mental health care is actually delivered and funds are spent. Given how adept many of the facility administrators are getting around the current system without being caught, how do you think the VA can most effectively perform that oversight?

Mr. TOLENTINO. Madam Chairman, to be perfectly honest, I do not have a very good answer for you because of the fact that the gaming is so prevalent. As soon as something in put out, it is torn apart to look to see what the work around is.

I feel that the reporting that is done is—it is very redundant reporting that feels like it goes nowhere. There is no feedback loop. One way we are telling you exactly what you in most times want to hear that we did at the facilities and even at the network, but there is no coming back and rechecking, or coming back and feedback to say, well, you said you spent this money on these services, but there is no workload to verify it. There is nothing concrete to be able to speak to what you say you have done.

In the short time that I worked there, many times we got vast amounts of financial monies for different programs, but very, very seldom did we ever get requests to verify what we have done with workload, with any kind of feedback reports, or anything like that. So I think opening the lines of communication and a very transparent feedback loop at that.

Chairman MURRAY. Mr. Schoenhard, my time is out. I want to turn it over to Senator Brown, but I do want to address a very important issue here.

The Department has announced 1,600 new mental health care providers, and I appreciate that step. I think it is really needed. But I am concerned that VA hospitals all across the country are going to run into the same hurdles that Spokane VA has been in not being able to hire health staff. And I hope that medical centers are doing everything, including using all available hiring incentives to fill those vacancies. By the way, I assure you that is the next question this Committee is going to look at.

But I want to ask you specifically how are you going to make sure that 1,600 new mental health care providers that you announced do not remain 1,600 new vacancies?

Mr. SCHOENHARD. Chairman Murray, that is a very important question. And we have stood up in our human resources group in VHA workforce two task forces to assist us with this. One is the recruitment and retention of mental health providers with a particular focus on psychiatry. That is where our greatest need and problem is in retaining and recruiting mental health providers.

The second task force is a hiring task force; that is, what can we be doing to expedite and make sure that we are having the process of recruitment as speedy as possible. The group has put together a number of good recommendations that we will be implementing.

Part of what Dr. Daigh spoke of earlier in terms of our four part mission, one of the great assets, having been in the private sector for many years before coming to VA, is that many mental health providers, including hundreds of trainees, currently today get part of their training in VA and have the opportunity to experience this going forward. We need to better link with these trainees and ensure that we have a warm hand off for employment when they finish this.

Chairman MURRAY. OK. That is one issue. But then how you arrived at your staffing plan is really unclear to me.

Mr. SCHOENHARD. Oh, I am sorry.

Chairman MURRAY. The new 1,600 mental health providers that you allocated and the information that we got from the Department yesterday on where that was going to go is not supported by any concrete facts or evidence. In fact, yesterday the VISN 20 director told Senator Begich and me that she learned about the new positions only a couple days ago, did not know if it was sufficient, and did not know how the Department even reached those numbers.

So I want to ask you, how did you arrive at that number of 1,600, and what makes you confident that it is going to be effectively placed across the country? What is the plan, staffing plan you used to do that?

Mr. SCHOENHARD. Thank you. I am sorry. I misunderstood the question. I am going to ask Dr. Schohn if she may want to speak

on this. But we used a model that looks at the volume of services. We are piloting this in three VISNs, and I would be happy to answer further.

Ms. SCHOHN. Thank you. Yes. As part of our response to the Committee in November, we plan to develop a staffing model. The staffing model——

Chairman MURRAY. I am sorry. You plan to develop a staffing plan that is not yet in place?

Ms. SCHOHN. No, no. We did develop a staffing model, but we submitted to you that that was part of our action plan in November. We developed a staffing model, and we are in the process of implementing it in VISNs 1, 4 and 22, to understand how to implement it. So we do not want to just simply say here is the number of staff without actually a plan for how this rolls out, issues the right number of staff, to really evaluate how well and how effective this methodology is.

Our plan, however, also is not to wait until we get a full evaluation of this plan, but basically to staff up so that we will be fully ready to implement this plan throughout the country by the end of the fiscal year. So we will have—we are planning—the plan itself is based on identification of existing staff at facilities, the veteran population, the range of services offered, and the demand for services. And our plan is to be able to use this to project the need so that we will have a standard model in the future that is empirically validated, that we all know how many staff we need.

Chairman MURRAY. My time is up. I do want to come back to this because it is critically important. But I will let Senator Brown and Senator Tester first speak.

Senator BROWN. Thank you.

So, Mr. Secretary, you announced last week that the VA will hire 1,900 additional mental health staff, 1,600 mental health providers and then 300 support staff. Yet in response to a question for the record submitted by Senator Burr, a poll of your facilities in December 2011 revealed that there were 1,500 open mental health positions.

So I guess my question is, are these 1,900 positions announced last week by the VA in addition to those already identified to Senator Burr as open?

Mr. SCHOENHARD. Senator, the 1,900 additional positions are based on what we believe are the needed complement——

Senator BROWN. I know. But is it in addition to the 1,500?

Mr. SCHOENHARD. It is in addition—these are additional positions, in addition to those that we are searching to recruit for, that are currently open.

Senator BROWN. So is it 3,400 positions you are going to be filling?

Mr. SCHOENHARD. No, sir. These are additional positions on top of what we are currently recruiting in terms——

Senator BROWN. You said in 2011, there are 1,500 open positions. And now you are saying you have 1,900——

Mr. SCHOENHARD. Fifteen hundred vacancies. And Dr. Schohn, you may want to comment to this. But I think it is important for this——

Senator BROWN. Who is in charge? Is it you or her, or what?

Mr. SCHOENHARD. Well, for the Committee, let me just clarify. These are not related to the number of vacancies. These are related to the number of positions that are needed in our facilities. And so we will be adding 1,900 positions, 1,600 in clerical and provider support, in addition to those that we are currently recruiting for.

Senator BROWN. All right. So how long do you think it will take to fill these positions?

Mr. SCHOENHARD. Well, it depends on the level of provider that we are searching for. But——

Senator BROWN. Give me an idea. Is it a week? Is it a month, a year?

Mr. SCHOENHARD. It can take four or 5 months, sir.

Senator BROWN. Four or 5 months. OK. And how do you determine the number of additional staff and which type of clinicians are actually needed? How do you make that determination?

Mr. SCHOENHARD. We are allocating the FTEE to the VISN for its distribution to the facilities. We will be working with the facilities in the VISNs. Part of what we have not described here that is in place now is a robust system by which Dr. Schohn is working with the mental health leads in the VISNs. And with a new management information system that we have in place, we have greater visibility to VISN management of this open and going forward.

Senator BROWN. So this is four to 5 months, then, still, that we are talking about?

Mr. SCHOENHARD. Sir, we are planning by mid May to have identified where the specific positions go.

Senator BROWN. But in the interim——

Mr. SCHOENHARD. But we want to do that in conjunction with the VISN leadership.

Senator BROWN. Thank you. But in the interim, you have soldiers that are killing themselves and people who are hurting and need services. I know that the Uniform Mental Health Services Handbook also says that you can actually—on a fee basis, you can actually refer out people who need help.

Mr. SCHOENHARD. Yes.

Senator BROWN. So I am curious as to—you read about these things. And if there is such an overload and there is such a breakdown, why is only 2 percent per year of the total unique patient population in mental health sent out for non-VA care. Why is it only 2 percent, yet the handbook says that you should and could do it?

Mr. SCHOENHARD. Yes. We do that where we can. Often where we have shortages, the community has shortages.

Senator BROWN. Well, it seems like there are—I mean, based on what we have heard and the testimony we have been receiving, there is clearly a shortage. So in the interim, before you work and upload these 1,900 people, why don't you get these people out the door and get them care and coverage right away?

Mr. SCHOENHARD. Sir, first let me clarify, for those who need urgent care, we are emphatic that we ensure that those who are at risk are well treated. And it is referred to as suicide prevention coordinator for immediate treatment.

Senator BROWN. Well, Jack Manning needed care and coverage, and he did not get it. And he killed himself. I mean, there are oth-

ers like that. So what is the definition of critical care and immediate care? I mean, to me it means immediate, like the guy calls; he gets help right then and there.

Mr. SCHOENHARD. Absolutely. Anyone who presents with any at risk factors should be seen and treated right away——

Senator BROWN. But they are not.

Mr. SCHOENHARD [continuing]. Within the 24-hour triage.

Senator BROWN. But they are not.

Mr. SCHOENHARD. They should be.

Senator BROWN. But they are not.

Mr. SCHOENHARD. Well——

Senator BROWN. Is that right? They are not.

Mr. SCHOENHARD [continuing]. We have an obligation to ensure that they are.

Senator BROWN. But they are not. Correct? So if they are not—I mean, I know the answer. So you can certainly just say that, yes, they are not. We have had some people slip through the cracks. If that is the case, then, we need to actually outsource and use these resources that we have, these other folks that are out there, who want to try to help.

We should be doing that. Do you agree or disagree?

Mr. SCHOENHARD. Sir——

Senator BROWN. Sir, do you agree or disagree?

Mr. SCHOENHARD. I think we should take them on in our system because we can best serve their urgent needs by——

Senator BROWN. Sir, with all due respect, that is not happening. OK? That is why we are here. That is why the IG report said that there is a breakdown with you meeting performance standards and actually not handling the individual needs of the individual soldiers who are killing themselves. So it is clearly not working.

So my question is, do you think we should be sending out more people or not—yes or no—to the fee based—outside the VA system?

Mr. SCHOENHARD. We should sent out where we do not have the capacity, but we should—for those who are most at risk that need urgent care, we should ensure that they receive treatment within the VA.

Senator BROWN. But you are not. Correct?

Mr. SCHOENHARD. Well——

Senator BROWN. I am not saying every time, but there are instances where there has been a problem.

Is that a fair statement?

Mr. SCHOENHARD. And where we do that, we need to ensure that we have——

Senator BROWN. Sir, listen. It is pretty simple. Are there instances in which we, the VA, collectively, everybody here, we have let somebody fall through the cracks.

Yes or no?

Mr. SCHOENHARD. There are instances where veterans——

Senator BROWN. OK. All right. We are not perfect. So in those instances, though, should we then be making sure that we do not do that again. And if there is a problem, that we refer them to the appropriate open agencies that can help right away.

Is that a fair statement?

Mr. SCHOENHARD. Yes, but——

Senator BROWN. We are only doing 2 percent. Only 2 percent of those folks actually are referred out. And it is clear that there may be some sectors, some VA sectors, where there is a problem. Not everybody. And these are not for the people who are out there working their tails off each and every day. I get it. They are overloaded. They are overworked. If that is the case, let us refer them out and get them care and coverage.

Mr. SCHOENHARD. Dr. Schohn or Dr. Zeiss may want to comment.

Senator BROWN. I will. I will get to them.

I just want to say, Nick, if you could just comment on the testimony you have heard, and comment on the fact that, based on your experiences in Manchester, do you see—or what do you think of the testimony from the Secretary, first of all? Number 1.

