DEPARTMENT OF VETERANS AFFAIRS

Congressionally Mandated Report: Report on Transparency in Mental Health Care Services

December 2022

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Abbreviations

AED	Automated External Defibrillator
AUD	Alcohol Use Disorder
BHIP	Behavioral Health Interdisciplinary Program
CCM	Collaborative Chronic Care Model
CWT	Compensated Work Therapy
EHR	Electronic Health Record
EBP	Evidence-Based Psychotherapy
FTE	Full-Time Equivalent staff
FY	Fiscal Year
GME	Graduate Medical Education
HPT	Health Professions Trainees
MBT	Measure Based Care
MHOC	Mental Health Onboard Clinical method for calculating staffing
MH RRTP	Mental Health Residential Rehabilitation Treatment Programs
OAA	Office of Academic Affiliations
OMHSP	Office of Mental Health and Suicide Prevention
OEND	Opioid Overdose Education and Naloxone Distribution
OUD	Opioid Use Disorder
PC-MHI	Primary Care-Mental Health Integration
PDSI	Psychotropic Drug Safety Initiative
PROM	Patient-reported outcome measures
PTSD	Posttraumatic Stress Disorder
REACH VET	Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment
Q	Quarter
QI	Quality Improvement
SAIL	Strategic Analytics for Improvement and Learning
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SUD	Substance Use Disorders
STORM	Stratification Tool for Opioid Risk Mitigation
VA	Department of Veterans Affairs
VA MISSION Act	John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VOA	Veterans Outcome Assessment
VSS	Veteran Satisfaction Survey

Introduction

Section 726(a) of the National Defense Authorization Act for fiscal year (FY) 2013, P.L. 112-239, required the Department of Veterans Affairs (VA) to develop and implement by December 31, 2013, a set of measures that would provide an accurate and comprehensive assessment of mental health care services furnished by VA, including the timeliness of that care, the satisfaction of Veterans who receive Veterans Health Administration (VHA) mental health services, the capacity to furnish mental health care and the availability and furnishing of evidence-based therapies. VA was also directed to develop and implement, by that same statutory deadline, guidelines for the staffing of general and specialty mental health services, including productivity standards for providers of mental health care.

In addition, § 726(e) requires VA, not later than June 30, 2013, and not less frequently than twice each year thereafter, to submit a report on VA's progress in developing and implementing such measures and guidelines to the Committees on Veterans' Affairs of the House of Representatives and the Senate. Specifically, these reports must each include a description of the development and implementation of the measures and guidelines required by section 726(a)-(b), a description of the progress made in developing and implementing such measures and guidelines, an assessment of VHA mental health care services using those developed and implemented measures, an assessment of the effectiveness of those developed and implemented guidelines and any recommendations for legislative or administrative action to improve the effectiveness and efficiency of VHA mental health services.

This report satisfies the December 2022 reporting requirement by providing an update on current measures available to assess capacity, timeliness, evidence-based therapy, patient satisfaction and staffing models.

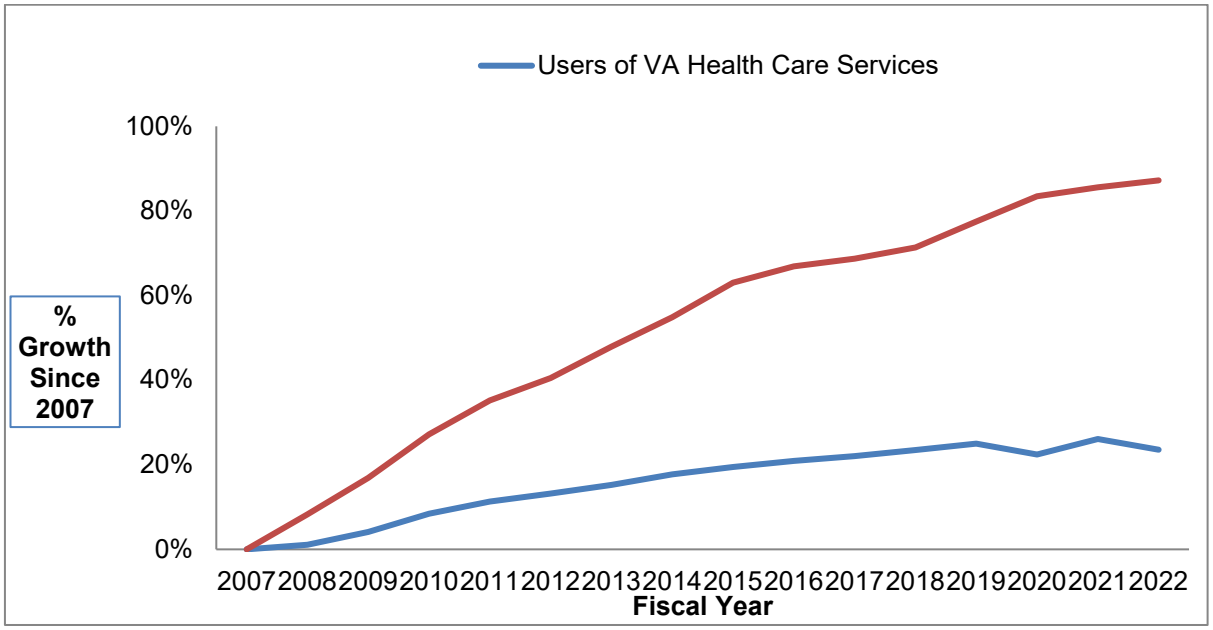
Growth in Demand

In the 2021 VA Survey of Veteran Enrollees' Health and Use of Health Care more than 25% of respondents reported needing assistance with emotional and cognitive needs, specifically in relation to stressful situations and anxiety. Between FY 2007 and FY 2022, the number of Veterans who received mental health care from VHA grew by 87%. This rate of increase is more than three times the rate for VHA users overall (see Figure 1 on page 2). In Figure 1, beginning in FY 2020, patients are counted as receiving mental health care even if this care was only delivered virtually. This reflects that a shift to virtual visits was clinically appropriate during the Coronavirus Disease, 2019 (COVID-19) pandemic. The increase in the number of outpatient mental health encounters or treatment visits has been even more dramatic, more than doubling from 10.7 million in FY 2006 to 21.8 million in FY 2019. Although the number of face-to-face outpatient mental health encounters or treatment visits declined in FY 2020 during the COVID-19 pandemic, VHA still provided more than 20.4 million outpatient mental health encounters and mental health telephone visits in FY 2020; 20 million encounters in FY 2021; and 19.6 million in FY 2022. In FY 2022, the proportion of patients who only

have telephone encounters decreased while the proportion of patients with face-to-face mental health encounters increased. The proportion of Veterans served by VHA who receive mental health services has increased over time from 20% in FY 2007 to 31% in FY 2022 (Figure 1).

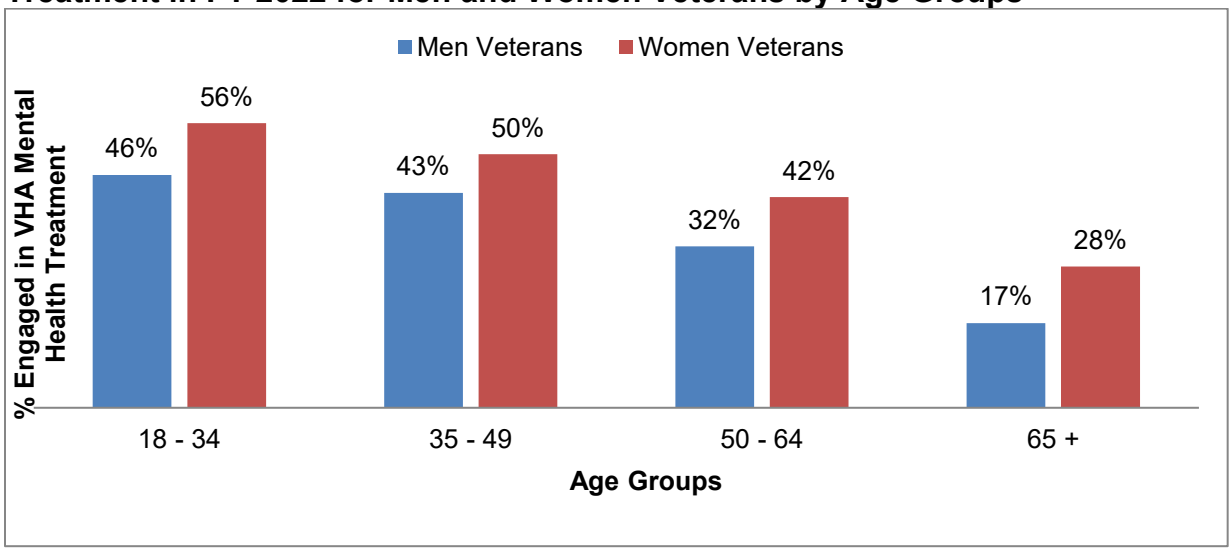
While any drop in treatment is concerning, since the COVID-19 pandemic began in FY 2020 it has caused massive disruption in service delivery in every U.S. health care system, and this continued into FY 2022. VHA adopted protocols in FY 2021 to keep patients with high-risk indicators engaged in mental health services and has conducted outreach to over 54,000 patients that resulted in almost 230,000 contacts through FY 2022.

Figure 1. Percentage of Growth Since FY 2007 in Numbers of Veterans Using VHA Mental Health Services and VHA Health Care Services Overall



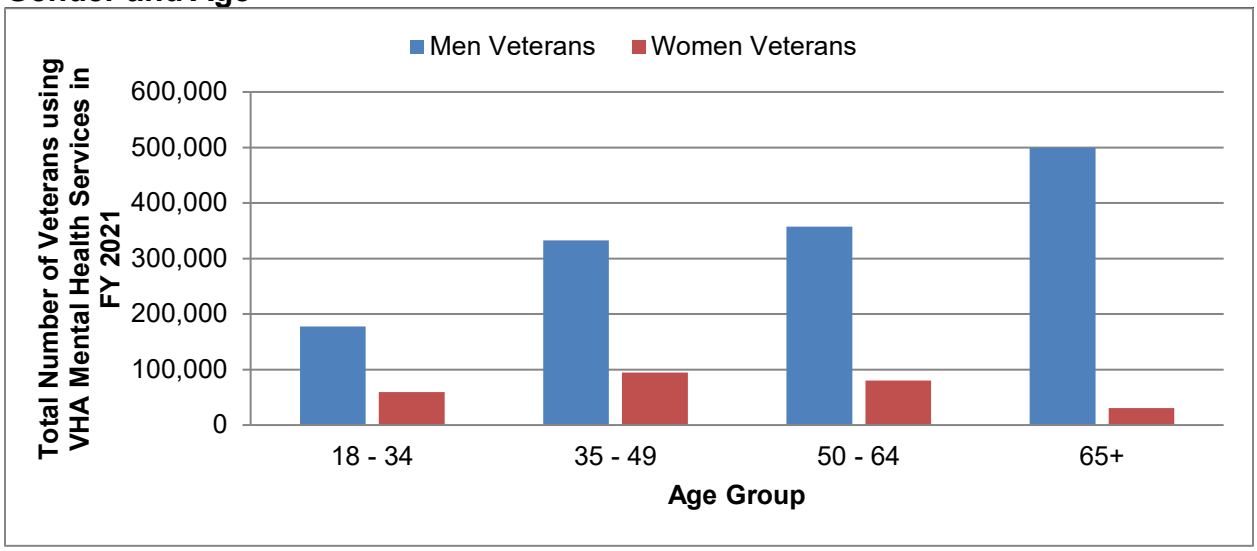
The proportions of VHA health-service users who receive mental health treatment vary across age groups for men and women (see Figure 2 on page 3). The proportions are highest among younger Veterans and decline with age. The proportions are also higher for women than men across all age groups. In FY 2022, the rate of all VHA users under age 50 who use VA mental health services was 41% while the rate for Veterans over age 50 was 21%.

Figure 2. Proportions of VHA Health Service Users Who Used Mental Health Treatment in FY 2022 for Men and Women Veterans by Age Groups



VA also considers the total distribution of men and women from different age cohorts, which determines the age profiles of men and women who use mental health services (shown in Figure 3 below). While women in each age group use mental health services at higher rates than men in the same age group, given the size of the older cohort of male Veterans, 53% of all users of VHA mental health services in FY 2022 were men over age 50, many of whom are over 65.

Figure 3. Number of Veterans Using VHA Mental Health Services in FY 2022 by Gender and Age



Women are a relatively small but a rapidly growing segment of VHA health services users, and they are concentrated in the age groups with the highest rates of mental health service use. Among women, 49% of the Veterans using VHA care in FY 2022 were under age 50, whereas among men, the comparable figure was 22%. Despite the

aging of the overall Veteran population using VA care, the increasing rate of use by the current generation of Veterans (especially women) may increase the demand for services, especially in the context of expanding eligibility to access mental health care discussed in the Access and Timeliness section starting on page 16. Different subgroups of Veterans may have distinct needs that require accommodation for VA to optimize mental health services. The work is underway to determine how mental health services may be adapted to meet the needs of women Veterans more effectively and to ensure that services are culturally sensitive.

Goals of VHA Mental Health Care

The mission of the VA Office of Mental Health and Suicide Prevention (OMHSP) is to promote, protect and restore Veterans' mental health and overall well-being, to empower and equip them to achieve their life goals and to provide quality, state-of-the-art care in a timely manner. VHA mental health services are based on a recovery-oriented model of care that offers rehabilitation to improve functioning, as well as treatment of symptoms. In this model, the Veteran and provider collaborate in developing the treatment plan to ensure that care is responsive to the individual Veteran's needs. Consistent with VHA's Whole Health approach to care, VHA mental health care rests on the principle that it is an essential component of overall health, and it requires the availability of a continuum of services, including self-help resources, telephone crisis intervention services, outpatient care, residential care and acute inpatient care.

The program requirements for the full range of mental health services that VHA delivers are specified in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers (VAMC) and Clinics (the Uniform Mental Health Services Handbook), published in 2008 and amended in 2015. The program requirements are currently being outlined in forthcoming directives. Although much of the information that follows is specific to outpatient care, ensuring access to the entire continuum of care is essential. VHA monitors capacity, timeliness, staffing and quality across the continuum.

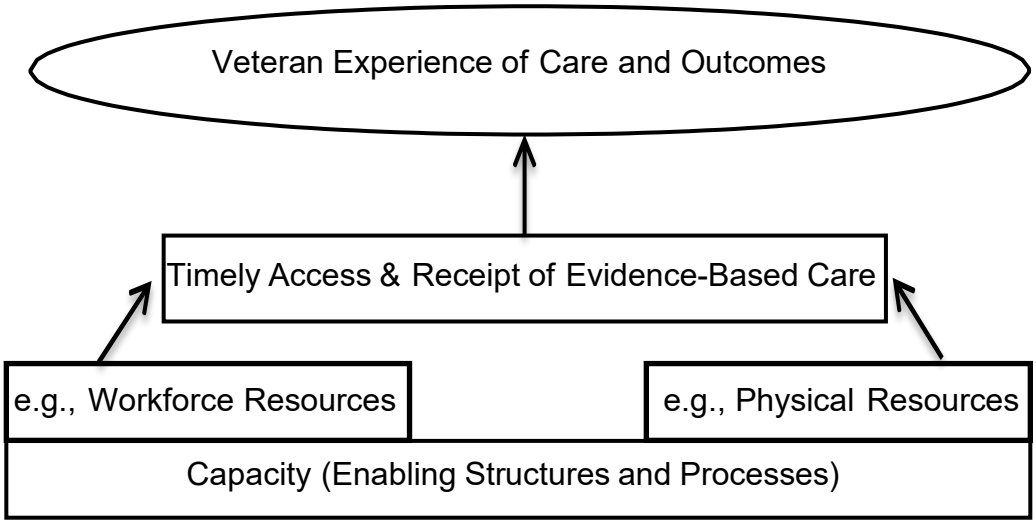
Performance Measurement

OMHSP uses existing administrative data to assess mental health programs and guide program improvement at various organizational levels, from national leadership to frontline providers and across the continuum of care (see Lemke et al., 2017; Schmidt et al., 2017 for examples of these efforts). The resulting measures provide information about the structure of VHA mental health services, the resources available and the process of care provision. The development of measures, their use and refinement will be a continuing, iterative process, to meet requirements such section 104 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 115-182) and the transition to the Cerner medical record system.

