COVER COMMISSION

Creating Options for Veterans' Expedited Recovery

Duty 4
Analytical Summary Report

October 21, 2019

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BACKGROUND & INTRODUCTION

Approach & Purpose

To satisfy the Duty 4 legislative mandate, existing quantitative and qualitative data sources were analyzed to inform the Duty 4 Workgroup and the Commission's final recommendations. The information collected by the Commission is summarized in this Appendix.

The Duty 4 Workgroup began identifying data sources in February 2019. This included meetings with various VA program offices to discuss existing quantitative and/or qualitative data sources that were relevant to the Commission's fourth legislative mandate.

By February 2019, the Workgroup began discussing the elements to be included in the analytical plan. The analytical plan served to guide the use and analyses of existing data sources identified to address the Workgroup's key questions. By March 7, 2019, the outline was drafted and included the identification of key questions that were aligned to the Quadruple Aim framework[1] and the mandate of Duty 4. The key questions were drafted by June 4, 2019 and finalized by July 9, 2019. The key questions ensure the legislative mandate is answered. Using the key questions, a full analytical plan was drafted by August 13, 2019 and finalized by August 20, 2019.

Figure 1. Timeline of the Duty 4 Analytical Approach and Milestones

Overview of Comprehensive Addiction and Recovery Act (CARA) of 2016

The Comprehensive Addiction and Recovery Act of 2016 (CARA), Section 931 Public Law 114-198 (see Appendix A for a copy of the legislation), mandates the establishment of a Commission, known as the Creating Option for Veterans' Expedited Recovery (COVER) Commission. The COVER Commission is charged to examine the evidence-based therapy treatment model used by The Secretary of Veterans Affairs for treating mental health conditions of Veterans and the potential benefits of incorporating complementary and integrative health treatments available in non-Department facilities (as defined in section 1701 of title 38, US Code).

[1] Feeley, D. (November 2017). *The Triple Aim or the Quadruple Aim? Four Points to Help Set Your Strategy*. Retrieved from http://www.ihi.org/communities/blogs/the-triple-aim-or-the-quadruple-aim-four-points-to-help-set-your-strategy. Accessed October 19, 2019.

Per the CARA legislation, for Duty 4, the Commission shall:

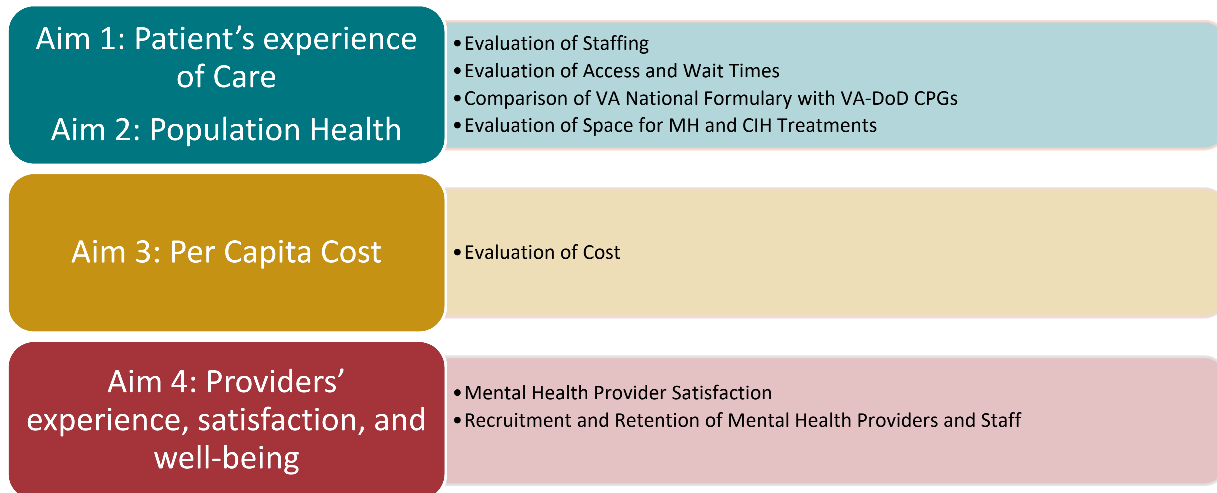
> *Study the sufficiency of the resources of Veterans Affairs (VA) to ensure the delivery of quality healthcare for mental health issues among Veterans seeking treatment within the VA.*

METHODOLOGY

Key Questions

See Appendix B for a full listing of the key questions identified for each subcomponent of the Quadruple Aim aligned to Duty 4. They have been grouped into the topics below.

Figure 2. Key Question Topics Aligned to the Duty 4 Legislative Subcomponents



Data Sources & Analysis

The overall methodology included evaluating each data source individually. In addition to using existing quantitative and qualitative data, the Workgroup also conducted literature reviews, identifying relevant tables and figures from peer-reviewed publications that have been aligned to the Quadruple Aim and the Duty 4 legislation. Each data source evaluates a different population and includes its own methodology. An overview of each data source and specific analyses conducted for each dataset are provided below.

Office of Human Resources Management. As stated on the VA's Office of Human Resources Management (OHRM) website, the OHRM provides "policies and guidance regarding staffing, recruitment, classification, pay and leave administration, performance management and recognition, work life and employee benefits." Data retrieved from Veterans Health Administration (VHA) Human Resources (HR) Smart data via VHA Support Service Center Capital Assets (VSSC) HR Employee and NOA cubes excluding Veteran Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees with assign codes T0-T9 current as of 08/31/2019 were provided to the Commission.[2] The Data Analytics Team from VA Human Capital Management, Workforce Management and Consulting Office provided completed analyses and explanations to the Commission. Graphs were created from the data for visual representation of the information. A limitation of these data included not being able to

[2] Data tables and information were provided by Dr. Cristina Byrne, Manager of the Data Analytics Team at the VA Human Capital Management

differentiate or identify the cause of the fluctuations with staffing, whether it was transfers, retirements, or losses, etc. that occurred, leading to the small net gains observed.

Peer Support Data. Additional Peer Support Specialists (PSS) data were received from two different sources (preliminary data was provided by OHRM). The first set of data were retrieved from the Veterans Equitable Resource Allocation (VERA) database, VHA Allocation Resource Center (ARC).[3] This included Peer Support numbers for the past three fiscal years (FY), from FY 2016 to FY 2018, by Veterans Integrated Service Network (VISN). ARC also provided completed analyses on the percent change and growth of PSS from the last three FYs. The second set of data were retrieved from VHA's Personnel and Accounting Integrated Data (PAID) database.[4] PAID data included the current number of PSS as of September 2019. These data also provided additional breakdown of the total number of PSS by those classified as "Apprentices", "Health Techs", or "Peer Support Specialists". Both sets of data were provided in Excel format. ARC PSS data was aggregated, stratified by VISN, and then compared to VHA utilization data provided by the Office of Mental Health and Suicide Prevention (OMHSP), for both total VA users as well as for MH service users for FY 2017 and FY 2018. PSS data from PAID was also stratified by VISN.

Turnover rates of PSS from the past five FYs (FY 2014 – FY 2018) were also provided to the Workgroup. These rates were calculated from data retrieved from Human Capital Systems and Services, VHA Workforce Management and Consulting (WMC) Office. This data analysis was performed on 3/1/2019 by the Data Analytics team at WMC. These data included VHA HR Smart data via VHA Support Service Center Capital Assets (VSSC) HR Turnover cube excluding Veteran Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees with assign codes T0-T9 current as of 01/31/2019.[5]

Pharmacy Benefits Management. As stated on the VA's Pharmacy Benefits Management (PBM) website, the VA PBM Services "offer a broad range of services and are committed to provide and deliver Veterans personalized, proactive, patient-driven health care. Their mission is to improve the health status of Veterans by encouraging the appropriate use of medications in a comprehensive medical care setting". PBM manages the VA National Formulary. The purpose of the VA National Formulary is to "provide high quality, best value pharmaceutical products while assuring the portability and standardization of the pharmacy benefit to eligible Veterans accepted by the Department of Veteran Affairs for care" (VA PBM website). See Appendix C for additional information about PBM and the VA National Formulary responsibilities.

A list of the evidence-based pharmacologic treatments was obtained from the VA-DoD Clinical Practice Guidelines (CPGs) and provided to the Workgroup.[6] These treatments were stratified by the MH conditions aligned to Duty 3 including Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD), Substance Use Disorder (SUD), Opioid Use Disorder (OUD),

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[3] VERA PSS data were provided by Ms. Ellen Bradley, Director of Information Reporting, Allocation Resource Center (ARC).
[4] PAID PSS data were provided by Dan O'Brien-Mazza, National Director of Peer Support Services, VHA OMHSP.
[5] Turnover rates and explanation were provided by Dan O'Brien-Mazza, National Director of Peer Support Services, VHA OMHSP.
[6] Information provided by Dr. Ilse Wiechers, Assistant Professor of Psychiatry at Yale University School of Medicine and Associate Director of the Northeast Program Evaluation Center (NEPEC) in the Office of Mental Health Operations (OMHO).

Alcohol Use Disorder (AUD), Generalized Anxiety Disorder (GAD), Bipolar Disorder (BPD), Chronic Insomnia Disorder, and Suicidal Ideation. The October 2019 listing of the VA National Formulary directly was obtained from the PBM website. The Commission then conducted a comparison analyses evaluating if the VA National Formulary includes the evidence-based pharmacotherapies identified and recommended in the CPGs for each of the MH conditions aligned to Duty 3. By convention, the VA National Formulary includes generic names for all medications.

VA All Employee Survey. The VA All Employee Survey (AES) is an annual, multi-mode survey administered to all VA employees each June. AES has collected information from VA employees since 2016.. The AES is delivered by the VA National Center for Organizational Development (NCOD) for the purpose of gathering information to better understand workforce perceptions of organizational strengths and opportunities for improvement. The AES is further used to inform effective and data-driven decision making across the VA. AES Coordinators, identified by their respective organization leadership, administer the AES across their organization. The 2019 AES was administered between June 3 – 24, 2019 and received a response rate of 65.5% (N = 256,807). Most respondents completed the survey via web administration (99.5%), followed by telephone administration (0.4%), and finally, paper administration (0.1%) (U.S. Department of Veteran Affairs, 2019).

In 2018, VA combined two annual workforce surveys, the former AES and the Federal Employee Viewpoint Survey (FEVS), to create the most recent edition of the AES survey. The 2019 AES included 57 questions, including 16 questions derived from the former FEVS and 15 questions capturing demographic information from respondents (U.S. Department of Veteran Affairs, 2019). AES survey items are designed to capture employee behaviors, including the employee actions to shape the workplace and employee interaction, and workplace environment which involves the shared belief systems between employees including unspoken norms. AES also captures employee feelings, thoughts and attitudes regarding their workplace. Prior to the dissemination of AES data, NCOD conducts extensive data cleaning and validation on the raw AES data. The 2019 AES data, published in August 2019[7] was provided to the Workgroup. The Commission performed secondary analyses of AES data via the AES Pyramid data cube , including creating a subsample of the data to examine the responses of MH providers, specifically over the past three years (2016-2019) by employee demographics and VISN.

Mental Health Provider Survey. The Mental Health Provider Survey (MHPS) was developed to better understand the perspectives of providers regarding access, quality, treatment delivery, and challenges working in the field. Responses received help guide and evaluate program improvement efforts at the local, VISN, and national level. The survey is conducted annually and is administered in late November through December. It includes 42 questions, the majority of which are measured on a Likert scale ranging from strongly disagree to strongly agree. All MH providers (i.e. outpatient, inpatient, licensed independent providers [LIPs], and non-LIPs) in VHA facilities nationwide are asked to participate to identify and better understand barriers

[7] Information and data provided by Chris Orszak, MHSA, Program Analyst, VHA National Center for Organization Development.

that may inhibit Veterans' access to high quality MH services. Both respondents and their responses remain anonymous.

The Commission was granted access to the MHPS dashboard[8] to examine responses from the 2018 MHPS. Sigma constructed bar graphs for each of the survey responses, displaying the response rates by question. Responses were analyzed at the national-facility level.

Strategic Analytics for Improvement and Learning. VA developed the Strategic Analytics for Improvement and Learning Value (SAIL) Model to measure, evaluate and benchmark quality and efficiency at medical centers. The SAIL model highlights successful strategies of VA's top performing facilities in order to promote high quality, safety, and value-based health care across all its medical centers. SAIL is one of the tools VA uses to improve health care delivery and access to Veterans. Each VA Medical Center (VAMC) is organized slightly different to best serve Veterans' health care needs, and SAIL is designed accordingly. SAIL's quality measurements consider the complexity level of each VAMC (e.g., patient volume, number of residents and complex clinical program, and research dollars) when comparing their relative performance. Unlike most other health industry report cards updated annually, SAIL is updated quarterly to allow medical centers to more closely monitor the quality and efficiency of the care delivered to Veterans (SAIL, 2019).

Given the Commission's charge, the Workgroup focused on the MH Domain of SAIL in addition to access and wait times information at the national level. The MH Domain of SAIL is divided into three composite measures including Population Coverage, Continuity of Care, and Experience of Care. There are 19 measures that inform the Population Coverage composite, and 13 measures inform the Continuity of Care composite. Both the Veteran Satisfaction Survey and the MHPS inform the Experience of Care composite. The MH composite scores were designed to provide a quick glance assessment of high-level organizational challenges that mental health and substance use disorder programs may be experiencing (SAIL, 2019).

The Commission received access to the MH Domain dashboard[9] and examined the most current data from Quarters 1 to 3 in FY 2019 at the national level. An Excel report was generated from the dashboard for all measures included in the domain. A supplemental Word document was created with additional descriptive information for each measure as well as the inclusion criteria for each measure's numerator and denominator to assist the Workgroup with interpreting the results of the measures (See Appendix C).

For access and wait times, the Workgroup used the most recent available information provided by VA on timeliness of care and access to specialty care at the national level.[10] A summary document was created for the Workgroup. A limitation of these data included not being able to differentiate wait times and access specific to MH.

[8] Data access and information was provided by Dr. Jodie Trafton, Director, Program Evaluation and Resource Center (PERC), Office of Mental Health and Suicide Prevention (OMHSP), VHA.
[9] Data access and information was provided by Dr. Jodie Trafton, Director, Program Evaluation and Resource Center (PERC), Office of Mental Health and Suicide Prevention (OMHSP), VHA.
[10] Information examined from VA's website https://www.accesstocare.va.gov/.

Veterans Equitable Resource Allocation. As stated by guest speaker, Ms. Ellen Bradley, Director of Information Reporting, Allocation Resource Center (ARC),the Veterans Equitable Resource Allocation (VERA) model is "designed to allocate general purpose funds (determined after specific purpose funds are deducted from the President's budget) to the 18 VISNs based on VISN-specific workload. The VERA Patient Classification system is used to classify all patients into hierarchically arranged, mutually exclusive classes based on total care received in a FY. This means that each patient will be placed in the *single highest class* attained during the fiscal year based on total care received (not just isolated services)." The classification system uses all care that is provided and purchased by VHA.

To help inform the third Quadruple Aim, the Workgroup requested information from the 2019 VERA model regarding funds aligned to MH. Three Excel spreadsheets were provided[11]

- The FY 2020 Advance Appropriation VERA Prices. The VERA Model funds a multi-year cohort of patients each fiscal year using these prices. Note that the VERA 2020 Model will fund over 7 million patients. A limitation of these data is that only using these prices for discernable mental health conditions would not fully capture the funding associated with the mental health population. For example, mental health patients that ultimately reside in a VHA community living center (i.e. a nursing home) for more than 90 days of bed care, would be funded in Price Group 10.5 because that class is higher on the hierarchy than the Chronic Mental Illness (CMI) classes.

- FY 2018 VERA Patient Classes includes a detailed breakdown of the number of unique patients, total cost, and cost per unique patient for different MH conditions, CIH, and SUD care provided.

- Patients with Mental Health Care includes a sum of all Veterans by price group and VERA class who had mental health care in FY 2018. The three spreadsheets can be found in Appendix C.

Evaluation of the Department of Veterans Affairs Mental Health Services. The *Evaluation of the Department of Veterans Affairs Mental Health Services* was a legislatively-mandated study designed to examine the access and quality of the mental health services provided to Veterans serving in Afghanistan and Iraq during Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND). The National Academies' of Medicine Committee set out to determine the extent to which Veterans are afforded mental health treatment choices and offered a full range of necessary mental health services. To achieve its charge, the Committee developed a mixed-methods study design that involved conducting both qualitative and quantitative original research; qualitative data collection was collected from site visits, and quantitative data were collected via a survey of OEF/OIF/OND Veterans who used VA mental health services and those who did not. Prior to the original data collection and several times over the course of the study, the committee performed a comprehensive literature review of existing research. Westat contractors assisted with the development of qualitative interview protocols for site visits, planned and executed the site visits, and submitted individual site visit reports as well as a final qualitative analysis report across all sites. The

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[11] VERA data and explanations were provided by Ms. Ellen Bradley, Director of Information Reporting, Allocation Resource Center (ARC) and Stephen Kendall, Director of ARC.

National Academies study began on September 30, 2013 and took 54 months to complete. The committee developed a plan to address its approach to the charge; to develop the survey and site visit methods, instruments, and analysis plans in consultation with Westat; to obtain information from invited speakers and members of the public during four information-gathering sessions; to deliberate on the body of evidence from the survey, site visits, literature, and other sources of information; to draft its report; and to develop and come to consensus on the findings, conclusions, and recommendations. The committee created a final report, *Evaluation of the Department of Veterans Affairs Mental Health Services*, that was released January 8, 2018.[12] From the COVER Commission's perspective, a limitation of the *Evaluation of the Department of Veterans Affairs Mental Health Services* was that it focused only on the population of OEF/OIF/OND Veterans and did not address other eras. Therefore, these results may not be generalizable to other Veteran populations.

The Workgroup created an abstract of information relevant to the Commission tasks from the National Academy of Medicine's report. The purpose of the abstracted review was to give the Commissioners and the COVER Commission writers a shorter summary of the most relevant data, information, and findings contained in this more than 400-page document. The Commission reviewed the report and abstracted Chapters 6 and 8-15. A copy of the abstracted review was provided to the Workgroup and the COVER Commission on October 16, 2019 via email.

[12] A copy of the National Academies of Medicine Report can be retrieved here: http://nationalacademies.org/hmd/Reports/2018/evaluation-of-the-va-mental-health-services.aspx

KEY FINDINGS

This section presents key findings for each data source aligned to the subcomponents of the Quadruple Aim and Duty 4.

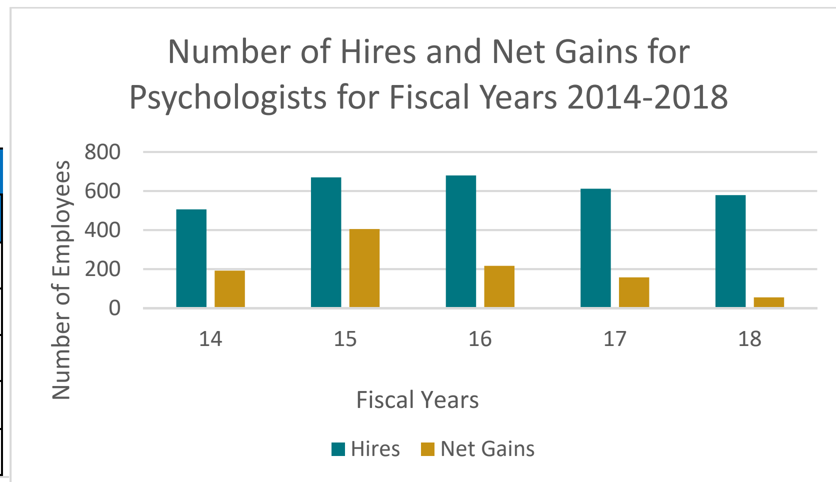
AIMS 1 & 2: Studying the sufficiency of resources of the Department to ensure the delivery of quality mental health care: patient's experience of care and population health perspective

Evaluation of Staffing

The following tables represent staffing hires and net gains for different MH positions from the last five fiscal years (FY 2014 to FY 2018) provided by OHRM. Per Dr. Cristina Byrne, Manager of the Data Analytics Team at VA Human Capital Management, "hires are the number of hiring actions processed in a given time period," in this case, for a given FY. The net gains are "the difference between total onboard Time 1 vs. Time 2, usually the end of the fiscal year." The measure shows growth and includes all staff fluctuations such as transfers, retirements, resignations, etc.

Psychologists

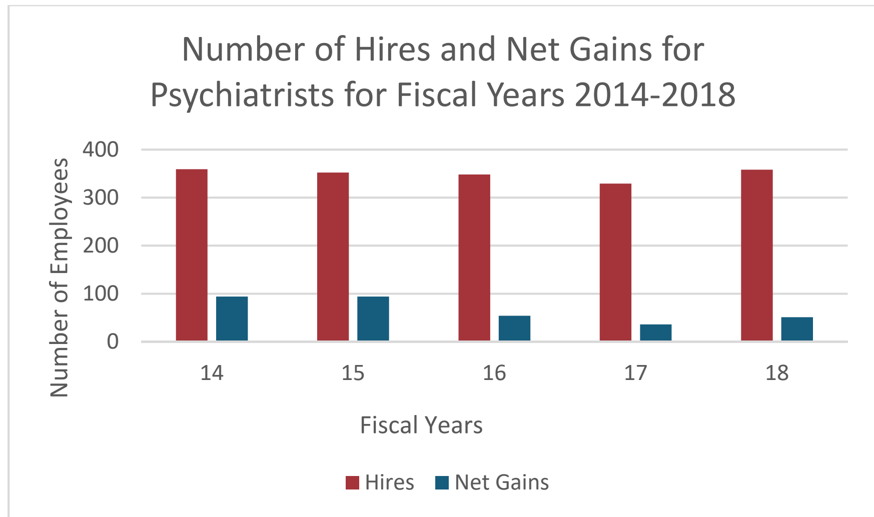
Psychologists		
FY	Hires	Net Gains
14	506	192
15	670	405
16	680	216
17	612	157
18	579	55



The data shows a steady number of hires for psychologists over the last five FYs. The most net gain was in FY 2015 whereas FY 2018 showed the smallest net gain. Per OHRM, it usually takes about 3-5 new hires to increase the number of onboard staff by 1.

Psychiatrists

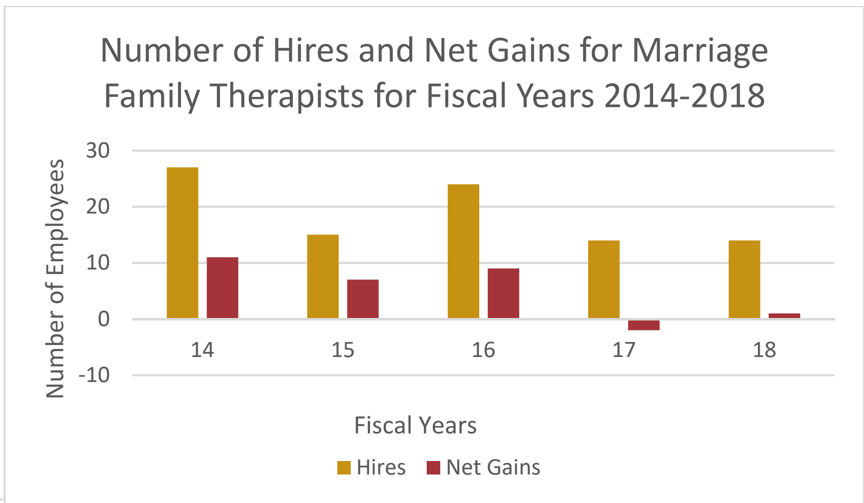
Psychiatrists		
FY	Hires	Net Gains
14	359	94
15	352	94
16	348	54
17	329	36
18	358	51



There has been a consistent number of psychiatrists hired over the past five FYs. FY 2017 showed the smallest net gain in numbers of psychiatrists, followed by FY 2018.

Marriage Family Therapists

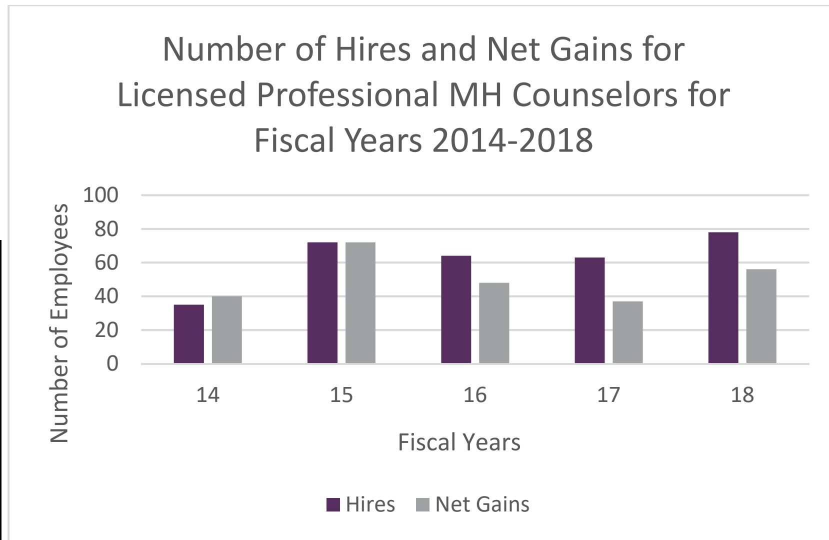
Marriage Family Therapists		
FY	Hires	Net Gains
14	27	11
15	15	7
16	24	9
17	14	-2
18	14	1



The negative number in FY 2017 indicates there was a net loss in marriage family therapists. That is, there were more losses/retirements/transfers that occurred professional group than the number of new hires.

Licensed Professional Mental Health (MH) Counselors (LPMHs):

Licensed Professional MH Counselors		
FY	Hires	Net Gains
14	35	40
15	72	72
16	64	48
17	63	37
18	78	56



Licensed professional MH counselors (LMPHs), compared to the other MH positions included in these data, showed the most stability in hires and net gains. In FY 2015, the number of hires for LPMHs equaled the net gain.

Peer Support:

According to the VA Office of Peer Support Services, Peer Support Specialist is a job title given to staff who are certified by a VA approved or state approved Peer Certification Training Not-For-Profit provider. They may be hired as a non-certified peer support apprentice and VA will get them trained within a year of their appointment date.[13] Other VA employees in different occupations may apply for open peer support specialist or peer support apprentice positions if they meet the qualifications, codified in Public Law 110-387 (see Appendix C for a copy of the legislation and additional data tables related to Peer Provider Activity). If they are selected, they vacate their current positions and work solely in the peer support position.