Number 2, am I missing something? Is there an appropriate way to refer people out like that? And is it being done? And if it is not, why not, and should it be done?

Mr. TOLENTINO. Senator, listening to the testimony so far, there are a couple of things I would like to comment on. One is the hiring practices, saying it is hard to recruit and fill these positions.

There are barriers that are on the front lines that are not being heard at this level up here, such as when these special purpose funds come in, they are for X number of years—1 or 2 years, whatever it may be. And a lot of facilities, many facilities—not just Manchester—those positions were then being listed as not to exceed 2 years, or not to exceed 1 year, to be able to go along with the special funding, so that they did not have to worry about their budget in the future, and instead gave them the option to opt out.

So if I am a psychiatrist or a mental health clinician, why, especially in this economy, am I going to leave a full time position to go to work for the VA if it is not even guaranteed that I am going to be there in 2 years, or that position is going to be there in 2 years? That is the reality. That is just one of many examples that the front lines are encountering in trying to get people in there.

Second, when you are talking about the fee service, it felt, where I was at—let me qualify that. It felt where I was at that the fee service was saying that our system was not adequate. So we are not going to send people out if we cannot deliver this care that we are so very proud of, that we offer. And when they were fee'd out, the problem that—in the Uniform Mental Health Handbook, it says that the VA is then responsible for ensuring the care management of those people out in the community. And that was not even evident either, because we did not have even the personnel to do that.

Senator BROWN. Thanks for your answer.

I also want to——

[Pause.]

Senator BROWN. I will stay all day, Madam Chair. I mean, this is an important issue.

I want to talk about the bonus program, to the fact that you have people who are getting salary, and then they are getting bonuses on performance. I would like to talk about that in the next round of questioning because I think it is important to note that if somebody is getting a salary to do their job, and they are just hitting

numbers to get a bonus, I find that a little bit surprising. So I would like to talk about that, and I will refer to the next round.

Chairman MURRAY. OK. Absolutely. And we will have as many rounds as we need, I assure you.

Senator Tester.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Madam Chair, and thank you for holding this hearing. I want to thank everybody who has testified today.

Just from a rural perspective, I will tell you that one of the reasons the VA cannot contract out in a rural State like Montana is because the private sector does not have any more mental health professionals than the VA has. And I just want to point that out because mental health professionals, whether it is in the private sector or in the VA, getting this to these folks is a big problem.

I very much appreciate Mr. Tolentino's—about nobody is going to go to work for a year or 2 years in the VA when in fact in the private sector, they have much more predictability in their jobs. And we need to take that into consideration when we start allocating dollars for the VA, to make sure that they have the advantage to be able to compete. I very much appreciate that perspective.

Along those same lines, I just want to ask—Senator Brown was right in the area of 1,500 positions opened and an additional 1,900. So there are about 3,400 positions. They may not all be psychiatrists, and they may not all be clinicians. But how you are going to fill those in an area where the private sector is sucking folks up? Because it is a big issue there, too. And the VA—it is interesting to me.

Do you have an allocation by a VISN of these 1,600 folks? Do you?

Mr. SCHOENHARD. Yes, sir.

Senator TESTER. Could we get a list of those? How they are they going to be allocated?

Mr. SCHOENHARD. Yes, sir.

Senator TESTER. I know you talked about metrics, number of veterans and that kind of stuff. Could you give me a list of metrics on why the numbers are there, how many are going to be psychiatrists, how many are going to be nurses, clinicians?

Are any of them going to be psychologists?

Mr. SCHOENHARD. Sir, we are leading to the VISN and in discussion with the facilities, it could be psychologists. It could be family—it could be a variety of different mental health providers.

Senator TESTER. Thank you. And when it comes to contracting out, do you guys typically only use psychiatrists, or can you use psychologists, too?

Mr. SCHOENHARD. No. We can contract with others.

Senator TESTER. Oh, super. That is good, because there are some accessibility of those folks in a place like Montana.

I want to put two things that Mr. Tolentino said along with Major General Jones. And, Major General Jones, I want to thank you for what you are doing. I very much appreciate it.

Mr. Tolentino said when he was there, it was clearly common if somebody came in with a problem, do not ask if there is another issue. There are all sorts of correlations here that are wrong. But I just want to tell you that—OK. So if that is done—and I believe he is probably right because that then became a problem. But if you combine that with what Major Jones said, that the folks that he is working with, the major stressor is unknown, we have a problem in our system here. Because the only way you are going to find out how to get to the real root of the problem when it comes to mental health—and I am not a mental health professional—is you have got to find out what that stressor is. You have got to find out what created that problem.

Does that kind of—well, let me just ask you. If you had a VA professional in one of the CBOCs or at one of the hospitals tell their people do not ask any questions because we do not want to know, I am hoping the hell that does not come from your end. And why would do they do that?

Mr. SCHOENHARD. Sir, if that is being done, that is totally unacceptable. And we will review the situation we had to review going on in Manchester. And we will continue to follow up any time that that occurs because——

Senator TESTER. I am going to tell you, I think you ought to do it in every VISN you have. That is just my opinion because that is totally unacceptable. We are not going to get our arms around this. You guys have been dealt this hand with multiple deployments. So the mental health issue is a big issue. And it is an issue that, quite honestly, if we do not get our arms around it, there are going to be more and more people who slip through the cracks, whether we want them to or not. That is the way it is.

Our use in the private sector is important. Our partnerships we develop are important. Nobody wants to dismantle the VA, but when it comes to mental health issues, I think it is all hands on deck. I just think it is all hands on deck.

Last, I just—and I have a bunch of questions here. They were written out. The metrics that are used—and I know the access to care metrics were the ones that one of you said—and it might have been you, Dr. Daigh, about those being flawed.

I do not know if this is the same thing or not, but the report I read means that they were kind of jimmying the numbers to look like people were getting treatment in a timely manner when they were not.

Dr. DAIGH. I think that the problem is that the schedulers were not consistently operating by a business rule that said you should schedule the appointment according to the date that was desired. And the desired date, what is the desired date? The desired date the patient wants, the doctor wants?

So in the to and fro of scheduling, I think VA created metrics which are not supportable in a systematic way. Then you look at the dataset. It is not usable from my point of view. So I think that is, in large measure, part of the problem with the access measures across the system.

We also hear reports of gaming and people trying to game the system. But I do not have evidence that I can give to you of gam-

ing, but I certainly can say that from the dataset, we do not think it accurately reflects access as it is in the VA.

Senator TESTER. OK. Well, one last thing, and this will be the last one. There is a stigma in this country, and probably in the world, but definitely in America, the United States, attached to mental health issues, injuries. I have multiple stories about folks who will not go get treatment because they are afraid it will be on their record, afraid they will not be able to get a job, afraid it might impact the job they do have, perception by family, friends, colleagues.

Does the VA have an active education program to try to reach out to those folks to let them know that this is part of—as Major General Jones says, it is increasing, it is present, and it is growing. And it is not uncommon, and it is OK.

Is there some kind of educational outreach going on?

Mr. SCHOENHARD. Yes, Senator. There is Make the Connection initiative that has just been undertaken. I think it gets back to the primary care integration of mental health, where we are able to screen for PTSD.

The other aspect of care that we have not mentioned today is the Vet Centers, which are also ways in which veterans can approach for help, for whatever reasons they would be reluctant to access a traditional system.

Senator TESTER. I agree. And before I go—and I want to thank the Chairman for the length—I just want to say thank you for all you do. Look, I put myself on the line for the VA every day because you guys have got a big job to do. But you have got to make sure that what is going on up here, things that the chairman says and other people on this Committee, that it actually gets to the ground, because we are hearing that things are not going so well in some areas. We are hearing things are going fine in others. And mental health is a huge challenge, and it is not easy. And please do make sure that it gets to the ground.

If there is stuff like Mr. Tolentino said about temporary dollars, temporary money, hell, I would not take a job like that if I was in demand. So let's figure out how to fix that, figure out how to make it work. And let's figure out also—by the way, because we have Healing Waters in my State that does a great job, and there are some others. Let's figure out how we can dovetail onto things like what Major Jones is doing because that can be an incredible paradox—I mean, you know, whether you are fishing or riding a horse, or whatever, I do not care. Those can be incredible programs to get people back on their feet.

Thank you very much, Madam Chair.

Chairman MURRAY. Thank you.

Senator Moran?

STATEMENT OF HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Thank you, Chairman, Chairwoman.

Secretary Schoenhard, I was pleased to hear the VA announce its plan to hire 1,900 mental health workers. And then I was additionally pleased with the announcement yesterday about the family

therapist and the licensed professional mental health counselors. My discouragement is how long it took for the VA to implement.

I have a history with particularly those two professions, that in 2006, Congress passed the Veterans Benefits Health Care and Information Technology Act. And part of that act was a piece of legislation that I introduced to encourage, authorize, and insist that you hire those two professionals within the VA. And now five and a half years later, it is occurring.

So while I think I will stay on the positive note, I am discouraged by how long it took, but I am very pleased at this point in time to see that you moved in that direction. I encourage you to hire those people and put them to work as rapidly as possible.

Part of my interest in this topic is coming from a State as rural as Kansas, in which our access to mental health professionals is perhaps even more limited than more urban and suburban States. And we need to take advantage of the wide array of professional services that are available at every opportunity. And so I am here to encourage you, now that you have made this announcement, let's bring it to fruition. And thank you for reaching the conclusion and getting us to this point.

I want to direct my question to General Jones. I thank you very much for your Semper Fi Odyssey efforts. I had a Kansan visit with me within the last month who has organized a program—I do not know that it is modeled after what you are doing, but the same kind of focus and effort. And it is somewhat related to the conversation or the questions of Senator Tester about kind of the stigma or lack of willingness to admit that one needs help; lack of perhaps knowledge about what programs are available; how to connect the veteran with what is there.

I wanted to give you the opportunity to educate me and perhaps others on what it is that you have been able to do to bring that veteran, who is not likely to know the existence of your program or programs like yours. And second, what can be done to overcome the reluctance of military men and women and veterans to access what is available, such as your program.

General JONES. Thank you, sir. Well, first off, I think that the Semper Fi Fund that I have been a board member of provides the ability for these veterans to come. Admittedly, most of the veterans that come back to their case workers of the Semper Fi Fund have some problems, or they would not be there, and they have had a difficult time making a transition.

So when they arrive in Western Pennsylvania for one of the week long sessions, they arrive with a major degree of skepticism and very tentative. And we try to restore them to the strength of their experience in the Marine Corps, the team, the cohesion, team building, and basically restoring their trust. I would say trust in the system and trust in others.

I think that my work through the Semper Fi Odyssey, because of the mental health professionals that have come in and really bought in to the program, and have really advertised the program and allowed me to speak to other groups, led to a project I am doing with the Institute of Defense Analysis, sponsored by OSD, that looks at best practices.