To organize a complex and expanding set of metrics, VHA uses a conceptual model to

integrate the domains in which measures have been identified (Figure 4 below). Specifically, the capacity domain consists of enabling structures and processes (physical, human capital and procedural) that allow other domains to function well. These other domains include access to care, which cannot be ensured unless capacity is adequate. Adequate capacity is in turn influenced by myriad other factors, including Veteran characteristics, needs and preferences. Adequate capacity and access are required to ensure timeliness of care, receipt of evidence-based treatments and, ultimately, Veteran satisfaction with care and positive outcomes.

Figure 4. Conceptual Model for Mental Health Services Quality Monitoring



Where possible, these domains are monitored using existing administrative databases. In addition, OMHSP has developed targeted surveys of mental health patients and providers. Each type of measure has an important role to play in ensuring quality assessment and improvement. Metrics developed from the surveys are being used for reporting and will guide improvement in mental health programs. These multiple perspectives allow for triangulation between the available resources; how these resources are being used; and the experiences of patients and providers.

The first Veteran Satisfaction Survey (VSS) specific to the receipt of VHA mental health treatment was administered at the end of FY 2013. Additional survey administration cycles were completed each year from FY 2015 to FY 2021. The purpose of this survey is to better understand barriers that may inhibit Veterans' access to and experience of mental health services. Since 2015, approximately 7,500 to 10,000 Veterans completed the survey every year except for a drop in FY 2021. To address low response rates, in January 2022 the VSS was updated and is now administered digitally. This report provides data from the 2,512 Veterans who completed the new VSS in August and September 2022. Data is reported back to facilities on a quarterly basis.

VHA also has conducted an annual Mental Health Provider Survey each calendar year since 2012. This survey is administered online to all VHA mental health providers

(licensed and non-licensed independent providers). The response rates have ranged between 25% and 63% of eligible facility staff (more than 11,000 completed the 2021 survey). Questions address issues of perceived Veteran access to care, workload and job satisfaction, physical infrastructure and quality of care provided. Questions about the impact of COVID-19 were added in 2020. To reassure respondents regarding the anonymity of their responses, limited personal information is obtained in this survey. For 2021 survey respondents, the most common range of job tenure with VHA was between 5-10 years (28%), and 49% had received some of their professional training in VHA. The 2021 administration of the survey was delayed several months because of COVID-19.

As part of VHA's quality improvement infrastructure, quality indicators derived from these surveys and from administrative and patient care databases are used to monitor and encourage action on institutional and clinical concerns. These quality indicators are selected to be relevant to the typical mental health treatment practice and are used by VHA mental health leadership to assist the Veterans Integrated Services Networks (VISN), facilities, specialty programs and individual clinicians to provide high quality, Veteran- centered, safe and effective treatment through education, technical assistance, action planning, systems redesign, quality improvement and related clinical initiatives.

In FY 2015, VHA added a mental health care quality composite score to the Strategic Analytics for Improvement and Learning (SAIL) Value Model (Lemke et al., 2017). SAIL is a web-based, balanced scorecard model that VHA developed to measure, evaluate and benchmark quality and efficiency at VA medical centers. The SAIL report is designed to offer high-level views of health care quality and efficiency, enabling executives and managers to examine a broad range of existing VHA measures. The report also has links to supplementary data reports allowing all VHA staff to work on quality improvement. The measures in the SAIL Mental Health Domain are updated every fiscal year and facility scores are updated on a quarterly basis.

The SAIL Mental Health Domain consists of the following three components: (1) population coverage which captures the proportion of patients with specified mental health conditions who received indicated mental health specialty care services; (2) continuity of care which assesses coordination of mental health services during high-risk patient transitions, cross-service care, active engagement of patients initiating services and use of proactive follow-up methods; and (3) experience of care which reflects patient and provider-perceived ease of access to mental health services and the quality and effectiveness of care. The overall SAIL Mental Health Domain is viewed as a diagnostic tool to alert senior managers to potential concerns about the quality of VHA mental health services at the VISN and facility levels.

VHA is consistently developing processes and tools to help staff address identified gaps in mental health services. For example, the Mental Health Management System report was created to integrate the SAIL Mental Health Domain scores with key factors associated with access to care and quality outcomes, such as staffing, productivity, clinical processes, space and rate of growth (Schmidt et al., 2017). Quarterly virtual

meetings involving OMHSP and VISN staff use this report to promote a common understanding of facility performance. These calls are also used to reinforce national priorities (e.g., access, suicide prevention initiatives and the importance of appropriate staffing). Facilities that have low performance on the SAIL Mental Health Domain can use the Mental Health Management System to identify barriers to their performance and the effects of efforts they have made to overcome obstacles, and to inform their plans to improve. A team of experts in the management and delivery of mental health services provide extended consultation, and there are many communities of practice and opportunities to reach out to subject matter experts or data experts. Positive changes year-to-year in the SAIL Mental Health Domain scores suggest that this approach is effective at improving the quality of mental health services.

Capacity

The capacity of VHA to deliver mental health care refers to the availability of resources required for the timely delivery of high-quality mental health services. Beyond the number of appointments available or the number of clinicians providing services, capacity assessment encompasses the physical and organizational infrastructure necessary to support the delivery of mental health care. VHA has taken a comprehensive view in developing the capacity to deliver mental health care. As the demand for mental health care has expanded, VHA has engaged both internal and external resources to assess, develop and evaluate the requisite workforce, organizational and physical resources required. This effort is guided by the theoretical model shown in Table 1 below (adapted from Meyer, Davis and Mays, 2012) and described in the following sections.

Table 1:Theoretical Model to Describe Capacity

Major Components of Capacity	Examples of Elements within Major Components
1. Fiscal and Economic Resources	• Budget • Expenditures • Spending per capita • Cost per service/program or health outcome
2. Workforce and HumanResources	• Number of full-time equivalent (FTE) employees • Staff knowledge/skills/expertise • Staffing configuration/availability/deployment • Demographics and diversity • Recruitment, retention, morale and compensation
3. Physical Infrastructure	• Office space and equipment • Treatment space across settings of care
4. Data and Information Technology Resources	• Communication tools (e.g., telehealth) • Clinical informatics • Computer and information technology equipment • Surveillance data (local, state, national) • Library resources and scientific evidence

Major Components of Capacity	Examples of Elements within Major Components
5. System Boundaries and Size	• Population and demographics (race and ethnicity, socioeconomic status) • Geography and distances to travel

Progress Made in Measuring Capacity in VHA Mental Health Care

Fiscal and Economic Resources

In the FY 2023 President's Budget Request for VA, VA obligations for mental health care were reported as approximately $11.211 billion in FY 2021; estimated as approximately $12.251 billion in FY 2022; and approximately $13.919 billion in FY 2023. In FY 2021, approximately 11% of VA health care spending was allocated to mental health care, a proportion that has been relatively stable over the past 5 years. VA also tracks per capita spending for Veterans receiving mental health services, which increased from $3,898 in FY 2011 to $6,160 in FY 2021, which is an approximate 58% increase over this 10-year period. In FY 2021, the COVID-19 pandemic dampened use of VHA mental health care which contributed to the increasing per capita cost. The per capita figure provides one indication of whether growth in mental health care spending has kept up with growth in the numbers of Veterans seeking such care. Numerous other factors, such as the severity of Veterans' mental health problems and inflation in medical care costs, also need to be considered when determining whether spending has kept up with increased demand.

Per capita spending also reflects efficiency in the provision of care. For example, because treatment programs vary in intensity and treatment length, the setting in which care is provided can influence per capita spending on mental health care. Research has shown that mental health treatment provided in outpatient programs is as effective as inpatient treatment for most patients and in most situations. Consistent with trends across the United States in recent decades, a shift from inpatient to outpatient mental health treatment has taken place in VHA, enabling more Veterans to be provided mental health services for the same cost. In FY 2021, the proportion of spending on outpatient mental health treatment in VHA was approximately 57% of the total mental health care obligations.

Workforce and Human Resources

Arguably, the most vital resource in the delivery of mental health care is human capital. Having sufficient, properly-trained and experienced clinicians to deliver care results in better outcomes of mental health care, such as treatment access and satisfaction. We briefly discuss several workforce characteristics, including data obtained from the 2021 Mental Health Provider Survey, as described in the Introduction. Later sections of this report focus on specific aspects of the capacity domain related to staffing. Specifically, the Evidence-Based Treatment section starting on page 24 explicitly addresses issues

of staff training, and the Staffing Model section starting on page 35 details VA's efforts to define the number and composition of mental health staff necessary to serve Veterans seeking mental health care.

Staff Demographics

At the beginning of FY 2022 Quarter (Q)3, 17% of VHA outpatient mental health providers were Veterans, and 67% were women. The average age of outpatient mental health providers was 48, and about a third of these providers were over the age of 55. Given the age of these providers, planning for staffing of mental health programs will need to account for increased rates of expected retirement over the next decade.

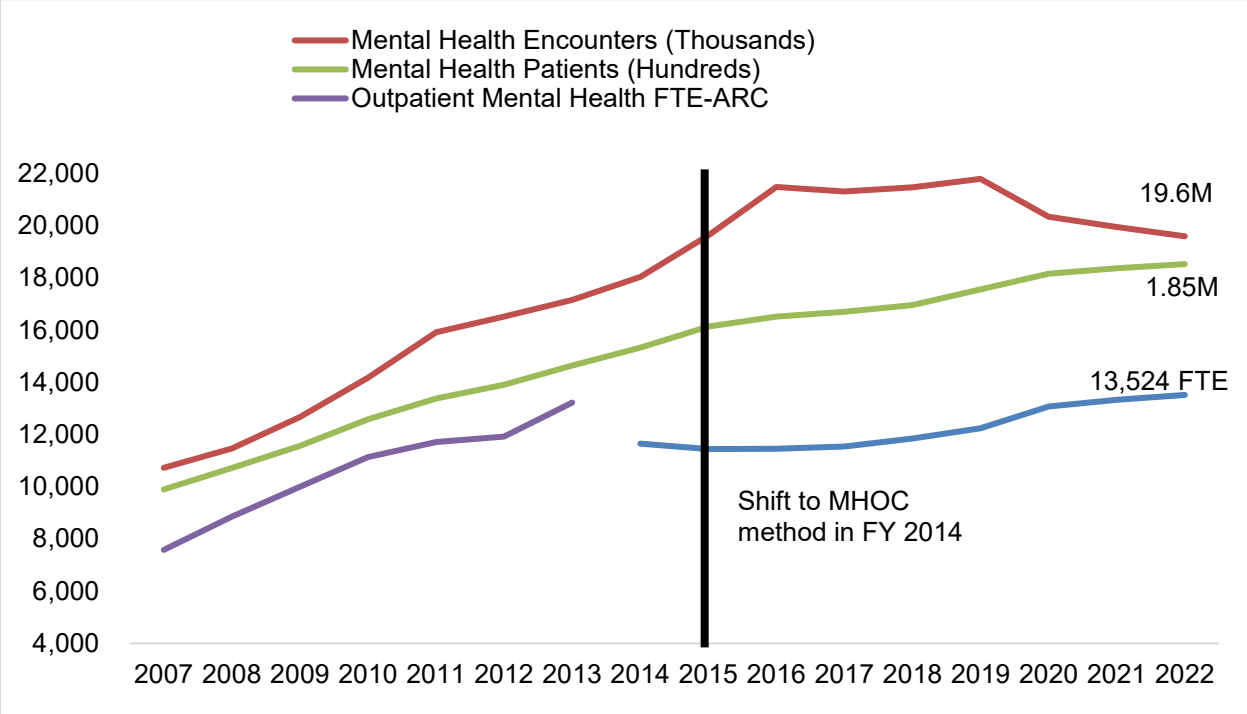
Staffing Levels

The rapid growth over the past decade in the number of Veterans seeking mental health treatment in VHA has posed staffing challenges. In Figure 5 on page 10, the annual growth in numbers of Veterans using mental health services is depicted, showing an increase from 990,215 in FY 2007 to 1,853,892 in FY 2022. This graph also shows the growth in numbers of mental health clinical staff, measured in terms of the FTE staff providing outpatient treatment. The number of patients is expressed in terms of hundreds to show staff and patient numbers on the same graph. For example, 10,000 on the vertical axis represent 1,000,000 patients and 10,000 staff FTEs. To include them in the same graph, mental health encounters are shown in thousands; 10,000 on the vertical axis represents 10,000,000 encounters or visits.

In 2013, OMHSP staff developed the Mental Health Onboard Clinical (MHOC) method of calculating and identifying employees providing mental health and homeless outpatient and inpatient (e.g., acute inpatient, residential) workload and productivity. Outpatient mental health staffing data provided throughout this report was calculated using the MHOC method and, in Figure 5 on page 10, the total mental health clinical staff in FY 2014 and forward is also based on this method. MHOC differs from the prior method primarily by only counting the time staff providing clinical services spend providing those clinical services, generating a lower total than the prior method of calculating total staff.

The MHOC method provides supervisors and program managers with detailed information to guide staffing assignments, gap analyses, program organization and management of individual provider productivity within mental health and homeless clinics. COVID-19 restrictions had a substantial impact on the number of staff providing inpatient care during the latter half of FY 2020, which continued throughout FY 2021 and FY 2022. In April 2022, the MHOC method identified the equivalent of 2,406 VHA FTEs providing inpatient and residential mental health care (versus 2,900 in January 2020). There were 13,524 FTEs providing outpatient mental health care, reflecting that most mental health care is provided in outpatient settings.

Figure 5. Growth in Annual Numbers of Patients Using VHA Mental Health Services, Encounters and Outpatient Mental Health FTEs, FY 2007 to FY 2022



Although the rate of increase in encounters has slowed since 2016, the ongoing growth in unique patients suggests there is a continuing demand among current VA users for mental health services. The COVID-19 pandemic is causing an ongoing, substantial impact on staffing. The total number of outpatient mental health staff may be inflated because providers used less leave which allowed more time for patient care. Fewer inpatient admissions and curtailed mental health residential operations in some locations also allowed more providers to work in outpatient settings. The shift in staffing appears to have increased the use of population-health approaches as evidenced by increases in the use of data-driven, proactive outreach and follow-up interventions.

Evidence-based, cost-effective mental health care delivery approaches, such as the Collaborative Chronic Care Model (CCM) and Care Management Program, focus on proactively maintaining communication with patients about their status and needs outside of traditional health care encounters. These approaches improve patient outcomes at a lower cost by identifying care needs earlier (costs fall due to decreased hospitalizations (Miller et al., 2020)). In addition, these approaches avoid clinical follow-up encounters when the patient does not need them. VHA has been transitioning toward these care delivery approaches, and, as a result, clinicians spend more time interacting with patients and managing their care outside of a documented clinical encounter (Bauer et al., 2019a). This reduces the rate of encounter growth, even while patient numbers are increasing, and patient outcomes are improving. Further discussion of this is included in the Staffing Models section.

Concerns have been raised about variation among VHA facilities in staffing levels for outpatient mental health. For example, at the beginning of Q3 in FY 2022, the average ratio of mental health outpatient clinical staff FTEs per 1,000 mental health patients seen during the year varied substantially across VHA facilities, from a low of approximately 5 staff FTEs per 1,000 patients to a high of about 15 staff FTEs per 1,000 patients. VHA has established minimum staffing targets for individual facilities (see Staffing Models section on page 35) and is monitoring adherence to these staffing recommendations. When discrepancies from the model are identified, VHA works to understand possible contributing factors and to address the barriers that prevent some facilities from meeting staffing goals.

