

VA Office of Inspector General

OFFICES OF AUDITS AND EVALUATIONS  
AND HEALTHCARE INSPECTIONS



# Veterans Health Administration

*Review of Veterans' Access  
to Mental Health Care*

April 23, 2012  
12-00900-168

## ACRONYMS AND ABBREVIATIONS

ARC	Allocation Resource Center
CBOC	Community Based Outpatient Clinic
CPT	Current Procedural Terminology
DSS	Decision Support System
Dx	Diagnosis
EBT	Evidence Based Psychotherapy
FTE	Full-Time Employee Equivalent
IOP	Intensive Outpatient Substance Use Treatment Program
Mgmt	Management
MH	Mental Health
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency, and Staffing
PAR	Performance and Accountability Report
PCT	Post-Traumatic Stress Disorder Clinical Team
PTSD	Post-Traumatic Stress Disorder
RVU	Relative Value Units
SUD	Substance Use Disorder
Tx	Treatment
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VSSC	Veterans Health Administration Support Service Center
WSDTT	Women's Stress Disorders Treatment Team
WVRU	Work Relative Value Units

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## Executive Summary

### Results in Brief

The Office of Inspector General (OIG) conducted this review at the request of the Chairman and Ranking Member, U.S. Senate Committee on Veterans' Affairs, the Secretary of Veterans' Affairs, the Chairman and Ranking Member of the U.S. House Veterans' Affairs Committee and the Chairwoman and Ranking Member of the Subcommittee on Health, House Committee on Veterans' Affairs, after they expressed concerns that veterans may not be able to access the mental health care they need in a timely manner. The request asked the OIG to determine how accurately the Veterans Health Administration (VHA) records wait times for mental health services for both initial (new patients) and follow-up (established patients) visits and if the wait time data VA collects is an accurate depiction of the veteran's ability to access those services.

### Background

VHA policy requires all first-time patients referred to or requesting mental health services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs and to trigger hospitalization or the immediate initiation of outpatient care when needed. Primary care mental health providers, other referring licensed independent providers, or licensed independent mental health providers can conduct the initial 24-hour evaluation.

One method VHA uses to monitor access to mental health services is to calculate patients' waiting times by measuring the elapsed days from the desired dates of care to the dates of the treatment appointments. Medical facility schedulers must enter the correct desired dates of care in the system to ensure the accuracy of this measurement. VHA's goal is to see patients within 14 days of the desired dates of care.

### VHA's Mental Health Performance Data Is Not Accurate or Reliable

VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services. VHA did not provide first-time patients with timely mental health evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment.

### VHA's Measurement of a First-Time Patient's Access to a Full Mental Health Evaluation was not a Meaningful Measure of Waiting Time

In VA's FY 2011 Performance and Accountability Report (PAR), VHA reported 95 percent of first-time patients received a full mental health evaluation within 14 days. However, this measure had no real value as VHA measured how long it took VHA to

conduct the evaluation, not how long the patient waited to receive an evaluation. For example, if a patient's primary care provider referred the patient to mental health service on September 15 and the medical facility scheduled and completed the evaluation on October 1, VHA's data showed the veteran waited 0-days for their evaluation. In reality, the veteran waited 15 days for their evaluation.

VHA's measurement differed from the defined objective of the measure that stated veterans should have further evaluation and initiation of mental health care in 14 days of a trigger encounter. VHA defined the trigger encounter as the veterans contact with the mental health clinic or the veteran's referral to the mental health service from another provider. VHA needs to redefine their measurement to ensure it meets the intent of the stated objective that is to make sure veterans receive a full mental health evaluation within 14 days.

#### VHA was not Providing All First-Time Patients a Full Mental Health Evaluation Within 14 Days

Using the same data VHA used to calculate the 95 percent success rate shown in the FY 2011 PAR, we selected a statistical sample of completed evaluations to determine the starting and ending points of the elapsed day calculation. We conducted an independent assessment by reviewing patient records to review patients' visit dates, clinical notes, and consult records to identify the exact date of the trigger encounter (the date the patient initially contacted mental health seeking services, or when another provider referred the patient to mental health). We determined when the full evaluation containing a patient history, diagnosis, and treatment plan was completed. Based on our analysis of that information, we calculated the number of days between initial contact in mental health and the full mental health evaluation. Our analysis projected that VHA provided only 49 percent (approximately 184,000) of their evaluations within 14 days. On average, for the remaining patients, it took VHA about 50 days to provide them with their full evaluations.

#### VHA Overstated Its Success in Providing Veterans New and Follow-Up Appointments for Treatment Within 14 Days

VHA does not consider the full mental health evaluation as an appointment for treatment, but rather the evaluation is the prerequisite for VHA to develop a patient-appropriate treatment plan. Once VHA provides the patient with a full mental health evaluation, VHA schedules the patient for an appointment to begin treatment. We found that VHA did not always provide both new and established patients their appointments within 14 days of the patients' desired date—VHA's goal for timely patient access to care. VHA defines the desired date as the date on which the patient or the provider wants the patient to be seen without regard to schedule capacity. We reviewed patient records to identify the desired date (generally located in the physician's note as the date the patient needed to return to the clinic or shown as a referral from another provider) and calculated

the elapsed days to the date of the patient's completed treatment appointment date. We projected nationwide that in FY 2011, VHA:

- Completed approximately 168,000 (64 percent) new patient appointments for treatment within 14 days of their desired date; thus, approximately 94,000 (36 percent) appointments nationwide exceeded 14 days. VHA data showed that 95 percent received timely care.
- Completed approximately 8.8 million (88 percent) follow-up appointments for treatment within 14 days of the desired date; thus, approximately 1.2 million (12 percent) appointments nationwide exceeded 14 days. Although we based our analysis on dates documented in VHA's medical records, we have less confidence in the integrity of this date because providers at three of the four medical centers we visited told us they requested a desired date of care based on their schedule availability. VHA data showed that 98 percent received timely care for treatment.

#### VHA Schedulers did not Consistently Follow Procedures

VHA schedulers were not following procedures outlined in VHA Directives, and, as a result, VHA's reported waiting time data was not accurate or reliable. For new patients, the scheduling clerks frequently stated they used the next available appointment slot as the desired appointment date for new patients. For established patients, medical providers told us they frequently scheduled the return to clinic appointments based on their known availability rather than the patient's clinical need. For example, providers may not have availability for 2–3 months, so they specify that as the return to clinic time frame.

OIG previously reported concerns with VHA's calculated wait time data in our *Audit of VHA's Outpatient Scheduling Procedures*, Report No. 04-02887-169, July 8, 2005 and *Audit of VHA's Outpatient Wait Times*, Report No. 07-00616-199, September 10, 2007. During both audits, OIG found that schedulers were entering an incorrect desired date. Given VHA's inability to correct this long-standing problem, VHA should reassess their training, competency, and oversight methods and develop appropriate controls to collect reliable and accurate appointment data.

#### Mental Health Staff Vacancies May Be Affecting VHA's Ability to Meet Timeliness Goals

According to VHA, from 2005 to 2010, mental health services increased their staff by 46 percent and treated 39 percent more patients. Despite the increase in mental health care providers, VHA's mental health care service staff still did not believe they had enough staff to handle the increased workload and consistently see patients within 14 days of the desired date.

In July 2011, the U.S. Senate Committee on Veterans' Affairs requested VA to conduct a survey that among other questions asked mental health professionals whether their medical center had adequate mental health staff to meet current veteran demands for care; 71 percent responded their medical center did not have adequate numbers of mental health staff. Based on our interviews at four medical centers, staff in charge of mental health services reported VHA's greatest challenge has been to hire and retain psychiatrists. Three of the four sites we visited had vacant psychiatry positions. We determined that a patient at the Salisbury VA Medical Center had to wait, on average, 86 days to see a psychiatrist. This was based on an analysis of VHA's data that identifies a provider's third next available appointment date for treatment. Staff at that facility told us they were still trying to replace three psychiatrists who left to go to a private practice in the past year. A comprehensive staffing analysis can help VHA determine if psychiatrist, or other mental health provider, vacancies are systemic issues impeding VHA's ability to meet mental health timeliness goals.

### **Measuring Access to VHA Mental Health Care**

The data and measures needed by decision makers for effective planning and service provision may differ at the national, Veterans Integrated Service Network, and facility level. No measure of access is perfect or paints a complete picture in isolation. Meaningful analysis and decision making requires reliable data, on not only the timeliness of access but also on trends in demand for mental health services, treatments, and providers; the availability and mix of mental health staffing; provider productivity; and treatment capacity. These demand and supply variables in turn feedback upon a system's ability to provide treatment that is patient centered and timely.

VHA's 14-day follow-up measure provides decision makers with a limited picture of a new patient's ability to access and begin mental health treatment. Additionally, depending on a veteran's point of access, this metric does not truly measure VHA's stated objective "to ensure timely access for all veterans who are new to mental health." A series of timeliness and treatment engagement measures might provide decision makers with a more comprehensive view of the ability with which new patients can access mental health treatment. Furthermore, although VHA collects and reports mental health staffing and productivity data, the complexity of the computations and inaccuracies in some of the data sources, limits the usability of productivity information to fully assess current capacity, determine optimal resource distribution, evaluate productivity across the system, and establish mental health staffing and productivity standards.

Private sector entities with whom we spoke reported that their managers use multiple measures to assess a range of access parameters. These entities disseminate their dashboard reports to all levels of management thereby facilitating timely response to changing access dynamics. Beyond measures of timeliness (or delay) to mental health care, a dashboard of user friendly measures that incorporate aspects of patient demand,

provider supply, clinic capacity, and provider productivity, anchored by a consistent set of business rules, might provide VHA decision makers with a more robust perspective from which to assess and timely respond to changes in access parameters.

## Conclusion

VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services. VHA did not provide first-time patients with timely mental health evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. As a result, performance measures used to report patient's access to mental health care do not depict the true picture of a patient's waiting time to see a mental health provider.

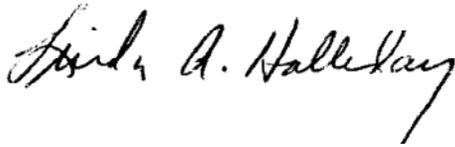
Although no measure of access is perfect or paints a complete picture in isolation, meaningful analysis and decision making requires reliable data, on not only the timeliness of access but also on trends in demand for mental health services, treatments, and providers; the availability and mix of mental health staffing; provider productivity; and treatment capacity. A series of timeliness and treatment engagement measures might provide decision makers with a more comprehensive view of the ability with which new patients can access mental health treatment.

## Recommendations

1. We recommend the Under Secretary for Health revise the current full mental health evaluation measurement to ensure the measurement is calculated to reflect the veteran's wait time experience upon contact with the mental health clinic or the veteran's referral to the mental health service from another provider to the completion of the evaluation.
2. We recommend the Under Secretary for Health reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments.
3. We recommend the Under Secretary for Health conduct a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the Veterans Health Administration's ability to meet mental health timeliness goals, and if so, develop an action plan to correct the impediments.
4. We recommend the Under Secretary for Health ensure that data collection efforts related to mental health access are aligned with the operational needs of relevant decision makers throughout the organization.