So for a long time, we never talked much about mental health issues until recently. As a Vietnam platoon commander, we never talked about it. But now there are programs in the Marine Corps, and I would say the Army, too, Comprehensive Soldiers Fitness, in the Army. The Marine Corps' program is Operational Stress Control and Readiness.

It is a great program, but it is not easy to overcome the stigma. And the program really rests on the strength of the NCO. No major general is going to ride into a link, or squad, or platoon, or company, and build immediate trust. It is going to come from the NCO.

So overcoming that skepticism, overcoming that chasm of trust is difficult, but it is happening, especially those units that have deployed four and five times; young NCOs, young officers, who are seeing the power of what a squad leader or platoon commander can do to identify problems when they are still in the category of combat stress injuries and have not migrated to combat stress illnesses.

I think that is the strength of the Marine Corps' program. I think the problem with—mind you, this is only my opinion now—the Army program is that it is very well built. The application is not focused on the young NCO as is the Marine Corps' program. I am not saying this because I am a Marine, but I just sense the NCO identifying in Iraq or Afghanistan if there is a problem.

You can start the dialog right there. You can start the reconciliation process right there. You do not have to wait 6 months after he returns and he has got this problem in his metal wall locker he pulls out then, when he is by himself.

So we try to restore, and very successfully restore, because all these veterans come in and actually volunteer their services. This past week, we did 35 Marines. We had an individual travel all the way from Oregon six times. His brother was killed in Vietnam as a company commander. He himself was a Marine Corps officer. He is a CEO of a very successful business, but he is giving up a week of his time.

We had an orthopedic surgeon come in as a team leader from Wyoming. Well, it does not take a Phi Beta Kappa very long to tell that, hey, these people are giving themselves for me, so that chasm of trust is taken care of pretty quickly. I would say by Wednesday of a 7-day program, these people start realizing these people care about me. Then you are on the road to identification. That is when the demons start coming out. That is when you find out that a guy, when the company commander was killed, feels guilty—irrationally but true—and he has never shared that with a clinician. That is when you find out a guy has been behind curtains of his own apartment in Racine, Wisconsin, for 2½ years, and the only person he has talked to is his clinician. He has never divulged to his clinician that he killed a Marine accidentally because their sectors aligned with each other.

So I think we have no full-proof system, but I think the power of the Corps and the power of the Army clearly has team, clearly has cohesion, clearly has trust. And if you can restore that to what degree you can restore that, then you are on the road to a good program.

There is no shortage of people that come and chronicle their experience with a clinician. And they are not damning the clinician at all, but the clinician simply does not understand the individual adequately enough to build that bond of trust.

Senator MORAN. General, thank you, for your service to our country and to the veterans. And thank you all for your interest and well being of our Nation's service men and women.

Thank you, Chairman.

Chairman MURRAY. Thank you very much.

Dr. Daigh, let me turn to you. As you well know, it is hard enough to get veterans into the VA system to receive mental health care. Once a veteran does take a step to reach out for help, we need to knock down every potential barrier to care. Clearly, the report your team produced shows a huge gap between the time that the VA says it takes to get veterans' mental health care and the reality of how long it actually takes them to get seen at facilities across our country.

Now, VA has concurred with all of your recommendations, but I think it is clear we all have some real concerns because some of these issues have been problems for years. So can you address a question of what you think it would take to get the VA to get this right this time?

Dr. DAIGH. I think, to begin with, the veteran population is dispersed across the country, and the VA is not evenly dispersed across the country. So those veterans that go to fixed facilities to receive their care, the VA, I am guessing, probably is trying to address in this current plan for 1,600 people. I have not seen the details of the plan, so I do not know.

So I think the first issue is to realize that you have a problem where you have facilities and where you do not have facilities. And I think the second problem is that, as has been stated here, there simply are not enough mental health providers to hire off the street in a timely fashion, I believe.

I mean, we looked at the other day—I think there is something like 1,200 psychiatry graduates a year in this country, from our medical schools. So there is a limited pool, and there is a great deal of demand for mental health providers. In our discussions with private sector, they said that because of the downturn in the economy and other facts, that the non VA, non military demand had also gone up, in their experience, 10, 20 percent the last couple of years.

We were asked several years ago to look at access to mental health care in Montana. And it was a very interesting review for me, in that Montana VA had linked up with the community mental health centers in Montana.

I believe that—I may be out of date by a couple years since we did it a couple of years ago—but there was an organization of community mental health centers. And by allowing veterans to go to those mental health centers, which are usually staffed by psychologists and social workers and usually not by physicians, they were able to dramatically improve the access time to get folks to talk to competent people in their neighborhood, in their city, to get some care.

I think in order to make that care cohesive, as Mr. Tolentino said, you have got to be able to get medical records back and forth so that there is a coordination of care.

So I think the all hands on deck idea is one that I wholly endorse and one where, if I look at some of the cases—tragic cases we have looked at in the past—it was not infrequent for veterans to show up at a community mental health center in their town. And because they were veterans, they were then sent to the VA, and there was not a link. They were not accepted, or there was no payment mechanism, or there was no authority. So I think that would be a useful step.

Second, I think you really do have to sit down—and as bad as metrics are, I think you just do have to sit down and model what you are going to do, and figure out what demand is, and try to lay out a business case for what you are doing.

Chairman MURRAY. Is that in place at the VA today?

Dr. DAIGH. I do not believe that they have for mental health the level of business plan that I think they should have, nor do I think they have it for most medical specialties.

Chairman MURRAY. Ms. Halliday, do you want to comment on that?

Ms. HALLIDAY. No. However, I would like to say, though, to your original question, where you said what is needed to fix this, I really believe VA needs to focus on the data integrity of the information they are collecting, along with the new set of metrics. And I think they need to hold the medical facility directors accountable to ensure that data integrity.

We have seen scheduling practices that resulted in gaming the system to make performance metrics look better at the end of the day, over the past 7 years, they need a culture change. To get that culture change, I think they really need to hold the facility directors accountable for how well the data is actually being captured.

The auditors that actually did the work in the field at the sites for this review had general observations, that the focus was always on the outliers, who was not getting care outside of, say, the 14-day window, but there really was very limited focus on how well the schedulers were capturing that information.

That is the information that starts to identify demand. It starts to tell you what type of services you are going to need and whether you need to address emergent care; or to strategically address care over the long term, you have to have reliable information. So coupled with I think a positive step to increase the staffing, that is clearly very important.

Chairman MURRAY. OK. Thank you very much.

Senator Brown?

Senator BROWN. Thank you very much.

So, Mr. Secretary, I want to get back to, obviously, the bonus issue. This year's budget for 2012 is $5.9 billion; next year, 2013, $6.2 billion, an obvious increase. And the VA gave out in 2011 $194 million to senior executive service employees.

Do you think that is appropriate?

Mr. SCHOENHARD. Well, sir, we have—at VA, under Secretary Shinseki's leadership—run an extensive review of performance bo-

nuses and have reduced those in both the number of outstanding ratings and the dollar amount that has actually been implemented.

Senator BROWN. So the number was actually higher at one point than——

Mr. SCHOENHARD. It was, sir.

Senator BROWN [continuing]. $100 million?

Mr. SCHOENHARD. Yes. We have taken this very much to heart. So let me just offer that the integrity of our performance measures, and the integrity of our scheduling system, and the fidelity with which we implement these and adhere to them that are veteran centric is extremely important to the Department. So we take very seriously the comments that have been made by the IG, and we will be rigorously following up.

We have been emphasizing the integrity of the system. And it is obvious that some of what we have put in, in my opinion, in performance measures, particularly as it relates to desired date, may get us into a discussion where it leads to this kind of confusion. Because what sometimes happens is that a scheduler will say I want to schedule you for when you want to next come in. And the veteran might say, "When are you next available? I will be happy to take whatever is there." And that is a trick bag we need to get out of, by going back, in our view——

Senator BROWN. Sir, listen. I understand that. But my question is really focusing on bonuses now. I understand that there are holes and we need to fix them. The Chairwoman brought up that this has been an issue since the mid 2000s, 2005, 2008, whatever, and it is something you are going to continue to obviously work on. And I get that. It is not perfect. I understand that as well.

But I am a little curious. What is the average salary for these people that are actually getting these bonuses?

Mr. SCHOENHARD. Sir, can we take that for the record?

Senator BROWN. Yes. I would like to—I am going to get you some—what is the salary? What are the bonuses based on? How do you justify $194 million of the tax dollars to go to pay for bonuses? This should be part of their job. I just want to make sure I understand it. And maybe if not, then I will stand corrected.

Nick, what do you think about the opinion of tying these bonuses to quality rather than quantity? What do you think about that possibility?

Mr. TOLENTINO. Senator, my opinion with the bonuses is that I think he already mentioned it. It is bonuses for doing your job. So if you are doing your job up to par, you are rewarded for that. And what I was always taught from my 14 years in the military is your bonus is your reward for going above and beyond. And clearly, I am not seeing that, in the treatment of veterans and the care that they need.

So my opinion is, I truly do not agree.

Senator BROWN. Do you think that money could be used somewhere better?

Mr. TOLENTINO. Beg your pardon?

Senator BROWN. Do you think that $194 million could be used somewhere better?

Mr. TOLENTINO. I do.

Senator BROWN. Thank you.

Mr. TOLENTINO. I do, Senator.

Senator BROWN. First of all, thank you once again. I enjoyed the testimony from Senator Moran.

Why do you think the veterans are reluctant to share their experiences with a clinician and that you are finding that during your situation in Semper Fi Odyssey and during that week, you have found that so many folks have actually opened up? Why do you think that—is it a trust issue? Is it just being in the military? Or what is it?

General JONES. Yes, sir. It is clearly a trust issue. The issue—the combat—obviously, there is operational stress. There is——

Senator BROWN. Can I just add one thing to that? And what do you think the VA could do to establish that bond that apparently you have?

General JONES. I think that the issue is a lot of—it is a trust issue, the lack of trust. And it is a fact that, quite honestly, many clinicians do not understand the nuances of combat stress. In fact, some of the tools that are being built now are much like a wreck on 95 in a traumatic event.

Combat stress is very different. It is very personal. And it is something that people have a fear and then trust with somebody else to share those experiences. And the longer the person waits for the reconciliation process, the more difficult the problem may be.

The answer to that, what I think they could do, is I think that we need to provide more opportunities, like we are doing at Semper Fi Odyssey, for some of these people in the mental health community. As mentioned before, I do not think that 1,900 more people, or 3,400 more people, are going to solve the problem unless you are hiring the person that really can, in fact, connect to the individual that will inspire him or her to share their perspective.

Senator BROWN. Great. Thank you. Thank you all very much.

Chairman MURRAY. Dr. Schohn, at this Committee's November mental health hearing, you said you were not aware of any facilities that were gaming the system and not fully reporting waiting times. You heard Mr. Tolentino's testimony about the Manchester VA regularly using loopholes to artificially meet their mental health performance measures, often at the direct expense of veteran care.

