COVER COMMISSION

Creating Options for Veterans' Expedited Recovery

Duty 5
Analytical Summary Report

October 21, 2019

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Creating Options for Veterans' Expedited Recovery

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BACKGROUND & INTRODUCTION

Approach & Purpose

To satisfy the Duty 5 legislative mandate, existing quantitative and qualitative data sources were analyzed to inform the Duty 5 Workgroup and the Commission's final recommendations.

The Duty 5 Workgroup began identifying data sources in February 2019. This process included meetings with various VA program offices to discuss existing quantitative and/or qualitative data sources that were relevant to the Commission's fifth legislative mandate.

By February 2019, the Workgroup began discussing the elements to be included in the analytical plan. By March 7, 2019, the outline was drafted including identifying key questions that were aligned to the subcomponents of the legislative mandate of Duty 5. The analytical plan served to guide the use and analyses of existing data sources identified to address the Workgroup's key questions. The key questions were drafted by May 28, 2019 and finalized by June 4, 2019. The key questions ensure the legislative mandate is answered. Using the key questions, a full analytical plan was finalized by August 9, 2019.

Figure 1. Timeline of the Duty 5 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 Options 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).

Per the CARA legislation, for Duty 5, the Commission shall:

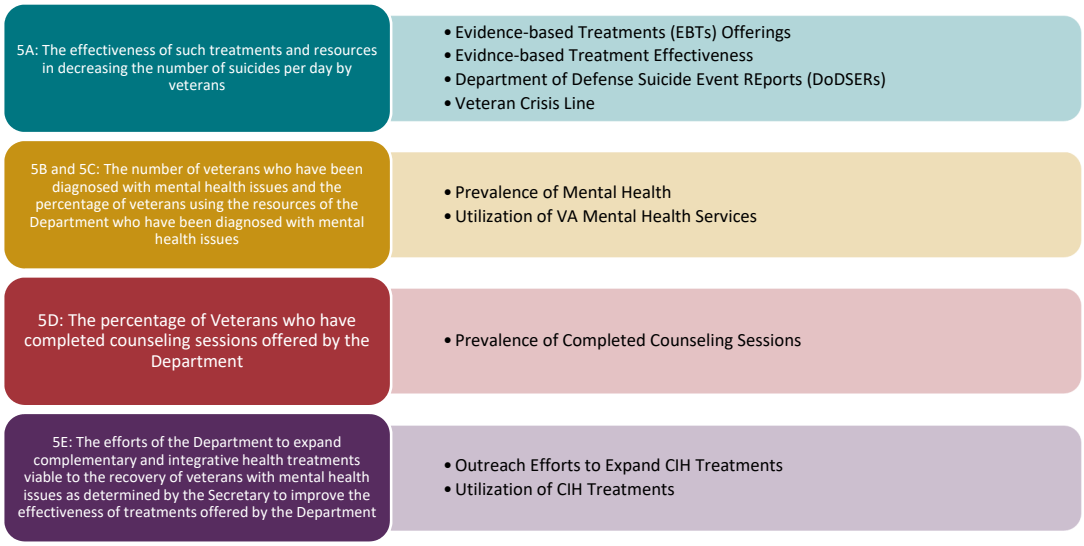
> *Study the current treatments and resources available within VA and assess:*
>
> *(A) The effectiveness of such treatments and resources in decreasing the number of suicides per day by Veterans;*
>
> *(B) The number of Veterans who have been diagnosed with mental health issues;*
>
> *(C) The percentage 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 VA; 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.*

METHODOLOGY

Key Questions

See Appendix B for a full listing of the key questions identified for each legislative subcomponent of Duty 5. They have been grouped into the topics below.

Figure 2. Key Question Topics Aligned to the Duty 5 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 conducted literature reviews, identifying relevant tables and figures from peer-reviewed publications that have been aligned to the key questions and subcomponents of the Duty 5 legislation. Each data source evaluates a different Veteran subpopulation and includes its own methodology. An overview of each data source and specific analyses conducted for each dataset are provided below.

Veterans Crisis Line. The mission of the Veterans Crisis Line (VCL) is to reduce the number of suicides by reducing immediate stress, offering callers options, and referring them to the nearest appropriate VA or community resources. The VCL connects Service members and Veterans in crisis, as well as their family members and friends, with qualified, caring VA responders through a confidential toll-free hotline, online chat, or text-messaging service.[1] For this report, the VCL team[2] provided caller demographic characteristics and outcomes data for FY 2018 (October 2017-September 2018). The VCL team provided deidentified data from the Medora database in an Excel spreadsheet. Estimates of prevalence were calculated for

[1] *Veteran Crisis Line*. Retrieved from https://www.mentalhealth.va.gov/suicide_prevention/veterans-crisis-line.asp. Accessed October 17, 2019.
[2] Data was provided by Mary Woodruff, LMHC, Advisor and Program Analyst for the Veterans Crisis Line, VHA, Office of Mental Health & Suicide Prevention (OMHSP), VA.

demographic characteristics of all callers, suicide behavior, desire to harm, risk assessment, and caller outcomes by month for FY 2018. Analysis was conducted using Excel. The VCL team also provided a PowerPoint presentation (PPT)[3] that was presented at the VA/DoD Suicide Prevention Conference in August 2019. The PPT provides an overview of VCL as well as presenting information on studying the effectiveness of VCL, Veteran suicide surveillance, and preventing suicide among VCL callers. See Appendix C for a copy of the PPT.

VCL has over 400 Suicide Prevention Coordinators, 520 responders, and 77 social service assistants (Miller et al. presentation, slide 6, see Appendix C). VCL offers comprehensive training and quality assurance programs with classroom training, on the job training, supervisor verification, and ongoing call monitoring for quality assurance to evaluate, coach, and continually improve service. On slide 10, Miller et al. states the goal of VA's suicide prevention efforts is not to get every Veteran enrolled in VA care but, rather, to equip communities to help Veterans get the right care, whenever and wherever they need it.

Limitations of the VCL data include there is no race or ethnicity information collected and the caller demographics being predominantly male, non-Hispanic white, and between 60-69 years old, so that the results may not be generalizable to other Veteran populations.

Clinical Inventory Questionnaire. The Clinical Inventory Questionnaire was developed by the Workgroup to determine which evidence-based mental and behavioral health treatments are offered by VA. The evidence-based treatments included in the questionnaire were identified using the VA-DoD Clinical Practice Guidelines (CPGs). Those treatments that were found to be effective, including evidence-based treatments that were recommended in the CPGs, were included in the questionnaire and stratified by the mental health (MH) conditions that align with Duty 3. The MH conditions included were Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD), Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), Suicide Prevention, and Chronic Insomnia Disorder.

Between September to October 2019, the Clinical Inventory Questionnaire was distributed, with the assistance of the Office of the Deputy Under Secretary for Health Operations Management (DUSHOM), to all 18 Veterans Integrated Services Networks (VISNs) and completed at the facility-level. The completed questionnaires were provided[4] to the Workgroup for analysis. In total, the questionnaire was completed by 97 healthcare facilities across 15 VISNs. VISNs 20, 22, and 23 did not respond to the questionnaire and were not included in the analyses. Using Excel, the Commission aggregated the questionnaire responses and reported results at the VISN-level to better assess the availability of treatments across VISNs.

Limitation of the data includes not all 18 VISNs are represented. As mentioned previously, VISNs 20, 22, and 23 did not submit any responses by the timeframe specified and were not included in the analyses. The data is also not representative of all the facilities within each of the VISNs that did participate; therefore, the estimates of prevalence may be underestimated.

[3] PowerPoint presentation was by provided Dr. Terrence Hubert, Health Systems Specialist, Suicide Prevention Office, Office of Mental Health & Suicide Prevention (OMHSP), VA.
[4] Casin Spero, Executive Director, COVER Commission, provided the completed questionnaires to the Workgroup.

Complementary and Integrative Health Veteran Preference Survey. In July 17-25, 2017, Taylor et al. (2019)[5] conducted the first national survey of Veterans' interest in, frequency of, and reasons for use of, and satisfaction with 26 complimentary and integrative health (CIH) approaches. A convenience sample was used, inviting members of the Veterans Insights Panel (VIP) via email (survey link provided) to participate in the survey and were given two weeks to complete the survey. VIP is a national online group of Veteran volunteers who regularly use VA services, designed to provide feedback on VA services and programs. A total of 3,346 surveys were collected, with 1,230 completed surveys, representing a 37% response rate. A copy of the full report can be found in Appendix C.

At the request of the Commission, Dr. Taylor[6] conducted additional analyses using the data collected from the CIH Veteran Preference Survey. The proposed analyses were developed by the Commission and provided to Dr. Taylor. The additional analyses evaluated comparing two subsamples, one for any Veteran who reported using CIH for depression or anxiety, substance use, PTSD, or for improving overall health and well-being ("MH/SUD/Health"= 467) and one for those who reported using CIH for any other reason, which includes pain ("Other"=178). Results were also summarized by Dr. Taylor and provided to the Commission in Word. Some limitations of the study Taylor et al. conducted included:

1. The VIP sample may not be representative of the Veteran population, in general, as they used a large convenience sample of volunteers.

2. The patient population who use VA healthcare is not representative or generalizable to the entire population of Veterans.