For most VISNs, the number of Peer Providers has remained consistent for the past three FYs as seen in Figure 3.

Dr. Byrne, Manager of the Data Analytics Team, VA Human Capital Management, stated in email communications to the Commission, is unsure why peer support appears to "have been reduced to some extent in terms of hiring and growth" as seen in Figure 4. Dr. Byrne added that "there is a possibility that the first few years of the program included a large hiring initiative that later normalized." From additional information provided by the VHA Peer Support Services Office[14], "OHRM has a high turnover rate among their recruitment staff at the local level, so standard operating procedures aren't always followed. For example, peer specialists and apprentices' corresponding job titles, series numbers, and title codes are not properly documented in the system. This results in many positions not being pulled when the data is

[13] Explanation provided by Dan O'Brien-Mazza, National Director, Peer Support Services, Office of Mental Health & Suicide Prevention (OMHSP), VHA.
[14] Explanation provided by Dan O'Brien-Mazza, National Director, Peer Support Services, Office of Mental Health & Suicide Prevention (OMHSP), VHA.

queried using the proper identifiers, helping to explain why the results may be an underestimate of the actual number of peer providers working in VHA."

Figure 3. Number of Peer Providers for Fiscal Years 2016-2018[15]

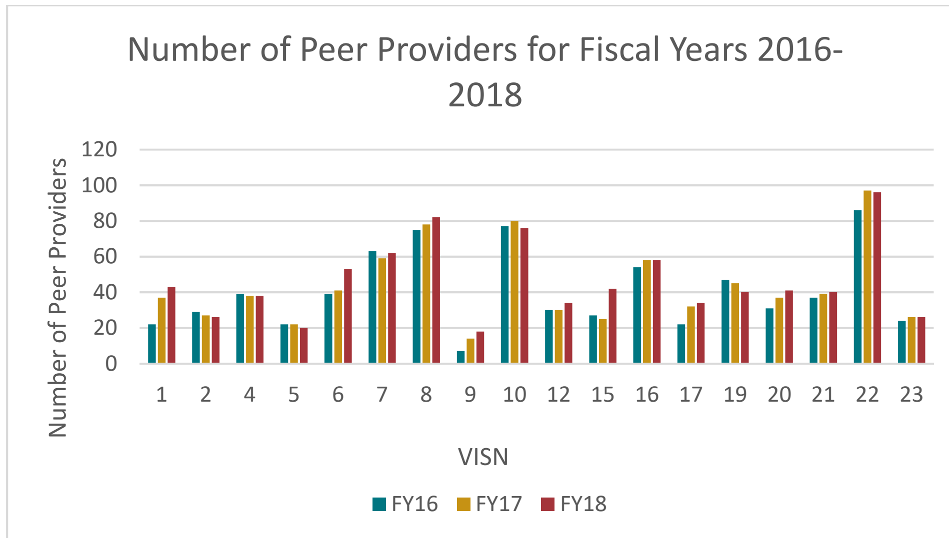
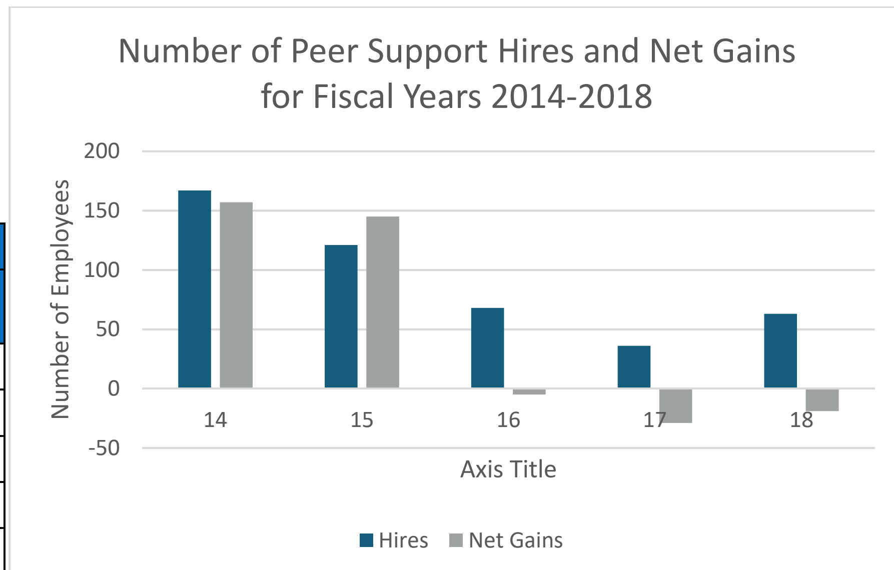


Figure 4. Number of Peer Support Hires and Net Gains for FY 2014-2018[16]

Peer Support		
FY	Hires	Net Gains
14	167	157
15	121	145
16	68	-5
17	36	-29
18	63	-19



OHRM data shows a low growth rate for Peer Support Specialists (PSS). Per Mr. O'Brien-Mazza, National Director, VHA Peer Support Services Office has been monitoring the number of Peer Support Specialists and Apprentices in VA's workforce. It has been their goal to slowly increase the number of peer specialists available to Veterans in all Mental Health programs,

[15] VERA PSS data were provided by Ms. Ellen Bradley, Director of Information Reporting, ARC.
[16] Data were provided by Dr. Cristina Byrne, Manager of the Data Analytics Team at the VA Human Capital Management

while sustaining the numbers hired during the large expansion of peer support in VA as a result of Executive Order 13625, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families in FY13.

Mr. O'Brien-Mazza believes "the negative growth rate is a result of competing demands on mental health management to provide services across a wide continuum of care that also provides reimbursement through Veterans Equitable Resource Allocation (VERA) funding. Since Peer Support Specialists are not eligible to have their services reimbursed by VERA, management prefers to hire other licensed mental health staff that will be eligible for bringing funds into their facilities. Peer support is a growing evidence-based practice that adds value to recovery-oriented care by supporting Veterans throughout their recovery process and is highly favored by Veterans, Congress, and the White House. However, budget conscious leadership in the networks see existing funding resources diminishing rapidly as healthcare costs soar and their default strategy is to hire staff who will bring revenue into the system."

Mr. O'Brien-Mazza added that, "potential solutions for this would require legislation or an executive or der to change the VERA reimbursement system, allowing services delivered by peer specialists to be counted, or for these positions to receive long-term fenced funding that would not expire, protecting them from having vacated positions left unfilled."

Table 1. Percent Change and Growth of Peer Providers FY 2016-2018

	Peer Providers	FTEE*	Encounters	Growth from Prior Year	% Change
FY16	**731**	**309.8**	**527,951**		
FY17	**785**	**354.2**	**585,673**	57,722	10.93
FY18	**829**	**384.2**	**624,354**	38,681	6.60

*FTEE are calculated based on the days the peer counselor works and their encounters.

When examining the percent change and growth of PSS over the last three FYs (Table 1), there was a 7% change from FY 2017 and 2018 and an 11% change from FY 2016 and 2017.

As shown in Table 2, VISN 22 had the lowest ratio of Peer Providers by total MH service users in FY 2017, so that one PSS supports approximately 1,482 Veterans. In FY 2017, the ratio of Peer Providers by total MH service users ranged from 1,482 to 5,428, whereas in FY 2018, the range was 1,482 to 4,314 (Table 3).

Table 2. Peer Provider Activity and VHA Utilization in FY 2017

VISN	#of VAMCs	Peer Providers	Total VA Service Users	Number of MH Service Users	Ratio of Peer Provider by Total VA Service Users	Ratio of Peer Provider by Total MH Service Users
1	7	37	246,131	68,099	6,652.19	1,840.51
2	7	27	287,998	81,080	10,666.59	3,002.96

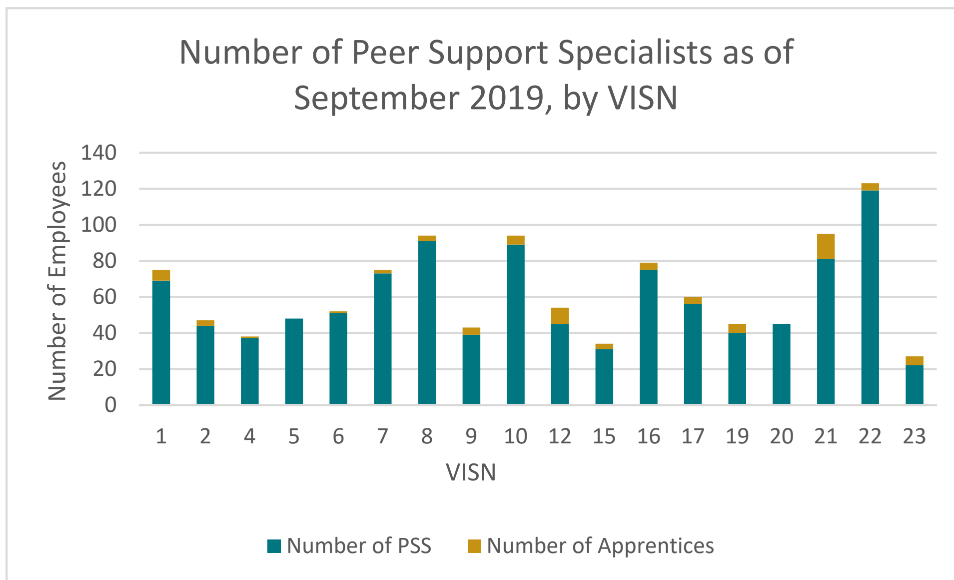
VISN	#of VAMCs	Peer Providers	Total VA Service Users	Number of MH Service Users	Ratio of Peer Provider by Total VA Service Users	Ratio of Peer Provider by Total MH Service Users
4	8	38	285,089	70,155	7,502.34	1,846.18
5	4	22	203,519	58,088	9,250.86	2,640.36
6	7	41	368,799	112,018	8,995.10	2,732.15
7	5	59	430,662	134,865	7,299.36	2,285.85
8	7	78	576,393	159,758	7,389.65	2,048.18
9	2	14	269,882	75,986	19,277.29	5,427.57
10	10	80	485,019	127,266	6,062.74	1,590.83
12	6	30	276,556	70,093	9,218.53	2,336.43
15	6	25	237,402	62,712	9,496.08	2,508.48
16	6	58	408,727	121,556	7,047.02	2,095.79
17	5	32	386,544	121,276	12,079.50	3,789.88
19	5	45	298,033	78,174	6,622.96	1,737.20
20	6	37	290,782	72,132	7,858.97	1,949.51
21	6	39	340,262	93,219	8,724.67	2,390.23
22	8	97	473,219	143,794	4,878.55	1,482.41
23	7	26	313,858	65,024	12,071.46	2,500.92
n=18	**112**	**785**	**6,178,875**	**1,715,295**		

Table 3. Peer Provider Activity and VHA Utilization in FY 2018

VISN	#of VAMCs	Peer Providers	Total VA Service Users	Number of MH Service Users	Ratio of Peer Provider by Total VA Service Users	Ratio of Peer Provider by Total MH Service Users
1	8	43	246,196	68,250	5,725.49	1,587.21
2	7	26	285,150	81,203	10,967.31	3,123.19
4	8	38	292,051	72,207	7,685.55	1,900.18
5	4	20	206,083	59,946	10,304.15	2,997.30
6	7	53	378,627	115,182	7,143.91	2,173.25
7	5	62	439,612	140,702	7,090.52	2,269.39
8	7	82	582,315	163,838	7,101.40	1,998.02
9	3	18	272,421	77,652	15,134.50	4,314.00
10	10	76	490,472	128,986	6,453.58	1,697.18
12	7	34	274,700	70,746	8,079.41	2,080.76
15	6	42	239,276	62,258	5,697.05	1,482.33
16	7	58	412,713	123,091	7,115.74	2,122.26

VISN	#of VAMCs	Peer Providers	Total VA Service Users	Number of MH Service Users	Ratio of Peer Provider by Total VA Service Users	Ratio of Peer Provider by Total MH Service Users
17	6	34	398,007	126,581	11,706.09	3,722.97
19	5	40	303,862	80,095	7,596.55	2,002.38
20	7	41	298,758	73,400	7,286.78	1,790.24
21	6	40	344,642	93,449	8,616.05	2,336.23
22	8	96	481,047	147,913	5,010.91	1,540.76
23	7	26	315,924	65,997	12,150.92	2,538.35
n=18	**118**	**829**	**6,261,856**	**1,751,496**		

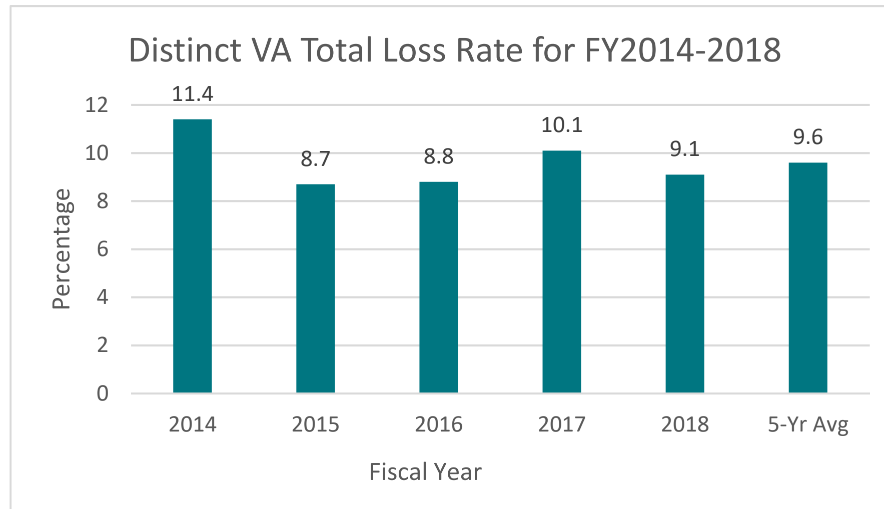
Figure 5. Number of Peer Support Specialists as of September 2019, by VISN



As of September 2019, VA employed a total of 1,128 Peer Support Specialists.[17] Figure 5 presents this total number of PSSs and apprentices employed in each VISN . VISNs 5 and 20 did not have any apprentices. The range of PSS was 27 (VISN 23) to 123 (VISN 22).

[17] Data retrieved from PAID and provided by Dan O'Brien-Mazza, National Director, Peer Support Services, Office of Mental Health & Suicide Prevention (OMHSP), VHA.

Figure 6. Turnover Rates of Peer Support Five-Year Total from FY 2014-2018



VA's distinct total loss rate for Peer Specialist over the past five years averaged 9.6%, with a range of 8.7% (FY2015) and 11.4% (FY2014) as seen in Figure 6 (See appendix C for the data table).

Evaluation of Access and Wait Times

As of October 2019, VHA scheduled over 11.1. million outpatient appointments for enrolled Veterans. 92% of those appointments for healthcare were scheduled within 30 days of the requested date while 8% were scheduled more than 30 days after the requested date. In August 2019, Veterans had 15, 897 referrals to a specialist for care needed immediately, of which 98% were resolved within seven days and 99.7% were resolved within 30 days.[18]

From the National Academies report (2018), between 2001 - 2017, approximately 61% of OEF/OIF/OND Veterans have enrolled in VA health care (including both mental and non-mental services) – a higher rate compared to previous eras. About 140,000 new Veterans become eligible for care each year with approximately 40% never access any type of VA health care. Among the 1.7 million Veterans who have a need for mental health, 55% are not receiving any MHS (mental health services).[19]

Comparison of VA National Formulary with VA-DoD Clinical Practice Guidelines

The VA National Formulary is a list of products generally covered under VA pharmacy benefits. These products must be available for prescription at all VA facilities. See Appendix C for the comparison table evaluating the VA National Formulary with the evidence-based pharmacologic treatments stratified by the MH conditions aligned to Duty 3.

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[18] Information examined from VA's website https://www.accesstocare.va.gov/.

[19] 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.

The following are key findings for each MH condition:

- For Major Depressive Disorder (MDD), 20 of the 25 evidence-based antidepressant medications are included.
- For Post-traumatic Stress Disorder (PTSD), six of the seven evidence-based medications are included.
- All VA/DoD pharmacotherapies identified for Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD) are included.
- Only Vortioxetine is not included as part of the VA National Formulary for Generalized Anxiety Disorder (GAD).
- 10 of the 12 medications for Bipolar Disorder (BD) are offered in the VA National Formulary.
- All three evidence-based pharmacotherapies for suicide ideation are included in the VA National Formulary. These include ketamine infusion (in patients with MDD), lithium (in patients with unipolar or BD), and clozapine (in patients with schizophrenia).

The VA National Formulary also offers Spravato (esketamine), administered as a nasal spray, as part of their listing for MDD. This medication is not listed as a recommended antidepressant medication in the MDD CPG but was recently FDA-approved for treatment resistant-depression on March 5, 2019.[20] In accordance with VHA PBM policies and guidance, VA providers can administer this drug to Veterans based on their clinical assessment and individual medical needs. Per Dr. Wiechers, Associate Director of the Northeast Program Evaluation Center (NEPEC) and Assistant Professor of Psychiatry at Yale University School of Medicine, "the current PBM policies for esketamine (Spravato) include in the Criteria For Use (CFU) an exclusion criteria for active suicidal ideation. That is to say, VA national policy guidance for Spravato is that the existing evidence does NOT support its use in acutely suicidal people. On the contrary, VA's PBM National Protocol Guidance is for Ketamine Infusion for Treatment Resistant Depression and Severe Suicidal Ideation. Hence, VA supports the use of ketamine infusion for suicidal ideation."

VA has two requirements for non-formulary drug use: 1) policy requires that urgently needed non-formulary medications (such as intravenous medications needed in critical care units, etc.) be provided immediately without a prospective review and that a review for appropriateness and conformance to VA prescribing criteria (if any exist) be completed afterwards, and 2) non-urgent requests are required to be adjudicated within 96 hours of a completed request being received.[21]

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[20] Information provided by Dr. Ilse Wiechers, Assistant Professor of Psychiatry at Yale University School of Medicine and Associate Director of the Northeast Program Evaluation Center (NEPEC) in the Office of Mental Health Operations (OMHO).

[21] Information provided by Michael Valentino, Chief Consultant, Pharmacy Benefits Management (PBM) and Jennifer Zacher, Assistant Chief Consultant, Pharmacy Benefits Management (PBM), VHA.

Evaluation of Space for MH and CIH Treatments and Services

When asked in the MHPS if staffing vacancies affected patient care, most providers (74%) either agreed or strongly agreed with this statement. Providers were also asked if space limitations and/or facility design impact their ability to meet privately with Veterans, to which 34% disagreed, 16% strongly disagreed, and 20% strongly agreed. Most providers (74%) agreed or strongly agreed that their team meets regularly to plan improvements to patient access.

AIM 3: Studying the sufficiency of resources of the Department to ensure the delivery of quality mental health care: per capita's cost perspective

AIM 3 was informed using information received regarding VERA. See the Background section for additional information on VERA.

Evaluation of Cost

While Acute Mental Disease had the highest number of unique patients (N=437,661) in FY 2018 as seen in Table 4, Substance Abuse had the highest cost per unique ($87,883).

Table 4. FY 2018 Patient Classification Data by VERA Patient Class

Patient Class Name	Unique Patients	ARC Cost ($)	Cost per Unique ($)
Addictive Disorders	28,555	123,894,830	4,339
Acute Mental Disease	437,661	1,721,049,110	3,932
CIH Therapies	43,668	414,705,424	9,497
Psych+Substance	41,942	708,372,276	16,889
Medical/Psych+Substance	282,286	5,035,780,952	17,839
PTSD Acute	16,269	406,806,822	25,005
PTSD-Chronic	6,581	152,553,244	23,181
Intensive Community MH Recovery (ICMHR)	6,961	344,449,227	49,843
Substance Abuse	558	49,038,768	87,883
Homeless – CMI	54,504	2,635,141,118	48,348
Other Psychosis	17,047	987,677,735	57,939
Schizophrenia & Dementia	10,021	678,142,673	67,672

While there are patients with mental health issues classified in higher VERA groups, an "even more prevalent group are the patients in the basic care class (price Group 6 or less) that also receive mental health care, but mental health care is not the predominant feature of their care." In FY 18, Acute Mental Disease had the most patients (N=430,783) followed by Medical/Psych and Substance Use (N=281,621), price groups 3 and 5, respectively.[22]

[22] Information and explanations were provided by Mr. Stephen Kendall, Director of VA Allocation Resource Center (ARC).

AIM 4: Studying the sufficiency of resources of the Department to ensure the delivery of quality mental health care: providers' experience, satisfaction, and well-being perspective

Mental Health Provider Satisfaction

The All Employee Survey (AES) provides insight into employee perceptions of their workplace, including reference to adequate resources, a manageable workload, feelings of competency amongst colleagues, the ability to further skills, and feelings of encouragement regarding innovative ideas. Refer to Appendix Tables C-7 to C-14.

AES collects information on job satisfaction and work group functioning, but not staff assessments of access and care quality issues for facility MH services overall. That information is collected via MPHS. See appendix C for the 2018 MHPS bar graphs for each survey response at the national level, and a copy of the report retrieved from the MHPS dashboard.

Demographics of AES Respondents

Female respondents made up the majority (64.1%) of the mental health professional respondent sample. This was evident across all years (2016 – 2019). In 2016, 63.0% of survey respondents were female, which increased to 65.0% of respondents in 2019. Most respondents across all survey years identified as White. In 2019, 69.2% of the survey respondents were White. The majority of respondents across all survey years were aged 30 – 59 years, followed by those aged 30 – 39 years (26.1%), 40 – 49 years (25.6%), and 50 – 59 years (24.8%). Almost half (45%) of respondents that provided mental health services worked in an outpatient setting. Regarding length of employment at the VA, 27.9% of respondents worked at the VA between 5 – 10 years, 25.1% worked at the VA for 2 – 5 years, and 13.4% worked at the VA for 10 – 15 years. VISN 22 (8.5%), VISN 10 (7.7%), VISN 8 (7.4%), VISN 17 (6.4%), and VISN 7 (6.3%) had the largest percentages of respondents who worked within the mental health field.

Provider Reported Evaluation of Resources Sufficiency

The AES includes several items that capture employees' perception of the adequacy of resources (including job support and training) to provide quality evidence-based care. The AES includes items related to **resources** ("I have the appropriate supplies, materials, and equipment to perform my job well"), **workload** ("My workload is reasonable"), **workgroup competency** ("My work unit has the job-relevant knowledge and skills necessary to accomplish organizational goals"), **skill development** ("I am given a real opportunity to improve my skills in my organization"), and **innovation** ("I feel encouraged to come up with new and better ways of doing things"). These items are rated on a scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating stronger agreement.

For MH professionals, male employees when compared to female employees, were more likely to agree that they have the appropriate materials to perform their role (3.8 vs. 3.68), their workload is reasonable (3.7 vs. 3.57), their workgroup has the skills to complete tasks (4.17 vs. 4.09), they are given an opportunity to improve their skills (3.88 vs. 3.79), and they feel encouraged to be innovative on the job (3.78 vs. 3.68). Average scores regarding level of agreement towards adequacy of resources has increased steadily over the four years.

Most providers (58%) participating in the 2018 MHPS either agreed or strongly agreed that their facility has a sufficient range of treatment options which allow Veterans to easily transition between various levels of healthcare. Approximately 46% of providers agreed and 27% of providers strongly agreed that within their role, they have flexibility to make clinical decisions regarding the level of care needed for a Veteran.

In regards to access to technology, in the MHPS when asked if they [providers] felt their facility had sufficient resources to deliver telemental health services (which allow Veterans to participate in care from their preferred location), 33% of providers agreed that their facility had adequate resources, while 19% disagreed, and 8% strongly disagreed.

Provider Reported Job and Care Delivery Satisfaction

Employee satisfaction with their overall position and the services they provide is captured across twelve AES items, including **supervisor listening** ("My supervisor listens to what I have to say"), **supervisor respect** ("My supervisor treats me with respect"), **supervisor trust** ("I have trust and confidence in my supervisor"), **workgroup respect** ("People treat each other with respect in my workgroup"), **workgroup collaboration** ("Work groups collaborate to accomplish shared objectives") , **workgroup communication** ("Members of my work group communicate well with each other"), **workplace inspiration** ("This organization really inspires the very best in me in the way of job performance"), **extra effort** ("I always do more than is actually required"), **personal recognition** ("How satisfied are you with the recognition you receive for doing a good job?"), **decisional involvement** ("How satisfied are you with your involvement in decisions that affect your work?"), **overall satisfaction** ("Considering everything, how satisfied are you with your job?"), and **organization satisfaction** ("Considering everything, how satisfied are you with your organization?"). The first eight items are scored on a scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating stronger agreement. The remaining four items are scored on a scale ranging from 1 (Very Dissatisfied) to 5 (Very Satisfied), with higher scores indicating greater satisfaction with the survey item.

Like workplace characteristics, for MH professionals, male employees when compared to female employees endorsed slightly greater job satisfaction across most survey items, including overall satisfaction (3.95 vs. 3.86) and with their organization (3.69 vs. 3.58). Of significance, female employees had higher average scores for "extra effort" (i.e., "I always do more than is actually required") compared to male employees (4.35 vs. 4.29). Across 2016-2019, all items regarding job satisfaction increased or stayed the same, except for 'extra effort' which decreased from 2018 to 2019.

The MHPS also captures information regarding provider satisfaction with their role and the care they provide to Veterans. Most providers (77%) agreed or strongly agreed that, at the time of the survey, they were working at their highest level of licensure or scope. Approximately 73% of providers strongly agreed that through their work they help Veterans improve their lives. For the same survey item, only 1% of providers disagreed or strongly disagreed. Additionally, providers were asked if their facility offers best practices in mental health treatment which 43% agreed, 36% strongly agreed, and 10% disagreed or strongly disagreed. Similarly, providers were asked if their facility had effective mental health programs which 45% of providers agreed and 44% of providers strongly agreed to this statement. Considering all aspects of their position, providers were asked how satisfied they were with their job overall

where 44% responded they were satisfied, 24% were very satisfied, 15% were neutral to this question, 12% were dissatisfied with their job, and 6% were very dissatisfied with their job.