## Under Secretary for Health Comments

The Under Secretary for Health concurred with the OIG's findings and recommendations and stated VHA is unequivocally committed to providing Veterans the best care possible. The Under Secretary stated VHA would act rapidly on all findings that may improve Veterans' access to mental health care. (See Appendix E for the full text of the Under Secretary's comments.) We consider the planned actions acceptable and will follow up on the implementation.



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## Introduction

### Purpose

The Chairman and Ranking Member of the U.S. Senate Committee on Veterans' Affairs, the Secretary of Veterans' Affairs, the Chairman and Ranking Member of the U.S. House Veterans' Affairs Committee and the Chairwoman and Ranking Member of the Subcommittee on Health, House Committee on Veteran's Affairs requested this review of veterans' access to mental health care. Specifically, they requested the Office of Inspector General (OIG) determine how accurately the Veterans Health Administration (VHA) records wait times for mental health (MH) for both initial (new patients) and follow-up (established patients) visits and if the wait time data VHA collects provides an accurate depiction of the veteran's ability to access those services.

### Background

VHA policy requires all new patients referred to or requesting mental health services receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days. VHA's goal is to see patients within 14 days of the patient's desired date of care.

To ensure reliable waiting times, schedulers must input the correct desired date of care when creating appointments for treatment. According to VHA Directive 2010-027:

- For new patients, the patient defines the desired date without regard to schedule capacity. Once the desired date is established, schedulers must not alter the date to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.
- For established patients, the provider or scheduler will communicate a specific or a general time frame and the patient establishes the actual desired date. The scheduler is to offer and schedule an appointment on or as close to the desired date as possible. If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment time frame.

VHA defines new patients as those who have not received care in a defined stop code or stop code group at that facility within the past 2 years; established patients represent all others. VHA measures the elapsed days from the desired dates of care to the dates of the appointments. Schedulers must enter the correct desired dates of care in the system to ensure the accuracy of this measurement.

## Results and Conclusions

### Issue 1: VHA's Mental Health Performance Data Is Not Accurate or Reliable

VHA's measurement of a first-time patient's access to a full mental health evaluation was not a meaningful measure to assess the time a veterans waits for a mental health appointment and VHA's performance data for mental health treatment appointments is not accurate or reliable. Our assessment showed VHA did not provide first-time patients with timely mental health evaluations and existing patients often waited more than 14 days past their desired dates of care for their treatment appointments. Based on our review, this occurred because VHA did not have an appropriate method in place to evaluate how well they were providing first-time patients a timely full mental health evaluation. Scheduling staff not following prescribed procedures, staffing shortages, and increasing workloads also contributed to inaccurate and unreliable data as well as delays in mental health care. As a result, VHA's leadership and decision makers' ability to make informed decisions for improving timely access to mental health care is constrained.

#### **VHA's Mental Health Performance Data Is Not Accurate or Reliable**

VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services. VHA did not provide first-time patients with timely mental health evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment.

#### VHA's Measurement of a First-Time Patient's Access to a Full Mental Health Evaluation was not a Meaningful Measure of Waiting Time

In VA's FY 2011 Performance and Accountability Report (PAR), VHA reported 95 percent of first-time patients received a full mental health evaluation within 14 days. However, this measure had no real value as VHA measured how long it took VHA to conduct the evaluation, not how long the patient waited to receive an evaluation. For example, if a patient's primary care provider referred the patient to mental health service on September 15 and the medical facility scheduled and completed the evaluation on October 1, VHA's data showed the veteran waited 0-days for their evaluation. In reality, the veteran waited 15 days for their evaluation.

VHA's measurement differed from the defined objective of the measure that stated veterans should have further evaluation and initiation of mental health care in 14 days of a trigger encounter. VHA Directive 2010-027 requires that all patients seeing a VA mental health provider for the first time receive a full evaluation within 14 days of either

the patient's referral to mental health or the patient's self-contact seeking mental health services. According to VHA senior officials, a full evaluation consists of patient history, diagnosis, and treatment plan. According to VHA criteria, this measures the ability of VHA to ensure veterans new to mental health services will have initial mental health care and further evaluation in less than 15 days of either the patient's:

- Walk-in to the clinic or directly accessing mental health clinic staff through other means, such as telephone (referred to as a trigger encounter).
- Referral to mental health service from either the primary care provider or other specialty care provider.

VHA needs to redefine their measurement to ensure it meets the intent of the stated objective that is to make sure veterans receive a full mental health evaluation within 14 days.

#### OIG's Assessment of How Long Patients Waited to Receive a Full Mental Health Evaluation

Using the same data VHA used to calculate the 95 percent success rate shown in the FY 2011 PAR, we selected a statistical sample of completed evaluations to determine the starting and ending points of the elapsed day calculation. Specifically, we reviewed patient records and used information in VHA's Compensation and Pension Records Interchange to review patients' visit dates, clinical notes, and consult records to identify when the patient initially contacted mental health seeking services or when another provider referred the patient to mental health. We determined if the full evaluation contained patient history, diagnosis, and treatment plan. Based on that information, we calculated the number of days between initial contact in mental health and the full mental health evaluation. Our analysis projected that VHA provided only 49 percent (approximately 184,000) of first-time patients their evaluation within 14 days. On average, for the remaining patients, it took VHA about 50 days to provide them with their full evaluations.

#### OIG's Site Visits to Four VHA Medical Centers

We visited four medical centers to evaluate their processes of scheduling first-time patients for mental health care. All four medical centers had a process in place to conduct an initial assessment within 24 hours to comply with VHA directives and ensure the patient was not in immediate risk. At that point, the scheduling processes varied, as highlighted in the procedures identified below.

- The Spokane VA Medical Center established an intake clinic staffed by multiple providers consisting of social workers and psychologists. The clinic contacted

patients within 24 hours and scheduled them for a full evaluation within 14 days. Clinic staff uses the 24-hour contact process to assess whether the veteran is in an immediate danger. If there is an emergency, the inpatient psychiatrists handle the intervention with the patient. Following the full evaluation, an intake committee, consisting of social workers, psychologists, and psychiatrists, meets every Tuesday and Thursday to discuss if the recommended treatment plan is appropriate. Because psychiatrists are in short supply, this process appears to make the best use of staff.

- The Salisbury VA Medical Center used a telephone triage system to contact the patient and assess the urgency of their condition. This triage (Current Procedural Terminology (CPT) code 98968) qualifies as a full evaluation because the triage performed collects a brief history, diagnosis, and treatment plan to follow up with a provider in the future. However, in discussions with triage staff, we found that this procedure consisted of talking to the veteran for at least 21 minutes using a template with a list of questions. The telephone triage staff would schedule the patient for their intake appointment, and this was usually at least 3 months in the future. The telephone triage staff stated that although VHA considers this effort a full evaluation and records it as such under CPT code 98968. They agreed that in 21 minutes they could only provide a minimum evaluation.

### **VHA Overstated Its Performance Outcomes to Provide Veterans New and Follow-Up Appointments for Treatment Within 14 Days**

Once VHA provides the patient with a full mental health evaluation, VHA schedules the patient for an appointment to begin treatment. VHA does not consider the full mental health evaluation as an appointment for treatment, but rather the evaluation is the prerequisite for VHA to develop a patient-appropriate treatment plan. VHA did not always provide patients their appointments within 14 days of the patients' desired dates—VHA's goal for timely patient access to care. Desired date is the date on which the patient or the provider wants the patient to be seen without regard to schedule capacity.

#### OIG's Assessment of How Long Patients Waited for their Mental Health Care Treatment Appointment

For treatment appointments of patients new to a specific mental health clinic, as prescribed by VHA Directives and training modules, we used the date a provider referred the patient to the clinic as the desired date. For example, a physician treating a patient in a substance abuse clinic determines the patient needs treatment for depression and on July 1 refers the patient to an appropriate clinic specializing in treating depression. We used July 1 as the desired date. When we could not identify a consult referral date, we used the appointment creation date as the desired date. In FY 2011, we projected nationwide that VHA completed approximately 168,000 (64 percent) new patient appointments within 14 days of their desired date; thus, approximately

94,000 (36 percent) appointments nationwide exceeded 14 days. VHA data showed that 95 percent received timely care.

For follow-up treatment appointments, we used the date the provider requested for the patient's return to the clinic. Although we based our analysis on dates documented in VHA's medical records, we have less confidence in the integrity of this date, because providers at three of the four medical centers we visited told us they requested a desired date of care based on their schedule availability. For example, if they knew they could not see the patient for another 2–3 months, they scheduled the patient's return to clinic in that time frame to align with their availability. VHA completed approximately 8.8 million (88 percent) follow-up appointments within 14 days of the desired date; thus, almost 1.2 million (12 percent) appointments nationwide exceeded 14 days. VHA data showed that 98 percent received timely care.

#### VHA's National Access List

VHA uses the national access list to monitor access and identify delays in mental health care. As of January 2012, VHA's national access list, which included both first-time patients and patients receiving follow-up appointments for treatment, reported about 15,000 mental health care appointments that exceeded VHA's standard of scheduling appointments within 14 days of their desired date. Approximately 12,600 (84 percent) appointments were scheduled from 15 to 60 days, and approximately 2,400 (16 percent) of the appointments were scheduled more than 60 days, from the patient's desired appointment date. We did not validate the completeness or accuracy of this list.

#### Next Available Appointment

VHA captures data to determine the number of days until the third next available treatment appointment for specific clinics. Calculating the wait time to the third next available appointment is a common practice for assessing a provider's ability to see patients in a timely manner. According to VHA data, the number of completed appointments in mental health clinics during FY 2011 was about 10.3 million with 7.3 million (71 percent) of these showing the third next available appointment was within 14 days. In other words, in FY 2011, VHA generally had the capacity to schedule 71 percent of their patients within 14 days.

Determining the wait time to the third next available appointment is not an absolute measure of VHA's ability to provide timely access (an appointment within 14 days) because there are two available appointment times prior to the third next available appointment that clinics can use to schedule patients. However, in July 2011, the U.S. Senate Committee on Veterans' Affairs requested VA to conduct a survey that among other questions asked mental health professionals whether they could schedule a patient appointment within 14 days in their own mental health clinics. Of the

respondents, 63 percent said they could schedule a new patient appointment, and 61 percent said they could schedule an established patient appointment within 14 days. The survey appears to corroborate VHA's data of the third next available appointment.

