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HEARING ON VA MENTAL HEALTH CARE STAFFING: ENSURING QUALITY AND QUANTITY

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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HEARING ON VA MENTAL HEALTH CARE STAFFING: ENSURING QUALITY AND QUANTITY

Tuesday, May 8, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 10:38 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Stearns, Lamborn, Bilirakis, Roe, Stutzman, Johnson, Runyan, Buerkle, Huelskamp, Turner, Brown, Reyes, Michaud, Braley, McNerney, Walz, Barrow, and Carnahan.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. What I would like to do before we actually start is I think the IG folks have stood down at this time. Mr. Secretary, we are glad to have you, and go ahead and call this hearing to order.

I want to welcome everybody to today's hearing. I apologize for being tardy, but we are going to be talking about VA Mental Health Care Staffing: Ensuring Quality and Quantity.

As I think most of the Committee knows, two weeks ago the VA inspector general released a report reviewing veterans' access to mental health care, something that we are all very interested in as are all veterans and Americans across this country.

And I have got to say that the findings in the report are more than troubling. It is an understatement to call them troubling.

One of the most disturbing things that the IG discovered is that more than half of the veterans who seek mental health care through the VA wait an average of 50 days, to receive a full mental health evaluation.

Let me be real clear from the outset—A veteran who comes to the VA for help should never, never under any circumstance have to wait almost two months to receive the evaluation they have asked for and begin the treatment they need.

And I do not believe anyone in this room thinks that there is any excuse for that type of delay.

Given the gravity of the issues we will discuss this morning, I invited Secretary Shinseki to participate in today's hearing.

I was a little concerned, Mr. Secretary, based on a letter from you last week that you may not be joining us this morning, but I

am very glad that you are here with us because I know that this is important to you and the people who work at VA.

As you know, leadership and accountability begin at the top, not with an under secretary, not with a deputy under secretary, but with the secretary.

And these hearings are much more than opportunities for this Committee to hear from the department. I think that it is important for the department to hear from Members of this Committee as well because we hear from our constituents on a daily basis.

There is no one better positioned to represent the VA than you. So, again, let me reiterate my thanks to you for being here this morning.

Two days before the IG report was released, interestingly enough, VA made a surprise announcement that VA was going to be increasing their mental health staff by 1,900 people, adding approximately 600 clinicians and 300 support staff to their current roster of just over 20,000 mental health professionals.

Ensuring the VA is staffed adequately to fulfill the care needs of our veterans and their families is a priority of mine and each Member of this Committee.

So on its face, this is an encouraging step. However, I am concerned by the timing and the implication of the announcement.

The IG's report clearly illustrates that the VA does not have meaningful or reliable data, to accurately measure a veteran's access to care or facilities' mental health staffing needs.

In fact, the IG states, and I quote, "The complexity of the computations and inaccuracies in some of the data limits the usability of productivity information to fully assess current capacity, determine optimal resource distribution, evaluate productivity across the system, and establish mental health staffing and productivity standards," end quote. Which begs the question, if the VA does not even have a complete picture of the problem, how confident can we be that access, in fact, will be increased and care enhanced by really what could be termed a knee-jerk reaction to what has been going on?

This is not the first time we have been here. There is a long history of IG, government accountability office, and stakeholder reports that have found serious deficiencies within the VA mental health system of care including appointment waiting times, scheduling processes and procedures, provider performance measures, and data collection efforts.

There is an equally long history of congressional oversight. Strides have been taken, but they are far, far from enough.

I would like to give the department the benefit of the doubt. I believe that we all have the best interest of our veterans at heart, but I am afraid that VA's response in this instance is yet another example of a Federal bureaucracy providing a quick fix, cookie cutter solution to a very serious multifaceted problem.

A true definition of access to care can be found in 1993 Institute of Medicine report which reads in part, "The most important consideration is whether patients have an opportunity for a good outcome, especially in those instances in which medical care can make a difference."

The 1.3 million veterans who sought mental health care through VA last year deserve better. The very least we owe our veterans is a chance. VA can make a difference. VA must make a difference.

And, again, Mr. Secretary, thank you for being here today.

And I yield to our Ranking Member, Ms. Brown, for an opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. CORRINE BROWN, ACTING RANKING DEMOCRATIC MEMBER

Ms. BROWN. Thank you, Mr. Chairman, for holding this hearing today on such an important issue.

I would like to thank all of you that are here today in support of the veterans.

Since 2007, VA has seen a 35 percent increase in the number of veterans receiving mental health services and a 41 percent increase in mental health staff. While only one percent of Americans have served in the war in Iraq and Afghanistan, servicemembers represent 20 percent of suicides in the United States.

The VA report that 52 percent of the returning veterans from Operation Enduring Freedom, Iraqi Freedom, and New Dawn who access VA health care do so for a mental health issue.

Oversight of VA mental health programs have long been a focus for this Committee. Numerous hearings have been held, funding has been increased, and legislation has been passed to ensure that veterans of all era active duty servicemembers and guards and reservists all have access to timely and quality mental health care service wherever they choose to live.

While I agree that much has been done, I am discouraged that we still hear stories of the struggles many veterans face when trying to access VA mental health care services. Whether it is a delay in care, denial of care, or that the care is not available, frustration with the system may lead the veterans to forego needed care altogether.

The inspector general's report was blunt and to the point. The report found that the Veterans Health Administration does not have a reliable and accurate method to determine whether they are providing patients timely access to mental health care.

I would like to hear how VA plans to move forward with the recommendations obtained in the IG's report on the heel of this report before the announcement from the department that 1,600 new mental health providers would be hired along with the addition of 300 support staff.

Given that there have been some inaccuracies in the information of the report over the last year, I am interested in hearing from the VA today what methods and modeling VA has used to arrive at the number and what and how long it is going to take for the hiring timeline.

Finally, because there have been many improvements and expansions in mental health services, I would like to recognize the hard work and dedication of the VA employees who go to work every day with the goal of making a positive difference in the veterans' lives.

And, Mr. Secretary, I want to thank you for coming here today. I want to thank you for your 38 years as a military person, and as the Secretary for the Department of Veterans Affairs.

I have been on this Committee for 20 years and I met with many, many secretaries. And I can tell you many of them, they come to this Committee, they talk a great talk, but they do not walk the walk or, as the veterans say, roll the roll. You do.

We have a big task. And we are a very bipartisan Committee and I am interested in working with you to make sure that we improve the lives for all of the veterans.

Thank you, Mr. Chairman, and I yield back the balance of my time.

The CHAIRMAN. Thank you very much, Ms. Brown.

I want to welcome again the panel to the table. We have already recognized the secretary of VA, the honorable Eric Shinseki.

Also, he is accompanied by Dr. Mary Schohn, the Director of the Office of Mental Health Operations; Dr. Antonette Zeiss, the chief consultant for Office of Mental Health Services; Annie Spiczak, the assistant deputy under secretary for Health Workforce Service; and also Dr. Jessee and Dr. Petzel.

Thank you for being here with us today.

Mr. Secretary, you are recognized. Thank you.

STATEMENT OF ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY MARY SCHOHN, DIRECTOR, OFFICE OF MENTAL HEALTH OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ANTONETTE M. ZEISS, OFFICE OF MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, CHIEF CONSULTANT, U.S. DEPARTMENT OF VETERANS AFFAIRS; ANNIE SPICZAK, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR WORKFORCE SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ROBERT A. PETZEL; ROBERT L. JESSEE

STATEMENT OF ERIC K. SHINSEKI

Secretary SHINSEKI. Thank you.

Mr. Chairman, Ranking Member Brown, distinguished Members of the Committee, thank you for this opportunity to speak on behalf both of veterans and their families but also the employees of VA about this important issue of mental health.

Mr. Chairman, I ask the department's prepared written statement that was previously submitted by Dr. Jessee be included in the record.

The CHAIRMAN. Without objection.

[THE PREPARED STATEMENT OF DR. ROBERT L. JESSEE APPEARS IN THE APPENDIX]

Secretary SHINSEKI. Okay. Thank you.

Well, joining me today, as you have introduced them, are the leaders and senior clinicians of the Veterans Health Administration, who are the appropriate experts to provide clinical staffing and policy information that you had requested in your letter.

I want to be clear. Mental health and well-being of our brave men and women who have served the Nation is the highest priority for me, for this department, and for our Nation. We are here to care for veterans' mental as well as physical health and well-being.

Today's testimony takes me back a few decades, Mr. Chairman, of my own experience coming back out of combat situation. And I think you will appreciate why this has priority for me and remembering some of the transitions I went through.

I am here to speak to America's veterans and their families as well and represent the dedicated employees of this department and especially today to the 20,590 mental health providers that are part of this discussion.

History shows that VA's requirements will continue to grow for a decade or more after the operational missions as they have in Iraq and next in Afghanistan come to an end.

And as veterans depart the military, we must ensure that all of them have access to quality mental health care. I believe we are all united in that pursuit. I believe the strong actions taken under the President's leadership have illustrated that clearly for the past four budgets.

And the last three years, VA has devoted more people, programs, and resources towards mental health services to serve the growing number of veterans seeking mental health care from VA. Last year, VA provided specialty mental health services, Mr. Chairman, as you pointed out, to 1.3 million veterans.

With the President's 2013 budget request, VA has increased the mental health care budget by 39 percent since 2009 and if we add to that the 2014 advanced appropriations request that is currently being considered, that increases that factor to 45 percent.

Since 2007, VA has seen a 35 percent increase in the number of veterans receiving mental health services, as the Ranking Member pointed out, but at the same time 41 percent increase in mental health staff to adjust to that.

And I think this describes a little bit of what we are dealing with and that is in our process here, Mr. Chairman, you resource us to a requirement and at best, those requirements, because of the advanced appropriations request that gives us a two-year budget, those requests are based on a prior year number of folks who walk in the door. We try to extrapolate that into some estimate of the future, but we are really covering about four years as we look forward.

And what this really means is we are essentially in a react cycle, that what walks in the door becomes the basis for understanding what the requirements could be in the future years.

And so if the trend line is smooth and uniform over time, there is an opportunity in this system to react because it is primarily reaction process.

Where we have spikes in that requirement, then we have these occasional needs to address the staffing issue as we have in this case.

Additionally, in 2010, I think we will all recall that the department simplified its rules for veterans submitting PTSD related disability claims which has greatly simplified access to care and bene-

fits and contributed to growth in the PTSD mental health requirements.

So that was done in 2010. The claims have been submitted and we are beginning to see a growth in PTSD mental health requirements and, therefore, not unexpectedly, a requirement to adjust our staffing.

VA's announcement on 19 April that we would add approximately 1,600 mental health clinicians to include psychiatrists, psychologists, mental health nurses, social workers, as well as 300 support staff to our existing workforce of 20,590 reflects both our commitment to mental health and acknowledgment that changes in policy are having an impact.

And our efforts will likely not cease with the announcement of 1,900 additional personnel being added to our workforce. Future adjustments may be likely.

VA has a long history of being on the cutting edge of mental health care whether through the use of vet centers, our National Center for PTSD, our veterans' crisis line, or integrating mental health into the primary care environment of our health care facilities.

We will continue to review and monitor our facilities and veterans' feedback so we can make other adjustments that are needed and we will not hesitate to take action again. And I appreciate the support of this Committee and the Congress over the past years as you continue to provide us the resources we need and the authorities we need to make this care available to our veterans.

My invitation is let's continue to work together along with our partners in the veteran service organizations focusing on what is important, providing timely access to care and benefits our veterans have earned.

And I look forward to working these issues with the Committee and look forward as well to your questions. Thank you, Mr. Chairman.

The CHAIRMAN. I apologize for the clock being on you, Mr. Secretary. I ordinarily would not have done that. I just noticed that it was on.

Did you have anything else you wanted to add? You kind of sped up at the end and I do not want to take time away from you in your testimony. Anything else you wanted to add?

Secretary SHINSEKI. No. I will let all the statements stand. You have accepted our written statement and I am happy to take questions.

The CHAIRMAN. Thank you. Thank you very much.

We will start a round of questions if we can. You talked about the press release on April 19th. You have acknowledged also that there are about, 1,500 mental health staffing vacancies. It could be a bit more or less. And your testimony today talks about maybe hiring more than 1,900.

So what I would like an answer to is, I know you are going to try to fill the 1,500 vacancies that exist and you are going to add an additional 1,900 plus staff. Is that correct? Then a couple other things.

How quickly do you think VA can hire the additional staff? Where are you going to put the additional staff? And how will you

be able to measure the impact that they will have on improving care?

Secretary SHINSEKI. Mr. Chairman, let me just make an opening statement here and then I am going to call on Ms. Annie Spiczak who does the recruiting and retention personnel work for us because you are asking to see what tools we have and what our expectation here is.

We think that we will get most of that done in the next six months, but some of these specialties are difficult to recruit and I would, you know, be honest with you. I am not sure I can pin a date when all of them will be in. But the vast majority of the work will be done in the next six months. Some of this may carry over into the second quarter of fiscal year 2013.

Let me call on Ms. Spiczak to talk about the process here.

Ms. SPICZAK. Thank you, Secretary.

Sir, I would say that we have a four-fold strategy to recruit and hire the mental health professionals that we need in VHA.

The first part of that strategy is to have a very robust marketing and advertising campaign to do that outreach to mental health providers and professionals. That is by the use of USA Jobs, using social media, getting all of those vacancy announcements posted to specialty sites and job boards.

The second part of that is using our national recruiters. We have 21 dedicated health care recruiters and they are very involved with the VISNs and the medical center directors to recruit those hard to fill positions, especially our psychiatrists and our psychologists.

Thirdly, we are going to recruit from our active pipeline of trainees and residents. VHA has a very robust training program and they are an integral part to filling that pipeline of our workforce.

And, fourthly, we are going to ensure that we have complete involvement and support of VA leadership.

Secretary SHINSEKI. Mr. Chairman, I am going to call on Dr. Petzel to just add some concluding points here.

But I would also point out that the national recruitment program, the 21 high-quality recruiters that Ms. Spiczak referred to all are veterans. Eighteen of them have extensive experience in recruiting.

And for any new individual who joins the team, they go through a training program and oversight, mentoring by some of the old-timers. And so this is a pretty robust tool we are talking about.

Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Mr. Chairman, I just wanted to add briefly the VA trains, has 1,000 psychiatric residency positions. We have over 730 internship positions for clinical psychologists just to mention a couple of the professions.

We are the largest trainer of mental health professionals in the country. And this group of trainees is the primary place that we are probably going to be recruiting those individuals to fill those 1,900 jobs.

And the last thing I would like to add is that the most difficult to recruit group is psychiatrists, particularly in rural or remote areas.

And we have recently sent a memo to the secretary which I believe he has signed or is about to sign to change the pay table for psychiatrists and to make available other incentives so that we can compete more equitably with the private sector and DoD in terms of recruiting psychiatrists.

The CHAIRMAN. Ms. Spiczak, how long does it take for VA to fill a vacancy like the 1,500 that are open now for mental health professionals? What is the average time that those positions have remained vacant?

Ms. SPICZAK. Sir, it takes anywhere from four to six. But for some of our hard to fill positions, it can take up to a year to fill those positions.

The CHAIRMAN. Have you ever been even close to a hundred percent staffed at the full level with the 1,500 that you currently have?

Ms. SPICZAK. Sir, we will always have a turnover rate, a vacancy rate, that we are always trying to close that gap, but you have my commitment that we are going to work very hard to close that.

The CHAIRMAN. At what level is the vacancy rate? Is it more at the upper level or the lower tier? I hate to say lower tier, but obviously the psychiatrist level downward, which is the higher rate?

Ms. SPICZAK. No, sir. Our turnover rate in fiscal year 2011 for our mental health professionals was 7.23 percent. And the Bureau of Labor Statistics for the health care industry shows a 28 percent turnover rate.

The CHAIRMAN. The last question that I would like to ask in this round is, how are we going to pay for the extra 1,900 mental health professionals?

Secretary SHINSEKI. For that question, I am going to call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Mr. Chairman, we have estimated that the cost in fiscal year 2012 will be relatively small because it is going to take some time to get these people on board. And we will use money that we have available in 2012. We expect that this will not exceed $29 million and maybe a bit less than $29 million.

In fiscal year 2013, we are going to separately identify the funding for this particular initiative as part of each one of the VISN's allocations and then the VISNs will receive a hiring target based on this allocation. And we are going to keep very close track of that hiring target.

Ms. Spiczak can give more detail about how we are going to do that, but we are basically going to be daily looking at how they are meeting that hiring target.

We will identify each one of these positions electronically on USA Jobs by a special number so that we can track all of the 1,900 new people as well as all of the vacancies that exist right now.

Secretary SHINSEKI. Mr. Chairman, just a data point. Psychiatrists are the toughest to recruit. And I think under this new model, we say it is about 57 that we are going to go after in this group of 1,900. Of 57, 37 have already been recruited. Seven are already serving. Thirty are being on-boarded.

And so we are beginning to hone in on this most difficult recruiting challenge and working it down. So there is some evidence that we can recruit what we need here.

The CHAIRMAN. Before I turn it over to Ms. Brown, I also want to say that I had the pleasure and the honor of accompanying Ms. Buerkle to Syracuse, to visit the medical center there. And I want to tell you that what I saw from their mental health professionals was exactly what I think you want to see around the country, the care and compassion they have not only for the veteran but for the veteran's family as well, and helping them to be able to assimilate and understand the issues that they are confronted with.

And, you know, those ghosts, if you will, that the veteran fights sometimes the family fights too. They have done what I think is an outstanding job at that facility.

With that, Ms. Brown, you are recognized.

Ms. BROWN. Mr. Chairman, I want to be the last on my side because I have a real in-depth knowledge of this issue since I have an educational specialist in counseling. And so I am thinking about a different approach.

The CHAIRMAN. Very well. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman, and thank you, Madam Ranking Member, for yielding.

And welcome, Mr. Secretary. We are looking forward to your visit later on this month in El Paso.

And I guess my first question, does the VA do an ongoing assessment? And the reason I am asking this question is because since the 2005 BRAC, I will use my district as an example, we gained the First Armored Division.

And as the downsizing of the army occurs down to 490,000, we anticipate, and we are seeing already, a rapidly increasing number of soldiers coming out of the army staying in the El Paso region and, therefore, impacting our VA facility.

So my question is, is there an ongoing assessment to be able to take care of areas like our district?

Secretary SHINSEKI. Congressman, this is a good point. And this is a little bit of that resourcing to requirement that I referred to. And the example I used was a decision to grant PTSD, combat verified PTSD to anyone who had served in combat. So for every generation from World War II to the current, suddenly a new opportunity for them to receive care and the numbers are beginning to reflect that.

Same issue here with the First Armored going to El Paso. We are not part of that decision process.

Mr. REYES. Right.

Secretary SHINSEKI. But we have worked very closely with Department of Defense for the last three and a half years to try to get better synchronization for us with understanding where they are headed. And in many cases, they have shared with us whatever they knew. Some of this First Armored going to El Paso was probably a later breaking issue than we would have been able to anticipate.

But, nonetheless, these are part of the changes that occur in the requirements that then drive us to go back and review our resourcing format. So, yes, I would expect that First Armored sol-

diers would remain in El Paso and requirement for veteran health care including mental health will go up and, hence, a discussion about a future VA medical facility becomes pertinent over time.

Mr. REYES. Well, the assessment itself, is it ongoing or how is that done by VA?

Secretary SHINSEKI. Well, heretofore it has been a sort of acknowledge the requirement when people walk in the door seeking help and that becomes a registration point of a requirement for health care.

We have worked with the Defense Department to create the single electronic health record so we would have a better handoff, a warm handoff of individuals departing the military who are coming to VA.

And we have worked at this with the attitude that everyone who leaves the military ought to be enrolled in VA. And part of the VOW Act was to create a transition assistance program and we have been in discussions with DoD about how to structure this.

For our purposes, during the transition period, we would like to see individuals still in uniform have access to my healthy vet, to e-benefit so that they are in our database before the uniform comes off.

And as you know, we are working towards this integrated electronic health record that will transfer automatically all the information that they have built up in their military service coming over to us.

And we are shooting to have integrated health record probably initially, initial form of it ready in about two years.

Mr. REYES. And at what point or at what stage will facilities like the one in my district get an idea of how many additional personnel will be coming out of the new hirees?

Secretary SHINSEKI. Let me ask Dr. Petzel to provide that.

Dr. PETZEL. Thank you, Mr. Secretary.

Congressman Reyes, we are right now discussing the allocations with the VISNs. Dr. Schohn and her group actually are doing that. And we expect that we will know within a couple of weeks at probably the latest what it is going to specific.

Let me just go back to the question that you asked the secretary and add one more thing. You talked about being able to anticipate a surge or an increase in the number of people.

The foundation for how we determined the 1,900 people that we felt we needed to distribute across the country is a prototype of a staffing model. No one in this country has a staffing model for mental health. We have developed what I want to call a prototype because it has not been fully vetted.

But that model then can be applied to any population of patients requiring mental health services to predict the kind of both support personnel and mental health professionals that are needed. This is going to be an ongoing assessment across the Nation of our needs.

And we would hope to be more anticipatory now with this model and less reactive than we have been in the past so that in terms of returning veterans, we will be able to predict the need and have the resources in place to be able to manage that.

Mr. REYES. Great.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Petzel, you are talking about the allocation of resources and it begs the question—what type of a workload analysis did you do prior to the announcement that 1,900 was the number? Could it be considerably more than 1,900, could it be less, or was that just kind of a middle figure that you worked with just to roll it out?

Dr. PETZEL. Chairman Miller, that is an excellent question.

And Dr. Schohn can talk more detail about how this prototypic model was developed, but it basically looks at the population of patients requiring mental health services. And it is able to say, as an example, across the country, we feel as if we need about 5.3 mental health professionals for every thousand patients that are presenting.

We began doing this, sir, back in November. This was not a reaction to the IG. We began looking at what kind of staffing increases we needed back in November. Dr. Schohn and her group developed a prototype of this model, applied it, as well as other information that we had and arrived at the number of 1,900.

It is being in a very detailed fashion tested in three networks to see how predictive it actually is, but we think it is going to allow us to do a better job of anticipating need in the future and we think it appears to be quite reliable.

The CHAIRMAN. If, in fact, you did start back in November, why wasn't this proposal in the President's budget submission this year?

Dr. PETZEL. We had not developed the model and we did not know for sure until at least into January how this might work and exactly the number of people that we would want to apply.

The CHAIRMAN. But I think even in January it would have been able to have been included. I mean, two weeks after the IG report comes out, it looks like a knee-jerk reaction. And I can appreciate the fact that you may, in fact, have been working on it.

But if you knew it was going to be an issue, I think it would have been wise to have included it, especially a number as large as 1,900, in the President's budget submission.

With that, Dr. Roe, you are recognized.

Mr. ROE. I thank the Chairman and I thank the secretary for being here.

And I would like to introduce a guest before I start with any questions. I would like to introduce a constituent of mine from east Tennessee, Staff Sergeant Derrik Plank. Derrik is a combat-wounded veteran who entered the army in 1995 right out of high school and went on to serve three tours of duty in the former Yugoslav Republic under General Shinseki, Bosnia, and Iraq.

Derrik served with the Fourth Infantry Division in Operation Iraqi Freedom. On May 5th, 2003, he suffered a traumatic brain injury caused by shrapnel wounds when his tank was attacked by an RPG. Derrik retired later that year.

As a reward for his bravery, Derrik was awarded the Bronze Star for valor, the Purple Heart, four army commendation medals, and a combat action badge.

He holds a master's degree in arts and education from East Tennessee State University as well as a doctorate in education from the University of Maryland.

He continues to be very active in the veterans community and is a strong advocate on their behalf. As a part of this support, Derrik recently wrote a lengthy dissertation on suicide prevention and the proper treatment of mental health injuries among veterans and servicemembers. And I would certainly recommend that you read it.

As a veteran and doctor and co-founder of the invisible wounds caucus, I recognize firsthand the need to address these issues.

And I want to thank Derrik for his service to our country and his efforts to continue supporting our veterans.

[Applause.]

Mr. ROE. I thank the Chairman.

And, Derrik, thank you for being here today.

And I do strongly encourage you to read this not from the bureaucratic point of view but from the eyes of a veteran who has been through the various treatments and sees the positives and the minuses.

I think one of the things he brought up in his dissertation that I read is, and it is a tough issue, Mr. Secretary, when a soldier goes in, we have been very sensitive in this country about culture, and it has been an issue as you have seen recently and the photos that have been made. Our leadership from someone like yourself has been very culturally sensitive.

The question is, is the VA being culturally sensitive when it treats veterans?

Derrik's concern is when he goes in to see someone who is a mental health provider who may be from a different culture, for instance, Major Hassan is a perfect example of that, it is very hard for these veterans to go and display these issues that they have with someone that a few weeks or months or years ago, even when these issues pop, that were the enemy. And it is a real issue.

Is there any sensitivity on the VA's part—maybe Dr. Petzel can answer this—in hiring individuals to treat these veterans because it has been an issue for Vietnam era veterans and certainly is an issue today for our Iraq and Afghanistan veterans?

Secretary SHINSEKI. Congressman, I am going to call on Dr. Petzel here to try to address the specifics of your question which is a good one.

But I am also reminded that this is why this model we are talking about is imperfect. I mean, it is the best we have right now. It will get better as we finish the piloting. And this is to get to the staffing issue.

What you are talking about is the special trust that develops between a patient in the mental health arena and the provider. And this is unlike the relationship in other disciplines of medical delivery. Without that trust, not much positive will come out of it.

And so I think here in the mental health side of medicine, we are into the art of understanding what the right staffing levels and capabilities are, whereas maybe in the other disciplines in medicine, it is more the science where you can measure and metric and get pretty accurate outcomes.

So when Dr. Petzel says he started with his staffing model and began to adjust it in ways that would be helpful to mental health, we are still learning how to do this because we have to get to this

answering what is the right number and what is the right relationship we are trying to develop here.

And I would expect that there would be some concern like you are describing that we would have to take on and deal with. But we will do that as we see patients. And let me ask——

Mr. ROE. I think these issues make it almost impossible for that veteran to get the quality care. It is not the quantity so much but the quality.

Secretary SHINSEKI. Yeah.

Mr. ROE. In his case, it was very difficult.

Secretary SHINSEKI. Yeah.

Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

And, Dr. Roe, thank you.

You bring up an incredibly important issue and that is the ability of not just in mental health but in medical care in general the provider being able to empathize culturally with the person that they are talking to. Do they understand where they are coming from? Do they understand what the nature of the experience is that they have had previously that have led them to seek medical care?

And I am proud to say the VA has pioneered a program to teach in medical schools and in other clinical education settings about the military culture, about the issues associated with combat, about the problems that may be faced by somebody who has recently been discharged.

And I would venture to say that in almost every medical school now in the country there is a section of education both for medical students and for residents about dealing with veterans and dealing with the issues of the military culture.

Mr. ROE. Dr. Petzel, I know Congressman Reyes and Congressman Walz, myself, others have served. And how many of these mental health individuals are veterans, because I think it is—you know, when you put your pants on every day with these guys and you go out in the tents and you go out with them, you have a different view? I can tell you you just see through a different set of lenses.

Dr. PETZEL. The only figure I know, Congressman Roe, is at our vet centers, the 300 vet centers that we have around the country, 70 percent of those people working in those vet centers are veterans.

Mr. ROE. What about the 37 psychiatrists that General Shinseki has spoken of and dealing with those?

Dr. PETZEL. I do not know, but we can certainly find out and get back to you about that.

Mr. ROE. And it does not mean that you cannot provide good care. I do not mean that at all. You certainly can. You do not have to have had a heart attack to treat one. I understand that. But certainly if you are treating combat stress, boy, an ideal person is somebody like Derrik or someone who has been there as General Shinseki has on many occasions. It is again a different set of lenses that you look through.

Dr. PETZEL. Just one more thing, Congressman, I would like to add that I neglected to mention earlier. We have started because

of legislation that Congress passed, we have started developing a peer counseling program and are in the process of training 400 peer counselors that will work in our medical centers. And these, of course, will all be veterans.

Mr. ROE. Okay. I yield back.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Thank you, Mr. Secretary, and the panel for coming here this morning on this very important topic, especially after the IG came out with their report last month.

And I am very pleased to see the VA's response. In the report and that I would like to quote, it says, and I quote, "Unequivocally committed to providing veterans the best possible care, the VHA would act rapidly on all findings that may improve veterans' access to mental health care," end of quote.

As the VA knows, the timeliness in providing that care is extremely important when you are dealing with PTSD patients and I really appreciate that.

My question is, do you believe that contracting to non-VA facilities that have a proven track record in this regard would be extremely important?

And the reason why I ask that question is looking at the 1,500 current positions that are vacant, looking at the 1,900 new staff that you are looking to be bringing on board, it is going to take some time to get those on board. And, unfortunately, some of our veterans I do not believe can wait that long. So you have to look at other areas where contracting has proven to be successful.

And I mention that because actually earlier this year, Congressman Mike Thompson invited me out to California to visit a program that they are currently offering out there in California, pathway homes. And I had a great opportunity to talk to a lot of the veterans that actually have gone through that particular program and they had nothing but high praises for the program.

And I also asked why did you not go to the VA and some of them mentioned they just felt like they were a number in the VA system. They did not feel that they were getting the appropriate health care needs that they thought they might get. So they went to this particular program which seems to be very successful.

So I know contracting out has always been a concern among some of the VSOs and the VA, but this program seemed to be a proven program.

So is the VA going to be looking towards contracting out to help relieve some of the burdens that is currently there in this area?

Secretary SHINSEKI. I am going to call on Dr. Petzel for that, Congressman.

Dr. PETZEL. Thank you, Mr. Secretary and Congressman Michaud.

We have several mechanisms for reaching out beyond the VA to provide care and we do use them. One of them is fee basis as I think you are familiar, non-VA care where we actually allow people to be seen by private practitioners. And they then bill us and we pay for the service.

And the other is contracting. And we do have in mental health as well as in other parts of our health care system, we do have con-

tracts on the outside, often in places that are quite remote or rural where we do not have a provider.

If you look at our system of community-based outpatient clinics, we have over 800 of them and we provide mental health services in virtually all of them. And many of them, that is done by contract. We have a contract with mental health providers in the community and that is the way we deliver services in that clinic.

So it is an excellent idea. It is an excellent suggestion. We do do it. And in some remote areas, I think we are going to have to be doing it more than we do now.

Mr. MICHAUD. In the interim, until you get all the new employees that you plan on hiring, I would assume that you probably would need to take care to do more of it at least initially for programs that have worked. And that is a concern that I have is the lag between when you get these new employees on.

You mentioned the CBOCs and the VA system. Are there current plans now to upgrade, you know, the business plan for these different areas to look at the increase of new employees? How far along is that process?

Dr. PETZEL. I am not sure I understand, Congressman Michaud, the question. In terms of the facilities, yes, we are updating their business plans to reflect the new people——

Mr. MICHAUD. New model.

Dr. PETZEL. —that are coming on board. Exactly. And you make an excellent suggestion about fee and contract. And we do have other things that they can do in the interim, locum tenens, and shifting some resources within the medical center. But fee and the possibility of contracting should also be a part of that. Absolutely agree with you.

Mr. MICHAUD. And my last question is, looking at the additional 1,900 new staffing, is that to take care of the current needs that are currently out there today and have you taken into consideration over the next five years that there is going to be about a million soldiers back in—will be into the VA system, a huge increase? So does that 1,900 address the one million that will be coming into the VA?

Secretary SHINSEKI. Congressman, the 1,900 addresses what we know are today's needs. And we have said, as I said in my opening statement, we are comfortable with this, but this requirement could likely grow and, hence, the importance of our relationship with DoD and being able to see what the future brings.

The one million figure I have used and others have used, as we talk to DoD, they indicate that that is not going to be as big a spike as at one time was predicted. That reality is it is going to be a much smoother transition out. It will still be an increase, but this will be something that we think with this model that they have created and we are piloting, we will begin to anticipate a little better than we have which has been primarily reaction.

Mr. MICHAUD. Thank you.

The CHAIRMAN. Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman, and thank you for having this hearing today.

I want to thank Secretary Shinseki for being here. It is good to see you and thank you for your service and all that you work to accomplish at the VA. This is obviously a very important issue.

And I represent northeast Indiana where we are going to be having a new outpatient mental health care facility that is being built there. And with the IG's report that has just come out, you know, this is obviously concerning.

And I am curious why these issues which have been raised numerously have not been resolved. I know the VA has convened a working group to attempt to address these problems in the IG report.

My question is is, what is going to be different about this particular group? What is going to be different about your approach this time in tackling these problems so that, you know, I can make sure that the veterans back home are confident of the services that they receive?

Secretary SHINSEKI. Let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary, Congressman Stutzman.

I will do just a little bit of history about measuring wait times which is, I think, what this is about. There are three different ways to do this. One of them is to look for the third next available appointment. That is called a capacity measure because it measures your capacity. It does not give us information about how long any individual would have waited. And we at one time used that to predict our capacity for seeing patients in the clinic setting.

But the two other ways of measuring this are desired date which is you ask someone, a provider or a patient when do you want to be seen. They say a date and then that becomes the mark and you see how close to that date you can actually get the appointment. It is called desired date.

The other is creating date. It means that there is no interest in what the desire of the patient or the clinician is. It is the day that that appointment is asked for. It becomes the create date, relatively inflexible, but very easy to measure and very easy to do.

We have used desired date since about 2007, 2008 and trained everybody about how to do desired date, et cetera. It is clear both from our look and from the IG's look that there are difficulties for new patients with desired date.

So the first change we are making is that new patients are going to be tracked based on create date so we can be absolutely certain of that particular date. It requires no judgment on a scheduling clerk's part. It is the date that that appointment is asked for. And I am quite certain that is the conclusion the work group is going to come to.

The second thing that we have to address then, and that is only 17 percent of our appointments, our new patients, relatively small amount. You have to remember that people access our system in a lot of different ways. They come into the emergency room. They call the crisis hotline. They are in a primary care clinic and they are treated for mental health there or they are referred out.

Very few people actually walk in or call in and say I want an appointment in mental health, so we have to address how we are going to measure appointment times with that other 83 percent of the patients and that is the primary job with this work group.

We need to. Absolutely agree with the IG. We need to be able to tell our veteran patients, our employees, and you how long people are waiting to get times. And we are not able to provide the data to be accurately doing that right now.

We will work with the IG after we come to a decision about what we want to do to be sure they understand and agree about the way we want to do this so when someone comes to audit this, we will not have the confusion and the issues that we had with this audit.

Mr. STUTZMAN. Okay. I know my time is short here. But in the next panel, we will hear from a private sector provider who states that they are able to increase patient access and satisfaction by trying to fill open appointment slots with patients waiting for appointments.

Does the VA have a similar system in place? If not, or yes, no?

Dr. PETZEL. I would ask Dr. Schohn to respond to that.

Ms. SCHOHN. Yes. Actually, at local sites, certainly people keep lists to get people in sooner. That is part of the sort of routine standard of practice.

Mr. STUTZMAN. Okay. All right. Thank you, Mr. Chairman. I will yield back.

The CHAIRMAN. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for coming today and your testimony.

There is no doubt in my mind about your commitment to this issue. There is no doubt in my mind about it and the dedication of your staff. I am sure that psychiatrists could make more money in the private sector, so working for the VA shows a certain amount of dedication. I appreciate that.

My first question is really following up on an earlier question. Dr. Petzel, I just want to be really clear in your answer about this. Do you believe that the VA should assume responsibility for treatments when the patient is referred to outside agencies by the VA for PTSD or TBI treatments?

Dr. PETZEL. Well, Congressman McNerney, yes, we are responsible. When we refer somebody out, the patient is still our responsibility. We have a responsibility to see that that is high-quality care, that it is done in a timely fashion, yes.

Mr. MCNERNEY. So the VA is assuming responsibility for payments to these outside agencies?

Dr. PETZEL. If we refer somebody to an outside organization, yes, we are responsible for the payments.

Mr. MCNERNEY. Okay. Thank you.

Secretary Shinseki, Chairman Miller, and this is a follow-up on Mr. Stutzman's question actually, mentioned that the IG report gives a two-month waiting period for some veterans seeking mental health assistance.

What was your reaction to that? It sounds like from Dr. Petzel's testimony that the standard for judging that two months is a little bit mushy, but I would just like to hear what your response is to that.

Secretary SHINSEKI. Congressman, I am not sure I would have concurred in the IG's report exactly the way the department did. And the reason I say that is like all of you, I am trying to figure out what the issues are and how to apply our resources and energy.

And so we have this large health care system in which if you enter a vet center, you are into mental readjustment counseling and if required, you get referred into the mental health system.

As Dr. Petzel has indicated, there are 300 of these vet centers out there. There are 800 plus community-based outpatient clinics in which you can enter the mental health system through contact with a primary care provider.

And that grows when you add our telehealth links, that people in remote or even not so remote community-based outpatient clinics can be linked in to psychiatrists, psychologists that is at a distant station. So there is a level of robustness here that I understand exists.

There are 152 medical centers and you can enter the system by going to the mental health clinic and the medical center or you can go enter the system through the primary care arena in that same hospital because we have integrated mental health care in with primary care providers or you can enter it through the emergency room after hours if you need care. There is an opportunity to get connected to a mental health provider and then referral.

So a fairly complex system and we have added to that with the homeless initiative that we have put in place. It is a robust system in which entry into mental health care is numerous.

I welcome the insights from the IG. I also welcome their help in helping us create a model that will solve this scheduling issue that occurs in a variety of ways. And it is not just at the scheduling desk in a mental health clinic. It is one entry point.

And I do not know that we fully understand and can measure right now the robust aspects of what we do in mental health. And my guess is we are doing good work here. We are just not able to document it.

Mr. MCNERNEY. Thank you.

Dr. Petzel, could you give me a little insight into the nature of the model that has been developing, the staffing model? Is it an Excel spreadsheet or how does it work? What are some of the details?

Dr. PETZEL. Congressman, I would like to turn that over to Dr. Schohn whose group actually developed that model.

Mary, could you help.

Ms. SCHOHN. Sure.

We developed the staffing model using the same kind of methodology that VHA previously used in developing a method to look for our staffing model for primary care. And that included looking in the literature to look and see what is out there, what has been published.

There is very limited literature on outpatient mental health staffing models, a little bit more literature on inpatient, but we were really focused on outpatient.

We also connected with other health care systems, so we are aware that DoD is actually piloting a staffing methodology and we got details from them and ran it by our subject matter experts.

It was promising, but we have a variety of different kinds of services than DoD offers to its constituents, so we were unable to effectively adopt that system.

We also talked to Kaiser Permanente to see, in fact, what kind of model they had and they currently do not have a model of the kind that we are looking for.

We were unable to get any information from other systems, so we looked to our own data and we looked at the utilization standards, staffing models and so on to look at the numbers.