Provider Reported Burnout

AES measures employee withdrawal (burnout) through the following survey items: **moral distress** ("In the past year, how often did you experience moral distress at work?"), **exhaustion** ("I feel burned out from my work"), **depersonalization** ("I worry that this job is hardening me emotionally"), **reduced achievement** ("I have accomplished many worthwhile things in this job"), and **high burnout**. All survey items, aside from 'high burnout', are scored on a scale ranging from 0 (never) to 6 (every day), in which lower scores are preferable and indicate lower endorsement of feelings of burnout. 'Reduced achievement' is reverse scored (i.e., higher scores are more favorable). 'High burnout' is a measurement of the percentage of respondents who reported high frequencies (responded with a 4 or greater) on the three primary burnout symptoms (exhaustion, depersonalization, and reduced achievement). 'High burnout' is recorded as a percentage ranging from 0 – 100%, where lower numbers are more favorable.

The "high burnout" measure identifies those employees who most highly endorse the three primary burnout symptoms (exhaustion, depersonalization, and reduced achievement). In 2019, Pacific Islanders and American Indians accounted for less than 2% (0.9% and 0.6%, respectively) of the total respondent sample for 2019, however, these racial groups had the highest average scores for 'high burnout', 4.88 and 4.12, respectively. Additionally, employees aged 25 years and under had the highest 'high burnout' score (8.63) across all age groups. Those working in an "inpatient" setting reported the highest burnout score (5.18) compared to all other work settings. VA employees with a tenure of 15-20 years also reported the highest burnout (4.88) when compared to other employees' duration of VA employment. Over the past three years, 'high burnout' increased significantly from 2016 to 2018, however, as of 2019, the average percentage of employees who endorse 'high burnout' has decreased slightly from 3.75 in 2018 to 3.70.

The MHPS also inquired about professional burnout. When providers were asked if they believed their workload was reasonable given their job responsibilities, 45% agreed with this statement, 15% strongly agreed, 17% disagreed, and 10% strongly disagreed. Providers were asked, based on their definition of burnout, how they would rate their level of burnout where 18% reported no burnout, 45% reported occasional stress, 24% reported some burnout, 9% reported frequent burnout, and 5% of providers reported they were completely burnt out.

Recruitment and Retention of Mental Health Providers and Staff

Mental Health Hiring Initiative:

Table 5. Mental Health Initiative Hires and Net Gains for MH Positions

June 2017 to January 2019	Hires	Net Gains
Psychiatrists	602	119
Psychologists	1,125	265
LPMHC/MFT	142	88

June 2017 to January 2019	Hires	Net Gains
Peer Support	94	-5
Nurses (Mental Health)	921	92
Social Workers (Mental Health)	1,072	320
Veterans Crisis Line*	-	166
Total	**3,956**	**1,045**

*The Veterans Crisis Line (VCL) number of hires is blank due to the differences in tracking this information. Per Dr. Byrne, VCL consists of several different occupations that aren't identified in their tracking system used. The Human Capital Management office received data from VCL regarding how many positions they have at a given time, so they were able to calculate the net gains but not the total number of hires.

Table 5 includes the hires and net gains that took place during the 20 months of the MH Hiring Initiative provided by OHRM. It crossed several FYs and took place between June 2017 and January 2019. The VA hit the Mental Health Hiring Initiative (MHHI) goal January 31, 2019 with over 1,045 net Mental Health Providers (total of 3,956 hires)[23].

Per Ms. Pierce, from VHA Workforce Management and Consulting (WMC) Office, "the Mental Health Hiring Initiative (MHHI) is officially closed. In August 2019, The Office of Mental Health and Suicide Prevention (OMHSP) and Workforce Management & Consulting (WMC) kicked off the new Mental Health Hiring – Sustainability Initiative (MHH-SI) with a goal to continuing the collaboration by working as a unified healthcare system to analyze current workforce trends to help facilities address the constant increase in demand for mental health care to promote sustainable local facility recruiting, hiring, and retention practices. Collaboration between: OMHSP, WMC, Office of Nursing Service (ONS), Office of Social Work and Care Management, Office of Academic Affiliations (OAA), as well as VISN Chief HR officers, and VISN Chief MH leads."

OHRM is also involved in the development of the MH Retention and Hiring Integrated Project Team to carry out the focus and goals of MHH-SI. This project team is tasked with carrying out the necessary identified deliverables to review and analyze workforce and patient load data to determine trends in demand for mental healthcare to identify gaps and barriers and recommend the necessary enterprise-wide changes needed to achieve appropriate mental health staffing across the full continuum. One deliverable includes a MH hiring sustainment plan focused on promoting a sustainable local facility recruiting, hiring, and retention practices.

OHRM is also creating Trainee Recruitment Events (VA-TRE) dedicated to connecting, matching, placing, and retaining highly qualified VA Health Professions Trainees (HPTs). First two VA-TRE pilots, 134 HPTs accepted offers at VA's across the nation. Currently the third and fourth VA-TRE's (Mental Health focused) are underway.

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[23] Information provided by Ms. Jessica Pierce, Project Manager, Project Management Support from VHA Manpower Management Office (MMO), part of Human Capital Management, VHA Workforce Management and Consulting (WMC) Office.

Barriers to Recruitment and Retention

VA experiences significant shortages of mental health providers due to "widespread national shortages of mental health professionals, lengthy and inefficient hiring processes, and high turnover in some areas. Difficulty recruiting, problems with retention, and lengthy hiring procedures contribute to high vacancy rates throughout the system, and these vacancy rates can be a barrier to service. Furthermore, some locations lack the physical space needed to fill some vacancies or adequately accommodate the size of their Veteran population." (National Academies, 2018).

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APPENDIX A: COMPREHENSIVE ADDICTION AND RECOVERY ACT, SECTION 931

COMPREHENSIVE ADDICTION AND RECOVERY ACT OF 2016

PUBLIC LAW 114–198—JULY 22, 2016 130 STAT. 695
Public Law 114–198; 114th Congress

Subtitle C—Complementary and Integrative Health

SEC. 931. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

(a) ESTABLISHMENT.—There is established a commission to be known as the "Creating Options for Veterans' Expedited Recovery" or the "COVER Commission" (in this section referred to as the "Commission"). The Commission shall examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health conditions of veterans and the potential benefits of incorporating complementary and integrative health treatments available in non-Department facilities (as defined in section 1701 of title 38, United States Code).

(b) DUTIES.—The Commission shall perform the following duties:

(1) Examine the efficacy of the evidence-based therapy model used by the Secretary for treating mental health illnesses of veterans and identify areas to improve wellness-based outcomes.

(2) Conduct a patient-centered survey within each of the Veterans Integrated Service Networks to examine—

(A) the experience of veterans with the Department of Veterans Affairs when seeking medical assistance for mental health issues through the health care system of the Department;

(B) the experience of veterans with non-Department facilities and health professionals for treating mental health issues;

(C) the preference of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective;

(D) the experience, if any, of veterans with respect to the complementary and integrative health treatment therapies described in paragraph (3);

(E) the prevalence of prescribing prescription medication among veterans seeking treatment through the health care system of the Department as remedies for addressing mental health issues; and

(F) the outreach efforts of the Secretary regarding the availability of benefits and treatments for veterans for addressing mental health issues, including by identifying ways to reduce barriers to gaps in such benefits and treatments.

(3) Examine available research on complementary and integrative health treatment therapies for mental health issues and identify what benefits could be made with the inclusion of such treatments for veterans, including with respect to—

(A) music therapy;

(B) equine therapy;

(C) training and caring for service dogs;

(D) yoga therapy;

(E) acupuncture therapy;

(F) meditation therapy;

(G) outdoor sports therapy;

(H) hyperbaric oxygen therapy;

(I) accelerated resolution therapy;

(J) art therapy;

(K) magnetic resonance therapy; and

(L) other therapies the Commission determines appropriate.

(4) Study the sufficiency of the resources of the Department to ensure the delivery of quality health care for mental health issues among veterans seeking treatment within the Department.

(5) Study the current treatments and resources available within the Department and assess—

(A) the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans;

(B) the number of veterans who have been diagnosed with mental health issues;

(C) the percentage of veterans using the resources of the Department who have been diagnosed with mental health issues;

(D) the percentage of veterans who have completed counseling sessions offered by the Department; and

(E) the efforts of the Department to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered by the Department.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 10 members, appointed as follows:

(A) Two members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(B) Two members appointed by the minority leader of the House of Representatives, at least one of whom shall be a veteran.

(C) Two members appointed by the majority leader of the Senate, at least one of whom shall be a veteran.

(D) Two members appointed by the minority leader of the Senate, at least one of whom shall be a veteran.

(E) Two members appointed by the President, at least one of whom shall be a veteran.

(2) QUALIFICATIONS.—Members of the Commission shall be individuals who—

(A) are of recognized standing and distinction within the medical community with a background in treating mental health;

(B) have experience working with the military and veteran population; and

(C) do not have a financial interest in any of the complementary and integrative health treatments reviewed by the Commission.

(3) CHAIRMAN.—The President shall designate a member of the Commission to be the Chairman.

(4) PERIOD OF APPOINTMENT.—Members of the Commission shall be appointed for the life of the Commission.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(6) APPOINTMENT DEADLINE.—The appointment of members of the Commission in this section shall be made not later than 90 days after the date of the enactment of this Act.

(d) POWERS OF COMMISSION.—

(1) MEETINGS.—

(A) INITIAL MEETING.—The Commission shall hold its first meeting not later than 30 days after a majority of members are appointed to the Commission.

(B) MEETING.—The Commission shall regularly meet at the call of the Chairman. Such meetings may be carried out through the use of telephonic or other appropriate telecommunication technology if the Commission determines that such technology will allow the members to communicate simultaneously.

(2) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive evidence as the Commission considers advisable to carry out the responsibilities of the Commission.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission.

(4) INFORMATION FROM NONGOVERNMENTAL ORGANIZATIONS.—In carrying out its duties, the Commission may seek guidance through consultation with foundations, veteran service organizations, nonprofit groups, faith-based organizations, private and public institutions of higher education, and other organizations as the Commission determines appropriate.

(5) COMMISSION RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such record.

(6) PERSONNEL RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such records.

(7) COMPENSATION OF MEMBERS; TRAVEL EXPENSES.—Each member shall serve without pay but shall receive travel expenses to perform the duties of the Commission, including per diem in lieu of substances, at rates authorized under subchapter I of chapter 57 of title 5, United States Code.

(8) STAFF.—The Chairman, in accordance with rules agreed upon the Commission, may appoint and fix the compensation of a staff director and such other personnel as may be necessary to enable the Commission to carry out its functions, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, without regard to the provision of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this paragraph may exceed the equivalent of that payable for a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(9) PERSONNEL AS FEDERAL EMPLOYEES.—

(A) IN GENERAL.—The executive director and any personnel of the Commission are employees under section 2105 of title 5, United States Code, for purpose of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of such title.

(B) MEMBERS OF THE COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

(10) CONTRACTING.—The Commission may, to such extent and in such amounts as are provided in appropriations Acts, enter into contracts to enable the Commission to discharge the duties of the Commission under this Act.

(11) EXPERT AND CONSULTANT SERVICE.—The Commission may procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, at rates not to exceed the daily rate paid to a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(12) POSTAL SERVICE.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

(13) PHYSICAL FACILITIES AND EQUIPMENT.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act. These administrative services may include human resource management, budget, leasing accounting, and payroll services.

(e) REPORT.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—Not later than 60 days after the date on which the Commission first meets, and each 30-day period thereafter ending on the date on which the Commission submits the final report under paragraph (2), the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and the President a report detailing the level of cooperation the Secretary of Veterans Affairs (and the heads of other departments or agencies of the Federal Government) has provided to the Commission.

(B) OTHER REPORTS.—In carrying out its duties, at times that the Commission determines appropriate, the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and any other appropriate entities an interim report with respect to the findings identified by the Commission.

(2) FINAL REPORT.—Not later than 18 months after the first meeting of the Commission, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate, the President, and the Secretary of Veterans Affairs a final report on the findings of the Commission. Such report shall include the following:

(A) Recommendations to implement in a feasible, timely, and cost-efficient manner the solutions and remedies identified within the findings of the Commission pursuant to subsection (b).

(B) An analysis of the evidence-based therapy model used by the Secretary of Veterans Affairs for treating veterans with mental health care issues, and an examination of the prevalence and efficacy of prescription drugs as a means for treatment.

(C) The findings of the patient-centered survey conducted within each of the Veterans Integrated Service Networks pursuant to subsection (b)(2).

(D) An examination of complementary and integrative health treatments described in subsection (b)(3) and the potential benefits of incorporating such treatments in the therapy models used by the Secretary for treating veterans with mental health issues.

(3) PLAN.—Not later than 90 days after the date on which the Commission submits the final report under paragraph (2), the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the following:

(A) An action plan for implementing the recommendations established by the Commission on such solutions and remedies for improving wellness-based outcomes for veterans with mental health care issues.

(B) A feasible timeframe on when the complementary and integrative health treatments described in subsection (b)(3) can be implemented Department-wide.

(C) With respect to each recommendation established by the Commission, including any complementary and integrative health treatment, that the Secretary determines is not appropriate or feasible to implement, a justification for such determination and an alternative solution to improve the efficacy of the therapy models used by the Secretary for treating veterans with mental health issues.

(f) TERMINATION OF COMMISSION.—The Commission shall terminate 30 days after the Commission submits the final report under subsection (e)(2).

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

APPENDIX B: KEY QUESTIONS ALIGNED TO THE DUTY 4 LEGISLATION AND QUADRUPLE AIM

Quadruple Aim	Key Questions
1. Patient's experience of Care and 2. Population Health	▪ What is the current number of MH professionals? What is the current number of VA vacancies for MH health professionals? ▪ What is the appropriate panel size for providers including Suicide Prevention Coordinators? ▪ What is the current number of certified peer support specialists at VAMCs for MH? What is the current number of peers for WH? ▪ How many vacant peer support positions are there? How many vacant positions for those working in WH? ▪ What are the current wait times for seeking MH services at VAMCs and CBOCs for initial access? Sustained access? ▪ Do Veterans report getting mental health appointments in a timely manner? CIH appointments? ▪ Is there appropriate physical space allocated for MH treatments and services offered? Including CIH treatments and services offered? ▪ Does the VA formulary include the evidence-based pharmacotherapies that Veterans need for mental health conditions (the MH conditions aligned to Duty 3)?
3. Per Capita Cost	▪ What are the average daily costs of VA inpatient care for MH services? ▪ What are the overall lengths of stay for psychiatric inpatient programs? Residential Rehabilitation & Treatment Programs? ▪ What are the average annual outpatient cost For Veterans with PTSD, MDD, AUD, OUD, Schizophrenia, Bipolar Disorder, GAD and Chronic Insomnia Disorder? ▪ What is the cost of Suicide Prevention Programs?

Quadruple Aim	Key Questions
4. Providers' experience, satisfaction, and well-being	▪ Do MH providers feel they have adequate resources to provide quality evidence-based care? – Support staff – Training/Education? – Technology – Space ▪ Are providers satisfied with the care they provide? With their jobs? ▪ What is the level of burnout reported by providers? Over the past three years? ▪ What has VHA done to improve recruitment and retention of MH providers (to include SUD providers)?

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

APPENDIX C: ADDITIONAL DATA BY DATA SOURCE

Peer Support Specialists

A copy of Public Law 110-387 is embedded below.

Public Law
110-387_Accessed 0!

The following were PSS data provided by Ms. Ellen Bradley, Director of Information Reporting, ARC is aggregated by VISN.

Table C-1. Peer Provider Activity in FY 2016

VISN	#of VAMCs	Peer Providers	FTEE*	Encounters
1	5	22	6.8	9,846
2	7	29	12.1	19,740
4	8	39	14.1	24,065
5	4	22	9.9	20,827
6	7	39	17.5	32,299
7	5	63	25.4	40,856
8	6	75	42.8	80,666
9	1	7	2.6	3,765
10	10	77	37	62,264
12	6	30	10.9	16,700
15	6	27	12.6	20,856
16	6	54	20.8	33,111
17	5	22	12.2	27,509
19	5	47	12.7	18,960
20	5	31	14.6	22,743
21	5	37	11.5	16,124
22	7	86	31.9	54,439
23	6	24	14.4	23,181
n=18	**104**	**731**	**309.8**	**527,951**

*FTEE are calculated based on the days the peer counselor works and their encounters.

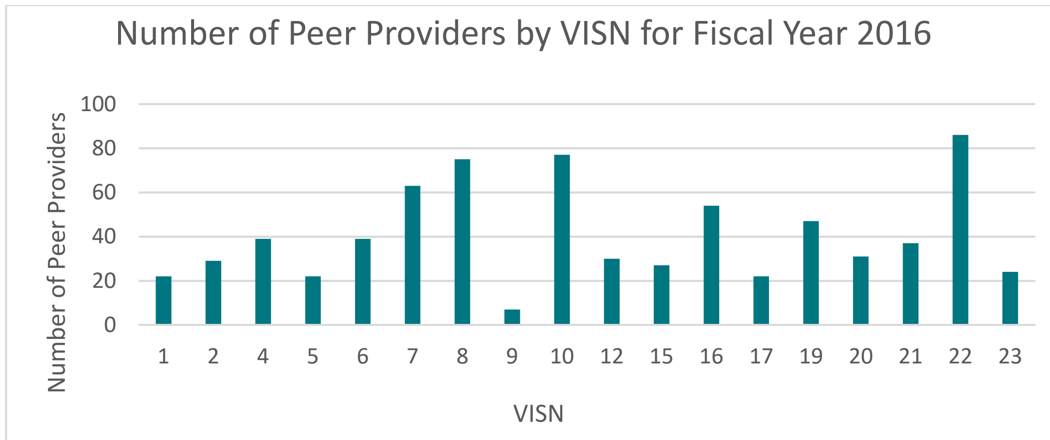


Table C-2. Peer Provider Activity in FY 2017

VISN	#of VAMCs	Peer Providers	FTEE*	Encounters
1	7	37	13.3	20,115
2	7	27	15.1	24,107
4	8	38	15.8	24,989
5	4	22	9.8	16,827
6	7	41	24.5	45,575
7	5	59	26.3	40,296
8	7	78	44.6	80,326
9	2	14	3.8	5,966
10	10	80	41.3	65,181
12	6	30	15.6	31,240
15	6	25	14.5	21,270
16	6	58	22.4	34,331
17	5	32	18.1	38,583
19	5	45	14.3	19,625
20	6	37	15.7	23,829
21	6	39	13.4	17,900
22	8	97	30.8	52,708
23	7	26	14.9	22,805
n=18	**112**	**785**	**354.2**	**585,673**

*FTEE are calculated based on the days the peer counselor works and their encounters.

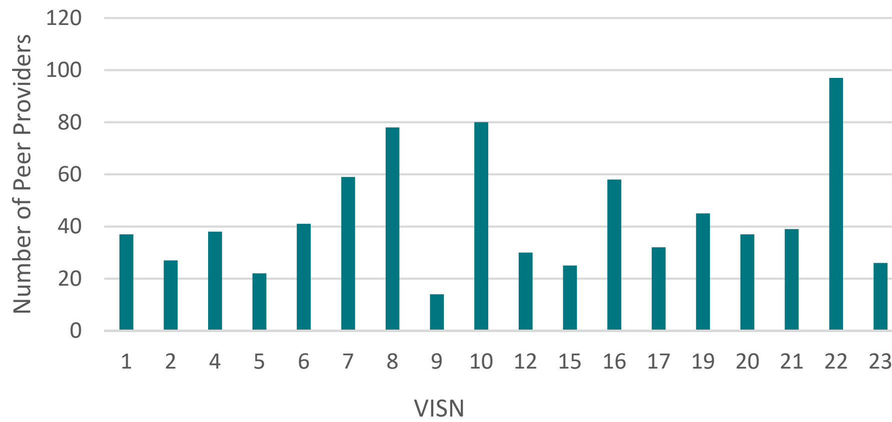
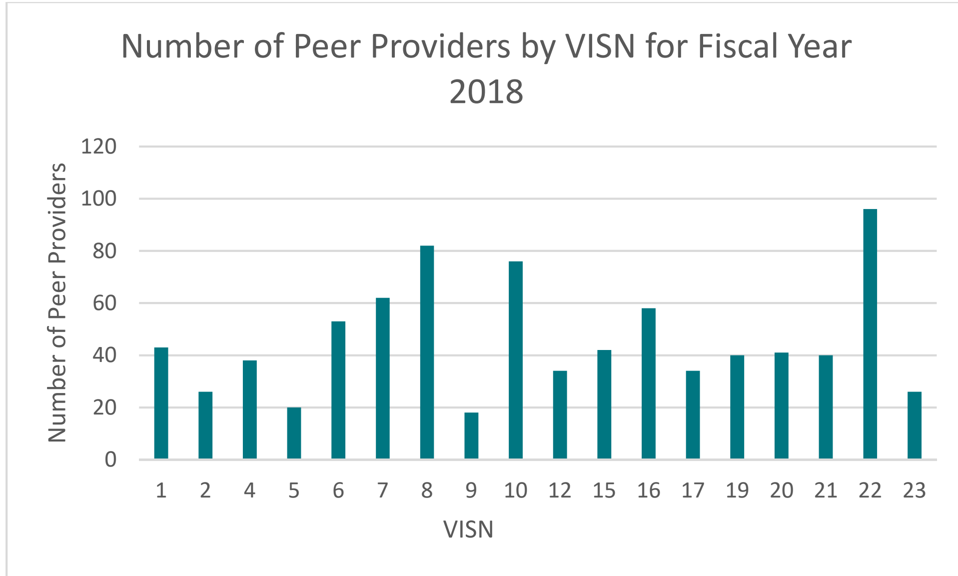


Table C-3. Peer Provider Activity in FY 2018

VISN	#of VAMCs	Peer Providers	FTEE*	Encounters
1	8	43	16.7	23,841
2	7	26	15.7	25,796
4	8	38	16.8	26,652
5	4	20	10.9	22,820
6	7	53	29	50,936
7	5	62	29.5	49,246
8	7	82	48.6	84,886
9	3	18	7.8	10,517
10	10	76	41	63,643
12	7	34	15.4	30,294
15	6	42	17	20,374
16	7	58	23.5	36,293
17	6	34	20.7	39,170
19	5	40	14.5	20,737
20	7	41	16.6	24,723
21	6	40	16.2	22,384
22	8	96	30.3	51,784
23	7	26	14	20,258
n=18	**118**	**829**	**384.2**	**624,354**

*FTEE are calculated based on the days the peer counselor works and their encounters.



The following tables were provided by the Office of Mental Health & Suicide Prevention.

The table below is from the FY 2017 National Mental Health Data Sheet from OMHSP.

Table 4: Mental Health Workload--FY 2017, by VISN

VISN	Total Service Users	Number of Service Users Who Received Mental Health Services	Percent of Service Users Who Received Mental Health Services	Unique Veterans Seen In			Mental Health Service Use by Service Setting Type			Average O/P Stops by Stop Type (Among Veterans with >=1 Stop)			Average Daily Census		
				Inpatient Mental Health	Residential Mental Health	Outpatient Mental Health	Inpatient Stays	Residential Stays	Encounters	Psychiatry	Substance Use Disorder	All Mental Health	MH Inpatient	MH Residential	All MH Bed Types
1	246,131	68,099	27.7%	3,515	1,325	68,098	5,881	1,879	1,066,543	13.1	24.7	15.7	230	220	450
2	287,998	81,080	28.2%	3,418	2,937	81,077	5,255	3,735	1,342,527	14.7	21.7	16.6	205	553	759
4	285,089	70,155	24.6%	3,161	2,326	70,153	4,684	2,982	1,013,522	12.3	17.8	14.4	141	343	484
5	203,519	58,088	28.5%	1,657	1,722	58,085	2,361	2,042	778,567	10.5	33.8	13.4	50	378	428
6	368,799	112,018	30.4%	4,089	1,826	112,014	5,802	2,073	1,151,535	9.2	13.7	10.3	175	227	402
7	430,662	134,865	31.3%	3,489	2,068	134,863	4,657	2,251	1,506,919	9.8	21.2	11.2	140	367	508
8	576,393	159,758	27.7%	5,314	1,697	159,752	7,761	1,928	1,838,048	10.3	16.6	11.5	180	300	481
9	269,882	75,986	28.2%	3,554	1,234	75,983	5,086	1,387	778,451	9.2	18.4	10.2	108	168	276
10	485,019	127,266	26.2%	4,361	3,509	127,245	5,930	4,066	1,695,285	11.4	20.5	13.3	186	557	743
12	276,556	70,093	25.3%	3,096	2,261	70,089	4,990	2,829	1,148,736	14.5	21.5	16.4	109	345	454
15	237,402	62,712	26.4%	2,639	1,393	62,709	3,928	1,767	794,018	10.6	31.0	12.7	83	217	300
16	408,727	121,556	29.7%	4,210	1,535	121,552	5,852	1,725	1,340,766	9.5	20.8	11.0	162	205	366
17	386,544	121,276	31.4%	3,042	2,861	121,273	4,197	3,489	1,377,547	10.2	20.6	11.4	68	521	589
19	298,033	78,174	26.2%	2,531	1,067	78,171	3,510	1,230	866,133	9.7	14.8	11.1	99	162	261
20	290,782	72,132	24.8%	1,781	2,132	72,123	2,337	2,461	857,332	10.2	18.2	11.9	47	375	422
21	340,262	93,219	27.4%	2,713	622	93,209	4,014	764	1,041,588	9.8	16.4	11.2	101	123	224
22	473,219	143,794	30.4%	4,742	2,184	143,791	6,808	2,549	1,804,064	11.3	20.1	12.5	198	494	692
23	313,858	65,024	20.7%	2,055	2,534	65,023	2,774	2,965	914,801	13.0	16.0	14.1	64	314	378
All VA	5,895,685	1,670,515	28.3%	57,889	34,363	1,670,444	85,827	42,122	21,325,762	11.2	20.1	12.8	2,349	5,867	8,216

The table below is from the FY 2018 National Mental Health Data Sheet from OMHSP.