3. 37% response rate, although standard for patient surveys, may have resulted in an overestimation of the use of and interest in CIH approaches.

Strategic Analytics for Improvement and Learning. VA developed the Strategic Analytics for Improvement and Learning (SAIL) Model to measure, evaluate and benchmark quality and efficiency at medical centers. The SAIL model highlights successful strategies of VA's top performing medical centers 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 care. Each VA Medical Center (VAMC) is organized slightly differently 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 VAMCs 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

[5] Taylor, S. L., Hoggatt, K. J., & Kligler, B. (2019). Complementary and integrated health approaches: What do Veterans use and want. *Journal of general internal medicine*, *34*(7), 1192-1199.
[6] Analyses and results provided by Dr. Stephanie Taylor, Associate Director, Greater Los Angeles VA HSR&D.

Experience of Care. There are 19 measures that inform the Population Coverage composite and 13 measures that inform the Continuity of Care composite. Both the Veteran Satisfaction Survey and the Mental Health Provider Survey 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[7] and examined the most current data from FY 2019 Quarters 1, 2, and 3 at the national level. An Excel report was generated from the dashboard for all measures included in the domain. The Commission created a supplemental Word document that includes 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 a copy of the detailed report measures and embedded Excel report.

For access and wait times, the Workgroup used the most recently available information provided by VA on their timeliness to care and access to specialty care at the national level.[8] The Commission examined the information and created a summary document for the Workgroup. A limitation of the data included not being able to differentiate wait times and access for MH.

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 their 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 was obtained from 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. The Committee developed 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 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; 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*,

[7] 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.
[8] Information examined from VA's website https://www.accesstocare.va.gov/.

released January 8, 2018.[9] Based on the COVER Commission's mandate to study the entire Veteran population, 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 requested an abstract of information contained in 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 aligned to the Commission's charge contained in this more than 400-page document. After review of the entire report and relevant information was abstracted from Chapters 6 and 8-15. A copy of the abstracted review was provided to the Workgroup and the COVER Commission via email on October 16, 2019.

Healthcare Analysis and Information Group. The FY 2015 VHA Complementary and Integrative Health (CIH) Services Survey was developed with the assistance of the Healthcare Analysis and Information Group (HAIG) to evaluate and report on the current state of Integrative Health services across VA. Data were collected using a web-based survey instrument administered by HAIG. The survey was distributed by VISN officers to facility Chiefs of Staff who collaborated with their CIH point(s) of contact and/or the appropriate Patient Centered Care point(s) of contact to complete the survey. The survey was administered between December 9, 2014 through January 22, 2015. The CIH survey was distributed to 141 VHA Administrative Parents consisting of Medical Centers and Health Care Systems. The response rate for the survey was 100%. Survey data were analyzed independently, in addition to being compared to previous VHA Complementary and Alternative Medicine (CAM) surveys from 2002 and 2011, as available. A copy of the completed report was provided to the Workgroup[10].

The Workgroup created an executive summary of the report, abstracting the key findings aligned to the Commission's and Workgroup's charge. See Appendix C for a copy of the FY 2015 HAIG report and the summary. A serious limitation of this study is that the results are outdated and may not reflect the current state of CIH Services since VHA has made significant efforts to incorporate these services into practice in the intervening time period. The Workgroup decided there is value to include this information as an historical baseline and have met with various VA Subject Matter Experts to discuss current and future CIH plans that address many of the recommendations identified in this report.

Department of Defense Suicide Event Report Annual Reports. The Department of Defense Suicide Event Report (DoDSER) is the official reporting system for suicide events in the U.S. Armed Forces. The DoDSER is an annual surveillance tool utilized to collect standardized data on every Service member who dies by suicide or makes a suicide attempt, regardless of Military Service, Component, or duty status. The DoDSER is primarily used to track, better understand, and communicate general and military-specific risk factors that contribute to the

[9] The National Academies report can be retrieved here http://nationalacademies.org/hmd/Reports/2018/evaluation-of-the-va-mental-health-services.aspx

[10] The report was provided by Brandy Drum, MBA, Project Manager, Healthcare Analysis and Information Group (HAIG), Office of Strategic Planning and Analysis (OSPA), Office of the ADUSH for Policy and Planning

occurrence of suicide. Following every death by suicide and each suicide attempt, the U.S. Armed Forces are required to conduct an extensive investigation into the details pertaining to the event. During the investigation, the DoDSER is used as the primary data collection tool to track specific data elements related to the event (DoDSER 2018).

The DoDSER Annual Report is the culmination of the data collection efforts and a comprehensive look at suicide and suicide-related behaviors across the U.S. Armed Forces. The report provides a thorough overview of the annual figures regarding all suicide events that occurred within the Army, Navy, Air Force, Marine Corps, Reserve Components, and National Guard Bureau over the course of the Calendar Year (CY). The CY 2016 DoDSER Annual Report includes cases of suicide death and suicide attempts by Service members that occurred between January 1, 2016 to December 31, 2016. The CY 2017 DoDSER report includes cases of suicide death and suicide attempts by Service members that occurred between January 1, 2017 to December 31, 2017. The CY 2016 and CY 2017 DoDSER annual reports' data collection forms contained more than 500 data elements which provided comprehensive information about the lives of the Service members who died by suicide or who engaged in suicide attempts. Data elements include medical and behavioral health information, military history, legal and/or disciplinary actions, and specific characteristics of the suicide death or suicide attempt that occurred (DoDSER 2018).

Interpretation of the DoDSER reports comes with certain limitations. The primary goal of the DoDSER Annual Report and of the DoDSER system overall is the collection, organization, and presentation of data relevant to the occurrence of suicide and suicide attempts in the military community. The DoDSER is a surveillance system and should not be regarded as a research study. It is not possible to analytically determine a causal relationship between risk factors and suicide-related behavior solely based on the data presented in the report. Further research is required before inferring any causal roles for specific risk or protective factors (DoDSER 2018). The Workgroup created executive summaries, one for each of the annual reports. The summaries abstract key findings and relevant data tables, relevant to the Commission's charge, to provide a shorter summary for both the Commissioners and the COVER Commission writers to examine. Copies of both reports and their respective executive summaries are found in Appendix C.

KEY FINDINGS

This section presents key findings for each data source aligned to the subcomponents of Duty 5.

Duty 5A: Assessing the effectiveness of the current treatments and resources available within the Department in decreasing the number of suicides per day by Veterans

Evidence-based Treatments (EBT) Offerings

The Clinical Inventory Questionnaire describes the availability of evidence-based treatments across VA facilities specific to Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD), Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), Suicide Prevention, and Chronic Insomnia Disorder. Overall, there were few Veterans Integrated Services Networks (VISNs) which do not offer most evidence-based treatments in at least one of their facilities. There is consistent variation in the treatment options available to Veterans who engage in health services at any of the surveyed health facilities. Refer to Tables C-4 to C-9 in the Appendix for additional details about the aggregated data, by VISN, for each of the MH conditions listed below.

Major Depressive Disorder (MDD)

All facilities that participated offered at least one evidence-based MDD treatment. Except for VISN 7, all VISNs offered all evidence-based MDD treatments in at least one facility within the VISN. No VISN 7 facilities reported offering Mindfulness-based Cognitive Therapy (MBCT) treatments.

Post Traumatic Stress Disorder (PTSD)

Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) were the most commonly endorsed therapies, as all facilities offered CPT services and 99% of facilities offered PE services. All VISNs offered at least one evidence-based treatment for PTSD; however, several VISNs (2, 6, 7, 9, 10, 15, and 16) did not have any facilities that offered Brief Eclectic Therapy (BET) or Narrative Exposure Therapy (NET) as a treatment option.

Alcohol Use Disorder (AUD)

Motivational Enhancement Therapy (MET) services were the most commonly offered intervention for AUD (99%). At least one evidence-based AUD treatment was offered across all surveyed facilities within each VISN. Except for VISN 7, all VISNs offered all evidence-based AUD treatments in at least one facility within the VISN. VISN 7 facilities did not report offering Community Reinforcement Approach (CRA) treatments.

Opioid Use Disorder (OUD)

Regarding pharmacotherapy interventions, 99% of facilities offered Buprenorphine/Naloxone therapies, while 31% offered Methadone therapies. Of note, no facilities in VISN 9 reported offering Methadone therapies. Regarding psychosocial interventions, 98% of VHA facilities

offered individual counseling, and 60% of facilities offered contingency management interventions.

Suicide Prevention

The evidence-based psychotherapies for Suicide Prevention in the questionnaire were Cognitive Behavior Therapy (CBT) for Suicide and Dialectical Behavior Therapy (DBT). DBT is the most commonly offered suicide prevention intervention; 80.4% of VHA facilities reported offering DBT services. Additionally, 61% of facilities reported offering CBT for suicide prevention.

Chronic Insomnia Disorder

The evidence-based psychotherapies for Chronic Insomnia Disorder in the questionnaire were Cognitive Behavior Therapy (CBT) for Insomnia and Brief Behavior Therapy for Insomnia. Approximately 98% of VHA facilities reported offering CBT for Insomnia, while only 44.3% reported offering Brief Behavior Therapy for Insomnia. No facilities within VISN 7 reported offering Brief Behavior Therapy for Insomnia.