### **Scheduling Procedures Were Not Followed**

VHA schedulers were not following procedures outlined in VHA Directives and, as a result, VHA's reported waiting time data was not accurate or reliable. For new patients, the scheduling clerks frequently stated they used the next available appointment slot as the desired appointment date for new patients. Even though a consult referral, or contact from the veteran requesting care, may have been submitted weeks or months earlier than the patient's appointment date, the desired appointment date was determined by and recorded as the next available appointment date. For established patients, medical providers told us they frequently scheduled the return to clinic date based on their known availability rather than the patient's clinical need. For example, providers may not have availability for 2–3 months, so they specify that as the return to clinic time frame.

Using inappropriate and inconsistent scheduling practices greatly distorts the actual waiting time for appointments. We analyzed VHA's data and found that:

- Of the new patient treatment appointments, VHA staff scheduled 81 percent (211,000) on the patient's desired date of care resulting in a 0-day wait.
- Of the established patient treatment appointments, VHA staff scheduled 88 percent (8.9 million) on the patient's desired date of care resulting in a 0-day wait.

Based on discussions with medical center staff and our review of data, we contend it is not plausible to have that many appointments scheduled on the exact day the patient requested. In our opinion, this data reflects inappropriate scheduling practices and it is not representative of how long the patient waited to receive care.

OIG previously reported concerns with VHA's calculated wait time data in our *Audit of VHA's Outpatient Scheduling Procedures*, Report No. 04-02887-169, July 8, 2005 and *Audit of VHA's Outpatient Wait Times*, Report No. 07-00616-199, September 10, 2007. During both audits, OIG found that schedulers were entering an incorrect desired date. VHA Directives require all scheduling staff to complete training on scheduling procedures and require VA Medical Center directors to:

- Ensure every scheduler successfully completes all training modules.
- Ensure all schedulers receive an annual competency assessment.
- Ensure completion of an annual scheduler audit of the timeliness and appropriateness of scheduling actions, and the accuracy of desired dates.
- Be vigilant in the identification and avoidance of inappropriate scheduling activities.

Our review did not fully analyze if the construct of VHA's training and oversight program contributed to the problems we identified. Regardless, given VHA's inability to correct this long-standing problem, VHA should reassess their training, competency, and oversight methods to ensure reliable and accurate appointment data is captured.

### **Increasing Workload and Staffing Shortages**

According to VHA, from 2005 to 2010, mental health services increased their staff by 46 percent and treated 39 percent more patients. Despite the increase in mental health care providers, VHA's mental health care service staff still did not believe they had enough staff to handle the increased workload and consistently see patients within 14 days of the desired dates.

The VA survey asked mental health professionals whether their medical center had adequate mental health staff to meet current veteran demands for care; 71 percent responded their medical center did not have adequate numbers of mental health staff. Based on our interviews at four medical centers, staff in charge of mental health services reported VHA's greatest challenge has been to hire and retain psychiatrists. We analyzed access to psychiatrists at the four medical centers we visited by determining how long a patient would have to wait for the physician's third available appointment. On average, a patient had to wait 41 days. Specifically:

- 19 days at the Denver VA Medical Center
- 28 days at the Milwaukee VA Medical Center
- 80 days at the Spokane VA Medical Center
- 86 days at the Salisbury VA Medical Center

Three of the four sites we visited had vacant psychiatry positions. The Salisbury VA Medical Center had an average wait of 86 days for the psychiatrists' third next available appointment. Staff at that facility told us they lost three psychiatrists to private practice facilities in the past year. VHA needs to conduct a staffing analysis to determine if psychiatrist, or other mental health provider, vacancies are systemic issues impeding VHA's ability to meet mental health timeliness goals.

### **Conclusion**

Most first-time patients waited more than 14 days for their full mental health evaluation and VHA could not always provide existing patients their treatment appointments within 14 days of their desired dates. Performance measure data for mental health appointments was not accurate or reliable. Without accurate and appropriate data, VHA's leadership and decision makers cannot make informed decisions for improving access to mental health care.

## Recommendations

1. We recommend the Under Secretary for Health revise the current full mental health evaluation measurement to ensure the measurement is calculated to reflect the veteran's wait time experience upon contact with the mental health clinic or the veteran's referral to the mental health service from another provider to the completion of the evaluation.
2. We recommend the Under Secretary for Health reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments.
3. We recommend the Under Secretary for Health conduct a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the Veterans Health Administration's ability to meet mental health timeliness goals, and if so, develop an action plan to correct the impediments.

## Under Secretary for Health Comments

The Under Secretary for Health concurred with the OIG's findings and recommendations. VHA has convened a work group to examine how best to measure wait time and develop an action plan to create new metrics. They are committed to developing measures that will reliably and accurately capture appointment scheduling performance for new and ongoing treatment. VHA began collecting vacancy data for mental health staff on January 31, 2012, and will assess the impact of vacancies on operations and develop recommendations for improvement. We consider the planned actions acceptable and will follow up on the implementation.

The Under Secretary for Health provided the following technical comments. The Under Secretary stated that the metric labeled in the report as "First-Time Patient's Access to a Full Mental Health Evaluation," was never intended to measure waiting time, but rather, as the OIG suggests, it was intended to measure how long it took VHA to conduct the evaluation. The Under Secretary also stated that the OIG did not use VHA's methodology of the desired date to assess the accuracy of the metric for new patient waiting time. Rather, OIG assessed waiting time based on the time the appointment was entered into the system, which was the create date.

## OIG Response to VHA's Technical Comments

The OIG does not agree that the metric was intended to measure how long it took VHA to conduct the evaluation. The metric states that veterans defined as new to mental health will have further evaluation and initiation of mental health care in less than 15 days of trigger encounter (walk in or direct access to mental health clinic) or a referral to mental

health service from either primary care provider or other specialty care provider. Therefore, we believe VHA should be measuring the time from when the patient directly contacts mental health service or the initial consult referral from a primary or specialty care provider.

We used the premise that new patients want to be seen as soon as possible to assess the accuracy of the metric for new patient waiting time. For appointments with a consult referral we used the referral date as the desired date. For appointments without a consult referral we used the appointment create date as the desired date since that was the earliest date indicating the veteran wanted mental health care.

## **Issue 2: VHA Measures Do Not Fully Reflect Critical Dimensions of Mental Health Care Access**

VHA's primary mental health access measure, the 14-day follow-up measure, provides decision makers with a limited picture of a new patient's ability to access and begin mental health treatment at VA. Additionally, depending on a veteran's point of access, it may not truly measure VHA's objective "to ensure timely access for all veterans who are new to mental health." A series of timeliness and treatment engagement measures that better reflect the various dimensions of access may provide VHA decision makers with a more comprehensive view of the ability with which new patients can access mental health treatment. Developing strong access measures not only requires an understanding of how veterans access and demand mental health services but also what VA's supply and availability is for services.

### **Defining Access**

In its 1993 report on Access to Health Care in America, the Institute of Medicine defined access as the timely use of personal health services to achieve the best possible outcomes. The authors noted their definition forces one to identify those areas of medical care in which services can be shown to influence health status and then to ask whether the relatively poorer outcomes of some population groups can be explained by problems related to access. The Institute of Medicine definition also emphasized the need to go beyond typical approaches relying mainly on enumerating health care providers, the uninsured, or encounters with health care providers to identify access problems. The authors also commented, "no matter how generally efficacious a particular health service may be, a good outcome cannot always be guaranteed. The most important consideration is whether people have an opportunity for a good outcome—especially in those instances in which medical care can make a difference."<sup>1</sup>

Access to mental health care is a multi-dimensional concept that can be assessed relative to a variety of domains including:

- Geographic location (travel time, distance)
- Temporal (time to appointments, waiting time, time of day, day of week)
- Setting (primary care versus mental health, general mental health care versus specialized mental health care)
- Urgency (emergency mental health treatment, routine treatment)
- Type of mental health service (medication management, psychotherapy, case management, group versus individual treatment)

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<sup>1</sup> Millman, M., Access to Healthcare in America, Institute of Medicine, Washington D.C., The National Academies Press, 1993.

- Provider (psychiatrist, psychologist, social worker, nurse practitioner, addictions counselor)
- Subjective consumer satisfaction
- Affordability<sup>2</sup> and utilization (number of encounters)
- Penetrance (percent of at-risk patients receiving treatment)

### **Overview and Definition of VHA Mental Health Access Measures**

At the November 30, 2011, Senate Committee on Veterans' Affairs hearing, "VA Mental Health Care: Addressing Wait Times and Access to Care," VHA reported that to address mental health access, a new four-part mental health measure would be included in the performance contract for VHA leadership. The measures in the performance contract would define what leadership is accountable to accomplish. Accordingly, in the FY 2012 Network Director Performance Plans, one of the items used to evaluate the performance of Veterans Integrated Service Network (VISN) Directors is "the Network Director assures timely and appropriate access to mental health services." The four measures referred to at the hearing are incorporated in the FY 2012 performances measures listed for this element. The performance plan includes a fifth measure based on desired date. The limitations of the desired date measure were discussed in an earlier section of this report. Table 1 includes an explanation of the numerator and denominator used for the four referenced measures. The four measures are:

1. Percentage of eligible patient evaluations documented within 14 days of new mental health patient index encounter
2. Mental health follow-up within 7 days of discharge from an inpatient mental health unit
3. Percentage of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans with a new diagnosis of post-traumatic stress disorder (PTSD), receiving eight therapy visits within a 14-week period within 1 year of the initial mental health visit
4. Percentage of patients with an activated suicide high-risk flag placed on charts who receive four follow-up visits within a 4-week period following inpatient hospital discharge

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<sup>2</sup> Managing Managed Care: Quality Improvement in Behavioral Health, Institute of Medicine, Washington D.C., The National Academies Press, 1997.

<b>Table 1. Measures/Monitors Used by VHA To Monitor Access to Mental Health Care</b>		
<b>Measure</b>	<b>Numerator</b>	<b>Denominator</b>
1. Percentage of eligible patient encounters documented within 14 days of new mental health patient index encounter (14-day follow-up for new patients)	Veterans with encounter in specific mental health stops with a full evaluation < 15 days from date of initial trigger encounter or referral (consult). <sup>3</sup>	Veterans with encounters in any stop code except compensation and pension, neuropsychological testing and smoking cessation for a mental health diagnosis /problem and no prior encounters in specific mental health stops in the previous 24 months at that specific medical center. Veterans with a Mental health diagnosis who are treated in Primary Care and not referred to mental health are not in this monitor.
2. Mental health Inpatient 7 day follow-up (7-day follow-up discharge)	Mental health discharges with a face-to-face, telehealth, or telephone encounter in a mental health stop code during the 7 days after discharge. The initial follow up encounter cannot be on the same day as the discharge from inpatient. If initial follow-up contact is by telephone within 7 days, a face-to-face or telemental health follow up must occur within 14 days.	VA inpatient discharges in which the patient had at least 1 bed day of care on a mental health service.
3. OEF/OIF veterans with 8 psychotherapy visits in 14 weeks (OEF/OIF Psychotherapy)	Those patients are then required to have 8 psychotherapy sessions (using the CPT codes 90801, 90806, 90807, 90808, 90809, 90818, 90819, 90821, 90822, 90853) within 14 weeks of one another sometime during that FY.	Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans who have primary PTSD diagnoses in two separate outpatient encounters are included in the denominator during the month of their second diagnoses.
4. High-risk suicide monitor (High Risk for suicide)	Total number of patients flagged as Suicide High Risk at discharge that received a qualifying follow-up mental health encounter with a specific provider Person Class in each of 4 weeks following discharge. <sup>4</sup>	Total number of patients with the health factor "Suicide High Risk PRF Placed on Chart" activated. Activation can be in either in or outpatient setting.