We also had looked at what are the predictors of staffing within VA. So we ran a model that looked at, you know, what predicts. It includes things like, not surprisingly, the number of patients served, the kinds of services, so including residential services, inpatient services, as well as some characteristics of facilities where patients are at, so things like, is it a teaching hospital, are all predictors.

We put that together and we looked at our data and identified that as kind of a starting point for us, 5.3 independent clinicians per 1,000 veterans looked like the place to start in terms of looking at does this effectively do what we want to do in terms of improving access as well as providing veteran and provider satisfaction.

Mr. MCNERNEY. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

And, again, Mr. Secretary, it is good to see you here today.

I am going to start off with a little bit of a difficult question. You know, year after year in annual budget submissions and annual performance reports, quarterly reports, congressional testimony, and in countless press releases and statements, the VA has consistently touted the 14-day standard as the number one measure of mental health care access.

In a five-month investigation, however, the IG found that measure to have no real value and to be essentially meaningless.

Mr. Secretary, how is it possible that that is not bubbling up to your level? How is it possible that you do not know that and who is responsible for misleading Congress and the public on this metric and how will they be held accountable?

Secretary SHINSEKI. Congressman, I do not think anyone has misled Congress here. Dr. Petzel described three methods of identifying in the scheduling arena capacity, desired date, create date.

They have in the mental health arena been using desired date now since 2007 and my understanding was this goes back to when we had a previous discussion like this.

I am not sure how the results were achieved, but it just seems to me that desired date and create date in the report are brought together in a way. It is hard for me to determine whether there was a pure assessment of whether desired date was being executed properly, whether staff were properly trained and following the instructions. That would allow us to focus on corrective actions.

Right now part of my discussion with Dr. Petzel is that we have got to sit down with the IG and make sure we come up with a clear standard here so that when we audit in the future, there is not this confusion about which date we are using and that we get a cleaner outcome and understanding.

I am not able to address the specifics here, but I would assure the congressman there is no misleading of Congress.

Mr. JOHNSON. I can certainly agree that there is no intention to do so, but I think we all agree here that the objective here is to make sure that those veterans that request mental health counseling get it as soon as absolutely possible.

Secretary SHINSEKI. I would just like to assure you so we do not confuse the two terms, access is being able to get treatment. Scheduling is the timeliness of this. Both are important. But I want to assure you that veterans who and even active component individuals who come to us for mental health care do have access.

We are going to go to work on the scheduling issue to make sure that timeliness standards are clear and that we can measure whether we are achieving them.

Mr. JOHNSON. Okay. Thank you.

Dr. Sawyer who we will hear from on the next panel mentioned in her written testimony an issue of space for clinicians at some VA mental health facilities.

What is your plan to make sure that the 1,900 new clinicians and support staff will have adequate space to do their jobs?

Secretary SHINSEKI. Let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Congressman Johnson, the two relatively rapid ways we have for dealing with space issues are the nonrecurring maintenance and repair money and the minor construction money.

We do have already in the pipeline projects in both those areas dealing with ambulatory mental health as well as other ambulatory space.

In addition to that, we can give priority right now because they fall into one of the five special categories, we can give priority to move nonrecurring maintenance and repair money projects that deal with mental health up. And we are going to do everything that we possibly can to see that the projects that need to be done to create this space is done.

I cannot argue with the statement that there is going to be or there are going to be space issues at some places. We are going to address those as quickly as we possibly can.

Mr. JOHNSON. Okay. One final question. Do your performance measures only apply to OIF and OEF veterans or any veterans?

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary and Congressman Johnson.

No, they do not. We have a long list, and I want to just briefly mention them, of performance measures that look at all categories of veterans.

Now, the timeliness is just one performance measure. There are many other things that we look at. Are patients timely referred if they are at risk for suicide? And we track that. Are patients getting the eight sessions of individual psychotherapy within eight weeks if it is prescribed and if it is needed? Are high-risk patients being referred to the high-risk patient case management in a timely fashion? Are we following up post discharge? Everybody is supposed to be contacted after discharge from a mental health facility within seven days of the discharge. Are all new patients being screened for depression, alcohol misuse, and in the case of OEF/OIF particularly PTSD?

So, no. The performance measures apply to every single one of our mental health patients.

Mr. JOHNSON. Okay. Thank you.

Mr. Chairman, I yield back.

The CHAIRMAN. Ms. Brown is going to go ahead and ask her questions, Mr. Walz, if that is okay with you.

Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

Recently I participated in a workshop with Secretary Donovan and the Mayor of Jacksonville and the issue was veterans, just veterans and veterans' mental health.

And we were discussing how we can combat this working with our partners, not just the VA, but how can we work with other stakeholders.

And recently I visited the VA facility in Los Angeles. And the reason why I mention that I had an educational specialist in counseling is because I think everything should be group and counseling and working in that group setting.

I was surprised the number of veterans talked about how they prefer or in addition like the online and accessing the system.

Can you tell us how you plan on expanding the system to include that aspect of, you know, video conferences and other aspects?

Secretary SHINSEKI. Let me call on Dr. Petzel. We are doing many of these things now, Congresswoman.

Ms. BROWN. You are, but I was surprised that they liked it.

Secretary SHINSEKI. That is a new generation.

Ms. BROWN. Yes, it is.

Secretary SHINSEKI. They are folks that are very comfortable with the technology and they do not mind that little gap distance——

Ms. BROWN. That is right.

Secretary SHINSEKI. —between themselves and the provider.

Dr. PETZEL. Thank you, Mr. Secretary.

Congresswoman Brown, you put your finger on what I think is probably the most important future development in not just mental health services delivery but in medical care delivery in general and that is tele-mental health and telehealth.

The VA is a pioneer in tele-mental health. We had over 150,000 people using tele-mental health facility services this last year. It is particularly important in rural and remote areas.

Just as an example, we have a telehealth PTSD treatment program on the Rosebud Indian reservation in South Dakota. It has been in existence for almost ten years now. And it provides PTSD treatment for Native American veterans living in Rosebud and Pine Ridge reservations being followed by a psychiatrist in Denver at the University of Colorado.

So we absolutely agree with you. This is a fundamentally important thing. We are pushing the development of tele-mental health particularly as rapidly as we possibly can.

One more example of that. I dedicated or helped dedicate a new mental health building at the Pittsburgh VA Medical Center, a state-of-the-art inpatient and outpatient facility. They have 19 cubicles for mental health providers to be providing tele-mental health at remote areas in Pennsylvania.

Ms. BROWN. Thank you, and that is very helpful.

But one of the reasons why I mentioned the meeting with Secretary Donovan was that we talked about the array of things that needs to go to help veterans like the housing, like the casework, making sure we have a caseworker there in the homes that we are working with. And we have many stakeholders and partners that is already doing it and want to partner with us.

Seems like we in Congress in many areas, we always talk about—I do not like the word even—outsourcing or, you know, that is a negative to me, but in this area, it seemed like it makes some sense to partner with people that have the same level of expertise as long as we have the oversight and making sure because the problem is so deep.

Secretary SHINSEKI. Congresswoman, good points. We do not rely on just our internal capabilities. I think Dr. Petzel has referred to fee basis contracting. Telehealth, telemedicine, you know, I think we are doing the right things in investing in the technology for the years ahead. I personally do not think we are investing enough. If this is the breakthrough in medical delivery in the future years that is going to create, reduce the tyranny of distance and get veterans, patients in need of help in contact with health care providers I think this is it. If it is, I think we could be doing more here in investments. But we are moving quite smartly. $360-some-odd-million this year investing in telehealth connectivity.

Let me call on Dr. Petzel for anything else he adds here. But especially in the area of mental health we talk about it as though it was all one kind of issue.

Ms. BROWN. Yes.

Secretary SHINSEKI. And it is all individual. And we also find out that you almost have to tune to the individual patient the care that is going to make a difference. And so we want to have as many options as are available and that we can afford to be sure that we have something that will work.

As you know we have five polytrauma centers. The most recent one opened in San Antonio. I happened to visit the one in Richmond and while they were giving me a tour I encountered—with a veteran briefing at each station. At one station I encountered a female person who in this polytrauma center was, spoke to me and there was no speech problems that I could see. Had all appendages. And I said, "This is a polytrauma center. Are you a member of the staff?" She says, "No, I am a patient here. I am one of those comatose patients who came in here some time ago and this place brought me back to consciousness and brought me back to the ability to speak, and walk, and do all the things I did before."

We are doing some terrific things here. And when I ask people, "What is opening the door?" You know, there is really no good answer. Because when you push the envelope you do not necessarily know how to seal the lid on things. You just keep going. So this young lady is a promotable master sergeant in the United States Air Force. She is going to leave Richmond here sometime this summer, according to plan, and she will go back and be promoted on active duty.

So we need as many tools as we can get, and that is what you are talking about here.

Ms. BROWN. Yes, sir.

Secretary SHINSEKI. And we will look to incorporate as many as we can and balance that in a way that is both efficient and cost effective.

Ms. BROWN. Thank you again for your service, sir.

The CHAIRMAN. Ms. Buerkle?

Ms. BUERKLE. Thank you, Mr. Chairman. And thank you, Secretary, for being here, and to all of you for your service to this Nation and to our veterans. I think that is the place we all start at, how can we make sure we are doing the right thing for our veterans?

I am chair of the Subcommittee on Health and many of you have been here and testified before the Committee. In December, on December 2nd, we had a hearing in the Subcommittee regarding suicide and the grave concern that we have at the rate of suicide. And of course, that plays into what we are talking about here today. There is not really the luxury of time, and that was part of that conversation, and it is again the part of this day's conversation. We do not have the luxury of time. We do not have the luxury of sitting down and trying to come up with plans and think tanks. We really need to act expeditiously.

In that hearing Dr. Jan Kemp spoke and she testified on behalf of the National Mental Health Suicide Prevention at the Veterans Health Administration. And she talked to us about the VA has significantly expanded its suicide prevention program since 2005, when it initiated the Mental Health Strategic Plan and Mental Health Initiative funding. So that has been in place. There is an awareness of Post Traumatic Stress. There has been an awareness. Why now is, it, I get the impression this morning that now the IG's report came out so now there is increased awareness. This is nothing new. This is, she assured us in that hearing that the proper steps were being taken. And my concern is that there is a lack of coordination. That many good things are happening within the VA, and as the Chairman pointed out in Syracuse we have an excellent facility, always ready to meet the needs of the VA. But I am concerned about a lack of coordination. We have heard that in other hearings, that one hand does not know what the other hand is doing. And ultimately those who get hurt are the veterans. So if you could comment on that?

Secretary SHINSEKI. Congresswoman, I could not agree with you more. Better coordination is needed. We think we are doing good work but there is more to be done. And I think the issue here is trying to come up with a good scheduling tool that will allow us to incorporate all of the opportunity that is available in the VA system and do what you are suggesting. And better coordination will enable us to have faster access to the right quality of care that veterans need.

We need a tool to do this. Right now we are operating one that is 20 years old?

Dr. PETZEL. Oh at least, yes.

Secretary SHINSEKI. And it has been useful but it has I think, you know, it has outlived its usefulness. We need to move on and we have taken steps to do that, come up with a new tool. Let me call on Dr. Petzel here.

Dr. PETZEL. Thank you, Mr. Secretary. Congresswoman Buerkle, you bring up, as the Secretary pointed out, an excellent point. A couple of things I would like to mention. First of all, the assessment of staffing goes back a long time. This was not a reaction to an IG report. We began looking at this long before the IG was even out in the field. We appreciate the fact that they substantiated what we feel is the case, and that is that we needed to have more staffing and particularly in certain parts of the country.

In terms of the integration and coordination, let me tell you how we try to accomplish this. We have set up within the last two years a unit in our operating organization. There is a group of people that operate the medical care systems. And up until two years ago when I got here there was no clinical presence there. It was basically an administrative operation. What we have done is taken clinical people from other parts of the central office organization and put them into operations. Dr. Schohn is the person who that is responsible centrally for the operation of the mental health system out in the field. She has a lead in each network. She has a council in each network composed of the leads from each one of the medical centers. And this is the way we intend to create a uniformity of distribution of care to assure that the evaluation of care is being done in a comprehensive, thorough way. So I think that we are going to have a much better grip on the integration of our health care deliver system.

But I do want to point out that this system is without question the best integrated mental health care delivery system in this country. Nobody has the breadth and the depth of services available that we do.

Ms. BUERKLE. Thank you, Dr. Petzel. I just, if I could, I would like to make comment of my colleague from Florida about the concern that, I do not believe that the VA can do it alone. We need to partner. We recently had a symposium in Syracuse about communities partnering. And I would please ask the VA and the way you think it is going to take the VSOs, it is going to take the private sector, it is going to take communities, it is going to take the clergy and churches to work together to make sure that the veterans have what they need and what they deserve. And we have got to stop thinking in terms of silos. We as communities, we as a country must reach out and provide what it is our veterans need. I thank you all very much.

Secretary SHINSEKI. Congresswoman, I could not agree with you more. And then if you were to look at what we have tried to do in the homeless effort, the thing I think I am proudest of is we have connected from our level, the national level, down through the network directors, down through our medical centers, and out into the communities, touching all of the providers and nonprofit organizations that work with the homeless to create this collaboration that you are talking about. And it has begun to show results. So I could not agree with you more.

Mr. BILIRAKIS. The gentleman from Minnesota, my good friend Mr. Walz. You are recognized.

Mr. WALZ. Well thank you, Mr. Chairman. And Mr. Secretary, thank you and your staff for being here today. This room with you being at the point of it understands care of our warriors is our top

priority, whatever it takes. And I have said it many times, I will continue to say it. I am your staunchest supporter and I can be your harshest critic as we ask. And so when the IG reports come out we value their input to this. But I want to, I want to make several things clear. I want to thank the Chairman for holding this. I would like to ask him, and hopefully right now let us schedule the follow-up for this because you will want us to see what happens in six months and things down the line. But the Chairman is not here, but I would make mention. I was going to ask him. I think his comments in his opening statement that this is an example of government bureaucracy gone wrong, if only it were that simple. We could handle that, I think, even though a tough one there.

This issue is far broader than that. This issue of mental health parity and mental health care is absolutely fundamental, one of the issues this country needs to face. And less than two weeks ago Senator Domenici, former Senator Domenici had an op ed in the Washington Post where he stated, "mental health insurance plans still refuse to cover lifesaving mental health treatment. Others create discriminatory barriers to care, such as imposing stricter prior authorization requirements for mental health care. And sadly, underscored in a recent report by Assistant Secretary for Planning and Evaluation at Health and Human Services levels of care for evidence based behavioral treatment such as residential psychiatric services are being eliminated because of uncertainty of what is required."

This is an issue of mental health parity and much broader. Senator Domenici spent a career on this, Senator Wellstone did so also. So I take this, that we do have to come together. It was echoed by Ms. Buerkle. It was echoed here. And I think you have talked about leading this, that this is a collaborative effort. This is our opportunity to create the model. There is no private sector model to go grab to fix the problem on this. Mayo Clinic's CEO met with me last week about trying to see if I can help foster collaboration on telehealth with the VA because we know that that is Mayo's model that they are moving to with the lessons that were learned.

So this is a much broader issue. This is an issue where we are going to have to, as Ms. Buerkle said, work together to find solutions because volume numbers do not matter, good intentions do not matter, outcomes matter. And we as a Nation are going to have to address this. So I am certainly not going to be an apologist for if there is care not being delivered appropriate, timely, and effective to our veterans. That is where I will be that harsh critic. But I think we need to look at this in the macro sense of what you are saying, how we are going to get there. How we talk about those use of resources.

And I want to be clear, the past is prologue on these. When these conflicts started, we were told it would be weeks not months. And if I recall there were a couple of voices at least telling us to look longer, that there would be issues here. So we as a Congress have a responsibility to get this. It is not as easy as just saying that the entire system failed and if you just farmed it out it would work its way right. I would lay in front of this Committee if the IG did a mental health care inspection of any major health care facility or

institution in this country you would come up with results that would not get to this. So we have to figure this out.

So I guess my question is, of listening to you and hearing you lay this out and where things are going, how do we accelerate the ability to move this forward? How do we recreate this model that you have heard all of my colleagues talk about to try and get to that place? Are we moving in the right direction? I know Dr. Petzel talked about it, talked about those measures. The public is going to pick up on when care was not delivered immediately, when the scheduling was an issue, when anything else came. But how do we build that together? And I will, the Chairman is back so he can defend himself as I was going after that. But please, Secretary?

Secretary SHINSEKI. Congressman, I would tell you as I said in my opening statement, based on what I know of what we have put our youngsters through for the last ten years, and based on my own recollection of what coming home from combat is like, this has my highest priority. And I am going to drive this hard. You know, we set a priority on homelessness and we got that ball moving. And we will bring this one along as well.

Mr. WALZ. Do you think we are getting there? And I think, I hear what Ms. Buerkle is saying because my constituents are telling me that too. They want more options. They want more choices. We are probably providing more than anything. This is going to come down to a question that is a fair question for us as both the watchdogs of the care of our veterans as well as the tax dollars, I too wonder if you have the resources. I do not know where you are going to put all these people, those 1,500. I am concerned. Do you have what you need to do the job? Is this a matter of now implementation and follow through?

Secretary SHINSEKI. Right now that is the assessment that is underway, Congressman. And as soon as I have an answer if I am in need of assistance we will come and talk.

Mr. WALZ. Well, I thank you. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Bilirakis, you are now recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Thank you, General. I appreciate your service and I think you are doing a great job as our Secretary. I really appreciate it very much on behalf of our veterans. How will the 1,900 new VA mental health employees be allocated amongst facilities?

Secretary SHINSEKI. Let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary. Congressman Bilirakis, we have a tentative distribution to the networks. We are now negotiating with discussing with the networks the actual distribution to each one of the facilities. And I had mentioned earlier in testimony that we hope to know the allocations to individual medical centers within about a couple of weeks.

Mr. BILIRAKIS. Okay, thank you very much. I want to follow up on Ms. Brown's testimony and questions with regard to telemedicine. I have spoken to many in my district, both health care providers and veterans, and have learned that stigma and individual will are significant barriers for servicemembers and veterans to seek out mental health services. Can you elaborate? You mentioned briefly on the telehealth services in your testimony and you an-

swered Ms. Brown's questions. The availability is very important. How are veterans informed that such services are available to them? How can they gain the access? In your opinion, will this reduce the stigma associated with mental health services, because that is important. And also, how effective are these services?

Secretary SHINSEKI. Dr. Petzel?

Dr. PETZEL. Congressman Bilirakis, you make an excellent point about stigma. And the VA is involved in a nationwide campaign to help reduce the stigma that is associated with seeking care for mental health. Two of the things that we are doing I think are significant. One is that we are providing mental health services now in the primary care clinics. So that a patient does not have to go into a special clinic that has got a sign saying "Mental Health" on the top of the door and be identified as somebody going into a mental health clinic. They get this care as a part of their primary care. Which I think is very reassuring, if you will, to those patients. Number two——

Mr. BILIRAKIS. Do they choose these types of services?

Dr. PETZEL. We provide it, we offer it——

Mr. BILIRAKIS. —voluntarily to do the telemedicine as opposed to the face to face appointments?

Dr. PETZEL. There is some choice associated. I just want to mention, telemedicine is the same way.

Mr. BILIRAKIS. Yes.

Dr. PETZEL. It is done in the clinic and it is not associated with walking into a particular mental health clinic. In some cases there is a choice. When it is available, it is offered. I can tell you that. Most people pick up on it, but not everybody.

Mr. BILIRAKIS. Thank you very much. Again, you know, we do not really want this to be utilized in lieu of face to face. But if we can have the telehealth appointments I think that is very, very important that they get the care they need immediately rather than waiting. Do you want to comment on that?

Dr. PETZEL. Oh, I absolutely agree with you. I will just give you, my personal opinion is that in terms of mental health ten years from now 40 percent or 50 percent of the encounters that you see in mental health are going to be done by a telemental health, I think. Not, I do not mean just in this system, but I mean across the country. And I think when you, when you talk about general consultations here is what I think is going to happen. You are going to have a primary care doctor who is going to see a patient, and he is going to say, "You need a cardiology consult." They are going to dial up on their webcams the cardiologist and that consultation is going to begin right then, whether it is 200 miles away or two floors away. It is definitely the wave of the future.

Mr. BILIRAKIS. Have VA looked into partnering with private telemedicine mental health providers? You are doing that currently. I believe there is a pilot program. But do you plan to expand that?

Dr. PETZEL. Well Congressman I am not aware that we are piloting, we have a pilot going or any interactions going with other telemental health providers.

Mr. BILIRAKIS. Maybe the Department of Defense?

Dr. PETZEL. With Defense, yes.

Mr. BILIRAKIS. Okay.

Dr. PETZEL. And the PTSD telemental health program I mentioned with you before is actually with the University of Colorado, a non-VA provider. So there are some examples of that. And we would certainly encourage doing that where we can.

Mr. BILIRAKIS. Okay, very good. Thank you very much. I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Carnahan?

Mr. CARNAHAN. Thank you, Mr. Chairman. And to our Ranking Member for holding this today. And for Mr. Secretary and your team for being here, and thank you for the work you do that oftentimes is difficult and sometimes may seem thankless. So I want to start with a thank you. And I want to really talk about, we have covered a lot of the issues that came out in the report today. But I really wanted to talk about two particular veterans and their stories and what, how that fits with the reforms that you are trying to make.

I saw a young new generation veteran in the last few weeks when I was back home in St. Louis. He knew he had mental issues. He had gone to the VA. He wanted to get well. And doctors there prescribed him medicine, but he could not get into see counselors. He was not getting that follow up, human interaction that he needed. And so he had to go elsewhere, out of his own pocket. Again, just out of his own willingness to get what he needed. But whether it was capacity, or delays, or whatever he was not, you know, the VA was not serving that veteran. And so my first question about this veteran is how is this additional capacity that you have planned you think going to help with those kind of delays for that veteran and veterans like him?

Secretary SHINSEKI. Let me call on Dr. Petzel and then I will close.

Dr. PETZEL. Thank you, Mr. Secretary and Congressman Carnahan. First of all, we would like to find out about that particular individual veteran so we can contact him and get him or her into the right kind of care with the VA. The issue that the increased staffing primarily is directed at addressing is this next level. As you pointed out, this patient came in, was seen, and began some treatment. And I am assuming from what you say that his treating physician felt he needed individual therapy and that was not available, at least in a timely fashion. And these people are intended to address that specific issue. So that we do have those services available in a timely fashion. So there is not an excessive wait. So that patients when they need to be seen can and will be seen.

Mr. CARNAHAN. Mr. Secretary?

Secretary SHINSEKI. I would just add part of this is also this scheduling issue that we are wrestling with. And so we have increased the staffing to shore up what we think are requirements. We also need to see where the capacity is that is not being used and make sure that we are maximizing all of what is out there, even as we bring on the 1,900.

I just mention I think that mental health is a large issue for us and this country. CDC, and it is, you know, one of those issues that is difficult to talk about. CDC has released ten-year studies that show suicide amongst Americans, the top ten causes of death in

this country, suicide figures very prominently in it. So it is an issue out there. And then when you subject youngsters to the stress of combat repeatedly, we have work to do here. Between ages 15 and 24 suicides, 15 and 25 suicides are number three cause of death amongst Americans.

Mr. CARNAHAN. Thank you, Mr. Secretary. That really is an important segue into the other issue I wanted to raise. Another issue, time is so important in how we address these issues. On the front end when treatment is going on, but the other time factor that we encountered, we had a Vietnam veteran that served on my local veterans advisory Committee. Had been a great advocate for veterans mental health for years, took his own life. And, you know, he is somebody that again just was not getting what he needed. And some veterans I think we are missing because of this time factor of having to get into the system within five years from discharge or release. And that we also need to look at that because, again, for the doctors here we do not always catch that in that initial five-year period. And I would like to ask your comment about that. And I have also worked with several other members on legislation that would remove that five-year limit so again we are not missing those kind of veterans. I would like your comment about that?

Secretary SHINSEKI. Well obviously we are having a discussion here. I think I agree with, you know, the idea here that sometimes PTSD shows up later than this five-year policy. I do not have enough data here to be able to say that it is a, how broadly this happens. But I do know that PTSD and perhaps other mental health issues do not follow the usual clock. That they may show up later, but I just do not know how broad a, you know, an issue that is. And I am happy to try to do some research, and provide you a better answer.

Mr. CARNAHAN. Yeah, if you all have additional information. Any others that want to, can address that issue in particular?

Secretary SHINSEKI. Dr. Jessee?

Dr. JESSEE. So we have mentioned outreach a few times here. And I just would like to take a second to talk to the extent that we are doing that. We, you know, public campaigns are all well and good but sometimes people who need help do not know they need help, and they have to be brought along. We are working very closely with our chaplains, for instance, with the Guard chaplains. But most, even more so they are working with lay chaplains to teach them about the very subtle signs that their returned hero is struggling. And in many rural areas that is the only mental health provider really, are the churches.

We do that in order that they know how to get people referred into our system. The Vet Center was a brilliant program established several years ago just to bridge a trust gap but to provide readjustment counseling. Because in many cases that is what people really need. But they are very well trained to identify the higher risk people and get them into the system.

And the one other thing I just want to be very plain about is mental health issues, like heart attacks, so I am a cardiologist, I can always refer it back to that, you know the first thing you have got to do is make sure people are safe. And I think we do that very

well. We see people very quickly. We have staffed up our emergency departments with very strict criteria about the mental health capabilities in the EDs because that is where people, that is the door to the hospital that is open 24/7. And we have to make safe and secure. And the one thing in the IG report is this first 24—hour evaluation and we do that well. So the safety piece I think is front and foremost. But outreach also means bringing people in. And as you say often it may take a lot longer time for them to come to grips with the fact that they have got a problem. The more we can work with them coming home the better we will be at that.

Mr. CARNAHAN. Well again, thank you. And thank you, Mr. Chairman. And I look forward to working with you all on that issue of that five-year limiting period to see really what the magnitude of that issue is in terms of who we are missing. Thank you.

The CHAIRMAN. Mr. Turner?

Mr. TURNER. Thank you, Mr. Chairman. Thank you, Mr. Secretary. Many mental health problems are accelerated and exacerbated through drug and alcohol abuse. Are you making use of any of the NGOs, particularly AA and NA, incorporated into these programs to kind of address the problem of drug and alcohol abuse?

Secretary SHINSEKI. There is certainly some tangentiation here between some of the mental health issues and also, you know, self-medication if you will. Let me call on the experts to be able to address this.

Ms. SCHOHN. In our drug and alcohol programs referral and use of AA and NA or other self-help groups for issues is often a critical component of it. So the VA recognizes that it is not just the VA itself that really has to be working to address these issues but that we do need to partner with community resources, particularly for times when a veteran is not in treatment and when he goes home and needs resources in the community. So it is a critical component of the care. And I will turn to Dr. Zeiss to add more.

Ms. ZEISS. Or one additional thought. We do work very closely with the Office of the National Drug Control Policy. And they have actually stressed that VA's substance use care is a model in terms of how it is integrated with mental health care and how we partner with nongovernment agencies, but also provide that integration with care in VA. And we certainly work with them, the ONDCP, on their yearly national policies and strategic goals. So we definitely are trying to partner on this issue as on others.

Secretary SHINSEKI. Congressman, if I would. I am the non-clinician at this table. My other concern is do we overmedicate and create some of the problems? I do not know the answer to that, but I get paid to ask the questions and get assured that we have good controls and good balance so we are not creating on our own the kinds of issues that you are referring to here.

Mr. TURNER. All right. Thank you, Mr. Secretary. I yield back.

The CHAIRMAN. One quick comment. I would hope that organizations that have a faith-based component are not squeezed out of the process. The fear that I have, and not just at VA but also within DoD and other Federal agencies, is that we do not allow these organizations to participate because they do have that component. I do not think at all that is anybody's intent at that table, but just to comment.

Secretary SHINSEKI. Fair enough. I will go take a look at it, Mr. Chairman.

The CHAIRMAN. Mr. Stearns?

Mr. STEARNS. Mr. Chairman, thank you very much. And Mr. Secretary, thank you very much for serving and for all you are doing under some difficult situations, obviously. I have got before me some audits of the VA Health Administration outpatient waiting times. And I have got another one dealing with outpatient scheduling procedures. And when you look at those I guess you wonder, you announced on April 19 of this year that you are going to hire 1,900 new mental health staff, is that correct?

Secretary SHINSEKI. That is correct.

Mr. STEARNS. And I guess the question is based upon these audits of the VA Health Administration how can you assure, I guess, to the Committee that these new employees, the 1,900 new employees, and perhaps even the current employees, are going to receive the proper training considering I guess these audits have indicated otherwise? And this goes back to 2003. So from 2003, 2004, 2005, 2006, 2007, on up they are saying that they have not got the training. So I guess the question is the Committee just wants to have an understanding that the new 1,900 are going to get the proper training? Is that legitimate, Dr. Petzel?

Dr. PETZEL. I will make an opening comment and then I think I will turn to the two mental health experts. There will be a period of orientation for anybody that is new to the VA, whether it is a licensed counselor, a pastoral counselor, a psychologist, a psychiatric social worker, a nurse mental health clinician, or a psychiatrist, they will all have an orientation to VA. An orientation to our approach to the treatment of the various kinds of disorders that we might see in our patients. So with that I would ask briefly just describe what happen?

Mr. STEARNS. Maybe the question is for your experts, are they aware of these audits, and what the audits have said about outpatient waiting times and outpatient scheduling procedures? How——

Dr. PETZEL. Let me ask Congressman Stearns, are you, is that the audit that addresses the scheduling clerks?

Mr. STEARNS. Yes, that is one of them. Yeah.

Dr. PETZEL. The scheduling clerks, sir, do undergo annual training and annual certification to demonstrate that they understand the scheduling procedures. But as we have said earlier we have a task force that is looking at the way we do scheduling in mental health as well as in every other area to try and simplify and clarify the scheduling task so that we can do a better job of saying how long someone is waiting to get an appointment, how long it takes for them to get an appointment. We agree with the IG in a general sense in terms of the recommendation, and that is that we have to find a better way of measuring the scheduling time. So yes.

Mr. STEARNS. Okay. You know, when I looked at some of the definitions here I think the VA has claimed about a 95 percent success rate in seeing veterans within 14 days. However, I guess a IG report this year indicated that the VA has been measuring when they see the veteran to conclusion not when and how long from their request, which averages about a 50 days wait. Does that seem

logical? Is that a fair explanation? That the IG report does not agree with your 95 percent success rate in seeing veterans within 14 days?

Dr. PETZEL. That——

Mr. STEARNS. Do you disagree with the IG?

Dr. PETZEL. That, Congressman, is an appropriate conclusion, that they did not agree with our 95 percent. That is correct.

Mr. STEARNS. So do you agree with what they said, that it is an average of 50 days wait? Do you agree with what they say?

Dr. PETZEL. There is some discussion with the IG, Congressman, about the way they measured versus the way that we measured. And while we——

Mr. STEARNS. Do you think they are wrong?

Dr. PETZEL. Sir, while we agree with their recommendation that we need to have a better system of scheduling so that we can measure the wait times, do not necessarily agree with the fact that only 49 percent of the people were seen in a particular period of time.

Mr. STEARNS. Okay. You mentioned earlier that the model used to measure wait times came from the previous model from the VA. What in the previous model has kept and what was changed or improved? I guess maybe a better understand of what, have you changed the model? Or have you used the model complete from the previous ways you have done this for the wait time?

Dr. PETZEL. Congressman Stearns, in——

Mr. STEARNS. It seems that the IG and you are having a little trouble understanding these procedures. So I am just trying to understand what model you are using.

Dr. PETZEL. The, Congressman we changed our method of measuring wait times to desired date. I explained this earlier in the hearing.

Mr. STEARNS. Okay.

Dr. PETZEL. Desired date back in 2007.

Mr. STEARNS. Yeah.

Dr. PETZEL. And there is another way to do this called create date.

Mr. STEARNS. Yes.

Dr. PETZEL. And the discussion with the IG is around the appropriateness of using desired date or create date. And our intention is after our task force comes to an agreement about what we need to do in the future to work with the IG so that we agree about the way to measure waiting times.

Mr. STEARNS. Okay. Mr. Chairman, it looks like we have got the difference between desire date and a create date. Is that not what you are saying? That there is a difference between you and the IG in those areas? Is that——

Secretary SHINSEKI. There is a third measure called capacity, I believe.

Mr. STEARNS. Okay. So between those, the capacity date, the create date, and the desired date, that is differentiation, the IG is not completely in agreement with you? Is that a fair statement or am I missing something?

Dr. PETZEL. I think that is a fair statement, correct.

Mr. STEARNS. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Stearns. Ms. Brown, closing comments?

Ms. BROWN. Thank you. Thank you, Mr. Chairman, and thank you for holding this meeting. And thank you Mr. Secretary for coming and bringing all of your people that is involved in the area of mental health. There are just a couple of points that I want to make. I want to first of all thank the President and the First Lady for their initiative including the entire family. And I hope as we develop mental health programs that we realize that it is not just the person in the military but it is the entire family that is involved, and making sure that we include it and make it inclusive of the entire family, the sessions, the programs, as we move forward. Because that person, that spouse, or that mother, whoever is with that person, knows that that person needs assistance even if that person that needs the assistance do not know it. So let us make sure we have some way to evaluate and include the family.

Secondly, we need to make sure we are evaluating that provider. Because the person that had a complete breakdown at Fort Hood was someone that was working for the government and was working in the area of mental health. So we need to have some checks and balances working with that person, obviously under stress, you know, doing the counseling, doing the advising. And so we need to make sure we include that.

And I want to once again thank all of the professional people that we have working with us. And just mention that the Chairman asked me to have a round table kind of hearing next Monday, May 14 and 15 down in Orlando about the Orlando facilities and meeting with the contractors and the VA to discuss how we can be online and changing the subject, but making sure that my hospital is one that will come in for our veterans that we have been waiting on for 25 years efficient, cost effective, and ready to operate as soon as it opens up, Mr. Secretary.

Secretary SHINSEKI. I hear you, Congresswoman.

Ms. BROWN. Thank you, Mr. Secretary. And with that I will yield back the balance of my time.

The CHAIRMAN. I think the lingering question in today's hearing from the department's perspective is if you have a vacancy rate of 1,500 individuals, and you are talking about hiring an additional 1,900, 3,400 new hires, how in the world are you going to accomplish that in a timely fashion in order to provide mental health care to the veterans who need it today? I do not know if you want to take that for the record, or if you want to respond. I do not think anybody at this Committee believes that you can quickly hire 3,400 plus people.

Secretary SHINSEKI. Fair enough. And I would like to take that for the record. But Mr. Chairman, if you think that we can achieve a zero turbulence turnover rate, you know, it is not going to happen. We will always have a working set of numbers because we do not require people to give us warning two years out that they are going to make a change decision, you know, in their lives. Sometimes we get it in about 30 days.

The CHAIRMAN. But even if you use the rate, though, that Ms. Spiczak quoted earlier of 7.5 percent, or even double it. Say 15 percent, even if you have a 15 percent vacancy rate you are talking

about a tremendous lift. Not that the veterans do not need those people out there, but the department has been unable to fill 1,500 slots. Now you are putting 1,900 plus on top. And if you would I look forward to your——

Secretary SHINSEKI. Fair enough. Let me provide that for the record. But I would say most large organizations, 7 percent turnover is not unexpected.

The CHAIRMAN. But I would say that you have got higher than 7 percent at this point. If I would, also, before you leave, Mr. Secretary, I want to ask that you work to provide the Committee with a couple of things that we have requested. And I would go ahead and outline them for you. On 29 November of 2011 we requested information on VA's SES bonus review. And after repeated follow ups with the Congressional Affairs Office I still await an answer for that.

On the 19th of April of this year we asked for information regarding VA facility activations. To date after again repeated inquiries there have been no information provided to us.

And then VA provided the Committee a delivery date of today for the Committee's post-hearing questions in connection with the February, the February budget hearing. And just a reminder, we continue to await those responses. I have got a couple other outstanding requests that the Committee staff will get to yours. But I ask a renewed effort from VA and a timely response to our Committee requests. I know that you are responding to our requests, as well as the Senate as well. But I would ask that you look into these and the others that we provide. And I thank you for providing the Committee your personal testimony today, Mr. Secretary. I appreciate you being here. And with that the first panel is excused. Thank you.

Secretary SHINSEKI. Thank you, Mr. Chairman, and the Committee for your courtesies and generosity. Thanks.

The CHAIRMAN. I will go ahead and call the second panel forward if we could. I apologize for the confusion. But joining us as the new second panel, because we did separate them from Secretary Shinseki's panel, Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections; and Linda Halliday, the Assistant Inspector General for Audits and Evaluations. Thank you both for agreeing to speak with the Committee this morning. And you are recognized for your opening comments.

STATEMENTS OF JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND LINDA A. HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF JOHN D. DAIGH, JR.

Dr. DAIGH. Thank you, Mr. Chairman, Ranking Member, members of the Committee. It is an honor to be able to testify before you here today. I and my staff from the Office of Healthcare Inspections address current clinical issues in VA on a daily basis and

I do believe that the leadership and employees at VA strive hard to provide the highest quality medical care possible. I also do believe that VA provides veterans with high quality medical care, to include mental health care.

The report that we published focused on access to care standards, which I think need a great deal of work as our report outlined. VA, though, however, is a leader in quality of care standards and has done a great deal of work in that area.

Listening to the comments made earlier, I would like to make a couple of comments. The first would be I think that the IG has worked for a long time, over five or six years at least, to get VA to develop what I would call staffing standards in order to be able to answer the question of how many people do you need to do any one particular job? Be it nurse staffing standards, or medical specialist staffing standards. So I think that VA needs to focus on its business practices in order to have the relevant data available to address the need and timing of hiring 1,900 people as they have indicated that they plan to do.

I would also be remiss if I did not indicate that there have been several software projects which have not been successfully concluded over the last period of years. One would be the scheduling effort, which was not successful several years ago and which I think VA does need a better scheduling platform. And the other two would be the Core FLS platform and Flight, both of which were financial systems which would allow the gentlemen in the first panel to have I think more accurate data on productivity and related issues that would allow them to make a better business case for the changes they think are required.

With that I will end my testimony and invite Ms. Halliday to comment.

[THE PREPARED STATEMENT OF JOHN D. DAIGH, JR. APPEARS IN THE APPENDIX]

STATEMENT OF LINDA A. HALLIDAY

Ms. HALLIDAY. Chairman Miller and members of the Committee, thank you for the opportunity to discuss the results of our recent report on veterans access to mental health services at VA facilities. We conducted the review at the request of the Senate and House Veterans' Affairs Committee and the VA Secretary. Today I will discuss our efforts to determine how accurately the VHA records wait times for mental health services for both new and established patient appointments. I am accompanied by Mr. Larry Reinkemeyer, our Director of our Kansas City Office of Audits.