Table 4: Mental Health Workload--FY 2018, by VISN

VISN	Total Service Users	Number of Service Users Who Received Mental Health Services	Percent of Service Users Who Received Mental Health Services	Unique Veterans Seen In			Mental Health Service Use by Service Setting Type			Average O/P Stops by Stop Type (Among Veterans with >=1 Stop)			Average Daily Census		
				Inpatient Mental Health	Residential Mental Health	Outpatient Mental Health	Inpatient Stays	Residential Stays	Encounters	Psychiatry	Substance Use Disorder	All Mental Health	MH Inpatient	MH Residential	All MH Bed Types
1	246,196	68,250	27.7%	3,356	1,302	68,247	5,619	1,861	1,064,344	13.0	24.8	15.6	232	225	457
2	285,150	81,203	28.5%	3,483	2,809	81,202	5,177	3,554	1,348,344	14.8	21.1	16.6	180	542	722
4	292,051	72,207	24.7%	3,029	2,214	72,204	4,362	2,740	1,002,490	11.8	18.7	13.9	125	322	447
5	206,083	59,946	29.1%	1,596	1,763	59,940	2,329	2,018	784,080	10.5	31.3	13.1	47	361	408
6	378,627	115,182	30.4%	3,921	1,832	115,175	5,638	2,229	1,150,682	9.0	13.0	10.0	159	228	387
7	439,612	140,702	32.0%	3,149	2,179	140,700	4,133	2,423	1,547,116	9.9	16.7	11.0	135	372	506
8	582,315	163,838	28.1%	5,274	1,777	163,834	7,702	1,961	1,836,123	10.0	17.9	11.2	185	297	482
9	272,421	77,652	28.5%	3,494	1,277	77,649	5,105	1,426	799,896	9.2	16.8	10.3	99	166	265
10	490,472	128,986	26.3%	4,185	3,426	128,977	5,696	3,967	1,681,566	11.1	19.8	13.0	161	559	721
12	274,700	70,746	25.8%	3,125	2,248	70,742	4,922	2,749	1,111,228	14.0	19.6	15.7	105	349	454
15	239,276	62,258	26.0%	2,596	1,479	62,258	3,849	1,832	772,230	10.7	26.5	12.4	79	224	303
16	412,713	123,091	29.8%	4,323	1,544	123,084	6,037	1,765	1,311,232	9.3	18.9	10.7	163	203	366
17	398,007	126,581	31.8%	3,158	2,700	126,579	4,364	3,199	1,361,361	9.6	19.7	10.8	69	459	528
19	303,862	80,095	26.4%	2,486	1,099	80,089	3,539	1,258	876,486	9.7	14.9	10.9	94	173	268
20	298,758	73,400	24.6%	1,759	2,029	73,392	2,344	2,390	867,847	10.4	16.9	11.8	48	363	411
21	344,642	93,449	27.1%	2,820	630	93,439	4,102	778	1,053,726	9.9	17.0	11.3	91	127	217
22	481,047	147,913	30.7%	4,528	2,198	147,909	6,459	2,611	1,797,916	11.0	18.7	12.2	184	427	611
23	315,924	65,997	20.9%	2,161	2,548	65,993	2,971	2,945	884,564	12.4	15.1	13.4	71	312	384
All VA	5,954,537	1,703,862	28.6%	56,929	34,018	1,703,798	84,348	41,706	21,261,879	11.0	19.2	12.5	2,226	5,709	7,936

The following data were provided from the PAID database by Dan O'Brien-Mazza, National Director, Peer Support Services, Office of Mental Health & Suicide Prevention (OMHSP), VHA. The data is aggregated by VISN.

Table C-4. Current Number of Peer Support Specialists, VISN, as of September 2019

VISN	Number of total PSS*	Number of PSS**	Number of Apprentices
1	75	69	6
2	47	44	3
4	38	37	1
5	48	48	0
6	52	51	1
7	75	73	2
8	94	91	3
9	43	39	4
10	94	89	5
12	54	45	9
15	34	31	3
16	79	75	4
17	60	56	4
19	45	40	5
20	45	45	0
21	95	81	14
22	123	119	4
23	27	22	5
Totals:18	**1,128**	**1,055**	**73**

*This includes apprentices, health techs (categorized as peer support) and peer support specialists
**The number of PSS includes health techs categorized as peer support

Table C-5. Turnover Rates of Peer Support Five-Year Total from FY 2014-2018

Measure	FY2014	FY2015	FY2016	FY2017	FY2018	5-Year Average
Onboard Employee	967	1,112	1,107	1,078	1,059	
Distinct VA Total Loss Number	110	90	97	110	98	
Distinct VA Total Loss Rate	11.4%	8.7%	8.8%	10.1%	9.1%	**9.6%**

Pharmacy Benefits Management

The Pharmacy Benefits Management Formulary Management Program Office is responsible for coordinating the VA formulary management process with the Medical Advisory Panel and VISN Pharmacist Executives Committee. It has the following responsibilities:

- Developing and maintaining an Evidence-based formulary
- Standardizing the drug benefit across the VA system to reduce geographic variation in cost and utilization
- Promoting appropriate drug therapy
- Improving drug safety
- Improving the distribution of pharmaceuticals
- Reducing drug inventory and acquisition costs

Table C-6. Evidence Based Pharmacologic Treatments for Specific Mental Health Conditions[1]

Evidence-based Pharmacologic Treatments for Specific Mental Health Conditions	Included
Major Depressive Disorder (MDD)	
Antidepressant Medications	
Citalopram	Yes
Escitalopram	Yes
Fluoxetine	Yes
Paroxetine	Yes
Sertraline	Yes
Vilazodone	No
Duloxetine	Yes
Venlafaxine	Yes
Levomilnacipran	No
Desvenlafaxine	Yes
Vortioxetine	No
Bupropion	Yes
Trazodone	Yes
Nefazodone	No
Mirtazapine	Yes
Amitriptyline	Yes
Imipramine	Yes
Nortriptyline	Yes
Desipramine	Yes
Doxepin	Yes
Isocarboxazid	No
Phenelzine	Yes
Selegiline patch	Yes
Tranylcypromine	Yes
Esketamine*	Yes
Augmentation, Adjunct and Alternative Medications	
Aripiprazole	Yes
Olanzapine	Yes
Quetiapine	Yes
Risperidone	Yes
Ziprasidone	Yes

Evidence-based Pharmacologic Treatments for Specific Mental Health Conditions	Included
Buspirone	Yes
Lithium	Yes
Liothyronine	Yes
St. John's wort	No
Post-Traumatic Stress Disorder (PTSD)	
Sertraline	Yes
Paroxetine	Yes
Fluoxetine	Yes
Venlafaxine	Yes
Nefazadone	No
Imipramine	Yes
Phenelzine	Yes
Substance Use Disorder (SUD)	
Insufficient evidence to support use of pharmacotherapy for any other substance use disorders other than Opioid Use Disorder (OUD) or Alcohol Use Disorder (AUD) as listed below.	
Opioid Use Disorder (OUD)	
Methadone	Yes
Buprenorphine or buprenorphine/naloxone	Yes
Naltrexone injectable	Yes
Alcohol Use Disorder (AUD)	
Naltrexone oral	Yes
Naltrexone injectable	Yes
Acamprosate	Yes
Disulfiram	Yes
Topiramate	Yes
Gabapentin	Yes
Generalized Anxiety Disorder (GAD)	
First Line Treatments	
Venlafaxine XR	Yes
Duloxetine	Yes
Paroxetine	Yes
Escitalopram	Yes
Sertraline	Yes
Fluoxetine	Yes
Second Line Treatments	
Diazepam	Yes
Alprazolam	Yes
Lorazepam	Yes
Clonazepam	Yes
Buspirone	Yes
Other Medications	
Hydroxyzine	Yes
Imipramine	Yes
Trazodone	Yes
Mirtazapine	Yes
Bupropion XL	Yes
Pregabalin	Yes
Quetiapine	Yes
Vortioxetine	No

Evidence-based Pharmacologic Treatments for Specific Mental Health Conditions	Included
Augmentation Agents	
Olanzapine	Yes
Risperidone	Yes
Quetiapine	Yes
Pregabalin	Yes
Bipolar Disorder (BPD)	
Lithium	Yes
Aripiprazole	Yes
Asenapine	No
Cariprazine	No
Olanzapine	Yes
Olanzapine/fluoxetine combination	Yes
Quetiapine	Yes
Risperidone	Yes
Ziprasidone	Yes
Carbamazepine	Yes
Lamotrigine	Yes
Divalproex sodium or valproate	Yes
Chronic Insomnia Disorder	
Suvorexant	No
Eszopiclone	Yes
Zaleplon	Yes
Zolpidem	Yes
Triazolam	No
Temazepam	Yes
Ramelteon	No
Doxepin	Yes
Suicidal Ideation	
Ketamine infusion (in patients with major depressive disorder)	Yes
Lithium (in patients with unipolar or bipolar depression)	Yes
Clozapine (in patients with schizophrenia)	Yes

[1]Pharmacologic Treatments not included in the VA National Formulary as of October 2019 are shaded in gray.

*This medication is not listed as a recommended treatment in the Clinical Practice Guideline cited above but was newly FDA-approved for treatment resistant-depression on March 5, 2019 and is now available for use within VHA.

All Employee Survey

Table C-7. Average Workplace Characteristic Scores by Survey Year, MH Professionals

	2016	2017	2018	2019	All FY
Resources I have the appropriate supplies, materials, and equipment to perform my job well.	3.58	3.56	3.66	3.71	3.63
Workload My workload is reasonable.	3.60	3.58	3.63	3.60	3.60
Workgroup Competency My work unit has the job-relevant knowledge and skills necessary to accomplish organizational goals.	*	*	4.10	4.11	4.11
Skill Development I am given a real opportunity to improve my skills in my organization.	3.71	3.72	3.80	3.81	3.76
Innovation I feel encouraged to come up with new and better ways of doing things.	*	*	3.68	3.70	3.69

*** Item not included in survey for that year**
All items are scored on a scale ranging from 1 - 6; 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree; 6 = Do Not Know. Higher values indicate greater agreement with survey item.

Table C-7 summarizes trends across average score on workplace characteristics by each year the survey has been administered. Survey items regarding workplace characteristics were scored on a scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating stronger agreement to the survey item. On average, the scores for 'resources' and 'skill development' have increased over the past three years. The scores for 'innovation' and 'work competency' saw a slight increased from 2018 to 2019, however, these two survey domains were first introduced during the 2018 AES survey cycle and therefore, analyses are limited to those two years. There was a significant increase in the average scores for 'workload' from 2017 to 2018, followed by a notable decrease in average score from 2018 to 2019.

Table C-8 provides a summary of the average scores for workplace characteristics across a sample of respondents that provide mental health services (N = 18, 500). On average, male respondents scored higher than female respondents across all survey items. Respondents that self-identified as Asian, on average, scored higher on 'resources', 'workload', 'skill development', and 'innovation' within the workplace, while White respondents scored the highest on 'workplace competency'. Average score did not vary significantly between age groups, however, respondents ages 26 – 29 years consistently scored marginally higher when compared to every other age group. Work setting referred to the primary area within the VA where respondents worked. Respondents that worked in a research setting had the highest scores for 'workload', 'workgroup competency', 'skill development', and 'innovation'. Respondents who have been employed with the VA for less than 6-months, on average, scored the highest across every survey item.

Table C-8. Average Workplace Characteristic Scores by Respondent Characteristics, Mental Health Professionals

	Resources	Workload	Workgroup Competency	Skill Development	Innovation
Gender					
Male	3.80	3.70	4.17	3.88	3.78
Female	3.68	3.57	4.09	3.79	3.68
Race					
White	3.72	3.58	4.15	3.85	3.73
Black	3.80	3.78	4.06	3.75	3.70
Amer Indian	3.54	3.58	4.04	3.52	3.55
Asian	3.84	3.83	4.14	3.94	3.85
Pac Islander	3.62	3.57	3.97	3.48	3.44
Multi-Racial	3.57	3.43	3.95	3.62	3.56
Ethnicity					
Hispanic	3.74	3.66	4.11	3.84	3.75
Not Hispanic	3.72	3.62	4.12	3.82	3.71
Age					
25 and under	3.82	3.75	3.87	3.75	3.68
26-29	3.92	3.80	4.13	3.98	3.77
30-39	3.73	3.60	4.11	3.90	3.77
40-49	3.69	3.58	4.10	3.80	3.72
50-59	3.69	3.62	4.10	3.74	3.66
60 years or older	3.78	3.65	4.20	3.80	3.68
Work Setting					
Administrative	3.75	3.53	4.06	3.72	3.72
Inpatient	3.77	3.92	3.99	3.73	3.72
Outpatient	3.69	3.51	4.14	3.77	3.60
Extended	3.89	3.93	4.04	3.83	3.77
Research	3.97	4.12	4.52	4.18	4.18
Education	3.67	3.98	4.08	4.02	4.08
Affiliate	2.90	3.73	3.70	3.18	3.20
NCA Field Prog.	4.00	3.23	3.86	3.36	3.50
Multiple Areas	3.72	3.55	4.16	3.93	3.84
VA Years					
<6 mos	3.92	4.02	4.31	4.12	4.01
6 mos-1 yr	3.82	3.85	4.15	3.99	3.80
1-2 yrs	3.80	3.72	4.14	3.91	3.79
2-5 yrs	3.69	3.60	4.06	3.82	3.67
5-10 yrs	3.67	3.51	4.10	3.77	3.67
10-15 yrs	3.67	3.51	4.14	3.77	3.71
15-20 yrs	3.79	3.61	4.10	3.69	3.61
>20 yrs	3.78	3.71	4.19	3.77	3.70
VISN					
VISN 1	3.70	3.56	4.17	3.84	3.77
VISN 2	3.73	3.67	4.08	3.76	3.70
VISN 4	3.73	3.56	4.05	3.75	3.67
VISN 5	3.63	3.71	4.15	3.92	3.72
VISN 6	3.57	3.61	4.12	3.76	3.63
VISN 7	3.62	3.51	4.01	3.61	3.47

	Resources	Workload	Workgroup Competency	Skill Development	Innovation
VISN 8	3.73	3.61	4.13	3.77	3.64
VISN 9	3.75	3.69	4.11	3.88	3.74
VISN 10	3.80	3.58	4.13	3.83	3.69
VISN 12	3.75	3.62	4.14	3.80	3.73
VISN 15	3.79	3.69	4.19	3.90	3.82
VISN 16	3.73	3.65	4.08	3.78	3.61
VISN 17	3.69	3.53	4.05	3.82	3.70
VISN 19	3.59	3.56	4.10	3.72	3.68
VISN 20	3.76	3.62	4.19	3.93	3.80
VISN 21	3.74	3.60	4.13	3.89	3.79
VISN 22	3.69	3.67	4.14	3.88	3.76
VISN 23	3.84	3.59	4.11	3.91	3.76

All items are scored on a scale ranging from 1 - 6; 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree; 6 = Do Not Know. Higher values indicate greater agreement with survey item.

Table C-9. Average Job Satisfaction Scores by Respondent Characteristics, Mental Health Professionals

	Supervisor Listening	Supervisor Respect	Supervisor Trust	Workgroup Respect	Workgroup Collaboration	Workgroup Communication	Workplace Inspiration	Extra Effort
Gender								
Male	4.22	4.37	4.13	4.11	3.76	4.01	3.60	4.29
Female	4.11	4.27	3.97	3.95	3.67	3.81	3.49	4.35
Race								
White	4.19	4.35	4.06	4.06	3.71	3.92	3.52	4.33
Black	4.07	4.21	3.92	3.82	3.71	3.77	3.61	4.37
Amer Indian	3.99	4.18	3.84	3.87	3.53	3.70	3.46	4.27
Asian	4.20	4.34	4.16	4.10	3.87	3.98	3.70	4.36
Pac Islander	3.81	3.97	3.75	3.69	3.46	3.56	3.32	4.26
Multi-Racial	3.99	4.19	3.90	3.81	3.55	3.72	3.37	4.29
Ethnicity								
Hispanic	4.15	4.30	4.02	3.94	3.73	3.83	3.59	4.35
Not Hispanic	4.15	4.31	4.03	4.01	3.70	3.89	3.52	4.33
Age								
25 and under	4.01	4.14	3.96	3.65	3.65	3.61	3.50	4.10
26-29	4.24	4.41	4.14	3.97	3.81	3.83	3.65	4.22
30-39	4.22	4.39	4.08	4.03	3.73	3.89	3.52	4.30
40-49	4.14	4.29	3.99	4.00	3.67	3.88	3.50	4.32
50-59	4.09	4.24	3.97	3.94	3.66	3.83	3.51	4.37
60 years or older	4.13	4.30	4.06	4.09	3.76	3.97	3.59	4.39
Work Setting								
Administrative	4.11	4.26	3.99	3.93	3.66	3.82	3.53	4.33
Inpatient	4.03	4.18	3.92	3.69	3.66	3.65	3.60	4.28
Outpatient	4.12	4.30	4.00	4.07	3.68	3.93	3.45	4.31
Extended	3.98	4.11	3.89	3.63	3.68	3.60	3.61	4.20
Research	4.32	4.42	4.21	4.44	4.27	4.16	4.22	4.35
Education	4.23	4.34	4.13	4.02	3.83	3.78	3.78	4.20
Affiliate	4.27	4.27	3.82	3.36	3.18	3.20	3.30	4.00
NCA Field Programs	3.79	3.86	3.69	3.64	3.57	3.38	3.62	4.36

	Supervisor Listening	Supervisor Respect	Supervisor Trust	Workgroup Respect	Workgroup Collaboration	Workgroup Communication	Workplace Inspiration	Extra Effort
Multiple Areas	4.23	4.38	4.09	4.09	3.75	3.94	3.56	4.40
VA Years								
<6 mos	4.40	4.51	4.34	4.24	4.09	4.14	4.06	4.23
6 mos-1 yr	4.27	4.42	4.19	4.03	3.82	3.90	3.79	4.28
1-2 yrs	4.25	4.39	4.14	4.00	3.75	3.87	3.64	4.32
2-5 yrs	4.13	4.31	4.00	3.95	3.67	3.81	3.50	4.33
5-10 yrs	4.13	4.28	3.98	4.01	3.65	3.89	3.42	4.36
10-15 yrs	4.09	4.24	3.95	4.01	3.66	3.90	3.45	4.34
15-20 yrs	4.09	4.25	3.98	3.94	3.67	3.84	3.45	4.32
>20 yrs	4.08	4.25	3.99	4.02	3.74	3.92	3.58	4.38
VISN								
VISN 1	4.26	4.40	4.13	4.07	3.76	3.94	3.54	4.34
VISN 2	4.12	4.26	4.00	3.94	3.67	3.83	3.52	4.33
VISN 4	4.06	4.19	3.93	3.83	3.66	3.72	3.53	4.29
VISN 5	4.27	4.39	4.12	4.05	3.72	3.92	3.58	4.36
VISN 6	4.09	4.27	3.94	4.03	3.67	3.89	3.46	4.34
VISN 7	4.05	4.25	3.95	3.90	3.52	3.82	3.32	4.33
VISN 8	4.09	4.30	4.02	4.01	3.74	3.91	3.52	4.41
VISN 9	4.11	4.26	3.98	4.03	3.77	3.91	3.60	4.37
VISN 10	4.10	4.28	3.99	4.03	3.68	3.91	3.53	4.30
VISN 12	4.11	4.29	3.96	3.89	3.74	3.78	3.60	4.34
VISN 15	4.22	4.39	4.13	4.07	3.74	3.94	3.61	4.34
VISN 16	4.05	4.20	3.89	3.89	3.61	3.77	3.48	4.37
VISN 17	4.12	4.28	3.98	3.90	3.71	3.79	3.50	4.32
VISN 19	4.11	4.29	4.03	4.07	3.66	3.93	3.37	4.28
VISN 20	4.19	4.34	4.03	4.12	3.74	3.93	3.44	4.26
VISN 21	4.23	4.36	4.09	4.11	3.79	3.94	3.60	4.36
VISN 22	4.14	4.31	4.06	4.05	3.79	3.96	3.56	4.33
VISN 23	4.17	4.31	4.03	3.95	3.67	3.84	3.58	4.26

All items are scored on a scale ranging from 1 - 6; 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree; 6 = Do Not Know. Higher values indicate greater agreement with survey item.

See Tables C-9 and C-10 for a summary of average score for job satisfaction across a sample of respondents who provide mental health services. On average, Male respondents scored higher than Female respondents across all job satisfaction survey items except ‘extra effort’. When compared to all other research settings, on average, respondents who worked in a research setting scored higher across all job satisfaction survey items. Respondents working in affiliate settings scored significantly lower than average on ‘decisional involvement’. Respondents who were employed with the VA for less than 6-months, on average, scored the highest on all job satisfaction items except for ‘extra effort’ – which saw the highest average scores from respondents who were employed with the VA for over 20-years.

Table C-10. Average Job Satisfaction Scores by Respondent Characteristics, Mental Health Professionals

	Personal Recognition	Decisional Involvement	Overall Satisfaction	Organization Satisfaction
Gender				
Male	3.59	3.53	3.95	3.69
Female	3.40	3.38	3.86	3.58
Race				
White	3.46	3.43	3.88	3.60
Black	3.52	3.50	3.99	3.73
Amer Indian	3.25	3.33	3.83	3.56
Asian	3.68	3.69	3.96	3.78
Pac Islander	3.28	3.23	3.70	3.42
Multi-Racial	3.30	3.23	3.71	3.43
Ethnicity				
Hispanic	3.48	3.49	3.92	3.67
Not Hispanic	3.47	3.43	3.89	3.62
Age				
25 and under	3.43	3.47	3.70	3.60
26-29	3.56	3.53	3.88	3.72
30-39	3.46	3.44	3.84	3.61
40-49	3.45	3.45	3.85	3.59
50-59	3.44	3.40	3.91	3.63
60 years or older	3.56	3.45	4.04	3.67
Work Setting				
Administrative	3.46	3.46	3.82	3.57
Inpatient	3.51	3.50	3.91	3.74
Outpatient	3.40	3.33	3.85	3.54
Extended	3.52	3.58	3.90	3.67
Research	3.94	4.13	4.12	4.15
Education	3.72	3.66	4.06	3.77
Affiliate	3.00	2.82	3.64	3.45
NCA Field Programs	3.79	3.21	4.07	3.57
Multiple Areas	3.51	3.51	3.91	3.63
VA Years				
<6 mos	3.95	3.86	4.18	4.11
6 mos-1 yr	3.70	3.64	4.05	3.89
1-2 yrs	3.57	3.52	3.97	3.77
2-5 yrs	3.42	3.38	3.85	3.59
5-10 yrs	3.38	3.36	3.81	3.52
10-15 yrs	3.38	3.38	3.84	3.51
15-20 yrs	3.42	3.43	3.85	3.56
>20 yrs	3.53	3.48	3.99	3.64
VISN				
VISN 1	3.50	3.42	3.88	3.56
VISN 2	3.49	3.51	3.88	3.59
VISN 4	3.44	3.37	3.80	3.58
VISN 5	3.57	3.49	4.00	3.65
VISN 6	3.43	3.41	3.87	3.60

	Personal Recognition	Decisional Involvement	Overall Satisfaction	Organization Satisfaction
VISN 7	3.29	3.23	3.78	3.42
VISN 8	3.45	3.41	3.89	3.67
VISN 9	3.52	3.50	3.96	3.73
VISN 10	3.45	3.37	3.86	3.65
VISN 12	3.49	3.45	3.93	3.73
VISN 15	3.53	3.51	3.96	3.68
VISN 16	3.39	3.36	3.84	3.59
VISN 17	3.41	3.45	3.80	3.57
VISN 19	3.33	3.34	3.76	3.44
VISN 20	3.53	3.39	3.80	3.45
VISN 21	3.54	3.56	3.86	3.66
VISN 22	3.55	3.52	3.92	3.64
VISN 23	3.46	3.42	3.90	3.66

All items are scored on a scale ranging from 1 - 6; 1 = Very Dissatisfied; 2 = Dissatisfied; 3 = Neutral; 4 = Satisfied; 5 = Very Satisfied; 6 = Not Applicable. Higher values indicate greater satisfaction with survey item.

Table C-11. Average Job Satisfaction Scores by Survey Year, MH Professionals

	2016	2017	2018	2019	All FY
Supervisor Listening My supervisor listens to what I have to say.	*	*	4.11	4.14	4.13
Supervisor Respect My supervisor treats me with respect.	*	*	4.28	4.30	4.29
Supervisor Trust I have trust and confidence in my supervisor.	*	*	4.00	4.01	4.01
Workgroup Respect People treat each other with respect in my workgroup.	3.99	3.99	3.96	4.00	3.99
Workgroup Cooperation The people I work with cooperate to get the job done.	*	*	4.02	4.03	4.02
Workgroup Collaboration Workgroups collaborate to accomplish shared objectives.	*	*	3.69	3.69	3.69
Workgroup Communication Members of my work group communicate well with each other.	*	*	*	3.87	3.87
Workplace Inspiration This organization really inspires the very best in me in the way of job performance.	3.53	3.56	3.50	3.51	3.53
Extra Effort I always do more than is actually required.	4.33	4.34	4.35	4.33	4.34

*** Item not included in survey for that year**

All items are scored on a scale ranging from 1 - 6; 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree; 6 = Do Not Know. Higher values indicate greater agreement with survey item.

Table C-12. Average Job Satisfaction Scores by Survey Year, MH Professionals

	2016	2017	2018	2019	All FY
Personal Recognition How satisfied are you with the recognition you receive for doing a good job?	*	*	3.42	3.45	3.44
Decisional Involvement How satisfied are you with your involvement in decisions that affect your work?	*	*	3.40	3.42	3.41
Overall Satisfaction Considering everything, how satisfied are you with your job?	3.88	3.87	3.87	3.88	3.87
Organization Satisfaction Considering everything, how satisfied are you with your organization?	3.55	3.55	3.57	3.60	3.57

*** Item not included in survey for that year**
All items are scored on a scale ranging from 1 - 6; 1 = Very Dissatisfied; 2 = Dissatisfied; 3 = Neutral; 4 = Satisfied; 5 = Very Satisfied; 6 = Not Applicable. Higher values indicate greater satisfaction with survey item.

Tables C.11 & C.12 summarize the trend analyses across job satisfaction survey items. All items saw an increase in average score compared to the 2018 survey, except 'workgroup collaboration' which say no change and 'extra effort' which saw a slight decrease. 'Workgroup communication' was first added to the AES during the 2019 survey cycle, and therefore does not have adequate data to compare across survey years.

Table C-13 displays the average scores for the burnout survey items across respondents who provide mental health services. There were no notable differences across average burnout scores between Male and Female respondents. Respondents that identified as Pacific Islander or American Indian had the highest 'high burnout' scores. When compared to all age groups, on average, respondents aged 25 and under score significantly higher on 'high burnout'. Respondents within the 25 and under age group also had the highest average scores for 'moral distress', 'exhaustion', and 'depersonalization'. Average scores on 'high burnout' were the highest for respondents who worked in an education setting, those who had been with the VA for 15 – 20 years, and those who worked within VISN 4.