Source: Table is from VA OIG. Numerators and Denominators are from VHA VSSC website.

<sup>3</sup> A stop code is a three-digit outpatient workload identifier that indicates the main clinical group responsible for care. Outpatient mental health clinics are indicated by stop codes 500–599. For patient encounters, primary and secondary stop codes can be indicated.

<sup>4</sup> A Person Class is a six-digit identifier used to classify providers by discipline, specialty, and subspecialty.

## Points of Access and Flow of Veterans With PTSD and Substance Use Disorder through VHA

Understanding how patients might access and move through VHA care provides a framework from which to construct meaningful access measures. The discussion that follows illustrates that in isolation, the first measure (14-day follow-up for new patients), provides decision makers with a limited picture of a new patient's ability to access and begin mental health treatment. A series of timeliness and treatment engagement measures might provide decision makers with a more comprehensive view of the ability with which new patients can access mental health treatment. Additionally, on closer review we found that depending on a veteran's point of access, measure 1 does not truly measure VHA's stated objective "to ensure timely access for all veterans who are new to mental health."

Further, meaningful analysis and decision making requires reliable data on not only the timeliness of access but also on trends in demand for mental health services, treatments, and providers; the availability and mix of mental health staffing; provider productivity; and long-term treatment capacity. These demand and supply variables in turn feedback upon a system's ability to provide treatment that is patient centered and timely.

To understand access measures within the broader context of VHA mental health care, it is important to understand how a patient may access and move through VHA care. In this section, we describe a qualitative model of flow into VHA care for patients with a PTSD diagnosis (Figure 1) and depict a model of flow through VHA for patients with PTSD and patients with a substance use disorder (Figures 2 and 3). These models illustrate that VHA care has multiple access points and that demand for care is dynamic. At a given point in time, not all patients who need care seek it, and of those patients who seek care, not all continue care.

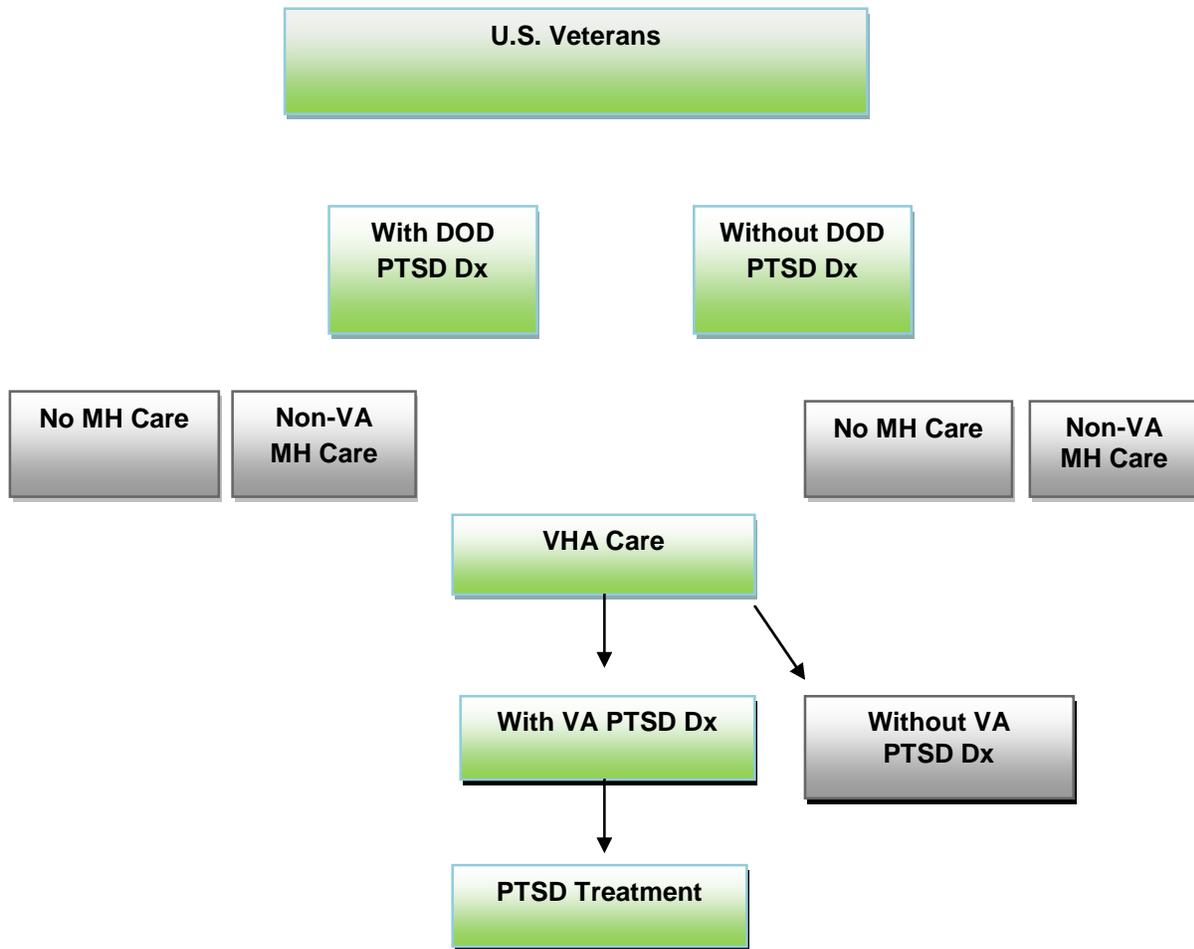
**Flow of Veterans with PTSD.** Figure 1 depicts the demand for VHA PTSD care. VHA's U.S. Vets database is a list of all veterans in the United States regardless of whether or not they have accessed or utilized VA care or benefits. Within the U.S. Vets population, some veterans may have been diagnosed with PTSD while in the military. Other veterans in the population may not have PTSD, did not display symptoms of PTSD while in the military, or were not diagnosed with PTSD during their military service.

Of those diagnosed with PTSD in the Department of Defense, some veterans do not seek mental health care after leaving the military (for example, those treated in Department of Defense with resolution of symptoms or veterans not seeking care due to stigma related concerns); some veterans seek care in the private, community mental health, or alternative public sectors (such as through Tricare); some veterans seek care through VHA; and others may initially seek care elsewhere and then through VHA at a later point in time.

Of those without a Department of Defense (DOD) PTSD diagnosis, some veterans are not in need of mental health care after leaving the military; some develop PTSD symptoms and seek care through private, community, or alternative public sector sources; some seek care through VHA for non-mental health-related conditions, and a sub-set of these veterans may subsequently develop PTSD symptoms; while other veterans develop PTSD symptoms and initially seek care through VHA for this condition. Figure 1, depicts the flow of patients with a PTSD diagnosis (indicated by Dx) into VHA. The green box and green arrow toward the bottom of the figure are used to represent the demand for PTSD evaluation and treatment within VHA.

Of note, the demand at a given VHA health care facility is dynamic and may fluctuate in relation to trends not only in the percentage of patients already within VHA care that need and/or seek mental health treatment at that location but to trends in the number of veterans who develop or initiate access to treatment within VHA for mental health-related conditions.

**Figure 1. DEMAND=f(x) POPULATION, PTSD BURDEN, PTSD Dx**



Not all patients in need of mental health treatment seek treatment. Some patients seek or are referred to care but do not keep appointments. Other patients may enter into care but are difficult to engage in sustained treatment. Timely entry into treatment and the receipt of services can influence the quality of mental health and substance use services.

#### Measure 1: 14-Day Follow-Up (New Patients)

A 2005 study of referrals to the Johns Hopkins Bayview Medical Center community psychiatry adult and child/adolescent outpatient programs from 1995 to 2000 found increased wait times for an initial appointment for services at a community mental health center adversely affected the rate of kept appointments. In their clinic population, the study's authors found a linear relationship between appointment delay and cancellations and no-shows. The rate of cancellations and no-shows was 12 percent for patients who were given an appointment on the same day as the initial contact and 23 percent for the patients who were given an appointment the day after the initial contact. The rate rose to 42 percent among the patients whose appointments were 7 days after initial contact and reached a maximum of 44 percent among patients for whom the initial appointments were 13 days following initial contacts. Of note, the effect of wait time to initial mental health appointment might differ in other clinics where the patient population characteristics differ from the population in the community mental health center utilized in the study.<sup>5</sup>

A 2011 study examined the impact of days to treatment admission on the probability of completing four sessions of care within outpatient addiction treatment program units funded by the Network for the Improvement of Addiction Treatment. Data was analyzed for a cohort of patients from October 2003 to December 2004 and a second cohort of patients from January 2005 to March 2006. The study findings demonstrated a strong decrement in the probability of completing four sessions of treatment with increasing time between the clinical assessment and first treatment session.<sup>6</sup> These studies suggest that the motivation to show for and engage in mental health evaluation in treatment may wane as the delay between referral and receipt of initial evaluation and treatment increases.

VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, states that evaluations and treatment for mental health conditions can be provided through primary care and other medical settings or by arrangements with non-VA community services. New patients requesting or referred for mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial 24-hour

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<sup>5</sup> Gerard Gallucci, M.D., M.H.S.; Wayne Swartz, L.C.S.W.-C.; Florence Hackerman, L.C.P.C., *Brief Reports: Impact of the Wait for an Initial Appointment on the Rate of Kept Appointments at a Mental Health Center*, Psychiatric Services, Vol. 56 No.3, March 1, 2005.

<sup>6</sup> Hoffman, K.A., et al., *Days to treatment and early retention among patients in treatment for alcohol drug disorders*, Addictive Behaviors (2011), doi:10.1016/j.addbeh.2011.01.031.

evaluation is to identify patients with urgent care needs and to trigger hospitalization or the immediate initiation of outpatient care when needed. The initial 24-hour evaluation can be conducted by primary care, mental health providers, other referring licensed independent providers, or by licensed independent mental health providers.<sup>7</sup>

The Deputy Undersecretary for Health for Operations and Management's Monitors and Guidelines for FY 2010 included what we refer to in this report as measure 1 within the domain of access. The monitor was titled "ensure timely access for all new veterans who need mental health care." According to VHA monitor documentation, the objective of measure 1 is to ensure timely access for all veterans who are new to mental health. Veterans defined as new to mental health will have further evaluation and the initiation of mental health care will occur within 15 days of a trigger encounter (walk in or direct access to mental health clinic) or a referral to mental health service from either primary care provider or other specialty care provider.<sup>8</sup>

In practice, how VHA collects and reports data for measure 1 differs in part from the objective described for the measure. The trigger for measure 1 is not usually a referral or consult. Instead, it is typically an initial visit at a mental health clinic 500 series stop code. This distinction is illustrated in Figure 2, which represents the flow of patients with PTSD symptoms through possible VHA outpatient treatment settings, toward possible treatment options in primary care and specialty mental health treatment venues. Not all specialized mental health clinics depicted in the diagram are located at each VHA site, such as a women's stress disorders treatment team (WSDTT), military sexual trauma clinic, or substance use PTSD treatment team clinic.