So now that you have read the IG report and performed your own audit of mental health practices at various VA facilities, and you have listened to his testimony, I want to ask you the same question today that I asked you in November.

Do you believe that VA facilities are gaming the system and now fully reporting wait times?

Mr. SCHOENHARD. Senator, I would say that we have zero tolerance for that. We are going to continue our audits and reviews to ensure, with additional training of scheduling practices, that this is not occurring. This is certainly not a practice that can be condoned.

Chairman MURRAY. Well, you heard Mr. Tolentino. He talked about the Manchester VA increasing their mental health workload numbers in order to get additional resources, despite not having enough staff to support that growth; the quantity over quality, I believe that you stated. And the result is veterans not getting the

care that they need. I am really shocked that the VA allowed providers to be put in that kind of dilemma, where they have to choose between following directions from the leadership and following the ethics of their profession.

So let me ask you, what are you going to do to ensure that the quality of care is not being sacrificed as you continue to meet these timeliness standards?

Mr. SCHOENHARD. I think it is a multifold approach going forward, that we are underway and have been implementing here. First, we need to ensure a staffing model that we will continue to perfect, that we have sufficient staffing on board to serve the veterans' needs. We also need to look, as Dr. Daigh said earlier, at the productivity of that. And there is a productivity directive that is being developed to ensure that care is being rendered in a productive way.

Second, we need to make sure that we have the measures in place to ensure that the veterans are receiving timely care in accordance with their condition.

If I might just go back to an earlier discussion with Senator Brown. As we were discussing those veterans who are most critically at need, who are urgently in need of crisis, I feel so strongly that we should be sure to respond to those. But certainly in the case where we would not have, say, an inpatient psychiatric bed available, we would fee that out to the private community. And that is something that should happen in order to ensure the veteran is cared for. But it is fundamentally important that we get visibility for this.

In the conversation with Senator Brown, what I was trying to emphasize is that we must have visibility, and we must respond to those who are most in crisis. And if that requires that we fee out because we do not have a bed available or something, we would do that. We do do that. But we would only do that after making sure we do not have the capacity because, candidly, part of the risk is the handoff to the private sector. And it is important we get visibility, we bring those veterans in, and we take care of them.

Chairman MURRAY. Let me go back to the scheduling issue because that is a critically important piece of all this. Back in 2005 and again in 2007, the IG released reports that highlighted problems with the patient scheduling, including the calculation of wait times, inconsistence practices by schedulers, all that. And despite having heard about this for 7 years now, here we are today.

So why is it so difficult to address these problems, and should we be more optimistic it is going to happen this time?

Mr. SCHOENHARD. Well, VHA has established needs, Madam Chairman, for scheduling, including a vision of a modern scheduling package that would, among other things, provide patients the ability to make their own appointments.

Chairman MURRAY. And the implementation date?

Mr. SCHOENHARD. We published an RFI in December 2001. We would like to take, for the record, when we will be implementing because we are underway in this new initiative.

Chairman MURRAY. Dr. Daigh, do you believe that is going to happen?

Dr. DAIGH. I do not have enough information to comment, ma'am. I would have to check and see where they are with this. I would just say this has been an issue for a number of years, and it has not been solved. So I am not aware of the specifics of what they are talking about.

Chairman MURRAY. OK. I have several other questions I am going to submit for the record.

But I do want to say, I want to thank all of you for being here today and sharing your views. Critically, access to VA health care in a timely fashion is absolutely essential, especially as we have a growing number of men and women who are returning from the war, where this is a signature wound that we are very cognizant of, and we need to be prepared. And this Committee is focused on this, wants answers and follow up, and not just this to be another hearing, but wants real action taken.

So, Mr. Schoenhard, I appreciate the VA stepping up to this today. I appreciate them accepting the IG report. I really appreciate the IG for all the work you did in a short amount of time. A large number of your resources were focused on this.

Of course, to our other witnesses, thank you very much for being here today.

I want to make it very clear: this is not something we are going to have a hearing on, and leave, and go do something else tomorrow. This has to be taken care of. We owe it to these men and women. I do not want to continue to hear that anybody is gaming the system. I want to know that the action plan is being put in place to make sure that the hiring you have announced is actually taking place. If there are barriers to that, we want to know about it.

And I want to know how you decided which VISNs are going to get the practitioners that you plan to recruit. I want VA to know that this is not just another hearing here in Washington, DC.

So this is very critical. I think we have made some progress, but, boy, do we have a lot of work ahead of us. And I think the Nation expects that of us. I intend to stand up to it, and I expect all of you to stand up to it as well.

I do want to just take a second and congratulate Ms. Halliday on her recent promotion to Assistant Inspector General. We do look forward to working with you.

With that, this hearing is adjourned. Thank you.

[Whereupon, at 11:12 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF CLAIRE HAAGA ALTMAN, EXECUTIVE VICE PRESIDENT/ CHIEF OPERATING OFFICER, HEALTHCARE CHAPLAINCY

Madam Chairwoman and Committee Members: Thank you for this opportunity to present the testimony of HealthCare Chaplaincy, Inc. My name is Claire H. Altman and I represent HealthCare Chaplaincy, a New York City based nonprofit organization founded in 1961, whose mission is to improve the effectiveness and efficiency of health care through the innovative ways chaplains promote and advance palliative care research, education, and practice. Fully understanding that the distress in a health care setting involves the mind, the body and the spirit, board-certified multi-faith chaplains serve as the spiritual care expert on medical teams. Our chaplains, employed in clinical settings alongside doctors, nurses and other health care professionals, work closely with patients and families, religious or otherwise, to help find comfort in difficult times.

With minor exceptions, every veteran who enters the VA has seen active duty in military, naval or air service. During their tours, they have worked side by side with chaplains. Chaplains in a military setting provide care to the spirit to servicemembers of any faith or no faith. Chaplaincy is a well-established and trusted institution in the Armed Forces. When a servicemember wants to have a confidential conversation about crisis of meaning and purpose, he or she is often more comfortable approaching the chaplain who has been in the trenches with them, as opposed to the social worker or psychologist. Off the battlefield, this attitude carries into civilian life. Chaplains are an understood and trusted presence.

Many veterans suffer from serious spiritual and mental distress; 22% of N.Y. Afghanistan and Iraq war veterans have probable diagnoses of Post Traumatic Stress Disorder (PTSD) and/or depression. It is difficult for them to discuss their issues with their families and friends, often exacerbating their distress and isolation. This distress can manifest itself in a number of ways—suicide, substance abuse, strained familial ties, difficulty finding or retaining a job, and the list goes on. As we are also seeing now, PTSD and/or depression are reemerging as older veterans confront age-related illness and loss.

Unfortunately, many veterans fear utilizing the more standard support services due to a potential stigmatization and loss of confidentiality, as well as not wanting to be perceived as "weak." However, veterans generally trust chaplains and speaking with them is not perceived as a sign of weakness. In addition, the confidential nature of the chaplain visit will not affect future deployment or career considerations.

Another barrier to service delivery is that veterans and their families who are experiencing crises of meaning and purpose often go unrecognized in civilian hospitals where otherwise chaplains and other health care professionals would be available to help them. We know of no civilian hospitals that ask patients or their family about their affiliation with military service.

HealthCare Chaplaincy recommends two actions: 1) include chaplaincy services in VA funded outposts/clinics to provide services that servicemembers know and trust; and 2) ensure that civilian hospital systems across the country include admissions questions asking if a patient is a veteran, has seen military combat or is a family member of a veteran.

We applaud the work of this Committee and are encouraged that these hearings are taking place to shine a much needed light on the critical needs of our servicemembers.

PREPARED STATEMENT OF AMERICAN SOCIETY FOR THE ADVANCEMENT OF PHARMACOTHERAPY

American Society for the Advancement of Pharmacotherapy
Division 55 of the American Psychological Association

April 25, 2012

Chairman Patty Murray
Senate Committee on Veterans' Affairs
142 Russell Senate Office Building
Washington, DC 20510

Ranking Member Richard Burr
Senate Committee on Veterans' Affairs
825A Hart Senate Office Building
Washington, DC 20510

Dear Chairman Murray and Ranking Member Burr:

Thank you for the opportunity to comment on the mental health services workforce shortage in the Veterans Administration. The American Society for the Advancement of Pharmacotherapy is deeply concerned that all available resources are not being effectively utilized to improve timely access to safe and effective mental health services for our nation's veterans.

The American Psychological Association (APA) was founded in July 1892 and is deeply rooted in the uniformed services of the United States and the Veteran's Administration. Following the end of World II the science and practice of psychology boomed; and the APA experienced its greatest membership growth between 1945 and 1970. Several factors fueled this growth ("APA History," 2012):

- Many returning servicemen saw the great need for better psychological services firsthand during the war and there was special interest in the domains of clinical and applied psychology.
- The GI Bill, the Veterans Administration Clinical Psychology training program, and the creation of the National Institute of Mental Health contributed to the increased interest in psychology.
- The Veteran's Administration accelerated the growth of professional psychology by collaborating to meet the needs of returning veterans.

APA's Center for Workforce Studies estimates that there are now upwards of 93,000 practicing psychologists in the United States. Today APA has approximately 150,000 members and 56 divisions representing subfields of psychology ("How Many Practicing Psychologists," 2012). The American Society for Advancement of Pharmacotherapy (ASAP) is Division 55 of the American Psychological Association.

ASAP was created to enhance psychological treatments combined with psychopharmacological medications. The Division promotes the public interest by working for the establishment of high quality statutory and regulatory standards for psychological care. Division 55 encourages the collaborative and interprofessional practice of psychological and pharmacological treatments as it endeavors to facilitate increased access to improved mental health services for all Americans (American Society, 2012). ASAP recognizes that the VHA is again striving to develop action plans and staffing models that better meet the mental and behavioral health demands of its growing veteran patient population (Review of Veterans' Access, 2012); and we applaud these efforts.

In anticipation of the return of our service men and women from the wars in Iraq and Afghanistan, members of ASAP encouraged VA psychologists to educate the leadership of the Veteran's Health Administration (VHA) regarding professional psychology's readiness to support its mission in the 21st Century as it did in the 20th Century following World War II; when psychology expanded its scope of practice with the support of the VA.

Like ASAP, the VHA is aware that there is a national shortage of psychiatrists and an over-abundance of veterans in need of mental health services. Due to the efforts of professional psychologists in 2008, the VHA is also aware of the availability of licensed medical/prescribing psychologists, who are licensed to prescribe medications as well as psychotherapy and other mental health services required by the VHA to improve mental health care access for returning veterans. In fact, for many years VHA physicians have been referring veterans to medical/prescribing psychologists for outpatient pharmacotherapy and psychotherapy (K.M. McGuinness, personal communication, April 24, 2012) (G. Ally, personal communication, April 24, 2012).