Staff Vacancy Rates

Unfilled staff positions reduce care capacity even when overall staffing levels are appropriate. Delays in hiring can leave critical functions inadequately staffed and may interfere with optimal use of staff time. In ongoing surveys of mental health providers, a substantial majority of respondents agreed that mental health staffing levels significantly affect patient care in their facility. In 2021, more than four out of five providers reported that vacancies interfered with meeting patients' needs, indicating that timely hiring was a significant and increasing concern for staff nationwide. VHA is currently undertaking a Mental Health Hiring Sustainability Initiative (begun in 2019), which is providing support for the facilities struggling the most with having adequate mental health staffing.

Staff Deployment

Extended hours can improve the ability to meet the needs of Veterans with competing responsibilities during daytime hours. Extended hours can also help increase capacity when space is limited. More than half of the respondents to the 2021 Mental Health Provider Survey agreed that they were interested in working flexible schedules.

Health Professions Trainees

Training the Nation's future health care providers is one of four core missions for VHA. Health Professions Trainees (HPT) form a recruitment pool from which VHA can hire mental health professionals with confidence in their training and commitment to the VHA mission. As noted earlier, half of the providers who responded to the 2021 Mental Health Provider Survey reported that they had obtained training through VHA programs. For some mental health professions, like psychology, this is higher: 73.5% of psychologists who responded to the 2021 All Employee Survey indicated that they have trained in VA. VHA training also prepares HPTs who will eventually work as clinicians outside of VHA to understand and manage Veteran-specific issues, which will benefit Veterans and their families.

In close collaboration with OMHSP, the Office of Academic Affiliations (OAA) initiated a mental health education expansion in 2013. Over the program's 9 years, more than 780 training slots have been added across 10 mental health professions. During the

expansion, OAA and OMHSP established funded internships for Licensed Professional Mental Health Counselors and Marriage and Family Therapists, as these professions are targeted for expanding the overall mental health workforce. Additionally, two expansion initiatives, occurring in 2016 and 2018, for Physician Assistant Mental Health Residency added ten additional resident positions across four facilities. These innovative initiatives provided physician assistants with expertise as psychotropic medication prescribers and prepared them to join physicians and nurse practitioners in this important aspect of mental health care.

The OAA Nurse Residency Programs aim to positively impact the VHA nursing workforce, facilitating VHA recruitment and retention goals. OAA has conducted multiple rounds of Requests for Proposals to expand VHA Nurse Residency programs that currently include 118 programs located at 64 VA facilities. There are 26 OAA Mental Health Nurse Practitioner Residency Programs across VHA. Each program is required to host a minimum of three full-time resident positions. For the 2022-2023 academic year, OAA has approved 87 Mental Health Nurse Practitioner resident positions.

In a parallel initiative, OAA completed the final distribution of the Congressionally mandated Veterans Access, Choice and Accountability Act Graduate Medical Education (GME) Expansion. To date, this Act has approved 364 FTEs in mental health and psychiatry GME positions to VHA facilities. Included in this group are positions in core psychiatry residency programs, as well as in geriatric, addiction, psychosomatic, child/adolescent and forensic subspecialties, along with addiction medicine fellowships. This increase improves mental-health-service access for Veterans.

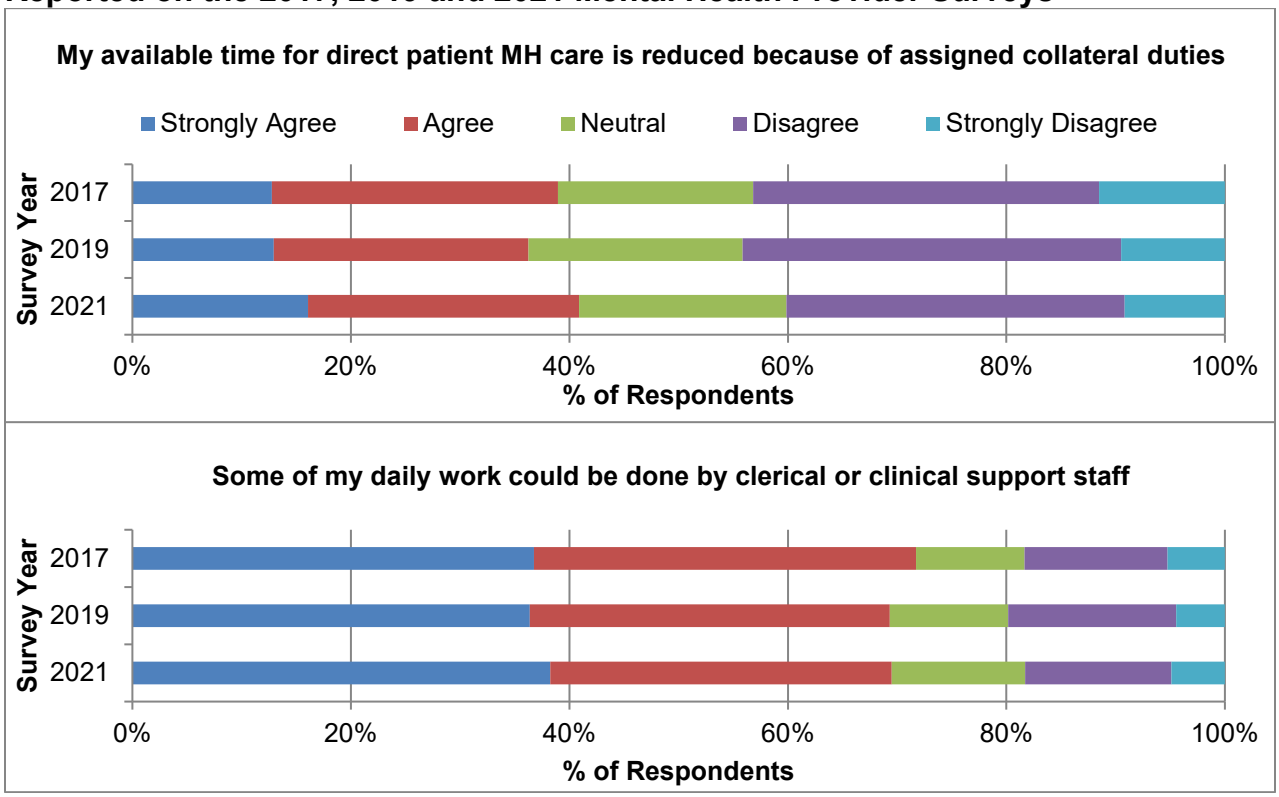
VHA is improving their competition with the private sector by continuing to expand trainee recruitment events in mental health occupations, including psychology, psychiatry, nursing, social work, licensed professional mental health counseling and marriage and family therapy. The Trainee Recruitment and Hiring Workgroup, a collaboration between OAA and Workforce Management and Consulting, is seeking strategies to automate matches between interested HPT candidates and open vacancies across the VHA system to enhance the use of non-competitive hiring flexibilities. Trainee recruitment activities through this workgroup have resulted in 789 accepted job offers by mental health HPTs since 2019. OAA responded to the COVID-19 pandemic by extending flexibilities for telework and tele-supervision for mental health HPTs, allowing them to deliver care to Veterans while continuing their clinical education.

Support Staff, Adjunct Professionals, and Peer Support Staff

The availability of clerical and administrative staff, adjunct professionals and peer support staff can increase facility capacity to meet the demands for mental health services by allowing professionals to spend more of their time working on activities at the top of their training and licensure. VHA monitors the availability of such support personnel and tracks provider perceptions concerning the effective use of their own time.

In the 2021 Mental Health Provider Survey, 74% of the respondents agreed that they are working at the top of their licensure, a figure that has been quite stable over recent years. However, 41% indicated that collateral duties reduced their availability for direct patient care, and 69% endorsed the statement that some of their workload could be performed by clerical and clinical support staff (Figure 6 below). Staff ratings on these items are quite stable.

Figure 6. Mental Health Staff Perceptions Regarding Optimal Use of Their Time as Reported on the 2017, 2019 and 2021 Mental Health Provider Surveys



Peer support services is an integral component of recovery-oriented care in VHA. Peer specialists in VHA are Veteran employees who self-identify with a lived experience of successful recovery from a mental health condition. They work as part of interdisciplinary treatment teams serving Veterans in outpatient, inpatient and residential mental health services as well as homelessness programs, primary care patient aligned care teams, vocational rehabilitation services, Veterans Justice Outreach and the Veterans Crisis Line's Peer Support Outreach Center. As of October 2022, there are 1,268 peer specialists currently working in the VA health care system. Peer specialists are trained to effectively use their personal lived experience with recovery to inspire hope and serve as relatable role models of recovery for other Veterans. They work with Veterans to identify their personal strengths, needed resources and desirable skills that support their personal goals. Peer specialists use a host of recovery tools to help Veterans enhance healthy coping strategies and improve self-management skills over their mental health conditions. They assist Veterans with navigating the VA health care system and connecting to available VA and community resources. Peer specialists

empower Veterans to learn and practice self-advocacy skills, reconnect with others and to find a sense of belonging and purpose both in VA and in their communities.

Staff Training

Staff training and expertise also influence the VHA capacity to provide needed services. VHA's Evidence-Based Psychotherapy (EBP) Provider Training Program trains providers in advanced, evidence-based clinical practice interventions. The program enhances VHA's capacity to deliver this care by helping providers to develop the expertise to provide clinical practice guideline recommended services to Veterans. VHA is a recognized leader in EBP training (Institute of Medicine, 2015) noted for meeting or exceeding the standards for clinical training that lead to the development of competence (Frank et al., 2020), and therefore increase the likelihood that providers deliver the therapies to Veterans post training. The key components of EBP training programs include both didactic and experientially based training elements, as well as a period of expert clinical consultation during which the trainees begin to provide the EBPs to Veteran patients.

Currently, there are 18 different EBP psychotherapy training programs that address the mental health disorders and problems that Veterans experience most, including increased risk of suicide, post-traumatic stress disorder (PTSD), depression, substance use disorders (SUD) and serious mental illness (SMI), as well as initiatives to address cross-cutting issues such as chronic pain, insomnia, motivation for treatment, relationship distress, coping and problem-solving skills. In addition, each VA facility has an EBP coordinator to facilitate selecting providers for training. As of the end of FY 2022, VHA's EBP Provider Training Program has trained over 21,000 clinicians in one or more of these EBPs. All training programs are evaluated for purposes of quality assurance and quality improvement. The program evaluation and research indicate that the training programs are both effective and efficient and that Veteran outcomes improve as expected. VHA will continue to train clinicians in EBPs to ensure there is capacity to offer Veterans' access to effective treatments regardless of location or circumstance.

Physical Infrastructure

Restrictions on physical space and equipment can reduce the capacity to provide high quality mental health care, even when all other elements of capacity are adequate. This is especially true in the face of rapidly expanding demand for services, such as has occurred for VHA mental health care. For this reason, the treatment space for Veterans with mental health needs is monitored in terms of the perceptions of providers as well as the square footage per mental health patient treated. On the 2021 Mental Health Provider Survey, 40% of the respondents agreed or strongly agreed that space limitations or design made it difficult to meet privately with patients, and 46% reported difficulty scheduling space for group treatment sessions. The 2021 survey indicates that year-by-year improvements seen since the first survey in 2012 are being maintained.

VHA continues to upgrade its physical infrastructure to offer state of the art environments to Veterans that support inpatient and residential treatment. Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) continue to be significantly impacted by the COVID-19 pandemic. Many programs are operating at reduced capacity to mitigate safety concerns and support care in other settings, with ongoing efforts to focus on increasing access and capacity when safe to do so. While residential capacity gradually expanded in FY 2022, impacts continued through the year due to physical infrastructure challenges that limited capacity when considering ongoing COVID-19 mitigation needs during periods of community spread. This was most prominent during the COVID-19 surge that occurred during Q2 of FY 2022. Many facilities only recently saw community transmission rates low enough to relax some of the physical distancing guidelines required when community transmission rates are high (e.g., distancing in group rooms, bedrooms, etc.). The ability of facilities to transition to guidelines appropriate to the local transmission rate is often affected by physical infrastructure considerations. OMHSP anticipates that ongoing safety requirements to mitigate the risk of exposure to COVID-19 in addition to broad staffing challenges that have occurred during the pandemic will prevent some programs from returning to full capacity.

Data and Information Technology Resources

In a system as large and complex as VA, accurate understanding of the changing needs of the Veterans being served is essential to providing services. Technology tools can directly affect capacity and may be particularly helpful where distances are great, space is limited, when physical distancing measures are in place or simply when Veterans prefer the convenience that technology offers. The Office of Connected Care oversees the expansion and provision of telehealth services through secure communication channels. Continuing proactive investment in the efficient use of informational resources and emerging technologies can have a significant impact on system capacity, but the adequacy of capacity in this area is very challenging to measure (e.g., adequacy of bandwidth), especially in the context of the ongoing large, rapid increase in telehealth use during the COVID-19 pandemic.

Among those who completed the VSS in August to September 2022, 72% had an appointment by phone or audio, and 68% had an appointment by video. More than 93% of those who had a phone or audio appointment reported their meetings went smoothly with few technical problems, and more than 92% reported this for their video appointments. Almost 79% indicated that their telehealth meetings were as helpful or more helpful than the meetings in person. Only 21% preferred only in person care. In the 2021 survey of providers, 68% agreed that meeting with patients by telehealth was just as effective as meetings in person, an almost 30% increase from 2019. In two recent studies of VHA mental health patients given video-enabled tablets (Jacobs et al., 2019; Gujral et al., 2022), Veterans with tablets increased their use of mental health care indicating new technologies are acceptable to patients. VA continues to implement several national strategies to help Veterans use telehealth including assessing their need for and providing VA loaned devices; helping them get set up on the devices; and

doing test calls.

System Boundaries and Size

A clear understanding of the numbers and characteristics of those likely to access services is important for planning and developing capacity. The capacity to deliver mental health care is affected by the geographic areas in which programs operate and the characteristics of the Veteran population in the region being served. For instance, Veterans who have a condition they deem directly related to military service are most likely to use VHA health care services. As part of population coverage measures in the SAIL Mental Health Domain, VHA monitors the proportion of Veterans who are service-connected for mental health conditions and who are receiving mental health care. As of FY 2022 Q3, 41% of Veterans who were service-connected for mental health conditions had received mental health care from VHA during the prior year.

Section 401 of the VA MISSION Act required VA to develop criteria to designate which VA health care facilities were underserved and a plan to address the problem of underserved facilities; VHA has done this and provides Congress annual updates to the plan to address underserved facilities. The most underserved facilities also developed action plans for better identifying and engaging their Veteran patients and Veterans who potentially need but are not yet receiving treatment. VHA has tracked these facilities over time to identify improvements in facilitating treatment for their population and has identified additional facilities that may be underserved.

Addressing Capacity Issues

As noted in the Introduction, OMHSP conducts quarterly calls with VISN leadership to review facility-level capacity measures that may point to unique challenges facilities face in ensuring adequate mental health treatment capacity. The ensuing discussions are designed to stimulate problem solving to address these challenges. Solutions may be generated locally or regionally, but they also may require national initiatives within VA, as well as possible legislative changes. VHA is working from many perspectives to expand capacity to serve historically underserved populations, including methods to target budget and resources, add staff and use novel care delivery methods.