Evidence-based Treatments Effectiveness

VA uses systematic and tested dissemination strategies to increase provider knowledge and the use of Evidence-based Practices (EBPs) in the treatment of Veteran mental health problems throughout its health system. However according to the *Evaluation of the Department of Veterans Affairs Mental Health Services* study, the availability of EBPs, the implementation of evidence-based psychotherapies and the fidelity to EBPs is low, especially for PTSD. Many Veterans diagnosed with PTSD, depression, and SUD do not receive the recommended treatments (National Academies 2018, chapter 11).

Comparative data show that VA outperforms the private sector on seven process-based quality measures assessing medication treatment for mental health disorders, suggesting that VA provides better care in these areas than does the private sector. Nonetheless, large percentages of Veterans are not getting care as set forth in clinical standards for dosage, frequency, and follow-up (National Academies, 2018, chapter 11).

Department of Defense Suicide Event Reports (DoDSERs)

The Department of Defense Suicide Event Report (DoDSER) describes the rate of suicide deaths and non-fatal suicide attempts among members of the U.S. Armed Forces. The DoDSER provides an annual glance at the number of suicide events that occurred the Army, Navy, Air Force, Marine Corps, Reserve Components, and National Guard Bureau over the course of the specified Calendar Year (CY).

In CY 2017, the suicide-mortality rate for the Active Component (combined across all military services) was 21.9 deaths per 100,000 population. The suicide-mortality rates across each service division were the following for CY 2017[11]:

[11] Pruitt, L. D., Smolenski, D. J., Tucker, J., Issa, F., Chodacki, J., McGraw, K., and Kennedy, C. H. (2019). *Department of Defense Suicide Event Report (DoDSER) Calendar Year 2017 Annual Report*. Psychological Health Center of Excellence, Research and Development, Defense Health Agency

- Air Force: 19.3 suicides per 100,000 population
- Army: 24.3 suicides per 100,000 population
- Marine Corps: 23.4 suicides per 100,000 population
- Navy: 20.1 suicides per 100,000 population
- Reserve Component (combined across all military services): 25.7 deaths per 100,000 population
- National Guard Component (combined across Air and Army National Guard): 29.1 deaths per 100,000 population.

In comparison to the CY 2016 DoDSER annual report, suicide-mortality rates were not statistically significantly different. In CY 2016, the suicide-mortality rate for the Active Component (combined across all military services), was 21.1 deaths per 100,000 population.

In CY 2017, there were 1,397 of non-fatal suicide attempts among Service members in the Active Component. Suicide attempts were most common among non-Hispanic White, male Service members, between 20–24 years of age. The CY 2016 DoDSER included 1,263 non-fatal suicide attempts, and the same demographic characteristics were identified as the most common factors.

In CY 2016, 44.1% of Service members who died by suicide had at least one mental health diagnosis, while 61.8% of those who attempted suicide had been previously diagnosed with a mental health condition. Health and/or social services were accessed 90 days prior to the event in 58.5% of suicide deaths and 69.3% of suicide attempts. In CY 2017, nearly half (48.5%) of the Service members in the Active Component of the military who died by suicide had at least one documented mental health diagnosis. Approximately 51.5% of Service members who died by suicide and 59.3% of Service members who attempted suicide received some form of health or social services within 90 days prior to the event (DoDSER 2019).

Veterans Crisis Line

The following presents FY 2018 Veterans self-reported responses from Veterans Crisis Line (VCL). Table 2 presents data on demographic characteristics of all VCL callers for FY 2018, by month. VCL does not capture race or ethnicity information. As seen in the table, there are many "unknown" for self-reported age among callers to VCL. There is representation from all age groups in FY 2018, with 60-69 years age group having the highest number of callers overall, followed by the 50-59 years age group. Most of the callers tend to be male. There is representation of all military branches using the VCL hotline, with a large number not stating any military branch. Of those Veterans that reported a branch of service, Army has the highest reported number of callers consistently for every month in FY 2018. Most callers report a Veteran status (n=406,607) compared to non-Veteran status (n=285,223). In FY 2018, besides the large number of "unknown", most of the callers are enrolled and have received VA services.

Appendix C (Table C-1) includes information on Veterans self-reported thoughts of suicidality and suicidal attempts in FY 2018, by month.

Most of the callers in Table 1, when asked about their desire to harm themselves or others, answered "no".

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Table 1: Veterans Self-reported Desire to Harm Self or Others in FY 2018

Month	All Records	Desire to Harm Self or Others - High	Desire to Harm Self or Others - Moderate	Desire to Harm Self or Others - No Answer	Desire to Harm Self or Others - None
	N	n (%)	n (%)	n (%)	n (%)
Oct-17	63,861	1,359 (2.13)	3,410 (5.34)	36,484 (57.13)	22,608 (35.40)
Nov-17	62,946	1,362 (2.16)	3,265 (5.19)	36,760 (58.40)	21,559 (34.25)
Dec-17	61,469	1,316 (2.14	3,213 (5.23)	35,687 (58.06)	21,253 (34.58)
Jan-18	63,004	1,268 (2.01)	3,247 (5.15)	36,789 (58.39)	21,700 (34.45)
Feb-18	56,872	1,091 (1.91)	2,958 (5.20)	32,518 (57.18)	20,305 (35.71)
Mar-18	61,944	1,264 (2.04)	3,230 (5.21)	34,924 (56.38)	22,526 (36.37)
Apr-18	57,194	1,287 (2.25)	3,071 (5.37)	31,225 (54.59)	21,611 (37.79)
May-18	48,574	1,001 (2.06)	2,480 (5.11)	26,150 (53.84)	18,943 (39.00)
Jun-18	53,358	1,151 (2.16)	3,010 (5.64)	28,740 (53.86)	20,457 (38.34)
Jul-18	54,301	1,197 (2.20)	3,100 (5.71)	29,877 (55.02)	20,127 (37.07)
Aug-18	55,430	1,282 (2.31)	3,122 (5.63)	30,076 (54.26)	20,950 (37.80)
Sep-18	55,003	1,251 (2.27)	2,894 (5.26)	30,371 (55.22)	20,487 (37.25)

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Table 2. Demographic Characteristics of all Callers in FY 2018