Our review found that inaccuracies in some of the data sources and inconsistent scheduling practices clearly diminishes the usability of information needed to fully assess current capacity, resource distribution, and productivity across the system. In VA's fiscal year 2011 performance and accountability report VHA reported 95 percent of first time patients received a full mental health evaluation within 14 days. However, we concluded that the 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 for the evaluation. Using the same data that VHA used to calculate 95 percent success

rate shown in the PAR report, we calculated the number of days between the first time patient's initial contact in mental health and completion of their evaluation. We projected VHA provided only 49 percent, or approximately 184,000 of the evaluations, within 14 days of either the veteran's request or a referral from 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 then 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 appointments nationwide exceeded 14 days. In comparison VHA's 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 within 14 days of the desired date. Thus, approximately 1.2 million, or 12 percent appointments, exceeded 14 days nationwide. In comparison, VHA reported 98 percent received timely care for treatment. We based our analysis on dates documented in VHA's own medical records. However, we have concerns regarding the integrity of the date information because providers told us they use the desired date of care based on their schedule availability. This is in direct conflict with the VHA directive. VHA should not use that, the date the patient requests.

I want to point out that we reported concerns with VHA's calculated wait time data in earlier audits of outpatient scheduling procedures in 2005, again outpatient wait times in 2007. During both audits we found schedulers were entering incorrect desired dates. And our current review shows these practices continue. For new patients the schedulers frequently stated they used the next available appointment slot as their desired appointment date for new patients. This practice greatly distorts the actual waiting time for patients. To illustrate, VHA's data showed 81 percent, or approximately 211,000 new patients, received their appointments on the desired date of care. We found veterans could have still waited two to three months for an appointment and VHA's data would show a zero 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 that exact day the patient desired. In conclusion, VHA needs a reliable set of performance measures and consistent scheduling practices to accurately determine whether they are providing patients timely access to mental health services. And they need to ensure the desired date of care is defined by the patient without regard to schedule capacity. That would be true as to whether they use the create date or the desired date of care.

Mr. Chairman, I would be happy to answer any questions.

The CHAIRMAN. Thank you very much for your report and your testimony. You have talked about the string of IG reports finding serious deficiencies and inaccuracies within the appointment scheduling and the performance measures that VA uses. Since you have begun your investigations and found fault with their scheduling processes and procedures, I think the Committee would like to

know has it gotten better. Or has it gotten worse? Because we have spent hundreds of millions of dollars in the process. What have you seen?

Ms. HALLIDAY. We went to four sites as part of this review. At three of the four sites, we found schedulers were not following VHA's own directives. That is a pretty compelling number, 75 percent. I cannot say it is getting better. I think that we were surprised at the delta that we saw between the 95 percent that VHA had said they had provided timely care for veterans and the 49 percent that we saw for the new patients, and then again, the difference with the follow on appointments. So I cannot say it is really getting better.

The CHAIRMAN. You may or may not be able to answer this question. But is it better for the veteran to accept a scheduling date that fits an open slot at VA? Or is it better for the veteran to get the care and the appointment when they need the care?

Ms. HALLIDAY. I am going to let David Daigh respond.

Dr. DAIGH. I think we would all agree it is better to get the care when they need to get the care.

The CHAIRMAN. And is it your testimony just a second ago that that is actually not what you found they were doing? That they were actually filling open slots, but not necessarily when the veteran needed the care?

Ms. HALLIDAY. That is correct.

The CHAIRMAN. Thank you. Ms. Brown?

Ms. BROWN. I guess I am concerned. Are you saying that the veterans, because they indicated, I guess you heard the testimony with the number of, did you test any of their stakeholders or partners that they was working with? Or you just did the VA?

Ms. HALLIDAY. We looked at the VA information to examine whether there was data integrity behind it. So we concentrated on the 10 million appointments for new patients and established patients. And those appointments, because they include follow up, really represented about 1.3 million unique veterans needing care.

Ms. BROWN. And your findings, would you expand on that a little bit? Because you said you went to four facilities.

Ms. HALLIDAY. We looked at scheduling procedures four facilities. What was the time it took to evaluate new patients getting care after the point of the first triage. We did feel VA did a good job when a patient made their first contact, saying they needed mental health services and there is a triage. And then from there they conduct a mental health evaluation. Based on what VA was reporting you would say that the majority of evaluations were accomplished in 14 days or less. We did not see that. And we also saw a very high number of patients that waited zero wait days. And it was basically because of the way the schedulers were inputting the information. What we are saying there, is that we did not think that information was plausible.

Ms. BROWN. Okay. And what are some of the recommendations that you all made?

Ms. HALLIDAY. We offered three recommendations in the report. To ensure a full mental health measurement is calculated from the veteran's initial contact with the clinic or the veteran's referral

from mental health, we want VA to put in place an access to care measure that measured the time a veteran waits for that care.

Ms. BROWN. On that point, what was mentioned earlier was that the veterans do not always come directly to the VA. They may be coming through an emergency room, or some other resource. Were you able to measure that? In other words, basically they are not walking into the VA and saying, "I need mental health services." Or calling. They are getting referred through other means. So did we compared that wait time?

Ms. HALLIDAY. No. We compared the point of when the veteran makes the contact, or there was a referral from a mental health provider that the veteran needed care. We do recognize that veterans seek care and come through different avenues in VA. But I think that our information, as I said before, was based on 10 million appointments nationwide and 1.3 million unique veterans seeking care. So it is a pretty good representation of what is happening in VA at this point.

Ms. BROWN. And you gave one recommendation. What were the other two?

Ms. HALLIDAY. The second was to reevaluate the mental health performance measures that could more accurately reflect the patient experience. As both Dr. Daigh and myself have said, VA needs a new set of performance metrics to measure to really know how long veterans are waiting for appointments. And then the third was to conduct a staffing analysis to determine if vacancies represent a systemic issue impeding VHA's ability to meet timeliness goals and if so to implement corrective action plans. This had been discussed well in advance of our report with the senior people in VHA. So, you know, it seemed logical to move forward on that. We believe based on what we heard at the sites that the vacancies for psychiatrists and mental health professionals were impeding the ability to provide all the services needed.

Ms. BROWN. I guess my last comments, but I guess you all did not do any evaluation on it, because I personally do not necessarily think that all of the services have to be in VA. VA could work with some of the other stakeholders. People in our community are providing mental health services every single day. They are just not getting reimbursements for it. And is there any way that we can measure the quality of some of these providers? Because the problem is that I do not necessarily think that we need to hire millions of psychiatrists because they do not even exist. But there are many levels of mental health professionals that could work in partnership with the VA and the VA making sure we have a certain standard of service, and working in conjunction with other stakeholders. I guess this is the only time I have ever supported outsourcing to some degree. Whew!

Dr. DAIGH. Ms. Brown, I think I would agree very much with you. If you take a look at the number of psychiatrists VA has on board, between last year and this year it actually went down. Over the last years, last four years, when they got a bonus of money they increased it by 600. So I think it will be difficult for them to hire new psychiatrists at any significant level.

Ms. BROWN. But you see, I do not necessarily think psychiatrists that, you are at a different level.

Dr. DAIGH. Right.

Ms. BROWN. I do not necessarily think everybody needs a psychiatrist.

Dr. DAIGH. Right, I——

Ms. BROWN. —they need, you know, it is the whole list of different kinds of services people need. When I said, when I went out to LA and saw the telemedicine, I was surprised that the veterans really like it. I would not like it at all. But they was very pleased with the services. But they are a different generation. I am old school. And the new school like the telehealth.

Dr. DAIGH. And we did a report a couple of years ago on access to mental health care in Montana. And in Montana VA had actually used the community mental health centers and linked up with them. And we showed where that made a dramatic impact on their access to usually not psychiatrist but the staff at the community mental health center. We found there thought that substance abuse treatment, however, was difficult to hire at that level. And so I think we would agree very strongly that there are not the resources for VA to hire as, or I am doubtful that they will be able to hire them as they say they will. And we think there are sources that they should look at within the community of non-VA providers.

Another source of providers would be how their own employees spend their time. So VA has several missions. One mission is patient care. One mission is research. One mission is training. There are several others. A physician can allocate their time between several different missions. So if the priority mission, which it is not currently stated as the priority mission, were patient care then one might align their time more with the primary mission. The FTE data are often FTE allocated to patient care, not the total on the employment roll.

The second area they might look at is VA has wonderful arrangements with academic medical centers.

Ms. BROWN. Yes.

Dr. DAIGH. All of whom have significant psychiatric staff. So there might be some room to, you know, to get some benefit there. And then the third would be outsourcing as you described with community mental health centers and other areas like that that I think would be useful.

Ms. BROWN. Or working with the universities. I mean, we partner with them in many different areas. But I will yield back my time and maybe I can get additional time to ask additional questions.

The CHAIRMAN. Mr. Stearns?

Mr. STEARNS. Thank you, Mr. Chairman. You heard earlier that the VA was talking about the three ways they define this waiting time. The capacity date, the desired date, and the create date. When you did your report in which you said, "our analysis projected that the VA provided only 49 percent, or approximately 184,000, of their evaluations within 14 days. On average for the remaining patients it took the VA about 50 days to provide them with their full evaluations." Were you using the create date as a model? Would that be a fair statement? Or is, are you using a different definition than the VA is using?

Ms. HALLIDAY. At the time we did the review we looked at the desired date. VHA's policy says the desired date should not be the date of clinic availability, it should be the date the patient requests or has a medical referral. The create date was used years ago and there were problems with that at that time. VA is now proposing to bring the create date back and use it again to rely on as a performance metric. I think if they clearly define it and put the right scheduling procedures in place to ensure it is at the point the veteran contacts and requests care, or gets the referral from a provider, it will improve the system.

Mr. STEARNS. So you, what I just read from your report was based upon when the veterans desired to be taken care of? And you said it actually was 50 days, whereas the VA is projecting 14 days. And I guess they are using that 14 days, so they must be using the capacity date or another type of thing. Is that true?

Ms. HALLIDAY. We looked at the desired date of care.

Mr. STEARNS. Yeah. You know, if you went out to the private sector and you said, "Okay, let us look at the capacity date." The capacity date is when the company could deliver the product, or when they could deliver the resources for the patient. Well, the patient is not really interested in whether you have the capacity. They just want to get it taken care of. So the whole idea of a capacity date seems to be a source of confusion because no one is interested when, what capacity, I mean, if you do not have the capacity then the date could be a hundred, ten years. I mean, if you do not have the capacity, that is not what we should be striving for. And as far as the create date, it seems to me that is more accurate. The desired date is what the customer wants, I understand that. But also the create date is based upon the physician recommended and also I guess based upon what the patient has recommended? I am having a little trouble understanding between the create date and the desired date. Go ahead.

Dr. DAIGH. Sir, the measurements are between two dates. So we have a time, how long it takes for something to occur.

Mr. STEARNS. Right.

Dr. DAIGH. So if you call in and say, "I would like an appointment." That would be the create date.

Mr. STEARNS. Okay.

Dr. DAIGH. You called in and the scheduler stamps that you called in on that date.

Mr. STEARNS. You called in today, you will get an appointment in two days.

Dr. DAIGH. Right. So if you desired an appointment in two days, then that date would be two days.

Mr. STEARNS. Mm-hmm.

Dr. DAIGH. But if the next available appointment was in a week then that date would be seven days.

Mr. STEARNS. And that would be the desired date?

Dr. DAIGH. That would be, well the desired date would be whatever you tell the scheduler.

Mr. STEARNS. Okay.

Dr. DAIGH. And then the actual date that the appointment was made on would be the next available appointment date.

Mr. STEARNS. Yeah. It just seems to me that if you are trying to make the customer happy, which is the veteran, and we have, we have given the Veterans Administration more money every year, sometimes as much as 18 percent a year, it seems like you should come up with one date and that should be the date that basically when the customer wants to be taken care of, if the customer is the one we are trying to satisfy. We should not be talking about when the VA has the capacity because that is all nebulous. It could be a long time.

Dr. DAIGH. One of the considerations, sir, is the cost of getting data. So the scheduling systems are designed to create certain data streams accurately. And if you create a metric that the scheduling system will not easily give you a reliable data stream for, for example the difference between, "I want to be seen on this day," and the appointment was actually made on that date, then it creates business rule problems for the actual schedulers. And in that it then makes the data set VA is using unreliable. So I am only saying, sir, that in the mix people need to look at what they are asking for.

Mr. STEARNS. Well I think the bottom line is you said it takes 50 days to provide this roughly 200,000 veterans with their full evaluation. That is what you are saying. And that is not good. And that should be changed. And I think that is, no matter what we are talking about, a capacity, a desired, or a create date, the bottom line is veterans, almost 200,000, are not getting serviced. And the Veterans Administration can use whatever terminology and definitions they want, but by golly these guys and gals are not getting taken care of and that is why we are here today. So thank you.

Ms. HALLIDAY. We agree.

The CHAIRMAN. Mr. Walz?

Mr. WALZ. Thank you, Mr. Chairman. And thank you both for your work. And I think that, again, if there is one veteran not being served on time that is one too many. Following up on what Mr. Stearns was saying, is there a private sector comparison? Not just to widgets, but to people with mental health issues? I brought up earlier that I think this is a broader issue of mental health parity and access to care. One of the things that is hard to measure is if you are denied insurance coverage for this your wait time is forever. There is no denying of care in the VA system. Everyone, and PTSD has been there. So with that being said, and not to, because I still think the wait time is too long and I want to figure out how that scheduling nexus with that, do you have data to show how the private sector is doing this on mental health scheduling?

Dr. DAIGH. So yes, sir, we have some. We went out and talked to three of the larger entities that provide comprehensive mental health care. And talked to them about their metrics. The first point they made was that they have seen an increase in demand of 15 percent to 20 percent over the last couple of years as VA has, they say probably from the economic downturn. And then they have a variety of metrics, both in terms of timeliness within which you get your appointment. So they would say for a new patient appointment, you call in being day one. You get your appointment, that being day two. That time span ought to be about 14 days for a new patient appointment. And then for follow up appointments people

often use capacity measures. For example, for PTSD it is desirable you get a certain set of appointments in a certain set of time. For oncology, for cancer therapy, it might be desirable——

Mr. WALZ. And those are based on best practices inside——

Dr. DAIGH. Right. So you might then say, "How many appointments, did these patients with these disorders get in the last 65 days?" So there are a variety of measures, usually driven directly off the appointment scheduling system, that are as close to reality and cost effective as it is to get the data and use it, that people use to try to manage their capacity being the number of patients that they can see.

Mr. WALZ. Does anybody have anywhere close to the capacity of the VA?

Dr. DAIGH. I do not think so, no.

Mr. WALZ. I mean, I am just wondering if there comes a diminishing return or if this is a program that should be exponentially be able to grow, to assume that. So if you have ten patients you should be able to schedule them the same way if you have 10,000 or 10 million.

Dr. DAIGH. Well the scheduling is all a very local issue. So if you are in charge of a clinic, your job is to manage a clinic, then you have to come in in the morning and see what no shows you have in your schedule, and how you can juggle the people you have to meet the demand that you have. So every physician's office deals with this problem, whether it is an institution——

Mr. WALZ. That is right. And your assessment was, though, it is not uniform. That there were some of these places were not as good at it as others. And if you rose, or pulled the standard up on some of these you would start to see improvements?

Dr. DAIGH. I think if VA would improve some of its business practices, and had a scheduling system that allowed it to leverage the data in a scheduling system accurately, I think they could manage their patient workload, or capacity, much better than they are currently doing.

Mr. WALZ. Very good. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Walz. You know, I think the thing that we are seeing is a very clear picture of VA hiding and manipulating numbers, for whatever reason. Of waiting times, of appointments, of statistics. Look, we all want the veteran to be seen when they need to be seen. We do not want them to be medicated with only drugs. We want them to get better. Thank you to the IG again for bringing these issues to the table. I hope somebody at VA is listening. Because if you are not, you are the only ones that do not hear the message that is being delivered by any number of people, including the IG. And I am sure the next round of witnesses will be bringing similar information to the table for us as well.

I would ask Ms. Brown if she would waive her next round of questions, only because we have a series of votes coming at the bottom of the hour. And I would like to try, if we can, to get to all of the witnesses that have very patiently waited. But if you have a question that you need to ask I would go ahead and yield to you at this time.

Ms. BROWN. No, sir. But as they change maybe I could have 30 seconds to say that I would just kind of disagree with the Chairman that they are trying to manipulate the numbers. Maybe we are reading them differently. And maybe we can get some clarity on how we are spelling out what the VA is saying and how we can better clarify.

But basically, we all want the same thing. We want the veterans to get service. And there are many ways that we need to define that. And it is not just, like I said, and what was said earlier, they are coming to us from the emergency room, they are coming to us in many different ways. And we need to make sure that we are utilizing the taxpayers' dollars and providing the service in the best efficient way. And I am interested in working with our stakeholders and partners. There are many universities that work very closely with the VA in the mental health area. How, you know, I would like some explanation of how this is working. University of Florida in Gainesville and Shands in Jacksonville work very strongly with the VA and they work in partnership. Did we capture that in any way? And how can we better serve the veterans?

You know it is a lot of, we have got a responsibility. It is not just the VA. It is all of us working together. And so Mr. Chairman, you know, I am not disagreeing with you. It is just that it is not us against them. It is, you know, one team, one fight. That is the Army's motto. And we are all in this fight together.

The CHAIRMAN. I thank you very much for your comments. And I would say, though, that if you are the one that is designing the metric it is very easy to decide a positive outcome based on that metric. And so I have got to say that everybody else understands and hopefully VA will pick up on that. With that I would say thank you very much for your testimony and I would like to call the next panel forward.

Ms. BROWN. Mr. Chairman, I do know that you all agree that we do not need to give them no more work, though. In other areas, like housing or labor.

The CHAIRMAN. I thank you very much to the next panel. Thank you for bearing with us while we separated the first two panels.

We are joined now by Nicole Sawyer, licensed clinical psychologist and former local evidence-based psychotherapy coordinator for the Manchester VA Medical Center; Diana Rakow, the executive director of Public Policy for Group Health Cooperative; Dr. James Schuster, the chief medical officer for Community Care Behavioral Health Organizations; and Thomas Carrato, retired rear admiral for the United States Public Health Service, now the president of Health Net Federal Services.

Thank you very much, and, Ms. Sawyer, you are recognized to proceed with your testimony.

STATEMENTS OF NICOLE L. SAWYER, LICENSED CLINICAL PSYCHOLOGIST; DIANA BIRKETT RAKOW, EXECUTIVE DIRECTOR OF PUBLIC POLICY GROUP HEALTH COOPERATIVE; JAMES SCHUSTER, CHIEF MEDICAL OFFICER, COMMUNITY CARE BEHAVIORAL HEALTH ORGANIZATION OF UNIVERSITY OF PITTSBURGH MEDICAL CENTER; THOMAS CARRATO, PRESIDENT, HEALTH NET FEDERAL SERVICES

STATEMENT OF NICOLE L. SAWYER

Dr. SAWYER. Thank you.

Members of the Committee, thank you for inviting me to participate in this important discussion. I am a licensed clinical psychologist. My primary focus is the treatment of trauma with both veterans and civilians.

I have worked in a number of clinical settings. However, my testimony today will be focused on my work at the VA medical center from which I recently resigned.

My goal today is to share with you some of the impact that VA culture and common practices have on our veterans as well as the impact it has on the ability of our skilled clinicians to provide effective mental health treatment.

Let us consider the fact that many of the men and women who seek mental health care at VA medical centers have been faced with decisions and taken action on matters far exceeding the imaginations of most.

But the decision to seek mental health treatment is for many of them an admission of failure, an inability to hack it. This decision feels humiliating and shameful. Many of them have spent years trying to hide these invisible wounds. They have avoided feelings and memories. They have pushed loved ones away and many of them have contemplated taking their own lives.

Some of them fear the part of themselves that was so capable of those deeds over there. Some vow to never let anyone know what they have seen, who they have hurt, or how it felt to do it.

Choosing treatment takes a series of gut-wrenching decisions. Admitting the need for help is the first one, making the telephone call is the second, showing up for the appointment is the third, but the fourth is the heaviest of all, actually speaking the pain.

Endless research and certainly my experience informs me that the closer together these three decisions occur, the more likely the veteran will commit to treatment. This is not rocket science. The more rapid the decision making process, the less likely any of us are to let our doubts and fears get in the way.

But VA health care facilities as was demonstrated in the recent OIG report leave a majority of veterans waiting more than 50 days to begin treatment.

In my experience, nearly 70 percent of the work of combat trauma treatment is in telling the trauma. Acknowledging the pain, the regret, the guilt, the shame that are associated with their experiences marks the beginning on the road to recovery, but it is not the beginning of treatment.

Treatment begins with trust. But trust for the combat veteran does not come easy. Trust is the belief that they will not be judged; that their feelings will be validated and accepted no matter what

they are, and that despite having told these things to another person that he, the veteran, remains in control of that information.

These are people who have done things, they have seen things, they have felt things that would be considered horrendous and evil if they happened at home.

For many of these men and women, trust in another person is a myth. Now, do not get me wrong. A soldier knows trust. He knows what it is to believe that the man next to him cares as much about his life as he does.

But to trust in a person who does not share those experiences is an incredible risk. Most VA clinicians understand this. They respect the pain. They are well-trained and they are dedicated. While most do not know the pain themselves, they do know what it takes to connect with their veterans and they understand the importance of trust.

But trust takes time. I appreciate the secretary's stated appreciation for this in his testimony, but time is not what most VA clinicians have when it comes to treating their veterans. Psychotherapy is a process, not a prescription. It is work that takes time.

For some of us, our strategies for coping and understanding the world and our experiences lead us astray and we find ourselves drifting or trapped in patterns that are harmful and destructive. Psychotherapy is intended to steer us back on track, but it requires the patient to trust in the process, and in the clinician to be successful. The VA fails to value the importance of trust.

Trauma treatment demands a session every week or every other week. Too much time between sessions allows suffering to linger too long after wounds have been opened up. And that suffering can lead to retraumatization, strengthening of those negative patterns, and loss of trust.

Effective treatment requires a full evaluation of needs and appointments should be scheduled as often as the veteran needs them. But both of these vital factors of effective care were noted to be chronic nationwide failures by the OIG report.

We let down our veterans and we set our clinicians up for failure. But the hidden tragedy in this whole thing is that many of the veterans failed by the system blame themselves. Like most people, they do know what effective mental health care is supposed to look like, they assume that they have failed to get better and they are too far gone to be helped.

As I mentioned, VA sets its clinicians up for failure too. Staffing is an obvious weakness in VA mental health care and last month's announcement of 1,900 additional staff is a welcome attempt at improving the situation.

But how do we know 1,900 is enough? The VA lacks any expectation for clinical productivity. There is no way to identify a clinician's caseload as full and, therefore, it is impossible to know if the flow of veterans into the service exceeds the capacity of its providers.

Developing a model for clinician caseload must be a priority for VA. Community mental health clinics and other mental health facilities have defined expectations for their clinicians. With a defined caseload, a clinician can make the time necessary to write

session notes, do treatment plans, consult with other providers, and return patient phone calls.

All of these tasks are demanded by the ethics that govern all of mental health professions and, yet, in my experience, they are seen as luxuries at the VA.

At my former VA medical center, clinicians could easily have hundreds of veterans assigned to them for care and that number grew daily as new veterans walked through the door.

Clinicians are virtually gagged under these circumstances. They cannot do their jobs. They will not rip open those trauma wounds only to let them fester untreated for weeks or even months until that next appointment. Clinicians are set up for failure and the veterans lose.

The VA struggles to fill the 1,500 vacancies already out there and now there will be 1,900 more positions to fill. But this problem has an additional concern. Where are we going to put all these new folks? Many VA facilities across the Nation simply do not have the space for more clinicians.

Where I worked, some clinicians dragged carts around the hallways because they did not have an office. This is not simply inconvenient. It is unprofessional and demeaning for the clinicians and has a significant impact on the veterans.

Safety in their space and predictability in their environment are important to many veterans struggling with PTSD. Attending therapy sessions in whatever office is available each time they arrive can be very distressing and lead to dropping out of treatment.

The VA has professionals with advanced degrees, passion, and the expertise to help our veterans, but often these highly-trained clinicians must set aside their own clinical judgment in response to requirements dictated by central office, performance measures, and other mandates.

Unfortunately, I have heard this story echoed across the Nation. It is not unique to just one or two facilities.

I want to thank you again for the opportunity to share my experience and perspective. I hope that if there is anything I communicated here it is that quality, effective care cannot be sacrificed for quantity.

When it comes to mental health and most anything else really, care that is not quality driven is not only useless, but it can be harmful to those who receive it.

Thank you. I am happy to answer any questions you may have and I have many thoughts to share in my response to the secretary and his panel if it interests the Committee. Thank you.

[THE PREPARED STATEMENT OF NICOLE L. SAWYER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Dr. Sawyer.

Ms. Rakow.

STATEMENT OF DIANA BIRKETT RAKOW

Ms. RAKOW. Good afternoon, Chairman Miller, Ranking Member Brown, and Members of the Committee.

I am Diana Birkett Rakow, Executive Director of Public Policy at Group Health Cooperative, an integrated health care coverage and delivery system based in Seattle, Washington.

Thank you for inviting me to be here this morning to discuss Group Health's experience managing mental health appointments for our members.

I appreciate your leadership on health care issues affecting our Nation's veterans and want to thank you for inviting me to discuss Group Health's experience managing behavioral health appointments.

Treating patients with behavioral health needs is a difficult challenge for any organization. At Group Health, we have created systems to ensure that our members have access to timely high-quality care.

Our success stems from our belief in patient-centered care and coverage. This philosophy is at the heart of a model of care we apply to mental health services as well as every other type of care we provide.

In simple terms, our model links aspects of health care: insurance, clinical care, information systems, and more in a tightly integrated system that facilitates a close relationship and collaboration between informed, engaged patients and multidisciplinary care teams.

Group Health members seek and receive mental health care through primary care as well as specialty behavioral health services and we provide many different routes into care, individual appointments, phone and group visits, and e-mail access to your health care provider and care team.

Our models enable us to provide high-quality care since we were founded in 1947, but it is the more recent implementation of Lean that has enabled us to achieve break-through results.

As you may know, Lean is a management philosophy developed by Toyota. Applying the Lean to health care is based on understanding patients' needs, develop systems and processes around them, and tracking results in order to continually improve patient health.

For patients with behavioral health issues, we look at a number of specific measures and goals. For example, an electronic medical record automatically measures how long it takes from the time a patient calls for an appointment to the time they are seen by a health care provider.

We set goals for timeliness based specifically on the urgency of a patient's needs as recommended by the National Committee on Quality Assurance.

We monitor access to follow-up appointments and track key indicators of capacity and productivity. For example, we track the percentage of patients seen three times within six weeks and patient satisfaction with their appointment frequency.

We also know that simply tracking these measures is not sufficient. We must make the information visible and use it to ensure that we are serving our patients well.

This is where Lean really helps. Last year, our behavioral health staff looked at appointment patterns and identified a high number of appointments that went unfilled, cancelled or skipped. Using this information, they developed a process called packaged intake, scheduling three appointments at once when a patient first calls to come in.

We also started doing group visits to maximize the use of our existing capacity for patients who would benefit from a group setting.

And a certain number of available appointments are held back to ensure that urgent and emergent needs are always met. Now clinic staff meet every morning to assess what appointments are still available and to reach out to waiting patients to see if they can come in sooner.

This set of strategies has enabled us to meet and exceed the targets that we set for timely access to care. And we saw a statistically significant increase in patient satisfaction with their access.

This is just one example of how Lean gives us the discipline to focus on our patients' needs and to address problems as they arise. These tools have enabled us to significantly improve how we serve our patients with behavioral health care needs over the last few years.

But it is important to acknowledge that this is an ongoing process. Our system is built around a culture of continuous improvement. Putting the patients' needs first and recognizing that as their needs change, so, too, must our approaches to meeting them.

Thank you again for the opportunity to share our experience and I look forward to your questions.

[THE PREPARED STATEMENT OF DIANA BIRKETT RAKOW APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Dr. Schuster.

STATEMENT OF DR. JAMES SCHUSTER

Dr. SCHUSTER. Thank you, and thanks for inviting me here today to talk about this important topic.

My name is Dr. James Schuster. I am the Chief Medical Officer for Community Care Behavioral Health Organization and a psychiatrist. And I agree with Congresswoman Brown. Not everybody needs a psychiatrist.

Community Care is a not-for-profit 501(c)(3) behavioral health managed care company and one of several payer insurance companies affiliated with UPMC, the University of Pittsburgh Medical Center, which is a large, integrated payer provider system based in Pittsburgh.

Community Care provides managed care behavioral health services to more than 650,000 Medicaid eligible persons in 36 counties in Pennsylvania and also manages behavioral health services based in facilities in 16 counties in New York.

It also serves both commercial and Medicare members through care coordination agreements with UPMC Health Plan.

Our data indicates that in any given year, 23 percent of the members in our Pennsylvania Medicaid plans are active consumers of behavioral health care. In light of this, little is more important to us than assuring that the membership has timely and adequate access to services.

However, ensuring access is anything but simple. I will try to touch on several high points here in my allotted time.

Ensuring that members with behavioral health needs have timely and adequate access begins by first deciding what is timely and

what is adequate. In practice, these terms can mean different things in different circumstances.

As has been discussed here for individuals with psychiatric emergencies, timely might mean right now. As such, our access standards require immediate appointments in emergency situations. In other circumstances where more routine care is appropriate, we allow up to a week initially between the initial contact and the initial appointment.

Establishing these access standards has required a dedicated effort on the part of Community Care. We work in collaboration with a wide range of stakeholders including accrediting bodies like the National Council on Quality Assurance and the Pennsylvania Department of Public Welfare. We also work with local government entities, advocacy groups, and families.

Among the most important collaborators, though, who help us establish access standards are the members themselves. We collect input through member surveys and through meetings with member advisory Committees who report directly to the board of directors.

We receive additional information through monitoring of member complaints around access and through site visits to provider services.

Defining the access standards would have somewhat limited value if we did not communicate them clearly to our staff, the providers in our network, our members and the community at large. We work to make sure that everyone is aware of what the access standards are and how they are measured.

The true value to Community Care in terms of collecting data around access has been its usefulness in devising necessary changes and interventions.

Over the years, we have created a wide range of changes related to the data. These include traditional types of intervention such as increasing numbers of subspecialists when those fall short of access requirements.

But they have also included more systemic changes such as increased funding, dedicated community-based services, and an expanded range of services such as mobile crisis service units, hospital diversion programs, psychiatric rehabilitation, and certified peer specialist programs.

These more systemic changes have probably had some of the most substantial impact on access to services broadly.

Access feedback has also prompted us to implement newer types of service delivery including tele-psychiatry. We currently support approximately 20 tele-psychiatry units in rural parts of Pennsylvania using secure forms of video transmission.

We have also worked with providers to create new clinical strategies to deliver care such as supporting shared decision-making strategies and physician-based services.

All of these services have created new ways to access care, as they are alternative to traditional inpatient and outpatient models.

We have also increased access to the broad and comprehensive range of community-based services. During the past decade, funding for community-based services in the Medicaid programs that we work with in Pennsylvania has risen from about 50 percent to about 80 percent of the total dollars spent on care.

In conclusion, what I would ask that the Committee take from my comments today is that improving and maintaining access to behavioral health services is, of course, critical, but it requires typically a broad set of efforts and collaborations among many stakeholders including the patients and members themselves.

We have learned much through our efforts over the past 15 years and are certainly happy to answer any questions that the Committee has today or in the future.

Thank you.

[THE PREPARED STATEMENT OF DR. JAMES SCHUSTER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Doctor.

Admiral.

STATEMENT OF THOMAS CARRATO

Rear Admiral CARRATO. Thank you, and thanks for the invitation to appear before the Committee.

Health Net is proud to be one of the longest-serving health care solution partners for the Department of Defense and Department of Veterans Affairs. Health Net currently serves as the TRICARE contractor in the TRICARE north region supporting three million DoD beneficiaries.

We also deliver behavioral health and wellness services to military servicemembers and their families through the military family life counseling program, a worldwide program which provides short-term problem-solving situational counseling.

Health Net also works with VA in support of veterans' physical and behavioral health care needs through community-based outpatient clinics and the rural mental health program in select rural counties in VISNs 19 and 20.

Appreciate the opportunity to offer our thoughts on addressing the growing and urgent need for veteran access to mental health services.

Untreated mental illness impacts overall health and reintegration into the community.

Chairman Miller, as you stated in a recent news release, these are wounds that cannot wait.

We appreciate VA's efforts to enhance capacity to address this growing need and respect its leadership in developing and deploying evidence-based treatment protocols and comprehensive clinical practice guidelines.

Moreover, we appreciate the fact that VA understands veterans' needs better than anyone else. But addressing the dramatic increase in the demand for VA mental health services is challenging. Clearly the demand has stretched VA's capacity.

Based on current services we provide to both VA and DoD, we believe there are ready approaches to address this urgent need quickly and effectively. These proven solutions for addressing both short-term and ongoing access issues can be performed without sacrificing clinical excellence which is a priority for the VA.

Health Net has collaborated with VA and DoD in delivering a full continuum of high-quality, flexible, and accessible solutions which augment existing capacity and capability.

These programs are very flexible in meeting demand from supporting the surge of returning servicemembers to reaching out to veterans living in remote geographic areas.

Our counselors have been carefully screened and then receive extensive training on military culture and relevant military and veteran issues. This training easily could be augmented with additional VA specific training.

Our rural mental health providers are trained on VA benefits and on addressing specific veteran issues.

For the military family life counseling program, we have a network of over 5,200 licensed counselors who are fully trained, highly experienced, and ready to deploy.

This network has drawn from a Health Net pool of over 50,000 qualified professionals which is further supported by over 22,000 behavioral health providers in the TRICARE provider network.

We believe a path forward for VA should be based upon existing proven programs using available clinical resources. Such an approach could effectively supplement VA's capacity without sacrificing clinical excellence.

Short-term actions might include deployment of clinical resources to alleviate short-term demand requirements at VA medical centers or community-based outpatient clinics using enhanced telephonic and Web-based counseling to provide veterans with easy access to ongoing support, and finally augmenting VA's capacity with an existing network of community-based mental health providers.

We commend the VA for promptly responding to the OIG report on access to mental health care. We also commend this Committee for its strong leadership over this critical issue for our Nation's veterans.

I look forward to your questions. Thank you.

[THE PREPARED STATEMENT OF THOMAS CARRATO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Admiral.

I have a question to pose to you that does not have anything to do with your testimony. You heard the bells ring just a minute ago; we are in our first series of votes. We have a little over two minutes to get to the floor.

So I would like to ask, if it would be amenable to you, if we could recess until about 2:30, come back to give us an opportunity to ask our questions and not feel rushed. We have one other panel after this. I think 2:30 would give you an opportunity also to take a break maybe and do some things.

Would that be okay with the panel?

With that, the Committee stands in recess until 2:30.

[Whereupon, at 1:36 p.m., the Committee recessed, to reconvene at 2:30 p.m., the same day.]

The CHAIRMAN. Thank you, everybody, for returning. I appreciate your indulgence to allow us to go over and have a series of votes and I had a quick speech that I had to make. Fortunately, it was here on the Hill.

I would like to begin the round of questioning first. In the department's written testimony, it states that no industry standards for accurate mental health staffing ratios exists. So my first ques-

tion is, is this a true statement and, if so, how does your organization determine mental health staffing ratios? Is there such a thing as an industry standard out there? And if there is no standard, I understand that, too.

Ms. Rakow, you are recognized.

Ms. RAKOW. Thank you, Mr. Chairman. We don't actually have a set standard that we use for our staffing ratios. I can't speak to whether or not there is one out there. So we use other measures of capacity and productivity, such as the number of slots that providers have still available to take on new cases. We use relative value units, which is a common measure of productivity in the health care industry to measure capacity, as well as productivity, and then use that as demand increases to translate whether or not we need to increase our supply.

Dr. SCHUSTER. Yes. But I think, generally, I would echo what Ms. Rakow said. There are standards in terms of access times, which we had talked about, but I think—and access availability in terms of how far someone might have to go to reach a practitioner. But I think the kind of productivity and staffing standards are probably more— idiosyncratic is too strong a word, but there is not one common standard that is used universally.

Dr. SAWYER. I just want to point out I think that having a staffing model is part of the problem. I think that we need to take a look at the actual productivity that a clinician can achieve while providing effective mental health treatment. The expectation right now is completely irrelevant. It is just as many people as you can cram into your schedule a day is your expected productivity.

However, in other facilities, community mental health, other mental health facilities, there is a certain expectation of a clinician. For example, a former mental health center I worked at there were 22 hours of therapy per week were expected for your 36 hour work week.

Now, those 22 hours could be made up of many different things. It could be made up of group therapy. It could be made up of individual therapy. You may be running a 90 minute session with someone, given whatever sort of methodology you were using. But those 22 hours were dedicated to psychotherapy of some form if you were a full time clinician. Now, the rest of the hours of the week were spent writing up notes, you know, providing consultation, all of the things that are important to providing effective care.

Now, that allowed a case load to be developed so, if you are effectively seeing your people in 22 hours per week of therapy, then that can be extrapolated into how many veterans you could actually have on your case load and treat them in a manner that is clinically relevant.

So approximately, in my experience with the community health, a full time clinician could carry about 40 people on their case load and treat them effectively with 22 hours of therapy per week because some people only need an every other week appointment. Some people need once a week. Some people are coming in for monthly check-ins.

So the intensity of the treatment that you are providing is disbursed among your case load when you have about 40 people. And that allows room for you to manage incoming, so you are taking on

new patients periodically when you are discharging others because they are getting well. So a system that actually has a case load and a productivity expectation for their clinicians allows a flow to take place because people are able to get better. Care is actually effectively provided.

Dr. SCHUSTER. If I could just add one other comment, which is what's optimal numbers per site might vary depending to some degree on the range of services that are available for a particular site. So, for example, if there is only outpatient services available, you might need more outpatient clinicians than if you have a broader range of services, case management, peer services, day hospital, etc. So it probably makes sense or it might make sense to look at each kind of level system in terms of what is available and how they can serve the population they are responsible for.

Dr. SAWYER. Certainly.

The CHAIRMAN. And if we can, let's go here because VA has said that they have been in consultation with other health care systems to, in fact, create a prototype staffing model for general mental health at outpatient care. Are any of you aware of this? Have they reached out to you or the folks that you represent? And if they have not, do you think it would work and would you be willing to work with VA to help them resolve this issue?

Ms. RAKOW. We would be glad to work with them. I was speaking to Dr. Petzel at the break and we would welcome members of the VA or members of the Committee and your staff to come visit Group Health and see what we do, if we can offer any lessons.

The CHAIRMAN. Dr. Sawyer, what do you think? I thought I heard you say you did not think that a staffing model would work.

Dr. SAWYER. Well, I guess my fear with a staffing model is this very global approach to, as Dr. Schuster pointed out, a very facility specific issue. So depending on a range of services that a facility is providing is what their case loads of their clinicians need to look like.

