Nick Tolentino, OIF veteran and former VA

TESTIMONY OF NICHOLAS TOLENTINO

BEFORE THE COMMITTEE ON VETERANS AFFAIRS

U.S. SENATE

"VA MENTAL HEALTH CARE: EVALUATING ACCESS AND ASSESSING CARE"

APRIL 25, 2012

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 of 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. However, 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 continue 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 substituting 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) services 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.