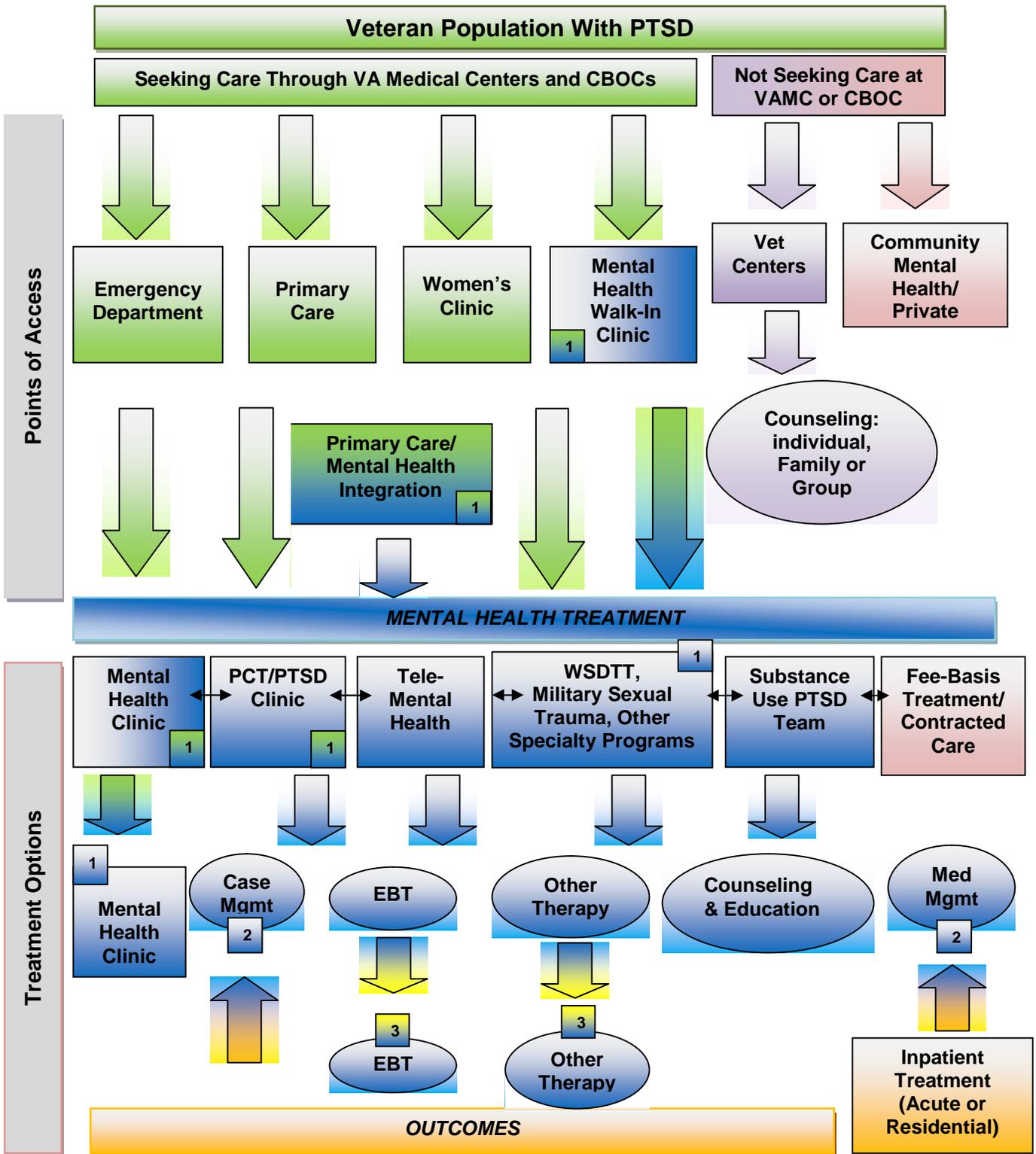
Alternative paths that trigger measure 1 are depicted in Figure 2. (See Appendix D for detailed legend of Figure 2.) The data underlying measure 1 informs decision makers regarding the timeliness within which comprehensive new patient evaluations are completed but not necessarily the timeliness within which patients requesting or referred for mental health services receive a comprehensive evaluation or treatment.

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<sup>7</sup> VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

<sup>8</sup> "Mental Health 14-Day Follow-Up Monitor Documentation," Last Updated 4/20/2011. Accessed at VHA Support Service Center (VSSC) website

**Figure 2. Flow of Patients With PTSD**



Source: VA OIG

As is apparent in Figure 2, there is not one uniform route or channel toward treatment for all patients but multiple potential channels through which patients may access evaluation and PTSD care and by which measure 1 will or will not be triggered:

1. Patients may utilize VHA primary care services but may seek mental health treatment outside of VHA through a private or community provider.
2. Patients may not seek or may decline PTSD treatment at the medical center or Community Based Outpatient Clinic (CBOC) but may seek counseling at a readjustment-counseling center (Vet Center). Evaluation at a vet center is not captured in measure 1.
3. Patients triaged in a primary care or mental health clinic may, under certain circumstances, be referred outside of VHA for treatment by a fee basis provider. Unless the fee basis provider treats patients on VA facility grounds, the time to completed evaluation is not captured in measure 1 for fee basis treatment.
4. Patients with PTSD symptoms may initially be screened and evaluated by a primary care provider in a primary care clinic or a comprehensive women's clinic in those facilities that have a women's clinic. Patients evaluated in these settings may decline referral to mental health and opt to be treated for PTSD symptoms by their primary care provider. These patients would not be captured by measure 1.
5. Patients presenting to a primary care or other medical clinic with PTSD symptoms may be referred to a specialized mental health primary care-mental health integration clinic provider who is co-located and or/collaborates with the patient's primary care provider. An integrated primary care-mental health visit is captured by the decision support system (DSS) stop code/identifier 534. If the patient was seen for comprehensive evaluation by the mental health clinician on the same day, the visit would be picked up by measure 1 as a 0 day wait. If a comprehensive evaluation cannot be completed by a primary care-mental health integrated clinic provider on that day, then the measure captures the time from the index primary care- mental health integrated clinic provider visit to the time of the next visit with a primary care-mental health integrated clinic provider at which the evaluation is completed.
6. If a patient is seen in a primary care clinic, another non-mental health medical clinic, or the emergency department and a referral is made for a mental health appointment at a specialized mental health clinic, for example mental health clinic or PTSD Clinical Team (PCT) clinic, the clock for measure 1 is not triggered until evaluation is initiated on the day the patient presents at the mental health clinic for the appointment. If a comprehensive evaluation was completed within the index visit to the mental health clinic, this would be captured as a 0 day wait. If the

evaluation is completed at a subsequent visit, then the time from the initial visit to the subsequent visit is captured by the measure.

7. If a patient calls PCT or another mental health clinic directly and sets up an appointment, again, the clock for measure 1 begins on the day of presentation (not when the appointment is requested) at the clinic, and the clock stops on the day a comprehensive evaluation is completed. If the evaluation was completed on the day of an initial trigger presentation, this would be captured as a 0 day wait. If the patient receives a triage evaluation at the initial visit, then the clock for measure 1 begins with the initial mental health visit and ends when evaluation is completed at a subsequent mental health clinic or PCT visit.
8. If a new patient spontaneously presents to a mental health walk-in clinic and a comprehensive evaluation is completed on the same day, this would be captured by measure 1 as having a zero day wait. A new patient spontaneously presenting to a walk-in clinic that receives an initial or triage evaluation and is scheduled for evaluation in another mental health clinic would trigger measure 1 at the time of presentation to the walk-in clinic. In this scenario, measure 1 would capture the time from the walk-in clinic visit to the day of completion of evaluation in the second mental health clinic.
9. While measure 1 provides information regarding completion of new patient evaluations within 14 days of an index mental health encounter, it does not capture the timeliness within which new patients are evaluated and treated from when they are initially referred or initially request an appointment. In addition, it would not capture the timeliness with which established patients are seen for a second, third, or subsequent mental health appointments.
10. Once a comprehensive evaluation is completed in a specialized mental health clinic, referral to a different specialized mental health clinic would not be captured in measure 1. For example, if a patient is evaluated and treated in a general mental health clinic for PTSD but is referred to in an intensive outpatient substance use treatment program (IOP) during the course of their treatment in the mental health clinic, the wait time from referral by the mental health clinic to treatment in the IOP clinic is not captured by measure 1 or another measure. The completion of an evaluation starting and ending during the initial or a subsequent visit to the PCT clinic would also not be captured in the measure because the patient is not new to mental health.
11. Access to specific mental health providers (psychiatrist, psychologist, social worker, nurse practitioner, substance use counselor) may vary by VHA site. Timeliness measures in isolation would not capture access to specific providers for which staffing, capacity, and productivity data would be informative.

### Measure 2: 7-Day Follow-Up Discharge

The weeks following discharge from inpatient mental health hospitalization represent a period of increased suicide risk. A British study found that patients receiving closer follow-up and more intensive aftercare were less likely to commit suicide.<sup>9,10</sup> A large Danish study found two sharp peaks for suicide around psychiatric hospitalization—one in the first week after admission and another in the first week after discharge.<sup>11</sup>

Measure 2 (follow-up within 7 days post hospitalization) is depicted in Figure 2. For measure 2, the clock for the measure begins when a discharge is entered into the system and ends when a face-to-face, telehealth, or telephone encounter is completed. The OIG will be collecting information related to measure 2 as part of the onsite Combined Assessment Program review process during the spring 2012 Combined Assessment Program cycle.

### Measure 3: OEF/OIF Veterans with Eight Psychotherapy Visits in 14 Weeks

Access to specific mental health treatment services including medication management, case management, individual or group evidence-based psychotherapy (EBT) for PTSD, other therapies (such as supportive therapy), and counseling and educational groups, may differ at each VHA site (such as a VA Medical Center or CBOC). The occurrence and duration of therapy appointments can be captured with CPT codes, but the content of the therapy provided, whether it is a form of EBT (such as cognitive behavioral therapy) or another type of therapy (such as supportive therapy), cannot be captured by existing administrative codes. Measure 3 (OEF/OIF veterans with a new diagnosis of PTSD, receiving eight therapy visits within a 14-week period within 1 year of the initial mental health visit), is used by VHA as an indirect marker of whether new OEF/OIF patients are receiving a course of evidence-based therapy (a specific mental health treatment).