So I get a little bit nervous when we start talking about this sort of global definition of what a staff should look like. It starts to make me think of mandates sort of trickling down onto the ground level and then we are all trying to figure out how to meet these demands.

So in terms of a staffing model, I feel like we need to look more at a case load model for clinicians. What do we expect our clinicians to be doing every day and how can we design that so that they are actually able to provide effective treatment.

Dr. SCHUSTER. And I found that, staffing models, particularly in behavioral health, it is, as the panelists have said, it is so dependant on the type of provider for psychiatry, for social work, for psychologists, whether it is acute inpatient, day treatment. So you do come up with staffing guidelines that can be used as a starting point to determine availability and accessibility, but it is a very complex undertaking.

Dr. SAWYER. Well, and you bring up an excellent point, as well. I am sorry. If I could continue to comment.

On the VA's statement that they have come up with this number of 5.3 mental health professionals per 1,000 veterans, what does that mean? 5.3 mental health professionals per 1,000 veterans, if

that's 5.3 psychologists, that means I am responsible for 200 veterans? That is absurd. I can't provide adequate care to 200 veterans at a time.

If you are a psychiatrist that is providing only 15 minute appointments, which no psychiatrist actually is, but if you are only providing 15 minute med checks, maybe you could manage a case load of 200 people. But a social worker, a psychologist, people who are providing psychotherapy, which runs in 50 minute increments at least, sometimes as much as 90, can't manage 200 people.

The CHAIRMAN. Mr. Walz.

MR. WALZ. Thank you, Chairman. Thank you all for being here. I really appreciate it and I tell you this not because I think you care, but it is a little bit of background. I represent the Mayo Clinic area and, as we got into this whole health care debate of looking at accountable care organizations, patient centered care, medical home models, it is kind of the air we breathe. And I still go back to this issue as much more systemic in the delivery of the mental health services in this country.

Would you agree that that is looking at that? I hear you speaking that way, that partnering together. The VA is a wonderful opportunity for us to learn on the private sector side, too. How to deliver mental health care in some complex situations. But I'm trying to figure out what you can teach them, too, about going down the line.

So I am going to go to Ms. Rakow first. I found some interesting things on GHC. They did a great commonwealth study on you that we were looking at in my office that I think—I think this sums up where VA is at and where you guys can maybe provide some help.

It says, "In recent years, however, GHC pushed to improve its competitiveness in the marketplace. It began to see the unintended consequence of a production oriented approach to primary patient care. Swollen patient model is reaching as high as 3,000 patients for a physician, increasing specialty care referrals, rising costs, costs of hospital care, emergency care, and signs of burnout in the workforce. Like other large health organizations, GHC was finding it difficult to recruit primary care physicians and struggling to improve performance by engaging patients in their own care."

But here is the good news on this. This is what your vice president said. "We were on a platform that was unsustainable." In response to these challenges in 2007, GHC began a pilot project to define and test a medical home model of primary care delivery in its Bellevue Seattle suburbs there and went through and listed some of these things.

Have you been there long enough, Ms. Rakow, to see this as it changed because, as we have talked about health care and health care delivery, the debate up here became that it was like any other commodity to be delivered. It was a supply and demand issue and all that and it would just work itself out in the marketplace. The problem with that is, especially with mental health care, it is not quite that simple.

And so what I am trying to figure out here is could the VA employ some of the things that you did, you think, to reduce these wait times and to get better outcomes on patients and their care?

Ms. RAKOW. Thanks for the question. I would hope so. I think when we actually started looking at access to behavioral health services in 2001, we had a wait time of, on average, often 50 days. So we have come a long way. And, similarly in primary care, we piloted the medical home model a few years ago. It proved workable and so we rolled it out to all of our clinics.

But it is really a multi-faceted strategy. On the one hand, we tried to maximize the use of our capacity with things like virtual consults with specialty providers from primary care, which we do with behavioral health services, as well, phone and group visits, email access to your doctor. We also at the same time are continuously working to improve. So with some of the tools and measures that we use, we do track supply and demand, but we also, at the same time, track quality and clinical effectiveness and we empower front line staff to actually be very involved in that tracking process, to visually report results in the clinic, to huddle every day and look at results.

Mr. WALZ. Those outcomes are what matter, what I am trying to get at.

Dr. Sawyer, I am going to end. I have my last two minutes to leave to you this issue of value care versus volume care. It is a problem we have in Medicare delivery, obviously, and it is what is the biggest cost driver in health care is. How do we get to that value based care?

Now, I am thinking two questions to you is why would a psychologist choose to work in VA? Why would a young psychologist coming out just with their doctorate now and they are ready to go, why would they choose to work in VA? And could you just briefly explain what a typical day as a VA psychiatrist looks like for a psychologist?

Dr. SAWYER. Sure. Thank you. So part one of that I guess is why a psychologist would come to work for the VA. I think that right now we have a tremendous opportunity with mental health professionals coming directly out of school, graduate programs, because the VA right now is an opportunity for them to serve their brothers and sisters that have gone off to war. I mean, we are talking about a generation of graduate students coming out of school who have watched their cohort go off to war and come back in a lot of pain. This is an opportunity for them and we need to seize it. This is something that we can really grab on to to help encourage psychologists to want to come to work at the VA.

The VA is not the place where they are going to make the biggest amount of money. It is going to be a lot of work. They can get a pretty good benefit package, but it is the feel good that comes with working at the VA that really motivates a lot of mental health professionals.

Mr. WALZ. Was your motivation tampered a little bit with some of the requirements that kept you in a box, that didn't allow you to practice your profession maybe?

Dr. SAWYER. Absolutely. I mean, one of the most difficult things about working at a VA in its current system is that you are coming into this system as a professional; You feel very good about the training that you have taken on. You feel very good about your expertise.

And then you get there and you are told, oh, no, no, no, that is not how we do it here. This is how we are going to practice. These are the treatments you are going to provide. This is how often you are going to see your veteran. This is what you are going to say to them about those treatments. I mean, it comes right down to how you actually practice.

Mr. WALZ. Is it your experience when you network across there? Because I try to get out to as many of my facilities as is possible and I know it is a gross generalization to say they are all the same, but you probably network closely with other professionals.

Dr. SAWYER. Yes. In my job as the evidence based psychotherapy coordinator, we had contact on a monthly basis with our local VISN, as well as nationally. And this is common across the board. It is the greatest frustration of psychologists and social workers, as well, who are providing psychotherapy is that their clinical judgment is tossed out the window. You know, we are-–everything is being dictated to us by the performance measures that the administration——

Mr. WALZ. Do you think that is a natural response, though, to cost benefits and where you are being funded? I say that as a professional educator where I said, wow, 51 kids in this class? I am not sure that is the best model for us to do this, but you are going to have to deliver. Do you think that happens in a lot of professions where you have to balance between what the cost is or is this one of those I have always made the case of whatever it takes to get it right, we need to do?

Dr. SAWYER. Well, I think the biggest problem with taking the clinical judgment away, not only is it certainly interfering with the retention of these professionals, but it also means that there is this very cookie cutter approach that starts to happen for veterans. And mental health cannot be cookie cutter. I mean, I can't even imagine another medical issue that can be less cookie cutter than mental health. But the VA is trying very hard to create this structure around health care to provide it to these veterans and that is a major turnoff to the professionals that are supposed to be sort of disseminating this care.

Mr. WALZ. Is it your judgment that that is simply to meet the demand, that there is just that many people?

Dr. SAWYER. Absolutely.

Mr. WALZ. Okay.

Dr. SAWYER. Absolutely.

Mr. WALZ. Thank you.

The CHAIRMAN. Ms. Brown, questions?

Ms. BROWN. I think my question is for Dr. Schuster. You have a medical degree. Ms. Sawyer have a educational degree. Both are very important, but a medical degree I guess is the top as far as treatment is concerned. I would imagine a person coming to you would have severe, severe problems as opposed to going to a, let's say, a social worker with clinical training, you know, in mental health.

It seems as if we want—we talk about psychiatrists or psychologists, which is a vast difference, but I know that we are providing care and need to provide care in many different ways. I think if you are talking about a professional coming out of school with no expe-

rience, that is a problem dealing with people with severe trauma, you know.

So can you share with me because I am pushing and I am going to talk to the next group that we need to have different tiers as far as providing care for veterans. I mean, when I see the soup line wrap around the kitchen and who is there are veterans, then we are not providing them the basic services that they need. And so we need a combination of working with our stakeholders in different levels and working with the professionals in a different level. And to integrate. I see the VA playing a major part, but I don't see them going out and hiring no 3,000 psychiatrists because that is not what we need.

Dr. SCHUSTER. Right. I mean, I think that the literature suggests that having a combined team of professionals available to treat groups of people is the most effective model, so you probably don't want just psychiatrists or just psychologists or just social workers but, really, a team of folks so that people can get what they need. And if people need to be seen by multiple professionals, then that is available to them, as well as I think other community based services.

You know, again, there are models for intensive treatment services that can be provided actually out in the community, including peer support services and case management and thinking about a broad spectrum of services is probably the most effective way to go. And I know we have talked some here about looking at different private models of delivering care, but I think it probably is also useful to have some feedback or think about models that are used in publicly funded systems to local mental health center systems and other systems because part of the VA population is probably more like that than might be seen in a commercial or a private setting. Some are probably more typical of what you might—folks who get their services in publicly oriented settings.

Ms. BROWN. Okay. Ms. Sawyer, do you want to respond to that?

Dr. SAWYER. I couldn't agree more. I mean, I think that the—there are many veterans that come through the VA that could be very well served in a community health setting. I think that the VA could be very good at doing a few very difficult things and then also being willing to partner with outside community and private providers.

The difficulty with that is that the VA right now requires-–first of all, it dictates how many sessions a veteran can have when it fees out to someone. So it may say, you know, we will fee you out to this psychotherapist in the community, this psychologist, and she is going to work with you, but we are going to give you eight sessions.

Now, that psychologist on the other side wants nothing to do with that situation. If you are going to put the liability of this person's mental health care in my hands, I want to be in control of how that treatment is provided. This is—I am the one providing it.

So the VA is saying to them, well, we are only going to give you eight sessions. I don't know, I haven't even met this person yet, whether or not I am going to be able to do anything for them in eight sessions.

Ms. BROWN. I understand what you are saying, eight sessions, but we are dictating the—we are dictating the costs and it is a limited amount that we are willing to pay.

Dr. SAWYER. Mm-hm.

Ms. BROWN. So it is a catch. The VA can't—it is a very frustrating for the VA because they can't satisfy because of our demands and, of course, the user end. So if eight is not the appropriate number, how do we control the costs? Because the people up here, that is all they are interested in.

Dr. SAWYER. Mm-hm.

Ms. BROWN. You know, that is all they are interested in. Costs.

Dr. SAWYER. I certainly understand what you are saying. I mean, there is definitely a catch there where we can't just let things run wild on that side. But I think that trying to find a balance with that so that we actually are respecting the clinicians that we are trying to fee these folks out to, while also being mindful of the costs that will come to the facility, there has to be a balance. We can't just choose one. And I think that is what is happening right now.

Ms. BROWN. All right, Mr. Chairman. I am sure I will get a chance to follow up.

The CHAIRMAN. I don't know. After that last comment, you may not get a chance. I would say that this Committee and the House has, in fact, offered up everything that the VA has asked for, I mean, to the point that we have got 1,500 empty positions right now that we can't get filled and they are asking for 1,900 more. And if that is what they need, this Congress is going to give it to them. But, again, I don't see how we do 3,500 positions in a timely fashion to a veteran who needs help today.

Now, Dr. Sawyer, you have said in your opening statement that you have some comments regarding the secretary's comments and you would be willing to provide them to this Committee if we would like to hear them. Now, we would and I would like to ask you to please expand on it.

Dr. SAWYER. Okay. Well, I think what struck me the most at one point in the secretary's statement was something that he said that represented clearly the problem that we face on the ground. The VA is not providing good care right now. We are trying our hardest. As providers on the ground, we are working as hard as we can, but we are simply not able to do the work. And he identified it as being we are providing good care. We are just not measuring it very well. That is what happens on the ground level. That is the message that we're getting from our administrators within our facility.

When they miss a performance measure or when for some reason, their VISN or central office comes down on a facility for not doing something well, how that translates to the clinicians who are busting their butts every day to try to see as many veterans as possible is you are not working hard enough. You are clearly not tracking your work load well enough. We need you to start keeping better track of how you are doing this, this, and this.

So when I heard that from the secretary, it was—we I guess, as clinicians, used to think it was a facility thing. And then, when it came directly from him, it was very disheartening to hear that. It is not that we are not measuring our work well. It is that we are

actually not providing the work. There isn't anything to measure. We are not doing the work that we need to do.

And part of that is because the clinicians are so overrun. They are completely incapable of providing the services that they are trained to do of 200 veterans per clinician, which is probably about average for some facilities and clinicians right now. Now that is going to be the expectation. We can't work with that now. So asking us to say, well, that is going to be your new norm is ridiculous. There is certainly no way that we can provide effective care in that way.

I guess some other thoughts that came up were comments regarding, you know, trainees, that there are a lot of facilities that have training programs, that I think they mentioned having many post-docs and interns and one of the biggest training organizations. I'm wondering, what I would have liked to have asked the secretary, is what are his thoughts on why we are not keeping those folks in our system. What is happening,

Ms. BROWN. Chairman?

Ms. BROWN. Excuse me. Mr. Chairman, I am not comfortable with this line of questioning. I don't mind the panel making whatever comments they want to about the testimony, but to say that we are responding directly to the secretary, I think that is inappropriate. The secretary is entitled to his comments and the panel is entitled to theirs. But to say that we are responding directly to the secretary, I think that is inappropriate.

The secretary has a broad experience and takes a broad view of the VA mission. You are talking about where you work and the environment you worked in, which is limited. So if we are talking about the entire system, you don't know what is going on in the entire system. You only know what goes on in your area that you were working in or the environment you worked. You have not talked to everybody in VA.

So I don't want to be put on the spot that I feel like I need to defend the secretary, but I do not want the panel saying we are going to comment or critique the comments of the secretary. That is inappropriate.

I have been on this Committee for 20 years. I guess I am the only one with institutional memory, but I never heard a panelist discuss what a secretary said and I don't think that is appropriate.

The CHAIRMAN. Thank you, Ms. Brown, for your comments. Dr. Sawyer, please continue.

Dr. SAWYER. Well, with all due respect, Congresswoman Brown, I actually do have a lot of contact with professionals across the Nation and within my system. And I am certainly not going to in any way imply that every facility is a disaster. That is certainly not the case. There are many facilities out there doing fantastic work. But there are a large number of——

Ms. BROWN. No. That is not appropriate. That I was not speaking to the panelists. I was speaking to you. And she needs to talk directly to you——

The CHAIRMAN. All right.

Ms. BROWN. —and not——

The CHAIRMAN. All right.

Ms. BROWN. Not through——

The CHAIRMAN. Ms. Brown, she is trying to talk to you. If you want her to go through me, that is fine, but she is trying to answer my questions. And you asked me a question. She is trying to answer your question. She is not a member of Congress. She is a doctor and she is trying——

Ms. BROWN. She a educational doctor. She is not a medical doctor. So make sure you get the comments from the medical doctor, also. She is a educational. She doesn't have a medical degree and it is a difference between the two.

The CHAIRMAN. I will let all my education friends know that you don't consider a Ph.D. a higher degree, which is what you just did.

Ms. BROWN. That is correct, sir.

The CHAIRMAN. Please continue. I really want to hear what you have to say and I think it is very appropriate for you to comment about the secretary's comments. Please continue.

Dr. SAWYER. Thank you, Chairman Miller. I guess the last—the last thing that came to mind with one of the secretary's comments was that we need to maximize the staff that we have. And I think that is certainly reasonable to look at it this way, but our staff are currently maxed out. I mean, I don't think anyone here was denying the fact that the staff in our VA facilities have been working extremely hard to meet the demand. And so there really is nothing left to maximize at this point. We need more staff and we need a more efficient way of using our staff. It is not about maximization. It is about efficiency.

The CHAIRMAN. Thank you very much. I thought you were leaving.

Ms. Brown, you are now recognized.

Ms. BROWN. Mr. Schuster, can you give us some——

The CHAIRMAN. Excuse me. It would be Dr. Schuster.

Ms. BROWN. M.D.? Yes, sir.

Your comments on how we should move forward as far as I understand the work load is tremendous. And I also understand we don't need to hire 3,000 Ph.D.s or E.D.D.s. We need a combination and a team. What are some of the recommendations that you can give us that we can move forward with and not criticize or critique the secretary in this Committee. As I said before, it is one team, one fight, and we are all fighting for the veterans.

Dr. SCHUSTER. Yes. I am not an expert on the VA per se, so I can't respond directly to that. But I am happy to provide some feedback in terms of strategy.

Ms. BROWN. So no one in this—no one up here is an expert on the VA and no one out there is an expert on the VA because there are many, many aspects of the VA.

Dr. SCHUSTER. Some strategies that we—that the company I work for has had experience with in terms of trying to address access, one is certainly looking at numbers of professionals. So it is certainly an important item to look at.

A second item that we would look at are access measures in terms of how long it takes people to receive appointments. We have also looked at and tried to get input from families and patients, as well as the people providing the care about what types of services seem like might be missing to help address people's needs because sometimes people access care through outpatient services, but

sometimes their more urgent needs and sometimes there are other needs that direct therapy or even medications might not address.

And then I think the one other thing that we have found helpful is, in addition to looking at some of the quality measures we talked about this morning, like time to appointment, we have also tried to look at some other measures, like time to follow up, and this was in the GAO report, time to follow up after a hospital stay, readmission rates, complaints about access, whether or not there are any concerns from the community about access to services.

So we have tried to—the GAO report talks about a dashboard around the outpatient services and we have tried to put together a series of items that really look like a dashboard, but address some items beyond the outpatient services, as well, that we call our provider benchmarking process. So we look at lots of quality indicators, including complaints and access to services.

So we found it helpful to certainly look at the items address here as part of to look at some other quality issues, as well, that might either affect this or be affected by it.

Ms. BROWN. I visited a program in the Tampa-St. Pete area that they work with the veterans. And one of the things that they did was they had some kind of horse therapy. That was, you know, the service organization working with the VA, but it proved to be very beneficial to the veterans.

So it's all kinds of therapists and all kinds of levels of services that you can provide. Like I said, we have the University of Florida in Jacksonville, but you also have them working with the VA and that is the urban model.

And how can we emphasize and support the different services because community health or the health department, they work with providing services. I do not see the VA going out and hiring 3,000 professionals. How can we better put together the teams that we need to provide immediate services? I guess that is the question. And we would just kind of overlook the other person. Would you like to respond, sir?

Dr. SCHUSTER. Yes, ma'am.

Ms. BROWN. Yes, sir.

Rear Admiral CARRATO. As you pointed out, the demand for behavioral health services is just increasing across the DoD and VA. And I would like to commend the VA for their work in developing clinical practice guidelines. And the issue is that the demand is just exceeding the resources. So to your point, we do need to involve the private sector, and community solutions.

And I just had three recommendations that I would make and, you know, I would like to caveat of them because one thing we don't like to hear is, you know, this is the way we do it here and you ought to do it and everything will get better. But just some lessons learned from the Defense Department. Again, the same folks wearing the uniform. When they take the uniform off, that demand continues to grow. We developed jointly with DoD the military family life counseling program.

Ms. BROWN. And you said you handle TRICARE also, don't you?

Rear Admiral CARRATO. TRICARE and——

Ms. BROWN. Which is the family?

Rear Admiral CARRATO. The military family life counseling program is sponsored by the under secretary for Personnel and Readiness. And to your point with the supply issue with psychiatry, this is based on using primarily licensed masters prepared social workers.

Now, there still is a supply issue, so we developed a rotational model where we are able to respond specifically to short term demands like the VA is facing now. So we can rotate social workers, psychologists around the world for 30, 60, 90, 120 day assignments on a rotational basis and we bring folks back, you know, into the states or back home into their active practice. The benefit is we can use professionals who are in active practice.

This isn't a staffing model because I know, as one of the panelists pointed out, when someone works up the courage to raise their hand and say I need behavioral health services, to go in to somebody who has no idea what you have gone through can just turn you away. So our folks get extensive training on military, culture, customs. They understand what it means to be deployed multiple times. And so a rotational model similar to the military family life counseling program could be effective.

The second suggestion I have, and, again, I know the VA is a pioneer in this area, but it is to use technologies, web enabled, Skype enabled counseling, telephonic counseling, to reach out to veterans and some harder to reach veterans. And this has proven to be effective.

And, finally, again, the point of augmenting the VA, there are, in the TRICARE program, the taxpayer has paid us to develop a network. They have paid Humana to develop a network. We have over 22,000 behavioral health providers in our network and there may be an opportunity for that network to be used to augment the VA.

So those are the suggestions I would have to address the immediate and the ongoing issues that the VA is facing.

Ms. BROWN. One last comment. We are working real hard to get the Department of Defense to work kind of seamlessly with the VA. And what recommendations do you have that how we can work closer together because I don't know why we lose someone when, you know, and there is that period between when they are out and they don't think they need services. And then when we get to them, it is almost too late sometimes.

Rear Admiral CARRATO. You know, I think it is just the ongoing communication. I know when I was still on active duty and was at DoD, I worked very closely with colleagues at the VA and I just encourage—would encourage ongoing communication around these common issues because, as you said, one team, one fight.

Ms. BROWN. Thank you. And thank you, Mr. Chairman. I yield back the balance of my time.

The CHAIRMAN. Dr. Schuster, how long did it take Community Care to develop and implement the timeliness benchmarks that you use? And, also, how often do you reevaluate those benchmarks?

Dr. SCHUSTER. Some of the benchmarks that we used we have used almost from the beginning. They were dictated by the State of Pennsylvania as part of its Medicaid program. Other benchmarks we developed and the company really started its work with

the Medicaid program approximately 15 years ago in Pennsylvania. Other benchmarks we adopted from NCQA, which is a company that accredits insurance companies, and we have had that accreditation for about ten years. So we adopted some of those additional standards between then.

And then we have really done evolving standards around access and trying to assess adequate access to care really on an ongoing basis in the different regions that we work in. We work very closely with the counties, with each county that we work within, and with the providers and the advocacy groups, of family and patient advocacy groups in that area.

So we have ongoing discussions, really, all the time to try to assess, if people feel like their needs are being met or, if not, what do we need to do to address it.

The CHAIRMAN. Admiral, same question. Do you, if you would, benchmarks, time to look at reevaluating programs.

Rear Admiral CARRATO. You know, pretty much agree with what Dr. Schuster said. It starts with establishing access standards, availability standards, and just monitoring closely. But as we have talked about before, in the behavioral health area, we are still—we are still learning.

The CHAIRMAN. Mr. Walz, any other questions?

Mr. WALZ. No. I'm good, Mr. Chairman.

The CHAIRMAN. Ms. Brown, anything?

Ms. BROWN. Just one last thing. I want to be clear, so when I read it.

I am not saying that a person with a educational degree is less qualified than one with a medical degree. I am saying we need all of those health care providers. I want to be clear. I think we need all of them, including the social worker and the community resource person and the family and the veteran. So it is a team effort and I want to be clear I am not putting down any profession. I think they are all very important as we develop this model that we are trying to address this problem. It is one team, one fight, even though it is the, I mean, we are working with all of the branches. Thank you.

The CHAIRMAN. Thank you very much. Thank you for your indulgence. You may be getting questions from the full Committee. For the record, we would ask for a timely response, if you would in getting those back. Thank you for being with us today. You are dismissed.

The CHAIRMAN. Thank you much for hanging with us for so long. The final panel today at the witness table is Joy Ilem, the Deputy National Legislative Director for the Disabled American Veterans, Alethea Predeoux, the Associate Director for Health Legislation for the Paralyzed Veterans of American, and Ralph Ibson, the National Policy Director for the Wounded Warrior Project. We thank you so much for being here. And, Ms. Ilem, you are recognized for five minutes.

STATEMENTS OF JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR FOR THE DISABLED AMERICAN VETERANS; ALETHEA PREDEOUX, ASSOCIATE DIRECTOR OF HEALTH LEGISLATION, PARALYZED VETERANS OF AMERICA; RALPH IBSON, WOUNDED WARRIOR PROJECT, SENIOR FELLOW FOR POLICY

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman, and members of the Committee. We appreciate the opportunity to offer our views on the problems confronting the VA in meeting the critical mental health needs of our Nation's veterans. For over a decade, the media has covered readjustment challenges that new veterans face upon returning home. Likewise, the House and Senate Veterans' Affairs Committees have held numerous hearings on VA mental health services, and GAO and VA's inspector general have evaluated and examined a number of related issues.

Typically, coverage focuses on veterans who have fallen through the cracks, taken their own lives, or gaps in VA and DoD mental health care. It is rare to see a positive report about VA mental health programs.

Nevertheless, over the past five years, VA has made remarkable progress in establishing a stronger foundation for mental health services. VA has worked hard to institute the principles of recovery and a national policy to ensure consistency and availability of mental health services throughout its 1,400 sites of care. State of the art approaches, evidence based treatments, and new technologies have been deployed.

All of this progress has occurred during a time of steadily increasing work loads and rising demand, culminating in the current situation VA is experiencing as it struggles to provide quality mental health care in a timely manner.

Despite significant improvements in care, the current environment makes it difficult to shift perception to the gains VA actually has made. The recent IG report and informal survey by the Senate Veterans' Affairs Committee continue to point out lingering and troubling findings. According to the IG, VA is only meeting its 14 day access goal for completing a full mental health evaluation and treatment plan for about half of the new patients it sees.

Based on these findings, VA reported it has developed a comprehensive action plan to enhance mental health services. It is conducting an external focus group to better understand the issues raised by front line providers, as well as conducting site visits to each of its medical centers to evaluate all mental health programs.

While VA has applied these actions, many contributing problems exist. For example, after more than a decade, VA's office of information and technology has still not completed development of a state of the art scheduling system that can effectively manage appointment scheduling or provide accurate tracking and reporting. Likewise, despite the addition of thousands of new mental health staff since 2002, demand for services by tens of thousands of new veterans has strained the system. VA recently announced it needs to hire 1,900 additional mental health staff, but experts have point-

ed out that increased staff alone will not fix the existing problems. We agree.

So the question is what could and should be done at this critical juncture. Unfortunately, the problems in VA's mental health program are multiple, system based, longstanding, and complex in some cases and cannot be resolved by any single action. However, as VA moves forward, we urge a focus on correcting the root of its problems to find real solutions, not just applying temporary measures for a quick fix.

We believe one of the barriers that prevents VA from being more effective in many of its programs is human resources policy and management practices surrounding them. Clinical leaders across the VA system have told VA for years the recruitment of new professionals is a lengthy and frustrating problem that contributes to VA's current issues. We urge the Committee to carefully examine VA and OPM appointment authorities and statute and regulation to learn how they are being applied and determine whether new legislation might offer some resolution.

VA must develop reliable data systems, fix the flaws in its appointment scheduling system, develop a usable staffing model that allows providers to address veterans with their physical, mental, and social health and do all of this in a patient centered manner. We make a number of other specific recommendations in our formal statement to the Committee and VA, as well.

In closing, we appreciate VA's progress in developing an improved mental health system of care and the Committee's continued funding commitment to VA mental health and its oversight efforts. DAV recognizes this progress and support, but it is eclipsed and obscured by the problems we are discussing here today and happening at the worst possible moment when expectations are the highest.

We believe, collectively, the recommendations we are making, along with VA's own planning measures and Congress' continued oversight, can help to begin to resolve these issues. And we urge VA to solidify its plan, and act expeditiously.

Mr. Chairman, that concludes my statement. I am happy to answer any questions.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Ms. Predeoux, you are recognized.

STATEMENT OF ALETHEA PREDEOUX

Ms. PREDEOUX. Chairman Miller, Ranking Member Brown, and Members of the Committee, thank you for allowing Paralyzed Veterans of America to testify today on one of the most important health care issues facing America's veterans and the health care system of the Department of Veterans Affairs. PVA believes that when veterans have timely access to quality mental health care services they in turn have the opportunity to establish productive personal and professional lives.

In recent years the VA has made tremendous strides in the quality of care and variety of services provided to veterans in the area of mental health. Although these improvements were much needed

and have helped many veterans, PVA believes that issues of access and mental health care within the VA continue to exist and more must be done to make certain that all veterans receive mental health care that is timely and effective.

The VA's Office of Inspector General report, entitled, "Veterans Health Administration: Review of Veterans' Access to Mental Health Care," identified many weaknesses within VA's Department of Mental Health that if improved upon will allow VA to continue in its progression of providing high quality mental health services to veterans. Overall, the report concluded that VHA's mental health performance data is not accurate or reliable and VHA measures do not fully reflect critical dimensions of mental health care access.

The report provided recommendations that PVA believes will help VA better identify and address the issues of access to VA mental health care services. In addition to those recommendations, PVA believes that increased attention to staffing, productivity and performance of providers, and patient demand will further assist VA in providing care that makes a difference in the lives of veterans.

The analysis and results from the VA OIG report on mental health access data shines light on the inconsistencies of policy implementation within VHA and how such inconsistencies can negatively impact veterans' access to quality care. For instance, VA requires that all first-time patients receive a treatment planning evaluation no more than 14 days from the initial request or referral for services.

As the VA OIG report makes clear, various mental health offices within VA have been interpreting this policy to have multiple meanings, and the end result is not having reliable data to accurately assess veterans' access to care or the performance of providers. The VA must ensure that staff adheres to all policies that are put in place to guarantee a high caliber of services for veterans, and must further develop safeguards that ensure such policies are carried out correctly from day to day.

As it relates to staffing for the past years, PVA's Medical Services and Health Policy department has identified consistent staffing deficiencies of mental health professionals within the Spinal Cord Injury System of Care.

Deficiencies in mental health staffing directly impact veterans' access to mental health services. For example, within VA's SCI system, veterans receive annual examinations that encompass a mental health screening. This annual mental health screening is extremely important for veterans who have sustained a catastrophic injury as they have a high propensity to face challenges involving self-esteem, independence, and quality of life. The aforementioned mental health staffing shortages have the potential to compromise quality mental health screenings and treatment for veterans within the SCI system of care who are dealing with symptoms of mental health conditions.

Another issue that impedes patient wellness involving VA mental health care is the inpatient mental health services readily available to veterans with catastrophic disabilities. PVA's Medical Services team has found that inpatient care is not always available to vet-

erans with a spinal cord injury or disorder due to a lack of accessible space, or the VA not being able to provide the necessary physical and medical assistance that is often needed when a veteran has a catastrophic injury or illness. When this is the case, these veterans are referred to alternative methods of treatment that may not always adequately meet their needs. The VA must work to provide all veterans with access to mental health services when they seek the help. A physical disability or multiple complex health conditions should not prevent veterans from receiving quality, effective mental health care.

PVA thanks Congress and VA for investing a great deal of resources into improving mental health services in recent years. While PVA does not believe that there is just one definite solution to improving veterans' access to VA mental health services, we do believe that a comprehensive assessment of veterans' needs and mental health staffing is a starting point for identifying both strengths and weaknesses within the delivery of mental health care. All veterans, regardless of generation should have access to timely, quality mental health services.

I would be happy to answer any questions that you might have.

[THE PREPARED STATEMENT OF ALETHEA PREDEOUX APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Mr. Ibson.

STATEMENT OF RALPH IBSON

Mr. IBSON. Thank you, Mr. Chairman. Chairman Miller, Ranking Member Brown, and Members of the Committee. Speaking for Wounded Warrior Project, VA can have few higher priorities than providing both timely and effective care to those with combat related mental health conditions.

Too often veterans are not getting either. Let me explain. Some weeks ago, Wounded Warrior Project initiated a survey of VA mental health staff to better understand the reality on the ground. With responses from clinicians in 17 of VA's 22 networks, 87 percent say their clinics or programs are understaffed. As one put it, "VA in this area is entirely overwhelmed and booked to capacity." 80 percent say staffing shortages are the reasons for the long delays veterans are facing, but most also indicate that staffing problems limit the kind of treatment they can provide. For example, 55 percent reported that OEF/OIF patients were either frequently or very frequently assigned to group therapy even though individual therapy would have been more appropriate. And almost 60 percent disagreed or strongly disagreed with the statement that they have leadership support to choose the most appropriate treatment for their patients.

We welcome VA's plan to hire more staff, but it seems clear from today's testimony that the Department really has no reliable way to know how many staff are needed in any given facility. And as is also attested to, many VA facilities don't even have space for additional staff.

As further discussed, with serious shortages of mental health professionals in this country, there are serious questions about the Department's ability to hire the additional staff and fill the many

vacancies. That challenge, as earlier discussed, is likely to be compounded, given that most of our survey respondents describe their work environment as highly stressful and more than 40 percent said they are considering leaving VA employment.

Let me share the perspective of just one of those clinicians. "The reality is that VA is a top down organization that wants strict obedience and does not want to hear about problems. I have little hope there will be real improvement. You'll only see bandaids and more useless performance measures designed to make management look good."

Just as some clinicians feel they are not heard, we question whether the veteran is heard. Particularly striking is VA's strong promotion of the use of two PTSD therapies that involve repeated intense exposures to wartime trauma. Many veterans just do not want that kind of therapy, but are not getting any other choice.

Ultimately it is critical to understand the impact the kinds of problems we have described today are having on the veteran. And let me just read a few of the observations that mental health staff shared with us:

"I have a patient who came very close to attempting suicide in between appointments. I strongly believe that if I could meet with him weekly or even more on occasion his suicidal ideation would have decreased and he would be less likely to act on his thoughts."

"Even telling patients that the only therapy we can offer them involves prolonged exposure to the traumas they have experienced sends them elsewhere."

"We have veterans who come hundreds of miles for their appointment and they get, at most, 30 minutes with us."

Mr. Walz's observations regarding mental health parity, I thought, were very telling and I think there is a real question as to whether or not there is mental health parity within the VA—parity in terms of resources, parity in terms of staffing, parity in terms of support for mental health care relative to needs of veterans.

But let me say, acknowledging that VA has offered solutions and is certainly trying very hard, that there's more that can be done. I think Representative Buerkle said it well. VA cannot do it alone. It is time for VA to reach out to its medical school partners, to organizations of mental health professionals, to the faith community and far wider, and be clear and say we cannot do it all, we need your help.

Certainly, as Ms. Brown and others suggested, VA must use community-based care options which are available on paper but not necessarily as widely used as they should be when it cannot provide Wounded Warriors timely effective treatment.

A second point: in a very real sense the VA operates two mental health care systems, its Vet Center System and system of care through medical facilities. Those two systems need to be better integrated, but we can also recognize and should recognize, in my view, that many Vet Centers are also under staffed, heavily, very subscribed to and sometimes over booked. They need additional staffing, too, and we probably need additional Vet Centers.

And a third point, again, I recognize and appreciate the hard work that a relatively small staff in VA Central Office is doing to

put out some of these mental health fires and to try and solve these problems.

But I think the earlier testimony we heard from Dr. Sawyer spoke to the strength, the dedication, the commitment, the zeal of those dedicated mental health clinicians at the facilities on the ground. Bring them into the process, too. Let them be part of the solutions. I think that's a critical step toward building the trust that is so critical to a healthy work place and to successful recruitment and retention.

Let me thank you for your continued focus on these issues through a long day and to your dedication to the importance of timely effective VA mental health services for our warriors.

I, too, would be happy to address your questions.

[THE PREPARED STATEMENT OF RALPH IBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much for your testimony and, again, bearing with us all morning and this afternoon. Ms. Ilem, I was struck in your testimony where you said it is a common practice for resource Committees to deny authorization to fill mental health and substance positions creating ghost positions that are listed in the service FTEE allocations, but can never be recruited. And we understand that in many locations the 1,900 newly allocated FTEEs will not even be sufficient to fill these vacancies. Would you elaborate on the idea of ghost positions?

Ms. ILEM. Sure. You know, as part of preparing for the hearing, we reach out to different mental health providers around the system and we feel that their input is extremely important. They are the people that are on the ground facing the challenges that they are, and this is just some of the information that a couple of folks have shared with us.

And we have heard that repeatedly. In the independent budget I know we have worked on some H.R. issues and asking what are these very long delays, why is it taking so long, and it seems to be at, maybe, perhaps certain facilities, you know, because of budget, budget concerns. That is a way to delay hiring someone, although it is an authorized position.

The CHAIRMAN. I would like to ask if any of you have heard reports that women whose combat experience is termed "unofficial" are being barred from group therapy sessions dealing with posttraumatic stress because they are reserved for combat veterans. Has this been brought to your attention? If so, do you think that VA needs to change the eligibility requirements for group therapy to include all patients diagnosed with combat-related PTS? And I would ask any of you that have heard of that, if you would comment. If you haven't, that is fine, too.

Ms. ILEM. I have not heard that regarding women veterans specifically. But certainly this has been an ongoing problem that we hear. There are a number of films that have come, brought to light, still, the recognition or the lack of recognition that women really are participating in combat or their exposure to combat is very, you know, is very real, and when they are coming back, they need the same types of services as male veterans. And oftentimes we are told that I am not believed or they just don't understand. They just

cannot comprehend that as a woman I have been exposed to these realities of combat.

So I think VA needs to work very hard and I know there are a number of ongoing research projects in women's health specifically about combat related PTSD. I mean, there are some small groups and ongoing research that we have been very closely monitoring and we think that we are going to see more and more of that and it absolutely has to be adjusted to accommodate women veterans as all veterans.

The CHAIRMAN. Thank you.

Ms. Predeoux, have you heard of that?

Ms. PREDEOUX. The same as my colleague, Joy, it has not been reported to me, but I have heard it through attending other sessions involving women veterans, and if that is the case with regard to VA policy, then I wholeheartedly do think the policy needs to be inclusive of all veterans regardless of gender and generation.

The CHAIRMAN. Mr. Ibson?

Mr. IBSON. Yes, Mr. Chairman. I believe one of the responses we got in our survey suggested that that was the experience at that particular facility. I would not be able to represent that that was widespread, sir.

The CHAIRMAN. Well, I appreciate that. It will be one of the follow-up questions that we do send to VA because it was buried in some questions I was going to ask the Secretary, but I just wanted to know from the Veteran Service Organizations if you are aware of it.

Ms. Brown?

Ms. BROWN. Thank you, Mr. Chairman. I guess my question, and I am glad you all were able to get lunch in that small window, but what do you believe is the number one barrier veterans are facing when they are accessing mental health services because we have a lot of discussion? And I really kind of like what the Admiral was saying the last time because I have been pushing that we need to have partners, and it is just not the VA. I don't see the VA going out hiring 3,000 people.

I see us working with people that are already doing it and, for example, he said the tri-care. They have people that work with tri-care, so they already are very familiar with working with veterans/military personnel.

Ms. PREDEOUX. With regard to the number one issue, they're all important, but I would say with regard to access, it would be the wait times and actually being able to get in and oftentimes that is due to the large patient panel and patient load that the mental health providers are taking on in the VA.