In 2008, however, the VHA considered and rejected a proposal to utilize medical/prescribing psychologists within the VA system, even though they were utilized by the VA as independent health care providers in local communities. Unfortunately, the question asked was not "How can the VHA benefit from the use of this resource?" Rather, the VHA restricted its consideration to the idea of a limited demonstration project and utilized outdated information from the DOD Psychopharmacology Demonstration Project of the 1990's to make its decision (Veterans Health Administration, Executive Decision Memo, April 28, 2008).

Based upon outdated information, unsupported assumptions and apparently flawed staffing predictions, the VA decided in 2008 not to utilize this resource, stating in an Executive Decision Memo that,

> "psychologists may not prescribe in VA at this time. VA may wish to reconsider this position once the education and training issues have been resolved, once there is a demonstrated need for psychologists to prescribe in VA, and once there is a

demonstrated interest among psychologists to engage in such training, provided that costs are reasonable (See Attachment 1, Executive Decision Memo)."

VA's focus on a demonstration project, rather than inviting medical/prescribing psychologists to apply for VHA jobs, is expressed in the Executive Decision Memo in the form of unfounded concerns and speculation about the cost to the VHA of educating and training such practitioners and whether psychologists would be interested in such training. Not surprisingly though, the question whether psychologists would pursue such training and the concern about education costs asserted in 2008 become moot when one looks at the facts. For example:

- Medical/prescribing psychologists, like other practitioners, have been paying for their own educations since the end of the DOD Psychopharmacology Demonstration Project in the 1990's;
- An estimated 2000 medical/prescribing psychologists have completed training since prescriptive authority for psychologists was first enacted (R.E. McGrath, personal communication, April, 2012);
- Since prescriptive authority for psychologists was enacted in New Mexico, medical/prescribing psychologists have increased the number of psychotropic prescribers by 25%, substantially improving the access to care problem in that state (E.S. Levine, personal correspondence, January, 2012);
- Since prescriptive authority for psychologists was enacted in New Mexico and Louisiana more than one hundred psychologists have become licensed to prescribe medications (Sammons, 2010);
- At present there are licensed medical/prescribing psychologists employed in federal agencies across the nation (McGuinness, K.M. & Tilus, M. R., 2010).

Even though the cost of education and training of medical/prescribing psychologists is borne by the individual practitioner, federal agencies do provide student loan forgiveness, student loan repayment and other incentives for medical/prescribing psychologists, as provided for by law and policy. Assumptions aside, and with the notable exception of the Veteran's Administration, all current evidence demonstrates that medical psychologists are recognized, independent, doctoral level health care providers in federal health care agencies and uniformed services with designated health care components (McGuinness, K.M. & Tilus, M.R., 2010).

Interestingly, the VA's Executive Decision Memo denying prescription privileges to medical/prescribing psychologists also called into question whether there was a "demonstrated need for psychologists to prescribe in VA." If there was no "demonstrated" need in 2008, the current report of the VA's Inspector General, Review of Veterans' Access to Mental Health Care, has clearly documented that there is a demonstrated need at this time for professionals who can both prescribe medication and provide the full range of diagnostic and evidence based treatment services. The fact that there is a growing pool of medical/prescribing psychologists in

federal agencies across the nation, while the VHA maintains prolonged wait times for its veterans in need of timely mental health care, begs a few questions:

- With regard to our veterans returning from Iraq and Afghanistan, has the VA abandoned its visionary and proactive problem-solving approach that proved so instrumental in meeting the needs of post-WWII veterans?
- Why does it seem that the VA is restricting its staffing pool to particular types of mental health practitioners, rather than utilizing all available resources?
- What does the evidence say?

It is without dispute that the VHA and all federal agencies have a responsibility to ensure safety for their constituents. While, the VA's Executive Decision Memo expressed concern about how to train psychologists to address co-morbidity, its authors seemed unaware that psychologists train themselves to address such issues, just as do psychiatrists. In fact, psychologists, particularly medical/prescribing psychologists, have well-established multidisciplinary and interprofessional practice models. (McGuinness, Tilus, McGuinness, & Sa, 2012; Cosgrove & Moore, 2012; Tilus, McGuinness, Sa, Sutherland, Moore, Barnes, Hartnell, & Tranchita, 2010). Safety, though, was never questioned in the 2008 Executive Decision Memo. Instead the memo emphasized and discussed at length, training issues, variations in state license laws, and whether other psychologists approve of prescriptive authority.

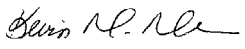
More to the point would have been a discussion of the following facts:

- Medical/prescribing psychologists can now be licensed in two states and one US territory;
- Under a variety of circumstances medical/prescribing psychologists in federal service can prescribe in any state or territory of the U.S. if they are licensed in just one state or territory (See 42 U.S.C. § 254d(j) (4));
- The American Psychological Association has a formal process in place for the designation of postdoctoral education and training programs in psychopharmacology for prescriptive authority; (APA Designation Committee, 2012);
- Since medical/prescribing psychologists began prescribing medications 7 years ago, not one adverse event has ever been reported against a licensed medical/prescribing psychologist to any state licensing board or the APA Insurance Trust. (See Attachment 2, R. Sherrill, personal correspondence, January, 2012) (G.Ally, personal communication, April, 2012) (B. Rom Rymer, personal communication, April 2012);
- Medical/prescribing psychologists are actively prescribing in the Army, Navy, Air Force, and agencies of the U.S. Public Health Service (including the Indian Health Service and the Health Resources and Services Administration/National Health Service Corps (McGuinness, K.M. & Tilus, M.R., 2010)

- Medical/prescribing psychologists are currently active in North Dakota, New Mexico, Louisiana, Montana and other states in Federally Qualified Health Centers and American Indian reservations. (K.M. McGuinness, personal correspondence, April, 25, 2011)
- The U.S Coast Guard, part of the U.S. Department of Homeland Security, is actively recruiting medical/prescribing psychologists for service at multiple locations on the east coast and at the same pay grade as their psychiatric colleagues. (See Attachment 3, Recent Coast Guard Positions for Medical-Prescribing Psychologist.)

A particularly embarrassing reality is that licensed medical/prescribing psychologists who have served our nation's military on the battlefield or at sea as Army, Navy, Air Force, Coast Guard or Public Health Service commissioned officers cannot serve them in the VHA. Yet, we continue to have an access to care issue within the VA.

The American Society for the Advancement of Pharmacotherapy is grateful for this opportunity to provide testimony and looks forward to supporting the Senate Committee on Veteran's Affairs and the Veteran's Administration as our nation seeks to serve those who have served us in uniform.



Kevin M. McGuinness, PhD, MP

President
Board of Directors

References

1- American Society for the Advancement of Pharmacotherapy. (2012). Retrieved April 25, 2012, from http://www.division55.org/

2- APA Designation Committee for Postdoctoral Education and Training Programs in Psychopharmacology for Prescriptive Authority. (2012). Retrieved April 25, 2012, from http://www.apa.org/education/grad/annual-report-2011.pdf. 3-

3- APA History. (2012). Retrieved April 25, 2012, from http://www.apa.org/about/archives/apa-history.aspx

4-Cosgrove, L. & Moore, B.A., (2012) Professional, Legal, Ethical and Interprofessional Issues in Clinical Psychopharmacology. In Muse, M. & Moore, B.A. (Eds.) Handbook of Clinical Psychopharmacology for Psychologists. Hoboken, NJ: John Wiley & Sons, Inc.

5- Halliday, L.A., & Daigh, J.D., (2012.). Review of veterans' access to mental health care. *Veteran's Health Administration.* Retrieved April 25, 2012, from http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf

6- How many practicing psychologists are there in the United States? (2012). Retrieved April 25, 2012, from http://www.apa.org/support/about/psych/numbers-us.aspx#answer

7- McGuinness, KM & Tilus, MR (2010). Prescribing in the Public Health Service. In McGrath, RE & Moore, BA. (Eds.) Pharmacotherapy for Psychologists: Prescribing and Collaborative Roles. Washington, DC: American Psychological Association.

8- McGuinness, K.M., Tilus, M.R., McGuinness, E.M., & Sa, M. (2012). Differential diagnosis in medical psychology. In Mark Muse and Bret A. Moore (Eds.) Handbook of Clinical Psychopharmacology for Psychologists. Hoboken, NJ: John Wiley & Sons, Inc.

9- Sammons, M.T., 2010. The Psychopharmacology Demonstration Project: What did it teach us, and where are we now? In R. McGrath R. & B. Moore (Eds.), Pharmacotherapy for psychologists: prescribing and collaborative roles. Washington, DC: American Psychological Association).

10-Tilus, M.R., McGuinness, K.M., Sa, M., Sutherland, E., Moore, B.A., Barnes, V., Hartnell, J., & Tranchita, A. (2010). Collaborative practice with pediatricians within the Indian Health Service: Taking care of frontier children. In George M. Kapalka (Ed.) Pediatricians and Pharmacologically Trained Psychologists: Practitioner's Guide to Collaborative Treatment. New York: Springer.

ATTACHMENTS

Attachment 1

VA Executive Decision Memo Denying Prescription Privileges to Licensed Medical/Prescribing Psychologists

Attachment 2

Letter from Dr. Robert Sherrill of the New Mexico Board of Psychologist Examiners Regarding the Absence of Any Adverse Outcomes Complaints

Attachment 3

Medical/Prescribing Psychologist Vacancy Advertisements from the U.S. Coast Guard

ATTACHMENT # 1

VETERANS HEALTH ADMINISTRATION
EXECUTIVE DECISION MEMO

Date:

To: Under Secretary for Health (10)

Thru: Deputy Undersecretary for Health (10A)

Thru: Chief, Patient Care Services Officer (11)

From: Office of Mental Health Services (116)

Subject: Prescribing Authority for VA Psychology

For Further Information Contact: Ira Katz, MD, PhD, (116) 202-461-7350

Action Requested:
X_____ Request for approval
_____ Request for discussion or further review
_____ For your information
_____ Other (specify)

STATEMENT OF ISSUE:
VA has been requested to explore the initiation of a model program as a trial of extending prescribing authority to psychologists. Current VA regulations do not allow psychologists to prescribe medications. There is at least one VA medical center (VAMC) that allows some psychologists to renew orders for nonprescription nicotine replacement products in smoking cessation clinics, but no other prescriptions are written or renewed currently by psychologists in the VA system. Prior to VA making a decision whether to undertake any model program extending prescribing privileges to psychologists, it will first need to identify the legal, licensure, training, ethical, patient care, work force/recruitment, and standard of care issues necessary to ensure excellent and safe patient care. VA will also need to determine whether such a change would fill an identified gap in service or demand for care, and VA will have to assess psychologist interest in obtaining prescriptive authority. The intent of this EDM is to address as many of these issues as possible with the data available.

RECOMMENDATION (of the requestor):
We recommend that VA not initiate a demonstration project to allow psychologists to prescribe. We recommend that VA maintain as its official position that psychologists may not prescribe in VA at this time. VA may wish to reconsider this position once the education and training issues have been resolved, once there is a demonstrated need for psychologists to prescribe in VA, and once there is a demonstrated interest among

psychologists to engage in such training, provided that costs are reasonable.