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Age	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
18-29	2,37 (3.72)	2,102 (3.34)	2,042 (3.32)	2,265 (3.60)	1,851 (3.25)	2,130 (3.44)	2,032 (3.55)	1,427 (2.94)	1,753 (3.29)	1,728 (3.18)	1,724 (3.11)	1,706 (3.10)
30-39	3,043(4.77)	3,021(4.80)	2,936(4.78)	3,230(5.13)	2,596(4.56)	2,846(4.59)	2,730(4.77)	2,371(4.88)	2,921(5.47)	2,848(5.24)	3,037(5.48)	2,816(5.12)
40-49	2,345(3.67)	2,261(3.59)	2,189(3.56)	2,290(3.63)	1,943(3.42)	2,366(3.82)	2,165(3.79)	1,935(3.98)	2,214(4.15)	2,269(4.18)	2,158(3.89)	2,127(3.87)
50-59	3,898(6.10)	3,720(5.91)	3,669(5.97)	3,771(5.99)	3,067(5.39)	3,375(5.45)	3,231(5.65)	3,077(6.33)	3,401(6.37)	3,179(5.85)	3,344(6.03)	3,039(5.53)
60-69	4,111(6.44)	3,857(6.13)	3,571(5.81)	3,708(5.89)	3,233(5.68)	3,591(5.80)	3,319(5.80)	3,093(6.37)	3,751(7.03)	3,547(6.53)	3,557(6.42)	3,594(6.53)
70-79	1,563(2.45)	1,547(2.46)	1,442(2.35)	1,857(2.95)	1,517(2.67)	1,565(2.53)	1,618(2.83)	1,522(3.13)	1,667(3.12)	1,660(3.06)	1,527(2.75)	1,624(2.95)
80+	705(1.10)	725 (1.15)	663 (1.08)	821 (1.30)	714 (1.26)	684 (1.10)	735 (1.29)	612 (1.26)	768 (1.44)	743 (1.37)	707 (1.28)	679 (1.23)
Under 18	880(1.38)	799 (1.27)	736 (1.20)	914 (1.45)	751 (1.32)	829 (1.34)	740 (1.29)	203 (.42)	260 (.49)	370 (.68)	420 (.76)	468 (.85)
Unknown	44,943(70.38)	44,914(71.35)	44,221(71.94)	44,148(70.07)	41,200(72.44)	44,558(71.93)	40,624(71.03)	34,334(70.68)	36,622(68.64)	37,955(69.90)	38,956(70.28)	38,950(70.81)
Gender												
Male	38,622(60.48)	37,762(59.99)	37,420(60.88)	38,827(61.63)	34,433(60.54)	38,057(61.44)	36,092(63.10)	31,712(65.29)	34,560(64.77)	34,726(63.95)	35,802(64.59)	35,043(63.71)
Female	9,731(15.24)	9,377(14.90)	9,381(15.26)	9,582(15.21)	9,249(16.26)	10,073(16.26)	9,187(16.06)	7,168(14.76)	8,183(15.34)	7,946(14.63)	8,232(14.85)	8,057(14.65)
Unknown	15,508(24.28)	15,807(25.11)	14,666(23.86)	14,593(23.16)	13,186(23.19)	13,814(22.30)	11,915(20.83)	9,694(19.96)	10,615(19.89)	11,629(21.42)	11,396(20.56)	11,903(21.64)
Military Branch												
Air Force	951 (1.49)	1,045(1.66)	851 (1.38)	884 (1.40)	713 (1.25)	863 (1.39)	862 (1.51)	804 (1.66)	919 (1.72)	932 (1.72)	907 (1.64)	814 (1.48)
Army	4,204(6.58)	4,102(6.52)	3,831(6.23)	3,900(6.19)	3,490(6.14)	3,885(6.27)	3,583(6.26)	3,512(7.23)	4,154(7.79)	3,736(6.88)	3,556(6.42)	3,325(6.05)
Coast Guard	69 (.11)	81 (.13)	74 (.12)	82 (.13)	56 (.10)	65 (.10)	60 (.10)	64 (.13)	81 (.15)	87 (.16)	73 (.13)	68 (.12)
Marines	1,597 (2.50)	1,568(2.49)	1,489(2.42)	1,337(2.12)	1,345(2.36)	1,464(2.36)	1,414(2.47)	1,371(2.82)	1,351(2.53)	1,443(2.66)	1,406(2.54)	1,237(2.25)
National Guard	204 (.32)	168 (.27)	157 (.26)	176 (.28)	197 (.35)	159 (.26)	200 (.35)	167 (.34)	162 (.30)	207 (.38)	181 (.33)	169 (.31)
Navy	1,683(2.64)	1,643(2.61)	1,548(2.52)	1,577(2.50)	1,489(2.62)	1,714(2.77)	1,595(2.79)	1,336(2.75)	1,592(2.98)	1,514(2.79)	1,518(2.74)	1,468(2.67)
None	55,153(86.36)	54,339(86.33)	53,519(87.07)	55,048(87.37)	49,582(87.18)	53,794(86.84)	49,480(86.51)	41,320(85.07)	45,099(84.52)	46,382(85.42)	47,789(86.22)	47,922(87.13)
Veteran Status												
Veteran	28,163(44.10)	28,852(45.84)	28,726(46.73)	29,313(46.53)	34,399(60.48)	38,022(61.38)	35,735(62.48)	33,841(69.67)	37,110(69.55)	36,744(67.67)	38,350(69.19)	37,352(67.91)
Non-Veteran	35,482(55.56)	33,905(53.86)	32,574(52.99)	33,514(53.19)	22,305(39.22)	23,726(38.30)	21,310(37.26)	14,570(30.00)	16,065(30.11)	17,363(31.98)	16,932(30.55)	17,477(31.77)
Refused to Answer	216 (.34)	189 (.30)	169 (.27)	177 (.28)	168 (.30)	196 (.32)	149 (.26)	163 (.34)	183 (.34)	194 (.36)	148 (.27)	174 (.32)
Veteran Enrollment Status												
Not Registered	970 (1.52)	935 (1.49)	876 (1.43)	951 (1.51)	916 (1.61)	953 (1.54)	928 (1.62)	775 (1.60)	956 (1.79)	932 (1.72)	928 (1.67)	892 (1.62)
Registered-Not Enrolled	263 (.41)	258 (.41)	215 (.35)	231 (.37)	221 (.39)	247 (.40)	230 (.40)	245 (.50)	329 (.62)	251 (.46)	236 (.43)	294 (.53)
Enrolled-No Services Received	383 (.60)	337 (.54)	343 (.56)	371 (.59)	351 (.62)	355 (.57)	363 (.63)	390 (.80)	440 (.82)	405 (.75)	403 (.73)	407 (.74)
Enrolled-Received Services	16,974(26.58)	16,284(25.87)	15,463(25.16)	16,293(25.86)	14,713(25.87)	16,350(26.39)	15,412(26.95)	14,724(30.31)	16,675(31.25)	16,540(30.46)	16,937(30.56)	15,874(28.86)
Unknown	45,209(70.79)	45,033(71.54)	44,500(72.39)	45,056(71.51)	40,594(71.38)	43,960(70.97)	40,175(70.24)	32,358(66.62)	34,878(65.37)	36,084(66.45)	36,842(66.47)	37,454(68.09)
Refused to Answer	62 (.10)	99 (.16)	72 (.12)	102 (.16)	77 (.14)	79 (.13)	86 (.15)	82 (.17)	80 (.15)	89 (.16)	84 (.15)	82 (.15)

Table 3: Risk Assessment by VCL Responder of Veteran based on Contact in FY 2018

Month	All Records	Risk Assessment - High	Risk Assessment - Moderate to High	Risk Assessment - Moderate to Low
	N	n (%)	n (%)	n (%)
Oct-17	63,861	1,096 (1.72)	2,111 (3.31)	60,654 (94.98)
Nov-17	62,946	1,082 (1.72)	2,022 (3.21)	59,842 (95.07)
Dec-17	61,469	1,053 (1.71)	2,000 (3.25)	58,416 (95.03)
Jan-18	63,004	1,073 (1.70)	1,978 (3.14)	59,953 (95.16)
Feb-18	56,872	927 (1.63)	1,765 (3.10)	54,180 (95.27)
Mar-18	61,944	1,021 (1.65)	1,947 (3.14)	58,976 (95.21)
Apr-18	57,194	981 (1.72)	1,787 (3.12)	54,426 (95.16)
May-18	48,574	814 (1.68)	1,478 (3.04)	46,282 (95.28)
Jun-18	53,358	960 (1.80)	1,843 (3.45)	50,555 (94.75)
Jul-18	54,301	984 (1.81)	1,832 (3.37)	51,485 (94.81)
Aug-18	55,430	1,021 (1.84)	1,834 (3.31)	52,575 (94.85)
Sep-18	55,003	1,006 (1.83)	1,775 (3.23)	52,222 (94.94)

The summation of the three risk assessment columns equate to the total number of callers for each month in FY 2018. Every caller undergoes a risk assessment by the VCL responder. In FY 2018, most callers were assessed as "moderate to low risk".

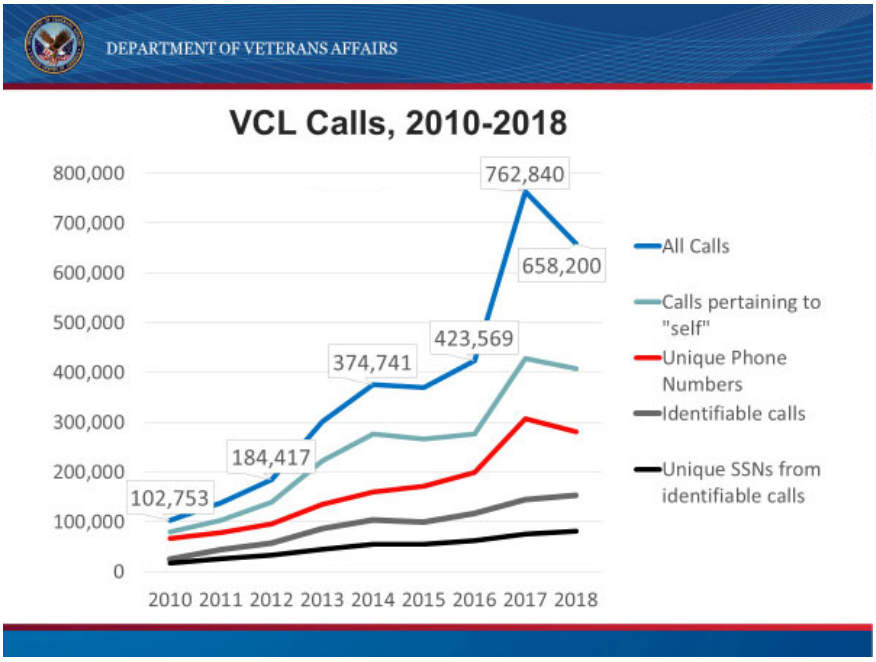
See Appendix C (Table C-2) for Caller Relationship to Veteran for all Callers in FY 2018. The summation of the columns also equate to the total number of callers for each month in FY 2018. Most callers called seeking assistance for themselves.

See Appendix C (Table C-3) for Call Outcomes for all Callers in FY 2018. There are 13 outcomes measured in the VCL dashboard. There are many callers that disconnect (20-25%); however, a larger number of callers (60-68%) stay on the line until the call ends normally. The smallest number of callers are those who went voluntarily to the Emergency Room (ER).

Utilization of VCL for FY 2018

In FY 2018, there were 356,798 unique phone numbers captured in VCL Medora. 670,899 total incoming calls were automatically captured in Avaya software. This includes abandoned calls and multiple calls by the same Veteran over the course in FY 2018. In total, 26,836 texts and 73,919 chat were handled in FY 2018 as well as 29,271 emergency dispatches. Lastly, there were 116,033 Suicide Prevention Coordinators (SPC) referrals to VAMCs for follow-up MH care. As shown in Figure 3: VCL Calls, 2010-2018, there has been an increase in the utilization of the VCL over time.

Figure 3: VCL Calls, 2010-2018



From Miller et al. (2019) PowerPoint presentation, slide 28.

Follow-up MH Care

In FY 2018, a total of 116,031 referrals were placed from Suicide Prevention Coordinators (SPCs) to VAMCs for follow-up MH care. Of those referrals, 97% resulted in timely close-out based on identified criteria, 18.5% were marked by SPCs as not located, and 11% were marked by SPCs as having a scheduled MH appointment.