We did the same as DAV, but we didn't send it out to mental health professionals. We sent our questions out to our national service officers through our benefits department, and there were some facilities where there were no wait times. Veterans were able to be seen in less than 14 days and then there were other facilities where it was 30 days or more before that initial, I guess, what was the create time from the initial point of contact.

So it is more so of getting the veterans in at the initial time and not having wait times discourage or further escalate issues.

Mr. IBSON. If I could take a shot at that, Congressman, you know, certainly staffing is a major issue and one could see that as the major barrier, and yet even to say that would be to oversimplify because staffing has so many elements.

It strikes me it is not just about recruitment as heard today, but it is also about retention, and you have to ask about VA's ability to retain clinicians when they don't have the opportunity to provide the type of treatment they think is clinically appropriate or when they don't have dedicated office space or when, as Dr. Sawyer described, they don't feel they have any independent judgment, but are recipients of directives from on high.

So it is a complicated question and a multi-faceted question as several have suggested earlier.

Ms. BROWN. Well, let me just ask you this follow up question because we are losing professionals in VA and in Federal government because lack of pay. We are not competitive with other areas. It is nice to think that you—pay is not a factor, but let us say someone goes to medical school or someone goes to a professional program. If there was some way that the student loan could be tied into working into some of the critical areas, then that would be incentive to encourage people to work in, let us say, the rural areas. You know, I live in Florida, so everyone wants to live in Florida, I guess.

But I wouldn't have the same to work in maybe a smaller town in Georgia, but if you could tie it in some way to that student loan, do you think that would encourage people to want to work in the VA for a certain period of time?

Mr. IBSON. I think that is certainly one possible strategy, but I would note Dr. Sawyer's very eloquent presentation of how young men and women in the health professions are motivated to help veterans and that pay is not necessarily the critical factor. Rather what seems important is the opportunity to be fulfilled and satisfied and work helping others, and to the extent that the system fosters that kind of environment, I think, VA would be a very conducive and attractive place to work, and I think that is a challenge.

Ms. BROWN. I agree with you, but I also heard someone coming right out of professional school, and I would think that some experience would be important working with, depending on the area of care that the person encountered. You want them to have experience, but you want them to have the academic book also. So it is a combination.

Mr. IBSON. I would agree.

Ms. BROWN. Yes, ma'am.

Ms. PREDEOUX. In our surveys that were sent out to our national services officers, pay was not a question. However, it did come up in a few responses with regard to structural issues and I did not have an opportunity to research further with regard to pay and I think it was specifically two psychologists. But the other side of that, also, and we also discussed it in the independent budget H.R. session, the VA currently has educational reimbursement programs and different scholarship programs, but they have not been increased for a significant period of time, so that is something to consider when addressing more of the systemic issues in keeping retention issues within VHA.

Ms. BROWN. Okay. I yield back.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Chairman. Thank you all for your testimony.

I do come back to the parity issue, Ralph, and this is a broader issue. I was thinking, looking at the numbers as we talk about access. In this country there is 340 people for every medical doctor. There are 3,400 for every psychologist or mental health practitioner. We are graduating about 18,000 to 20,000 doctors per year and we are already experiencing a great shortage in general practitioners. We are graduating about 4,000 psychologists. It is just impossible to keep up with those numbers. I think it goes back to where Ms. Brown and others were talking about of how we build this model to collaborate to try and drop on the resources we have. There is both a shortage in the private sector as well as the VA.

My concern is, and I will start with you, Mr. Ibson, and maybe just ask each of you. I, for one, do believe that there is an opportunity here to use some other people outside the system. I have seen it happen. I also know one of the problems is, is how do we ensure that these providers are providing evidence-based care and the outcomes we want to see, too, because if we are going to ask the VA to take taxpayer dollars and fund it out, then we are going to be asked to be accountable for every penny of that just like we are doing today.

How do we know that we are going to get the care there also, if we have to drop on outside resources? I don't know, Ralph. Have you had any thought on that or how that moves forward because I think—I just don't see the numbers here on the ability for us to deliver care as quickly because there is just not that many mental health care providers for the need that is going to be there. We cannot even keep our head above water and it is going to get worse.

Mr. IBSON. Well, at the risk of ducking your question, I did want to observe the importance of your earlier emphasis and reemphasis on outcomes because it is one thing that VA is not measuring, and given a department that is so committed to being a leader, this is an area where leadership is desperately needed in terms of developing measures of outcomes. Ultimately, having performance measures which give us indicators of inputs and throughputs and numbers and percentages, but don't tell us whether veterans are getting better. Such measures are not going to advance our veterans' well being.

I think that would be an important step to VA's solving its own problems.

Mr. WALZ. You are not as concerned on this evidence-based outcome because you are not convinced it is happening inside the VA as it stands. I don't want to put words in your mouth, but——

Mr. IBSON. I think that is fair, sir. But I think you are certainly quite right. We can't just willy-nilly put veterans in the hands of individuals who don't have the clinical competence or the cultural competence to provide them effective treatment.

Mr. WALZ. Any of us who have been at this for a while experiences this. We have the psychologist or the care provider who has worked with veterans for decades, starting with Vietnam and they

do it brilliantly and then they don't get the ability, in some cases to get fee for service. They come to us with their veterans and say, I want to see Dr. So-and-so who is outside the system and then they see it as the VA being, you know, kind of provincial, kind of holding their stuff in and they don't want to help anybody, but for every good Doctor A, there may be one out there that doesn't have that experience or isn't providing evidence based, so I am trying to find that rationale of where we set those guidelines.

Mr. IBSON. You know, I think one step forward in the spirit of this being a larger problem than just VA's, would be for VA to provide training to community clinicians in terms of just the military culture issues which are such an important part of connecting with the veteran and developing the kind of trust that Dr. Sawyer's testimony suggested was so important.

Mr. WALZ. Do the rest of you have any comments on this as a concern as we try and broaden the provider base for our veterans?

Ms. PREDEOUX. I think it is a very complex issue, especially when you are dealing with holes that are evident within the VA system, and rather than being able to quick fix, in the meantime we have veterans who need care. I do think that making sure that there are standards and safeguards in place so that there is accountability, is very important, and along the same lines of not necessarily training, but making sure that there are actual levels of literal standards that providers must meet before the VA is able to enter into that type of agreement for outside care.

Ms. ILEM. And I would just add, I think, from the previous panel, it was noted, we have some of our tri-care provider networks that obviously have that connection, the veteran cultural competency in place. VA does have, I believe, a few small pilots with a couple of them related to mental health. I think it is more in rural health right now, at least they are attempting to. It just has not been on any significant scale.

And given all of the remarks, you know, from all of the panels today, we are hoping that VA will come away with at least keeping an open mind to trying to address this problem. I have had a couple of, you know, experts say we don't think VA can buy their way out of this issue in terms of, you know, just ramping up the numbers. We know how long it is taking them to get actual people online——

Mr. WALZ. Well, I think the potential is great here to run both ways. As I said, my meetings with Mayo Clinic of looking for partnerships on Tele-Health and those types of things, I think, show that the private sector is willing to be there, and I think at least the overtures from VA is their willingness to go both ways.

I think there is a potential here for us to expand that care in both sides, and I think there is a lot of good lessons learned from our VA practitioners that can apply into the public sector, whether it is domestic violence issues or whatever they might be.

So, well, thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much, Mr. Ibson. Would you—in your testimony you talked about cultural problems facing VA. We know that there are cultural problems facing VA, but you talked about a perception that leadership employs, and I am not talking about any particular secretary. I am talking about leader-

ship as a whole, employs a command and control model without regard to whether the facility's clinical staff actually has the means to carry them out, and what I would like to ask you to do is expand a little bit about that statement.

Mr. IBSON. Well, I am attempting in that statement to echo the sentiments of many providers who responded to our survey conveying that thought. This was an anonymous survey, but of those who expressed a willingness to speak and with whom I followed up, this was a common theme. I think Dr. Sawyer expressed it perhaps better than I am. But it's about a workplace climate, which is perhaps born of good will, but which stems from centrally directed performance measures which ultimately as they find their way to the clinic level, overtake good clinical judgment and come across as mandates and directives, and seem difficult to understand.

I am thinking, for example, of a provider who reflected on a requirement to discuss smoking cessation therapy with patients and who commented that "I have a veteran sitting across the table from me whose wife just died and how ludicrous it is to think that I should set those compelling issues aside to discuss his smoking habit with him."

It is, again, I think, a matter of well intended measures that are proxies for good care, but which at the clinic level, at the provider level, don't necessarily translate to good care and overtake and impede good care.

The CHAIRMAN. Ms. Brown, Mr. Walz, any other comments?

Ms. BROWN. I do have one last question. How do you all feel—I personally feel that the VA cannot go it alone. We need to work with our partners and stakeholders and in that there was a discussion about having a series of one-day conferences to bring in the partners that were with us. How do you feel about how we can get the community more involved? For example, Jacksonville and CSX was the first wounded warrior program in the country and I am very proud of that, but how do we get more—because I don't see government just doing it alone.

I think we have to work with our partners and stakeholders in the private sector and the universities and the community colleges. It is really a team effort. And to think that the VA can just do it by themselves is ludicrous. It is too many veterans. It is too many issues. I mean we are talking about mental health, mental health. It affects my mental health if I can't pay my mortgage and I am about to lose my home. It affects my mental health—many, many things affect my mental health. When you lose a spouse, it is many things. It is not just one. So it is the whole village, and how do we engage the community and how do we get different stakeholders to participate. And so any comments on that?

Mr. IBSON. I think this hearing offers a wonderful opportunity to advance that theme. I think I hear it as a bipartisan matter and I think Admiral Mullen has spoken so eloquently of that sea of goodwill out there. I think it is a matter of harnessing that spirit and offering some leadership, and I think this Committee is in a position to do that.

Communities are desperate for avenues of engagement and I don't know that the Department of Veterans Affairs feels it has the clear signal to acknowledge its limitations and to reach out in a

way in which it, I think, very effectively could to those communities such efforts would look different, community to community, but there are, I think, enormous opportunities to advance those goals through partnerships.

Ms. BROWN. I think you all play a very important part working with us to push for these efforts that I think is like one team, one fight. I think you all, you all, the service organization, play a very important part.

Mr. IBSON. It is certainly our view.

Ms. ILEM. And I would just add, I think the community over seven or eight years ago, I mean, we have seen it repeatedly on occasion to have, you know, them come and group together saying we want to know how we can help our veterans and what we can do.

I think one of the things VA might do—as we know, many people choose not to go to VA for whatever reason. Not everybody is going to go, but certainly they may need mental health and touch the community and it may be a family member or other people within the family that are struggling along with that veteran, so if VA does have an opportunity to share their expertise through their national center for PTSD for, you know, perhaps in some cases for those who suffered trauma through military sexual trauma and other traumas, it could be very helpful if VA was able to offer that in some way for those that are seeing people in the community already.

Ms. BROWN. In closing, let me just say that I have participated in numerous workshops and town hall meetings and hearings that we had with women veterans and, you know, part of the problem a lot of women are experiencing, that they indicated, is the culture of the VA and the culture of the military. So I suggested, well, maybe we could farm this out using different organizations, outsource—oh, I hate that word—but maybe we can outsource this to different providers. And they said, no, we want the VA to provide it.

So basically we have this culture that I don't think is as conducive to women, which is the fastest growing group, but they want the VA to provide it and one example that they talked about when they walked in, but you know, they had cat calls. Well, you know, when you walk down the street, you may get cat calls, but how do you change not the people that work there, but the other people that are there in the facilities? How do you not integrate the services to provide the kinds of services that the female veterans want?

And I am not saying it for an answer. I am just spelling out some of the challenges that the VA experienced and it is going to take all of us working together to solve some of these problems. It is not just the VA. It is us, you all and us, Members of Congress, working bipartisan to try to solve these challenging issues that are so many, many, many. Whether it is our community getting together doing the stand downs that I participate in or working to eradicate the homelessness among veterans. You can't expect just veterans to do it, but it is veterans, VA hard labor, all of us working together, everybody doing their job, everybody being on their A game and not just expecting the VA to go it alone. It is a team effort. Thank you, and I yield back the balance of my time.

The CHAIRMAN. I thank you very much. I would ask unanimous consent that all members would have five legislative days to revise and extend their remarks.

And without objection, so ordered.

And I want to again thank the witnesses for remaining with us. Dr. Petzel, thank you, sir, for remaining the entire time of this lengthy hearing. We know that it is important to you and we appreciate you being here.

And with that, this hearing is adjourned.

[Whereupon, at 3:58 p.m. the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman

The Committee will come to order.

Good morning, and welcome to today's Full Committee hearing "VA Mental Health Care Staffing: Ensuring Quality and Quantity."

Two weeks ago yesterday, the VA Inspector General (IG) released a report reviewing veterans' access to mental health care.

To say that the findings in that report are troubling would be a serious understatement.

Perhaps most disturbing is IG's discovery that more than half of the veterans who seek mental health care through VA wait an average of FIFTY days to receive a full mental health evaluation.

Let me be very clear—a veteran who comes to VA for help should never—under any circumstance—have to wait almost two months to receive the evaluation they have asked for and begin the treatment they need. There is no excuse for this.

Given the gravity of the issues we will discuss this morning, I invited Secretary Shinseki to participate in today's hearing.

Sir, I was concerned, based on a letter from you last week, that you would not be joining us this morning.

I am very glad that is not the case.

As you know, leadership and accountability begin at the top.

These hearings are much more than just opportunities for the Committee to hear from the Department.

They are also opportunities for the Department to hear from us.

And, in both respects, there is no one better positioned to represent VA than you are.

Thank you for being here this morning.

Interestingly, just days before the IG report was released, VA made a surprise announcement that VA would be increasing their mental health staff by nineteen hundred—adding approximately sixteen hundred clinicians and three hundred support staff to their current roster of just over twenty-thousand mental health professionals.

Ensuring VA is staffed adequately to fulfill the care needs of our veterans and their families is a priority of mine. On its face this is an encouraging step.

However, I remain deeply concerned by the timing and implication of this announcement.

The IG's report clearly illustrates that the VA does not have meaningful or reliable data to accurately measure a veteran's access to care or a facility's mental health staffing needs.

The IG states—and I quote—"... the complexity of the computations and inaccuracies in some of the data sources, limits the usability of productivity information to fully assess current capacity, determine optimal resource distribution, evaluate productivity across the system, and establish mental health staffing and productivity standards."

Which begs the question—if VA doesn't even have a complete picture of the problem, how confident can we be that access will be increased and care enhanced by VA's knee-jerk reaction?

This is not the first time we have been here.

There is a long history of IG, Government Accountability Office (GAO) and stakeholder reports that have found serious deficiencies with the VA mental health system of care, including appointment scheduling processes and procedures, PROVIDER performance measures, and data collection efforts.

There is an equally long history of Congressional oversight.

Strides have been taken, but they are far from enough.

I would like to give the Department the benefit of the doubt.

I believe that we all have the best interests of our veterans at heart.

But, I am afraid that VA's response in this instance is yet another example of a Federal bureaucracy providing a quick-fix, cookie-cutter solution to a very serious, multifaceted problem.

A true definition of access to care can be found in a 1993 Institute of Medicine report which reads, in part, "[t]he most important consideration is whether [patients] have an opportunity for a good outcome—especially in those instances in which medical care can make a difference."

The one point three million veterans who sought mental health care through VA last year deserve better.

The very least we owe our veterans is a chance.

VA can make a difference and VA must make a difference.

Thank you all for being here today. I now yield to the Ranking Member, Ms. Brown.

Prepared Statement of Robert L. Jesse, M.D., Ph. D.

Chairman Miller, Ranking Member Filner, and Members of the Committee, I appreciate the opportunity to address access to, and quality of, VA's mental healthcare. I am accompanied today by Mary Schohn, Ph.D., Director, Office of Mental Health Operations, Antonette Zeiss, Ph.D., Chief Consultant, Office of Mental Health Services, and Annie Spiczak, Assistant Deputy Under Secretary for Health for Workforce Service, supporting all of VHA.

Over the past several years VA has been transforming its mental health delivery system in response to the growing demand for these services. Over the previous year, VA has learned a great deal about both the strengths of our mental healthcare system, as well as areas that need improvement. VA's Office of Inspector General (OIG) recently completed a review of our 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 along with our internal reviews to implement important enhancements to VA mental healthcare. VA constantly strives to improve, and any data and assessments—positive or negative—will be used to help enhance services provided to our Veterans.

The OIG confirmed that Veterans seeking an initial mental health appointment did generally receive the required rapid triage evaluation in a timely manner. This is an important step to identify high risk patients who need immediate intervention. While a mental health evaluation within 14 days following the triage referral generally occurs, we agree with the OIG that not all Veterans were able to receive a full diagnostic and treatment evaluation required by VA policies, 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—VA must do more to deliver the mental health services that Veterans need in a time period that supports their care.

Based on these findings, we are enhancing staffing and recruitment efforts, updating scheduling practices, and strengthening performance measures to ensure accountability. By taking these steps, we are doing more than ever to deliver accessible, high quality mental healthcare to Veterans. My written statement describes how we have traditionally evaluated access to mental healthcare 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. In light of these discussions, I will conclude with an explanation of VA's recent enhancement of mental health staffing.

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. Access can be realized in many ways: through face-to-face visits, telehealth, phone calls, online systems, mobile apps, and community partnerships. 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. VA believes that mental healthcare must constantly evolve and improve as new research knowledge becomes available. As more Veterans access our services, we recognize their unique needs and needs of their families—many of whom have been affected by multiple, lengthy deployments. In addition, proactive screening and an enhanced sensitivity to issues being raised by Veterans have identified areas for improvement.

In an effort to increase access to mental healthcare and reduce the stigma of seeking such care, VA has integrated mental health into primary care settings. Since the start of fiscal year (FY) 2008, VA has provided nearly two million Primary Care-Mental Health Integration (PC–MHI) clinical visits to more than 575,000 unique Veterans. Primary care physicians systematically screen Veterans for depression, post-traumatic stress disorder (PTSD), problem drinking, and military sexual trauma to identify those at risk for these conditions. Research on this integration shows that as a result, Veterans who would not otherwise be likely to accept referrals to separate specialty mental healthcare are now receiving mental health treatment. Among primary care patients with positive screens for depression, those who receive same-day PC–MHI services are more than twice as likely to receive depression treatment than those who did not. These are important advances, particularly given the rising numbers of Veterans seeking mental healthcare.

In August 2011, VA conducted an informal survey of line-level staff providers at several facilities and learned of concerns that Veterans' ability to schedule timely appointments may not match data gathered by VA's performance management system. These providers articulated 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 finding, VA took three major actions. First, VA developed a comprehensive action plan aimed at enhancing mental healthcare and addressing the concerns raised by its staff. Second, VA conducted external focus groups to better understand the issues raised by front-line providers. Third, VA is conducting a comprehensive first-hand assessment of the mental health program at every VA medical center. As of April 25, 2012, 63 of 140 (45 percent) site visits have been completed, and the remainder will be completed by the end of the fiscal year.

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 VHA Handbook 1160.01 entitled Uniform Mental Health Services in VA Medical Centers and Clinics, 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 October 2011. 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 healthcare system in the country faces similar challenges in scheduling appointments, but as a leader in the industry, and as the only healthcare 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 will modify the current appointment performance measurement system to include a combination of measures that better captures each Veteran's unique needs throughout all phases of his or her 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). VA will ensure this approach is structured around a thoughtful, individualized treatment plan 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 (the metric used by the OIG during its review), 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 regarding the quality and timeliness of their appointments.

Quality of Care

VA has made deployment of evidence-based therapies a critical element of its approach to mental healthcare. 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 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. 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. Providing the best treatments with the strongest evidence base is crucial to care, but is only one piece of a broader, ongoing commitment to rehabilitative care and treatments for other co-occurring mental health problems or other psychosocial problems that may develop.

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 healthcare was superior to other mental healthcare 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.

VA's realignment of VHA last year created an Office of Mental Health Operations with oversight of mental health programs across the country. This has aligned operational needs and connected resources across the agency with data collection efforts 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.

Enhancing Mental Health Staffing

Decisions concerning staffing and programs were determined historically at the facility level to allow flexibility based on local resources and needs. In the past year, as evidence accumulates, it has become clear that sites can benefit from more central guidance on best practices in determining needed mental health staff. While no industry standards for accurate mental health staffing ratios exist, VA developed and is piloting a national prototype staffing level model for general mental health outpatient care. This staffing level model uses a methodology that considered findings in academic literature, consultation with other healthcare systems, and utilization and staffing data. This staffing model will be further refined as VA monitors its effectiveness and incorporates team-based concepts. VA will build upon the successes of the primary care staffing model and apply these principles to mental health practices. The model is based on the following guiding principles:

- Delivering quality comprehensive mental healthcare;
- Coordinating mental healthcare across all MH disciplines and the integration with primary care;
- Ensuring effectiveness and efficiency of service delivery by having all staff working at their highest level possible;
- Promoting team staffing to support all providers to function at the highest level;
- Dedicating time for indirect patient care activities (for example, care planning and team coordination); and
- Supporting a team response to emergent and non-emergent patient and family needs (for example, unscheduled phone calls).

The model's clinical staffing ratio is as follows:

Employee Category	Full Time Employee Equivalent for Mental Health Clinic Panel Size of 1,000
Total Mental Health Clinician	5.1–5.5
Administrative Clerical Support	0.5–1
Clinical Support Direct	1
Total FTEE	**6.6–7.5**

Applying this model and these ratios, VA determined an additional 1,700 mental health staff members (including administrative and clerical staff) were needed to augment existing resources across the country. Clinical staff will represent all specialties, including psychologists, psychiatrists, social workers, mental health nurse, licensed professional counselors (LPC), licensed marriage and family therapists (MFT), and others. In addition, VHA projected an additional 100 compensation and pension examiners would be needed. Each Veterans Integrated Service Network (VISN) is receiving some additional support in either clinical or clerical staff or compensation and pension examiners. VA is also adding 100 staff to the Veterans Crisis Line to support projected increases in the use of this service. These enhancements in total will add more than 1,900 employees to VA's existing mental health staff of more than 20,500. VA Central Office is providing technical assistance to VISNs to help them with implementation and is providing additional funding to aid recruitment and hiring. VA's Office of Mental Health Operations will obtain monthly updates from facilities receiving funding to ensure implementation is timely and that resources are used appropriately.

We are testing this model through a pilot program in VISNs 1, 4, and 22, and we anticipate national implementation of this new model by the end of this 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 that VA is addressing. We will use this staffing level model, with refinements made over time, to guide staffing decisions in the future. This will be combined with a review of revised clinical outcome measures, to be developed in consultation with other subject matter experts from VHA and the OIG, to evaluate whether enhanced staffing results in enhanced performance on more valid measures. We will reassess levels of care needs and specialty services based on these multiple data sources.

Despite the national challenges with recruitment of mental healthcare professionals, VA continues to make significant improvements in its recruitment and retention efforts. Specialty mental healthcare occupations, such as psychologists, psychiatrists, and others, are difficult to fill and will require a very aggressive recruitment and marketing effort. VA has developed a strategy for this effort focusing on the following key factors:

- Implementing a highly visible, multi-faceted and sustained marketing and outreach campaign targeted to mental healthcare providers;
- Engaging VHA's National Health Care Recruiters for the most difficult to recruit positions;
- Recruiting from an active pipeline of qualified candidates to leverage against vacancies; and
- Ensuring complete involvement and support from VA leadership.

VA anticipates the majority of hires for this effort will be selected within approximately 6 months, with the most "hard-to-fill" positions filled by the end of the second quarter of FY 2013. A VHA task force is targeting the recruitment and staffing requirements to bring these new employees into VA as effectively and efficiently as possible to meet our goals leveraging all available tools to bring needed providers on board.

Implementation of the model will also support linking patients to their Patient Aligned Care Team (PACT) for care management (including medication maintenance and monitoring), enhance care transitions, expand peer-led services and community engagement for supportive care, and increase access to evidence-based individual and group psychotherapies, family and marital psychotherapies, and psychopharmacological treatments. The model will guide optimal team composition and provider-to-patient ratios assessed based on facility complexity levels and patient care needs.

VA Central Office 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.

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 healthcare. These additional staff will increase access by allowing more providers to schedule more appointments with Veterans. Simultaneously, VA is providing additional resources to expand peer support services across the Nation to support full-time, paid peer support technicians. While providing evidence-based psychotherapies is critical, VA understands Veterans benefit from supportive services other Veterans can provide.

Finally, VA's efforts to nurture and sustain our academic affiliations provide opportunities across the country for residents in different disciplines, including psychiatry and psychology, to continue their education while helping our Veterans. VA currently supports more than 2,500 training positions in mental health occupations (including psychiatry, psychology, social work, and clinical pastoral education residency positions).

Conclusion

By adding staff, offering better guidance on appointment scheduling processes, and enhancing our emphasis on patient and provider experiences through specific performance measures, 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. 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 healthcare 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 healthcare. As VA reaches out to serve all generations, and as our intensive, effective outreach programs bring in greater numbers of Veterans to VA's healthcare 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.

Mr. Chairman, we know our work to improve the delivery of mental healthcare 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.

Prepared Statement of John D. Daigh, Jr., M.D.

INTRODUCTION

Mr. 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 healthcare services at VA facilities. We conducted the review at the request of the Committee, the VA Secretary, and the Senate 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 healthcare 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 healthcare. 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 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 healthcare 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 decision makers 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 healthcare 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

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

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 time frame.

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 healthcare providers, VHA's mental healthcare 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 decision makers 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 decision making 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 measureable in practice given existing infrastructure.
- Are clinically or administratively relevant.
- Provide complementary or competing information to other measures used by decision makers.
- 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 1-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 refers 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 decision makers 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 healthcare, 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 decision makers 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 measures 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 decision makers 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 healthcare 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 healthcare 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 decision making requires reliable data. A series of paired timeliness and treatment engagement measures might provide decision makers with a more comprehensive view of the ability with which new patients can access mental health treatment.

Mr. 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.

Prepared Statement of Nicole L. Sawyer, PSYD

Chairman Miller, Ranking Member Filner and Members of the Committee:

Thank you for inviting me to participate in this important discussion regarding the "quality versus quantity" dilemma facing VA mental healthcare.

I want to convey my appreciation for the efforts of this Committee and its clear commitment to the mental healthcare of our veterans. I recognize that mental health is only one of the vast concerns under your authority and I value your diligence in this matter.

I am a licensed clinical psychologist with a primary focus on the treatment of trauma in both the veteran and civilian population. In addition to having worked at a VA medical center, I have worked in a number of clinical settings including Federal prison, an urban psychiatric inpatient facility, a college campus, two community mental health centers, and currently in my own private practice where the majority of my caseload consists of combat veterans and adult survivors of such traumas as childhood sexual abuse, domestic violence and sexual assault.

In addition to my clinical practice I am an appointed member of the New Hampshire Legislative Commission on (military service-connected) PTSD and TBI (SB102), an active member of the New Hampshire Psychological Association Continuing Education Committee, and I am also a training board member and mentor for psychology interns and post-doctoral fellows working in my local community mental health center.

In October of 2009, in addition to my established private practice, I took a part-time position as the Local Evidence-Based Psychotherapy Coordinator for the mental health service line at the Manchester VA Medical Center in Manchester, NH. My job was to coordinate clinician training and implementation of the Evidence-Based Psychotherapies (EBPs) the VA had been rolling out since 2005. I soon found that I needed to be more involved with the structure and function of the service to do my job effectively, so I took a significant role in the Mental Health Systems Redesign Committee and began working on several projects important to improving the function of our service line and thus the application of EBPs in our clinic. In these roles I had the opportunity to work closely with our veterans and also work intimately with the clinicians on the service. I met with clinicians regularly, both formally and informally, to discuss their needs as providers and the problems they were encountering clinically and with regard to self-care. In addition, my roles brought me into close and frequent contact with the leadership of our mental health service where I worked to get training opportunities approved and lobbied for clinic and clinician availability to provide the treatments required by the Uniform Mental Health Service Handbook. My role also required at least monthly contact with other EBP Coordinators in the network and nation-wide as well as attendance at required conferences and trainings that brought all of us together to discuss the successes and failures we were facing at our respective facilities.

Due to increasing ethical concerns about the care and treatment of our veterans in Manchester, I chose to resign my position this recent February. I hope to share with you here some of the concerns that led to this difficult decision, as well as the impact that VA culture and common practices have on the ability of dedicated clinicians to provide quality mental healthcare to our veterans.

PTSD and the Veteran's Dilemma

Many of the men and women that cross the threshold of a VA medical center have been faced with decisions, and taken action, on matters far out reaching the imaginations of most. Many have made choices, and followed orders, that carry weight impossible to endure alone, though they try. For most, the decision to seek mental health treatment is an admission of failure, an inability to "hack it." For many, the decision feels humiliating and shameful; it is the admission of weakness and the declaration of vulnerability.

Many combat veterans spend years trying to cover their invisible wounds; they carefully tend the scabs they have created to protect those exposed places. Many of the symptoms of PTSD are reinforced through misguided attempts to tend and protect their mental injuries. They may avoid things that remind them of experiences and actions they would rather forget. They may push loved ones away in order to ensure no one sees their weakness. They may drink to numb the memories, the nightmares, and the pain. And tragically some take their own lives to escape the hurt, or to protect others from the hurt that they believe they will inevitably cause.

"If she only knew . . . " is an all too common phrase I hear in my therapy sessions with combat veterans. The deep belief, and fear, that if others, especially loved ones, "knew" what they had done, they would no longer love them. They would be ashamed, angry, and worst of all, afraid of them.

Most of us have only the vaguest sense of the experience of combat and war. The successful military leaves its civilians largely ignorant of war's horrors. Combat veterans are no longer ignorant, but try to play along, because for them, even at home, the job never ends.

Entering into mental health treatment is wrought with gut-wrenching decisions. Admitting the need for help is the first one, making the telephone call is the second, showing up for the appointment is the third; but the fourth is the heaviest of all, speaking the pain.

Endless research, and certainly my experience, informs me that the closer together decisions 1 through 3 occur, the more likely the veteran will commit to the task. This is not rocket-science: the more rapid the decision-making process the less likely any of us are to let our doubts and fears derail us. But VA healthcare facilities too often fail our veterans before they are even faced with the critical fourth decision—unburdening themselves of the trauma they have experienced. This was clearly demonstrated in the recent OIG report that identified the lack of timely access to mental healthcare, resulting in a majority of veterans having to wait more than 50 days to begin treatment.

The Fourth Decision: Speaking the Pain

In my experience, and from my perspective, nearly 70% of the work of combat trauma treatment is in the telling. The telling doesn't have to be to the therapist, though it often is at first. But the telling must occur. Speaking the story, the pain, the regret, the guilt, and the shame that are fixed to the experiences that drive a veteran into treatment marks a beginning on the road to recovery, but it is NOT the beginning of treatment.

Treatment begins long before the story is told. It begins with trust. Our veterans must trust in the system meant to serve them, trust in the process of therapy, and trust in the clinician assigned to their care.

Trust for the combat veteran does not come easy. Trust is the belief that one's story will not be judged, that the individual's feelings will be validated and accepted, and that despite having spoken one's pain to another soul, the veteran remains in control of that information. For a person who has done things, seen things and felt things that—if they had occurred at home—would be considered monstrous and evil, trust is a myth. Don't get me wrong, a soldier knows trust, he knows what it is to believe that the person next to him cares as much about his life as he does, but to trust in a person who does not share your pain is a risk exceeding all manner of bravery. Fear of judgment tends to lead the pack of fears held by those considering mental health treatment. They fear that their actions and the feelings attached to them are rare and will be misunderstood by those unfamiliar with war.

Most VA clinicians are ready to hear the pain. They are well trained, dedicated, committed and passionate about veterans. They understand the fears and reservations and are prepared to knock them out at a pace that provides safety and comfort for the veteran sitting across from them. Most do not know the pain themselves, but they know what it takes to connect with their veterans and they know what it means to trust.

But trust takes time, and time is NOT what most VA clinicians have when it comes to the treatment of their veterans.

The Clinician's Dilemma: Professional Ethics or Performance Measures

Mental health is subjective. It is not easily defined and nearly impossible to measure. It does not fit neatly into a medical model the way the diagnosis and treatment of hypertension or diabetes often does, and the stigma associated with the need for care is nearly unmatched by any other health issue. But the VA, like most managed care organizations, attempts to squeeze mental healthcare into a medical framework. Inevitably, corners are cut in order to make it fit.

Psychotherapy is a process, not a prescription. It is work that takes time and builds upon the successes and failures of the previous sessions, and life lived in between. The professional psychotherapist is trained to help the patient identify needs, feelings, and goals that are often hidden or buried under old habits, experiences, and beliefs about themselves and the world. We are all shaped by our experiences and we all develop methods for understanding and coping with those experiences, for better or for worse. For some, our strategies for coping and understanding lead us astray and we find ourselves drifting or trapped in patterns that are harmful and destructive. Psychotherapy is intended to steer us back on track with new strategies and better understanding that will lead to acceptance. Some types of psychotherapy are strictly guided and directed, other types are more evolving and flowing; both have their place in quality mental healthcare, and both require the patient to trust in the process and in the clinician, to be successful.

The VA struggles to understand and value the importance of trust in the success of mental health treatment. We all value trust in our lives. We trust our children with babysitters, we trust our accountants with our money. We took time to develop trust in these individuals. Why is it not obvious and a priority to value the development of trust in the service of mental health treatment? It is not a difficult task to achieve, hire competent staff and give them the time to do their jobs well: trust will follow.

Given a small mental health staff relative to the ever-growing numbers of veterans seeking mental healthcare, the dedicated clinicians with whom I worked at the Manchester VA Medical Center faced a daily ethical dilemma: the veterans sitting before them were often in great need, and might be motivated and anxious to open up old wounds, air them out, and begin the healing process. But often, the clinicians could not join them in this journey. Ethically, they could not rip open those wounds. Faced with a patient caseload that was growing exponentially, and no open appointments in sight, that clinician could not, and rightfully would not, open a wound only to let it fester untreated for the weeks or months it might take to see that veteran again.

As I said, psychotherapy builds upon the successes and failures of the previous sessions; it requires consistency and predictability in scheduling and frequency of appointments. Trauma cannot be treated haphazardly based on random blocks of availability. Trauma treatment demands a session every week or every other week. Too much time between sessions allows suffering to linger too long after wounds have been opened. Too much lingering leads to re-traumatization and bolstering of the negative patterns the treatment is intended to dismantle.

It is apparent that at many facilities across the country, VA clinicians are overrun with veterans in need. Mental Health Service Lines are pushing as many veterans into clinician schedules as possible to meet their performance measures, but those veterans are not getting effective treatment. Effective treatment takes time. It requires a full and timely evaluation of needs, a chronic and nationwide deficit noted by the recent OIG report. It requires a frequency of sessions in a timely manner consistent with the clinical needs identified by that full evaluation, another chronic deficit noted by the OIG. It requires trust and predictability. Too often, under the circumstances which VA facilities and mental health clinicians are working, an emphasis on addressing "quantity" is overtaking a commitment to the quality of treatment.

The effects of a "quantity over quality" approach to mental health treatment has obvious and not-so-obvious repercussions for veterans. Some veterans cling to the hope for years that somehow those randomly occurring sessions with their therapist will help them find relief from their demons. They arrive for every appointment, but as I have discussed, little in the way of demons can be explored. Others drop out quickly, angrily muttering about the "waste of time" and conclude that therapy can't help them. Often, they never return, to the VA or elsewhere, for mental health treatment. But what is most tragic is that many of those veterans blame themselves for not getting better. Like most people, they do not know what effective mental healthcare is supposed to look like. They assume, deep in that place where their guilt and shame lay, that they have failed to get better, that they are too far gone to be helped. I have heard those words from the mouths of the veterans I have had the honor to treat, on the off-chance that they gave psychotherapy one more try.

Caseload and Productivity

Staffing is an obvious weakness in VA mental healthcare and Secretary Shinseki's announcement last month of 1900 additional mental health staff is a welcome attempt at strengthening this service. But how do we know if 1900 is enough?

In order for a service to be able to evaluate its need for staff and resources it must be able to assess the demand on its clinicians. The VA, however, lacks any definitive

expectation for clinical productivity. Without such parameters it is impossible to identify a clinician's caseload as "full" and therefore it is impossible to determine if the flow of veterans into the service exceeds the capacity of the clinic. Without this critical information a service struggles to know how many clinicians it needs to meet the demand.

Determining clinician caseload is exceedingly important and must be a priority for VA. Community mental health clinics and other mental health facilities, including group practices in the private sector have defined the expectations for their clinicians. The factors that go into making these determinations exceed the scope of my testimony, but the benefits to clinicians, patients, and to organizations are clear. When a clinician has a productivity expectation, that is, a clear expectation of how many hours per week he or she is expected to be providing direct services to veterans, he or she can build into their day the time necessary to meet the administrative demands essential to effective treatment. The clinician can plan for writing of session notes, treatment plan reviews, formal consultation with other providers on a case, and returning patient phone calls. The clinician might even have the flexibility to see more urgently, an established patient who is on the verge of a crisis, and stave off an emergency. All of the tasks I noted here are basic requirements of effective mental healthcare. They are tasks demanded by the ethics that govern all mental health professions, and yet, in my experience, they are seen as luxuries at the VA. These important tasks are given no priority because the system relies on so-called "workload" data, and this important work is not easily captured.

When productivity for a clinician is defined, a caseload definition easily follows. The size of a clinician's caseload can be somewhat flexible when consideration is given to the intensity of treatment needed by each veteran. When a clinician's productivity is measured based on the number of hours they spent providing therapy that week, the caseload is defined by how many veterans that clinician can treat in a clinically responsible way. For example, in a community mental health center in which I worked, clinicians in the adult outpatient department were expected to provide 22 hours of psychotherapy per 36 hour work week. This productivity expectation rounded out to roughly 40 patients on a full-time clinician's caseload. The caseload would inevitably be composed of some patients in need of weekly sessions, some in need of every other week sessions, some coming only for monthly maintenance check-ins and still others who were not yet committed to a treatment schedule. The challenge for the clinician and the service was to juggle the number of outgoing (discharged) patients who had achieved their goals and were no longer in need of services with the number of new patients to accept into their caseload. This particular mental health center simply required all clinicians to conduct two "intakes" per week to be included in their 22 hours of productivity. It wasn't a perfect system, but it provided an access expectation along with a productivity expectation that easily communicated our staffing needs and allowed us to prepare for and predict seasonal influxes of referrals. In contrast, at the Manchester VA and other facilities, a clinician could easily have hundreds of veterans on his or her "caseload." Caseloads grew exponentially for a number of reasons: among them, 1) Incoming veterans were doled out like cards in a deck with no regard for the number of veterans each clinician was already trying to serve, no regard for availability of appointments, or expertise in the area of need. 2) When a veteran is only able to be seen on a sporadic basis with weeks and even months between appointments, psychotherapy is impossible and little clinical progress is made. With little clinical progress veterans do not achieve their goals and/or find relief from their symptoms, and without these markers a clinician cannot effectively discharge veterans from care. 3) Chronic understaffing, clinician turnover, and facilities refusing to backfill positions lead to other clinicians having to "pick up" hundreds of veterans left abandoned when a clinician resigns.