Access and Timeliness

Access to care is the core mission of VHA. Each year, VHA provides mental health care to an increasing number of Veterans. VA projects a 50% growth in inpatient and outpatient care during the period from FY 2020 through FY 2030, which represents an increase to 31 million encounters. This strong projected growth demonstrates ongoing high demand for mental health services (Figure 5 on page 10). While encounters for mental health care have declined since FY 2020 due to the COVID-19 pandemic and changes in how Veterans engage in mental health care, Veterans continued to have access to these services. In FY 2022, 1.85 million Veterans (28% of all VHA users) received mental health services within VHA, defined as individual or group treatment

provided by a mental health professional. More than 78% of the almost 2.4 million Veterans using VHA in FY 2022 who had a mental health diagnosis received treatment.

Connecting Veterans to the soonest and best care is one of the six current VHA priorities, and VHA has consistently demonstrated commitment to the mission of improving access to mental health care. Activities are focused on same-day access for primary care, mental health services and suicide prevention. All VAMCs can provide immediate attention to any Veteran in crisis or needing urgent mental health care when that Veteran presents at a VAMC or Community-Based Outpatient Clinic. Additionally, VAMCs can provide initial screening evaluations the next day for any Veteran with a non-urgent mental health need seeking mental health care for the first time.

Timeliness is a measure of the *appropriate* timing of services; yet measurement of timeliness poses several challenges. A single metric and target performance for timeliness across all VHA services and settings is not appropriate and can run counter to the provision of quality care. Currently, patient perceptions of access are monitored throughout the year and provider perceptions of access are monitored annually. VHA has developed multiple internal tools that allow program managers and administrators to track wait times on a continuing basis.

Progress Made in Measuring Access and Timeliness for VHA Mental Health Care

Expanded Eligibilities for Mental Health Care

The work to improve access continues through implementation of Executive Order 13822, Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life, which required VA to work with other specified agencies to develop a Joint Action Plan which would provide, to the extent consistent with the law, transitioning Service members with seamless access to mental health treatment and suicide prevention resources. As part of implementing Executive Order 13822, the VA Solid Start Program (Solid Start) calls newly separated Service members three times in their first-year post-separation to provide information that includes how to access VA mental health services and additional outreach initiatives. Solid Start prioritizes calls to eligible Veterans who had a mental health appointment within their last year of active-duty service and meet other criteria. Of the more than 40,000 Veterans in the priority group, 77% have been successfully reached.

Similarly, section 101 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act), P.L. 116-171, requires VA to develop a strategic plan to expand health care to any Veteran during the 1-year period following the discharge or release of the Veteran from active military, naval or air service, and section 763 of the William M. (Mac) Thornberry National Defense Authorization Act for FY 2021, P.L. 116-283, allows VA, in consultation with the Department of Defense, to furnish mental health services to members of the Reserve components of the Armed Forces. VA is also currently implementing section 203 of the Comprehensive Prevention, Access to Care, And Treatment Act of 2020 (the COMPACT Act),

P.L. 116-214, which expands access for Veterans during a suicidal crisis. Since FY 2017, VHA has been providing emergent mental health services to former Service members with Other than Honorable administrative discharges, who are determined to be tentatively eligible for care under 38 C.F.R. § 17.34.

Expanded Entry Points for Mental Health Care

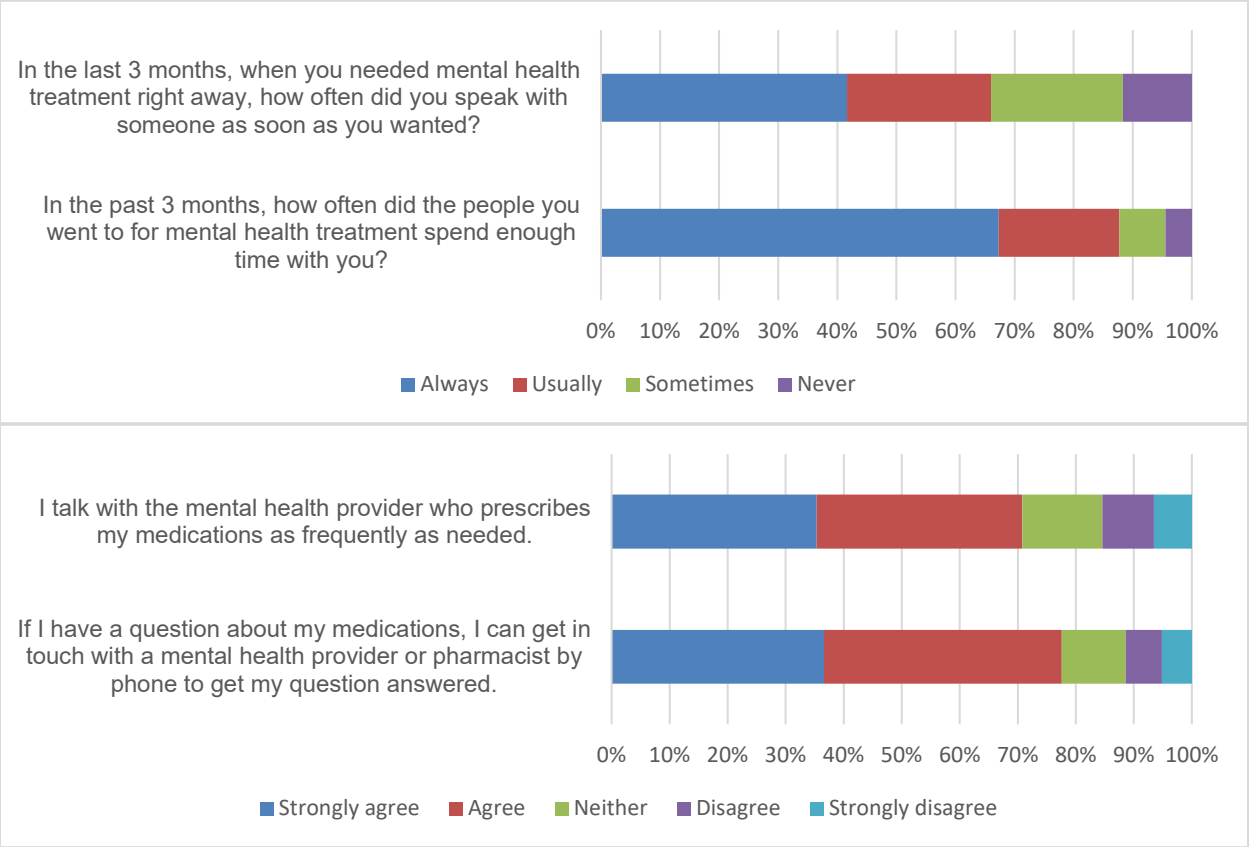
Comprehensive information on VA treatment programs is available through VA treatment locators at https://www.mentalhealth.va.gov/ and the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator at https://findtreatment.samhsa.gov/. VA also continues to make it easier for Veterans to schedule outpatient mental health appointments through online scheduling and self-scheduling options and to talk to a provider through VA Video Connect or other telehealth modalities. Rapid expansion of telehealth for mental health care has been a critical component of maintaining access during the COVID-19 pandemic and VHA has invested in promoting access to mental health care through telemental health (See Five ways to access VA care virtually during and after COVID-19 pandemic - VAntage Point). More than 12,700 VA outpatient mental health providers (97%) had completed a clinical video visit as of the end of FY 2022.

Open access is a key principle in the implementation of Primary Care-Mental Health Integration (PC-MHI), and full implementation of PC-MHI at all required locations is one strategy to fulfill the commitment to same-day access. Despite a dramatic decrease in primary care visits in FY 2020, patients who were seen in primary care still had same-day access to mental health care. In FY 2022, 36% of the new PC-MHI patients had a same-day, warm hand-off between the primary care provider and a PC-MHI provider. Same-day warm hand-offs increase treatment engagement, reduce missed appointments and improve patient satisfaction.

Veteran Ratings of Access to Care and Timeliness

For Veteran-centered mental health services, a key measure is the experience that patients have in obtaining their mental health appointments. Since the first VSS in 2013 and in subsequent surveys, patients generally reported that they were able to obtain mental health appointments in a timely manner. In 2022, the VSS questions were updated but the findings are similar. In August to September 2022, 37% reported they had needed care right away, and, of those, 64% reported they were usually or always able to speak with someone as soon as they wanted (22% were neutral). Encouragingly, 86% reported providers usually or always spent enough time with them. Only 14% said they could not talk with the mental health provider who prescribes their medications as frequently as needed and only 10% were not able to have questions about their medications answered by phone. A full breakdown of these survey responses is in Figure 7 found on page 19. VSS also asks about difficulties Veterans might encounter in accessing mental health treatment, and 65% reported that therapies they were interested in were available when they were ready.

Figure 7. Responses to Access Items on the August to September 2022 VSS

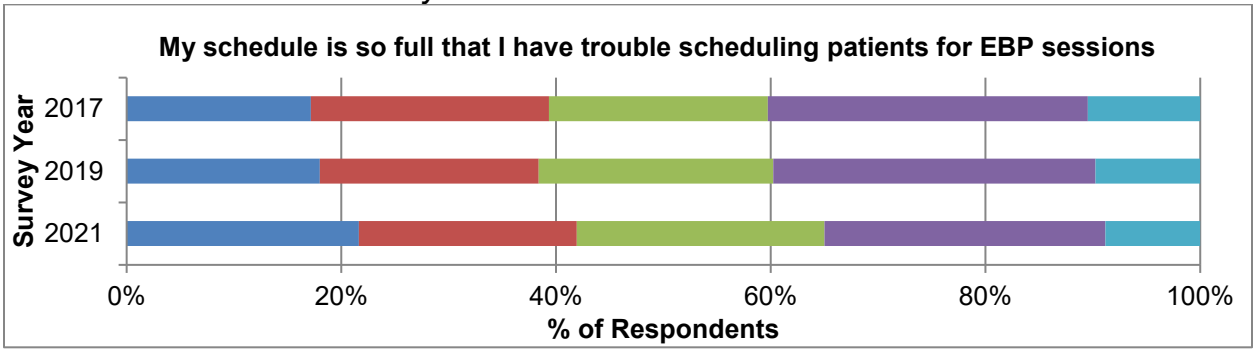


Staff Ratings of Appointment Access

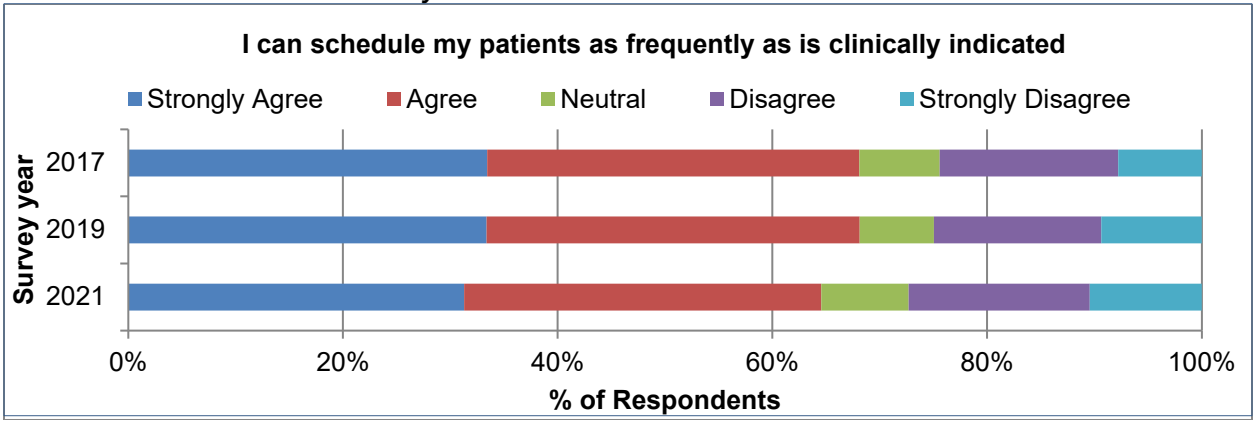
Consistent with the general experience of mental health patients, most mental health providers report being able to schedule patient appointments as frequently as needed. Staff ratings of access items have been stable over the past few years. Nevertheless, on the 2021 survey, providers were somewhat less likely than patients to confirm good appointment access: 65% agreed or strongly agreed with the statement that they could schedule patients as frequently as clinically indicated (see Figure 8 on page 20), which is a substantial improvement from 48% in 2012 but a decline from 2020.

Figure 8. Responses to Appointment Access and Workload Items

Responses to Appointment Access and Workload Items on the 2017, 2019 and 2021 Mental Health Provider Surveys



Responses to Appointment Access and Workload Items on the 2017, 2019 and 2021 Mental Health Provider Surveys



Some EBP protocols that specify weekly sessions were a challenge to schedule for 42% of responding providers in 2021 (see Figure 8 above), which also represented an improvement compared with 53% in 2012, but was a decline from 2020. As an indicator of the breadth of mental health quality improvement efforts, 73% of staff agreed that they have been involved in actions to improve patient access and 76% agreed that their team meets regularly to plan patient access improvements. These levels of staff engagement with issues of access have been stable since 2012.

Trends in Average Wait for Appointments

VHA tracks average wait times for new and established patient appointments. Since April 2017, VA has been publicly reporting average wait time data for new and established patient appointments in mental health on the *Access to Care* website: www.accesstocare.va.gov/PWT/SearchWaitTimes. Prior to an update in July 2022, the average wait time for new patient appointments was measured from the day a scheduler along with the Veteran created the appointment in the VA scheduling software to the date the appointment was completed. Beginning in Q3 of FY 2022, VA made the following updates to average appointment wait times measures for both the *Access to Care* site and internal monitoring:

1. For new patient appointments accompanied by a referral, the start for the average appointment wait time is the date the referral is entered into the system. If there is no consult accompanying the appointment, the wait time for new patient appointments is still measured from the day a scheduler, along with the Veteran, creates the appointment in the VA scheduling software.
2. The *Access to Care* site now includes future pending scheduled appointments that have yet to occur and presents average wait times for appointments scheduled within the past rolling 30 days.
3. The site breaks down mental health appointments into specific sub-categories of care to provide more accurate average wait times for individual clinics.

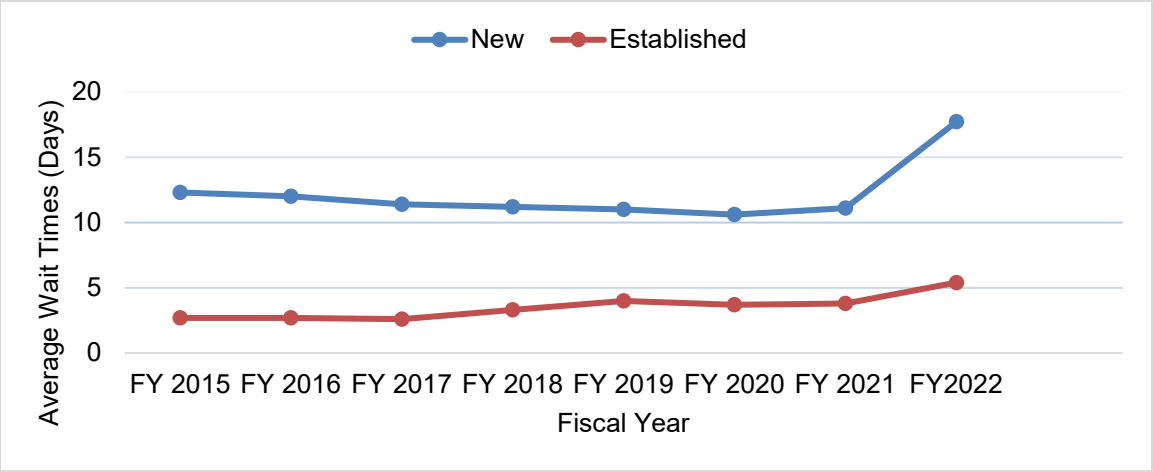
The average wait time for established patient appointments is still measured by the elapsed time from the date that the provider and Veteran agree that a follow-up appointment should occur, to the date the appointment is completed.

