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STATEMENT OF

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VETERANS HEALTH ADMINISTRATION (VHA)

DEPARTMENT OF VETERANS AFFAIRS (VA)

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

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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 collaborative 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.