This lack of administrative management of caseload interferes with the quality of care a clinician can provide. While trying to attend to the veteran in front of them, clinicians are forced to think about how far out they are booked before asking a question, challenging a thought, exploring a perception. Knowing that the veteran is not likely to make his or her way back into their office for several weeks, if not months, is enough to derail what might have been a poignant intervention with big potential for healing. Clinicians are virtually gagged under such circumstances and stressed by the helplessness they face with unfettered inflow of veterans and minimal potential for outflow. This ongoing experience creates a chronic sense of failure and undermines the expertise and skill required to be an effective psychotherapist.

In short, development of productivity expectations and clinician caseload definitions are essential to the accurate determination of staffing needs at the facility level. Without this data there is no way to determine if 3, 5, or 20 additional clinicians will be enough to meet the demand of an individual mental health service.

And without these parameters, there is no way a clinician and a service can ensure adequate frequency and timely access for a veteran to get the kind of care they deserve.

Why VA Can't Fill Vacancies

Veterans, particularly combat veterans and victims of military sexual trauma, are an intense population to treat. From my perspective the rewards are unmatched, but in order to reap the rewards a provider has to be in a position to help.

The VA has 1500 vacant mental health positions for which they are currently recruiting. Secretary Shinseki recently approved 1900 more positions. I have already discussed the difficulty in knowing if this number will be enough, but one can reasonably ask how VA will fill these new positions when 1500 positions are currently sitting empty, and have been for months and even years.

But this is not the only pertinent question. Many VA facilities across the Nation simply do not have space for more clinicians. Buildings are outdated, space is poorly distributed among specialty departments; services have simply outgrown their walls. At Manchester, for example, clinicians hired recently spend time dragging carts full of paperwork and other necessary resources around the hallways because they lack offices. They show up to work each day unsure whose, if anyone's, office they might be able to use for the afternoon or maybe for an hour. This is not simply inconvenient, unprofessional and demeaning for the clinician, but it has a significant impact on the patient. Continuity and predictability are important aspects of quality clinical care. In particular, safety in their space and predictability in their environment are important to many veterans struggling with PTSD. Attending therapy sessions in a different office, possibly on a different floor of the building, every time they arrive, is distressing and can impede progress, possibly even contribute to abandonment of treatment. The lack of space is a significant barrier not only to quality care for veterans, but for the hiring and retention of staff.

Psychologists and psychiatrists, in particular, have among the highest turnover rates in the VA for mental health service. These higher rates are likely a result of the pay versus "hassle" ratio that is difficult to overcome in the current VA system. VA compensation for psychologists and psychiatrists, in most regions, is comparable, if not less, than what the same professional could make in another facility or on his or her own. It is not surprising that some psychologists and psychiatrists will choose to go elsewhere for employment. Those that do choose to work for the VA often become overwhelmed and frustrated by what some feel are ethical compromises and minimal respect.

Clinical social workers, on the other hand, face a different dilemma. VA compensation for a clinical social worker, in most regions, is well above, even double, what he or she could make at another facility in the community. The compensation can become a trap for these dedicated professionals. Seeking employment elsewhere is not typically an option but the chronic disrespect and ethical compromises some experience lead to burn-out and high levels of personal stress.

Much of the stress and disrespect felt by many clinicians stems from the very limited clinical independence most are afforded. In most facilities, clinicians have little or no control over their schedule or how their time is allotted, have no control over their caseload, and are required to provide services and use methodology that they believe clinically inappropriate for their veteran. And worst of all, many VA mental health clinicians must set aside their own clinical judgment in response to the overriding requirements dictated by Central Office performance measures and other mandates that direct how veterans are to be treated. The need to meet numbers motivates facilities to abandon some treatment modalities in favor of others, regardless of the clinical indication for the veteran. Clinicians are generally helpless to fight against this, though they try, as many clinicians at my facility did. This can be humiliating for a mental health professional with an advanced degree, passion, and experience in helping those in need.

Without a real effort to address these cultural issues, the VA will be hard pressed to hire and retain the quality professionals our veterans deserve.

Conclusion

In conclusion, I want to thank the Committee again for the opportunity to share my experience and insights. I hope that if there is anything I have communicated here, it is that quality care—and by that I mean effective care—must not be sacrificed for quantity. VA has a responsibility to provide veterans timely, effective mental healthcare. Among the critical steps it must take to meet that responsibility is to establish a productivity and caseload model for mental health clinicians and ensure that adequate space is available to provide treatment. But it must go further: in raising the standard of care, it must also reinstate trust—a critical element

in making VA a place where veterans in need want to get their care, and where dedicated, skilled clinicians want to be employed.

I am happy to answer any questions you may have.

Thank you.

Prepared Statement of Diana Birkett Rakow

Good morning, Chairman Miller, Ranking Member Filner, and members of the Committee. I am Diana Birkett Rakow, Executive Director of Public Policy at Group Health Cooperative, an integrated healthcare coverage and delivery system based in Seattle, Washington.

Thank you for inviting me to be here this morning to discuss Group Health's experience managing mental health appointments for our members. We recognize and appreciate your leadership in ensuring our Nation's veterans receive the high-quality mental healthcare they deserve. While our patient population and the context in which we provide care differ from the Veterans Health Administration, we share a commitment to ensuring that patients get the care they need, in a timely and effective manner, to improve and preserve their health. We are grateful for the opportunity to share our best practices, and hope this information is useful as the Committee and the Veterans Administration work to continually improve mental healthcare for our Nation's veterans.

Group Health Cooperative is a nonprofit health system that provides both coverage and care. Directly and through our subsidiaries, we cover more than 660,000 residents of Washington State and northern Idaho, about 60 percent of whom receive care in Group Health owned and operated medical facilities. Over 1,000 physicians are part of the Group Health group practice, and we contract with more than 9,000 providers throughout the state. We offer health coverage through public programs and in the commercial market—in Medicare, Medicaid, the State Basic Health Plan, State and Federal employee programs, in the individual market, and to small, medium, and large employer groups. We also support employers who have elected to self-fund their employee health coverage.

Today I will discuss how Group Health has created a model and systems that have allowed us to provide, track, and ensure timely access and high-quality care for our patients, in particular those with mental health needs. Our success in this area is due to the interaction of our philosophy, our model of care, and the tools we employ to establish processes and systems to track and continuously improve performance.

Group Health is committed to patient-centered care and coverage, a philosophy that guides our approach to mental health services, the subject of this hearing, as well as every other type of healthcare we provide. This philosophy provides a foundation for our model of care, which is based on the Chronic Care Model. This model, designed by Dr. Ed Wagner—the founding Director of the Group Health Research Institute—is an evidence-based framework for healthcare that delivers safe, effective, and collaborative care to patients. In simple terms, this means that our model is designed to link all aspects of the healthcare system together—health insurance, healthcare providers, clinical information systems, and more—to facilitate productive, continuous interaction between engaged, informed patients and a multi-disciplinary care team.

This philosophy and model of care have been critical to our success, but it has been the more recent implementation of Lean tools and processes that have enabled us to take our work to a new level. Lean is a management method made famous by companies like Toyota, and in healthcare it provides the discipline and focus to commit to understanding the needs of patients, to building systems and processes designed around the patient's needs, and to continuously track outcomes and improve processes to meet to meet quality and performance goals.

Behavioral Health at Group Health

Research shows that 25 percent of people have a diagnosable behavioral health issue—whether a mental health issue or a chemical dependency—arise within a given year, and 50 percent over the course of a lifetime. Among those with a behavioral health issue, about 80 percent seek help in the primary care environment. This can be for several reasons: because the patient is more comfortable in that environment, because his condition has presented as or alongside a physical ailment, or because primary care services are most readily available. About one-third of patients with a behavioral health issue ultimately access help in Behavioral Health Services.

At Group Health, the Behavioral Health Services department is responsible for delivering mental healthcare in seven of our own outpatient clinics, managing behavioral healthcare delivered by our contracted network providers, and providing consultative specialty services to primary care physicians who provide care through our Patient-Centered Medical Home.

We employ over 150 behavioral health professionals including psychiatrists, clinical psychologists, Masters-level psychotherapists, nurses, care managers, and chemical dependency providers. In addition, we have contracts with approximately 800 behavioral health specialists in the network. Together, these providers offer a full continuum of mental health and chemical dependency treatment services from outpatient to acute inpatient care. In 2011, Group Health provided specialty behavioral healthcare to over 50,000 members, about 8 percent of our patient population. Approximately 45 percent (22,550) of members receiving specialty behavioral health services are served in the group practice clinics and 55 percent (27,561) were served in the network. The majority of chemical dependency services and all inpatient services are provided in the network.

The combination of philosophy, model of care, and Lean tools described above has enabled Group Health to address and improvements in three areas critical to mental health services: initial appointment access, follow-up appointment access, and provider capacity and productivity.

Initial Appointment Access

For some patients, ensuring timely access to behavioral health services can literally be a matter of life or death; for all patients, timeliness is important. Our data have shown that timely appointing is one of the top drivers of a patient's satisfaction with her behavioral healthcare experience. But timely access—both initially and for follow-up care—requires collaboration, sound clinical judgment, rigorous processes, and consistent measurement and evaluation.

Collaboration is illustrated by the close relationship developed between primary care providers, specially-trained appointing and triage staff, and behavioral health professionals. When a patient contacts us seeking an appointment, either directly or after having been referred by his primary care provider, a standard process to assess the urgency of the patient's needs is triggered. Appointing staff ask the patient a series of evidence-based questions and rate the patient's level of urgency as routine, urgent, or emergent. A routine patient is of low to moderate risk and verbalizes that she can wait between 7 and 14 days to be seen. An urgent patient is in severe emotional distress but able to wait 48 hours for an appointment. A patient considered emergent may be psychotic, suicidal, have withdrawal symptoms, or a sense of desperation, and needs to be seen within 6 hours.

Under our standard process, patients who convey a sense of urgency on the initial call are immediately transferred to a care coordinator—a Master's level counselor—to further assess the urgency of her needs. At this stage, clinical judgment is critical. Patients judged to be at immediate risk for a suicide attempt, who are going through acute withdrawal, or who are gravely disabled are sent to the emergency room or urgent care. In some cases the police are called.

These standards for scheduling an initial appointment were adopted from the National Committee for Quality Assurance's (NCQA) standards for behavioral health appointment access. Group Health has maintained an NCQA "excellent" level of accreditation since the late nineties, based upon a set of measures that includes access to behavioral health services. At Group Health, we aim to ensure that 90 percent of our patients with emergent needs receive an appointment within 6 hours, 85 percent of patients with urgent needs receive an appointment within 48 hours, and 80 percent of patients with routine needs receive an appointment within 14 days. These targets were set based on the clinical urgency of the patients and to factor in patient preferences and scheduling needs.

We are able to measure access to routine appointments that occur in our group practice model electronically, thanks to our system-wide electronic medical record, and do so monthly. For routine patients who seek care within our contracted network, we do not have an automated way to measure initial access, but review claims data at the end of the year to monitor access.

Collaboration comes into play in one other area related to initial appointing access, and that is in collaboration between primary and behavioral healthcare providers. For some patients, primary care is their preferred source of mental healthcare; for others, it is simply an essential complement. In 2010, Group Health researcher and physician Elizabeth Lin developed a model called TEAMcare,[1] an

[1] *New England Journal of Medicine* 2010 Dec 30; 363(27):2611–20

intervention for multiple chronic conditions, which has been integrated into standard care in the Group Health Patient-Centered Medical Home. Within one year—compared with the standard care control group—patients with the TEAMcare intervention were significantly less depressed and also had improved levels of blood glucose, low-density lipoprotein (LDL) cholesterol, and systolic blood pressure. A recent study showed that by starting medications sooner and managing them more effectively, primary care physicians and nurses could improve their patients' outcomes for both medical and mental health conditions. [2]

Follow-up Appointment Access

The ability to be seen in a timely manner for follow-up appointments is as important to patients as timely intake appointments. Our patient-centered approach, combined with proactive planning and, again, rigorous tracking, has led to our positive outcomes in this area. We track the use of group therapy (a measure that leads to increased capacity and improved follow-up access), the percentage of new patients seen three times in the first six weeks of treatment, and patient satisfaction with access to follow-up appointments.

Since behavioral health is a continuous, as well as episodic, concern—different from many medical issues but similar to other chronic illnesses—we have developed several ways that patients can access mental healthcare, increasing the likelihood that one or more of these routes will lead to timely access. Through our electronic health record system, patients can send secure messages back and forth via email with members of their care team, including mental health providers. Patients can also set up phone visits for times when getting into the clinic is either unnecessary or not feasible. And, responding to a need among a certain sub-group of patients, in 2010 our staff designed a group psychotherapy program for patients with anxiety and depression.

In 2011, we established a goal of seeing at least 70 percent of patients three times within a six-week period. This measure is objective, based on what our patients said they wanted and what is indicated in relevant research literature. Over the last year, we have met and exceeded our target in this area, thanks to strategies and processes monitored by many of the other measures described here.

We have also begun tracking access as a part of our patient experience survey. We know that a positive therapeutic relationship significantly contributes to patient experience, but have found, not surprisingly, that access matters too. Like many things at Group Health, we have decided to approach access from an evidence-based perspective, as illustrated by the measure above, but also from a patient-centered one. To assess patient satisfaction, we have chosen to ask whether patients are getting back into the office in a timeframe suitable to them. For some patients, this could mean a matter of days—others, weeks. But over the last year we have seen a statistically significant increase in this measure, with patients saying that they were seen again by a behavioral health provider when they needed to be.

Supply & Demand, Measures of Capacity and Productivity

Behavioral health is a poignantly human issue, but access to care can also be a simple one of supply and demand. To meet the demand for care, we must ensure that there is adequate supply, as measured by capacity in the system, and productivity to make the most of existing capacity.

In a group practice model, such as Group Health, unused capacity in the system (such as unfilled appointment slots and providers being less productive than benchmarks) leads to waste that can ultimately impact patient access. Therefore, we track a number of capacity and productivity measures, including appointment fill rate, number of new cases per provider, and relative value units (RVU). (RVUs are a measure of value used in the Medicare reimbursement formula for physician services. They are nonmonetary standard units of measurement that indicate the value of services provided by a healthcare provider.)

We seek to fill at least 90 percent of the appointments available in a provider's schedule on a given day. Each morning, clinic administrative staff members try to fill any open slots in a provider's schedule first by calling patients who are on a waiting list for an earlier appointment, and then by calling patients who are scheduled beyond 14 days to see whether they are available to come in earlier. Through this process, we have seen a reduction in wasted appointment slots and are currently filling 91 percent of all appointment slots. We have also set standards for new case targets. Each Masters-level counselor and psychiatrist has a weekly target number of new cases to ensure adequate initial patient access.

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[2] *Annals of Family Medicine* January/February 2012 10:6–14; doi:10.1370/afm.1343

Developing and Monitoring the Measures

While measurement is critical, measurement in a vacuum is worthless. The Lean approach starts with a focus on assessing and working around the needs of the patient, then developing systems and processes to meet those needs, developing measures to assess performance, and continuously looking for and developing new ways to improve. Leadership, in commitment to this system, is key, but so is listening to patients, and to the people on the front lines who are caring for them and working with them directly.

To continuously track performance and to make it visible and transparent to staff at all levels, visual systems and checking tools are developed to monitor metrics on a daily, weekly and monthly basis, and to reflect whether targets are met. Lean suggests what are called "tiered checking tools" to ensure that information is shared up and down a management chain. For example, an identified metric will be measured at the tier one level by the staff doing the work; at the tier two, or departmental, level; and at tier three by primary care leadership. The highest-priority metrics are reflected and reviewed in tiers four and five by our CEO and Executive Leadership Team. These tiers refer to visual illustration of performance on these measures, over time and by clinic in the form of charts, graphs, and other tools, which are posted conspicuously on the walls in our clinics so that performance is visible to staff doing the work and to unit managers. Clinic staff meet each morning to review challenges for the day and discuss how to address them. Departmental leaders conduct "rounds" on the clinics' visual systems at least monthly to monitor performance, and more importantly, to coach the staff in solving problems that arise.

These tools can help give patients, staff, and leaders confidence that performance is high, but they can also identify gaps. Our culture supports continuous improvement through the identification of gaps and the application of countermeasures to ameliorate these gaps. For example, last year a group of behavioral health staff tracked appointment patterns and identified a high number of appointments that went unfilled, were cancelled, or weren't attended by the patient. They used these data to develop a new process of monthly checks and adjustments of appointments across the week and time of day to increase the probability of increasing the number of appointments kept, and they began to review medical records monthly to identify and track patient preferences for appointment times. These strategies and others have allowed us to meet challenges as they arise, to address the needs of a broad range of patients, and to significantly improve the access to and quality of behavioral healthcare in our system over the last several years.

Group Health's journey with Lean began in 2007, and in behavioral health we first began using Lean to develop a care management system for our most vulnerable patients. Lean offered us a method for making work standard, visible and actionable via the coordinated efforts of individuals and teams. Although there were some significant challenges in changing and adapting to new processes and a new culture, the results were unquestionably positive. Patients received better care that reduced their suffering and improved their lives. And, our total cost of care (per member per month) was less in 2009 than 2008. In part that was a result of better management of inpatient care—our largest controllable expense.

Over the last five years, our systems, processes, and measures have continued to develop and improve. We are proud of our model and its ability to provide timely, high-quality access to behavioral healthcare—and all health services—for our members. But we also acknowledge that this is a journey. Our system is built around a culture of continuous improvement—putting the patient and her needs first. Thank you again for the opportunity to share our experience and for your attention. I welcome your questions.

Prepared Statement of James Schuster, MD, MBA

INTRODUCTION

I begin by first providing some background information as to the context from which I approach the very important topic of adequate and timely access to behavioral health services here today. I am the Chief Medical Offer for Community Care Behavioral Health Organization of UPMC.

Community Care Behavioral Health Organization is a 501(c)(3) tax exempt, nonprofit Pennsylvania-based behavioral health managed care organization. Community Care was created primarily to respond to the behavioral health needs of members of HealthChoices, Pennsylvania's mandatory behavioral health managed care program for Medicaid recipients. Community Care also serves UPMC Health Plan's

commercial and Medicare members, via service cooperation agreements. Community Care currently employs more than 500 people to serve individuals in 36 counties in Pennsylvania and 16 counties in New York. We manage the behavioral health services for over 650,000 Medicaid eligible persons, approximately 23% of whom are active consumers of care.

Community Care's approach to behavioral health managed care is grounded in public sector commitment, expert clinical competencies, and both program and fiscal accountability. It is and has long been Community Care's philosophy that, in the end, quality is best measured by the improved health and well-being of the communities that we serve. Community Care is committed to continuous and systematic quality improvement across all domains.

UPMC is an integrated payer-provider headquartered in Pittsburgh, Pennsylvania, which includes a comprehensive provider-based clinical delivery system, a suite of health insurance and health management companies, and a longstanding collaboration with the University of Pittsburgh, a premier academic institution. With 20 hospitals, more than 55,000 employees, 2,700 employed physicians, 2,500 independent but affiliated physicians, thousands of mid-level providers, 400 clinical locations, and insurance companies offering commercial, Medicare and Medicaid products, all of which have large contracted networks, UPMC operates amongst the largest integrated delivery and financing systems in the Nation.

UPMC is organized into four major operating units: Physician Services, Hospital Operations, Insurance Services, and International and Commercial Services. Community Care is in the UPMC Insurance Services Division which also includes physical health plans that operate in the Commercial, Medicare and Medicaid markets. Collectively, Community Care and the associated companies of the UPMC Health Plan offer health coverage products and services to nearly 1.8 million members.

UPMC Health Plan, the second-largest health insurer in western Pennsylvania, offers a full range of commercial and government products and services, including commercial group health insurance, Medicare, Medical Assistance, Special Needs (SNP), and Children's Health Insurance (CHIP), as well as disease management and behavioral health programs. The UPMC Health Plan's provider network includes more than 90 hospitals (including academic, advanced care, and specialty hospitals), cancer centers, physician practices (including more than 9,800 physicians), and long-term care facilities. Collectively, the network represents one of the largest and most diverse teams of healthcare professionals in Pennsylvania.

ACCESS AND BEHAVIORAL HEALTH SERVICE DELIVERY AND PAYMENT

Achieving and maintaining only the highest quality over a wide-range of metrics has been a goal toward which Community Care, UPMC Health Plan, and UPMC have long dedicated their efforts, including ensuring that members have adequate and timely access to behavioral health services.

We believe that ensuring such access requires concerted effort across five areas: (1) defining the criteria that are reliable and valid measures of adequate and timely access; (2) developing measures to accurately capture variability within chosen criteria; (3) training and educating individuals tasked with applying chosen measures to do so in a consistent and systematic manner that produces meaningful results; (4) identifying patterns, progress, and opportunities for improvements; and (5) targeting meaningful solutions and/or corrective action plans for those areas in which the need for improvement is identified. We have found that a problem in any of the aforementioned functional areas can render our best intentions to ensure adequate and timely access meaningless. Accordingly, through various internal initiatives as well as through stakeholder partnerships and collaboration, all of which are focused on outcomes, we systematically address all 5 requisite areas.

I'd like to talk a little bit about the steps we at Community Care and UPMC Health Plan have taken to implement best practices in each of these areas mentioned above. While the majority of my comments below will be provided from a payor perspective, many if not most are fundamentally applicable and relevant from a provider vantage as well.

Defining Criteria that are Representative of Timely and Adequate Access

Most would agree that, insofar as healthcare delivery is concerned, adequate and timely access to services is a critical component of quality. If members cannot access a service, that service is of little or no use. In the context of access, however, "adequacy" and "timeliness" are relative terms that do not necessarily lend themselves to standard definitions, particularly in the behavioral health arena. Whereas a 24-hour access standard may seem like nothing short of overkill for most healthcare services, anything longer would simply not be sufficient in the face of potential lethality or other psychiatric emergency. As such, identifying timely and adequate

access as a marker of quality is merely a first-step; establishing measurable standards necessarily follows.

Despite the relative nature of "timeliness" and the endless array of factors that impact this relativity, a failure to settle upon a measurable standard or to allow each unique circumstance to define or determine its own standard were not options for Community Care or UPMC; specific adequacy and timeliness standards had to be identified. To assist in this end, Community Care turned to other stakeholders, accrediting bodies (including NCQA and the Pennsylvania Department of Public Welfare), and existing statutory and regulatory requirements for guidance in setting appropriate timeliness benchmarks. Through these efforts and collaborations, Community Care has derived a comprehensive set of timeliness standards, beginning, for example, with a 24-hour telephonic triage and referral team assembled to assess members' immediate needs and determine the most appropriate levels of intervention. Team members assist callers with emergent or urgent needs and ensure that provider visits are arranged as quickly as possible and always within the following timeframes: immediately for life-threatening emergencies; within one hour for non-life-threatening emergencies; and within 24 hours for urgent referrals.

While identifying these specific and/or mandatory timeframes as "quality-indicators" based upon objectively defined urgency standards is critical and important, Community Care recognized early in the process that members' opinions of accessibility were equally important. While, for example, a 14-day timeframe within which to be seen for an evaluation has a certain appeal, it is equally (if not more) important to ascertain what members view as reasonable or adequate timeframes; members are our best barometers of what should be. As described in the section below, Community Care and UPMC developed a number of different means by which to capture such subjective input.

After identifying the timeframes within which it thought members should be seen and surveying members for additional input, Community Care considered the additional factors that could directly or indirectly impact adequate and timely access. It was important that Community Care and UPMC Health Plan as payors (and UPMC as a provider) not lose sight of the fact that timeframes are not met (or missed) in a vacuum. To the contrary, often a timeframe is little more than the consequence of competing variables. For Community Care these variables include things such as penetration rates, which identify the proportion of a member population who are actually utilizing services. The higher the penetration rate, the higher number of providers necessary to satisfy access standards. Additional variables include network adequacy, the member's self-identified needs, the member's clinical condition(s), and the array of available services. On the UPMC provider-side, variables such as staff-to-patient ratios and the type and range of staff employed are critical. Failing to recognize the interrelationship between these variables and timeliness could result in a failure to satisfy timeliness standards going forward; as such, a multi-dimensional assessment and approach to timely and adequate access is essential.

Measuring the Quality Metric "Timely and Adequate Access"

After identifying those standards and indicators that Community Care and UPMC Health Plan considered to be quality indicators with respect to timely and adequate access, it was necessary to develop valid and reliable means by which to measure and track those indicators. Community Care and UPMC Health Plan employ a number of different strategies to accomplish this end.

Community Care and UPMC Health Plan both include timeliness access standards within their respective network provider agreements; contracting entities are expected to maintain established timeframes or will be considered in breach of the agreement. Timeliness standards vary based upon urgency of care, i.e., emergent, urgent, and routine. Providers are additionally required to notify Community Care immediately when they are unable to accept new members into treatment. While contractually imposing these requirements may seem severe, Community Care and UPMC Health Plan believe that clearly delineating timeliness standards in advance is preferable to allowing contracting parties to be uncertain about amorphous standards.

Providers contracted with Community Care and UPMC Health Plan additionally agree to allow us to audit their compliance with these contractual requirements. Pursuant to these audit requirements, Community Care and UPMC Health Plan routinely audit contracting parties for compliance with these standards. Site visit surveys are conducted for non-licensed or non-accredited facilities (both at time of credentialing and at recredentialing), or whenever Community Care receives three or more site complaints within a 6-month period. If deficiencies are identified, quality improvement plans are required.

As set forth above, while auditing contractual compliance is an efficient means by which to measure the more objective timeliness standards imposed by Community Care and UPMC Health Plan, particularly those contractually required, Community Care/UPMC utilizes member satisfaction surveys to assess member sentiments in terms of timely and adequate access. Over the past few years, Community Care has seen an increase in member-reported satisfaction as to timely access (76.1% in 2008 to 78.2% in 2011).

Another means by which Community Care/UPMC tracks member satisfaction (or dissatisfaction) with access standards is via member complaints. Community Care, for the purposes of member complaints, defines dissatisfaction with access to services as "difficulty obtaining an appointment within a certain time period or within a certain distance, or the failure of a provider to meet the above required timeframes for providing a service." In 2011, less than 1% of all Community Care complaints were related to access to services. During the same time period, UPMC Health Plan received no complaints related to access.

Given that timely access is impacted directly and indirectly by variables such as network adequacy, member need, and array of providers within provider network, Community Care tracks and measures these variables as well. Here again, Community Care relies upon requirements and benchmarks imposed by accrediting bodies such as NCQA and the Department of Public Welfare to serve as a guide to minimum sufficiency. For example, NCQA requires that Community Care contract with inpatient, residential, and ambulatory providers. As detailed more fully below, simply monitoring a timeliness standard alone would not be productive. Instead, Community Care carefully measures the sufficiency of and changes in the many ancillary factors that collectively result in or impact timeliness overall.

Training and Educating Those Measuring Access

Evaluating the success (or lack of success) of Community Care and UPMC Health Plan's efforts to define and measure timely and adequate access standards could be undermined absent the comprehensive training, education, and outreach of all of those individuals tasked with measuring chosen criteria. It appears that this is one of the confounding factors experienced by the Veteran's Administration despite its efforts to adequately track and monitor access.

Community Care/UPMC utilizes a broad array of means by which to make certain all stakeholders measure access in a consistent and standardized manner. Information about access requirements is included in both our provider manual and provider newsletters. We also routinely disseminate supplemental information during provider meetings and at any time upon request. All new providers are required to attend a comprehensive provider orientation, during which both the member access requirements and the means by which to capture and measure adherence are detailed.

Community Care uses its audit and site-visit process as yet another educational touch point with providers. Included in Community Care's "Site Visit Tool" is a requirement to review the provider's policy on appointment availability. Among the requirements are that (i) routine appointments are provided within 7 calendar days of request, (ii) life threatening emergencies are given immediate appointments; (iii) non-life threatening emergency are seen within 1 hour of contact; and (iv) members with urgent needs are seen within 24 hours of first contact. Community Care is of the mindset that the audit process is not a punitive process or a process aimed necessarily at identifying problems. Rather, it is valuable opportunity to share information and to work with providers toward understanding the myriad requirements facing them, including accurately and consistently tracking and measuring access.

In addition to educating providers on the standards expected of them, we inform members of what they can expect regarding access timeframes. We believe that members equipped with adequate information in this regard are in the best position to provide real-time, meaningful feedback as to how successful our providers and we are in meeting requisite standards. We rely on the member-complaint process as well as the care-management process for additional information regarding access performance. Furthermore, we routinely review triage and other referral calls to ensure access.

While adequately educating all stakeholders upfront is of critical importance, Community Care and UPMC Health Plan have learned that consistent monitoring thereafter cannot be overstated. A failure to reinforce the specific access requirements or the means by which to measure and track those requirements could weaken all of our efforts in these regards. As such, we employ a dedicated staff across multiple departments to accomplish these ends.

Analyzing Data Collected

The data gathered and maintained by Community Care and UPMC Health Plan is useful only to the extent that it tells us something about how we are performing with respect to access benchmarks. Here again, we engage a dedicated staff to analyze the information gathered via the myriad sources mentioned above. Such analyses are performed both for specific providers and sub-populations and for our collective provider networks; identifiable and aggregate reporting and analyses provide different but equally critical types of information. Where, for example, targeted information can inform us as to a given provider's progress in meeting requisite benchmarks and serve as an indicator of compliance with contractual obligations, aggregate data provides insight into broader systemic trends.

As discussed above, our analyses are not limited merely to resultant timeliness. In addition, we routinely track and analyze provider sufficiency, both in terms of overall network capacity and within specific provider-types, such as psychiatrists or psychologists. We also closely monitor existing and anticipated member need (including diagnostic trends and condition prevalence) to anticipate and predict where added specialists may be required going forward. As discussed below, this information is then used for targeted contracting and/or hiring purposes.

Community Care and UPMC Health Plan track penetration rates to determine the rates at which members are accessing services. We believe that increased use, for example, of ambulatory and/or outpatient services ultimately contributes to decreasing the use of more restrictive levels of care. Generally, we have witnessed a trend toward increased penetration rates for less restrictive services. Over the past decade the percentage of dollars spent for inpatient services in Community Care's behavioral health HealthChoices contracts has fallen from about 50% to just over 20%. In fact, when reviewing the results of the Community Care approach to care management, we have succeeding in significantly increasing overall number of users of service, while holding costs steady or even decreasing costs per member served.

Among Community Care's routine reports is an "availability of providers" report, prepared by plotting the location of each member using address and zip code information and then comparing it to similarly plotted provider information. The resulting report shows the overall coverage for various provider types of service overlaid with the geographic location of our members. The report demonstrates the travel time for each member and then summarizes the precise percentage of members with access within the established drive time standards for each level of care. This information is used to enhance network development activities.

Our quality Committees share analyses and results such as those described above both with targeted providers and with broader groups of stakeholders, including county administrators, accrediting bodies such as the Department of Public Welfare and NCQA, provider groups, and members. We believe strongly that, until this feedback is looped back to those providing, funding, and receiving care, it is of limited value.

Using Analyses to Prompt Change

While data for data's sake may be interesting to some, its true value to Community Care and UPMC Health Plan is its usefulness in targeting necessary change and intervention. Over the years, data-analyses have prompted a wide range of change. These changes include traditional type of interventions such as targeted increases in certain types of providers, e.g., psychiatrists, as well as systematic planned development, such as increased funding dedicated to community-based services. If upon analyses, it is determined that timely access is only problematic within certain sub-specialties, Community Care may target its employment and/or contracting efforts to increase providers of this type. Hiring and/or contracting with more professionals, however, has been only one of many solutions implemented by us over time. A one-dimensional approach to change would be ineffective, particularly given the finite number of professionals in any given area, particularly in more rural regions. Moreover, records maintained by UPMC's human resources department suggest that the time it takes to fill at least some behavioral health positions can be substantially longer than positions of other types.

Access feedback has also prompted Community Care/UPMC to explore and implement newer potentially revolutionary types of service-delivery, including telepsychiatry initiatives. Community Care now supports approximately 20 telepsychiatry sites throughout Pennsylvania using secure forms of video transmission. Psychiatrists working across locations within the same agency staff some sites. Other sites are staffed by UPMC psychiatrists who are supporting service providers in more rural parts of Pennsylvania. Community Care has tracked both provider and member satisfaction of these services with very positive results. Published research on

telepsychiatry indicates that patient satisfaction is generally as high as with in-person services.

Mobile service delivery is another creative solution garnering increased interest by Community Care. Mobile therapy is particularly useful with those populations least likely to leave their homes to seek care, including the frail and elderly and individuals living in rural areas, as well as those whose behavioral health conditions render routine outpatient care difficult. An ample network is meaningless unless those persons who need services are able to access them. We have also worked with other stakeholders to substantially expand the range of services available to members. These additions include crisis services, hospital diversion programs, psychiatric rehabilitation, and certified peer services. All of these services have created new ways to access services and alternatives to traditional inpatient and outpatient models.

Community Care routinely works with a wide-range of stakeholders, including providers, county authorities, and members, in all implementation efforts. We feel strongly that collaboration is essential to sustainability.

CONCLUSION

Adequate and timely access to services is a critical component of quality. Ensuring access to services requires a sustained, systematic, and coordinated approach. We at Community Care, UPMC Health Plan, and UPMC believe that we have made great strides in these regards. I personally would like to thank you for the opportunity to discuss the work that we have done to improve access to services for members. I speak for Community Care and all UPMC affiliates when I offer any and all assistance that may be helpful going forward.

Prepared Statement of Thomas Carrato, USPHS (Ret)

Biography of RADM Thomas Carrato, USPHS (Ret)

Thomas Carrato is President of Health Net Federal Services, responsible for the daily leadership and management of Health Net's Government Services Division. His responsibilities include the management and oversight of Health Net's Department of Defense and Department of Veterans Affairs lines of business to include the DoD's TRICARE program for the North Region and the worldwide Military & Family Life Counseling contract.

Mr. Carrato has over 30 years of experience, success and accomplishments in both the public and private healthcare sector as senior executive, chief operating officer and clinician. He served as Assistant Surgeon General of the United States, Regional Health Administrator for the U.S. Department of Health and Human Services, Deputy Assistant Secretary of Defense for Health Plan Administration, and Group Vice President for a publicly traded government services company. Mr. Carrato joined Health Net in March 2006 as Vice President and DoD Program Executive.

Previously, Mr. Carrato served as Deputy Assistant Secretary of Defense for Health Plan Administration and Executive Director of the TRICARE Management Activity where he directed and managed worldwide operations and performance of the TRICARE health plan. In an earlier role as the Department of Health and Human Services' Regional Health Administrator for Region IV, Mr. Carrato was the Department's principal representative, providing advice and participating in policy development and implementation of key healthcare initiatives in the southeastern United States. He managed regionally based programs of the Office of Public Health and Science including the Offices of Emergency Preparedness, Minority Health, Women's Health, and Population Affairs.

Mr. Carrato holds a Master of Science in Accounting from Georgetown University and is a licensed Certified Public Accountant. In addition, he holds a Master of Social Work from the University of South Carolina and is a licensed clinical social worker.

Mr. Carrato, retired as a Rear Admiral in the Commissioned Corps of United States Public Health Service. His decorations include the Defense Distinguished Service Medal and the Public Health Service Distinguished Service Medal.

A Partnership History

Chairman Miller, Ranking Member Filner and Members of the Committee, I appreciate the opportunity to testify on Veterans' access to mental healthcare services.

Health Net is proud to be one of the largest and longest serving healthcare administrators of government and military healthcare programs for the Departments of Defense (DoD) and Department of Veterans Affairs (VA).

In partnership with DoD, Health Net serves as the Managed Care Support Contractor in the TRICARE North Region, providing healthcare and administrative support services for three million active duty family members, military retirees and their dependents in 23 states. We also deliver a broad range of customized behavioral health and wellness services to military services members and their families, including Guardsmen and reservists. These services include the Military Family Life Counseling (MFLC) Program providing non-medical, short-term problem solving counseling, financial counseling, rapid response counseling to deploying units, victim advocacy services, and reintegration counseling.

In collaboration with VA, Health Net supports Veterans' physical and behavioral healthcare needs through Community Based Outpatient Clinics and the Rural Mental Health Program. The Rural Mental Health Program was launched by VA in 2010 to provide access to community mental health services in select rural counties in three Veterans Integrated Service Networks (VISNs). Health Net delivers these services for VA in VISNs 19 and 20.

While helping VA meet the needs of Veterans, Health Net also has collaborated with VA in its efforts to ensure efficiency in the non-VA care (Fee) program, helping VA save and recover millions of dollars since 1998. The monies recovered through these programs (less program expenses) are available to provide or enhance services for our Nation's Veterans.

Health Net also is proud to support a number of VA's national sports and rehabilitation programs, such as the Disabled Veterans Winter Sports Clinic and the National Veterans Summer Sports Clinic. At the summer clinic, we provide behavioral health coaches who conduct education sessions designed to help Veterans take what they learn at the summer clinic home with them and apply it to their everyday lives.

It is from this long-standing commitment to serving servicemembers, Veterans and their families that we offer our thoughts on addressing Veteran access to mental health services.

Call to Action

According to the Department of Veterans Affairs, the number of Veterans seeking mental health services has climbed by a third. VA faces a significant challenge with respect to providing access to care with more and more servicemembers returning from Iraq and Afghanistan with mental health issues stemming from their military service [1]. It is imperative that Veterans receive care in a timely manner. With the rising tide of suicides [2], access to timely care can mean the difference between life and death. Untreated mental illness impacts overall health and reintegration into the community, as well as the long term security, productivity, and well-being of this generation of Veterans, their families, and their communities. Chairman Miller, as you stated in a recent news release, "These are wounds that cannot wait."

As this Committee knows, the VA Office of Inspector General (OIG) recently released a report that was critical of VA's methods for recording patient wait times for both initial and follow up mental health visits, as well as its ability to provide access to these services in a timely manner. VA has been quick to respond to the April 2012 OIG report. Likewise, we understand the urgency of the situation identified in the OIG report and the need for a prompt response.

Addressing the dramatic increase in the demand for VA mental health services is challenging. Clearly, the demand has stretched VA's capacity to its limits. We appreciate VA's efforts to enhance capacity for the unique care needs of today's Veterans and respect its leadership in developing comprehensive guidelines for ensuring clinical quality, particularly in the area of Post Traumatic Stress Disorder (PTSD).