While the intent of the measure appears sound, upon review of recent data for this measure we noted that totals of veterans meeting the measure for certain VISNs exceeded the national total, and the variation among VISNs was very wide. The Office of Mental Health Service explained these discrepancies by noting that data extraction techniques for the measure were still being refined in order to resolve counting effects of patients receiving therapy in overlapping 14-week periods and fiscal years.

<sup>9</sup> Hunt I.M., Kapur N., Webb R., Robinson J., Burns J., Shaw J., and Appleby L., *Suicide in recently discharged psychiatric patients: a case-control study*, *Psychological Medicine*, 2009, 39, 443-449.

<sup>10</sup> *Suicide After Psychiatric Hospitalization*. Review of Hunt I.M. et al. (cited in previous footnote), *Journal Watch Psychiatry*, May 11, 2009.

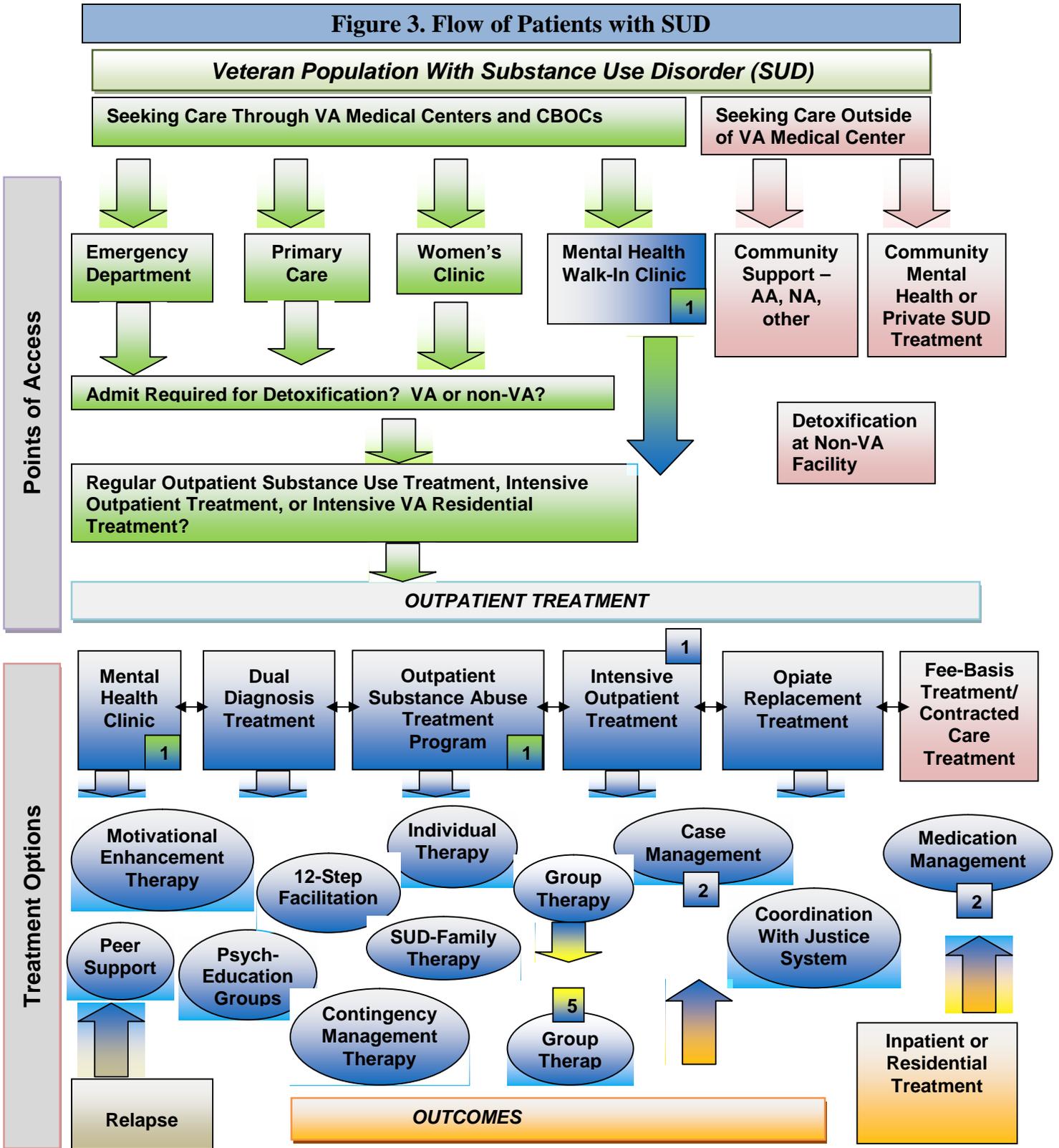
<sup>11</sup> Qin, Ping and Nordentoft, Merete, *Suicide Risk in Relation to Psychiatric Hospitalization*, *Archives of General Psychiatry*, Volume 62, April 2005, p.427-432.

#### Measure 4: High-Risk Suicide Monitor

Measure 4, which requires four follow-up visits in 4 weeks following discharge for patients flagged as high risk, is not depicted in Figure 2 but would be represented in a fashion similar to that shown for measure 3 with an arrow initially emanating from inpatient care. The OIG will be collecting information related to measure 4 as part of the on-site Combined Assessment Program review process during the Spring 2012 Combined Assessment Program cycle.

**Flow of Veterans With Substance Use Disorders Through VHA.** Figure 3 depicts the multi-channel flow of patients with substance use issues through possible VHA treatment settings, toward possible treatment options in primary care and specialty mental health treatment venues. The conventions are similar to those used in Figure 2. The complexity of flow is heightened by the potential need for inpatient or outpatient detoxification, residential versus outpatient rehabilitation and recovery treatment, and relapse potential.

As in Figure 2, the small squares containing a number 1 and a number 2 refer to measures 1 and 2. The small square containing a number 5 is used to depict a VHA monitor that captures the percent of patients beginning a new episode of treatment for substance use disorder who maintain continuous treatment involvement for at least 90 days as demonstrated by at least 2 days with visits every 30 days for a total of 90 days in any outpatient specialty substance use clinic. This is a measure of treatment engagement. As with patients with PTSD, there are multiple points of access and measure 1 invariably reflects access contingent on the patient's point of entry into treatment.



Source: VA OIG

## **Bundled and Competing Access Measures**

The data and measures needed by decision makers for planning and service provision may differ at the national, VISN, and facility level. No measure is perfect or paints a complete picture in isolation.

A bundle of related timeliness measures, if feasible, might include a measure of time from referral, no matter where a patient presents (by self or by primary care or other medical provider), to initial triage evaluation (time  $t_0 - t_1$ ); time from initial evaluation to completed comprehensive evaluation (time  $t_1 - t_2$ ); time from the date of completed evaluation to the next treatment appointment (time  $t_2 - t_3$ ) or from the initial evaluation to initiation of treatment ( $t_1 - t_3$ ); an engagement measure (percentage of patients seen a threshold number of times during the first  $t_x$  days of treatment, such as 45 days), and a measure from time of referral by one specialized mental health clinic (such as General Mental Health) to other select specialized mental health clinics (for example, PCT or IOP).

Beyond measure of timeliness (or delay) to mental health care, a composite or family of measures to broadly inform access might also include: (1) provider panel size; (2) a measure of demand for services; (3) measures of supply for services encompassing both short and long-term treatment capacity, available supply of treatment, and utilization of treatment; (4) trend measure of scheduled clinic appointments either missed or cancelled by patients and by clinics; (5) mental health provider productivity data; and (6) balancing or competing measures.

As discussed to this point, meaningful analysis and decision making requires reliable data not only on the timeliness of access but also on trends in demand for mental health services, treatments, and providers. However, understanding the availability and mix of mental health staffing, provider productivity, and treatment capacity is critical as well.

## **VHA Mental Health Staffing and Productivity Data**

According to VHA's informal survey of frontline mental health professionals, 71 percent reported that, in their opinion, their facilities did not have adequate mental health staff to meet current demand for care. Supply of mental health staff can be reflected in terms of the number and mix of providers, as well as the productivity of available providers. Although VHA collects and reports mental health staffing and productivity data, the complexity of the computations and inaccuracies in some of the data sources presently hinders the usability of productivity information by VHA decision makers to fully assess current capacity, determine optimal resource distribution, evaluate productivity across the system, and establish mental health staffing and productivity standards.

The primary offices that generate mental health staffing information in VHA are the Allocation Resource Center (ARC) and the Office of Productivity, Efficiency, and

Staffing (OPES). The ARC and OPES have different purposes for generating and disseminating this information—the ARC generates the information for budget planning and allocation purposes; OPES generates it to construct productivity models intended to assist VHA managers in making resource management decisions, primarily at the facility level.

**ARC Staffing Reports.** In 2005, the ARC introduced a series of Mental Health Tracking Reports to report VHA’s status on the Mental Health Enhancement Initiative, a special purpose fund created to support VA’s implementation of a mental health strategic plan.

ARC staffing reports show full-time employee equivalents (FTE) for “Core Mental Health Staff,” which broadly includes psychiatrists; psychologists and psychology aides and technicians; social workers and social work aides and technicians; registered nurses, licensed practical nurse, licensed vocational nurses, and nurses aides; physician extenders, including nurse practitioners, physician assistants, clinical nurse specialists, and pharmacists; and therapists, including physical therapists, occupational therapists, and other types of therapists. Users can also drill down in the ARC’s web-based staffing reports to determine FTE levels for specific disciplines, as well as analyze staffing at the facility, VISN, or national level. The reports do not include FTE for non-VA providers, such as contract or fee basis physicians. The primary data sources for the ARC reported FTE are DSS, VA’s cost accounting system, and Financial Management System.

As Table 2 shows, the number of core mental health staff has increased by about 29 percent since 2008; although, the annual rate of increase each year has declined. The largest increases over the 4-year period have occurred with social worker FTE (not including social work aides or technicians) and psychologist FTE (not including psychology aides or technicians), for which FTE increased by 66 and 46 percent, respectively, between 2008 and 2011. Physician FTE increased 23 percent during the same period.