Outcomes of VCL

Per Miller et al. (2019, slide 16), calls from callers rated as being at high risk by responders and calls during weekday hours (6 AM – 6 PM, EST) were more likely to result in a referral, than in non-resolution or non-referral. Responders use caller intent to die and absence of future plans to determine risk. VCL is mostly used to complement existing VHA mental healthcare, rather than a portal for high-risk Veterans entering VHA (slide 18).

According to the VCL, given the large number of unidentified callers, programs to prevent suicide among Veterans Crisis Line/Military Crisis Line callers should target both Veterans Health Administration (VHA) users and non-users.

From October 1, 2018 to September 30, 2019, VHA screened 3,800,983 unique Veterans were screened for suicide behavior in its ambulatory care clinics. Of those, 2.83% (107,563) screened positive for suicidal ideation. One half of one percent of the 3.8 million go on to require comprehensive suicide risk assessment based on a positive secondary screen. This screening data does not capture Veteran suicidality self-reported in other VHA settings (e.g.. Veterans Crisis Line)[12].

[12] Information provided by Dr. Susan Strickland, Associate Director, Research & Evaluation, OMHSP, VA.

Duty 5B and 5C: Assessing the number of Veterans who have been diagnosed with mental health issues and the percentage of Veterans using the resources of the Department who have been diagnosed with mental health issues

Prevalence of Mental Health

The National MH Data Sheets[13] define "confirmed mental illness" as:

> *A confirmed mental illness is defined as at least two outpatient encounters with any mental health diagnosis in any diagnostic field, or an inpatient/residential stay in which the Veteran had a mental health diagnosis in any diagnostic field. At least one of the outpatient stops must be an in-person encounter; i.e., both encounters can't be telephone contacts. Stays include being in a bed at the end of the fiscal year.*

Table 4. Prevalence of MH among VA users in FY 2016-2018

Fiscal Year	Total VA Service Users	Number of Service Users with Confirmed Mental Illness	Percent of Service Users with Mental Illness
2018	5,954,537	1,593,970	26.77%
2017	5,895,685	1,510,926	25.63%
2016	5,841,668	1,460,685	25.00%

As seen in Table 4, for the past three Fiscal Years (FYs), the percent of service users with mental illness has been between 25-27%. There has been about a 1% increase each FY from 2016-2018. A copy of the FY 2018 National MH Fact Sheet is in Appendix C.

Utilization of VA Mental Health Services

In-person Outpatient Mental Health has the largest proportion (86.78%) of utilization among Veterans with confirmed mental illness in FY 2018. This remains the same for FY 2017 and FY 2016 as seen in Table 5.

Table 5. MH Service Utilization by Veterans with Confirmed Mental Illness in FY 2016-2018

		Proportion of Veterans with Confirmed Mental Illness Seen in:			
FY	Number of Service Users with confirmed Mental Illness	Any Mental Health	Inpatient Mental Health	Residential Mental Health	In-person Outpatient Mental Health
2018	1,593,970	86.79%	3.55%	2.13%	86.78%
2017	1,510,926	87.92%	3.81%	2.27%	87.92%
2016	1,460,685	88.92%	3.95%	2.29%	88.91%

[13] Information provided by COVER Commission subject matter experts, Dr. John Klocek, Dr. Kendra Weaver, and Dr. Stacey Pollack, Office of Mental Health and Suicide Prevention (OMHSP).

Duty 5D: The percentage of Veterans who have completed counseling sessions offered by the Department

Prevalence of Completed Counseling Sessions

This subcomponent of the legislation is being satisfied with a White Paper the Workgroup requested to be completed by one of the COVER Commission's subject matter experts, John Klocek, PhD, with the assistance of Commissioner Shira Maguen, PhD. Presented below are the preliminary results of the White Paper[14].

Counseling

The first consideration is the definition of "counseling." Given that each and every encounter with a mental health provider (including peer support specialists) could be defined as counseling, we may wish to interpret "counseling" as counseling (or psychotherapeutic) services delivered by a mental health provider which does not involve the prescription of medication as a part of the encounter. This is not to diminish the importance of counseling/psychotherapy delivered by prescribing providers, but to emphasize the counseling/psychotherapy provided that is solely dedicated to the delivery of counseling to Veterans.

These services can be clearly tracked through Current Procedural Terminology (CPT) codes. CPT codes are the billing codes defined by Centers for Medicare and Medicaid Services (CMS) that are used by all providers (VHA and private sector) to describe the services provided. For example, the CPT code 90837 describes a 60-minute psychotherapy session. Various VA Mental Health measures on SAIL (please refer to presentation by Dr. Smith from Tampa) use these CPT codes to identify the delivery of counseling/psychotherapy.

Additional considerations would be the setting of care (outpatient; inpatient; residential) and the credentials of the provider delivering the care (Licensed independent providers vs. others)

Completed Counseling

We could think of "completed" in a variety of ways – completed one session, completed a number of sessions, or completed a course of counseling as defined by a measure of successful counseling. I would recommend thinking of it in terms of the tripartite model of access – crisis, initial, and sustained access to counseling/psychotherapy.

<u>Completed Counseling - Crisis/Same Day</u> – The Commission may wish to consider identifying the number or percentage of Veteran's who "completed counseling" on a crisis or same-day basis. We would be able to identify those through the identification of the use of a crisis CPT code, same-day workload, and a measure which identifies the % of Veterans who receive a Primary Care and Primary Care Mental Health Integration encounter on the same day from a licensed independent provider. (*Crisis access*)

<u>Completed Counseling – One Session</u> – VHA Mental Health regularly tracks the number and percentage of Veterans with mental health diagnoses who receive one session of counseling

[14] Information was provided and presented at the January 2019 COVER Commission meeting by Dr. John Klocek, Mental Health Technical Assistance Specialist, Office of Mental Health and Suicide Prevention (OMHSP), VA.

(psychosocial services). These measures would serve to identify the number/percentage of Veteran's able to have "*initial access*" to counseling.

Completed Counseling – Multiple Sessions - While there are anecdotal reports of "single-session cures," the overwhelming consensus is that multiple sessions of psychotherapy are necessary (*sustained access*). The necessary number, however, is not at all clear. Evidence-based treatments typically recommend between 8 and 20 sessions. Others approaches suggest that far more are needed. An older body of research – the "dose-response" research – identified the need for at least 8 sessions regardless of approach (and noted that there was no evidence to support more than 52 sessions). Currently, VHA MH identifies sustained access to counseling as having received 5 sessions of counseling in a 10-week time frame. There are existing measures in SAIL to assess this for Veterans diagnosed with Depression, PTSD, substance use disorder, and serious mental illness (SMI).

Completed Counseling – Completed Treatment – Another way to define completed counseling would be to measure completed counseling is through overall symptom reduction or functional improvement. This is currently the focus of the Measurement Based Care initiative in VHA. However, as this is currently in the process of implementation, it is not possible to assess symptom reduction using validated standardized measures of symptoms for all Veteran's engaged in care. It should be noted that this has not been done in the area of Mental Health in any other healthcare system and VA is leading the charge on this nationally. Ongoing assessment of functional improvements (e.g., family relationships, ability to work, ability to engage in social activities, etc.) is also not routinely measured in (or out of) VHA mental health care. Thus, VHA currently does not have the capacity to directly measure completed counseling per symptom improvement at this time. There is limited ability to measure functional improvement for specific programs (e.g., employment at discharge from Supported Employment services).

Example numbers for the Suggested Approaches

Completed Counseling: Crisis/Same Day:	FY18 Q3:	130,208
	FY18 Q1–Q3:	384,395

Those are "unique" Veterans. The numbers are a summation of the crisis appointments and same day appointment data.

For Completed Counseling: Single Session, the data was pulled the data by the diagnostic groupings for SAIL data. Please note that because many Veterans have multiple diagnoses and may be receiving care for more than one diagnosis, there is unquestionably overlap in the numbers below in FY 2018:

- Depression: 416,979
- Serious Mental Illness (SMI): 96,127
- PTSD: 377,034
- Substance Use Disorders: 201,665

Completed Counseling: Multiple Sessions the same caveat as above holds. Veterans are receiving services for more than one diagnosis and so there is unquestionable overlap between the numbers below in FY 2018:

- Depression (5 sessions in 10 weeks): 72,879
- Serious Mental Illness (SMI; 5 sessions in 10 weeks): 34,362
- PTSD (5 sessions in 10 weeks): 119,210
- Substance Use Disorders (4 sessions in 8 weeks): 85,560

Table 6. Suggestions for Consideration for Duty 5D

	Proposed Definition	Existing Measures
Counseling	Services that are defined as being psychosocial in nature only. All encounters involving the likely management or prescribing of medications would be excluded. This may underrepresent services provide by prescribing providers that would be considered counseling.	These services could be identified using Current Procedural Terminology codes (CPT codes; used by all providers in and out of VHA to define services delivered).
Completed Counseling – Crisis/Same Day	The number or percentage of Veteran's who "completed counseling" on a *crisis or same-day basis (crisis access)*	Use of a crisis CPT code, same-day workload, and a measure which identifies the % of Veterans who receive a Primary Care and Primary Care Mental Health Integration encounter on the same day.
Completed Counseling – One session	The number/percentage of Veteran's able to have "*initial access*" to counseling.	Number and percentage of Veterans with mental health diagnoses who receive one session of counseling (psychosocial services).
Completed Counseling – Multiple sessions	The overwhelming consensus is that multiple sessions of psychotherapy are necessary – thus the number/percentage of Veteran's able to have "*sustained access*" to counseling.	Currently, VHA MH identifies sustained access to counseling as having received 5 sessions of counseling in a 10-week time frame. There are existing measures to assess this for Veterans diagnosed with Depression, PTSD, substance use disorder, and serious mental illness.
Completed Counseling – Completed treatment	Overall *symptom reduction or functional improvement*.	VHA currently does not have the capacity to directly measure completed counseling per symptom improvement at this time. There is limited ability to measure functional improvement for specific programs (e.g., employment at discharge from Supported Employment services).