The updated calculation means average wait times for mental health are appearing longer in many cases, as VA now captures more steps in the appointment process than in the past. VA believes this is more reflective of the complete process of requesting and receiving care. The updated average wait times have never been used to determine an individual Veteran's eligibility for community care under the wait time access standard. For internal consistency when trending data over fiscal years, VA still observes only completed appointments when gauging average wait times for internal reporting purposes. This report contains both the average wait times VA calculates internally and the new wait times calculated for reporting on the VA Access to Care site.

Internal Calculations

Figure 9.1 uses the completed appointments only cohort to trend new and established patient average wait times from FY 2015 to FY 2022 Q2 by fiscal year. The average wait time for new patient appointments increased from 12.3 days in FY 2015 to 14.0 days in FY 2022 Q1 and Q2. In FY 2021, many of VHA's mental health appointments were done virtually on demand without an appointment and did not contribute to a wait-time calculation. The average wait time for established patient appointments increased from 2.7 days in FY 2015 to 5.6 days in FY 2022 Q1 and Q2. In FY 2022 Q2, only new patients had a 14.2-day average wait time and established patients had a 6.1-day average wait time. Appointment wait times decreased starting in March 2020 due to the COVID-19 pandemic. The average wait times for new and established patients were steady from FY 2020 to FY 2021 but have increased in FY 2022 Q1 and Q2. While established patient wait times have risen by about 3 days, the average wait is 5.6 days, which is well below the VA MISSION Act wait time standard of 20 days, as established in 38 C.F.R. §17.4040. Based on the update in the wait time definition beginning in FY 2022, the FY 2022 overall wait times for new and established patients in Figure 9.1 found on page 22 have both increased. The 6-day increase is congruent with the average number of days to schedule consults which is approximately 6 to 7 days.

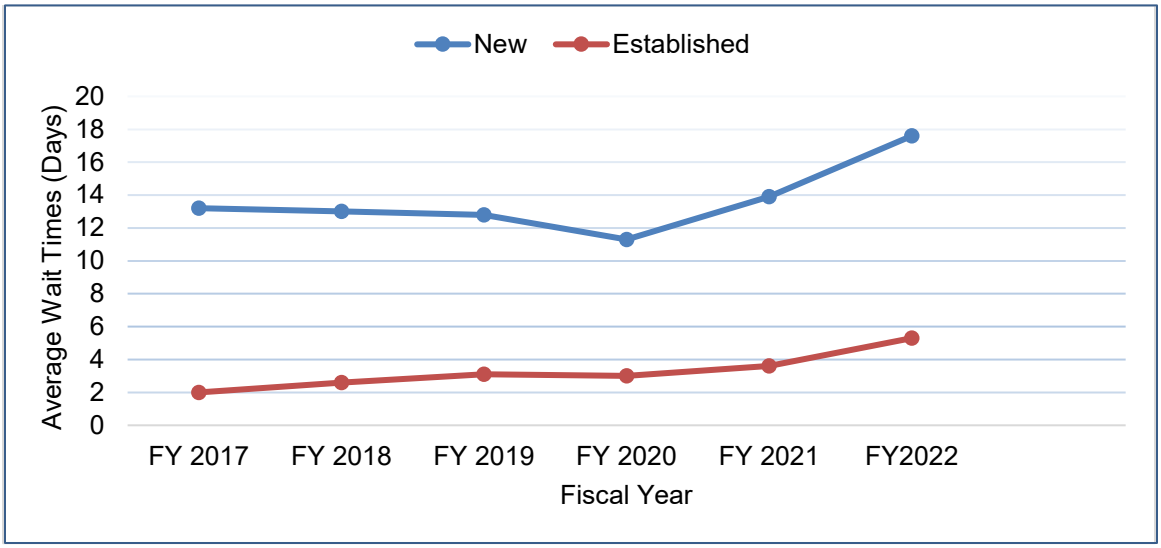
Figure 9.1 Average Waiting Times Trend for VHA Completed Mental Health Appointments for New and Established Patients from FY 2015 to FY 2022: Original Definition



Access to Care site calculations

Figure 9.2 found below uses the updated average wait time definition that includes future pending scheduled appointments and additional mental health services from FY 2017 to FY 2022. For a more accurate review of trending average wait time using a consistent definition, the data in Figure 9.2 was calculated retrospectively using the updated definition. Even though the average wait time definition for established patients has not changed, the additional mental health services results in increases in established patient average wait times as well.

Figure 9.2 Average Waiting Times Trend for VHA Completed Mental Health Appointments for New and Established Patients from FY 2017 to FY 2022: updated definition



Access to Mental Health Residential Treatment

Access for mental health residential treatment remains a priority area of focus for VHA. Prior to the COVID-19 pandemic the average time between screening and admission to a MH RRTP was 21 days with half of Veterans admitted within 12 days (FY 2020, Q1). Average wait times increased during the COVID-19 pandemic due to capacity restrictions. OMHSP continues to work collaboratively with other key stakeholders to increase capacity while ensuring staff and Veteran safety. Beginning in August 2022 and continuing into FY 2023, OMHSP is supporting regional conferences focused on access. A primary goal of the regional meetings is to improve access by addressing known barriers, working towards a goal of access within 48 to 72 hours for those Veterans with identified need. The conferences include presentations by national leaders as well as breakout sessions during which MH RRTP managers and staff discuss access with VISN representatives to develop VISN level plans for moving forward. FY 2022 average and median wait times are approaching pre-COVID-19 levels. Since January 2021, wait times have decreased from 40 days on average to 22 days in FY 2022, with half of Veterans admitted within 11 days.

Use of Technology to Improve Access to Treatment

Research has demonstrated that treatment delivered at a distance through telehealth technology is effective and improves treatment access and engagement for Veterans. Historically, Veterans who were early adopters leveraged telehealth to meet a specific access need (such as rural or underserved locations). Providers who were early adopters provided mental health services to address staffing shortages. In FY 2020, Q3 and Q4, VHA shifted mental health care delivery almost entirely to virtual care in response to the COVID-19 pandemic. In July 2020, OMHSP issued guidance that outpatient mental health visits should be conducted via virtual modalities as clinically appropriate and technologically feasible. The scale of the shift to telehealth was dramatic. In FY 2021, VA provided more than 5.6 million telemental health visits, surpassing the FY 2020 annual total telemental health visits by more than 3.2 million. Video telemental health visits continued to increase in FY 2022, outpacing previous years. In FY 2022, VA provided more than 5.9 million telemental health visits and 97% of these visits were into a Veteran’s home or offsite location.

Telehealth is now part of routine clinical practice and is expected to be a core component of mental health care delivery. VHA’s goal is to offer it to all Veterans seeking mental health care, when appropriate. The COVID-19 pandemic increased opportunities for Veterans, caregivers and their families to use video. In general, Veterans who have used video as an option for their mental health care are very satisfied with this modality and have a strong preference for future care by video. In a sample of more than 65,000 Veterans surveyed in FY 2022 when asked about their preferences after completing a video-to-home mental health visit, more than 45% of the Veterans preferred video over all other modalities for their care (33% prefer in person, 5% prefer telephone and 17% had no preference).

VHA is engaging in several efforts to ensure Veterans can access telehealth for their care if they choose, such as VA loaned devices, discounts on for some mobile data plans, test calls and help desk support. In FY 2022, work continued to establish integrated Clinical Resource Hubs (including both primary care and mental health) to support telehealth in all VA regional networks; this includes a new partnership initiative whereby more than 90 providers have been hired to offer virtual, evidence-based treatment for suicide prevention for Veterans with a history of suicidal self-directed violence behaviors. VHA will continue to promote the use of telehealth where appropriate and to monitor the reach of these programs beyond the COVID-19 pandemic.

Addressing Access and Timeliness Issues

The first national comparison of appointment wait times experienced by Veterans for both VA and non-VA clinicians found that mean VISN-level wait times for mental health were shorter for VA than for community care but there was substantial regional variation (Feyman et al, 2022). It is unknown if the COVID-19 pandemic will result in a long-term decline in the numbers of Veterans using VHA mental health services or if demand will recover to pre-pandemic levels in FY 2023. VHA is focused on maintaining timely access for Veterans who seek care and identifying Veterans who would potentially benefit from care for proactive outreach.

Evidence-Based Treatment

Evidence-based treatment refers to the use of emerging scientific literature and information gathered in the conduct of daily care to evaluate and improve the treatments that are provided. Broadly speaking, evidence-based treatment for mental health disorders consists of the provision of a tailored plan of care, including consideration of psychotherapies, pharmacotherapy, rehabilitative services and supportive psychosocial services. VHA mental health providers are required to work with their patients to tailor the treatment plan to address the Veteran's mental health comorbidities, psychosocial status and level of functioning, in a manner that is sensitive to the Veteran's preferences and goals. This work continues during the COVID-19 pandemic.

Evidence-based treatment includes the use of treatment modalities that have been shown to consistently produce improvement in the conditions they are designed to treat. Within each treatment category, specific treatment protocols have been identified as being particularly effective for individual disorders (e.g., for PTSD, prolonged exposure has been shown to be an effective psychotherapy, and selective serotonin reuptake inhibitors have been shown to be effective pharmacotherapy). VHA operates multiple initiatives to improve accessibility and quality of specific evidence-based treatments for mental health disorders. These initiatives are expanding access to diverse, effective treatments, allowing Veterans greater options. We also expect these initiatives to improve the quality and delivery of evidence-based treatments, ensuring that they are delivered with high fidelity to guidelines that have been optimized for efficacy and safety (see also the Staff Training paragraphs on EBPs in the Capacity section).

Progress Made in Measuring Availability of Evidence-Based Treatment in VHA Mental Health Care

Evidence-based Treatment Measures

Existing treatment tracking systems limit what can be known about the specific activities taking place in treatment sessions. OMHSP has developed proxy measures of delivery of specific EBP protocols that capture only whether psychotherapy was delivered within a timeframe and session frequency that is consistent with the recommended protocol. However, for many mental health diagnoses, evidence supports multiple approaches that vary in terms of typical delivery pattern and treatment duration. These measures do not provide any information about the content of the sessions, which is considered the key information needed to distinguish use of highly effective EBP protocols from other psychotherapy practice. Interpretation of measures that use these non-specific procedure codes as proxies is difficult and subject to error.

The proxy measures identify when providers use note templates in the electronic health record (EHR) to document therapy protocol-based session content. Templates have been released to support EBPs for PTSD, depression, SUD, SMI, suicide prevention, insomnia and couple's therapy. As providers use these templates more consistently, VHA will be able to track availability and the use of specific EBP protocols. Incentives to complete note templates for these EBP protocols were added to psychotherapy measures across the SAIL Mental Health Domain in FY 2019, and in FY 2022 providers used templates 2 or more times in sessions with more than 61,400 patients.

VHA currently uses metrics to track the proportions of Veterans with mental health diagnoses who receive psychotherapy, pharmacotherapy and supportive psychosocial and rehabilitative services, as well as the average intensity of services received by those making use of these treatments. The development of these metrics involved defining the types of services within each category that are evidence-based for each disorder.

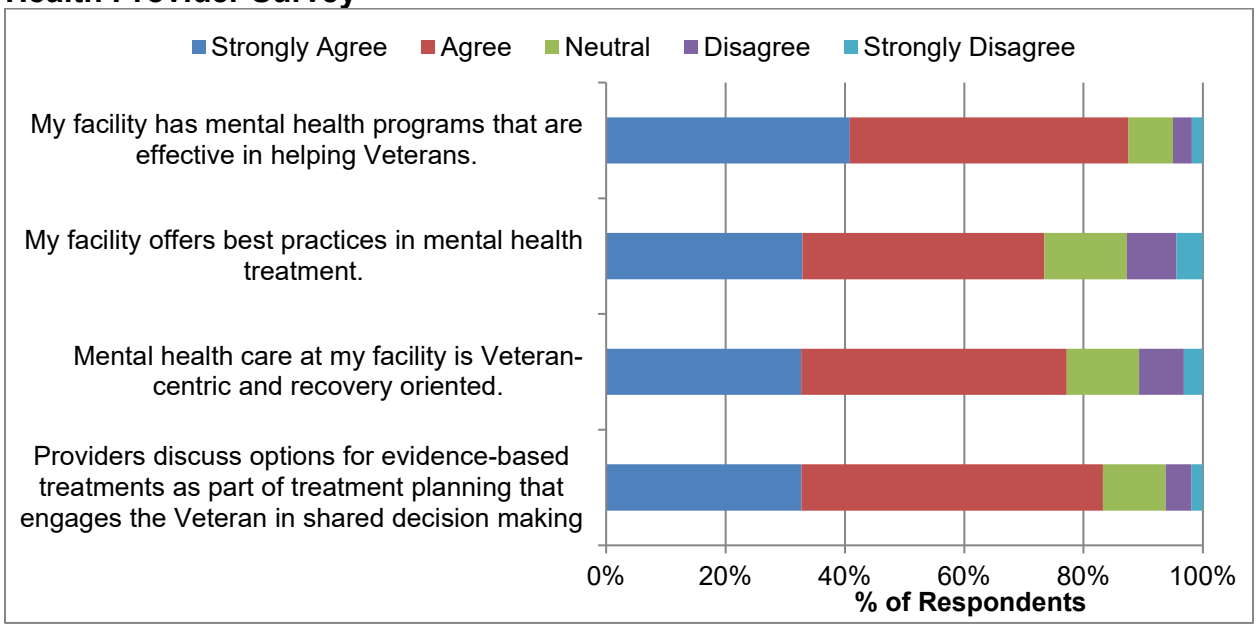
There are four measures on the SAIL Mental Health Domain that capture the proportion of patients with depression, SMI, SUDs and PTSD who access individual, or group psychotherapies or psychosocial treatments targeted at those disorders. Due to the efforts to integrate data from the Cerner EHR into SAIL metrics, we are only able to report FY 2022, Q3 data at this time. In FY 2022, Q3, 36% of the patients with depression accessed psychotherapy, 37% of the patients with SMI accessed psychosocial treatment, 34% of the patients with SUDs accessed psychosocial treatment and 50% of the patients with PTSD accessed psychotherapy. These patients may receive ongoing care through individual or group therapy. In addition, 48% of the patients with a mental health diagnosis were seen by a prescriber with psychiatric specialty training or in a mental health setting. The other patients had psychiatric medications managed through their primary care provider.

In Q3 of FY 2022, over 5,100 patients with SMI received intensive treatment for their

condition through Intensive Community Mental Health Recovery Programs, and almost 5,700 patients received care in a Psychosocial Rehabilitation and Recovery Center. Among the patients with PTSD, more than 70,000 accessed specialty PTSD outpatient care, and among the patients with SUDs, almost 18,000 accessed intensive SUD treatment.

The Mental Health Provider Survey offers additional evidence regarding the availability of appropriate, high-quality treatment. On the 2021 survey, a large majority of mental health staff agreed or strongly agreed that their mental health programs are effective (88%); that their facility offers best practices (74%); and that the mental health care is recovery oriented and responsive to the Veteran patient's needs (77%). Of the 2021 survey respondents, 83% indicated that they discussed options for evidence-based treatments with Veterans as part of treatment planning and shared decision-making. A breakdown of these 2021 responses is shown in Figure 10 below.

Figure 10. Responses to Evidence-based Practice Items on the 2021 Mental Health Provider Survey



Evidence-based Treatment Initiatives

VHA has undertaken multiple initiatives to improve the provision of practices and services that evidence shows are effective for mental health conditions. These initiatives are continually monitored and may eventually result in useful performance measures.

Evidence-based Psychotherapy Initiative

As noted in the Capacity section of this report which starts on page 7, VHA Mental Health has invested substantial effort in ensuring the effective implementation of manualized EBPs. Availability of EBPs is monitored by surveys, which show broad adoption and training of staff.