Table 2. ARC Selected Mental Health Staffing for 2008–2011								
FTE	2008	2009	Percent Change 2008–09	2010	Percent Change 2009–10	2011	Percent Change 2010–11	Overall Change 2008–11
<b>Mental Health Core Staffing</b>	17,127.2	19,252.5	12.4%	20,853.9	8.3%	22,032.0	5.6%	28.6%
<b>Physician Only</b>	2,073.1	2,288.1	10.4%	2,452.8	7.2%	2,544.1	3.7%	22.7%
<b>Psychologist Only</b>	1,788.5	2,122.7	18.7%	2,464.9	16.1%	2,613.5	6.0%	46.1%
<b>Social Worker Only</b>	2,844.8	3,510.9	23.4%	4,155.2	18.4%	4,725.7	13.7%	66.1%

Source: Allocation Resource Center, Core Mental Health Staff by VISN accessed on February 2, 2012

**OPES Staffing and Productivity Reports.** OPES' role is to develop tools that VHA managers can use to assess and optimize clinical productivity.<sup>12</sup> Examples of resources available from OPES include workforce reports for specialty programs, including mental health, and the Physician Productivity Cube.

OPES' Mental Health Workforce reports show staffing levels for physicians (psychiatrists) involved in direct patient care and associated mental health providers, including psychologists, social workers, clinical nurse specialists, nurse practitioners, and physician assistants. Data for the reports is extracted from VA's payroll system and, for the physicians, labor-mapping information from DSS. Labor mapping is a process by which VHA facilities allocate employees' time to various activities, including inpatient and outpatient and clinical, administrative, research, and educational activities. (VHA's labor mapping process and definitions are discussed in more detail in the next section on productivity.)

For physician FTE, OPES uses the number of *worked* hours from the Personnel and Accounting Integrated Data System and reported *direct patient care* time by provider in DSS, plus estimated FTE for contract and fee physicians. The estimated contract and fee physician FTE is calculated based on the average workload of VA paid physicians. Since social workers, clinical nurse specialists, nurse practitioners, and physician assistants are also used by other specialties, such as medicine, and because DSS labor mapping information is not available at the individual provider level, OPES uses Budget Object Codes (accounting codes used to describes types of goods or services being purchased) and mental health Clinic Stop Codes to estimate the associated provider time dedicated to mental health.

OPES' Physician Productivity Cube, is intended for facility managers to use, in conjunction with other data, to evaluate productivity at the service or department level. According to OPES officials, the cube is most useful when it is combined with other facility-level information, such as practice models or patient complexity. The cube can assist facility managers in decision making about staffing distributions, hiring and contracting, and other resource allocation decisions.

The focus of the cube is to provide information on physician productivity. It draws from multiple data sources to calculate physician productivity, and it relies on a complex set of business rules to make the calculations. The methodology involves multi-step processes to determine: (1) workforce, (2) workload, and (3) productivity.

Workforce. The physician FTE reported in the cube represents *worked, direct patient care (or clinical) FTE* of full- and part-time VA paid physicians. Productivity is not

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<sup>12</sup> VHA Support Service Center (VSSC) website, OPES Mission, <http://opes.vssc.med.va.gov/Pages/Default.aspx>, accessed on 1/30/12.

calculated for non-physician providers. Determining physician direct care FTE involves several steps.

- **Person Class.** Every physician in VA is supposed to be mapped into a specialty (such as internal medicine, psychiatry, or surgery). This is done by assigning them a “Person Class” in the Veterans Health Information Systems and Technology Architecture (VistA), VA’s integrated system of patient care software applications, in order to exercise their clinical privileges and to have their workload captured in the Patient Care Encounter application.<sup>13</sup> Person Class, represented by numerical codes, was originally developed in the private sector to classify providers for billing purposes; it reflects aggregate groupings, provider types, and areas of specialization or focus. For example, Person Class 182906 corresponds to aggregate grouping by medical doctor, provider-type psychiatry, and specialization geriatric psychiatry.
- **Labor Mapping.** Direct care FTE is computed using facility-reported data on the allocation of physicians’ time. VHA policy requires that facilities map the time all full- and part-time VA paid physicians and dentists spend in direct patient care, administration, research, and education.<sup>14</sup> Labor mapping is done in DSS, the designated managerial cost accounting system for VA. VHA Directive 2011-009 describes the activities included in each time category (called Account Level Budgeter Cost Centers).
  - **Direct Patient Care** includes time spent in preparing, providing, and following up on the clinical needs of patients. This may include reviewing patient data, consulting with colleagues about patients, contacting patients or caregivers, and supervising residents. Direct patient care also includes attending education programs aimed at maintaining or enhancing clinical skills.
  - **Administration** includes time spent performing managerial or administrative duties, such as preparing performance reviews, meeting reporting requirements, managing a program or service, and participating in service, facility, national or professional society committees.
  - **Research** includes time spent performing formal, approved health care research or activities that support approved research, such as working on projects, serving on research committees, supervising research, and writing or presenting publications. Research does *not* include clinical research where workload is captured under clinical care.
  - **Education** includes time spent preparing for and providing formal, didactic training, such as giving classroom lectures or conferences or managing

<sup>13</sup> VHA Directive 2005-059, *Person Class File Taxonomy*, December 7, 2005.

<sup>14</sup> VHA Directive 2011-009, *Physician and Dentist Labor Mapping*, February 28, 2011.

residency programs and serving on medical school committees. Education does *not* include programs taken to maintain or enhance clinical skills.

Using the Person Class and DSS labor-mapping information, OPES calculates clinical time for physicians (annotated as MD FTE(C)). The difference ( $\Delta$ ) between MD FTE and MD FTE(C) represents potential physician resources currently involved in other activities such as administration, research, and education. Based on OPES' supporting data, non-clinical psychiatrist FTE associated with administration, research, and education on aggregate represents roughly 15 percent of total physician FTE, with some facilities reporting up to 32 percent.

For psychiatrists (and other non-surgical specialties), they further adjust this FTE to *exclude* time mapped to inpatient activities. According to OPES officials, they do this because of issues with the reliability and completeness in how facilities are capturing inpatient workload data for non-surgical specialties. Therefore, the Adjusted MD FTE(C) used for calculating psychiatrist FTE (and productivity) reflects *worked, outpatient, direct patient care FTE*.

Workload. Within the cube, workload is allocated to physicians using several business rules in an effort to reduce double counting or overlap. Workload is reported in terms of patient encounters and work relative value units (WRVU).<sup>15</sup> Workload is only captured for work performed “within the walls” of VHA facilities—it does not include work performed by off-site, fee basis, or contract physicians.

- Patient Encounters and RVUs. To determine provider workload, the cube uses monthly extracts from the National Patient Care Database, which includes outpatient and inpatient CPT codes transmitted from the Patient Care Encounter package. Workload is assigned to a specialty based on the Person Class of the first attending physician associated with the encounter. If during an encounter, a patient is seen by two physicians from *different* specialties, the workload is assigned to each physician. However, if the patient is seen by two providers from the *same* specialty, the workload is assigned only to the first listed attending physician to avoid possible double counting. Using these rules, workload is aggregated for each provider, and WRVUs are calculated using values contained in Centers for Medicare and Medicaid Services Physician Fee Schedule RVU files.
- Inpatient Workload. At present, there are limitations in the cube for accurately reporting *inpatient* workload for non-surgical specialties, including mental health.

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<sup>15</sup> RVUs are widely used in the health care industry to reflect the resources required to perform medical procedures (designated by Current Procedural Terminology or CPT codes) and are used as the basis for reimbursement under Medicare and other health insurance. Procedures comprise three RVUs—Work RVUs reflect the time and intensity to perform a procedure in relation to other procedures, Malpractice RVUs reflect the costs related to maintaining malpractice insurance, and Practice RVUs reflect the costs associated with maintaining a medical practice. For workload measurement and productivity, only the WRVUs are relevant.

Although VHA Directive 2009-002, issued in January 2009, requires mental health providers to “document and enter encounter data on all mental health professional services provided in an inpatient setting,”<sup>16</sup> there does not appear to be full or consistent compliance with the directive. Therefore, it is not clear how accurate or complete the inpatient workload shown in the cube is for the non-surgical specialties. Anecdotally, OPES officials know that some medical facilities are diligent about reporting inpatient workload, while others are underreporting workload or not reporting it at all.

**Productivity.** Despite the fairly complex business rules for calculating direct patient care FTE and workload, the productivity calculation for psychiatrists is straightforward:

$$\text{Productivity} = \text{WRVU} \div \text{Adjusted MD FTE}(C)$$

In this calculation, Adjusted MD FTE(C) represents the direct outpatient clinical time physicians worked in a given fiscal period. WRVU reflects workload as measured by Work RVUs. It is important to note that if a facility is diligent about capturing inpatient psychiatry workload, the WRVU will reflect both inpatient and outpatient workload, even though the FTE reflects only outpatient effort, thereby potentially overstating productivity.

**Limitations with Productivity Data.** While the Physician Productivity Cube may provide a ballpark measure for looking at and benchmarking service-level or facility level productivity, it has several limitations that prevent using it as a nationwide tool to gauge the true supply and availability of mental health providers in VA. These limitations are primarily due to incomplete or inaccurate information in the data sources used to calculate productivity. Specific limitations include:

- The cube is based on numerous complex business rules resulting in various adjustments to and calculations of the source data. Consequently, reconciling to source data in the cube is cumbersome.
- The cube only shows productivity for VA paid full- and part-time physicians. It does not compute productivity for other physicians, such as contract, fee basis, or without compensation physicians, who serve veterans at VHA facilities or at non-VA facilities.
- The cube currently does not show productivity for non-physicians who may play significant roles in delivery of mental health care, including psychologists, social workers, clinical nurse specialists, nurse practitioners, and physician assistants.

<sup>16</sup> VHA Directive 2009-002, *Patient Care Data Capture*, January 23, 2009.

- In calculating psychiatrist productivity, the cube uses only outpatient FTE because of OPES' concern that facilities are not fully or accurately capturing inpatient workload. However, for those facilities that do accurately capture inpatient workload, productivity may be overstated since the denominator is just outpatient FTE, yet the numerator is both outpatient and inpatient workload.
- FTE (and consequently productivity) is calculated based on physicians' direct patient care time, excluding administration, research, and education activities. As a result, decision makers may not get a complete picture as to the impact that non-clinical activities have on meeting patient workload demands or in terms of VA's full capacity to provide services.
- The cube relies heavily on labor-mapping information contained in DSS and Person Class identified in VistA, which are self-reported by facilities. However, there is variability in how accurately, frequently, and consistently facilities are updating DSS labor mapping data, which makes it difficult to compare productivity across facilities.
- Although the cube includes a measure of facility complexity, it cannot account for local practice approaches (such as use of interdisciplinary teams), case mix, availability of support staff, or quality issues, which limits the cube's usefulness for benchmarking between medical facilities or identifying outliers.

The next section of this report describes what measures a few, large private sector health care organizations use to monitor and manage the timeliness of access to mental health services and will review what other data VHA already collects that may inform internal assessment of access to mental health care.

### **Measuring Access to Mental Health Care in the Private Sector**

The challenge of meeting the demand for mental health services and measuring access are not unique to VHA. We interviewed the directors of behavioral health services for three private sector health care organizations based in the Pacific Northwest, California, and the Southeast. The organizations included a large, national health care system and two regionally-based systems. All three organizations have multiple mental health clinics distributed throughout their geographic service delivery area. These clinics vary widely in size, available resources, and patient demographics. Two of the organizations use electronic medical record systems for all aspects of patient care. All three have a mechanism to refer patients to providers outside their organizations to augment the capacity or range of services provided.