Table C-13. Average Employee Withdrawal (Burnout) Scores by Respondent Characteristics, MH Professionals

	Moral Distress	Exhaustion	Depersonalization	Reduced Achievement†	High Burnout**
Gender					
Male	1.53	2.38	1.96	1.74	3.66
Female	1.52	2.49	1.90	1.79	3.63
Race					
White	1.52	2.53	1.99	1.70	3.62
Black	1.39	2.07	1.53	2.02	3.69
Amer Indian	1.75	2.42	1.94	1.88	4.12

	Moral Distress	Exhaustion	Depersonalization	Reduced Achievement†	High Burnout**
Asian	1.57	2.37	1.94	1.80	2.81
Pac Islander	1.85	2.60	2.26	2.00	4.88
Multi-Racial	1.76	2.64	2.10	1.83	3.23
Ethnicity					
Hispanic	1.60	2.35	1.90	1.86	3.63
Not Hispanic	1.51	2.46	1.93	1.76	3.64
Age					
25 and under	1.68	2.68	2.16	2.16	8.63
26-29	1.64	2.49	2.16	2.07	4.30
30-39	1.62	2.66	2.16	1.93	3.98
40-49	1.56	2.55	2.01	1.79	3.98
50-59	1.48	2.33	1.81	1.70	3.49
60 years or older	1.33	2.08	1.47	1.52	2.25
Work Setting					
Administrative	1.47	2.45	1.93	2.01	4.01
Inpatient	1.55	2.10	1.74	2.13	5.18
Outpatient	1.49	2.53	1.97	1.68	3.21
Extended	1.54	1.87	1.52	2.38	3.61
Research	1.09	2.09	1.28	1.69	2.94
Education	1.15	1.84	1.42	2.06	4.55
Affiliate	1.40	2.11	2.30	2.00	0.00
NCA Field Programs	2.29	2.36	1.86	2.00	0.00
Multiple Areas	1.59	2.59	2.00	1.68	3.50
VA Years					
<6 mos	1.02	1.09	0.92	2.14	1.41
6 mos-1 yr	1.36	1.92	1.43	1.93	2.12
1-2 yrs	1.47	2.32	1.76	1.90	4.36
2-5 yrs	1.57	2.59	2.05	1.81	3.98
5-10 yrs	1.61	2.67	2.09	1.73	4.11
10-15 yrs	1.56	2.59	2.08	1.68	3.36
15-20 yrs	1.53	2.51	1.98	1.68	4.88
>20 yrs	1.45	2.19	1.66	1.59	2.73
VISN					
VISN 1	1.50	2.52	1.89	1.70	3.22
VISN 2	1.48	2.27	1.72	1.79	3.28
VISN 4	1.52	2.55	1.98	1.84	5.26
VISN 5	1.29	2.17	1.62	1.80	2.40
VISN 6	1.52	2.46	1.88	1.81	3.78
VISN 7	1.41	2.48	1.96	1.89	4.34
VISN 8	1.64	2.47	2.00	1.80	4.39
VISN 9	1.40	2.32	1.81	1.66	3.29
VISN 10	1.54	2.48	1.93	1.80	3.64
VISN 12	1.53	2.39	1.85	1.77	2.94
VISN 15	1.38	2.33	1.92	1.72	4.14
VISN 16	1.49	2.39	1.84	1.81	3.92
VISN 17	1.64	2.44	1.97	1.89	5.21
VISN 19	1.78	2.63	2.16	1.87	4.47

	Moral Distress	Exhaustion	Depersonalization	Reduced Achievement†	High Burnout**
VISN 20	1.70	2.69	2.15	1.65	3.05
VISN 21	1.61	2.56	2.00	1.82	3.60
VISN 22	1.55	2.42	1.91	1.77	3.06
VISN 23	1.58	2.59	2.06	1.69	2.45

† Reverse-scored
** High burnout measures the percent of employee's who are feeling burned out on all three burnout symptoms at a frequency of 'once a week' to 'every day'. This item is scored 0 - 100% where a lower score is more favorable

All items are scored on a scale ranging from 0 - 6; 0 = Never; 1 = A few times a year or less; 2 = Once a month or less; 3 = A few times a month; 4 = Once a week; 5 = A few times a week; 6 = Every day. Higher values indicate greater burnout symptoms.

Table C-14. Average Employee Withdrawal (Burnout) Scores by Respondent Characteristics, MH Professionals

	2016	2017	2018	2019	All FY
Moral Distress					
In the past year, how often did you experience moral distress at work?	*	*	1.55	1.53	1.54
Exhaustion					
I feel burned out from my work.	2.68	2.76	2.40	2.47	2.57
Depersonalization					
I worry that this job is hardening me emotionally.	1.98	2.06	1.84	1.94	1.95
Reduced Achievement†					
I have accomplished many worthwhile things in this job.	1.51	1.53	1.76	1.78	1.65
High Burnout**					
High Burnout	3.09	3.35	3.75	3.70	3.49

* Item not included in survey for that year
† Reverse-scored
** High burnout measures the percent of employee's who are feeling burned out on all three burnout symptoms at a frequency of 'once a week' to 'every day'. This item is scored 0 - 100% where a lower score is more favorable

All items (aside from 'High Burnout') are scored on a scale ranging from 0 - 6; 0 = Never; 1 = A few times a year or less; 2 = Once a month or less; 3 = A few times a month; 4 = Once a week; 5 = A few times a week; 6 = Every day. Higher values indicate greater burnout symptoms.

Table C-14 summarizes trends in average burnout score across each year the AES was administered. 'Reduced achievement' steadily increased from 2016 to 2019. Average 'High burnout' score increased from 2016 to 2018, and slightly decreased from 2018 to 2019. 'Moral distress' was first included on the AES during the 2018 survey cycle – from 2018 to 2019, there was a slight decrease in average score.

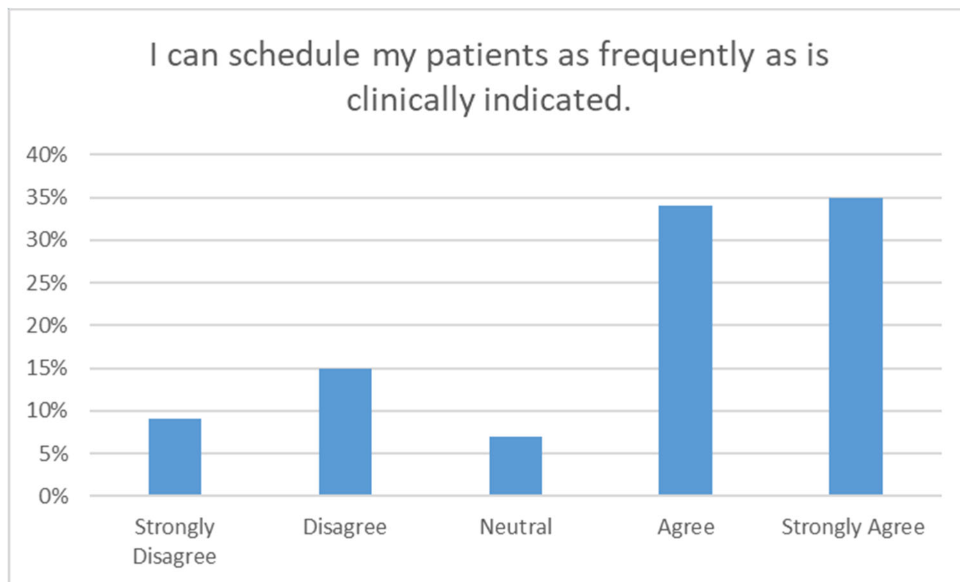
Mental Health Provider Survey

Embedded is a copy of the FY 2018 MHPS results from the dashboard.

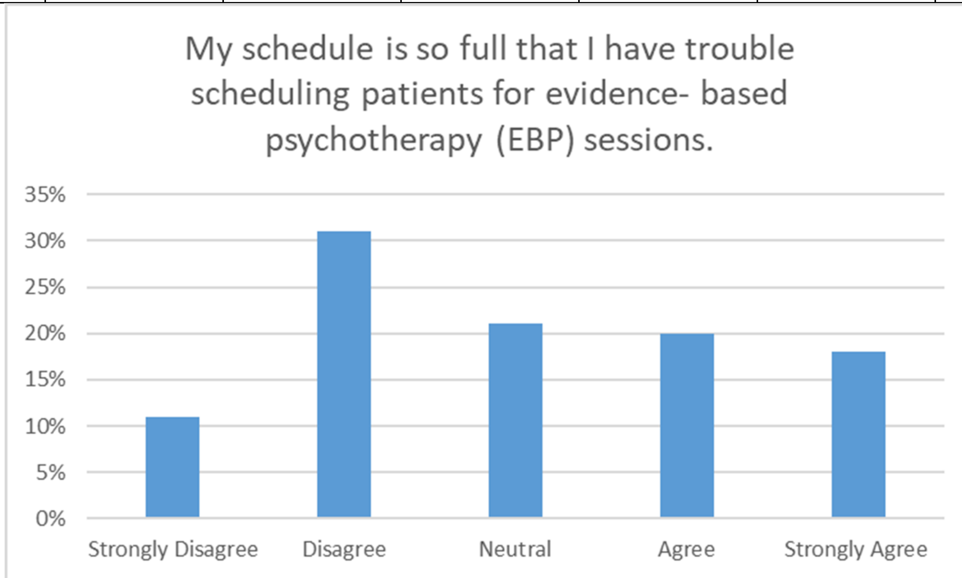
MHPS_2018
National-facility-all r

The following are bar graphs constructed from responses to each question in the FY 2018 MHPS.

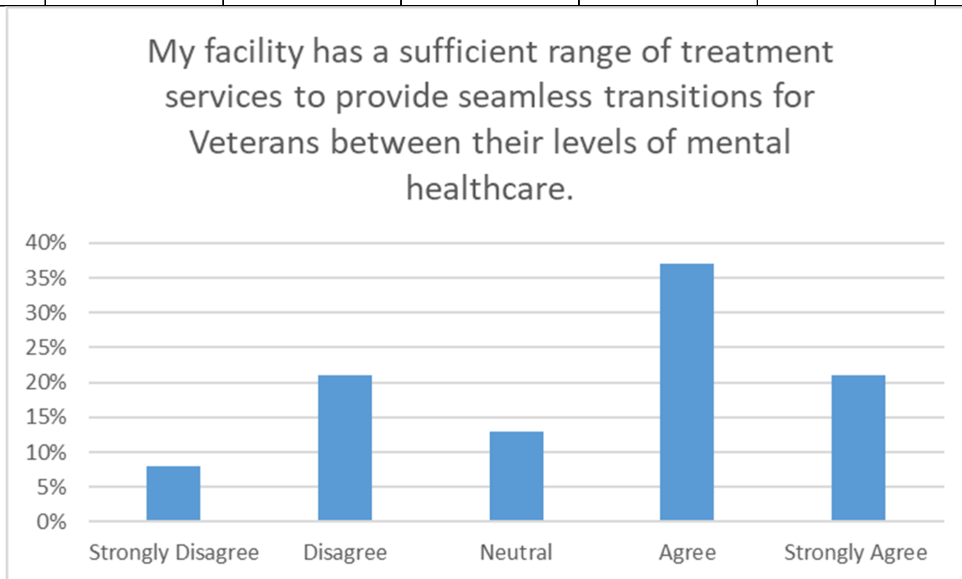
I can schedule my patients as frequently as is clinically indicated.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.68	0.39	140	0	140



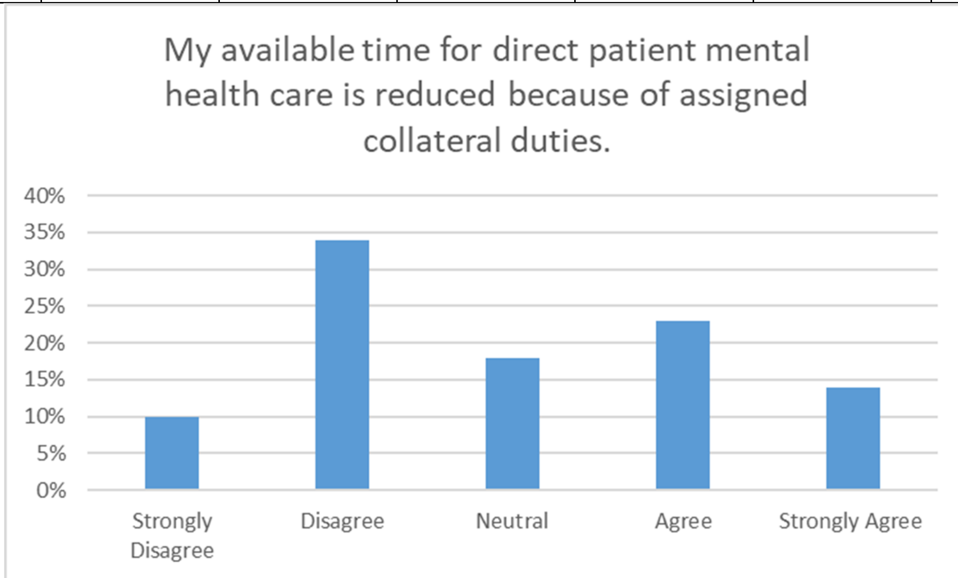
My schedule is so full that I have trouble scheduling patients for evidence- based psychotherapy (EBP) sessions.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.09	0.36	140	0	140



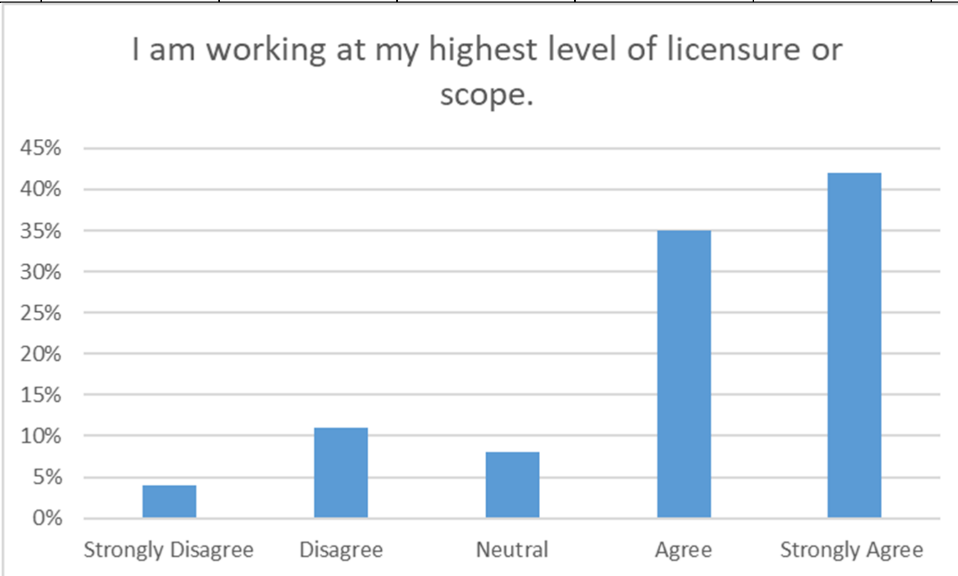
My facility has a sufficient range of treatment services to provide seamless transitions for Veterans between their levels of mental healthcare.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.33	0.49	140	0	140



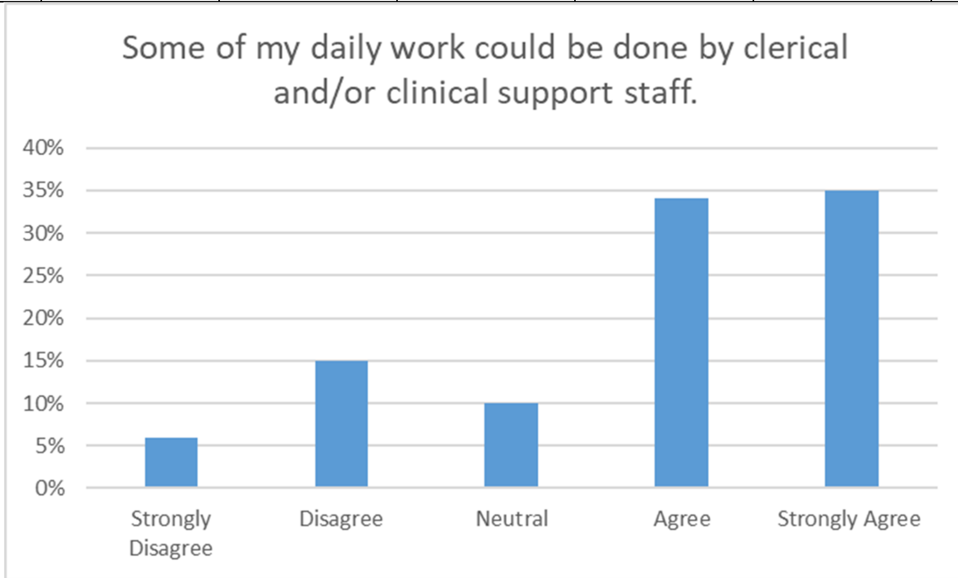
My available time for direct patient mental health care is reduced because of assigned collateral duties.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	2.97	0.29	140	0	140



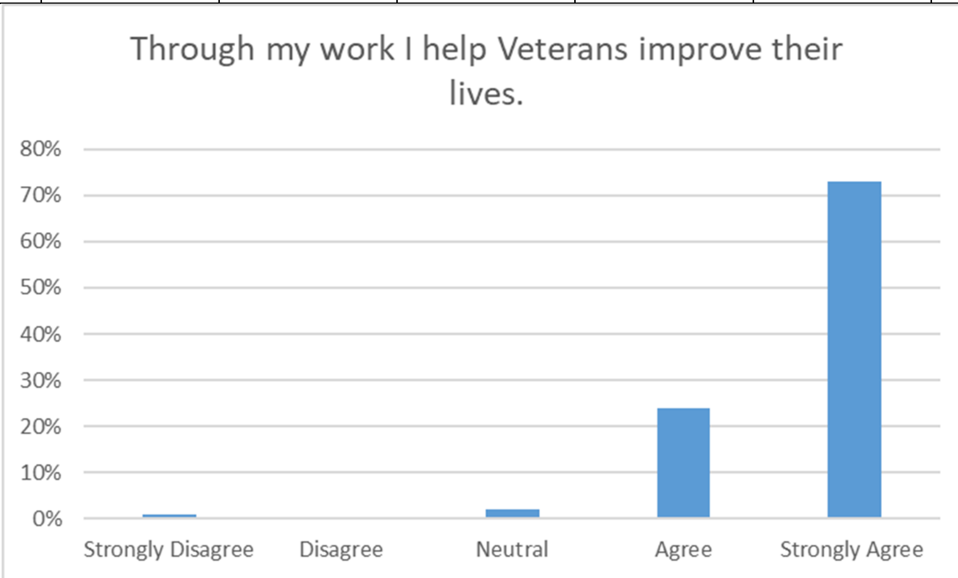
I am working at my highest level of licensure or scope.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.97	0.22	140	0	140



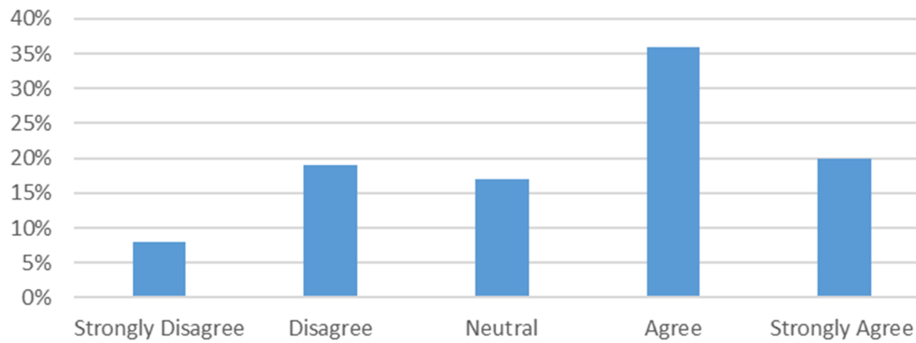
Some of my daily work could be done by clerical and/or clinical support staff.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.77	0.29	140	0	140



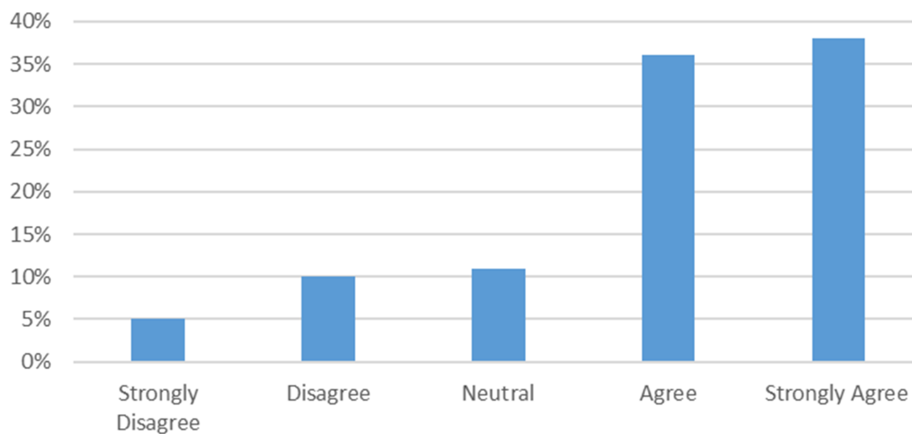
Through my work I help Veterans improve their lives.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	4.68	0.11	140	0	140



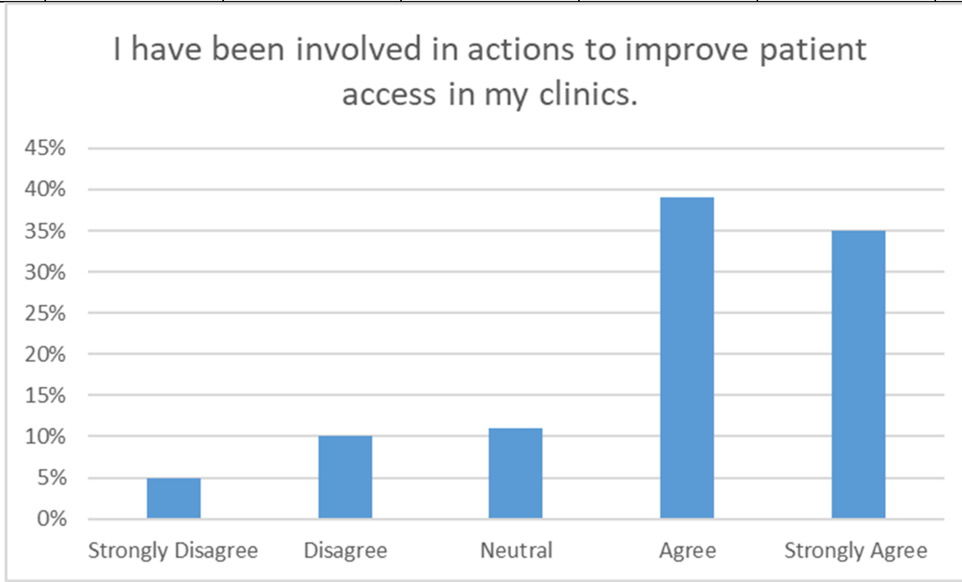
Care is well coordinated in Veterans receiving mental health care at my facility meaning that referrals within and between mental health programs are smooth and seamless.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.39	0.43	140	0	140



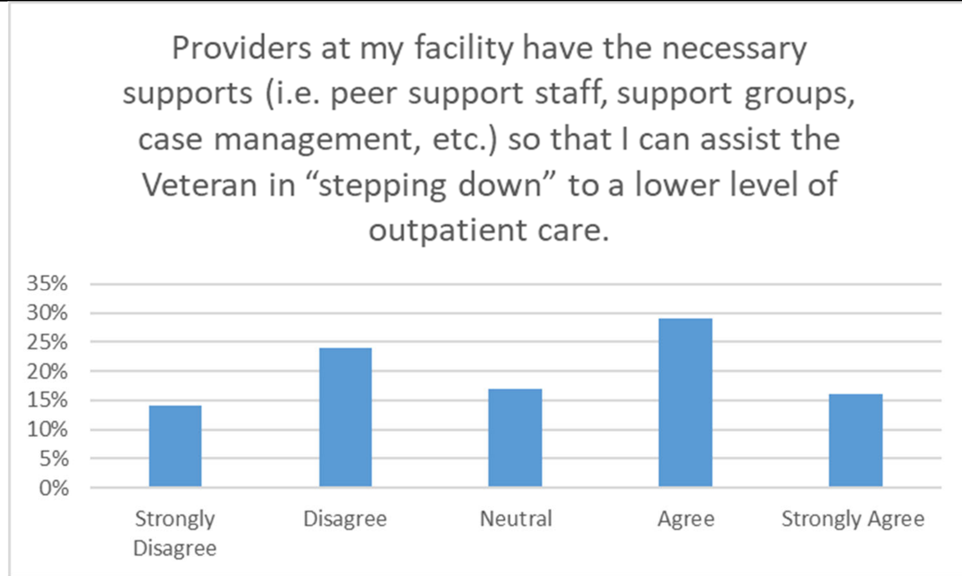
My team regularly meets to plan improvements in patient access.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.86	0.33	140	0	140



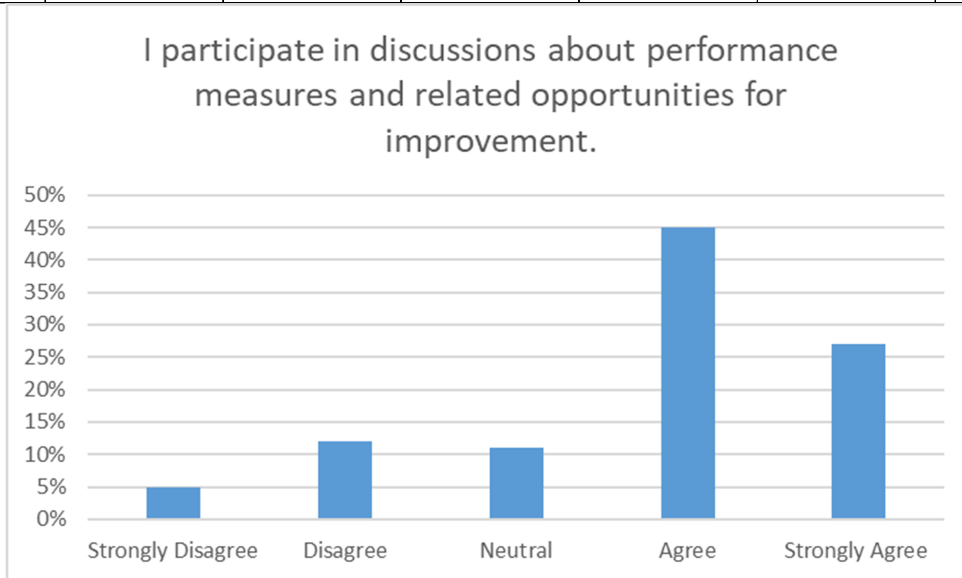
I have been involved in actions to improve patient access in my clinics.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.85	0.3	140	0	140