Measurement Based Care (MBC) Initiative

The implementation of MBC across mental health services is a high priority goal for OMHSP. The MBC in Mental Health Initiative partners with OMHSP leadership, other VHA offices and the field to provide consultation, education and support for the implementation of MBC in mental health care. Currently, MBC is required by VHA policy in PTSD clinical care, MH RRTPs and in outpatient SUD Programs. It is also required as part of Joint Commission Behavioral Health accreditation standards in the Intensive Community Mental Health Recovery Programs, Psychosocial Rehabilitation and Recovery Programs and VHA Vocational Rehabilitation. MBC uses quantitative data from patient-reported outcome measures (PROM) to enhance care and to empower Veterans and providers to collaborate on goal setting and treatment planning. MBC is defined as a three-part clinical model explained below:

- Collect: Veterans complete PROMs routinely and repeatedly throughout care to track progress over time.
- Share: Measure results are shared and discussed with the Veteran in a timely manner to ensure a shared understanding. Recording data in the medical record allows other providers involved in the Veteran's care to benefit from the information.
- Act: Together, providers and Veterans use outcome measures to have meaningful conversations about individualized goals, collaboratively develop treatment plans, assess progress over time and inform shared decisions about changes to the treatment plan.

Gains have been observed in PROM use since the inception of the MBC Initiative in FY 2017. The percentage of providers who administered any core PROM per quarter across outpatient and residential settings increased from 37% FY 2017, Q1 to 54% FY 2022, Q3. The use of PROMs in mental health was value added during the response to the COVID-19 pandemic. As providers switched from face-to-face care to telehealth, the use of PROMs provided structure to remote visits and allowed providers to quickly assess individual Veterans for changes in clinical status. Although overall use of PROMs decreased during the early phase of the COVID-19 pandemic, its use has rebounded to pre-pandemic levels in FY 2022, most likely due to the implementation of new technologies to support asynchronous collection of data from patients. The impact of initial efforts is evident in the MH RRTPs where PROMs were used in 91% of residential stays during FY 2022. The 2021 Mental Health Provider Survey (MHPS) asked about PROMs, and 74% of the providers agreed that these measures are valuable for patient care. At intake, 72% said that they use these measures most or every time, but after initial assessment 60% of providers report using these measures most or every time.

Data from VSS in FY 2022 indicate that Veterans' perceptions of their care match the MHPS. Over 50% of Veterans stated that their mental health provider had administered a questionnaire or survey "about how I'm doing with my mental health." Of those who received such a questionnaire, 73% agreed with the statement that it was administered

twice or more (collect) and 64% agreed that the results had been used to discuss their treatment goals (act). This was the first year these questions were included in VSS.

In January 2020, the MBC in Mental Health Initiative began a series of workgroups in collaboration with mental health program offices comprised of field-based MBC experts to provide MBC recommendations for specific program areas. The following three guidance documents have been released: MBC in specialty care for Veterans with PTSD; MBC in Behavioral Health Interdisciplinary Program – Collaborative Chronic Care Model; and MBC for PC-MHI. The initiative is working with other program areas to form new workgroups for FY 2023. There is enormous interest in MBC across VHA mental health. OMHSP sponsored a virtual MBC conference that was repeated on a second date due to high registration numbers. More than 1,100 VA mental health personnel attended, and the material was recorded and is available for others to review. As the MBC initiative matures, VHA expects use of MBC to continue to increase.

Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment initiative (REACH VET) Initiative

Each month the REACH VET Initiative uses a statistical algorithm to identify Veterans in VHA care who are in the top 0.1% tier of predicted risk for suicide. The algorithm reviews data from the prior 2 years of VHA health care services to identify at-risk Veterans. Facility REACH VET Coordinators review the records of identified Veterans, notify their primary provider (the REACH VET provider) and inform the provider of required next steps. The REACH VET provider evaluates the Veteran's care to explore opportunities to enhance care and mitigate risk. REACH VET providers reach out to newly identified Veterans to collaboratively discuss care and review risk, and when clinically indicated, reach out to recurring Veterans (those who have been reidentified in the top 0.1% risk tier). Since the program began in 2017, REACH VET has identified more than 105,000 VHA patients. Evaluation findings document that inclusion in REACH VET is associated with increased receipt of completed outpatient appointments, fewer documented suicide attempts, fewer inpatient mental health admissions, fewer emergency department days and greater completion of new suicide prevention safety plans (McCarthy et al, 2021).

Evidence-based Pharmacotherapy Initiatives

VHA uses practice guidelines, the latest research and decision support systems to ensure evidence-based pharmacotherapy for mental health treatment. The delivery of evidence-based pharmacotherapy for mental health conditions requires the following:

- Prescribing medications known to be effective for the patient's mental health condition;
- Considering other somatic, psychotherapeutic and rehabilitative interventions as additional or alternative treatments;
- Prescribing medications in the correct dose and mode of administration;
- Avoiding drug-drug and drug-disease interactions;

- Monitoring adherence, therapeutic responses and side effects;
- Modifying medications, doses, or the treatment plan, as appropriate, when there are incomplete responses, side effects or adverse reactions; and
- Evaluating patients who respond to treatment to determine if discontinuing medications or continuing treatment to prevent relapses and recurrences is warranted.

VHA has an established infrastructure for providing pharmacotherapy for mental health conditions. This infrastructure includes well-trained psychiatrists, mid-level prescribers and pharmacists as well as integration of key mental health services in primary care settings to augment the expertise of primary care providers. Decision support for prescribing is provided through clinical practice guidelines and reminders incorporated in the EHR. In addition, the Psychotropic Drug Safety Initiative (PDSI), launched in December 2013, as a VHA nationwide quality improvement (QI) program, works to improve the quality of mental health care for Veterans across VHA by improving the access to and quality of psychopharmacologic treatments for Veterans' mental health needs. VISNs and facilities choose an area of prescribing on which to focus from options consistent with nationally identified priorities. They then develop and implement QI plans to improve care in those areas. PDSI supports facility-level QI through quarterly quality metrics, clinical decision support tools (the PDSI Clinical Management System), technical assistance for QI strategic implementation and a virtual learning collaborative.

The PDSI Clinical Management System includes several tools that allow for real-time tracking of prescribing practices for psychotropic medications. The PDSI Patient-Level Report, launched in October 2014, is a continuously updated list of patients at a given facility who meet indicators for clinical review based on the PDSI prescribing metrics. The report also presents relevant diagnoses, prescriptions, indicators of adherence, as well as information about prescribers and future appointment dates. The report promotes evidence-based prescribing practices for psychotropic drugs by facilitating clinical review of patients who may need a re-evaluation of their psychotropic medication regimen. Medication adjustments might include clarification of diagnoses, increased monitoring frequency, modification of prescriptions, better coordination of care between clinicians or improved documentation. The report is intended to encourage proactive panel management practices and to guide targeted education and quality improvement.

Phase 1 of PDSI focused on improving a broad set of psychotropic prescribing practices. Phase 2 focused on psychotropic prescribing practices for geriatric patients and phase 3 focused on access to evidence-based psychopharmacology for Veterans with SUDs. Key results from the program evaluation of PDSI phase 3 include increased prescribing rates for both Veterans with Alcohol Use Disorder (AUD) and Veterans with an Opioid Use Disorder (OUD) (Hermes et al., 2020). Ongoing efforts to support SUD pharmacotherapy resulted in further increases after phase 3 was completed. The national focus of PDSI phase 4 (FY 2019, Q3 through FY 2022, Q1) was reducing benzodiazepine use in high-risk populations, including the following: (1) Veterans aged

65 and older; (2) Veterans with PTSD; (3) Veterans with AUD, OUD or sedative-hypnotic use disorder; and 4) Veterans with co-prescribed benzodiazepine and opioids. Scores on metrics for all four high-risk populations slowly and steadily decreased throughout the initiative. In addition, the percentage of patients prescribed a benzodiazepine who had a prescription drug monitoring program check in the past year rose from 57% to 95% by the end of phase 4.

PDSI Phase 5 began in January 2022 and will last 3 years. Phase 5 will address both stimulant use disorder and stimulant prescribing. The objectives of phase 5 are as follows: (1) to ensure guideline concordant treatment of Veterans with stimulant use disorder; and (2) the safe and appropriate prescribing of stimulant medication. The first year of PDSI phase 5 focused on increasing capacity to provide guideline concordant evidence-based practices for stimulant use disorder. During the first 9 months of phase 5, 9 VA facilities have added contingency management programs (a 20% increase); 103 VA providers have been trained to deliver cognitive behavioral therapy for SUD (a 14% increase); and the number of Veterans with stimulant use disorder who have received naloxone to prevent overdose increased by 7.6%.

VHA has developed similar data systems that use VHA administrative data and predictive modeling to support opioid safety efforts. The VHA Stratification Tool for Opioid Risk Mitigation (STORM) is a clinical decision support tool available to VHA staff (Oliva et al., 2017). The key features of STORM include the following:

- *Identifying patients* who are at risk for adverse events such as drug overdose or suicide.
- *Listing risk factors* that place patients at risk (e.g., previous adverse events, mental health and medical diagnoses).
- *Displaying risk mitigation strategies*, including non-pharmacological treatment options, which have been employed or could be considered.
- *Displaying patients' upcoming appointments and current treatment providers* to facilitate care coordination.

STORM is updated nightly and provides risk scores and risk mitigation strategies for patients with an active outpatient opioid prescription or who have a diagnosed OUD. In FY 2022, over 17,000 interdisciplinary reviews were completed on patients STORM identified as very high risk for an overdose or suicide-related event or who received a new opioid prescription. A well-controlled evaluation of outcomes associated with the mandate that very high-risk patients receive an interdisciplinary risk review found that being mandated for review was associated with a significant reduction in all-cause mortality risk over the next 4 months (Strombotne et al., 2022). Based on these positive results, an additional policy notice was issued to expand the population receiving risk reviews.

Naloxone Distribution Initiative

The VA Opioid Overdose Education and Naloxone Distribution (OEND) Program aims

to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose and training on the rescue response, including provision of naloxone. VHA recommends offering OEND to Veterans prescribed or using opioids who are at increased risk for opioid overdose or whose provider deems it clinically indicated. On February 24, 2021, VHA released the memorandum titled, Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder, which aims to increase naloxone distribution among this high-risk population. Between FY 2021, Q1 and FY 2022, Q3 there was a 25% increase in naloxone distribution among patients with OUD (from 39% to 64%). VA issued a series of subsequent memoranda aimed at expanding OEND efforts to reach patients who use stimulants (given the high rates of stimulant overdose deaths involving opioids), require post-overdose reporting and improve post-overdose care through interdisciplinary risk reviews.

The VA Academic Detailing Service has also promoted OEND through individualized, evidence-based educational outreach visits and consultation for clinicians by clinicians. Through FY 2022, Q4, academic detailers had completed more than 30,000 such visits with more than 23,000 health care professionals nationwide. Since implementing the OEND program in 2014, over 44,500 VHA prescribers, representing all VHA facilities, have prescribed naloxone, and more than 837,200 naloxone prescriptions have been dispensed to over 394,300 Veterans (as of FY 2022, Q4). In 2018, VA already dispensed a naloxone prescription for one in six patients on high dose opioids compared to one in 69 patients in the private sector (Guy et al., 2019). Through FY 2022, Q4, as documented through spontaneous reporting of overdose reversal events as well as through the national note, over 3,200 overdose reversals with naloxone have been reported.

In September 2018, VHA launched a Rapid Naloxone Initiative consisting of the following three elements: (1) OEND to VA patients at-risk for opioid overdose; (2) VA Police Naloxone; and (3) Automated External Defibrillator (AED) Cabinet Naloxone (Oliva et al., 2021). In July 2021, the National Quality Forum awarded VA's Rapid Naloxone Initiative the prestigious John M. Eisenberg National Level Innovation in Patient Safety and Quality Award.

Rehabilitative Services Initiatives

In addition to treatments that address the underlying causes and symptoms of mental health conditions, VHA also provides evidence-based interventions to improve the daily functioning of Veterans with mental health problems. Rehabilitative services initiatives are underway to strengthen these services. Vocational rehabilitation services addressing employment have strong empirical support as a component of Veterans' mental health treatment. Individual Placement and Support Supported Employment, an evidence-based model, was implemented in 2005 and continues to be offered. This approach includes an emphasis on access to employment services based on a desire to return to employment, services based on Veteran preference and the integration of mental health treatment with vocational services. Nationally, more than 49,000 Veterans

received VHA Vocational Rehabilitation Services in FY 2021; 32,000 collectively were served in Compensated Work Therapy (CWT) Supported Employment, Community Based Employment Services and Transitional Work Programs; almost 16,000 received Vocational Assistance services. The COVID-19 pandemic affected vocational rehabilitation participation rates in FY 2021 due to its economic impact on community employment, its impact on operation of CWT's therapeutic work and on Veteran choice regarding continued engagement in services and new referrals.

Self-help Resources

VHA has developed mobile apps that can be used as self-help tools or as a supplement to traditional care with a mental health provider. Efforts have focused on several mobile apps that support the implementation of EBP protocols. PTSD Coach, VA's first mobile app, provides information and exercises to help manage symptoms that often occur after trauma. The app's features include tools for screening and tracking symptoms, direct links to support and resources for friends and family. The COVID Coach app was developed in 2020 specifically to support self-care and overall mental health during the COVID-19 pandemic. Additional mobile apps serve as therapy companions for EBP protocols and support self-management for Veterans. These apps are free, publicly available, and can be used anonymously. More information on the entire suite of VA mental health mobile apps is available at: https://mobile.va.gov/appstore/mental-health.

VHA has created a series of web-based, self-directed mental health resources for Veterans at www.VeteranTraining.va.gov. These stand-alone courses can be used independently or with a provider. The courses are free, self-paced, interactive and confidential, which appeals to many returning service members and Veterans. Courses currently available include the following:

- Moving Forward: Overcoming Life's Challenges is based on Problem-Solving Therapy, an EBP that has been successfully used throughout VHA.
- Parenting for Veterans teaches parenting skills and tools to help manage the transition into civilian life.
- Anger and Irritability Management Skills is based on a widely used manual from SAMHSA that provides participants with cognitive behavioral tools to manage problematic anger and irritability.
- Path to Better Sleep includes a brief sleep self-assessment, education about sleep and sleep apnea, and a self-guided course modeled after Cognitive Behavioral Therapy for Insomnia.
- My Recovery Plan empowers Veterans in recovery from a mental health condition to proactively manage their recovery by recognizing warning signs and triggers, creating an individualized action plan, and identifying supportive contacts such as a Peer Support Specialist or mental health clinician.