Concur/Non-Concur: M Agarwal MD 4-15-08
Madhu Agarwal, MD, MPH — Date
Chief Patient Care Services Officer

Concur/Non-Concur: 28 Apr 08
Gerald M. Cross, MD, FAAFP — Date
Principal Deputy Under Secretary for Health

APPROVE/DISAPPROVE: Option 1

COMMENT:

Michael J. Kussman 4/28/08
Michael J. Kussman, MD, MS, MACP — Date
Under Secretary for Health

I. STATEMENT OF ISSUE:

VA has been requested to explore the initiation of a model program as a trial of extending prescribing authority to psychologists. Current VA regulations do not allow psychologists to prescribe medications. There is at least one VAMC that allows some psychologists to renew orders for nonprescription nicotine replacement products in smoking cessation clinics, but no other prescriptions are written or renewed currently by psychologists in the VA system. Prior to VA making a decision whether to undertake any model program extending prescribing privileges to psychologists, it will first need to identify the legal, licensure, training, ethical, patient care, work force/recruitment, and standard of care issues necessary to ensure excellent and safe patient care. VA will also need to determine whether such a change would fill an identified gap in service or demand for care, and VA will have to assess psychologist interest in obtaining prescriptive authority. The intent of this EDM is to address as many of these issues as possible with the data available.

II. SUMMARY OF FACTS AND/OR BACKGROUND:

Prescriptive Authority for Other Non-physician Clinicians. The VA permits certain mid-level practitioners, including advanced practice nurses, clinical pharmacy specialists, and physician assistants, to prescribe non-controlled substances, without regard to State Practice Acts. Similar privileges could be extended to trained psychologists by VA if the VA were to determine/decide that medication prescribing

authority is within the standard of practice for psychologists. This would allow psychologists to prescribe antidepressants, antipsychotics, and mood stabilizing agents.

Medication prescribing for VHA's Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), Clinical Pharmacy Specialists (CPSs) and Physician Assistants (PAs) was initially authorized by VHA Directive 10-95-019 on March 3, 1995. The Under Secretary for Health determined that for non-controlled substances, VA exercises its authority in defining inpatient and outpatient medication prescribing privileges for CNSs, NPs, CPSs and PAs.

Requirements for prescriptive authority vary somewhat by provider group. CNSs and NPs must have a current license as a Registered Nurse in any state, a current nationally-recognized certification as a CNS or NP, and completion of an approved upper division or continuing education course in pharmacology. CPSs may be authorized to prescribe medications provided the individual CPS possesses a current state license and a Pharm.D. or M.S. degree (or equivalent). Examples of equivalent qualifications include (but are not limited to) completion of an American Society of Hospital Pharmacists accredited residency program, a specialty board certification, or two years of clinical experience. PAs must be graduates of a PA training program accredited by the Committee of Allied Health Education and Accreditation and maintain current certification by the National Commission on Certification of Physician Assistants (NCCPA) or, if exempted by VA from NCCPA certification, a current, full, unrestricted and active license by a state that authorizes medication prescribing and the prescribing privileges are consistent with the limitations of the license.

VHA policy requires that each practitioner have a locally determined scope of practice that will include the individual's prescriptive authority. For example, the scope of practice for Clinical Pharmacy Specialists notes that all inpatient pharmaceutical orders and outpatient prescriptions written by CPSs which are not specifically identified in their individual scope of practice are cosigned by a physician prior to their being filled. In order to prescribe controlled substances, the CPS's State of licensure or registration must permit them to do so in accordance with the Federal Controlled Substances Act and applicable regulations contained in Title 21 CFR Part 1300.

Current Status of Licensure Laws Allowing Psychologists to Prescribe. At the present time two states, New Mexico and Louisiana, and the U.S. territory of Guam offer licensure to psychologists for prescribing psychotherapeutic medications. Requirements for licensure have not been uniformly standardized across these practice locations.

New Mexico requires an applicant to be a doctorate-level psychologist and to have completed 450 hours of classroom training in the basic, applied and clinical sciences including anatomy, neuroanatomy, pathophysiology, pharmacology, and pharmacotherapeutics. Applicants must then complete a physician-supervised practicum of at least 400 hours treating at least 100 patients and pass the Psychopharmacology Examination for Psychologists (PEP) developed by the American Psychological Association (APA) College of Professional Psychology. A two-year probationary period follows in collaboration with a supervising licensed physician. Once the conditions of the probationary position have been met, a two-year license is granted to prescribe without a physician's oversight, with the conditions that the psychologist

"shall maintain an ongoing collaborative relationship with the health care practitioner who oversees the patients general medical care...," and shall participate in 20 hours of continuing education related to psychopharmacology or psychopharmacotherapy each year.

Louisiana requires "medical psychologists" to be graduates of a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution or its equivalent and to have passed the PEP exam; no period of supervised experience in prescribing is required. The Louisiana law requires that psychologists "shall prescribe only in consultation and collaboration with the patient's primary or attending physician, and with the concurrence of that physician." The Louisiana law allows medical psychologists to prescribe from a formulary of all medications customarily used in the treatment of medical disorders, except that the formulary specifically excludes narcotics.

The Department of Defense (DOD) also allows some psychologists to prescribe medications under specific circumstances once licensure requirements have been met. Section 1094(a)(1) of title 10, United States Code, requires independently practicing health-care professionals in a military department to possess a full and unrestricted licensed to practice their profession. However, it also provides that the Defense Secretary may waive the licensure requirement due to "unusual circumstances" that are prescribed by regulation. The term "health-care" includes psychologists 10 USC 1094(e)(2). VA does not have such broad authority to waive licensure (See 38 U.S.C. 7407(b)(1).

As of June 2007 in New Mexico, two psychologists had been granted unrestricted licenses to prescribe, seven held conditional prescribing certificates, and seven were near completion of their practicum and/or PEP. In addition, thirty-two Medical Psychologists were practicing in Louisiana. Despite passing legislation licensing psychologists to prescribe in 1998, no psychologist prescribers have been trained in Guam with the apparent reasons being because liability insurance is difficult to obtain and because the implementing rules and regulations have yet to be written (LeVine, E.S. "Prescribing/Medical Psychology An Overview." Presentation at IHS/SAMHSA National Behavioral Health Conference, Albuquerque, NM, July 2007).

Training Psychologists to Prescribe. Nine web-based training programs are in existence, with at least five offering a postdoctoral master's degree in clinical psychopharmacology that appear to vary in their offerings and requirements of student-faculty contact. However, there is currently no sanctioned, designated curriculum to train psychologists to prescribe, and there are significant differences between the state laws in the two states where psychologists have prescriptive authority about what course of study is needed.

The American Psychological Association developed a Proficiency in Psychopharmacology in 1995 that includes a training curriculum consisting of at least 300 contact hours of didactic instruction and a clinical practicum requiring treating a minimum of 100 patients in both inpatient and outpatient settings. However, APA has not yet established an official set of standards that state licensing boards or other credentialing bodies could use to determine if a psychologist has received appropriate training. The Board of Educational Affairs (BEA) of the American Psychological

Association has been working with the Committee for the Advancement of Professional Psychology (CAPP) to develop a model curriculum and licensure law. While these models have not yet been approved by the American Psychological Association, BEA and CAPP will be meeting in the near future to continue developing a designation system against which to judge the quality of the training programs. In the absence of this designation system, the National Register of Health Service Providers in Psychology, in conjunction with the Association of State and Provincial Psychology Boards, developed its own set of standards. While these two efforts do not differ much on what content is needed in a training program, they do apparently disagree over how the training is delivered. One area of disagreement concerns whether coursework must be university-based or can be delivered through a series of continuing education programs. Other areas of disagreement concern the placement of practicum experience (following the completion of the coursework or interspersed throughout the coursework) and the ability to waive the requirement for training in the biological sciences if similar coursework was completed during graduate school.

Outcome Data. At present, outcome data relevant to psychologist prescribers is limited. The laws in New Mexico and Louisiana are relatively recent, and there has not been time for practice patterns to shift in any significant manner. One source stated that the 32 Medical Psychologists in Louisiana had written 45,000 prescriptions "without serious adverse effects." (LeVine, E.S. "Prescribing/Medical Psychology: An Overview." Presented at the IHS/SAMHSA National Behavioral Health Conference, Albuquerque, NM, June 2007). However, the source of data for this claim was self-report of the prescribing psychologists.

The DoD training program, known as the Psychopharmacology Demonstration Project (PDP), began in 1991 with a class of four psychologists who completed two years of didactic work at the Uniformed Services University of the Health Sciences plus another year of clinical training. The training of subsequent classes consisted of a one-year didactic and one year of clinical training. Clinical training in the inpatient and outpatient settings took place at Walter Reed Army Medical Center and Malcolm Grow Medical Center. The PDP ended in 1997 after having graduated 10 prescribing psychologists.

The American College of Neuropsychopharmacology, after conducting six annual assessments of the DoD's PDP, stated in its final report in 1998 "that the graduates had performed well in all the locations where they were assigned, that they had performed safely and effectively as prescribing psychologists, and that no adverse outcomes had been associated with their performance," as cited in the following GAO Report: Prescribing Psychologists--DoD Demonstration Project Participants Perform Well but Have Little Effect on Readiness or Cost, June 1999, GAO/HEHS-99-98. The same GAO report concluded that the costs to train psychologist prescribers would be greater than the cost of a mix of psychiatrists and psychologists, resulting in an average of 7% (approximately $9,700) more spent annually per psychologist prescriber. Congress accepted the GAO's report and terminated the project. The DoD currently has a tri-service two-year postdoctoral Psychology fellowship at Tripler Army Hospital, where the second year is utilized for medication training so the psychologist can prescribe. The work group has also been informed that the U.S. Army and Navy are no longer training psychologists to be prescribers, while the Air Force has reportedly established its own program utilizing the curriculum available at Nova Southeastern University and has trained one additional psychologist.

Debated Issues. Prescribing authority for psychologists has been endorsed by the American Psychological Association, but it remains a contentious issue within the profession. One of the concerns of those against the prescribing psychologists initiatives is their concern that psychologists' practice patterns would change, resulting in a negative impact on the delivery of health care services (including within VA). In particular, they suggest that psychologist prescribers would provide fewer psychotherapy services that are now central to their practice (Stuart, R.B., & Heibe, E. E. [2007]. To Prescribe Or Not To Prescribe: Eleven Exploratory Questions. The Scientific Review Of Mental Health Practice, 5, 4-32). These psychotherapy services are often the key, most effective therapeutic intervention to conditions with increasing prevalence in veterans such as posttraumatic stress disorder, depression, and anxiety. For these problems, medications are only partial treatment solutions, and they typically treat specific symptoms and complaints rather than the overall condition (e.g., PTSD) or have been shown to be effective in treating the condition but with greater likelihood of relapse than for those treated with psychotherapy (e.g., depression).