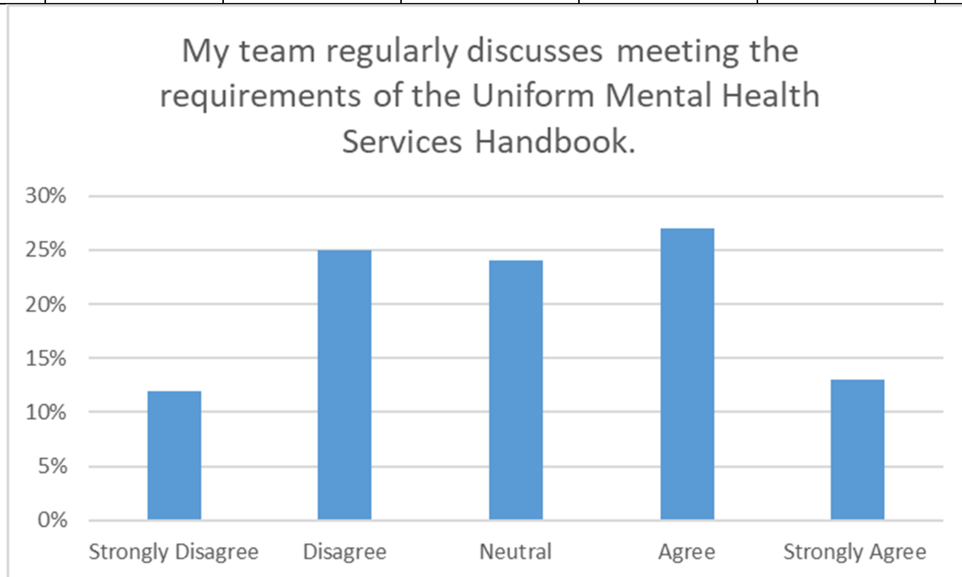
Providers at my facility have the necessary supports (i.e. peer support staff, support groups, case management, etc.) so that I can assist the Veteran in “stepping down” to a lower level of outpatient care.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.01	0.44	140	0	140



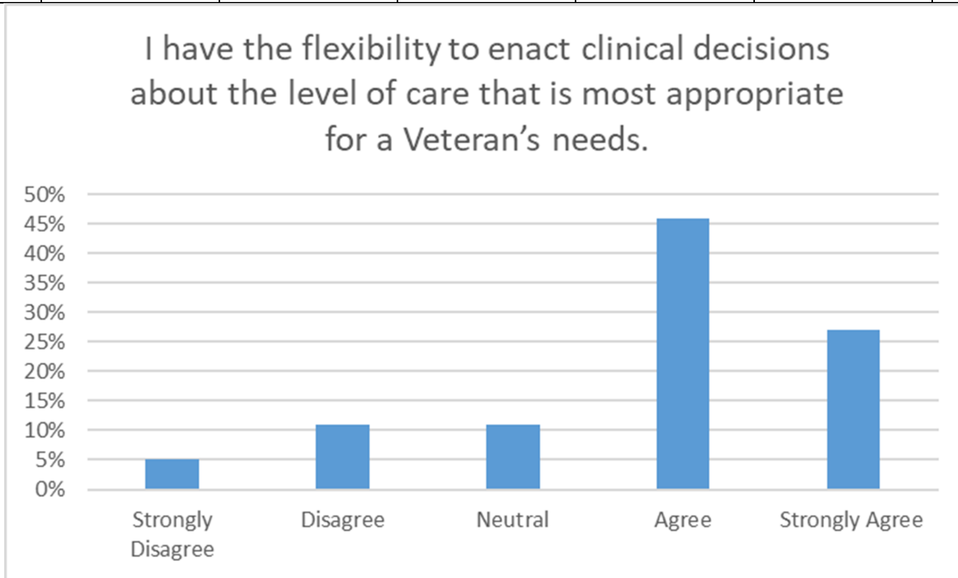
I participate in discussions about performance measures and related opportunities for improvement.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.74	0.29	140	0	140



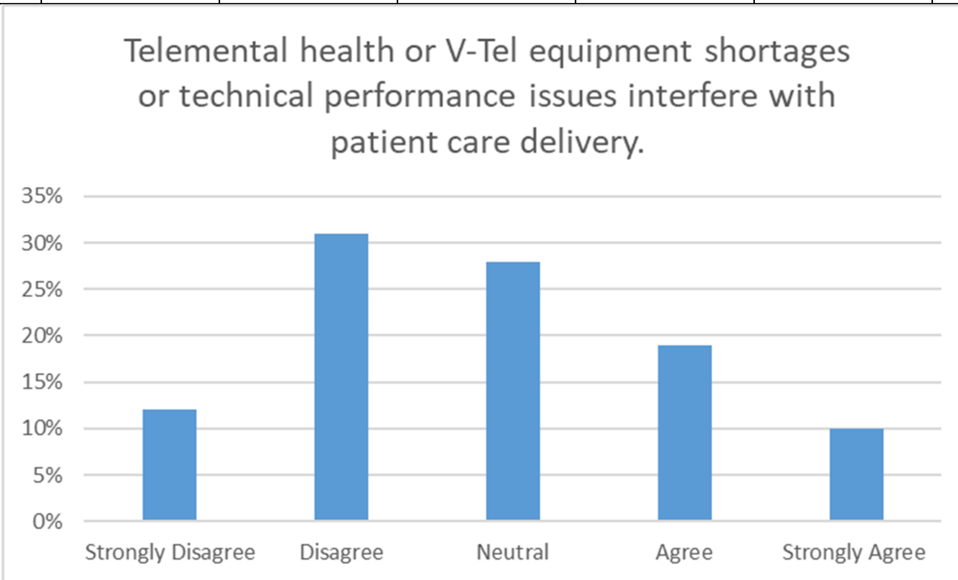
My team regularly discusses meeting the requirements of the Uniform Mental Health Services Handbook.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3	0.32	140	0	140



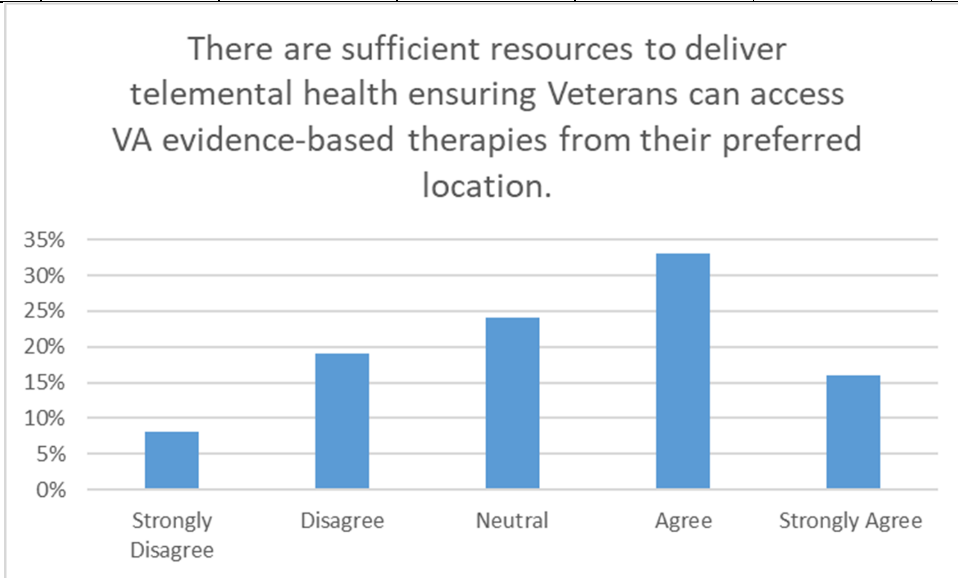
I have the flexibility to enact clinical decisions about the level of care that is most appropriate for a Veteran's needs.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.79	0.26	140	0	140



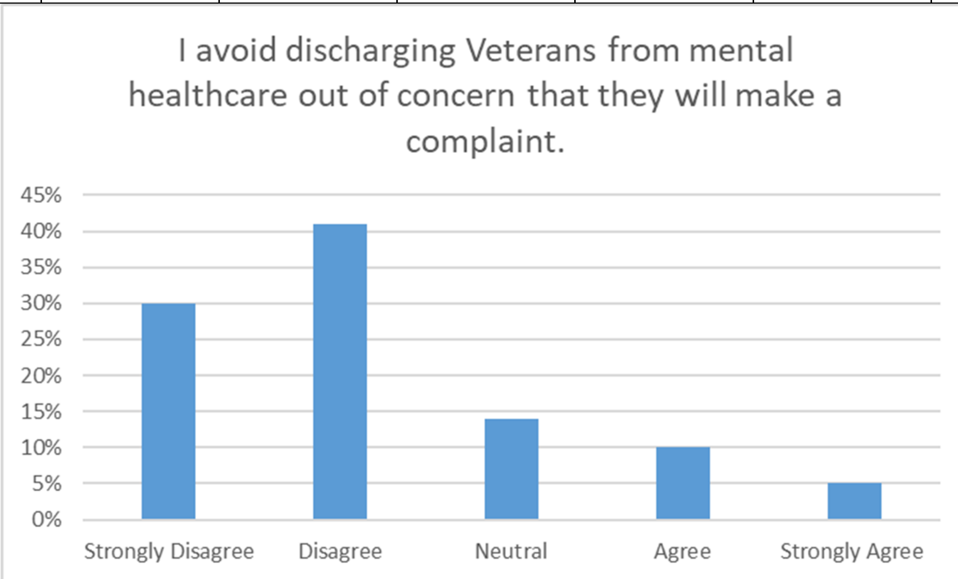
Telemental health or V-Tel equipment shortages or technical performance issues interfere with patient care delivery.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	2.86	0.29	140	0	140



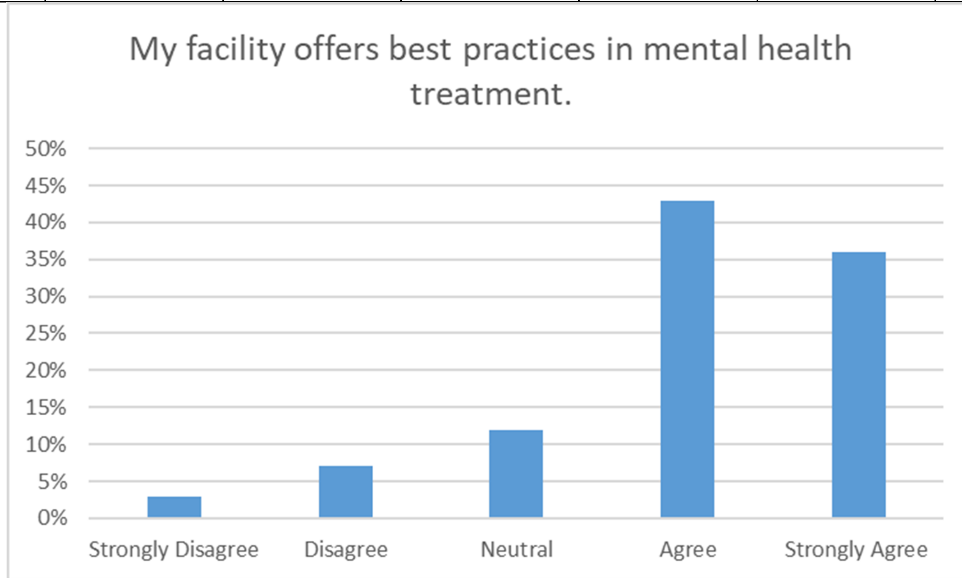
There are sufficient resources to deliver telemental health (i.e., staff trained on VA Video Connect or other telehealth modalities; equipped with video technologies; and supported with appropriate VA bandwidth)—ensuring Veterans can access VA evidence-based therapies from their preferred location.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.26	0.4	140	0	140



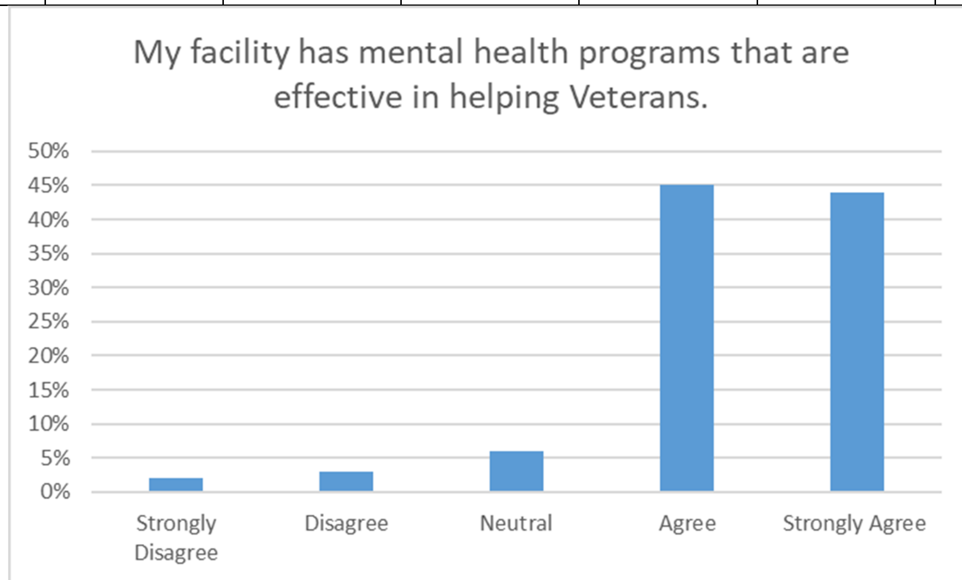
I avoid discharging Veterans from mental healthcare out of concern that they will make a complaint.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	2.21	0.23	140	0	140



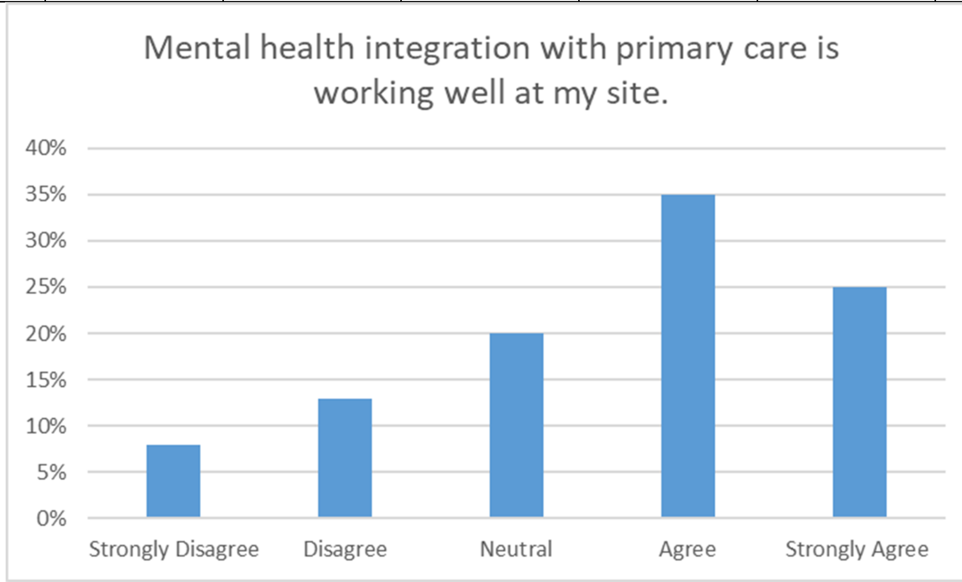
My facility offers best practices in mental health treatment.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.97	0.34	140	0	140



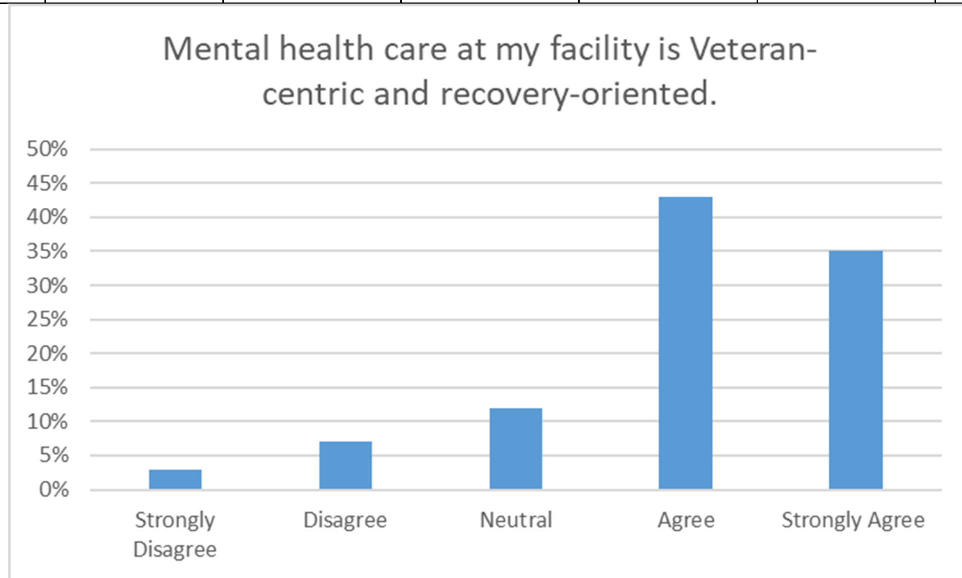
My facility has mental health programs that are effective in helping Veterans.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	4.25	0.25	140	0	140



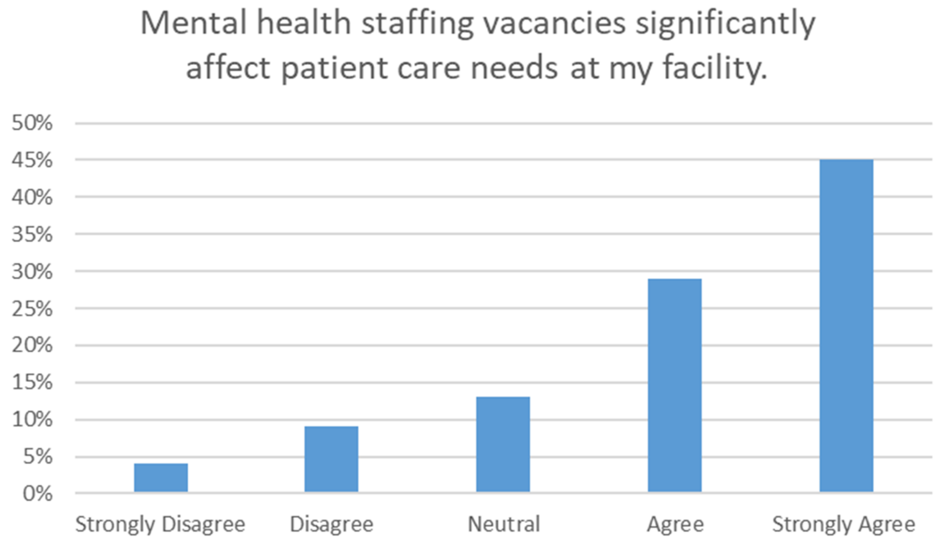
Mental health integration with primary care is working well at my site.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.52	0.42	140	0	140



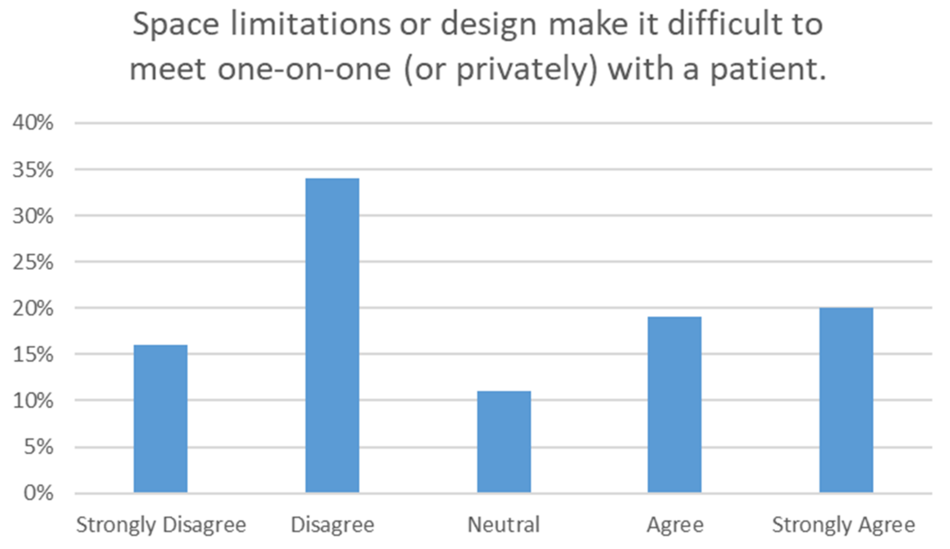
Mental health care at my facility is Veteran-centric and recovery-oriented.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.98	0.29	140	0	140



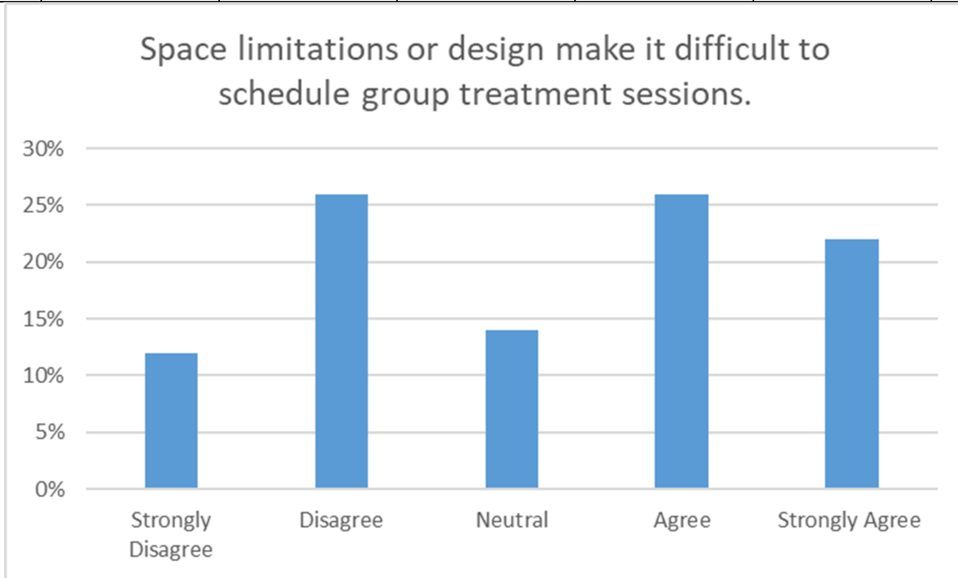
Mental health staffing vacancies significantly affect patient care needs at my facility.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	4.09	0.42	140	0	140



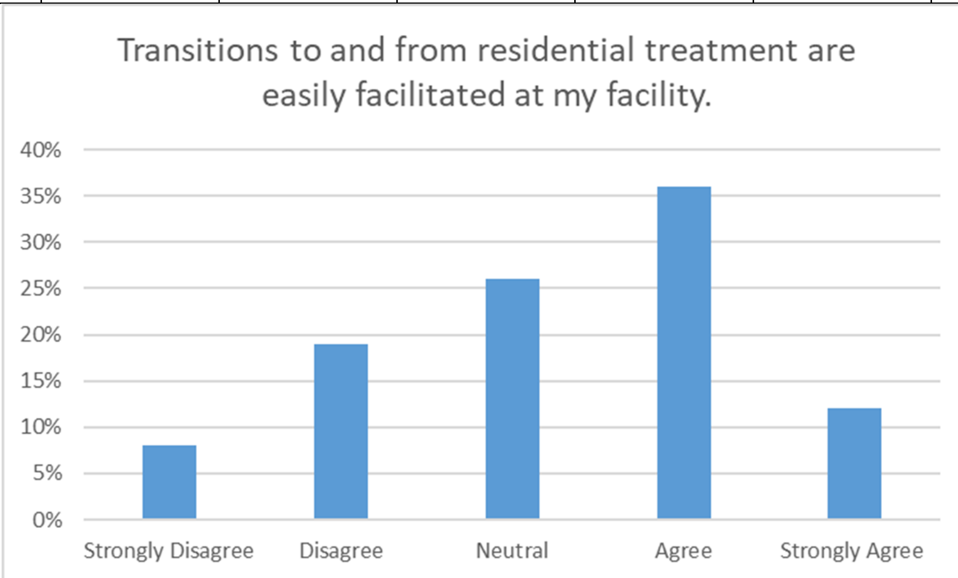
Space limitations or design make it difficult to meet one-on-one (or privately) with a patient.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	2.92	0.48	140	0	140



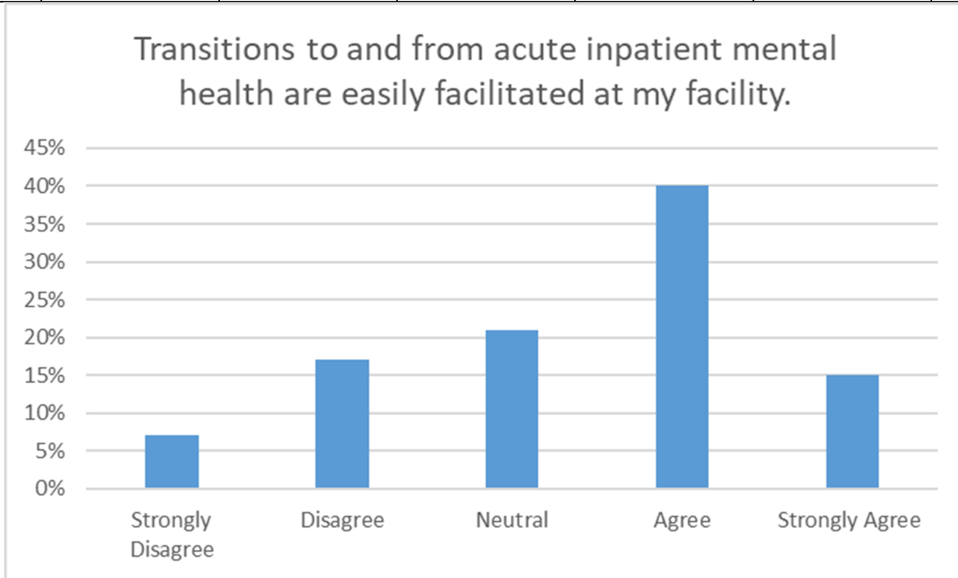
Space limitations or design make it difficult to schedule group treatment sessions.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.22	0.44	140	0	140