Duty 5E: The efforts of the Department to expand complementary and integrative health (CIH) 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

Outreach Efforts to Expand Complimentary and Integrative Health (CIH) Treatments

At least one CIH service was offered in 89% of the sampled facilities in 2011, which increased to 93% in 2015. The 2015 VHA CIH Services HAIG report (Appendix C) details the locations, organized by VISN, that have offered specific CIH services across 2002, 2011, and 2014. The factors most commonly noted as enabling the delivery of CIH services include consistency with the patient-centered model of care (93%), promotion of overall well-being (92%), chronic disease management (83%), and patient preference (79

Outpatient facilities that most commonly offered CIH services included mental health (89%), rehabilitation (79%), primary care (64%), and women's health (51%). In an inpatient setting, CIH services were most commonly used within mental health (53%), extended care (55%), and palliative care (47%) facilities. Stress management relaxation therapy (85%), mindfulness (82%), guided imagery (74%), and yoga (73%) were the CIH services most commonly provided by VA staff, while acupuncture (49%) and chiropractic procedures (66%) were most often referred to outside providers (HAIG 2015).

Analysis of the FY 2015 CIH HAIG survey results led to eight recommendations for future initiatives regarding the integration of CIH services within VHA. These included the following[15]:

1. There is an additional need for a more systematic method to capture the provision of CIH services within the VHA.

2. The VHA should repeat the CIH survey at specific intervals, which will allow the VHA to track changes in CIH service delivery and availability.

3. A survey of Veterans on their interest in CIH would assist VHA in developing an appropriate level and variety of CIH services.

4. Strategies should be developed to assess the value and sustainability of CIH services.

5. Further study should focus on the use of CIH services for Mental Health conditions to determine the value and effectiveness.

6. Additional study should focus on CIH services that may enhance the overall care provided to Veterans when administered in conjunction with conventional medicine.

[15] Gaudet, T., & Vandenberg, P. (2015). FY 2015 VHA Complementary & Integrative Health Services (formerly CAM). *Healthcare Analysis & Information Group (HAIG). May.*

7. Consideration should be given to alleviate common barriers to developing or supporting CIH services.

8. The term CIH should be eliminated as these practices should simply be considered part of VA care.

Utilization of CIH Treatments

Demographic characteristics of all participants from the FY 2015 CIH HAIG survey administered can be found in Appendix C, in the full report. Overall, 52% reported any use of CIH. Those using CIH approaches were more likely to be under the age of 65 (45%), non-Hispanic White (81.1%), and male (80.9%).

From the additional analyses conducted comparing MH/SUD/Health group with those using CIH for all other reasons, Table 7 presents the demographic characteristics. For those using CIH for MH/SUD/Health purposes, most were married (61%), male (79%), middle age (39%), and reported a low utilization of VA health care services (59%).

Taylor, Hoggatt, & Kligler (2019) stated that Veterans have a high need for management of chronic pain and symptoms of anxiety or depression, conditions for which some types of CIH might be effective. This is supported by the fact that Veterans represent 7% of the population, tend to have less income and education, are predominantly male, and are more disabled than the general population. They also suggested predictors of any CIH use and no CIH use, where users of CIH are more likely to be middle-aged, female, non-Hispanic Native Hawaiian/Pacific Islander, or American Indian/Native American. The top three CIH approaches were massage therapy (44%), chiropractic (37%), and mindfulness (34%). Except for battlefield acupuncture, Veterans appeared to be more likely to use CIH approaches outside of VA as opposed to within a VA setting. The top three reasons reported for CIH use included pain, stress reduction/relaxation, and to improve overall health and well-being. The most helpful approaches for stress/relaxation were hypnotherapy/hypnosis and animal-assisted therapy. Overall, 84% reported they would be interested in trying or learning more about at least one CIH approach (Taylor et al. 2019).

Lastly, Taylor et al. (2019) concluded prevalence of CIH utilization appears to be higher among Veterans than the general population reported in 2012. Several reasons for the higher prevalence were provided in the study such as CIH approaches are provided at low to no cost to Veterans using VA services. Also, Veterans interested in CIH approaches may be more likely than other Veterans to complete the survey, meaning the rates of use and interest among the wider Veteran population may be lower.

From the additional analyses conducted[16], patients who used CIH for MH/SUD/Health were significantly more likely than those using CIH for other reasons to use: acupressure (18% vs. 6%), acupuncture (18% vs. 12%), healing touch (12% vs. 2%), animal assisted therapy (19% vs. 4%), progressive relaxation (26% vs. 5%), biofeedback (8% vs. 3%), guided imagery (12% vs. 2%), hypnotherapy (5% vs. 0%), mindfulness meditation (44% vs. 7%), mantram meditation (14% vs. 3%), other meditation (29% vs. 12%), yoga (31% vs. 8%), qi gong (5% vs. 1%), tai chi

[16] Analyses and results provided by Dr. Stephanie Taylor, Associate Director, Greater Los Angeles VA HSR&D

(13% vs. 2%), Native American Healing (7% vs. 1%), creative art therapy (11% vs. 1%), and movement therapy (21% vs. 9%).

Results were not significantly different in Veterans use of battlefield acupuncture (2% vs. 2%), reflexology (13% vs. 8%), massage therapy (46% vs. 38%), chiropractic care (35% vs. 43%), EMDR (3% vs. 1%), and pilates (7% vs. 3%).

Table 7: Demographic Characteristics of Additional Analyses Conducted

Demographic Variable	Used CIH for MH/SUD/Health (n=467)	Used CIH Only for Other Reasons (n=178)
Marital Status		
Single/Never Married	7%	5%
Married	61%	68%
Separated/Divorced/Widowed	32%	27%
Age*		
Young (Born 1979+)	11%	6%
Middle Age (1955-1978)	39%	33%
Older (1954 and Before)	51%	61%
Household Income		
Less than $10,000	3%	3%
$10,000-$19,999	9%	11%
$20,000-$39,999	24%	20%
$40,000-$59,999	17%	19%
$60,000-$79,999	14%	14%
$80,000-$99,999	9%	10%
$100,000 or more	12%	13%
I don't know/I don't want to say	12%	11%
Use of VA Healthcare Services		
High	36%	26%
Low	59%	69%
Not Answered	5%	5%
Have Medicare/Medicaid Health Insurance	39%	46%
Have Tricare Health Insurance*	22%	12%
Have Private Health Insurance	27%	32%
Have "Other" Health Insurance	4%	5%
Have No Health Insurance	31%	25%
Self-Rated Health Status		
Poor/Fair	34%	29%
Good	34%	40%
Very Good/Excellent	32%	31%
Gender*		
Male	79%	87%
Female	21%	13%

*=Statistically significant, p<=0.05

Within each of the two main groups being examined, too few people responded to the survey item on effectiveness to be able to conduct an accurate examination for almost all types of CIH. Specifically, five or more people responded to the effectiveness survey item within each of the two groups being examined for the set of analyses producing these results. (Also, given the low

cell count, it cannot be determined which differences are significant, so that results can only say that the groups "appear" different):

1. Of people using chiropractic care, patients who used it for MH/SUD/Health reasons (74%) appeared more likely than those using it for other reasons (57%) to find it very or moderately helpful for lowering their number of medications.

2. Of people using meditation (not mindfulness or mantram meditation), patients who used it for MH/SUD/Health reasons (62%) appeared slightly more likely than those using it for other reasons (55%) to find it very or moderately helpful for stress reduction or relaxation.