Those in favor of prescriptive authority for psychologists suggest that one advantage might be the ability to manage both the psychotherapy and pharmacotherapy of a patient's mental illness, thus negating the need for separate visits with two clinicians. Those in favor of prescriptive authority for psychologists further note that there is poor access to psychiatrists in the less populated parts of the country and that the waiting time to get an appointment with a psychiatrist is exceedingly long. Whether psychologist prescribers will increase access and decrease wait time to mental health professionals and treatment will depend on whether shortages of prescribers exist in VA, where they exist, and whether prescribing psychologists can be recruited to fill those openings.

The Office of Mental Health Services provided data regarding current staffing levels and anticipated workloads in mental health. Overall, from FY 2005 through December of FY 2008, the number of psychologist FTE employed in VA increased by 37.6%. The number of nurse practitioner FTE increased by 19%, and the number of pharmacist FTE increased by 5%. On the other hand, the number of clinical nurse specialist FTE decreased by 8%. While there were no specific figures for the number of psychiatrist FTE, the number of full-time physician FTE assigned to mental health settings (and overwhelmingly psychiatrists) increased by 20%, and the number of part-time physician FTE in mental health settings increased by 6%, with the majority of these physicians being psychiatrists.

There has been rapid growth in clinical positions through the Mental Health Enhancement Initiatives since FY 2005. Although there has been concern that a substantial number of the new positions might remain unfilled, hiring has proceeded effectively, particularly since FY 2007. There also has been concern that the length of time to fill these positions is longer for psychiatrists than it is for other professions. According to data provided by the Office of Mental Health Services, as of January, 2008, only 10% of the psychologist positions, 15% of the psychiatrist positions, and 20% of the advanced practice nurse positions remain unfilled, and most unfilled positions were recently awarded and are in the hiring pipeline. Based on a sampling of the positions awarded through the Mental Health Enhancement Initiatives, on average,

it takes 3.4 months to fill a psychologist position, 4.8 months to fill a psychiatrist position, and 6.2 months to fill a nurse practitioner position. There was considerably more variability in the psychiatrist and nurse practitioner data than in the psychologist data.

This increase in staffing accompanied an increase in the number of enrollees in VA. Between FY 2006 and FY 2007, there was a 2% increase in the overall number of enrollees. This figure is expected to rise in increasingly smaller amounts until FY 2011, at which point the number of enrollees is expected to decrease. This decrease is expected to continue through FY 2027. The projections for mental health show continued, relatively steady growth beyond the overall growth in the number of enrollees and in all inpatient and outpatient arenas except for inpatient substance abuse treatment. In fact, between 2% and 10% growth per year is expected for outpatient mental health visits through FY 2027. The number of unique veterans treated for mental health purposes in FY 2007 was 990,051, a 6% increase over FY 2006. Although there are no projections of the number of veterans who will receive mental health care through FY 2027, it would be reasonable to expect a similar growth pattern to the projected number of visits.

It is unclear how much additional growth in mental health staffing will occur in the next several fiscal years. However, further hiring is projected on two bases. First, the proposed budget for FY 2009 includes further increase in mental health enhancement initiative funding, and this is anticipated to be used to fund implementation of the Uniform Mental Health Services Package which is currently being developed. In addition, according to the Office of Management Support in VA Central Office, between 16% and 22% of the psychiatrists and between 16% and 19% of the psychologists are expected to retire each year over the next seven fiscal years. If VA is to meet the demand for mental health services, it must replace those clinicians who retire in addition to funding new positions.

III. SYNOPSIS OF SIGNIFICANT RELATED ISSUES:

Prescribing controlled substances. The Federal Controlled Substances Act (FCSA) and implementing Drug Enforcement Administration regulations require the practitioner to possess a license that authorizes them to prescribe controlled substances. Thus, a VA psychologist would need to possess a license that specifically authorizes the prescribing of controlled substances and would need to comply with any State restrictions on such prescribing authority. Accordingly, VA psychologists could not prescribe controlled substances unless they were licensed in New Mexico, Louisiana, or Guam. However, any VA psychologists so licensed could prescribe controlled substances at any VA facility in any State. To obtain a license in New Mexico, Louisiana, or Guam would require satisfying the State's/territory's requirements including any practicum under the supervision of a physician approved by State examining bodies. Thus, it appears that practicum training must take place in the State where licensure is pursued unless the applicant completed the DoD PDP. Controlled substances likely to be prescribed by psychologists if granted authority include benzodiazepines (e.g., diazepam or Valium) for anxiety and sleep disorders.

Co-morbidity. The DoD demonstration project limited the scope of practice for prescribing psychologists to adults between 18 and 65 without medical complications. While the 1999 GAO report noted no adverse effects of psychologists prescribing medications, it is unclear whether the results would have been the same if the psychologists had been treating a more medically ill population. In fact, the GAO Report noted that almost all of the psychologist prescribers in the DoD project practiced in an outpatient environment rather in an inpatient environment, which would likely have more complex and more severely ill patients. Within VA, patients are generally much older; current mean age is 59.5 years old and the mean age is projected to increase to 60.4 by 2018, i.e., over the next ten years. Further, VA patients with mental health disorders often have significant co-morbid conditions, including substance use disorders and complex medical conditions such as diabetes, hypertension, hepatitis, and HIV/AIDS. A study of veterans in the mid-Atlantic region found the most prevalent medical co-morbidities among patients with bipolar disorder were hypertension (35%), hyperlipidemia (23%), diabetes (17%), and alcohol use disorder (25%). Compared to a national VA cohort, the prevalence of diabetes, hepatitis C, lower back pain, and pulmonary conditions were significantly greater among veterans with bipolar disorder [Kilbourne AM, Cornelius JR, Han X, et al. Burden of general medical conditions among individuals with bipolar disorder. Bipolar Disorders 2004;6:368-73]. Medication-induced medical conditions are associated with antipsychotic medications used to treat schizophrenia and bipolar disorder. Patients taking antipsychotics must be monitored for the onset of diabetes, hyperlipidemia, weight gain/obesity, and the metabolic syndrome and sometimes treated for these conditions with additional medication. Psychologist prescribers would need to be trained to order these monitoring tests and to understand how these other conditions and treatments can interact with other medications. From the information available, it does not appear that the management of such complicated patients is part of past or current training requirements.

IV. CRITERIA FOR DECISION MAKING:

The following issues were used to shape the three recommendations provided in this document.

- The differences in the licensure laws
- The ability to prescribe controlled vs. non-controlled substances
- The current status of education and training, including the time and costs necessary
- The extent and severity of co-morbidities among veterans with mental health disorders
- Need for additional prescribers for mental health disorders within VA
- The potential of recruiting psychologist prescribers for underserved VA locations
- Potential for shift in practice patterns away from psychotherapy to pharmacotherapy management
- Methods for assessing performance according to patient outcomes and standards of practice
- Alternative solutions to improve patient access to mental health treatments (e.g., telehealth)
- Ethical issues that reflect the VHA touchstones

When determining which option to recommend, the following criteria were used:

- **Need:** What is the demonstrated need to add psychologists to the list of

prescribers in VA, and is there an quality gap that would be resolved if psychologists could prescribe psychotropic medications in VA?

- **Urgency:** Would allowing psychologists to prescribe in VA solve an urgent need to provide pharmacological treatment to veterans that cannot be met through other means?
- **Cost:** How much would it cost to implement a demonstration project in VA to teach psychologists to prescribe? If psychologists were allowed to prescribe, would VA realize a cost saving or a cost increase?
- **Risk:** Can psychologists prescribe safely in VA? What risks and benefits would result?

V. CROSSCUTTING ISSUES:

The relationship between physicians (particularly psychiatrists) and psychologists in VA could be affected negatively, given the strong contrary positions of the American Psychological Association, the American Medical Association, and the American Psychiatric Association on this issue, outlined in section VI. below. Also, the relationships among psychologists could be affected, since developing authority for psychologist prescribers is not a universally embraced concept within the profession. Additionally, since not all psychologists would be required to gain prescriptive authority, members of interdisciplinary teams may be confused about the role a given psychologist has on the team. Finally, all VA clinical policies regarding psychologists would need to be reviewed and potentially revised around any new variation in psychologists' privileges or scope of practice.

VI. STAKEHOLDER INVOLVEMENT:

Draft recommendations have not been shared with any Field Advisory Committee, other groups within VA or agencies outside of VA, including those that may advocate for veterans or health care professionals.

Granting prescribing privileges to psychologists is a divisive issue between health care professional organizations and individual professionals within the same or from different disciplines. The American Psychological Association is in favor of psychologist prescribers, and its Practice Directorate in particular has worked hard to support state legislative initiatives across the country. However, there is not unanimity within its membership. Although there are no definitive data on the percentage of psychologists who support prescriptive authority for psychologists, a meta-analysis showed a relatively equal split between psychologists who support prescriptive authority and those who do not [Walters, G. D. (2001). A meta-analysis of opinion data on the prescription privilege debate. Canadian Psychology, 42, 119-125.]. This study also showed greater support for the concept of training psychologists to prescribe than desire to actually obtain that training, and there appeared to be generational difference such that psychologists in training were more supportive of prescriptive authority than were established, practicing psychologists. This study, however, is somewhat dated and was conducted prior to licensure laws being passed in two states. A more contemporary study might show a shift in these data. Both the American Medical Association and the American Psychiatric Association have opposed the legislation favoring such a practice.

The National Alliance on Mental Illness (NAMI) has often been asked to state a definitive position on the feasibility and desirability of psychologists prescribing medications. Although some individual state chapters of NAMI and some NAMI members have been publicly supportive of this issue, NAMI's national office provides a "wait-and-see" response: "Based on the information and evidence obtained. . . staff believe that it would not be appropriate at this time for NAMI to adopt a position in support of state legislation allowing prescribing privileges for psychologists. . . . Implementation of the New Mexico law . . . should be carefully monitored . . . to assess its impact on patient safety and outcomes as well as its impact on addressing serious human resource shortages in public sector mental health" [NAMI, "Prescribing Privileges Task Force Report and Recommendations to the NAMI Board of Directors," December 2002.] NAMI recognizes the shortage of qualified mental health professionals, especially in rural areas, and believes that more emphasis should be placed on addressing this problem instead of on the "contentious debate" about whether or not psychologists should be allowed to prescribe.

VII. OPTIONS AND ARGUMENTS:

Option 1: Take no action and maintain the status quo in VA by not going forward with any demonstration projects.