VA has led in the validation of evidence-based treatment and, in collaboration with the DoD, in the development of clinical practice guidelines and provider educational materials addressing PTSD. VA also has taken steps to address access and to reduce the stigma associated with seeking these services. The DoD and VA are both actively training behavioral health providers in the delivery of these treatment modalities, and the VA has endeavored to make evidence-based mental health services available to Veterans across the range of treatment settings.

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[1] GAO VA Mental Health Report to Ranking Member, HVAC: *Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access;* 10/14/11.

[2] *Suicide, PTSD, and Substance Use Among OEF/OIF Veterans Using VA Health Care: Facts and Figures;* Congressional Research Service; 8/16/11.

Based on current services we provide to VA, as well as the DoD, we believe there are ready approaches to address this urgent need quickly and effectively. Moreover, these proven solutions for addressing both short-term and ongoing access issues can be performed without sacrificing clinical excellence which is so appropriately a priority for VA.

Access Pressure Points

The demographics of the Veteran population are changing. There are more Veterans living in rural areas and a growing number of female Veterans. For example, of the over 8.3 million Veterans currently enrolled in the VA Health System, about 41 percent live in rural or highly rural areas, and approximately 30 percent of rural enrolled Veterans have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).[3] Currently, women Veterans comprise over eight percent of the total United States Veteran population, and their numbers have grown by 31 percent since 2006.[4] It is expected that the proportion of women Veterans will continue to grow—VHA projects that women will represent ten percent of the total Veteran population in 2020, increasing to nearly 14 percent by 2030.[5] Women comprise nearly 12 percent of OEF/OIF Veterans.[6]

From Surge to Rural Access

Building upon over 20 years of experience serving active duty military servicemembers, their families, and Veterans, Health Net has developed a full continuum of programs to meet the behavioral health needs of this population. Throughout the design and implementation of these various programs, Health Net has collaborated with VA and DoD in delivering high quality, accessible programs which augment existing capacity and capability, both within VA and DoD.

Overview of Programs Offered by Health Net

(please refer to Attachment 1 for detailed description)

- **Military & Family Life Counseling Program (MFLC) Program:** Provides short-term, problem-solving situational counseling; program includes a network of more than 5,000 credentialed, trained, and experienced counselors supporting 320 military installations in 50 states, 4 territories, and 13 countries
- **TRICARE North Region:** Provides managed care support services to 3 million activity duty servicemembers, military retirees, and their families in 23 states and the District of Columbia, provider network includes 22,500 licensed, credentialed behavioral health providers and 392 facilities, have offered web-enabled, video short-tem counseling
- **Community Based Outpatient Clinics:** Provides primary care, mental health and preventive health services to Veterans
- **Rural Mental Health Program:** Provides care to Veterans close to home, behavioral health services provided by a network of clinicians and peer support specialists

These programs are very flexible in meeting demand, from supporting a "surge" of returning servicemembers to reaching out to Veterans living in remote geographic areas located many hours away from a VA Medical Center. We are able to deliver a full spectrum of services from preclinical to clinical, using a combination of face-to-face, telephonic, and video counseling with licensed clinicians to help servicemembers and their families and Veterans to address the unique issues of the military lifestyle and the challenges of transitioning from active duty to Veteran status. In addition, these programs are further enhanced through educational training and workshop presentations led by clinicians for patients and community providers.

The success of these various programs has been noted by military leaders and beneficiaries. For example, the Military Family Life Counseling Program was the subject of a recent independent study performed on behalf of the Deputy Assistant Secretary of Defense (Military Community and Family Policy) by Virginia Tech University. In this study, recipients of MFLC support were asked to complete a brief survey, which indicated that 96 percent were mostly or completely satisfied with MFLC services.[7]

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[3] Presentation for National Rural Health Day: *Caring for Rural Veterans;* Dr. Mary Beth Skupien, Director of VHA Office of Rural Health; 11/17/11.

[4] http://www.womenshealth.va.gov/WOMENSHEALTH/facts.asp

[5] *Women Veterans by the Numbers,* Lisa Foster and Scott Vince; California Research Bureau; 9/09/09.

[6] http://www.womenshealth.va.gov/WOMENSHEALTH/facts.asp

[7] DoD Counseling Program Evaluation, Partner: Virginia Tech; Examining the Perceived Effectiveness of Two Innovative Models of Mental Health Service Provision to Service Members and Their Families: Military One Source (MOS) and the Military Family Life Consultants (MFLC); January, 2001.

Established Best Practices

The Department of Defense has engaged private sector firms like Health Net as partners in addressing the needs of servicemembers and their families up to the point of discharge from the service. Many of the services developed for servicemembers and their families as a result of this partnership are innovative, proven effective, and now considered "best practices" throughout the military. Among the "best practices" developed through this partnership are the following:

- The development and deployment of a standby capacity that is delivered when and where it is needed on a temporary basis. This "surge" capability can provide brief, non-medical, problem-oriented counseling to address issues that arise in connection with deployment-demobilization-re-deployment cycles of the troops and their families. This standby capacity is comprised of a network of highly trained, credentialed mental health professionals who are willing to serve in this standby force.
- The engagement of civilian and community-based networks of trained, credentialed, mental health professionals to reach the servicemembers and their families who are not in the vicinity of a Military Treatment Facility. This is often the case for the National Guard and Reserve components. The networks also meet the clinical behavioral health needs of military beneficiaries assigned to a Military Treatment Facility when the demand for behavioral health services exceed the capacity or the scope of care which can be provided within the military facility.
- The use of telephonic and web-based tools to provide fast access to resources that can assist with identifying serious cases early, before anything dramatic can occur.

The Department of Veterans Affairs, likewise, has developed a number of innovations and "best practices" to deliver quality clinical services to Veterans.

- Through the Rural Mental Health Program, Veterans may access mental health or peer support services through a network of licensed behavioral health specialists and peer support specialists. All providers are trained on VA benefits and are able to address specific Veteran issues and conditions which occur among the Veteran population, including traumatic brain injury (TBI) and PTSD. VA specific training covers the mission of VA, describes the patient population, explains VA customer service, instructs providers on VA documentation of health records and outlines VA patient rights.
- Through the Claims Repricing Program, Health Net has helped VA reduce Fee Program claims costs by identifying more than $650 million in discounts since the program's inception in August 1999. These discounts are the result of applying claims pricing available with Health Net's nationwide provider networks.
- Through a national recovery audit program, Health Net has helped VA in identifying over $113 million in overpayments for inpatient and outpatient care.

Access to Care Solutions

Recruitment and training of clinical staff is paramount to the effective delivery of behavioral health services. Overall, Health Net has a national network of over 50,000 behavioral health providers. For the Military Family Life Counseling Program, we have a network of over 5,200 licensed counselors who have been carefully selected, are fully trained, and ready to deploy on short notice as needed. These networks are further supported by 22,500 behavioral health providers in the TRICARE provider network.

In this program, Military Family Life Counselors provide brief, problem-oriented non-clinical counseling services. They are required to assess risk in the context of non-medical interactions and to make referral into clinical behavioral health services when indicated. They have particular expertise in engaging servicemembers and their families in ways that minimize or mitigate stigma.

Military Family Life Counselors are deployed on an as needed basis. When they are not deployed in support of the MFLC program, many of these masters-level behavioral health providers maintain clinical behavioral health practices in their home communities.

As part of our program, MFLC counselors receive extensive core training and orientation. To ensure clinical approaches are current, we have established an independent Expert Curriculum Review Panel composed of an expert panel of retired military and academic researchers who specialize in deployment related psychology and military family resiliency.

Health Net also has recognized the need to educate and train community providers about the unique needs of the military and Veteran population. Health Net, along with the American Red Cross and the Penn State Hershey College of Medi-

cine, sponsored 1-day conferences targeting primary care and behavioral health providers. The conference was designed for primary care and behavioral health-care professionals to improve understanding, assessment, and treatment of the invisible wounds of war: PSTD and TBI.

Providers expressed satisfaction with the content, based on a survey performed 6–12 months following participation: 84 percent of respondents expressed increased confidence in caring for returning servicemembers; 41 percent had implemented new strategies of asking about military service in their clinical practice. Additional programs are planned for 2012 in New York, Washington, D.C., and Ohio.

As an industry leader in behavioral health, Health Net has committed extensive resources to developing effective programs to support the military and Veteran populations. Our highly trained and credentialed provider network is the foundation for healthcare delivery, whether on a military installation, in nearby population centers, or in rural, hard –to-reach locations.

A Path Forward

We believe that these same clinical resources—a highly trained, credentialed mental health surge capacity, along with community-based, specially trained mental health providers—could effectively supplement VA's capacity to quickly and effectively address the access issues identified by the OIG without sacrificing VA's clinical excellence.

In addition, enhanced use of telephonic and web-based tools, many of which VA has pioneered, offer Veterans with easy access to ongoing support, helping to destigmatize the care, as well as facilitating access for harder to reach Veterans.

Specifically, we believe the urgent need created by today's environment—increased demand, strained resources, stressed facility capacity—requires a comprehensive approach, one that is designed to augment and enhance VA, based on the specific needs of each VA Medical Center. The components of this approach should include:

- A standby capacity to address urgent, short-term demand, similar to models used by the Department of Defense. Such an approach would be an effective and efficient model to provide rapid deployment of resources to alleviate short-term demand requirements at a VA Medical Center (VAMC) or a Community Based Outpatient Clinic (CBOC). In short, it would be an effective means to address the urgent mental health needs of today's Veterans, "wounds that cannot wait."

  These rapid-response or surge providers would work alongside VA providers, using the same clinical guidelines. In addition, this standby capacity would enable the early identification of Veterans who might be at risk for suicide or have other serious mental health issues. Such Veterans could then be triaged into a high priority process to gain access to VA providers and facilities as soon as possible.
- Telephonic and web-based tools that would offer the possibility of reaching deeper into the Veteran population to identify and serve those in need.
- A network of community-based mental health providers that would augment VA's capacity and reach, enabling VA to meet the needs of Veterans who do not live near a VA Medical Center or a Community Based Outpatient Clinic. Since this capacity already exists, it could be brought to bear almost instantaneously. An added benefit of using community-based provider networks similar to the ones we use for the Military Family Life Counseling Program and TRICARE is that they include a number of female clinicians to support treating the special needs of women Veterans.

Specific considerations for VA to consider in developing this approach include:

- Deploy only a cadre of supplemental providers who are professionally competent and credentialed, as well as specifically trained in military culture.
- Exploit existing network and standby capacity to implement the solution very quickly. Time is critical here.
- Utilize surge techniques to concentrate the mobilization of the supplemental capacity in areas where the demand arises quickly as a consequence of force downsizing.
- Use of a single VA medical record system to record all services provided to ensure that care is delivered in close coordination with other VA providers.

Taken together, the components of this model could transform the experience of Veterans in gaining access to their earned benefits in a timely fashion.

Conclusion

We commend the VA for promptly responding to the VA OIG report on Veterans' access to mental healthcare. As VA seeks to address this urgent issue, we strongly

encourage consideration of a comprehensive approach that builds upon VA's strengths in clinical quality excellence; one that draws upon best practices of not only the Department of Veterans Affairs, but also other Federal agencies and the private sector. Doing so provides VA with the fastest means for providing more immediate results for this Nation's well-deserving Veterans.

Chairman Miller and Ranking Member Filner, thank you again for the opportunity to testify before this Committee today. More importantly, thank you for your strong leadership over this critical issue for our Nation's Veterans. I am happy to answer any questions you may have of me.

Background on Health Net, Inc.

Health Net, Inc. is one of the Nation's largest publicly traded managed healthcare companies and is currently ranked #179 on the 2011 Fortune 500. Health Net's government services division is one of the largest and longest performing administrators of government and military healthcare programs. Our health plans and government contracts subsidiaries provide health benefits to approximately six million individuals across the country through DoD, VA, as well as group, individual, Medicare, and Medicaid programs. As a leader in behavioral health, Health Net provides behavioral health benefits to approximately five million individuals across the U.S. and internationally through its subsidiaries, MHN, Inc. and MHN Government Services.

Health Net Federal Services manages several large contracts for the government operations' division of Health Net, Inc. and is proud to be one of the largest and longest serving healthcare administrators of government and military healthcare programs for the DoD and VA.

In partnership with DoD, Health Net serves as the Managed Care Support Contractor in the TRICARE North Region, providing managed care services for three million active duty family members, military retirees and their dependents in 23 states. In collaboration with VA, Health Net supports Veteran healthcare to meet the physical and behavioral health needs of Veterans through CBOCs and the Rural Mental Program. Additionally, Health Net also supports VA by applying sound business practices to achieve greater efficiency in claims auditing, recovery and re-pricing.

MHNGS delivers a broad range of customized behavioral health and wellness services to the military services' members and their families and to Veterans. These services include military family counseling, financial counseling, rapid response counseling to deploying units, victim advocacy services, and reintegration counseling.

Attachment 1

Program	Brief Description
Military & Family Life Counseling (MFLC) Program	• Develop and manage a network of more than 5,000 credentialed, trained, and experienced licensed counselors, including 1000 qualified personal financial counselors, who serve 320 installations in 50 states, 4 territories, and 13 countries • Deploy on average 1,400 consultants world-wide in any given month to provide private and confidential, non-medical and financial short-term, situational, problem-solving counseling assistance and support services to Service Members (including the National Guard) and their families • An additional 280 MFLCs [on average, per month] travel throughout geographically dispersed areas to ensure access to care for National Guard families; these MFLCs provide support at Pre-Deployment training events, welcome home ceremonies, departure ceremonies, and Yellow Ribbon events on weekends through the On Demand component of the MFLC Program • Provide problem-solving, situational counseling in support of active duty service, guard, and reserve members and their families, during reunion/reintegration and mobilization/de-mobilization; non-medical problem-solving counseling support is intended to augment existing military and civilian support services • Develop and support other components: the Marine Individual Ready Reserve (IRR) Outreach program and Joint Family Support Assistance Program (JFSAP), Child and Youth Services, Personal Financial Counseling, DoDEA Summer Enrichment Program, Victim Advocacy Support, Purple Camps, Recruiting Command, Victory Resilience, and the U.S. Army Recruiting Command effort — Marine IRR Outreach—Provide support to Marine Reservists who often live far from their command structure and other Reservists, with limited support network to address the experiences of combat and the inevitable changes that have occurred while at war; provide telephone outreach to homecoming IRR citizen warriors; Address administrative issues associated with activation/deactivation, as well as life issues typical for returning servicemembers, such as readjusting to family life, reestablishing sleep habits, and rebuilding relationships at work; Placed over 22,000 outreach calls to Marine Reservists — JFSAP—Provide services at geographically dispersed and rural locations; Bring behavioral health and financial support services to active duty servicemembers, Guardsmen, and Reservists and their family members who might otherwise be unable to access such support through MFLCs personal financial counselors; Help reduce deployment and reintegration stress, teach coping skills, build resiliency, develop community resources, and support mobilization and reintegration activities
TRICARE North Region	• Serve over 3 million active duty servicemembers, military retirees, and family members in 23 states and the District of Columbia • Provide behavioral health services contracting and credentialing • Established network of 22,500 licensed, credentialed, behavioral health providers, and contracts with 392 behavioral health facilities • Awarded original TRICARE North Region contract in 2004 (post DoD consolidating 12 regions into three: North, South, and West); re-awarded contract in May 2010 • Provided healthcare and associated services in California and Hawaii through CHAMPUS Reform Initiative (CRI), first contract awarded in 1988 and became the foundation for future TRICARE contracts • Awarded three contracts for five regions in 11 states to provide managed healthcare services to over 2.5 million beneficiaries following CRI

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Program	Brief Description
TRIAP Program	• Provided expert short-term services available on demand to help beneficiaries cope with normal reactions to abnormal/adverse situations • Delivered short-term, solution-focused counseling for situations resulting from deployment stress, relationships, personal loss, and parent-child communications • Tested the use of web-based technologies to quickly provide information and short-term services to beneficiaries, and determined if services and platform increase DoD's ability to: — Identify beneficiaries in need of medical mental healthcare at an early stage — Refer beneficiaries quickly or facilitate access to appropriate level of mental healthcare
VetAdvisor Support Program (subcontractor to a SDVOSB)	• Provided behavioral health counseling, military family counseling, and rapid response counseling to deploying units, victim advocacy services, and reintegration counseling programs for this pilot program • Provided telephonic outreach offering benefits and behavioral-health risk assessments for returning Veterans
Rural Mental Health (VISNs 19 and 20)	• Delivers care to Veterans at locations closer to the Veteran's home than the nearest VA Medical Center or Community Based Outpatient Clinic • Veterans are eligible to receive therapy services as well as peer support services • All providers are trained on VA benefits, and on addressing specific Veteran issues (i.e., Military sensitivity, women Veteran issues, TBI, and PTSD) • Peer support specialists are certified through a nationally accredited organization; network providers are licensed psychiatrists, psychologists, and master's level therapists • Available to OEF/OIF Veterans within certain counties
Rural Mental Health (VISN 6)	• Used excess funds to establish a Rural Mental Health program that mirrored many of the pilot program's requirements (the VISN 19/20 Rural Mental Health program is a pilot program) • Veterans were eligible to receive therapy services (peer support was not included). • All providers were trained on VA benefits, and on addressing specific Veteran issues (i.e., Military sensitivity, women Veteran issues, TBI, and PTSD) • Program was available to all Veterans (not just OEF/OIF Veterans) within certain counties • Program ended in December 2011 due to lack of funding
Warrior Care Support	• Provide complete healthcare planning and coordination services for warriors severely injured or with combat-related behavioral health diagnoses, and support for their families through TRICARE Program • Assist Veterans transition from military to VA care • Provide warrior with a ''Health Care Coordinator''—acts as single point of contact for healthcare services and works with military and VA to achieve a seamless transition

Prepared Statement of Joy J. Ilem

Mr. Chairman and Members of the Committee:

Thank you for inviting Disabled American Veterans (DAV) to testify at this important hearing. We appreciate the opportunity to offer our views on the problems confronting the Department of Veterans Affairs Veterans (VA) and its Veterans Health Administration (VHA) in meeting the critical mental health needs of some of our Nation's veterans—particularly newer veterans now struggling with post-deployment mental health challenges. As requested by the Committee, we focus this testimony on mental healthcare staffing; barriers to access; quality of care; reliability of data; and, systemic issues impeding care, wellness and recovery.

Over the past five years both the House and Senate Committees on Veterans' Affairs have held numerous hearings on VA mental health. Topics included access to care; closing the gaps; waiting times; invisible wounds; suicide and its prevention; treatment of post-traumatic stress disorder (PTSD); and, VA's Mental Health Stra-

tegic Plan and its Uniform Mental Health Services Handbook.[1] Both the Government Accountability Office (GAO) and VA's Office of Inspector General (OIG) have evaluated and examined many of these issues, sometimes at the request of Congress, including the latest report, issued on April 23, 2012—*Review of Veterans' Access to Mental Health Care.* Likewise, for over a decade the print and electronic media has widely and repeatedly covered the many challenges new war veterans face with physical and mental health—including the perception that VA seems unable or has failed to help some of them. Predictably, this coverage focuses predominantly on veterans who have fallen through the cracks, taken their own lives, or has highlighted gaps in VA and DOD care, documented particular mistakes and failures in individual cases, cited the ever-present bureaucracy, and made observations examining barriers to care, including mental health stigma that prevents some veterans from even seeking VA care. It is rare to see media coverage of VA mental health in a positive light although over the past five years it has made remarkable progress in establishing a strong foundation of mental health services. DAV continues to be concerned about the constant negativity of the reports on VA mental health. Without proper balance in reporting we fear many veterans who need care the most may not come to the system designed to meet their unique needs.

As noted, the unprecedented efforts made by VA over recent years to transform itself and improve consistency, timeliness, and effectiveness of VA's mental health programs, provide evidenced-based treatments and care that bring veterans hope for recovery, and reduce stigma associated with mental health, are rarely discussed and virtually never applauded. Likewise, published reports and research on the tens of thousands of dedicated VA healthcare professionals and staff who provide specialized mental health services to troubled and ill veterans frequently go without any recognition, thanks or gratitude. Unfortunately, in the current environment it is difficult to shift public perception to the positive gains VA has actually made. Compared to the private sector, VA's mental health and substance abuse system gets high marks. However, given the troubling findings of the Senate's informal July 2011 mental health query of mental health providers[2] and the most recent OIG report[3] pointing out lingering and significant flaws and limits, VA seems to have fallen short of its own goals to provide the best possible accessible care to veterans,

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[1] April 25, 2012, Senate Veterans Affairs Committee, "VA Mental Health Care: Evaluating Access and Assessing Care." *http://veterans.senate.gov/hearings.cfm?action=release.display&release—id=b030f350-2b9f-4e85-9903-0731e03be8e1*

November 20, 2011, Senate Veterans Affairs Committee, "VA Mental Health Care: Addressing Wait Times and Access to Care." *http://veterans.senate.gov/hearings.cfm?action=release.display&release—id=a9c9fd7c-36e8-4e4b-a9a4-dbff47a4fe5d*

July 14, 2011, Senate Veterans Affairs Committee, "VA Mental Health Care: Closing the Gaps." *http://veterans.senate.gov/hearings.cfm?action=release.display&release—id=a005eefd-f357-4f33-b702-196597a9a187*

June 14, 2011, House Veterans Affairs Committee, "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." *http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg67193/pdf/CHRG-111hhrg67193.pdf*

March 3, 2010, Senate Veterans Affairs Committee, "Mental Health Care and Suicide Prevention for Veterans." *http://veterans.senate.gov/hearings.cfm?action=release.display&release—id=d1a8548c-de2c-49a8-b7f9-d0855265d435*

April 30, 2009, House Veterans Affairs Committee, Subcommittee on Health, "Charting the US Department of Veterans Affairs' Progress on Meeting the Mental Health Needs of Our Veterans: Discussion of Funding, Mental Health Strategic Plan, and the Uniform Mental Health Services Handbook." *http://veterans.house.gov/hearing-transcript/charting-the-us-department-of-veterans-affairs-progress-on-meeting-the-mental*

June 4, 2008, Senate Veterans Affairs Committee, "Systemic Indifference to Invisible Wounds." *http://veterans.senate.gov/hearings.cfm?action=release.display&release—id=74f01638-542e-49d7-b3bb-f0ac55671f28*

May 5, 2008, House Veterans Affairs Committee, "The Truth about Veterans' Suicides." *http://veterans.house.gov/hearing/the-truth-about-veterans%E2%80%99-suicides*

April 1, 2008, House Veterans Affairs Committee, Subcommittee on Health, "Post Traumatic Stress Disorder Treatment and Research: Moving Ahead Toward Recovery." *http://veterans.house.gov/hearing/post-traumatic-stress-disorder-treatment-and-research-moving-ahead-toward-recovery*

December 11, 2007, House Veterans Affairs Committee, "Stopping Suicides: Mental Health Challenges Within the US Department of Veterans Affairs." *http://veterans.house.gov/hearing/stopping-suicides-mental-health-challenges-within-the-us-department-of-veterans-affairs*

[2] United States Senator Patty Murray, Official News Release, "VETERANS: After VA Survey Shows Long Wait Times for Mental Health Care, Chairman Murray Calls for Action." October 4, 2011. *http://www.murray.senate.gov/public/index.cfm/newsreleases?ID=87890f52-e2dd-4f01-af31-43329f09adec*

[3] VA Office of the Inspector General, Offices of Audits and Evaluations and Healthcare Inspections, "Veterans Health Administration, Review of Veterans' Access to Mental Health Care." April 23, 2012 *http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf*

many of whom are in desperate need of receiving VA's specialized mental health services. VA is not meeting its access standards and has not provided the needed services consistently to every veteran in every VA facility across the country. While not true in most cases, VA bears the brunt of this perception and consequently pays a high price in the minds of the public and the veteran community.

The informal query VA conducted at the request of your counterparts in the Senate found that mental healthcare providers did not agree that veterans' ability to schedule timely appointments matched data reported by VA's performance management system and identified a number of constraints on their abilities to best serve veterans, including inadequate staffing, space shortages, limited hours of operation and competing demands for scarce appointment slots. Seventy-one percent of those survey respondents indicated that their medical centers had inadequate numbers of mental health staff. VA recently testified that it was taking two major actions as a result of the findings of this survey. VA developed a comprehensive action plan to enhance services and to address the VA staffs' concerns and it conducted an external focus group to better understand the issues raised by front-line providers. VA also stated it is conducting site visits to each VA medical center this year to evaluate mental health programs. [4]

The OIG was asked to determine how accurately VHA documents waiting times for mental health services for new and established patients, and whether the data VA collects is an accurate depiction of veterans' ability to access needed services. VHA policy requires new patients who are referred to, or who are requesting, mental health services, to receive initial evaluations within 24 hours of request, and be provided a more comprehensive diagnostic and treatment planning evaluation within 14 days of request. VA has reported that 95 percent of its first-time patients receive a full mental health evaluation within VA's 14-day goal. Nevertheless, the OIG report found that VHA's mental health performance data is not accurate or reliable and that VHA's measurement of first-time access to a full mental health evaluation was not a meaningful measure of waiting times.

The OIG conducted its own analysis and projected that in VHA only 49 percent of patients (versus 95 percent) received full evaluations, to include patient history, diagnosis, and treatment plan, within 14 days and for the remainder of patients, it took 50 days on average. Additionally, VHA could not always provide existing patients their treatment appointments within 14 days of their desired dates. DAV began an informal, anonymous online survey for veterans in December 2011, asking about their experience seeking and receiving VA mental health services. To date, nearly 1,050 veterans from all eras of service have responded to the survey, and our findings were close to those reported by the OIG on waiting times for follow up appointments. A complete report of DAV's survey results can be found on line at *http://www.standup4vets.org.* The OIG report also noted that several mental health providers whom inspectors interviewed had requested desired dates for patients for follow up care based on their personal schedule availabilities rather than the patients' requests, or based on observed clinical need in some cases. Likewise, VHA schedulers did not consistently follow VHA policy or procedures but scheduled return clinic appointments based on the next available appointment slots, while recording the patients' "desired" and actual dates as if they were compliant with VA policies. Since the OIG had found a similar practice in previous audits nearly seven years earlier, and given that VHA had not addressed the long-standing problem, OIG urged VHA to reassess its training, competency and oversight methods and to develop appropriate controls to collect reliable and accurate appointment data for mental health patients. The OIG concluded that the VHA " . . . patient scheduling system is broken, the appointment data is inaccurate and schedulers implement inconsistent practices capturing appointment information." These deficiencies in VHA scheduling system have been documented in numerous reports. After more than a decade, VA's Office of Information and Technology has still not completed development of a state-of-the-art scheduling system that can effectively manage the scheduling process or provide accurate tracking and reporting.

The OIG also recommended that VHA conduct a comprehensive analysis of staffing to determine if mental health provider vacancies were systemic issues impeding VA's ability to meet its published mental health timeliness standards. Most importantly, the OIG report noted that meaningful analysis and decision making required reliable data, not only related to veterans' access but on shifting trends in demand for services, the range of treatment availability and mix of staffing, provider productivity and treatment capacity of the facilities. References were provided by the OIG

[4] Senate Veterans Affairs Committee, "VA Mental Health Care: Evaluating Access and Assessing Care," April 25, 2012. *http://veterans.senate.gov/hearings.cfm?action=release.display&release—id=b030f350-2b9f-4e85-9903-0731e03be8e1*

to VHA on managing a better response to a number of shifting dynamics, through "dashboard reports" used in the private sector that incorporate patient demand, clinic capacity and provider productivity in a consistent set of business rules in which to assess and respond quickly to changes in access parameters. The OIG made four major recommendations to VHA on the above noted issues. Similar to previous external reviews, the VA Under Secretary for Health has agreed with all these recommendations and stated that a number of measures are currently underway. [5]

As we noted earlier in this testimony, despite obvious progress, it is clear to us that much still needs to be accomplished by VHA to fulfill the Nation's obligations to veterans who are challenged by serious and chronic mental illness, and particularly to those with post-deployment mental health and transition challenges. VA's duty is clear—all enrolled veterans, and especially servicemembers, Guardsmen and reservists returning from current or recent war deployments, should be afforded maximal opportunities to recover and successfully readjust to civilian and domestic life. They must gain user-friendly access to VA mental health services that have been demonstrated by current research evidence to offer them the best opportunity for full recovery.

We must stress the urgency of this commitment. Sadly, we have learned from our experiences in other wars, notably in the post-Vietnam period, that psychological reactions to combat exposure are not unusual: they are common. If they are not readily addressed at onset, they can easily compound and become chronic and lifelong. The costs mount in personal, family, emotional, medical, financial and social damage to those who have honorably served their Nation, and to society in general. Delays or failures in addressing these problems can result in self-destructive acts, including suicide, job and family loss, incarceration and homelessness. Currently, we see the pressing need for mental health services for many of our returning war veterans, particularly early intervention services for substance-use disorder and evidence-based care for those with PTSD, depression and other consequences of combat exposure. As we have learned from experience, when failures occur, the consequences can be catastrophic. We have an opportunity to save a generation of veterans, and help them heal from war, but decisive action is essential.

Mr. Chairman, in mental health, VA is now at a crossroads, and its next steps are critical ones. This issue is extremely serious—and everyone wants to ensure that VA gets it right. We observe that Congress is frustrated, as are we. Billions of new dollars and personnel for improving VA mental health services have been pumped into the system over the past five years—and despite the significant number of new hires, a 46 percent increase in staff between 2005–2010, [6] VA recently reported it still needs to hire 1,600 additional mental health clinical and 300 support staff. [7] Many have pointed out [8] this increment alone will not fix the problem. So, the question is what can and should be done at this critical juncture? What are the best solutions to solve the existing problems? Within the next couple of years, more combat veterans will be returning home and many will need VA's services. We concur with remarks made by Deputy Under Secretary for Health for Operations and Management, William Schoenhard, at the April, 25, 2012, Senate Veterans' Affairs Committee Hearing that sending these veterans out of the system en masse is not the answer—this group particularly can benefit from VA's expertise in treating post-traumatic stress, PTSD, substance-use disorders, traumatic brain injury and other post deployment transition issues. To that end, it is essential that VHA address and resolve the issues that tolerate variable provision of mental health and substance abuse care and prevent consistent, timely access to care at VA facilities nationwide.

Unfortunately, the problems in VA's mental health programs are complex, and cannot be resolved within any single dimension. The VHA is facing systemic challenges that are similar in nature to the organizational problems that the Veterans Benefits Administration (VBA) is facing with respect to its seemingly intractable backlog of disability claims. The root causes are multiple, systems-based, long-standing, and complex. DAV has been a staunch advocate for correcting the *root* problems in VBA—not just managing a symptom of the problem by reducing the

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[5] Ibid.

[6] VA Office of the Inspector General, Offices of Audits and Evaluations and Healthcare Inspections, "Veterans Health Administration, Review of Veterans' Access to Mental Health Care." April 23, 2012 *http://www.va.gov/oig/pubs/VAOIG—12-00900-168.pdf*

[7] United States Department of Veterans Affairs, Official Press Release, "VA to Increase Mental Health Staff by 1,900," April 19, 2012. *http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302*

[8] The New York Times, Editorial, "Does the V.A. Get It?" April 24, 2012. *http://www.nytimes.com/2012/04/25/opinion/does-the-va-get-it.html*

backlog on a crash basis. We believe the same holds true for VA's mental health clinical programs.

One of the most troubling barriers that prevents VA from being more effective in many of its programs is VA's own human resources (HR) policies and the practices surrounding them. Practitioners and clinical program leaders across the VA system have told DAV for years that recruitment of new professionals is a vexing and frustrating challenge that contributes to VA's failings and deficits. Even when new candidates are plentiful, well-qualified, and eager to join VA employment, the process that leads to offers of VA employment can linger for months, and in rare cases, years, before an employment commitment can be made. Many excellent candidates wait for months without feedback from VHA and simply move on to other opportunities. Delays of such magnitude are due to a variety of factors, but one principal reason for them is that human resources personnel are accountable only to their program officials in HR, but not to clinical selecting officials. In our opinion, they do not treat recruitment as an urgent process requiring the highest level of customer service to both the internal and external customers. This is especially ironic, given that about 100,000 health professionals train in VA facilities annually. Many of these young professionals may want to stay in VA but their personal and financial circumstances prevent them from waiting months or years for a VA job offer.

As a part of the *Independent Budget* (IB), DAV has been calling for reform in VA's human resources policies.[9] Recent hearings on VA mental health in the Senate confirm that the lack of responsiveness of human resources offices and management policies are contributing to deficits in VA's mental health programs. Sadly, unresponsive HR practices are also affecting all of VA's key missions. We urge the Committee to carefully examine VA and Office of Personnel Management appointment authorities in statute and how they are being applied within VA to determine whether additional legislation would offer any helpful resolution. VA should develop and track measures of performance in HR recruitment, on-boarding and retention of clinical staff. Almost as important, the Committee should provide targeted oversight in examining why VA human resources programs are so weak and unaccountable at a time when they should be acting forcefully and supportively to ensure VA programs in VHA, VBA and Memorial Affairs are properly staffed to meet their missions. With help from Congress, we believe this aspect of VA's challenges can be solved with better leadership and more responsiveness, beginning at the local level and extending throughout the system.

I must also report that many VA facility executives seem to tacitly support current bureaucratic practices in HR as a means to conserve facility funding and stretching healthcare budgets. Almost every VA facility operates a "resources committee" or similar function to examine every vacancy occurring and then to require selecting officials to justify in writing (and sometimes by making personal appearances and appeals before the Committee) why vacancies should be filled at all. This grueling process that constitutes a "soft freeze," can consume months, all the while allowing the facility to "save" the personal services funds that would have been paid in salary and benefits associated with those unencumbered positions. It is common practice for resource committees to deny authorization to fill mental health and substance positions, creating "ghost" positions that are listed in the Service FTEE allocations but can never be recruited. We understand that in many locations, the 1,600 newly allocated FTEE will not even be sufficient to fill these vacancies. We believe, certainly now in the face of inadequate mental health access, that such practices should be halted. With the massive and rising unmet needs being reported today, VA must become very sensitized and make every effort to quickly fill all mental health provider vacancies and their support staff positions as a high priority in HR offices. VHA Central Office and VA Medical Center leadership should be accountable to ensure that this occurs.

Despite all these staffing challenges, the transformation of the VHA's mental health program over the past decade has been revolutionary. As the wars in Afghanistan and Iraq were raging, VA inaugurated its internal reforms in the beginning of 2004 and developed a Mental Health Strategic Plan rooted in the principles of recovery-oriented care. In 2008, VA instituted a national Uniform Mental Health Services Handbook to ensure consistency of available services throughout the healthcare system's 1,400 sites of care. Full implementation of the Handbook is still ongoing, and now a patient-centered care model has been added to the mix for all of VA healthcare. Likewise, state-of-the-art approaches to care, evidenced-based treatments and new technologies have been validated by research for some mental

[9] The FY 2013 Independent Budget, "The Department of Veterans Affairs Must Strengthen Its Human Resources Program," pp 178–182. *http://www.independentbudget.org/2013/05-47-220-MC-C.pdf*

health challenges, including PTSD. All of these activities have occurred during a time of steadily increasing patient care workloads and rising demand for services. Despite the addition of thousands of new mental health staff, demand for these services by tens of thousands of new veterans has obviously overwhelmed the system and made it difficult for VA mental health providers to translate transformational mental health policies and cutting edge clinical services into consistently delivered clinical practices.

Today's wars are truly different, and accompanied by multiple and longer deployments than any previous experience of military servicemembers, National Guard or reserve personnel. Additionally, the VA must not only contend with a new generation of war veterans but continue longer term treatment of a significant number of veterans from prior eras of military service with mental health challenges and a large, older population with debilitating chronic and serious mental illnesses. We believe the clinical policy changes VA has made over the past eight years are positive and will ultimately equate to better patient care and improved mental health outcomes—but significant challenges have arisen now on a daily basis, and these will need continued attention, intensity, resources and oversight—and the development of sound and workable solutions to ease the pressure while meeting veterans' needs. The VHA must develop a number of short and long range goals to resolve existing problems identified by the OIG, Congress and the veterans service organization (VSO) community. However, even those gains will not be enough unless VA conquers the challenge of making its own transformational cultural change across the healthcare system and at every service delivery point nationally. The HR function discussed is but one significant challenge that cries out for immediate reform.

VHA must develop reliable data systems; fix the flaws in its appointment and scheduling system with effective policies and IT systems that fill the current gaps, and is responsive to mental health needs; develop an accurate mental health staffing model that accounts for both primary and a multitude of complex specialty mental health capacity demands; revolutionize its hiring practices and eliminate the barriers that obstruct timely hiring of mental health providers and support staff; adjust its practices to address the complexities of co-occurring general health, mental health and psychosocial problems of veterans in a truly patient-centered manner, and re-establish credibility and trust with the veterans that VA is charged to serve.

In addition to these general principles we have recommended to guide VA reforms, DAV also makes the following specific recommendations for additional oversight or legislation, as warranted:

- There is an immediate need for VHA to implement a National Tele-mental Health Program, modeled on the National Tele-radiology Program, that provides the infrastructure, professional expertise and staff support needed to deliver consistent, evidence-based mental health services at all VA healthcare facilities. Facilities could access the program to address surge demand for services and meet the challenges of staffing shortages. If sites were established on the East Coast, West Coast and in Hawaii, extended evening clinic hours could be offered that would ease the burden on veterans for time off work and child care. An effective tele-mental health program could also help ease the recruitment challenges being reported by smaller and more rural VA facilities that have difficulties recruiting and retaining mental health professionals.
- With Congressional oversight, VA should institute a Secretary's Task Force or Commission on Mental Health and Substance-Use Services, composed of VA and non-VA mental health and policy leaders and with participation by VSOs. This body should be given a broad directive, the staff, resources and mandate to provide comprehensive analysis and advice on the organization and delivery of VA mental health, substance abuse, and suicide prevention programs.
- The VHA should institute an external Mental Health Assessment and Site Visit Program to evaluate local fidelity and adherence to national mental health and substance-use disorder policy in the Uniform Services Handbook, as well as become a monitor for access, satisfaction, and quality of care issues. An external assessment will increase the objectivity and visibility of the site visit process. The current internal, VA staff review should serve as a pilot for this external comprehensive program evaluation and reporting process.
- The recent VHA reorganization divided the mental health program management responsibility and organized them under two different Deputy Under Secretaries—the the Deputy Under Secretary for Operations and Management and the Deputy Under Secretary for Policy and Services. This management change was implemented to ostensibly increase "integration" but, in our opinion, instead has increased VA Central Office staff redundancy, reduced responsibility and accountability, and removed valuable professional staff resources from coordinated care delivery. Given the deteriorating performance of mental health

programs and the difficulties now being highlighted, the wisdom of this reorganization should be reexamined and full authority returned to the Patient Care Services and the Office of Mental Health.
- As a high priority, VHA should address the co-morbidity of mental health and chronic pain syndromes in Operation Iraqi Freedom/Operation Enduring Freedom veterans in order to provide better treatment guidance and reduce the epidemic of prescription drug misuse and the use of high risk opioid prescriptions.
- The VHA should revise the Veterans Equitable Resource Allocation (VERA) funding model to account for, and fund, the rising cost and complexity of comprehensive mental health and substance-use care in VHA.
- The Committee on Care of Veterans with Serious Mental Illness, which was authorized by law as a monitor on the quality of mental healthcare in VHA, and has been staffed by VHA, does not meet the original congressional intent, functions, and responsibilities. Congress should re-charter this Committee to ensure that it provides input from expert advisors in the mental health, substance abuse, and veterans communities, receives staff support and access to data in order to assess the performance of the program and healthcare facilities, present its findings to VHA and VA leaders, and advocate for all veterans who need outreach and anti-stigma, mental health, substance use, and especially suicide prevention programs. The VSOs should be active, full members of the Committee, rather than be part of its external consumer liaison group.