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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 5 LEGISLATION

Legislative Mandate	Key Questions
5.A The effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans	▪ What are the evidence-based treatments found to be effective for MDD, SUD, PTSD, Suicide Prevention, Chronic Insomnia Disorder by the VA-DoD Clinical Practice Guidelines (CPGs)? ▪ What are the current evidence-based treatments offered/available within VA? Which have been rolled out as part of a formalized training program? How many providers have been trained in each EBT? ▪ Which VA Medical Centers (VAMCs) offer the evidence-based psychotherapies identified by the VA-DoD CPGs? ▪ How many Veterans utilize the identified MH evidence-based treatments? Do Veterans believe treatments received are improving outcomes? What are the Veterans' self-reported outcomes over the past three years? ▪ What is the prevalence of Veterans self-reported suicidality? ▪ How many Veterans use (call, chat, or text) the Veterans Crisis Line? Annually? By VISN? ▪ What are the reported outcomes for Veterans using the Veterans Crisis Line? How many emergency dispatches are requested/initiated? How many referrals to VAMCs for follow-up MH care? How many Veterans engage in follow-up MH care? Timeliness of care? ▪ What does the national SP branch of OMHSP do for outreach? Partnerships?
5B. and C. The number of veterans who have been diagnosed with mental health issues and the percentage of veterans using the resources of the Department who have been diagnosed with mental health issues	▪ What are the number of Veterans seeking VHA care who have been diagnosed with MH conditions? – Over the past five years? – Stratified by the major MH disorders that align with Duty 3's EBR (i.e. MDD, PTSD, SUD, OUD, AUD, Bipolar Disorder, Chronic Insomnia Disorder and GAD). ▪ Prevalence of MH conditions in the general population and the general Veteran population. ▪ Of those seeking VA healthcare services, what is the prevalence of Veterans diagnosed with MH issues? – At the national level? – At the VISN level? – At the VAMC level? – At Veteran Readjustment Counseling Centers (Vet Centers)?
5.D The percentage of Veterans who have completed counseling sessions offered by the Department	▪ Of those seeking VA healthcare services, what is the percentage of Veterans who have completed evidence-based psychotherapy treatments offered by VA?

Legislative Mandate	Key Questions
5.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	▪ What are the efforts of VA to expand CIH treatments viable to the recovery of Veterans with MH issues as determined by SECVA to improve the effectiveness of treatments offered by VA? ▪ Where (what facilities? VISNs?) are these CIH treatments offered? ▪ What are Veterans' preferences for CIH interventions? ▪ How many Veterans participate in the CIH treatments available? ▪ How does VA market or communicate the available CIH treatments offered? ▪ Are Veterans aware of the available CIH treatments?

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

APPENDIX C:
ADDITIONAL DATA TABLES

Veterans Crisis Line

Miller, M., Britton, P., & McCarthy, M. (2019) Veterans Crisis Line: Mission, Activity, Enhancements, & Evaluation [PowerPoint Slides].

VCL-VA DoD
Conference Mission

Table C-1: Veterans' Self-reported Thoughts of Suicidality and Suicidal Attempts in FY 2018[1]

Month	All Records	Thinking of Suicide	Thought of In Last Two Months	Ever Attempted Suicide
Oct-17	63,861	8,895	13,557	12,319
Nov-17	62,946	8,413	13,020	11,569
Dec-17	61,469	8,119	12,177	11,766
Jan-18	63,004	8,243	12,459	11,882
Feb-18	56,872	7,260	11,468	10,656
Mar-18	61,944	8,019	12,321	11,455
Apr-18	57,194	7,403	11,577	10,779
May-18	48,574	6,080	9,778	9,471
Jun-18	53,358	7,511	11,820	10,963
Jul-18	54,301	7,413	11,607	10,738
Aug-18	55,430	7,708	11,756	10,747
Sep-18	55,003	7,723	11,618	10,560

[1] Please note, the last three columns will not add up to all the records. These represent callers from the total who are thinking of suicide, thought of suicide in the past two months, or have *ever* attempted suicide.

Table C-2: Caller Relationship to Veteran for all Callers in FY 2018

Month	All Records	Family	Friend	Non-Veteran	Self	Unknown
	N	n (%)	n (%)	n (%)	n (%)	n (%)
Oct-17	63,861	4,390 (6.87)	1,560 (2.44)	10,327 (16.17)	35,057 (54.90)	12,527 (19.62)
Nov-17	62,946	4,335 (6.89)	1,456 (2.31)	8,972 (14.25)	35,543 (56.47)	12,640 (20.08)
Dec-17	61,469	4,163 (6.77)	1,476 (2.40)	8,375 (13.62)	34,975 (56.90)	12,480 (20.30)
Jan-18	63,004	4,388 (6.96)	1,440 (2.29)	8,700 (13.81)	35,997 (57.13)	12,479 (19.81)
Feb-18	56,872	4,247 (7.47)	1,374 (2.42)	8,492 (14.93)	32,000 (56.27)	10,759 (18.92)
Mar-18	61,944	4,668 (7.54)	1,611 (2.60)	8,781 (14.18)	35,379 (57.11)	11,505 (18.57)
Apr-18	57,194	4,479 (7.83)	1,417 (2.48)	7,935 (13.87)	33,209 (58.06)	10,154 (17.75)
May-18	48,574	4,017 (8.27)	990 (2.04)	4,342 (8.94)	31,472 (64.79)	7,753 (15.96)
Jun-18	53,358	4,499 (8.43)	1,414 (2.65)	5,081 (9.52)	34,318 (64.32)	8,046 (15.08)
Jul-18	54,301	4,548 (8.38)	1,408 (2.59)	5,219 (9.61)	33,888 (62.41)	9,238 (17.01)

Month	All Records	Family	Friend	Non-Veteran	Self	Unknown
Aug-18	55,430	4,623 (8.34)	1,352 (2.44)	5,427 (9.79)	35,426 (63.91)	8,602 (15.52)
Sep-18	55,003	4,542 (8.26)	1,358 (2.47)	5,405 (9.83)	34,615 (62.93)	9,083 (16.51)

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Table C-3: Call Outcomes for all Callers in FY 2018

Month	All Records	Caller Disconnected	Prank Call	Rescue Called Without Suicidal Behavior	Caller Stayed on the Line Until the Call Ended Normally	Rescue Called with Suicidal Behavior	Rescue Called with Suicide Completion	Responder Terminated Call	Caller Went Voluntarily to ER	Text Transfer to VCL	Noteworthy Caller Protocol Followed	Facility Transport Plan	Responder Attempted to Contact Veteran and Left Message	Responder Attempted to Contact Veteran and Was Unsuccessful
	N	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Oct-17	63,861	14,937 (23.39)	1,325(2.07)	1,300(2.04)	39,305(61.55)	1,264(1.98)	0 (0)	1,606(2.51)	76(.12)	129(.20)	450(.70)	927(1.45)	1,569(2.46)	973(1.52)
Nov-17	62,946	15,290(24.29)	1,236(1.96)	1,375(2.18)	38,347(60.92)	1,252(1.99)	1 (0)	1,621(2.58)	68 (.11)	111(.18)	535(.85)	852(1.35)	1,457(2.31)	801(1.27)
Dec-17	61,469	15,403(25.06)	1,100(1.79)	1,408(2.29)	37,044(60.26)	1,153(1.88)	0 (0)	1,579(2.57)	54 (.09)	122(.20)	480(.78)	819(1.33)	1,435(2.33)	872(1.42)
Jan-18	63,004	15,200(24.13)	953(1.51)	1,420(2.25)	38,938(61.80)	1,273(2.02)	0 (0)	1,390(2.21)	58 (.09)	113(.18)	565(.90)	888(1.41)	1,360(2.16)	846(1.34)
Feb-18	56,872	12,486(21.95)	840(1.48)	1,166(2.05)	36,673(64.48)	1,118(1.97)	0 (0)	1,268(2.23)	58 (.10)	84 (.15)	454(.80)	814(1.43)	1,182(2.08)	729(1.28)
Mar-18	61,944	13,755(22.21)	688(1.11)	1,425(2.30)	39,833(64.30)	1,229(1.98)	0 (0)	1,316(2.12)	76 (.12)	143(.23)	414(.67)	922(1.49)	1,350(2.18)	793(1.28)
Apr-18	57,194	12,481(21.82)	580(11.17)	1,294(2.26)	37,180(65.01)	1,181(2.06)	0 (0)	1,199(2.10)	69 (.12)	103(.18)	383(.67)	853(1.49)	1,158(2.02)	713(1.25)
May-18	48,574	10,190(20.98)	350(.72)	1,053(2.17)	32,267(66.43)	948(1.95)	0 (0)	1,008(2.08)	73 (.15)	125(.26)	253(.52)	757(1.56)	895(1.84)	655(1.35)
Jun-18	53,358	10,585(19.84)	381(.71)	1,183(2.22)	36,089(67.64)	1,081(2.03)	0 (0)	939(1.76)	44 (.08)	129(.24)	280(.52)	842(1.58)	1,122(2.10)	683(2.10)
Jul-18	54,301	11,663(21.48)	368(.68)	1,207(2.22)	35,416(65.22)	1,116(2.06)	2 (0)	947(1.74)	49 (.09)	226(.42)	345(.64)	896(1.65)	1,316(24.83)	750(1.38)
Aug-18	55,430	11,333(20.45)	301(.54)	1,349(2.43)	36,363(65.60)	1,113(2.01)	0 (0)	1,060(1.91)	76 (.14)	293(.53)	729(1.32)	897(1.62)	1,162(2.10)	754(1.36)
Sep-18	55,003	11,699(21.27)	401(.73)	1,246(2.27)	34,849(63.36)	1,114(2.03)	0 (0)	1,220(2.22)	52 (.09)	312(.57)	1,136(2.07)	913(1.66)	1,259(2.29)	802(1.46)

Clinical Inventory Questionnaire

Table C-4. Major Depressive Disorder Evidence-based Psychotherapies

VISN	# Facilities within VISN	ACT	BT/BA	CBT	IPT	MBCT	PST
1	7	7	6	7	5	5	6
2	7	6	5	7	7	5	7
4	9	9	6	9	8	2	9
5	6	6	4	6	4	3	6
6	7	7	4	7	6	5	7
7	2	2	2	2	1	0	1
8	8	8	4	8	8	5	7
9	5	5	4	5	5	1	4
10	11	10	8	11	9	5	10
12	1	1	1	1	1	1	1
15	6	6	2	6	5	2	4
16	8	7	7	8	7	2	8
17	6	6	5	6	5	4	5
19	6	6	4	6	6	4	5
21	8	7	7	7	7	5	7
TOTAL	**97**	**93**	**69**	**96**	**84**	**49**	**87**
% TOTAL		95.9%	71.1%	99.0%	86.6%	50.5%	89.7%

* Numbers represent the sum of facilities that offer the therapy within a specific VISN

The evidence-based psychotherapies for Major Depressive Disorder (MDD) in the questionnaire included: Acceptance and Commitment Therapy (ACT), Behavioral Therapy/Behavioral Activation (BT/BA), Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Mindfulness-based Cognitive Therapy (MBCT), and Problem-solving Therapy (PST). CBT was the most commonly endorsed therapy – 99% of facilities offered CBT services. Additionally, 96% of facilities offered ACT services, 90% offered PST services, 87% offered IPT services, 71% offered BT/BA services, and 51% offered MCBT services. Of note, none of the facilities in VISN 7 offer MCBT services.