Arguments Pro:

- Even if a demonstration project were to be undertaken, the issues of education, training and licensure are too poorly developed, complex, and expensive to provide a reasonable cost-benefit for expansion within VA.
- While the DoD's demonstration project showed that psychologists could be safe and effective prescribers within the limitations of their practice, the costs of the project and the lack of interest among psychologists to learn to prescribe ultimately resulted in the project not being extended by Congress. There are no data to suggest that undertaking a similar demonstration project in VA would be any less expensive or more successful in recruiting trainees.
- Further, VA patients represent a very different population--older and sicker--than the patients treated by prescribing psychologists in the DOD project.
- Based upon the available data, a demonstration project is not a viable solution to possible VA work force and recruitment concerns. The money spent developing and implementing a demonstration project could be spent on providing better incentives to recruit psychiatrists.
- The information on the quality of care provided by psychologist prescribers is quite limited. The existing information suggests that psychologists can be safe prescribers for relatively healthy mental health patients without medical complications; however, a substantial proportion of veterans with mental health problems have concomitant serious medical problems.
- There is concern that a shift in practice patterns could reduce the availability of non-pharmacologic therapies offered by psychologists.

Arguments Con:

- Recruitment of psychiatrists into VA is a problem in some parts of the country, even in some relatively large, metropolitan areas.
- Successful training and recruiting to VA of psychologist prescribers would add to the number of providers who can address pharmacologic treatment of mental health disorders.

Unknowns:

- Whether VA psychologists eligible for training would be interested.
- Whether there is an actual shortage of prescribers in VA to care for veterans with mental health disorders.
- Whether psychologist prescribers would be any more willing to relocate to underserved areas.

Option 2: To allow demonstration projects in VA to train psychologists to prescribe medications used for the treatment of mental health conditions.

Arguments Pro:

- This would allow psychologist prescribers to initiate and manage both non-pharmacologic and pharmacologic treatments for common psychiatric conditions such as depression, schizophrenia, bipolar disorders, and substance use disorders.
- This would provide information relevant to determining the level of interest in VA among psychologists in expanding their practice authority.

Arguments Con:

- The issues of education and training are still problematic and would not be reduced or easily resolved. There remains no accepted standard for training psychologists to prescribe, and it is unclear whether there will be such a standard in the near future.
- Cases complicated by co-morbidities that require treatment with other medications would have to be referred or co-managed with an appropriately licensed clinician.
- Psychologists receiving prescriptive authority would need to track lab values related to medication use, or lab values would need to be managed with an appropriate licensed clinician in a supervisory capacity.
- The shift in practice patterns, and the fact that this change would apply to some but not all psychologists, is another concern that would potentially affect the mix of treatment services for patients with mental health disorders, the dynamics of interdisciplinary efforts at quality improvement, and VA policies regarding psychologists.
- The existing training programs are very expensive, and the experiential component of the training would require interested psychologists to relocate to one of the states where the licensure law allows psychologists to prescribe. VA also would have to identify VA staff physicians in those states willing to supervise the experiential components of training. If it

were prohibitively expensive for VA to contract with the existing programs, the alternative would be for VA to establish its own training program. The DoD demonstration project was exorbitantly expensive, and there is no reason to assume that the costs for a VA project would be any less expensive.

Option 3: To allow a demonstration project only in selected VA facilities in New Mexico and Louisiana.

Arguments Pro:

- The lack of an accepted standard for training is resolved because the licensure laws define what training is required.
- Trainees' costs would be reduced because they would not need to travel to complete the experiential component of the training.
- A smaller scale project would reduce the overall costs for VA.
- Success on a small scale in VA could set the standard for training that is currently lacking from the American Psychological Association, just as VA set the current standard for training psychologists.

Arguments Con:

- The costs are still likely to be substantial to undertake such a project.
- Because of the differences in the New Mexico and the Louisiana laws, there would be differences in how prescribing psychologists would practice. There still is no standard education program to teach psychologists to prescribe.
- There is no demonstrated interest among psychologists in these states to learn to prescribe medications.
- The data on the safety and effectiveness of psychologists prescribing medications for the complex patients seen in VA are limited.
- Efforts to recruit and retain psychiatrists and other prescribers could be enhanced with the money that would be earmarked for this demonstration project. If successful, these staff could provide prescription services to a wider array of patients, and psychologists could devote their efforts to providing nonpharmacological treatments for mental health problems.

VIII. RECOMMENDED OPTION:

The following summarizes our findings for the criteria for decision-making listed above.

Need: There has been no demonstrated need for psychologists to prescribe in VA. Psychiatrists, other physicians, clinical pharmacists, and advanced practice nurses can all prescribe psychotropic medications.

Urgency: There is clearly a need for some veterans to be prescribed psychotropic medications, and it appears that this need will increase in the upcoming years. However, current and future needs for prescribing psychotropic medications can be met

more fully and more quickly by expanding efforts to recruit psychiatrists and other prescribing clinicians.

Cost: The costs for the DoD demonstration project were very high, and the GAO reported that it cost 7% more to employ psychologist prescribers than to employ the typical mix of psychiatrists and psychologists. There is no reason to expect the costs for VA to be different.

Risk: There are no robust data demonstrating that psychologists can prescribe safely with the complex patients seen in VA.

Therefore, considering all of the information presented in this document, we recommend that VA adopt Option 1 as its official position on the subject of allowing a prescribing psychologist demonstration project in VA. VA may wish to reconsider this position once the education and training issues have been resolved, once there is a demonstrated need for psychologists to prescribe in VA, and once there is a demonstrated interest among psychologists to engage in such training, provided that costs are reasonable.

IX. DISSENTING OPINIONS REGARDING RECOMMENDED OPTION: None.

X. EFFECT OF RECOMMENDED OPTION ON EXISTING PROGRAMS AND/OR FACILITIES: None.

XI. LEGAL OR LEGISLATIVE CONSIDERATIONS OF THE RECOMMENDED OPTION: None.

XII. ETHICAL CONSIDERATIONS OF THE RECOMMENDED OPTION:

The most significant value underlying the issue of providing a demonstration project allowing psychologists to prescribe is the provision of high-quality health care services by properly trained professionals. A secondary value is providing timely access to mental health services. The workgroup believed that both values could be upheld by maintaining the status quo and by improving the recruitment incentives available to psychiatrist and other current prescribers.

XIII. BUDGET OR FINANCIAL CONSIDERATIONS OF THE RECOMMENDED OPTION: None.

XIV. PUBLIC RELATIONS OR MEDIA CONSIDERATIONS OF THE RECOMMENDED OPTION: Maintaining the status quo and not authorizing a prescribing psychologist demonstration project in VA is contrary to the wishes of the American Psychological Association and might strain the relationship between this organization and the Office of Mental Health Services.

XV. CONGRESSIONAL OR OTHER PUBLIC OFFICIAL OR AGENCY CONSIDERATIONS OF THE RECOMMENDED OPTION: A discussion of any Congressional and/or other public official or agency notification or involvement considerations raised by the recommended action.

XVI. IMPLEMENTATION: N/A

ATTACHMENT #2

ROBERT SHERRILL, JR., Ph.D.

PRESCRIBING PSYCHOLOGIST
NEUROPSYCHOLOGICAL ASSESSMENT

Rep. Bob Wooley
4504 Verdre Drive
Roswell, New Mexico 88201

1 January 2012

Dear Rep. Wooley:

You may recall that I wrote you last December to report that five years had passed since practicing psychologists in New Mexico who had taken intensive additional training in psychopharmacology had been prescribing medications for emotional disorders. Over that time there had been no complaints at all to the state Board of Psychologist Examiners of patients having been harmed. Also, there had been no allegations of improper or inappropriate prescribing which had been verified after review by the state Board of Pharmacy.

It is now six years since this healthcare initiative was implemented. There were no complaints at all this past year to the Board of Psychologist Examiners of patients having been harmed by prescribing psychologists, or of improper prescribing. The grim predictions that prescribing psychologists would cause harm to the public which were made in the Legislature when the prescribing psychologist bill was being considered in 2002 have been proven to be unfounded.

Those of us who have been licensed to prescribe continue to work with a variety of underserved populations. For example, here in Farmington I do medication consulting at our county jail, and at our local substance abuse treatment programs.

To my knowledge, no legislation will be introduced in the upcoming session concerning prescribing psychologists. I am writing instead to thank you once again for your trust in the commitment of psychologists who choose to return to school, sometimes after many years of practice, to expand the services they can offer to their patients.

Happy New Year! May you continue to feel the serenity of the holidays even during the upcoming legislative session.

Sincerely,

Robert Sherrill Jr., PhD

701 West Apache / Farmington, New Mexico 87401 / (505) 327-2777

ATTACHMENT # 3

Recent Coast Guard Positions for Medical-Prescribing Psychologists #1

Job Title: Clinical Psychiatrist OR Psychologist: U.S. Coast Guard Academy, New London, CT (O6 billet)

Job Description: The U.S. Coast Guard is seeking a psychiatrist to provide evaluation, diagnosis, and treatment at the U.S. Coast Guard Academy, New London, CT (O-6 billet). Responsibilities include ongoing care and treatment of college age recruit population, active duty members, and other beneficiaries. The incumbent shall apply U.S. Coast Guard policy and procedures, and performs fitness for duty evaluations on CG members. Hours are generally 07:30 AM- 4:00 PM M-F. No inpatient duties, limited call by telephone. Serve your country in uniform and have fun doing it! Call us.

Psychologists with additional training and credentialing to prescribe medications are encouraged to apply. Preference will be given to applicants with previous military psychologist background, particularly those coming from recent duty in other services who are often well embedded into both the operational and healthcare systems.

Training: License: A current, unrestricted, and valid license as a clinical Psychiatrist or Psychologist from a U.S. State, District of Columbia, Commonwealth, Territory, or other jurisdiction is required.

Geographic stability in this position can be expected for 5 years.
Location of Position: New London, CT

Contact Information: To apply please e-mail your CV and cover letter to CAPT Wade McConnell at wade.b.mcconnell@uscg.mil

Application deadline: Open until filled

RECENT COAST GUARD POSITIONS FOR MEDICAL-PRESCRIBING PSYCHOLOGIST #2

Job Title: Clinical Psychiatrist / Psychologist: U.S. Coast Guard Training Center Cape May, NJ (O6 billet)

Job Description: The U.S. Coast Guard is seeking a psychiatrist to provide evaluation, diagnosis, and treatment at the U.S. Coast Guard Training Center Cape May in Cape May, NJ (O-6 billet).

Responsibilities include ongoing care and treatment of college age recruit population, active duty members, and other beneficiaries. The incumbent shall apply U.S. Coast Guard policy and procedures, and performs fitness for duty evaluations on CG members. Hours are generally 07:30 AM- 4:00 PM M-F. No inpatient duties, limited call by telephone. Serve your country in uniform and have fun doing it! Call us.

Psychologists with additional training and credentialing to prescribe medications are encouraged to apply. Preference will be given to applicants with previous military psychologist background, particularly those coming from recent duty in other services who are often well embedded into both the operational and healthcare systems.

Training: License: A current, unrestricted, and valid license as a clinical Psychiatrist or Psychologist from a U.S. State, District of Columbia, Commonwealth, Territory, or other jurisdiction is required.
Geographic stability in this position can be expected for 5 years.
Location of Position: Cape May, NJ

Contact Information: To apply please e-mail your CV and cover letter to CAPT Wade McConnell at wade.b.mcconnell@uscg.mil

Application deadline: Open until filled