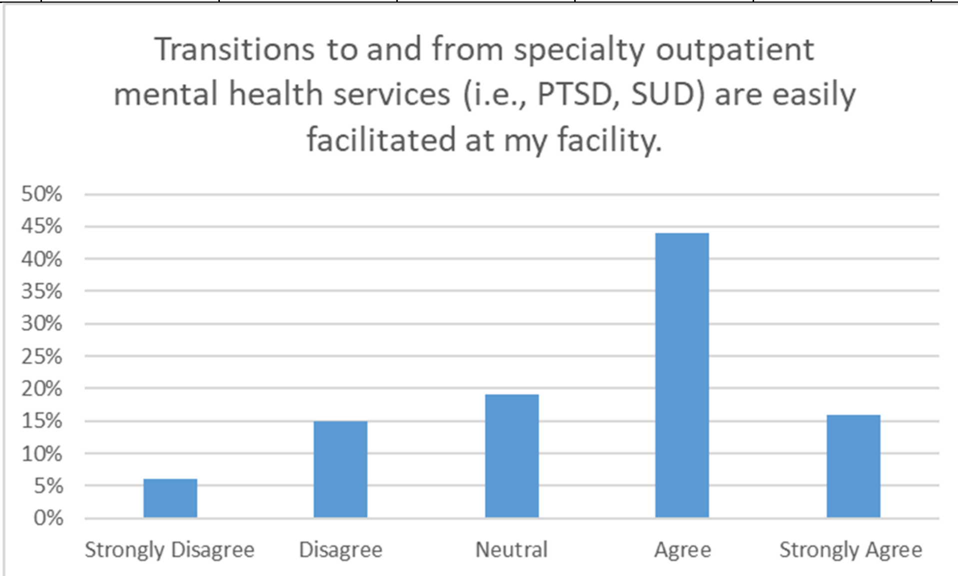
Transitions to and from residential treatment are easily facilitated at my facility.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.23	0.35	140	0	140



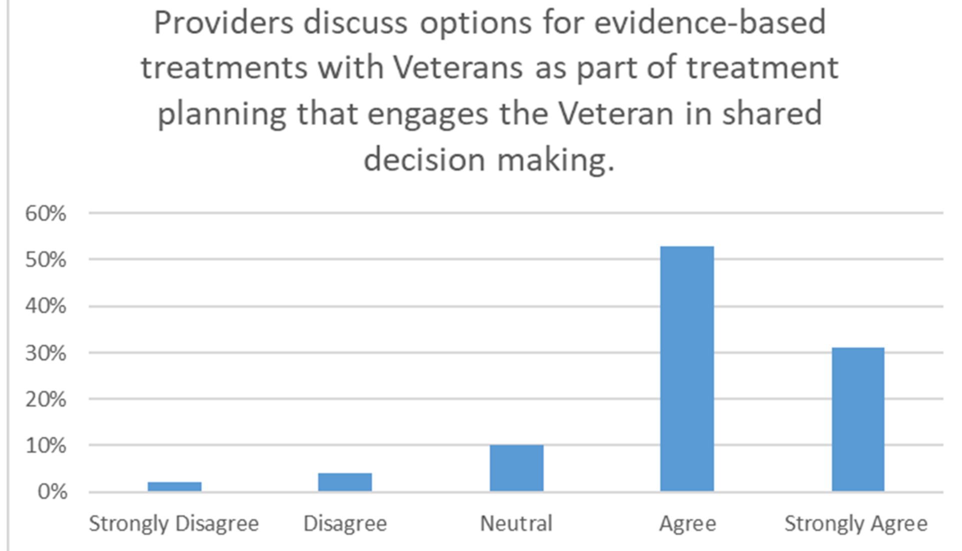
Transitions to and from acute inpatient mental health are easily facilitated at my facility.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.35	0.37	140	0	140



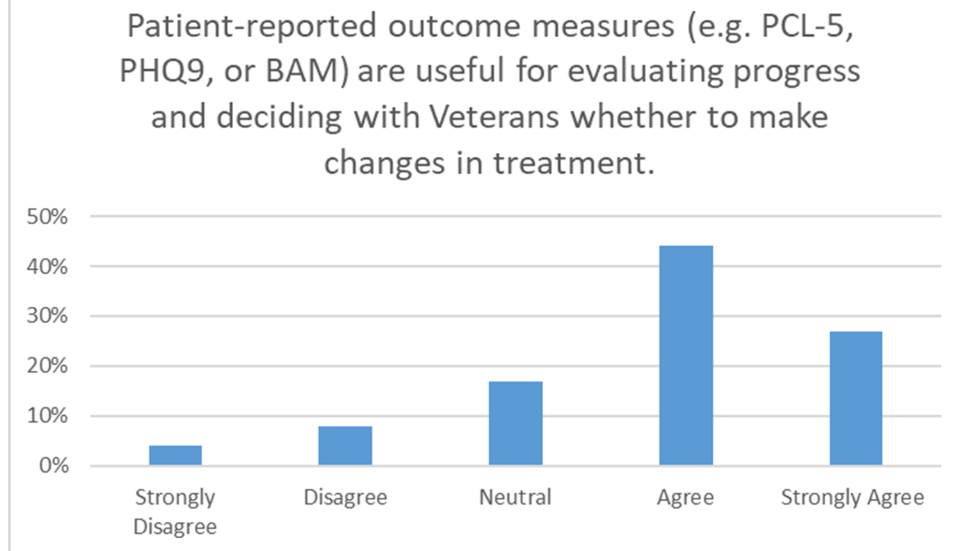
Transitions to and from specialty outpatient mental health services (i.e., PTSD, SUD) are easily facilitated at my facility.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.48	0.35	140	0	140



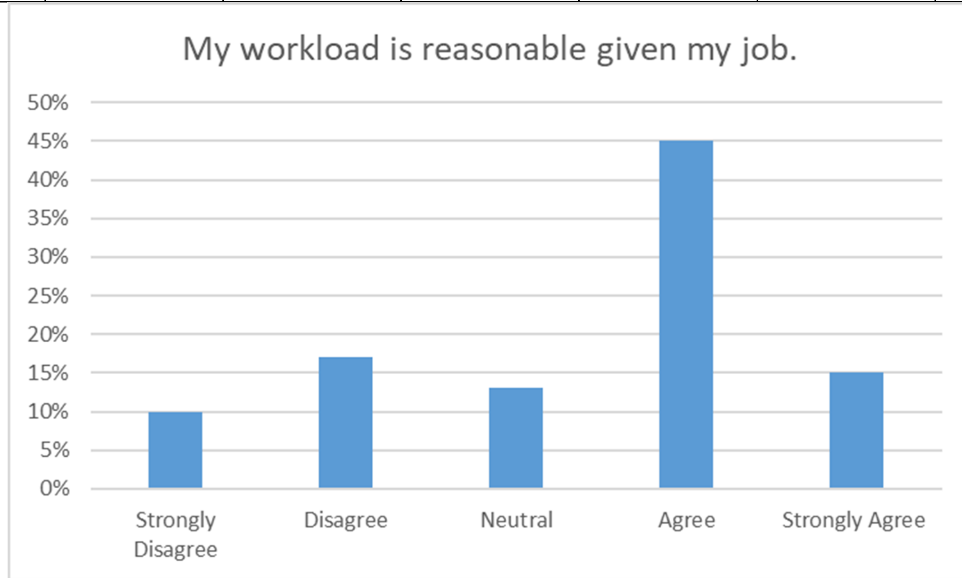
Providers discuss options for evidence-based treatments with Veterans as part of treatment planning that engages the Veteran in shared decision making.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	4.04	0.22	140	0	140



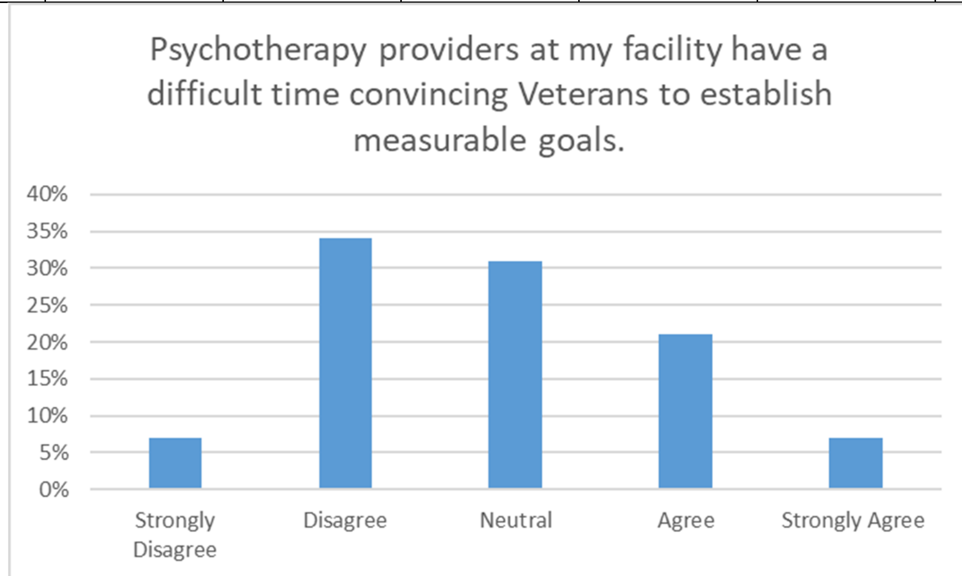
Patient-reported outcome measures (e.g. PCL-5, PHQ9, or BAM) are useful for evaluating progress and deciding with Veterans whether to make changes in treatment.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.79	0.25	140	0	140



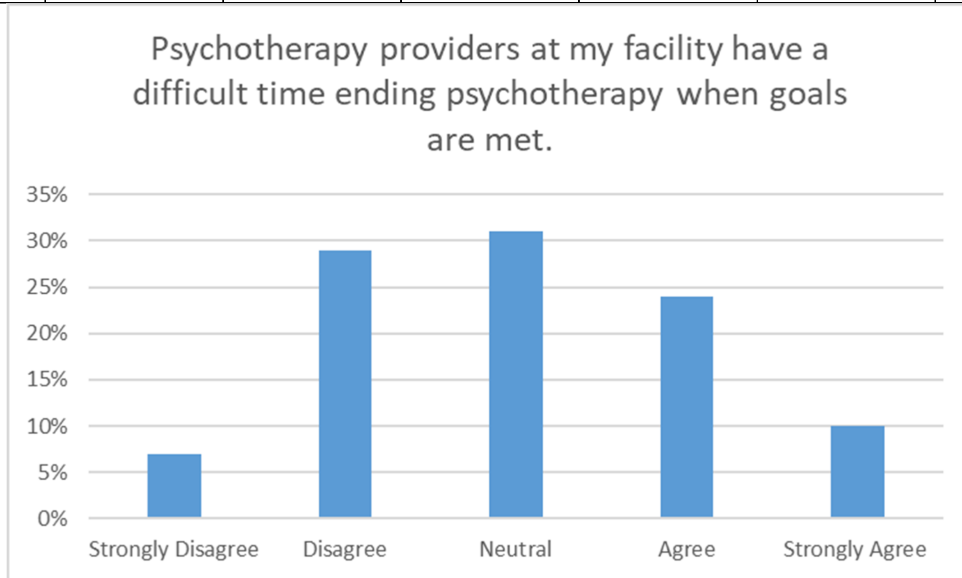
My workload is reasonable given my job.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.34	0.34	140	0	140



Psychotherapy providers at my facility have a difficult time convincing Veterans to establish measurable goals.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	2.87	0.22	140	0	140

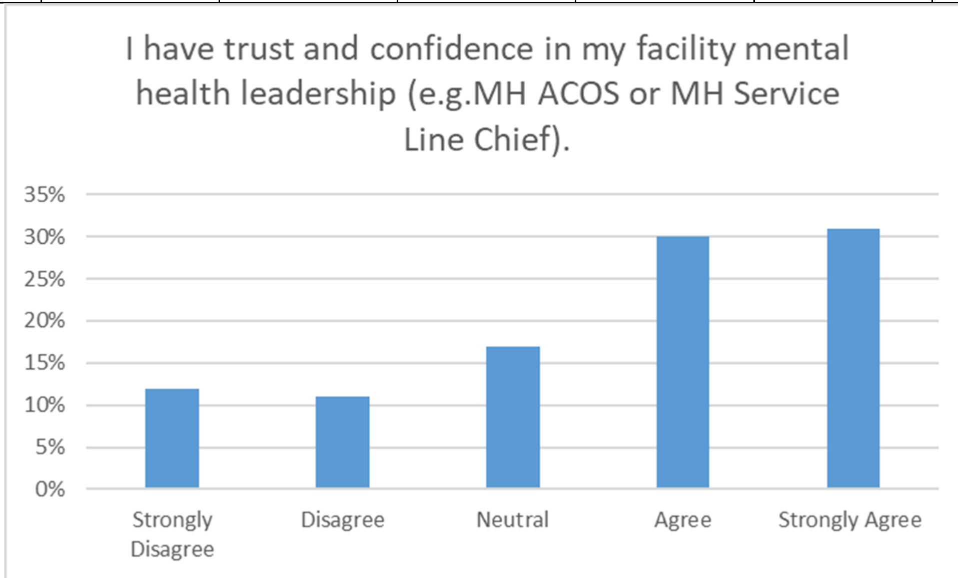


Psychotherapy providers at my facility have a difficult time ending psychotherapy when goals are met.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.04	0.29	140	0	140

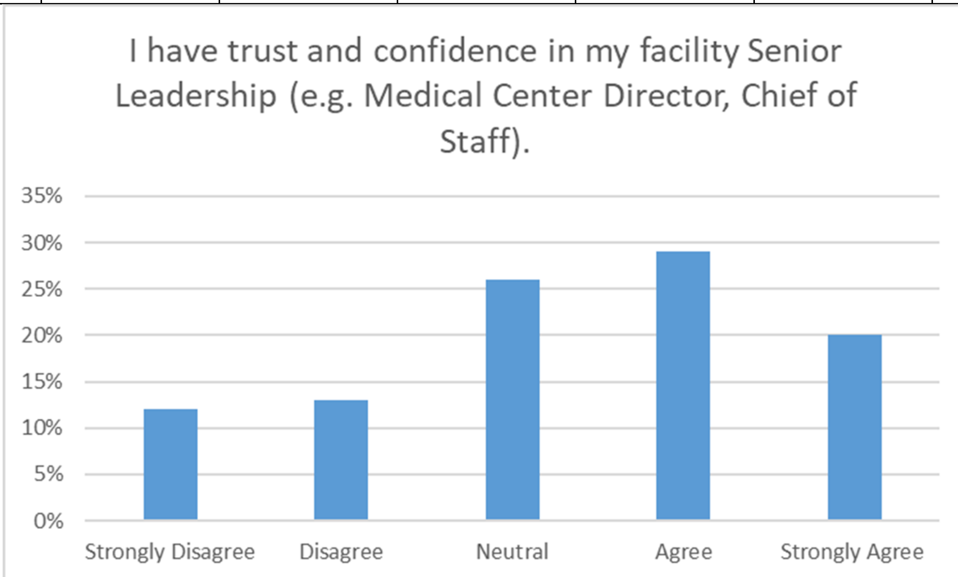


I have trust and confidence in my direct supervisor.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.92	0.34	140	0	140

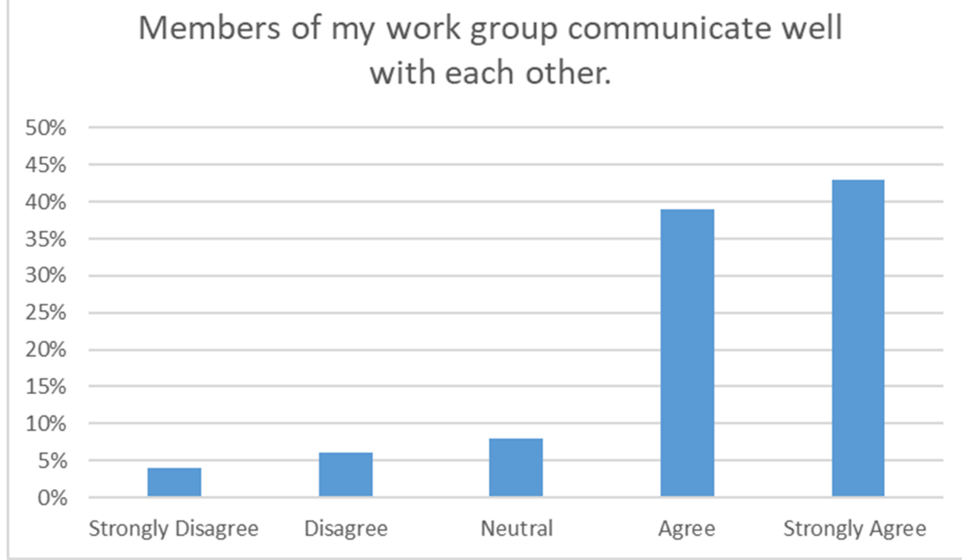
I have trust and confidence in my facility mental health leadership (e.g.MH ACOS or MH Service Line Chief).						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.53	0.5	140	0	140



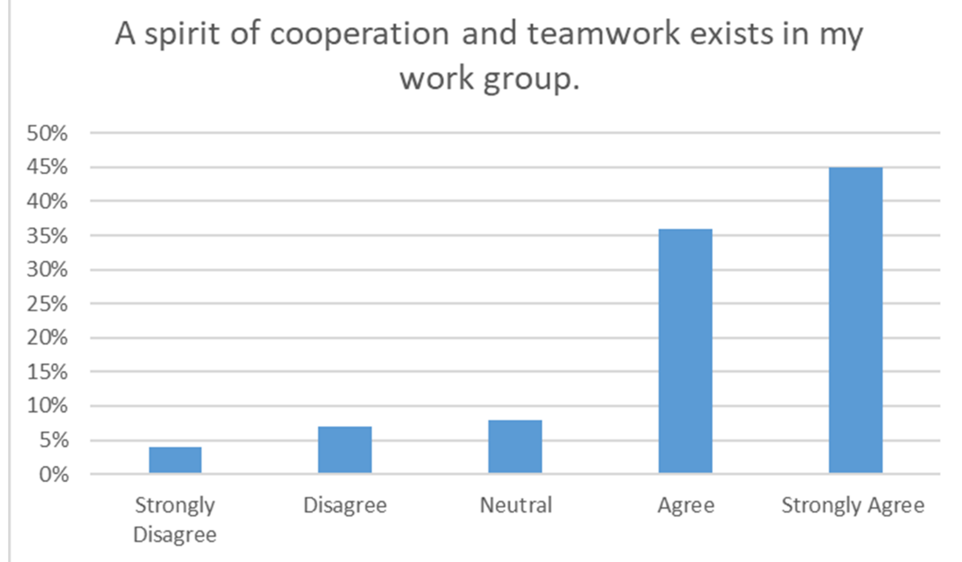
I have trust and confidence in my facility Senior Leadership (e.g. Medical Center Director, Chief of Staff).						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.27	0.43	140	0	140



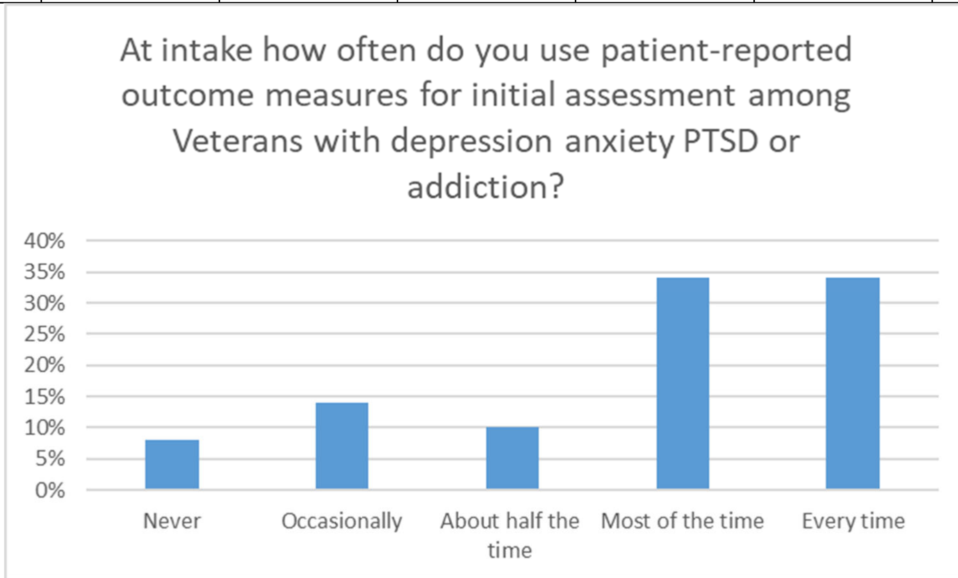
Members of my work group communicate well with each other.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	4.1	0.25	140	0	140



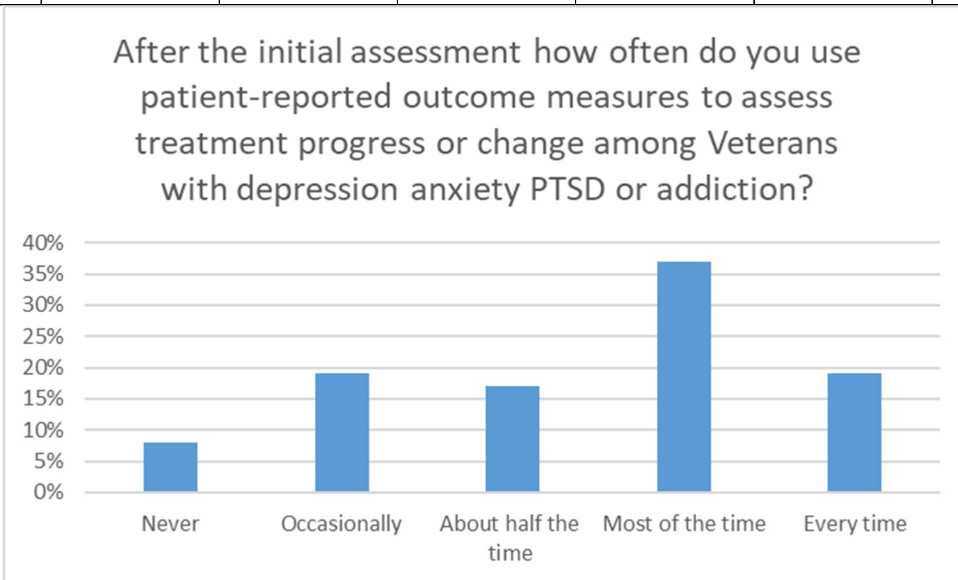
A spirit of cooperation and teamwork exists in my work group.						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	4.09	0.26	140	0	140



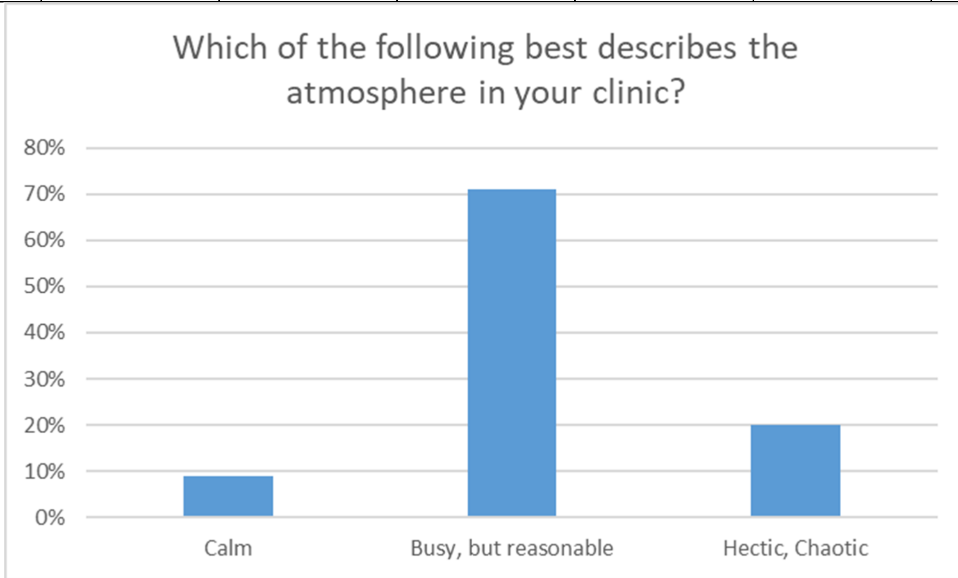
At intake how often do you use patient-reported outcome measures for initial assessment among Veterans with depression anxiety PTSD or addiction?						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.68	0.31	140	0	140