Veteran Satisfaction

VHA is committed to ensuring that Veterans are satisfied with their health care services

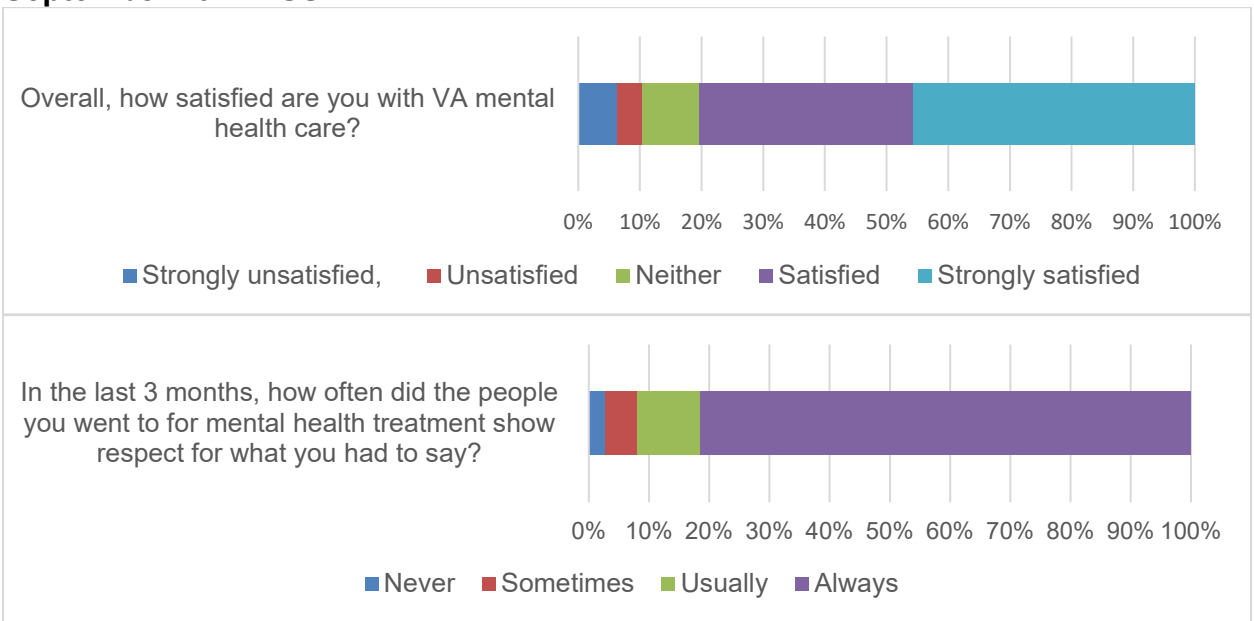
and that these services help them achieve desired outcomes. VHA has regularly monitored Veterans' experience with mental health treatment since FY 2013. To develop VSS, a workgroup of mental health evaluation and measurement experts considered previous studies, available survey instruments and currently available VHA data sources related to patient satisfaction, experience of care and outcomes. Because research specifically focusing on patient satisfaction with mental health services is quite limited and existing measures and data sources have several shortcomings, the workgroup developed additional data collection efforts which have continued to evolve since the initial VSS was created.

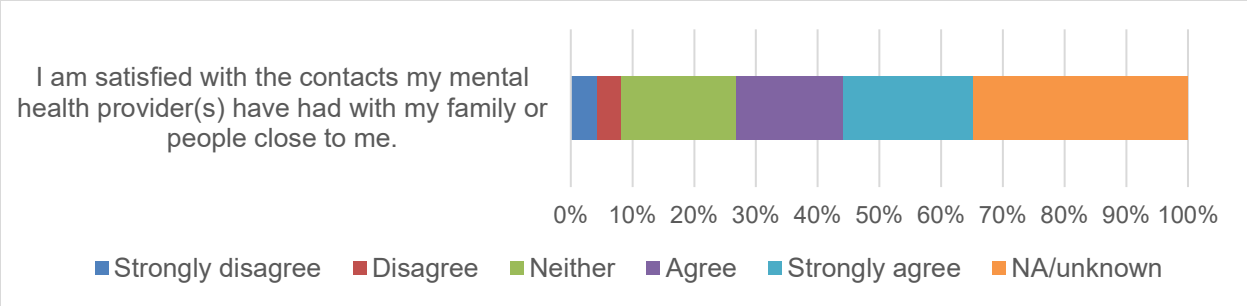
Progress Made in Measuring Veteran Satisfaction and Outcomes in VHA Mental Health Care

Veteran Satisfaction Survey (VSS)

Survey responses to the updated VSS from August to September 2022 reveal a high level of satisfaction with care (80%) (Figure 11 below). The vast majority of responding Veterans reported that they are treated with respect by VHA mental health staff (90%), that staff listen carefully to them (87%), that they are involved as much as they want in their treatment (82%) and that mental health treatment has been helpful in their life (84%). Opinions regarding these items are consistent with similar questions on the prior version of VSS. Only 39% of those reporting contact between their mental health providers and family were satisfied, but 35% did not respond to the question and 19% were neutral, suggesting an area that continues to need increased awareness.

Figure 11. Responses to Selected Satisfaction Items from the August to September 2022 VSS





Veterans Outcome Assessment (VOA)

In addition to directly asking respondents about satisfaction with services they receive, the VHA VOA workgroup adopted a broadened conceptualization of experience of care to include achievement of desired outcomes, such as a reduction in symptoms and improved functioning. After a pilot project in 2012-2013 demonstrated the feasibility VOA, a workgroup developed a survey of treatment outcomes and satisfaction. Items in the survey were drawn from existing measures that have shown reliability and validity, including sensitivity to treatment quality. The resulting survey, VOA, was finalized in August 2013 and approved by the Office of Management and Budget, and data collection has proceeded every year since March 2015.

VOA data collection focuses on patients entering care in general mental health services, primary care-mental health integrated services and subspecialty PTSD and SUD programs, as well as patients who were discharged from mental health inpatient and residential care programs. Those who agree to a follow-up survey are contacted three months after initiating treatment. The expanded VOA includes standardized mental health measures known to be sensitive to change over time. Response rates are typically below 15% but 10,000 pairs of baseline and follow-up surveys have been completed for most years.

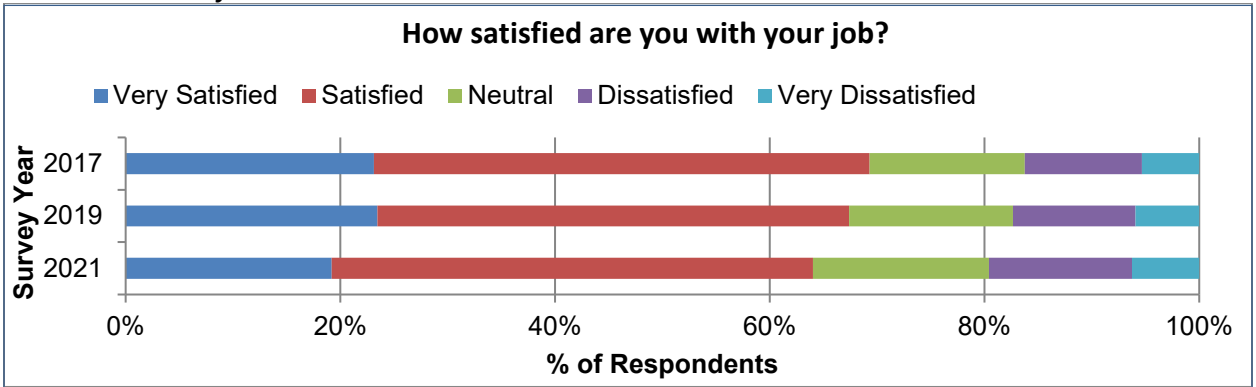
As previously reported, studies have used VOA data to examine the relationship between patient outcomes and treatment. New studies have found that patient experience, evaluated through ratings of communication with providers and of the perceived quality of mental health care, had a significant impact on outcomes across a broad range of measures including treatment retention (Liebmann et al, 2022a, 2022b; Katz et al, 2021). The findings suggest the importance of further evaluations of communication between providers and patients and of possible high value of improving quality as perceived by patients.

Staff Morale and Satisfaction

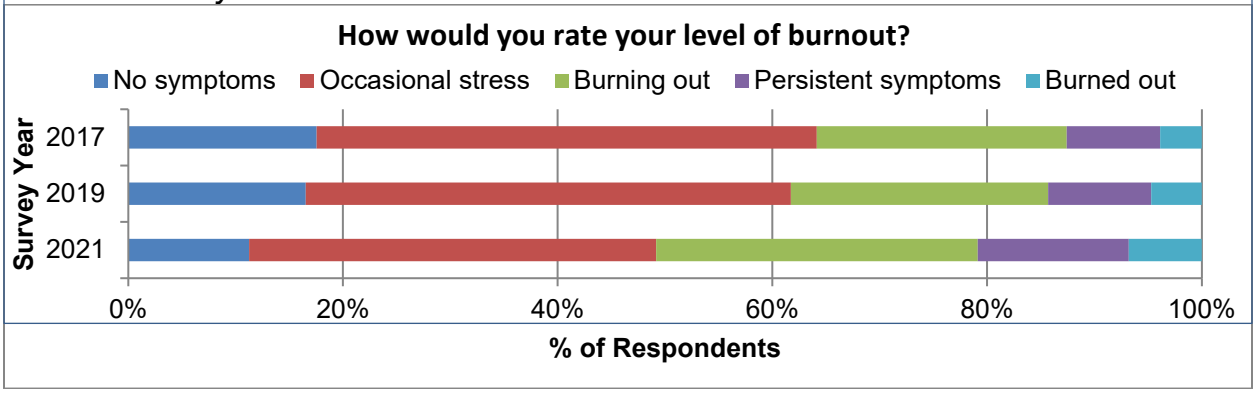
Satisfied staff have lower turnover rates which increases patient satisfaction. Since 2013, VHA has been directly assessing workgroup functioning and staff satisfaction as part of the Mental Health Provider Survey. On the 2021 survey, 64% of the providers reported being satisfied with their job and 7% reported being burnt out (see Figure 12 on page 35). Although job satisfaction metrics changed little from 2019, 38% of the

providers who responded to the survey in 2021 reported occasional stress from their job and 31% reported that their workload is unreasonable, which is an increase from 2020. Burnout rates have increased across health care professions as a result of the COVID-19 pandemic, and in response, VHA has launched the Reduce Employee Burnout and Optimize Organizational Thriving Task Force. Turnover rates are closely monitored at the national level by VHA Workforce Management and Consulting.

Figure 12. Job Satisfaction and Burnout as Reported
Job Satisfaction and Burnout as Reported on the 2017, 2019 and 2021 Mental Health Provider Surveys



Job Satisfaction and Burnout as Reported on the 2017, 2019 and 2021 Mental Health Provider Surveys



Staffing Models

Various findings continue to suggest that many VHA facilities do not have enough mental health services available to meet Veteran demand in a timely manner. The rapid growth in the number of Veterans seeking mental health treatment in VHA poses challenges for maintaining adequate mental health staffing to provide timely access to mental health services. Treatment services are often clustered at large VAMCs, and distance to care and other logistical barriers have limited some patients' engagement in services. Lack of on-site mental health providers at smaller outpatient clinics can contribute to under-detection of mental health conditions. The wait times for care; lack of local availability of specific desired services (e.g., specific EBPs); fear of stigma; and poor experience with prior care can all drive down use of mental health services by VHA patients with mental health needs. As previously mentioned, VA embarked on a Mental

Health Hiring Sustainability Initiative in 2019 to facilitate hiring and retention at facilities with severe shortages of mental health staff. Mental health staff are also being integrated into settings such as pain clinics and oncology clinics.

Progress Made in Refining Staffing Models for VHA Mental Health Care

VA has developed multiple staffing models that it uses in combination to identify staffing needs, including a 'minimum' model (described in VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Providers), and growth-based and population coverage-based staffing models. Section 501 of the Hannon Act requires a staffing improvement plan for VHA mental health providers that includes filling any open positions. In response, VA has submitted the Congressionally mandated report, Staffing Improvement Plan for Mental Health Providers of Department of Veterans Affairs. This report includes an estimate of the number of positions for mental health providers that the Department needs to fill to meet demand and steps that the Secretary will take to address mental health staffing for the Department. It also identified numerous region-specific hiring incentives that are currently available.

In 2011, VHA leadership identified the need for a model to match mental health staffing level to Veteran demand. The model set an overall target for staffing across three settings of outpatient mental health care: (1) PC-MHI; (2) general mental health; and (3) specialty mental health. PC-MHI works with patients in primary care to address mental health concerns that require only low intensity treatment and provide maintenance treatment to stabilized patients with chronic mental health conditions. General mental health settings provide interdisciplinary recovery-oriented care for patients, including common psychotherapies for mental health conditions (e.g., cognitive behavioral therapy for depression), medication, case management and psychoeducation. Specialty mental health settings, provide time-limited or diagnosis-specific specialty care for patients, including intensive SUD and PTSD treatment, intensive community mental health case management, psychosocial rehabilitation and recovery programs, and methadone maintenance.

To support the ongoing optimization of staffing levels, VA continued to evaluate mental health staffing models (Schmidt et al., 2017, Boden et al., 2019, 2021; Smith et al., 2021). VA demonstrated that variation in outpatient mental health staffing ratio is associated with differences in comprehensive mental health access. Population access, timely access to care and the ability to provide a "full-dose" of care (i.e., intensity of services) were limited at VA facilities with lower outpatient mental health staffing ratios. Poorer patient and provider care experiences were observed at facilities with lower staffing ratios as well. Analyses show that higher staff-to-patient ratios are associated with better implementation of a variety of quality improvement measures designed to represent compliance with the Uniform Mental Health Services Handbook. VA does not expect the COVID-19 pandemic to eliminate the impact of staffing gaps on access to care and quality of care.

Mental Health Outpatient Clinical (MHOC) Staffing Model

Recognizing that the distribution of care between general and specialty outpatient mental health services varies across facilities, the adopted outpatient staffing model allows for local flexibility in the organization of staff between general and specialty outpatient mental health services. The MHOC staffing model has been empirically validated and implemented as policy in VHA Directive 1161. This model focuses on two critical perspectives: (1) having enough staff to treat the patients who initiated outpatient mental health care; and (2) having enough staff to serve the Veterans/VHA patients in the health care systems catchment area. The resulting model sets a target of 7.72 outpatient clinical mental health FTEs per 1,000 mental health outpatients. The model also sets a goal for the psychiatrist-to-patient ratio. Psychiatrists are essential members of outpatient mental health programs. The salaries of psychiatrists are greater than that of the average mental health provider FTE, and they are harder to recruit in some areas. For psychiatrists, the model aims for at least 1.22 psychiatrist FTEs for every 1,000 mental health patients treated. The methodology does not fully account for staff who do not traditionally capture workload, and the nature of care in MH RRTP and inpatient settings may result in an underrepresentation of all staff working in those settings.

The PC-MHI initiative began in 2007 and has resulted in the implementation of a PC-MHI specific model in most VAMCs and large community-based outpatient clinics. Full implementation of PC-MHI is expected to require 0.67 mental health FTE per patient aligned care team (1,200 primary care patients); 0.5 FTE for co-located collaborative care; and 0.17 FTEs for care management per team. For planning purposes, it is assumed that while PC-MHI staff are included in the 7.72 overall outpatient staffing ratio, it would be inappropriate to dismantle existing general or specialty mental health programs to fully implement PC-MHI. Facilities would need to hire enough staff to bring their PC-MHI program up to recommended minimums or their overall staffing ratio up to 7.72, whichever was greater. Moreover, it was expected that additional funding beyond the standard funding for these mental health FTEs would be needed when additional psychiatrist FTEs was recommended, given that the psychiatrist salary is greater than that of average mental health provider FTEs.

Facility alignment with staffing recommendations is being monitored. VHA estimates needed hiring based on the current models for overall mental health outpatient providers and psychiatrist staffing. At the beginning of FY 2022, Q3, the mean outpatient mental health staffing ratio was 8.17, reflecting an increase from the level in April 2012, when the 7.72 target was developed (based on the average staffing ratio at that time). This ratio increased in part because providers used less leave in FY 2022 and other providers shifted to working in outpatient settings. This situation inflated the number of FTEs counted as outpatient staff, as the mean staffing ratio in FY 2020, Q1 before the COVID-19 pandemic was 7.48. The ratio at the beginning of FY 2022, Q3 varied substantially across VHA facilities, from a low of about 5 to a high of about 15 mental health outpatient clinical FTEs per 1,000 mental health patients. The situation is similar for psychiatrists. As of the beginning of FY 2022, Q3, the psychiatrist ratio was 1

(range from approximately 0.19 to 2.18 FTEs per 1000 patients treated), a substantial decline from the average of 1.22 present in April 2012.