The evidence-based psychotherapies for Post-Traumatic Stress Disorder (PTSD) in the questionnaire included: Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioral Therapy (CBT) for PTSD, Brief Eclectic Therapy (BET), and Narrative Exposure Therapy (NET). EMDR and CBT for PTSD were both offered by 76.3% of facilities. Additionally, 34% of facilities offered NET services and 12.4% of facilities offered BET services.

Table C-5. PTSD Evidence-based Psychotherapies

VISN	# Facilities within VISN	PE	CPT	EMDR	CBT for PTSD	BET	NET
1	7	7	7	7	6	3	5
2	7	7	7	4	6	0	5
4	9	9	9	6	8	1	0
5	6	6	6	4	4	1	2
6	7	7	7	7	6	0	3
7	2	2	2	1	2	0	1
8	8	8	8	6	6	1	2
9	5	5	5	4	3	0	0
10	11	11	11	8	7	0	5
12	1	1	1	1	1	1	1
15	6	6	6	4	5	0	1
16	8	8	8	7	5	0	2
17	6	6	6	4	5	1	2
19	6	6	6	6	3	1	2
21	8	7	8	5	7	3	2
TOTAL	**97**	**96**	**97**	**74**	**74**	**12**	**33**
% TOTAL		99.0%	100.0%	76.3%	76.3%	12.4%	34.0%

* Numbers represent the sum of facilities that offer the therapy within a specific VISN

Table C-6. Alcohol Use Disorder Evidence-based Psychosocial Interventions

VISN	# Facilities within VISN	IBI	BCT for AUD	CBT for SUD	CRA	MET	12-Step
1	7	7	6	7	1	7	6
2	7	5	1	7	2	7	6
4	9	5	4	8	1	9	3
5	6	5	3	6	1	6	4
6	7	6	5	7	2	7	6
7	2	1	1	2	0	2	2
8	8	7	2	8	1	8	6
9	5	3	4	5	1	5	5
10	11	6	4	10	2	11	7
12	1	1	1	1	1	1	1
15	6	5	2	6	2	6	3
16	8	6	2	7	3	8	7
17	6	4	2	6	2	6	6
19	6	4	4	6	2	6	4
21	8	7	3	7	3	7	3
TOTAL	**97**	**72**	**44**	**93**	**24**	**96**	**69**
% TOTAL		74.2%	45.4%	95.9%	24.7%	99.0%	71.1%

* Numbers represent the sum of facilities that offer the therapy within a specific VISN

The evidence-based psychosocial interventions for Alcohol Use Disorder (AUD) included in the questionnaire include: Initial Brief Intervention (IBI), Behavioral Couples Therapy (BCT) for AUD, Cognitive Behavioral Therapy (CBT) for Substance Use Disorders (SUD), Community Reinforcement Approach (CRA), Motivational Enhancement Therapy (MET), and 12-Step Facilitation. 96% of facilities offered CBT for SUD services, 74.2% offered IBI services, 71.1% offered 12-Step services, 45.4% offered BCT for AUD services, and 25% offered CRA services. No facilities in VISN 7 offered CRA services.

Table C-7. Opioid Use Disorder Evidence-based Pharmacotherapy and Psychosocial Interventions

		Pharmacotherapy Interventions		Psychosocial Interventions	
VISN	# Facilities within VISN	Buprenorphine/ Naloxone	Methadone	Individual Counseling	Contingency Management
1	7	7	3	6	5
2	7	7	1	7	3
4	9	9	2	9	7
5	6	6	2	6	3
6	7	7	1	7	2
7	2	2	1	2	2
8	8	8	2	8	5
9	5	5	0	5	5
10	11	11	7	11	7
12	1	1	1	1	1
15	6	6	2	6	5
16	8	8	1	8	4
17	6	6	2	6	3
19	6	6	2	6	3
21	8	7	3	7	3
TOTAL	**97**	**96**	**30**	**95**	**58**
% TOTAL		99.0%	30.9%	97.9%	59.8%

* Numbers represent the sum of facilities that offer the therapy within a specific VISN

The evidence-based pharmacotherapy and psychosocial interventions for Opioid Use Disorder (OUD) in the questionnaire included: Buprenorphine/naloxone, Methadone in an Opioid Treatment Program, individual counseling, and contingency management. Each VISN offered at least one evidence-based OUD treatment, across both pharmacotherapy and psychosocial interventions. Except for VISN 9, all VISNs offered all evidence-based OUD therapies in at least one facility within each VISN. VISN 9 did not offer Methadone services at any facility within the VISN.

Table C-8. Suicide Prevention Evidence-based Psychotherapies

VISN	# Facilities within VISN	CBT for Suicide	DBT
1	7	7	6
2	7	4	5
4	9	5	6
5	6	3	4
6	7	5	6
7	2	2	2
8	8	3	6
9	5	3	5
10	11	8	10
12	1	1	1
15	6	4	4
16	8	3	6
17	6	3	5
19	6	4	6
21	8	4	6
TOTAL	**97**	**59**	**78**
% TOTAL		60.8%	80.4%

* Numbers represent the sum of facilities that offer the therapy within a specific VISN

Of the two therapies, all VISNs offered both therapies to Veterans in at least one facility within each VISN. Between the two therapies, DBT was more frequently offered across the surveyed facilities.

Each VISN offered at least one evidence-based treatment for chronic insomnia disorder across all the facilities that were surveyed. Except for VISN 7, all VISNs offered both evidence-based treatment for chronic insomnia disorder in at least one facility within the VISN. VISN 7 did not include any facilities that offered Brief Behavioral Therapy for insomnia.

Table C-9. Chronic Insomnia Disorder Evidence-based Psychotherapies

VISN	# Facilities within VISN	CBT for Insomnia	Brief Behavioral Therapy
1	7	7	2
2	7	7	4
4	9	9	3
5	6	6	3
6	7	6	4
7	2	2	0
8	8	8	6
9	5	5	1
10	11	11	3
12	1	1	1

VISN	# Facilities within VISN	CBT for Insomnia	Brief Behavioral Therapy
15	6	6	3
16	8	8	2
17	6	6	3
19	6	6	3
21	8	7	5
TOTAL	**97**	**95**	**43**
% TOTAL		97.9%	44.3%

* Numbers represent the sum of facilities that offer the therapy within a specific VISN

Complementary and Integrative Health Veteran Preference Survey

As of July 2017, the VIP panel self-reported the following characteristics:

- Health status was very good or excellent (32%), good (38%), or poor (31%)
- Residence was urban (63%) or rural (37)
- Length of time using VA services as 10 years or more (39%), 5-9 years (26%), or 1-4 years (29%), or less than 1 year (2%), or do not use VA services (4%)
- Level of VHA utilization as at least once/month (28%), every few months or less (68%), with the 4% non-VA users not responding to this question

Embedded is a copy of the Taylor et al. (2019) report.

Taylor et al. CIH Approaches_What d

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.

MHDomainCompositeSummary_Nationa

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.

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.
- 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 Transformed			HRF1 Scor Transfor			HRF1 Scor Transfor
							HRF2 Score Transformed			HRF2 Scor Transfor			HRF2 Scor Transfor
							HRF5 Score Transformed			HRF5 Scor Transfor			HRF5 Scor 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	MHOO27	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	MHOO28	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.

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.

Healthcare Analysis and Information Group

A copy of the full FY 2015 report is embedded below in addition to the executive summary.


FY2015_VHA_CIH_signedReport_HAIG R


HAIG 2015 Executive Summary_

Department of Defense Suicide Event Reports

A copy of CY 2016 and CY 2017 DoDSERs reports are embedded below in addition to their respective executive summary.

CY 2016 DoDSER:


DoD Suicide Event Report CY 2016 Ann


DoDSER 2016 Executive Summary_

CY 2017 DoDSER:


DoDSER_CY_2017_Annual_Report_508_C


DoDSER 2017 Executive Summary_

Office of Mental Health & Suicide Prevention

A copy of the FY 2018 National MH Data Sheet is embedded below:


FY 2018_National Mental Health Data

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