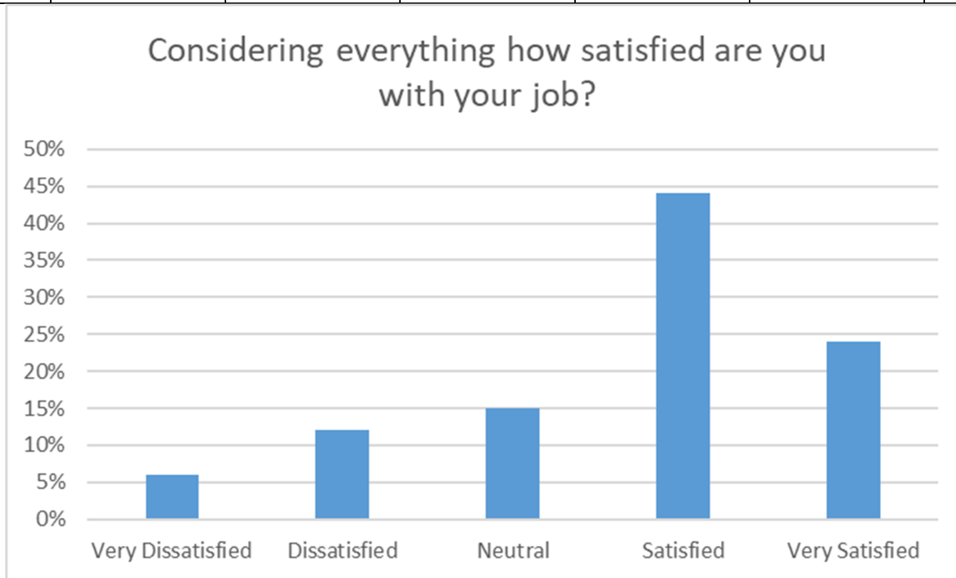
After the initial assessment how often do you use patient-reported outcome measures to assess treatment progress or change among Veterans with depression anxiety PTSD or addiction?						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.37	0.29	140	0	140



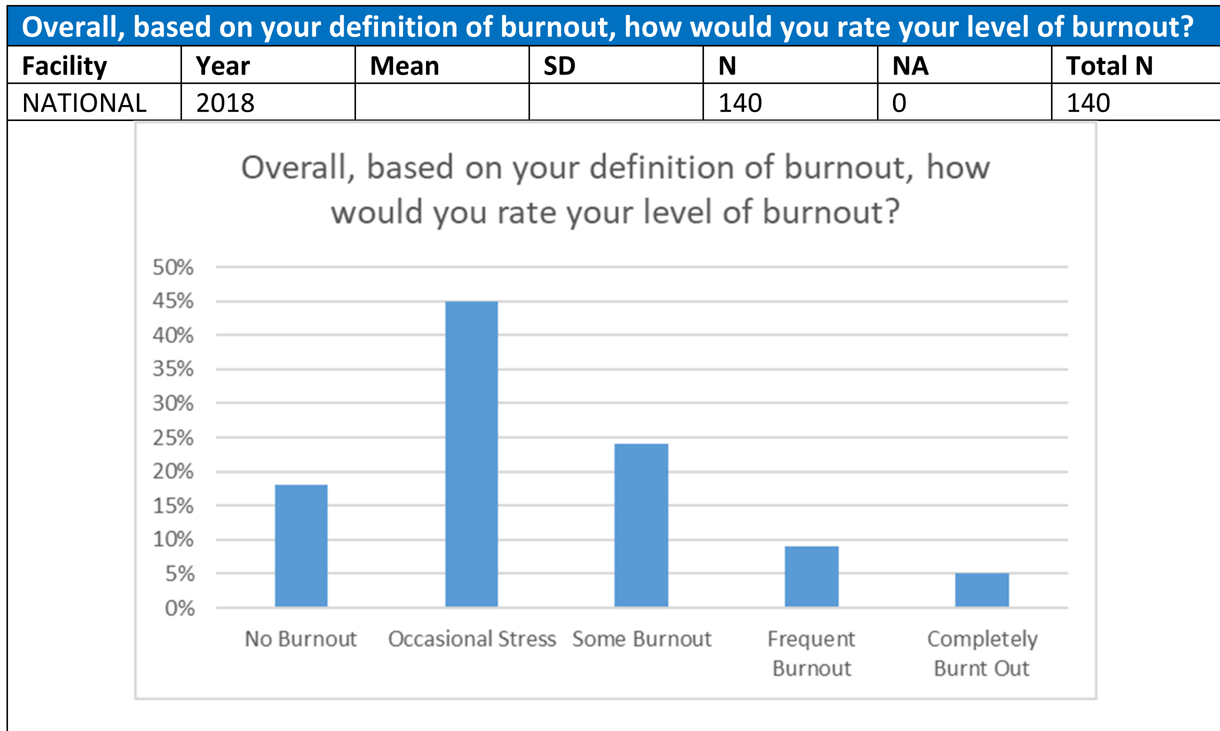
Which of the following best describes the atmosphere in your clinic?						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	2.12	0.13	140	0	140



Considering everything how satisfied are you with your job?						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018	3.66	0.32	140	0	140



Overall, based on your definition of burnout, how would you rate your level of burnout?						
Facility	**Year**	**Mean**	**SD**	**N**	**NA**	**Total N**
NATIONAL	2018			140	0	140



Strategic Analytics for Improvement and Learning

Embedded is the Excel report generated from the MH Domain dashboard of SAIL for the last three quarters of FY 2019 at the national level.

MHDomainCompos
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COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

MENTAL HEALTH (MH) DOMAIN OF SAIL – DETAILED VIEW

A. Population Coverage Composite

- For the measures below, look at each individual numerator and denominator when interpreting each measure. Each of the individual measures below all help explain the overall picture of population coverage (access) to VA MH services and care. Low scores may indicate issues with access or resources.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
MH Population Coverage	PCov2		↑	-0.5: -0.1: 0.7	--	--	0.02	--	--	0.02	--	--	0.02
% MH-treated patients w/ family	Fam2	1	↑	0.7: 1.3: 2.0	29,140	2,155,941	1.35%	30,014	2,195,408	1.37%	30,718	2,218,271	1.38%

- MH population coverage consists of 16 population-coverage measures. In this summary, it represents the national average.
- Measure Description: Fam2 indicates the percentage of MH-treated patients with a family psychotherapy visit.
- Numerator: The number of Veterans who received specialty MH treatment and a family psychotherapy visit.
- Denominator: The number of Veterans who received specialty MH treatment.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Vets w/ ICMHR-targeted dx	HIAS21	1	↑	2.9: 4.2: 6.1	8,674	205,034	4.23%	8,691	206,222	4.21%	8,748	206,678	4.23%

- Measure Description: Percentage of Veterans with Intensive Community MH Recovery (ICMHR)-targeted diagnosis receiving ICMHR services.
- Numerator: Number of Veterans with ICMHR-targeted diagnoses who received ICMHR-services.
- Denominator: Number of Veterans with ICMHR-targeted diagnoses.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Vets w/ PRRC-targeted dx served	HIAS72	1	↑	0.4: 0.9: 2.3	13,281	1,331,160	1.00%	13,618	1,369,640	0.99%	13,782	1,385,118	1.00%

- Measure Description: Percentage of Veterans with Psychosocial Rehabilitation and Recovery Center (PRRC)-targeted diagnoses served by PRRC.
- Numerator: Number of Veterans with PRRC-targeted diagnoses served by PRRC (at least three outpatient encounters).
- Denominator: Number of Veterans with PRRC-targeted diagnoses.

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% VHA pts using MH services	MPT1	1	↑	**17.7**: 23.5: 27.6	1,093,061	4,885,217	22.37%	1,106,442	4,909,435	22.53%	1,120,479	4,950,114	22.63%

- Measure Description: Percentage of VHA patients using MH services.
- Numerator: Number of VHA enrollees who received MH services.
- Denominator: Number of enrolled Veterans that receive benefits (identified by VETSNET data and must have a positive award amount for inclusion).

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% primary care patients with PC-	PACT15	1	↑	**5.5**: 8.1: 11.2	357,862	4,106,922	8.71%	365,728	4,109,477	8.90%	371,007	4,106,067	9.04%

- Measure Description: The percentage of primary care patients engaged in Primary Care MH Integration (PCMHI).
- Numerator: The total number of assigned primary care patients seen in PCMHI during the past 12 months for required divisions.
- Denominator: Number of patients enrolled in primary care.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% pts w/ MH dx who have a MH E&M	PMED1	1	↑	**39.3**: 49.8: 59.5	1,074,657	2,138,547	50.25%	1,086,035	2,177,846	49.87%	1,094,182	2,200,558	49.72%

- Measure Description: Percentage of patients with MH who have a MH Evaluation and Management (E&M) visit.
- Numerator: Number of Veterans with MH or SUD diagnoses and an E&M visit.
- Denominator: Number of Veterans with MH or SUD diagnoses.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% MH-service-connected Vets in the	Pop6	1	↑	**39.5**: 47.7: 55.7	929,807	2,025,604	45.90%	940,921	2,056,375	45.76%	952,413	2,093,368	45.50%

- Measure Description: Percentage of MH-service-connected Veterans in the facility catchment with MH care.
- Numerator: Number of Veterans service-connected for a MH diagnosis who were treated in a MH specialty program.
- Denominator: Number of Veterans in facility catchment area who are service-connected for a MH diagnosis (per VBA).

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% depression-dxed pts w/	Psy32	1	↑	**32.2**: 38.5: 46.3	426,004	1,073,921	39.67%	436,025	1,090,832	39.97%	443,247	1,105,857	40.08%

- Measure Description: Percentage of depression-diagnosed Veterans with psychotherapy visit for depression.
- Numerator: Number of Veterans with depression diagnoses and a psychotherapy visit for depression.
- Denominator: Number of Veterans with depression diagnoses (all diagnostic positions) from an outpatient visit in the last four quarters.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% SMI-dxed Vets w/ psychosocial tx	Psy34	1	↑	**34.3**: 41.8: 49.7	96,729	231,817	41.73%	97,433	232,476	41.91%	97,527	233,039	41.85%

- Measure Description: Percentage of Serious Mental Illness (SMI)-diagnosed Veterans with psychosocial treatment for SMI.
- Numerator: Number of Veterans with SMI diagnoses and a psychotherapy or psychosocial treatment visit for SMI.
- Denominator: Number of Veterans with SMI diagnoses (all diagnostic positions) from an outpatient visit in the last four quarters.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% SUD-dxed Vets w/ psychosocial	Psy36	1	↑	**31.5**: 39.3: 49.1	203,145	508,022	39.99%	205,868	515,128	39.96%	206,591	520,115	39.72%

- Measure Description: Percentage of Substance Use Disorder (SUD)-diagnosed Veterans with psychosocial treatment for SUD.
- Numerator: Number of Veterans with SUD diagnoses and a psychotherapy or psychosocial treatment visit for SUD.
- Denominator: Number of Veterans with SUD diagnoses (all diagnostic positions) from an outpatient visit in the last four quarters.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% PTSD-dxed patients w/	Psy38	1	↑	**46.1**: 56.1: 66.5	380,624	689,373	55.21%	385,547	698,902	55.16%	388,186	707,953	54.83%

- Measure Description: Percentage of Post Traumatic Stress Disorder (PTSD)-diagnosed Veterans with psychotherapy visit for PTSD.
- Numerator: Number of Veterans with PTSD diagnoses and a psychotherapy visit for PTSD.
- Denominator: Number of Veterans with PSTD diagnoses (all diagnostic positions) in the last four quarters.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% PTSD-dxed patients receiving	PTSD56	1	↑	**10.6**: 18.1: 30.3	130,172	699,601	18.61%	131,238	717,346	18.29%	130,447	726,309	17.96%

- Measure Description: Percentage of PTSD-diagnosed patients receiving specialty PTSD outpatient care.
- Numerator: Number of Veterans with PTSD diagnoses who had at least two visits to a specialized outpatient PTSD specialist or program, or at least two evidence-based psychotherapy templates for cognitive processing therapy or prolonged exposure.
- Denominator: Number of Veterans with PTSD diagnoses (all diagnostic positions) in the last four quarters.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Pts w/ schizophrenia, bipolar	SMIE1	1	↑	**0.4**: 1.4: 2.8	3,576	235,717	1.52%	3,655	238,839	1.53%	3,714	239,218	1.55%

- Measure Description: Percentage of patients with schizophrenia, bipolar disorder, or other psychoses using supported employment services.
- Numerator: Number of Veterans with schizophrenia, bipolar disorder, or other psychoses diagnoses who used supported employment services in the last four quarters.
- Denominator: Number of Veterans with schizophrenia, bipolar disorder, or other psychoses diagnoses.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Number of Veterans with opioid	SUD16	1	↑	**17.0**: 30.9: 46.9	24,875	65,933	37.73%	25,490	65,976	38.64%	25,963	65,982	39.35%

- Measure Description: Percent Number of Veterans with opioid use disorder (OUD) diagnoses who received medication-assisted treatment (MAT).
- Numerator: Number of Veterans with OUD diagnoses who received opioid agonist or antagonist treatment or who had a visit to an opioid substitution clinic.
- Denominator: Number of Veterans with OUD diagnoses.

Population Coverage Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% SUD-dxed patients with intensive	SUD4	1	↑	**2.8**: 5.6: 10.1	31,157	532,475	5.85%	31,459	539,144	5.83%	31,338	544,047	5.76%

- Measure Description: Percentage of SUD-diagnosed Veterans who used intensive SUD treatment.
- Numerator: Number of Veterans with SUD diagnoses who received intensive SUD treatment.

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- Denominator: Number of Veterans with SUD diagnoses (all diagnostic positions) from an outpatient visit, residential stay or inpatient stay in the last four quarters.

B. Continuity of Care Composite

- Continuity of MH care measure is comprised of 13 continuity-of-care measures.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
Continuity of MH Care	Cont3		↑	-0.5: -0.1: 0.5	--	--	0.08	--	--	0.13	--	--	0.18
% Vets w/ ICMHR-targeted dx and	HIAS22	0.33	↑	30.2: 54.6: 75.4	4,574	8,674	52.73%	4,985	8,691	57.36%	5,258	8,748	60.11%

- Measure Description: Percentage of Veterans with ICMHR-targeted diagnoses and services with at least 12 ICMHR visits in the past 90 days.
- Numerator: Number of Veterans with ICMHR-targeted diagnoses and services who received 12 or more ICMHR visits in the past 90 days.
- Denominator: Number of Veterans with ICMHR-targeted diagnoses who receive five or more ICMHR visits in the past year.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Vets w/ PRRC-targeted dx and	HIAS73	0.33	↑	38.2: 53.4: 67.5	7,015	13,281	52.82%	7,041	13,618	51.70%	7,391	13,782	53.63%

- Measure Description: Percentage of Veterans with PRRC-targeted diagnoses (schizophrenia, bipolar disorder, other psychoses, PTSD or depression) and services with at least 3 PRRC visits in the past quarter.
- Numerator: Number of Veterans with PRRC-targeted diagnoses (schizophrenia, bipolar disorder, other psychoses, PTSD or depression) and services with at least 3 PRRC visits in the past quarter.
- Denominator: Number of patients with PRRC-targeted diagnoses (schizophrenia, bipolar disorder, other psychoses, PTSD or depression) from an outpatient visit or inpatient stay in the last four quarters who also received three or more PRRC visits in the last four quarters.

Continuity of Care Composite							FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
Care process composite for Veterans at high risk for suicide	HRF7	1	↑	-0.5: 0.4: 0.8	--	--	0.33	--	--	0.50	--	--	0.50
							HRF1 Score			HRF1 Scor			HRF1 Scor
							Transformed			Transfor			Transfor
							HRF2 Score			HRF2 Scor			HRF2 Scor
							Transformed			Transfor			Transfor
							HRF5 Score			HRF5 Scor			HRF5 Scor
							Transformed			Transfor			Transfor

- Measure Description: Care process composite for Veterans at high risk for suicide. HRF1: Percentage of Veterans with a new assignment or reactivated High Risk Flag (HRF) with a Safety Plan documented within 7 days before or after flag initiation, or on or before discharge; HRF2: Percentage of Veterans with a new assignment or reactivated HRF who received at least four MH visits within 30 days or flag initiation; HRF5: Percentage of Veterans with a new assignment, reactivated, or continued HRF who received a case review within 100 days after flag initiation.
- Numerator: Total of equally weighted, transformed or standardized scores for the three measures minus low HRF activity.
- Denominator: Veterans who are assigned a new assignment or reactivated HRF for suicide (all constituent measures), and Veterans whose HRF was continued (for constituent measure HRF5 only).

Continuity of Care Composite							FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% pts on new antidepressant med	MDD43h	0.5	↑	62.9: 76.4: 85.9	64,358	83,927	76.68%	65,065	83,891	77.55%	71,190	91,386	77.90%

- Measure Description: Effective Acute Phase Treatment (12 weeks).
- Numerator: Number of depression-diagnosed patients who received greater than or equal to 84 days of antidepressant medication through 114 days after index prescription start date (115 total days).
- Denominator: Number of patients with a depression diagnoses newly treated with antidepressant medication.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
Effective Continuation Phase	MDD47h	0.5	↑	**49.3**: 60.7: 69.6	52,037	83,927	62.00%	52,290	83,891	62.33%	57,605	91,386	63.03%

- Measure Description: Effective Continuation Phase Treatment (6 months).
- Numerator: Number of depression-diagnosed patients who received greater than or equal to 180 days of antidepressant medication through 231 days after index prescription start date (232 total days).
- Denominator: Number of patients with depression diagnosis newly treated with antidepressant medication.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% pts diagnosed with SMI who have	MHO027	0.5	↑	**69.2**: 77.4: 83.5	222,080	290,117	76.55%	224,036	293,147	76.42%	225,243	294,148	76.57%

- Measure Description: Percentage of patients diagnosed with SMI who have an assigned primary care provider and a primary care visit.
- Numerator: Number of Veterans with SMI diagnoses who have an assigned primary care provider and a primary care visit.
- Denominator: Number of Veterans with SMI diagnoses (outpatient encounter or inpatient stay in the past eight quarters).

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% high-risk pts diagnosed with SMI	MHO028	0.5	↑	**66.3**: 69.9: 75.5	121,701	174,310	69.82%	123,558	177,553	69.59%	123,828	177,855	69.62%

- Measure Description: Percentage of high-risk patients diagnosed with SMI who have a MH visit every six months.
- Numerator: Number of high-risk Veterans with SMI diagnoses who have one or more MH visits every six months in the past year.
- Denominator: Number of Veterans with SMI diagnoses who have an adverse or high-risk event in the past two years.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Inpatient and residential MH	PDE1	1	↑	**63.5**: 70.9: 80.9	88,854	121,337	73.23%	88,565	120,659	73.40%	89,387	121,415	73.62%

- Measure Description: Percentage inpatient and residential MH discharges with outpatient MH care engagement within 30 days post-discharge.
- Numerator: Number of qualifying discharges in Groups 1-3 with the respective number of face-to-face, telehealth or telephone encounters in any primary or secondary 500-series MH stop code 30 days after discharge.

- Denominator: Number of qualifying discharges in Groups 1-3. Group 1: Number of discharges from MH RRTP or medical treating specialties with principally diagnosed MH conditions. Group 2: MH inpatient discharges. Group 3: Discharges with an active high-risk flag or diagnoses related to suicide.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% depression-dxed & trtd Vets w/ 5	Psy33	0.25	↑	**14.0**: 20.5: 30.0	76,131	373,360	20.39%	76,299	378,624	20.15%	78,143	385,275	20.28%

- Measure Description: Percentage depression-diagnosed and treated Veterans with 5 psychotherapy visits in 10 weeks.
- Numerator: Number of Veterans with depression diagnoses and a psychotherapy visit for depression who received at least five psychotherapy treatments for depression in a 10-week period, weighted to apply a 30% higher weight to cases when at least three visits were provided using an evidence-based psychotherapy protocol for depression.
- Denominator: Number of Veterans with depression diagnoses and a psychotherapy visit for depression in the last four quarters.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% SMI-dxed&trtd Vets w/ 5	Psy35	0.25	↑	**27.7**: 39.8: 54.1	34,840	87,159	39.97%	34,688	87,121	39.82%	34,795	87,119	39.94%

- Measure Description: Percentage SMI-diagnosed and treated Veterans with five psychosocial treatments in 10 weeks.
- Numerator: Number of Veterans with SMI diagnoses and a psychotherapy visit for SMI who received at least five psychotherapy treatments for SMI in a 10-week period, weighted to apply a 30% higher weight to cases when at least three visits were provided using an evidence-based psychotherapy protocol for SMI.
- Denominator: Number of Veterans with SMI diagnoses and a psychotherapy or psychosocial treatment for SMI in the last four quarters.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% SUD-dxed&trtd Vets w/ 4	Psy37	0.25	↑	**37.0**: 47.6: 57.5	86,542	187,050	46.27%	86,204	186,905	46.12%	86,650	187,835	46.13%

- Measure Description: Percentage of SUD-diagnosed and treated Veterans with four psychosocial treatments in eight weeks.
- Numerator: Number of Veterans with SUD diagnoses and a psychotherapy or psychosocial treatment visit for SUD who received at least four psychosocial or psychotherapy treatments for SUD in an eight-week period, weighted to apply a 30% higher weight to cases when at least two visits were provided using an evidence-based psychotherapy for SUD.
- Denominator: Number of Veterans with SUD diagnoses and a psychotherapy or psychosocial treatment visit for SUD in the last four quarters.

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Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% PTSD-dxed & trtd Vets w/ 5	Psy39	0.25	↑	**27.7**: 35.7: 48.4	121,718	337,320	36.08%	121,326	338,378	35.86%	121,780	340,603	35.75%

- Measure Description: Percentage of PTSD-diagnosed and treated Veterans with five psychotherapy visits in 10 weeks.
- Numerator: Number of Veterans with PTSD diagnoses and a psychotherapy visit for PTSD who received at least five psychotherapy treatments for PTSD in a 10-week period, weighted to apply a 30% higher weight to cases when at least three visits were provided using an evidence-based psychotherapy protocol for PTSD.
- Denominator: Number of Veterans with PTSD diagnoses and a psychotherapy visits for PTSD in the last four quarters.

Continuity of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Denominator	Score	Numerator	Denominator	Score	Numerator	Denominator	Score
% Pts w/ schizophrenia, bipolar	SMIE3	0.33	↑	**17.9**: 38.5: 62.3	1,346	3,576	37.64%	1,598	3,655	43.72%	1,680	3,714	45.23%

- Measure Description: Percentage of patients with schizophrenia, bipolar disorder, or other psychoses using supported employment services with three supported employment (SE) visits in the last 90 days.
- Numerator: Number of Veterans with schizophrenia, bipolar disorder, or other psychoses diagnoses who received three or more SE services visits in the past 90 days.
- Denominator: Number of Veterans with schizophrenia, bipolar disorder, or other psychoses diagnoses who received three or more SE visits in the past year.

C. Experience of Care Composite

- Experience of MH Care is composed of both provider (annual MH Provider Survey) and patient (quarterly Veterans Satisfaction Survey) survey responses.

Experience of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Total N	Score	Numerator	Total N	Score	Numerator	Total N	Score
Experiences of MH Care	ExpC1		↑	**-0.8**: -0.1: 1.0	--	--	0.02	--	--	0.03	--	--	0.00
MH Provider Survey--Collaborative	MHPC3	0.25	↑	**3.4**: 3.7: 4.0	--	--	3.73	--	--	3.77	--	--	3.77

- Measure Description: Mean or average of six MH Provider Survey collaborative care items including team meets regarding improving patient access, actions to improve patient access, discuss program improvement, discussion Handbook requirements, workgroup communicates well, and cooperative spirit.

- Numerator: Average of the six items described above.
- Denominator: 30 possible points from the six included items.

Experience of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Total N	Score	Numerator	Total N	Score	Numerator	Total N	Score
MH Provider Survey--Job	MHPS4	0.25	↑	**3.3**: 3.7: 4.0	--	--	3.66	--	--	3.63	--	--	3.63

- Measure Description: Mean or average on two MH Provider Survey job satisfaction items including 1) considering everything, how satisfied are you with your job? And 2) Overall, how would you rate your level of burnout?
- Numerator: Average of the two items.
- Denominator: 10 possible points from the two included items.

Experience of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Total N	Score	Numerator	Total N	Score	Numerator	Total N	Score
MH Provider Survey--Quality of MH	MHPQ2	0.25	↑	**3.5**: 3.9: 4.2	--	--	3.85	--	--	3.82	--	--	3.82

- Measure Description: Mean or average of five MH Provider Survey quality of care items including well-coordinated care, facility has best practices; MH programs effective; MH integration with Primary Care working well; facility MH care Veteran-centered and recovery-oriented.
- Numerator: Average of the five items.
- Denominator: 25 possible points from the five included items.

Experience of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Total N	Score	Numerator	Total N	Score	Numerator	Total N	Score
MH Provider Survey--Timely Access	MHPA1	0.25	↑	**2.5**: 2.8: 3.1	--	--	2.82	--	--	2.85	--	--	2.85

- Measure Description: Mean or average of six MH Provider Survey timely care items including schedule patients as needed, schedule allows evidence-based practice sessions, workload reasonable, collateral duties reduce care time, support staff could do some of work, and vacancies affect patient care.
- Numerator: Average of the six items.
- Denominator: 30 possible points of the six included items.

Experience of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Total N	Score	Numerator	Total N	Score	Numerator	Total N	Score
Veteran Satisfaction Survey--MH	VSAA1	1	↑	3.7: 3.9: 4.0	--	--	3.84	--	--	3.85	--	--	3.84

- Measure Description: Mean or average of eight Veteran Satisfaction Survey access to care items including appointments on the day I want; can see providers as much as I should; will get a call back if I leave a message; therapies I am interested in are available when I am; can see provider who prescribes medications as frequently as needed; can get in touch with provider or pharmacist by phone; asked if I need to speak with a provider immediately; and asked if interested in having other involved in treatment.
- Numerator: Average of the eight items.
- Denominator: 40 possible points of the eight included items.

Experience of Care Composite					FY2019 Qtr1			FY2019 Qtr2			FY2019 Qtr3		
Measure Description	Measure Name	Measure Weight	Preferred Direction	FY18 Nat'l Score 10th-50th-90th ptile	Numerator	Total N	Score	Numerator	Total N	Score	Numerator	Total N	Score
Veteran Satisfaction Survey--Patient-	VSPC2	1	↑	4.0: 4.1: 4.3	--	--	4.14	--	--	4.14	--	--	4.14

- Measure Description: Mean or average of eight Veteran Satisfaction Survey patient-centered care items including treated with respect and kindness; treatment has been helpful in my life; feel more hopeful about the future; focus on the computer rather than engaging with me; able to choose treatments I want; taken my personal preferences and goals into consideration; and open to discussing potential changes to my treatment plan.
- Numerator: Average of the eight items.
- Denominator: 40 possible points of the eight included items.

Veterans Equitable Resource Allocation

Embedded are both Excel spreadsheets provided to the Workgroup.

2020 Hiearchy.xlsx

October data requests for FY18 da

Patients with MH care FY18_11052019.

National Academies of Medicine Evaluation of the Department of Veterans Affairs Mental Health Services

This is the link to the full report and abstracts on MAX.gov:
https://community.max.gov/display/VAExternal/NAM+Study