As part of the Mental Health Hiring Sustainability Initiative, understaffed facilities were asked to identify barriers that limit them from meeting staffing goals. Despite recent gains in the average staff-to-patient ratio, some facilities are expected to have lower than recommended staff-to-patient ratios and will require additional hiring, contracting arrangements or telehealth services to meet the models' minimum recommended staffing levels. OMHSP works continuously with these facilities to improve staffing levels and care access, and interventions will be tailored to help facilities address identified barriers. Although barriers vary by locality, regular discussions with VISN and facility leadership suggest that common barriers include lack of space for offices and clinical care delivery; difficulty finding qualified candidates; the inability to compete with salary levels in the community; budget limitations; and delays due to shortages in human resources support. These barriers are consistent with findings from the National Academies' evaluation of VA Mental Health. To reinforce the importance of mental health staffing, VA issued memos in March 2020, 2021, and 2022 emphasizing that "the recruitment process should start immediately" for a significant number of new specific purpose funded positions and directing facilities to remove hiring barriers.

Team Model in General Mental Health

Building on the implementation of a team model in VHA primary care, VHA implemented the Behavioral Health Interdisciplinary Program (BHIP) team-based care model in outpatient mental health settings. The existing literature, consultation with external health care systems and review of VHA utilization and staffing data informed initial development of the staffing guidelines for the BHIP model. The current staffing model recommends a minimum of 6 FTE clinical providers (i.e., licensed independent providers and advance practice providers), 1 FTE of other staff (i.e., peer specialists), 1 FTE for care coordination and 1 FTE administrative and clerical staff for a team panel size of 1,000 Veterans. The model did not specify the provider types that needed to be included on the team because general outpatient mental health functions can be effectively performed by multiple types of providers and local availability of specific provider types varies.

Since 2013, at least one BHIP team has been required in every VAMC, and BHIP teams have increased in general mental health clinics throughout the VHA health care system. The present focus of the BHIP initiative is on implementing the team-based staffing model and use of CCM, an evidence-based practice, to provide proactive, comprehensive and Veteran- centered mental health care. The goal is anticipatory, continuous, evidence-based, collaborative care through the following: (1) organizational leadership and support; (2) work role redesign; (3) Veteran self-management support; (4) provider decision support; (5) information management; and (6) community linkages.

Consistent with previous data showing positive Veteran and staff impact, a nine-site VA implementation trial demonstrated that CCM can be successfully implemented with

practical, scalable facilitation support, and that this support is associated with improvements in team function, decreased hospitalization rates at substantial cost savings to VA and improvements in the mental health quality of life for complex patients (Bauer et al., 2019b). Supported by this evidence, VA is expanding BHIP-CCM nationally, with each facility required to develop a plan to transition outpatient general mental health services to BHIP-CCM care in the next 5 years. This plan is consistent with the VHA Plan for Modernization milestone supporting "full deployment of integrated care and team-based care in specialty mental health strategies across the enterprise." To promote greater consistency and uptake nationally, a range of implementation support options is available to all facilities, including the BHIP-CCM Enhancement Guide (a step-by-step guide for self-assessment and facilitating alignment of care processes with the CCM) and various levels of consultation and facilitation. The Guide was streamlined, and the staffing model adjusted to reflect current population needs.

Assessment of Staffing in VHA Mental Health Care

In August 2021, the VA Office of Inspector General found that although progress has been made, critical shortages in mental health staff within VA remain (Review of Veterans Health Administration Staffing Models, Report #20-01508-214). This mirrors staffing gaps across the United States (Strategy to Address Our Mental Health Crisis, March 2022). The report specifically identified the lack of assigned responsibility for implementing staffing models in VHA as a critical gap. Facilities that encounter difficulties recruiting desired staff are encouraged to meet patient demand by making use of contracts or other agreements with community providers or by providing services by telehealth using VHA staff hired for this purpose at other sites. Both are facilitated by the VA MISSION Act, § 701 of the Hannon Act and the VA Video Connect initiative. The general discussion of health care workforce needs is fraught with uncertainty about the impact of alternative practice models (e.g., group visits or peer counseling), advances in clinical care and the ongoing impact of the COVID-19 pandemic and the shift to telehealth. Such changes may either decrease or increase demand for services (Cunningham, 2013). All staffing models and actions must be viewed as provisional and highly dependent on evolving conditions.

Overall Assessment, Recommendations and Future Directions

The measures and guidelines mandated by P.L.112-239 § 726(a)-(b) are continuously being developed, implemented and evaluated. Where measures provide a valid, reliable overview of VHA mental health treatment, they are made more broadly available to facility staff for program improvement and on public websites to educate Veterans and their families about the availability and quality of the mental health services VHA offers (e.g., https://www.mentalhealth.va.gov/mentalhealth/about/index.asp). Existing evidence indicates that Veterans have positive views of their mental health treatment overall, and that mental health treatment providers are widely able to offer specific evidence-based treatments. OMHSP is committed to working with facilities that are not able to offer timely access to high-quality mental health treatment, to identifying the individual barriers that these facilities face and to developing strategies for addressing these

barriers. In this way, VHA will be able to improve the consistency of care across facilities and the overall quality of care nationwide.

Where data are currently available, they have been reported above. Data on capacity are being monitored over time and will be linked with information on Veterans' treatment outcomes and experience of care to establish empirically based capacity guidelines. In addition, analyses will continue to examine whether increasing the average staff-to-patient ratios reduces local and regional disparities in access to specific mental health services and wait times across VHA's facilities. The overall staffing model will be revised and adjusted as needed based on findings.

The quality of VA mental health care has been repeatedly validated by external evaluations. A comprehensive review of VHA mental health treatment by the National Academies of Sciences, Engineering and Medicine in 2018 found, in part, that VHA "provides mental health care of comparable or superior quality to care provided in private and non-VA public sectors." It also found that while many Veterans who are aware of VA mental health care services say the process of accessing these services is "burdensome", "a majority of [Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn] Veterans who use VA report positive experiences with its mental health services, including the availability of services, privacy and confidentiality of medical records, the ease of using VA mental health care and the staff's skill, expertise and courtesy toward patients." These are partial findings from the comprehensive review. In 2020, the independent evaluation of VHA's mental health programs and suicide prevention services mandated by the Clay Hunt Suicide Prevention for American Veterans Act of 2015, P.L. 114-2, found "[i]t is evident from the findings of our evaluation that mental health services provided by VA to Veterans are effective at reducing mental health symptoms and lowering risk of suicide behaviors, including ideation, attempts and death by suicide." A 2022 study found a "VA advantage" on mortality and cost for all patients that was even stronger for patients with mental health conditions or SUDs. (Chan et al., 2022).

VHA will continue to work proactively toward improved measures of quality and effectiveness of VHA mental health treatment programs. In a recent RAND report, the authors found that VHA "has a long-standing and robust approach to quality measurement" (Farmer et al, 2022, p. 27). VA strives to align measures across legislative purposes and concepts where possible. Section 104 of the VA MISSION Act, requires VA to develop "quality standards" that could validly assess performance in both VA and in non-Department health care settings. The purpose of measures required by section 104 of the VA MISSION Act and P.L.112-239 § 726(a)-(b) differs, as do the specific concepts being measured to meet these two laws. Nonetheless, measures responsive to section 104 of the VA MISSION Act will potentially be relevant to areas described in this report including capacity, availability or adherence to evidence-based treatment and patient satisfaction. Section 104 of the VA MISSION Act also added a new section 1703B on "access standards" which may subsume the timeliness of care measures this report describes. Consistent with the VA MISSION Act, measures to be used as "quality standards" were recommended to the VHA Office of Healthcare

Transformation and prepared for reporting. Measure revisions put in place by the National Committee for Quality Assurance have altered what will be calculated outside VHA, thus requiring additional planning.

Considerable future complexity has also been added to meeting the requirements of P.L. 112-239 §§ 726(a)-(b) by the transition to the Cerner Millennium EHR. To ensure that VA is able to continue monitoring the quality of care and other domains required by law, OMHSP staff are working closely with the Cerner team to design capabilities in the Cerner EHR that enable continuity of mandated monitoring and reporting functions. OMHSP makes data from the Cerner EHR available on nightly-updated data reports.

Several mental health access barriers potentially requiring legislative or administrative action have been identified during ongoing quality improvement work. VA proposed legislation in the President's FY 2023 Budget Submission to address such barriers. VA legislative proposals are found in FY 2023 Budget Submission Volume I, Supplemental Information and Appendices Congressional submission at the following link: https://www.va.gov/budget/products.asp and include the following:

- Eliminate Veteran cost sharing for the first three mental health outpatient visits per year: to expand access and reduce out of pocket costs (addresses access).
- Expand eligibility for access to treatment of military sexual trauma: to amend VA's authority to treat these patients (addresses access).
- Establish uniform Federal standards for telehealth-controlled substance prescribing: to maintain consistent access to critical treatments (addresses capacity, access and evidence-based treatment).
- Aggregate Pay Limitation for VHA Physicians, Podiatrists and Dentists: to make changes to how VHA sets compensation for physicians, including psychiatrists (addresses capacity).
- Temporary excepted service appointments of staff in Title 5 Occupations during a period of emergency: to allow the Secretary of VA authority to use Schedule A hiring authority (addresses capacity).
- Consultation on Specific Cases for Community Providers: to grant authority that facilitates VHA providers collaborating with community providers on PTSD treatment (addresses evidence-based treatment).
- Additional Services for Veterans with Severe Mental Illness: to extend authority to VA for 5 five years to expand specific services for homeless Veterans 38 U.S.C. 2031 (addresses access).
- Services for Seriously Mentally Ill Veterans, Including Homeless Veterans: to extend authority for VA for 5 years to provide services to this population 38 U.S.C. 2033 (addresses access).

References

Bauer MS, Weaver K, Kim B, Miller C, Lew R, Stolzmann K, Sullivan JL, Riendeau R, Connolly S, Pitcock J, Ludvigsen SM, Elwy AR. The Collaborative Chronic Care Model for Mental Health Conditions: From Evidence Synthesis to Policy Impact to Scale-up and Spread. *Medical Care*, 2019a, 57(10 Suppl 3): S221-S227.

Bauer MS, Miller CJ, Kim B, Lew R, Stolzmann K, Sullivan J, Riendeau R, Pitcock J, Williamson A, Connolly S, Elwy AR, and Weaver K. Effectiveness of Implementing a Collaborative Chronic Care Model for Clinician Teams on Patient Outcomes and Health Status in Mental Health: A Randomized Clinical Trial. *JAMA Network Open*, 2019b, 2(3): e190230.

Boden MT, Smith CA, Klocek JW, Trafton JA. Mental Health Treatment Quality, Access, and Satisfaction: Optimizing Staffing in an Era of Fiscal Accountability. *Psychiatric Services*, 2019, 70(3): 168-175.

Boden M, Smith CA, Trafton JA. Investigation of population-based mental health staffing and efficiency-based mental health productivity using an information-theoretic approach. *PLoS One,* 2021 Aug 16; 16(8): e0256268.

Chan DC, Card D, Taylor L. Is there a VA advantage? Evidence from dually eligible Veterans National Bureau of Economic Research (NBER) Working Paper Series, 2022, No. 29765. Available online at: https://www.nber.org/ papers/w29765/.

Cunningham R. Healthcare workforce needs: projections complicated by practice and technology changes. Issue Brief, George Washington University, National Health Policy Forum, 2013 Oct 22, (851): 1-15.

Farmer CM, Smucker S, Ernecoff N, Al-Ibrahim H. Recommended Standards for Delivering High-Quality Care to Veterans with Invisible Wounds. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1728-1.html. Also available in print form.

Feyman Y, Asfaw D, Griffith K. Geographic Variation in Appointment Wait Times for US Military Veterans. *JAMA Network Open*, August 25, 2022; 5(8): e2228783.

Frank HE, Becker-Haimes EM, Kendall PC. Therapist training in evidence-based interventions for mental health: a systematic review of training approaches and outcomes. *Clinical Psychology: Science and Practice*, 2020, 27(3): e12330.

Gujral K, Van Campen J, Jacobs J, Kimerling K, Blonigen D, Zulman DM. Mental Health Service Use, Suicide Behavior, and Emergency Department Visits Among Rural US Veterans Who Received Video-Enabled Tablets During the COVID-19 Pandemic. *JAMA Network Open*, 2022; 5(4): e226250. doi:10.1001/jamanetworkopen.2022.6250.

Guy GP Jr., Haegerich TM, Evans ME, Losby JL, Young R, Jones CM. Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018. *MMWR Morbidity and Mortality Weekly Report*, 2019; 68: 679–686.

Hermes EDA, Wiechers IR, and Hoff R. Psychotropic Drug Safety Initiative: Phase 3 Evaluation of Impact and Activities. VA Office of Mental Health and Suicide Prevention. West Haven, CT: Northeast Program Evaluation Center. July 2020.

Institute of Medicine. Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards, 2015. Washington, DC: The National Academies Press.

Jacobs JC, Blonigen DM, Kimerling R, Slightam C, Gregory AJ, Gurmessa T, Zulman DM. Increasing Mental Health Care Access, Continuity, and Efficiency for Veterans Through Telehealth with Video Tablets. *Psychiatric Services*, 2019; 70(11): 976-982.

Katz IR, Resnick S, Hoff R. Associations between patient experience and clinical outcomes in general mental health clinics: Findings from the Veterans Outcomes Assessment survey. *Psychiatry Research*, 2021 Jan; 295: 113554.

Lemke S, Boden MT, Kearney LK, Krahn DD, Neuman MJ, Schmidt EM, Trafton JA. Measurement-based management of mental health quality and access in VHA: SAIL Mental Health Domain. *Psychological Services*, 2017, 14(1): 1-12.

Liebmann EP, Resnick SG, Hoff RA, Katz IR. Associations between patient experience and clinical outcomes in substance use disorder clinics: Findings from the Veterans Outcomes Assessment survey. *Journal of Substance Abuse Treatment*, 2022 Feb; 133: 108505.

Liebmann EP, Resnick SG, Hoff RA, Katz IR. Interpreting patient reports of perceived change during treatment for depression: Findings from the Veterans Outcome Assessment survey. *Psychiatry Research,* 2022 Mar; 309: 114402.

McCarthy JF, Cooper SA, Dent KR, Eagan AE, Matarazzo BB, Hannemann CM, Reger MA, Landes SH, Trafton JA, Schoenbaum M, Katz IR. Evaluation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration. *JAMA Network Open,* 2021, 4(10), e2129900.

Meyer AM, Davis M, Mays GP. Defining organizational capacity for public health services and systems research. *Journal of Public Health Management and Practice*, 2012, 18(6): 535-44.

Miller CJ, Griffith KN, Stolzmann K, Kim B, Connolly SL, and Bauer MS. Team- Based collaborative care in outpatient general mental health clinics. *Medical Care*, 2020, 58(10): 874-880.

National Academies of Sciences, Engineering, and Medicine. 2018. Evaluation of the Department of Veterans Affairs Mental Health Services. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24915.

Oliva EM, Bowe T, Tavakoli S, Martins S, Lewis ET, Paik M, Wiechers I, et al. Development and applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to improve opioid safety and prevent overdose and suicide. *Psychological Services*, 2017, 14(1): 34-49.

Oliva EM, Richardson J, Harvey MA, Bellino P. Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative*. The Joint Commission Journal on Quality and Patient Safety*, 2021, 47(8): 469-480.

Schmidt EM, Krahn DD, McGuire MM, Tavakoli S, Wright DD, Solares HE, Lemke S, Trafton J. Using organizational and clinical performance data to increase the value of mental health care. *Psychological Services*, 2017, 14(1): 13-22.

Smith CA, Boden MT, Trafton JA. Outpatient provider staffing ratios: Binary recursive models associated with quality, access, and satisfaction. *Psychological Services*, 2021 Nov 15. Online ahead of print.

Strombotne KL, Legler A, Minegishi T, Trafton JA, Oliva EM, Lewis ET, Sohoni P, Garrido MM, Pizer SD, Frakt AB. Effect of a Predictive Analytics-Targeted Program in Patients on Opioids: a Stepped-Wedge Cluster Randomized Controlled Trial. *Journal of General Internal Medicine*, 2022 May 2. Online ahead of print.