Mr. Chairman and Members of the Committee, in closing we applaud VHA for its focus on providing veteran-centered care and changing to a recovery-based model of care with the goal of not only symptom control and reduction but a goal of helping veterans achieve improvement in their overall wellness and functionality in society. Likewise, we appreciate the Committee's continued oversight efforts in VA mental health and for continuing to insist that VA dedicate sufficient resources in pursuit of comprehensive mental health services to meet the needs of veterans VA serves—particularly the post-deployment mental and transition readjustment needs of returning war veterans. DAV recognizes this strong support and progress, but it is eclipsed and obscured by the problems we are discussing here today, and happening at the worst possible moment when expectations are highest. VA should expeditiously work toward real reforms to make the system stronger, while properly prioritizing and addressing the urgency of the current findings. We believe the recommendations provided by the OIG and the VSO community, along with VA's measures, can collectively be used to solve these challenges.

Chairman Miller, this concludes my prepared statement. I am pleased to address any questions you or other Members of the Committee may wish to ask.

Prepared Statement of Alethea Predeoux

Chairman Miller, Ranking Member Filner, and members of the Committee, thank you for allowing Paralyzed Veterans of America (PVA) to testify today on one of the most important healthcare issues facing America's veterans and the healthcare system of the Department of Veterans Affairs (VA). PVA believes that when veterans have timely access to quality mental healthcare services they in turn have the opportunity to establish productive personal and professional lives. PVA thanks this Committee for their continued oversight and hard work on this important healthcare issue.

In recent years, the VA has made tremendous strides in the quality of care and variety of services provided to veterans in the area of mental health. These improvements include incorporating mental health into VA's primary care delivery model, increasing the number of Vet Centers, launching mental health public awareness campaigns, and creating call centers that are available to veterans 24 hours a day, 7 days a week. While these improvements were much needed and have helped many veterans, PVA believes that issues of access to mental healthcare within the VA continue to exist and more must be done to make certain that all veterans receive mental healthcare that is timely and effective.

The VA's Office of Inspector General (OIG) report, entitled, "Veterans Health Administration: Review of Veterans' Access to Mental Health Care," identified many weaknesses within VA's Department of Mental Health that if improved upon will allow VA to continue in its progression of providing high quality mental health services to veterans. Overall, the report concluded that the Veterans Health Administration (VHA) mental health performance data is not "accurate or reliable, and VHA measures do not fully reflect critical dimensions of mental healthcare access." More specifically, the report stated that "VHA's measurement of a first time patient's ac-

cess to a full mental health evaluation was not a meaningful measure of wait time; VHA was not providing all first time patients a full mental health evaluation within 14 days as required by VA policy; VHA schedulers did not consistently follow procedures; and VHA overstated its success in providing veterans new and follow-up appointments for treatment within 14 days as required by VA policy." [1]

While PVA is deeply concerned by these findings, such conclusions were not completely surprising. In fact, this year's *Independent Budget* states, "One overreaching concern of the IBVSOs is the lack of clear and unambiguous data to document the rate of change occurring in VA's mental health programs, as noted in the May 2010 GAO report . . . VA needs more effective measures to record and validate progress." [2] Four main recommendations were made by the VA OIG: 1) Revise the current full mental health evaluation measurement to ensure the measurement is calculated to reflect the veteran's wait time experience upon contact with the mental health clinic; 2) Reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments; 3) Conduct staffing analysis to determine if mental health staff vacancies represent a systemic issue that impedes VA's ability to meet mental health timeliness goals; and 4) Align data collection efforts related to mental health access with the operational needs throughout the organization. [3]

PVA supports these recommendations and believes that the recommended actions will allow for VA to better identify and address the issue of access to VA mental healthcare services. In addition to these recommendations, PVA believes that increased attention to staffing, productivity and performance of providers, and patient demand will further assist VA in providing care that makes a difference in the lives of veterans.

The analysis and results from the VA OIG report on mental health access data shines light on the inconsistencies of policy implementation within VHA, and how such inconsistencies can negatively impact veterans' access to quality care. For instance, VA requires that all first-time patients receive a treatment planning evaluation no more than 14 days from the initial request or referral for services. As the VA OIG reports states, various mental health offices within VA have been interpreting this policy to have multiple meanings, and the end result is not having reliable data to accurately assess veterans' access to care or the performance of providers. The VA must not have policies just for the sake of having policies. The VA must ensure that staff adheres to all policies that are put in place to guarantee a high caliber of services for veterans, and must further develop safeguards that ensure such policies are carried out correctly from day to day.

On April 25, 2011, the Senate Veterans Affairs' Committee held a hearing entitled, "VA Mental Health Care: Evaluating Access and Assessing Care." During this hearing a veteran and former VA mental health professional testified that too often the VA mental health system places a burdensome emphasis on having staff meet numerical performance goals at the expense of providing veterans with the best care possible. [4] PVA believes that VA leadership must make certain that policies and regulations are developed to provide safe, quality health services for veterans, without compromising the professional integrity of the qualified providers who deliver the care. VA policies must be pragmatic and attainable, and improve the delivery of care by creating benchmarks and measures that help assess strengths and weaknesses of healthcare services and delivery.

PVA's Medical Services and Health Policy Department conducts regular site visits to VA Spinal Cord Injury Centers on a monthly basis. PVA's medical professionals that facilitate these visits, along with VA leadership from the various medical centers, compile staffing and bed capacity data for a monthly report. Included in these reports is the required number of staff that is needed to care for patients within a medical center as determined by VA policy. The reports also include the actual number of staff available for duty during the month of the visit. Staff members

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[1] The Department of Veteran Affairs, Office of Inspector General, Offices of Audits and Evaluations and healthcare Inspections; "Veterans Health Administration, Review of Veterans Access to Mental Health Care." April 23, 2102, 12–00900–168; *http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf*

[2] The Independent Budget, FY 2013, pg. 71; *www.independentbudget.org*

[3] United States Government Accountability Office, Report to the Ranking Member, Committee on Veteran Affairs, House of Representatives, "VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access." GAO–12–12; October 2011; *http://www.gao.gov/assets/590/585743.pdf*

[4] 4 Senate Veterans Affairs Committee, "VA Mental Health Care: Evaluating Access and Assessing Care." April 25, 2012. *http://www.veterans.senate.gov/hearings.cfm?action=release.display&release—id=f485cb0d-3ad4-407f-99a8-9f517d9c3af6*

counted in the report include nurses, physicians, social workers, psychologists, and therapists.

For the past year there have been consistent deficits in one or more of the mental health positions included in the report. Such deficiencies in mental health staffing directly impact veterans' access to mental health services. For example, within VA's Spinal Cord Injury System of Care, veterans receive annual examinations that encompass a mental health screening. This annual mental health screening is extremely important for veterans who have sustained a catastrophic injury as they have a high propensity to face challenges involving self-esteem, independence, and quality of life. The aforementioned mental health staffing shortages have the potential to compromise quality mental health screenings and treatment for veterans within the SCI system of care who are dealing with symptoms of mental health conditions.

Without sufficient staffing, providing care when it is needed is difficult. Timely care is critical to preventing and treating mental health conditions. If VA is going to provide mental healthcare services in a timely manner, it must be equipped with adequate staffing in the various types of mental healthcare that it provides. For instance, within VA SCI primary care, our site visit reports indicate that psychologist positions in VA medical centers have extremely high turnover rates due to low compensation scales and high patient panels. This is a systemic issue within VA that involves various departments—human resources, primary care, and mental health. Ultimately, staffing issues such as this impede veterans' access to mental healthcare and overall patient wellness.

The VA recently announced increasing the mental health workforce by an additional 1,900 mental health professionals. To ensure that these staff increases are effective, PVA recommends that the VA conduct a comprehensive analysis of the mental healthcare needs of veterans and hire additional staff based on those needs. The VA cannot accurately assess the performance and productivity of providers if they do not have an understanding of the needs that the providers are expected to meet. As the VA OIG report emphasizes, accurate data on access, as well as trends in demand and provider productivity will help provide care that is timely and meets the healthcare needs of veterans. PVA also encourages the VA to develop a mental health staffing model that focuses on adequate staffing of mental health professionals throughout the numerous systems of care within the VA. Again, this model should be based on a patient needs assessment of veterans.

Another systemic issue that impedes patient wellness involving VA mental healthcare is the lack of inpatient mental health services readily available to veterans with catastrophic disabilities. PVA's Medical Services team has found that inpatient care is not always available to veterans with a spinal cord injury or disorder due to a lack of accessible space, or the VA not being able to provide the necessary physical and medical assistance that is often needed when a veteran has a catastrophic injury or illness. When this is the case, these veterans are referred to alternative methods of treatment that may not always adequately meet their needs. The VA must work to provide all veterans with access to mental health services when they seek help. A physical disability or multiple complex health conditions should not prevent veterans from receiving quality, effective mental healthcare.

PVA thanks Congress and VA for investing a great deal of resources into improving mental health services in recent years. However, we believe that more must be done to improve access. While PVA does not believe that there is one definite solution to improving veterans' access to VA mental health services, we do believe that a comprehensive assessment of veterans needs and mental health staffing is a starting point for identifying both strengths and weaknesses within the delivery of mental healthcare, and improving the delivery of services to veterans. All veterans regardless of generation should have access to timely, quality mental health services.

PVA appreciates the continued oversight from this Committee on this extremely important issue.

PVA would like to once again thank this Committee for the opportunity to testify today, and we look forward to working with you to improve VA mental health services for our veterans. I would be happy to answer any questions that you might have. Thank you.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $262,787.

Fiscal Year 2010

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $287,992.

Prepared Statement of Ralph Ibson,

Chairman Miller, Ranking Member Filner, and Members of the Committee:

Thank you for conducting this important hearing and inviting Wounded Warrior Project (WWP) to offer our perspective.

Mr. Chairman, you posed a critical question last June at a full Committee hearing on mental health that asked, in essence, whether VA is able to provide timely, effective, and accessible care to veterans struggling with mental health conditions. In testifying at that hearing, we observed that VA has instituted policies designed to achieve those goals, but that the gap between VA mental-health policy and practice can be wide. We have since learned much from both our warriors and VA mental health staff as to how wide that gap is. Thank you for your ongoing efforts to close that gap.

IG Findings: Symptoms of Deeper Problems

Late last month, VA's Inspector General released a hard-hitting report that highlighted systemic flaws in both VA's scheduling of patients for mental evaluations and appointments, and in the reliability of its scheduling data. In our view, VA's scheduling failures and inaccurate reporting on performance data are symptoms of far deeper problems. In short, despite heroic efforts of dedicated clinicians across the system, *VA is not consistently meeting its fundamental obligation to provide timely, effective mental healthcare to OEF/OIF veterans who are struggling with combat-related mental health conditions.*

It has been our observation that the Department of Veterans Affairs is quick to characterize many of the challenges it attempts to confront as "priorities." But we can think of few higher priorities for VA than healing the psychic wounds of war.

Multiple surveys, including a survey last year of our own warriors,[1] have made it clear that many VA facilities lack sufficient mental health and support staff, and many lack sufficient space to accommodate the numbers who seek treatment. These and related problems have taken a troubling toll. We've all seen the results: veterans facing long waits for evaluation and treatment; veterans who need intense treatment being seen too infrequently; and far too often, veterans getting treatment that is simply inappropriate clinically, or dropping out of treatment altogether.

For too long and as recently as during budget hearings earlier this year, Department leaders assured the Veterans Affairs Committees—despite strong evidence to the contrary—that VHA has all the mental health staff it needs. In hearing after hearing, VHA officials have testified to the large numbers of returning veterans with PTSD who had been "seen" in VA facilities, as though being "seen" is the same as receiving timely, effective treatment. VA testimony has described multiple initiatives that have been mounted over a period of years, but "new initiatives" haven't necessarily translated into veterans getting the help they needed. Late last year, the Department for the first time acknowledged that real problems exist, and described "action plans" which in essence, promised further study rather than specific action.

Squarely facing irrefutable documentation of deep problems and unanswered questions regarding its plan to recruit 1900 additional mental health staff and fill longstanding vacancies, VHA testified recently to efforts currently underway. Appearing before the Senate Veterans Affairs Committee last month, VHA representatives testified that in addition to its plan to add staff, it (1) has convened a "work group" related to scheduling, (2) is planning to implement an as yet undefined mental health staffing model next fiscal year, (3) is reviewing its data regarding patient access, and (4) is continuing a process of facility site reviews. While we don't seek to denigrate these efforts, the lack of specificity fails to constitute a real plan, and

[1] WWP asked Wounded Warriors to participate in a survey in November 2011 that asked about their experiences with VA mental healthcare. Of more than 935 respondents, 62% had tried to get mental health treatment or counseling from a VA medical facility; some 2 in 5 of those indicated that they had difficulty getting that treatment. And of those reporting that they had experienced difficulty, more than 40% indicated that they did not receive treatment as a result. Getting timely appointments was a frequent problem.

certainly don't address what we see as underlying systemic problems. Yet with no real remedy in place and mounting evidence that veterans are falling through the cracks, VA's Under Secretary for Health continues to urge veterans with mental health concerns to enroll for VA care. [2]

We ask this Committee to press VA to make mental health a real, ongoing top priority, and to ensure that it goes well beyond addressing the broken scheduling system the IG identified. As one VA mental health clinician described it to us—

"Getting someone in quickly for an initial appointment is worthless if there is no treatment available following that appointment."

Our warriors certainly echo that view. But to understand even more keenly the gravity and extent of those problems, WWP is currently surveying VA mental health staff across the country to learn what they're seeing at close hand. The survey [3] is still underway and the data we're sharing is only preliminary. We did not have an avenue to distribute this survey to every VA mental health provider, but we believe the data provide a helpful snapshot of the problems clinicians are encountering daily. For example, with responses from VA staff in 17 of VA's 22 VISNs, 87% reported that their clinic or program lacks adequate staffing to meet current demand. Two providers capsulized it as follows:

"Understaffing is a huge problem . . . The mental health service line has grown over the past several years in terms of veterans enrolled, but has shrunk in terms of staff." "VA in this area is entirely overwhelmed and booked to capacity. The families and the combat veterans are both suffering. Access to therapy on a timely basis is nonexistent."

Among the most common reasons for understaffing, respondents (who were invited to identify all applicable reasons) cited the following problems at their facilities:

- administration policy against adding or filling positions (67%);
- increase in volume of veterans seen for mental healthcare (67%);
- funding constraints (63%);
- Human Resources' delays in recruiting/hiring (56%);
- greater intensity in patients' need for services (44%); and
- clinicians being detailed to other duties (43%).

To its credit, VA has at last acknowledged a staffing deficit. But the lack of an operational staffing model raises real questions as to how new staff positions will be allocated. And it's not clear that VA clinicians themselves have any role in identifying staffing needs. As one clinician described it,

"Staff at my facility have repeatedly been told that we are viewed by the VISN as 'overstaffed;' . . . I do not understand how we can be viewed as overstaffed, given the clinical realities of caseload sizes, waiting times for first appointments, and time between subsequent appointments."

We understand that VA Central Office is at last focused on mental health staffing, but the reality on the ground certainly does not inspire confidence in recent hiring practices. Citing the fact that it has taken many months for the hiring process to be completed, one clinician working in a VA mental health crisis program reported that *"my program was without a nurse practitioner for 11 months and we have now been again without a nurse practitioner for 16 months."* He described these as *"ridiculous amounts of time for any clinic or team to go without needed help,"* and observed that *"other staff burn out and start looking elsewhere in the interim, and so the cycle seems to go on and on."*

The implications of VA's staffing problems are stark. Some 80% of survey respondents cited insufficient numbers of staff as the principal factor in delaying veterans' access to needed mental healthcare. Facility leadership appear to deal with staffing shortages in different ways, but these shortages are clearly compromising quality of care, as widely reflected in our survey responses. For example, 55% of respondents reported that at their facility OEF/OIF patients were either frequently or very frequently assigned to group therapy even though individual therapy may have been more appropriate. And nearly 59% of respondents either disagreed or strongly disagreed with the statement that they had leadership support to choose the most appropriate treatment for their patients, including longer-term psychotherapy.

Were VA able to hire 1900 additional staff and fill its 1500 existing vacancies, it would apparently confront other critical shortages—from a basic need for space

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[2] Department of Veterans Affairs press release, "VA to Increase Mental Health Staff by 1,900," (April 19, 2012), accessed on May 1, 2012 at *http://www.va.gov/healthbenefits/*

[3] Wounded Warrior Project, Survey of VA Mental Health Staff, accessible at *www.woundedwarriorproject.org/vasurvey*

and privacy in which to provide this sensitive kind of treatment, to having any support staff. As survey-respondents put it,

"Let us not forget that space issues are significant as well. It's hard for management to feel very compelled to hire additional staff when they already have no idea where to put the staff they have. We have had psychologists and social workers at this facility go literally months without an office, relying on the daily absences of other staff members to free up an office in which to see patients."

"I have no waiting room, no on-site clerk, no one to schedule/cancel appointments. I do it all and it takes a lot of time from direct patient care."

Impact on Veterans

Ultimately, it is critical to understand the impact these systemic problems are having on veterans. Responding to our survey, VA mental health staff shared the following observations:

"I have a patient who came very close to attempting suicide in between appointments. I strongly believe that if I could meet with him weekly, or even more on occasion, his suicidal ideation would have decreased and he would be less likely to act on his thoughts."

"One veteran whose appointment was cancelled several times at one of our CBOC clinics ended up committing suicide."

"Veterans who are ambivalent or anxious about therapy for problems like PTSD need a fair amount of encouragement and contact in the beginning if they are to engage optimally in treatment. I have seen many veterans drop out of treatment, or relapse, or end up hospitalized due to a crisis, due to time between contacts being too long."

"Veterans have opted to utilize vet centers or private providers. Those that continue to wait until their next appointment which could be months, suffer in silence. Some veterans are afraid to speak up fearing retaliation."

"Effectively we have no mental health at our clinic. We are told to tell Vets they need to go to the VA hospital for mental health. However it is difficult for some because of travel distance . . . I think there are a lot of vets who call or inquire about mental health at our clinic, are told of lack of room, and then give up."

"I am aware of several veterans who have attempted suicide, or who have died by overdose . . . and believe that more time with clinicians and easier access to programming may have changed things."

"Even with two community based outpatient clinics, the catchment area is so large that it is still very difficult for some patients to access care AND in cases where a patient may be at high risk for suicide, the outpatient clinics often cannot or will not accommodate care due to it being a "complicated case" requiring care by the 'mother ship' [the VA medical center], so vets get NO care because they are too debilitated to expend extra energy to get to the 'mother ship.'"

Improving the Culture of Caregiving

Finally, in setting out the array of systemic issues that compromise the effort to provide veterans timely, effective mental healthcare, it is important to consider the "culture" within which care is provided. As one clinician described it succinctly,

"The reality is that the VA is a top-down organization that wants strict obedience and does not want to hear about problems . . . Consequently, I have little hope that there will be real improvement. You will only see band-aids and more useless performance measures designed to make management look good."

This is not an isolated view. VA faces a real challenge as it relates to the culture at many facilities, given at least the perception that leadership employs a kind of command and control model—issuing policy directives and setting performance standards—without regard to whether facilities' clinical staff actually have the means to carry them out, or whether they are really measures of—or even reasonable proxies for—good care.

A clinician at a major VA tertiary-care facility put it even more starkly:

"There is an environment of fear instigated by mental health leadership. Staff are scared to bring patient care concerns to leadership because of retaliation that happens frequently. Turnover is high and mental health leadership explicitly tells clinicians that we are replaceable."

We commend VHA for conducting medical center site visits, and including time in those visits to meet with mental health providers (as schedules permit). It is not clear, though, how safe VA staff might feel to share the honestly critical concerns that an anonymous survey can elicit. VHA officials have been vague at best as to what those site visits have revealed. But while our own survey is still ongoing, the preliminary data suggest reason for real concern as it relates to an often unhealthy work climate. Asked, for example, about factors staff had experienced recently re-

lated to challenges in providing clinical services, respondents (asked to identify all applicable challenges), identified the following as among the greatest:

- experiencing high level of stress themselves (56%);
- feeling ethically compromised (50%); and
- considering leaving VA employment (44%).

Just as some staff perceive that they are not heard, one should question the extent to which the veteran is heard. For example, VA has been strongly promoting the use of particular modes of therapy for treating PTSD that involve repeated intense exposures to their wartime trauma. But, just as any patient would expect their doctor to respect a decision to reject a recommended surgical intervention—even if that surgery represents optimal, evidence-based treatment for the problem—a veteran with PTSD should be afforded options. But that's not necessarily the case, as some have reported. To illustrate——

"Even telling patients that the only therapy we can offer them involves prolonged exposure [to the trauma they've experienced] sends them elsewhere. These patients should not just be offered short term treatment that may be too intense for them."

"I know many unhappy clinical staff . . . related to requiring them to provide [exposure-based therapies] whether appropriate or not, and then having that be the end of the therapy."

In that regard, VHA leaders seem so insistently focused on evidence-based treatments that veterans' preferences can get lost. Last year, for example, the Richmond VA Medical Center last year terminated a group-therapy program over the strong objections of its participants and defended the decision, asserting that the group-therapy didn't constitute an evidence-based practice. VA Central Office officials' rigid rejection of the veterans' position remains inexplicable. The upshot, though, is that several of the group participants turned away from any further VA treatment because of the broken trust they believe they experienced.

Unfortunately, our warriors often perceive that VA medical facilities don't offer them reasonable scheduling options. To illustrate, numbers of our employee-survey respondents cited veterans' concerns regarding this problem. The observations of two of who voiced a similar perspective:

"I'm aware of a number of veterans who are trying to maintain jobs or stay in school, and who have essentially been forced to choose between treatment and those other obligations. This could be easily ameliorated if our managers would agree to recent requests made by a number of well-trained clinicians for flexible schedules. (Granting these requests would also, incidentally, greatly improve the morale of these therapists, whose personal reasons for wanting the change to a flexible schedule are valid and are being dismissed; I know at least one psychologist who will likely leave the VA because of this issue.)"

"Many patients have requested evening appointments because of work/school schedules, and we cannot always accommodate them. Many staff have requested alternative work schedules to accommodate patients who request evening hours; however, mental health leadership at my facility have a policy against approving alternative work schedules."

It should go without saying that veterans' mental healthcare must take account of patients' wishes. Indeed VA policy reflects that core principle.[4] But our concern again is with a system in which the gap between policy and practice can seem like a chasm.

Needed: A New Paradigm for Transforming VA Mental Health Care

The problems that returning veterans—and dedicated VA mental health clinicians—are encountering extend beyond gaining full implementation of VA policy. In our view, the barriers that impede too many OEF/OIF veterans from getting timely, effective mental healthcare also make it critical that VA address several broader issues.

1. It is no longer reasonable, in our view, for the Department to foster the belief that "VA can do it all." The prevalence of war-related mental health conditions among OEF/OIF veterans, the high percentages of veterans either foregoing VA care or dropping out of treatment, and the risks in their NOT getting needed treatment make it imperative that VHA acknowledge the limitations of its own healthcare system and seek out other partners. Limitations in VA mental health staffing, space, and geography underscore that the Department cannot do it all, and cannot go it alone. Institutional pride must give way to engaging a broader community to lend support. It's time, in our view, for VHA to reach out—to its medical school partners,

[4] Department of Veterans Affairs, VHA Handbook 1160.01, Uniform Mental Health Services in VA medical facilities and clinics, (September 11, 2008), sec. 5.b.(2)(a).

to organizations representing mental health professionals, to state and local government, to the faith community and other communities—and state clearly, "We need your help in providing for the mental health needs of returning warriors! We can't do it alone." As a bare minimum, VA must employ community-based care options when it cannot provide wounded warriors timely treatment.

2. In a very real sense, VHA operates two almost-parallel mental health systems—one providing treatment through medical centers and clinics, the other in Vet Centers. Our veterans are consistently positive about their experience at Vet Centers, but with isolated exceptions report problems in accessing treatment at VA medical centers and clinics. Some 36% of those VA mental health staff who responded to our recent survey effort reported that their facility either did not have a close working relationship with the local Vet Center, or that relationship was less than optimal. These two systems should be much better coordinated, and should operate as though they are integral parts of a single mental health system, but that is not the case today.[5] Moreover, VHA's acknowledgement of a need to increase staffing at VA medical facilities begs the question of Vet Center staffing. Some Vet Centers too are overwhelmed and require additional staffing, while there are indications that some areas of the country need additional sites. And as we testified last June, VA medical facilities have much to learn from Vet Centers, particularly as it relates to providing peer-support.

3. VA faces many challenges in remedying the problems we've discussed—to include developing a reliable mental-health staffing methodology, streamlining the clinician-hiring process, developing mental-health performance requirements that measure patient outcomes and cannot be "gamed," and fostering a healthier work climate. The Department has been attempting for some time, and with a relatively small staff, to "put out fires" relating to veterans' mental health. Without in any way minimizing the complexity of the issues and the hard work dedicated staff have given these efforts, the gravity of the tasks argues, in our view, for bolder steps than we have seen and for an approach which is far less reactive. It is time, in our view, to move beyond reliance on ad hoc work groups (whose members are likely pulled from clinical care), and instead to enlist independent expertise (whether through the Institute of Medicine or independent-expert consultants) for needed help. Surely VHA can also more productively enlist and engage its own mental health staff in cooperative problem-solving at the facility level, and in doing so foster the trust and confidence critical to a healthy workplace and to success in recruitment and retention.

Thank you for your continued focus on the importance of timely effective VA mental health services for our warriors.

I would be pleased to answer any questions you may have.

Statement For The Record

Hon. Tim S. McClain, President, Humana Government

Chairman Miller, Ranking Member Filner, and members of the Committee:

Introduction

Thank you for the opportunity to submit a statement for the record on the Department of Veterans Affairs' (VA) mental health staffing, quality and quantity; a topic critical to the thousands of Veterans and their families facing serious mental health issues. As mental health issues among our Nation's Veterans and servicemembers continue to dominate the headlines, VA faces the challenge of meeting this growing demand for quality mental healthcare and services.

Humana Veterans Healthcare Services, Inc. (Humana Veterans), a part of the Humana Government organization, has answered the call and is helping VA to meet the mental health needs of our Veterans when the Department is unable to provide the care at a VA facility. Through contracts with VA, Humana Veterans provides access to quality non-VA healthcare through two congressionally-mandated pilot programs—Project HERO (Healthcare Effectiveness through Resource Optimization) and Project ARCH (Access Received Closer to Home).

Last month, Secretary Shinseki announced VA's intent to hire 1,600 mental health clinicians and 300 support staff. As the Committee examines the proper staffing levels of mental health providers at VA, we urge the Committee to consider the

[5] VA's Uniform Mental Health Services Handbook, which "defines minimum clinical requirements for VHA Mental Health Services . . . that must be provided" addresses only what must be provided at each VA medical center and clinic. It does not address Vet Centers.

existing contractual resources such as Project HERO and ARCH, which are already available to Veterans and can quickly be mobilized to help meet their mental health needs. An understanding of all resources available to VA, including underutilized non-VA and VA resources, will help this Committee and VA to make informed decisions on the proper mental health staffing levels at the Department.

Mental Healthcare Quality and Staffing

The quality of mental health providers certainly has a direct impact on Veterans' health outcomes. The mental health providers in Humana's network are fully credentialed and qualified to deliver a very high level of care. When examining staffing quality and health outcomes, care coordination is a critical element that should not be overlooked. With Project HERO contract scheduled to end on September 30, 2012, VA is planning a follow-on national program referred to as Patient Centered Community Care (PCCC). Because mental health is among the planned services excluded from PCCC, this program will not result in Veterans receiving patient-centric coordinated mental healthcare. Exclusion of key services such as mental health goes against the very concept of care coordination, and makes it impossible for Veterans to fully realize the benefits of care coordination. Also, VA's decision to exclude mental health from PCC is misguided, especially when research clearly shows that physical issues often accompany mental conditions. For example, Post Traumatic Stress Disorder (PTSD) is a mental health condition that often coexists with Traumatic Brain Injury (TBI), which is a physical condition. Last month the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a report that stated the following:

Research has found a strong relationship between physical and mental health. People with mental health illnesses are more likely to have co-occurring physical health conditions, resulting in higher healthcare costs and disability. Co-occurrence of mental and physical health problems can increase healthcare utilization and complicate treatment plans. [1]

The lack of care coordination is further exacerbated by VA's apparent decision to remove the administrative functions from PCCC that are associated with non-VA care authorizations, visits and treatment. VA is in the process of implementing a national program called NVCC (Non-VA Care Coordination), which requires the Department to invest significant resources, both in staff and necessary tools, to build in-house capacity to handle the "back door" administrative functions. For example, this includes helping Veterans make and keep medical appointments, ensuring the return of clinical information, and making timely payments to non-VA providers. Humana Veterans is in the business of providing cost-effective administrative services and has developed an excellent personalized service model in Project HERO, which produces excellent results through **metrics** reported every month to VA. VA apparently intends to attempt to duplicate a large portion of the model internally. VA intends to build internal functions that insurers and health plans have as a core capability. VA should do what it does best (i.e., providing excellent healthcare) and contract with commercial companies for required administrative services, which is what they do well. VA's proposed course moves them closer to becoming more like a payor/insurance system similar to TRICARE and Medicare. Further, VA must recognize that an unintended consequence of removing contractor-provided administrative services from the proposed PCCC program threatens the contractor's ability to maintain a provider network that is responsive to VA's changing needs. It also means that VA will not be able to obtain advantageous pricing, since the contractor cannot negotiate a better price with their network providers in the absence of a predictable minimum workload and without the ability to guarantee a low no-show rate, and timely, predictable payments.

VA cannot ensure that Veterans receive high quality care if they move forward with the current plans for PCCC, which excludes mental health and other key administrative and care coordination functions. Instead, Veterans will receive only fragmented care that is neither effective, efficient nor timely, which is in effect the current Fee system.

Long-Term Effects of Combat

Combat and exposure to combat condition, especially wounded, dead and dying individuals, profoundly affects a servicemember's future mental health status. A recently released research paper by the Syracuse University Institute for Veterans and Military Families includes the following findings:

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[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health. "Physical Health Conditions Among Adults with Mental Illness," April 5, 2012.

Veterans exposed to combat experience the lingering mental health effects of that trauma for decades after combat exposure; for many, the effects are permanent. This research shows that the effects of combat exposure are more pronounced for those whose service includes more traumatic events, such as exposure to dead, dying, or wounded people. Knowing this, our society can better predict the outcomes that these veterans will experience over time and the VA can better target resources and predict long-term resource demand.

Based on our Gulf War parameters, we estimate that the costs of mental health declines to be between $87 and $318 per year for each soldier with combat service and exposure to dead, dying, and wounded people. [2]

Non-VA Mental Health Services Available

Humana serves Veterans in VISNs 8, 16, 20, and 23 through Project HERO, and provides care to Veterans living in four out of the five pilot sites for Project ARCH which includes Farmville, VA; Pratt, KS; Flagstaff, AZ; and Billings MT. For both of these pilot programs, Humana provides access to a competitively priced network of physicians, institutions, and ancillary providers to supplement the VA healthcare system while adhering to high quality and access to care standards. Currently, we have the authority to provide mental healthcare to Veterans living in any of the VISNs participating in HERO, but our authority to provide such care is limited to Pratt, KS under Project ARCH. Our robust network of mental health providers is comprised of 4,539 for HERO and 7 for the ARCH site at Pratt, KS. The geographic distribution of these providers is such that Veterans can easily access them by traveling an average of 14 miles for their care. VA's utilization of these two programs for mental health referrals has been low. For example, since Project HERO's inception in October 2007, we have received a total of 1,096 mental health referrals through 30 April 2012. We began implementing Project ARCH in Pratt, KS on 28 August 2011 and to date, **have received** *zero* **mental health referrals.**

There is abundant research that point to the mental health staffing shortage in our healthcare system. Thus, VA will likely face recruitment and retention challenges for the newly announced 1,600 mental health providers. There is certain to be delays in identifying qualified providers, and even when VA is able to do so, the bureaucracy of the Federal personnel system will further delay the on-boarding of the new hires. This could mean years before all 1,600 providers are deployed in the VA healthcare system and available to treat Veterans. VA should assess existing resources that can be deployed quickly. This includes an assessment of the existing contracts that VA has in place with community partners such as Projects HERO and ARCH, and tapping these underutilized resources to provide timely mental healthcare for Veterans. VA can also re-examine the pilot program's eligibility criteria and the definition for the pilot sites, especially with ARCH, which Congress intended to be a VISN-wide program. In addition, VA should examine its current mental health workforce to determine ways to best maximize the productivity and efficiency of the staff, which requires proper metrics and incentives.

An informed decision on the proper staffing levels is only possible if VA identifies and maximizes underutilized non-VA and VA resources. Humana has a proven service model and stands ready to assist VA in delivering to Veterans quality mental health services in a timely manner. Humana Veterans has existing capacity to handle additional mental health referrals under Projects ARCH and HERO and is committed to further expanding our network, if needed, to properly accommodate the referrals from VA.

Conclusion

VA must not miss an opportunity to implement real care coordination of mental health and other services.

Improving the mental health and well-being of our Veterans is certainly a daunting task; however, our society cannot and must not fail the men and women who bravely served this Nation. No single entity has the capacity to fully address the mental health needs of our Veterans. This is a national problem and a local community problem. VA cannot do this alone just as the communities across the Nation cannot do it alone. Instead, it will require collaborative partnerships and **care coordination** among all mental health assets. VA can begin by assessing the partnerships it has in place under existing contracts and programs such as HERO and ARCH. In addition, PCCC is an opportunity for the VA to mobilize networks of mental health providers in the communities where Veterans live. Rather than excluding

[2] "Combat Exposure and Mental Health: the Long-Term Effects Among Vietnam and Gulf War Veterans," Daniel M. Gade, Ph.D. and Jeffrey B. Wenger, Ph.D. Institute for Veterans and Military Families, Research Brief, released May 4, 2012.

mental health and other services inherent in a care coordination program from proposed PCCC model, VA should rethink their approach and infuse strong care coordination elements into the program design to include medical surgical, laboratory, mental health, and health & wellness elements. We look forward to continuing and enhancing our collaboration with VA to bring excellent mental health services to our Nation's heroes.

Thank you, Mr. Chairman, for the opportunity to submit this statement for the record.

Thomas J. Berger, Ph.D., Executive Director, Veterans Health Council, Vietnam Veterans of America

Chairman Miller, Ranking Member Filner and distinguished members of the House Veterans' Affairs Committee, on behalf of President John Rowan, our Board of Directors, and our membership, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record on "VA Mental Health Care Staffing: Ensuring Quality and Quantity".

As has been already reported by various sources, the Inspector General (IG) report of April 23, 2012, concluded that the VA does not have a reliable or accurate method of determining whether they are providing veterans timely access to mental healthcare services and that the VA is unable to make informed decisions on how to improve the provision of mental healthcare to veteran patients due to the lack of meaningful access data. VVA finds this absolutely unacceptable

Veterans Health Administration policy requires that all first-time patients requesting mental health services receive an initial evaluation within 24 hours, and a comprehensive diagnostic appointment within two weeks. For years now, VHA officials have claimed that 95 percent of its new patients were seen in that time frame. But the recent IG report called those calculations confused and inaccurate. By IG researchers' count, fewer than half of those patients were seen within the 14-day requirement. The average wait for a full evaluation among the rest was 50 days.

The report also sharply criticized VHA staffers for not following proper scheduling procedures, further confusing the data collection. For new patients, scheduling clerks frequently stated they used the next available appointment slot as the desired appointment date for new patients, thereby showing deceptively short wait times. For established patients, medical providers scheduled return appointments based on known availability, rather than the patient's clinical need. The report found that the V.A.'s system for measuring waiting times for evaluations "had no real value" because it measured how long it took the department to conduct the evaluation, not how long the patient waited to receive it. As a result, the report said, even if a patient waited weeks for an appointment, the V.A. could say there was zero waiting time if it completed the evaluation on the same day it was conducted.

Although IG investigators also blamed some of the long wait times on shortages in mental health staff throughout the department and noted that from 2005 to 2010 mental health services increased their staff by 46 percent. However, according to the report "VHA's mental healthcare service staff still did not believe they had enough staff to handle the increased workload and consistently see patients within 14 days of the desired dates." These flaws in the VA's appointment system has for example, led to an average wait time of 28 days for patients at the Milwaukee VA Medical Center and over 80 days at the Spokane VA center in Washington state. And in several extreme cases reported in the media, lack of immediate access to mental health services has resulted in veteran suicides.

Although the IG recommended, among other things, that the VA revise its method of measuring waiting times and analyze its staffing levels to ensure that it is able to abide by its own policies, it remains unclear as to how this will be accomplished so that VA facility and VISN directors can no longer "game" the system. Under Secretary for Health, Dr. Robert A. Petzel, said in a letter to the IG that the VA generally agreed with the recommendations and that it would initiate a timeliness review of its entire medical system, not just the four regions analyzed by the inspector general. Thus VVA is forced to ask the questions: **Precisely how will this be accomplished** so as to finally end this and other "gaming the system" practices that we know are used in many (if not most) clinics around the country, and exactly what productivity and performance measures will be utilized to determine whether the VA's measurements and analyses are real and correct?

Furthermore, in July 2011, the Senate Committee on Veterans' Affairs requested VA to conduct a survey that among other questions, asked mental health profes-

sionals 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. Now in May 2012 we hear of VA's plan to hire an additional 1,900 mental health staff. VVA asks if there is or will be a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the VA's ability to meet mental health timeliness goals, and if so, will the VA develop a transparent but accurate action plan to correct the impediments.

Clearly the VA mental health scheduling and staffing systems needs a complete major overhaul.

VVA agrees with a statement from the Chair of the Senate Veteran Affairs Committee who said earlier this spring: "Getting our veterans timely mental-healthcare can quite frankly often be the difference between life and death." VVA also hopes that this HVAC Committee will directly oversee VA's efforts to do so, and we offer our assistance.

Again, thank you for the opportunity to offer a statement for the record on this important veterans' issue.

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