Despite a decrease in outpatient utilization since 2009,<sup>17</sup> the private sector health care organizations reported increased demand for mental health services by as much as 20 percent over the past 2 years. The directors attributed this increase to multiple factors, including declining public community mental health resources and worsening economic and financial pressures on individuals and families. Their primary strategy to address increased demand involves actively managing their clinic capacity and efficiency. For the most part, this includes reallocating resources to open new triage and evaluation slots, transitioning stable patients back to primary care, or transitioning eligible patients from individual to group encounters.

Private sector health care organizations we contacted all used performance “dashboards” (or “scorecards”) that report different dimensions of access, such as timeliness, continuity of care, efficacy of treatment engagement, capacity, patient satisfaction, and quality.

Dashboards are the key decision support tools managers use to monitor and respond to the changes in demand for mental health services. The dashboards provide managers at all levels of the organization real-time data to assess supply and demand, allowing local managers to rapidly adjust and reallocate clinical resources to meet needs and upper-level managers to quickly assess the adequacy of responses and ensure that quality of care is not compromised. Different types of dashboard reports are available within the organizations, from high-level aggregated executive summaries to point-of-care tracking sheets. Wide dissemination and visibility of the dashboards is critical to ensure performance goals are communicated and met within the organizations. For example, in local clinics, dashboards are displayed in areas for all employees to see.

Dashboards display different measures designed to track various dimensions of access (that is, timeliness, continuity of care, efficacy of treatment engagement, capacity, patient satisfaction, and quality). Directors typically use multiple measures to monitor trends within each of the dimensions. Frequently measures are complementary—improved performance for one measure may be offset by performance decline of another. The most common dimensions reflected in the dashboards are discussed below.

**Timeliness of Care.** When measuring timeliness of mental health services, the private sector organizations consider both new patient appointments requested through self-referral or consult requests and follow-up appointments for established patients. Measuring timeliness of new patient appointments is a key focus. For new patients, the underlying assumption is that most patients want to initiate treatment as soon as possible and typically want appointments within 2 weeks.

The organizations apply similar approaches for new patient appointments—triage, then intake, followed by treatment initiation with a goal of rapid stabilization. Triage

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<sup>17</sup> Johnson, Avery, Jonathan D. Rockoff, and Anna Wilde Mathews. “Americans Cut Back on Visits to Doctors,” *The Wall Street Journal*, July 29, 2010.

management is also consistent between the organizations. Patients requesting services, either as walk-ins or by phone, are immediately triaged. Depending on urgency, a patient will receive active treatment for emergent cases in less than 24 hours (ideally within 6 hours), urgent cases within 48–72 hours, and routine cases within 2 weeks. For consult requests or referrals by primary and specialty care providers, clinic staff contact patients within 24 business hours after the consult request to schedule appointments.

The organizations measure “time to first appointment” as the number of days between the time the patient first requests an appointment or a consult is created by a referring provider to the day of the patient’s first appointment with a mental health provider for initiation of treatment with a psychiatrist, psychologist, or mental health nurse practitioner. The scheduling software electronically captures  $T_0$  when a clerk opens the appointment schedule to create a new patient appointment. Two of the directors we interviewed stated that they expect clinics to provide 95 percent of new patient appointments within 2 weeks of a patient’s first request or a consult.

**Continuity of Care and Follow-Up Appointments.** The private sector organizations share a uniform goal of rapid stabilization of symptoms early in the treatment course. They strive to achieve close monitoring of new patients during the initial phase of treatment to allow for symptom assessment, initialization of medications, and monitoring for medication side effects. Their dashboards include measures of continuity of care, timely follow-up appointments, and the ability clinics have to continue treatment after a new patient’s initial visit.

The directors at each organization established a pre-determined average number of visits within the first 45–60 days of an initial new patient appointment. How they achieve this goal varies. Typically, a form of recurring scheduling is used to guarantee access to 4–6 appointments within a pre-determined time frame goal. Some clinics achieve this by scheduling the entire set of appointments at the time of initial presentation; others schedule the first several appointments at the conclusion of the first treatment session.

On average, behavioral health directors expect new patients to have at least four visits within the first 45–60 days of treatment. Accordingly, the organization dashboards include measures of the length of time between subsequent visits, that is the time to the second ( $T_2$ ), third ( $T_3$ ), and fourth ( $T_4$ ) visits.

**Treatment Engagement.** The private sector behavioral health directors consider treatment engagement an essential element of their access performance measures. They define engagement as both the ability to provide treatment to patients who initially seek care (capture), as well as their ability to provide continued and sustained participation in treatment after the initial visit (engagement).

As a reflection of patient engagement in treatment, the dashboards report the percent of patients who continue treatment after their initial appointment. The percent of patient

engagement—that is, the percent of patients who complete a second appointment—can be expressed as:

$$\text{Engagement } (E_2) = (N \text{ patients with } T_2 \text{ appointment} / N \text{ patients seeking care } T_0) \times 100$$

Treatment engagement measures may also indirectly reflect the quality of care delivered. The behavioral health directors expect at least 60 percent of new patients to return for a second appointment. Some also track the patient's ability to see the same provider for their follow-up care, an important factor in establishing a strong patient-provider relationship.

**Capacity.** Closely monitoring availability of future appointment slots is essential to be able to respond to increased demands for service. Dashboard capacity measures include time to first available appointment, third-next available appointment,<sup>18</sup> and the number of available new appointments per week.

This dashboard information is particularly useful to local clinic managers and providers who can then reallocate resources required to meet patient needs. Local managers review the number of open appointments available each day, the following week, and over the following month. They assess their capacity by the type of appointment—new intakes, return appointments, medication management, and individual or group therapy. Capacity for each type of provider (such as psychiatrist, psychologist, nurse practitioners or clinical specialists, and social workers) is tracked to assist in matching patients' individual needs with the clinics' available resources. Local clinics can also predict the average number of new patients expected for treatment. If their current schedule cannot accommodate their predicted demand, they initiate an informal team meeting with providers and staff and identify ways to open more appointment slots.

In tandem with capacity measures, managers closely track the ability to maximize available patient care resources at local clinics. These measures include monitoring appointment “fill rate” (the percent of available appointment times actually utilized to deliver services), as well as “no-show” (patient fails to arrive for a scheduled appointment) and “cancellation” rates.

Most of the local private sector clinics reportedly use waiting lists when there are unexpected spikes in demand. According to one director, for about 20 percent of patients, going on a wait list was preferable to the option of seeing a provider outside the organization because these patients perceived the organization's staff to be more desirable. The longest wait, on average, was 3–4 weeks from the time a patient requested services. However, all of the directors we interviewed told us their local clinics routinely review fill rates, no-show, and cancellations and manage their wait lists in an effort to

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<sup>18</sup> The third-next available appointment open for scheduling eliminates overestimates of available services caused by high no-show or cancellation rates, which reduce the “1<sup>st</sup> next available” wait time.

quickly move patients with the longest wait times to more timely appointments (that is, within the 2-week goal).

**Patient Satisfaction.** Patient satisfaction is also a key element in the dashboards. All of the organizations solicit patient input through surveys and patient-initiated feedback. The directors especially rely on patient satisfaction measures for assessment of contracted care services, where access to electronic scheduling data is not available. Some include these measures as an ongoing deliverable in their contracts. Regional managers closely review discrepancies between local clinics patient satisfaction data and other dashboard performance measures. Such conflicts frequently serve as early indicators of access, engagement, or quality issues.

### **Application of Private Sector Measures to VHA**

VHA currently reports mental health access metrics on the VHA Support Service Center (VSSC) Systems Redesign website. Some timeliness data captured by VSSC are similar to those we reviewed from the private sector. The current VHA scheduling system is able to electronically capture a “creation date” when a clerk opens the scheduler to create a new appointment. VHA reports can include a metric parallel to the private sector “time to first appointment” by measuring the time between the “creation date” and the date of the first evaluation and treatment provided by a psychiatrist, psychologist, social worker, or other mental health provider. With adaptation and testing, the first use of an International Classification of Disease (ICD-9) code for a specific mental health diagnosis (for example, PTSD) has potential for use as the trigger to start the clock for a measure to timeliness of mental health evaluation and treatment.

Similar to private sector entities, measures of time to the second, third, and fourth mental health visit could be reported. To ensure that treatment visits are captured, the measures would need to specify the type of provider (for example, psychologist or psychiatrist) or type of service (such as evaluation, treatment visit) to avoid inclusion of complementary visits (such as educational groups). An engagement measure, such as the percentage of patients seen a threshold number of times during an initial period of treatment (for example, the first 45 days), would indirectly reflect both a facility’s ability to provide serial follow-up visits during early treatment and to sustain patient involvement in the initial phase of treatment.

The inability to readily track capacity imposes a major limitation on the support tools available to VISN and facility decision makers. VHA officials reported the present scheduling software is 25 years old and the software interface is not “user-friendly.” Schedulers must click between several screens during the scheduling process requiring anywhere from 30 seconds to 5 minutes to schedule an appointment. VHA officials asserted that calendar-based systems used in the private sector are quicker and more user-friendly.

Additionally, VHA officials reported that ascertaining provider availability using the existing scheduling software is challenging. Each provider may have assigned several stop codes under which the provider sees patients. The stop codes are used in part to allow for reporting of utilization of specific clinics (such as PCT). For example, a psychiatrist may use DSS stop codes 509 (psychiatry-individual), 557 (psychiatry-group), and 562 (PTSD-individual) among others to capture their outpatient work on a given day. The system will treat each stop code as if each were a separate clinic with separate schedules.

While local facilities do construct ad hoc reports to identify future appointment availability (appointments available that day, the following week, and the following month), the process is labor intensive. Measures of capacity by type of appointment (new patient, medication review, follow-up), or by type of provider (psychiatrist, psychologist, social worker, nurse practitioner) are not readily available.

## **Conclusions**

The data and measures needed by decision makers for planning and service provision may differ at the national, VISN, and facility level. No measure of access is perfect or paints a complete picture in isolation. Meaningful analysis and decision making requires reliable data, on not only the timeliness of access but also on trends in demand for mental health services, treatments, and providers; the availability and mix of mental health staffing; provider productivity; and treatment capacity. These demand and supply variables in turn feed back upon a system's ability to provide treatment that is patient centered and timely.

Our review found that VHA's 14-day follow-up measure provides decision makers with a limited picture of a new patient's ability to access and begin mental health treatment. Additionally, depending on a veteran's point of access, this metric does not truly measure VHA's stated objective "to ensure timely access for all veterans who are new to mental health." A series of timeliness and treatment engagement measures might provide decision makers with a more comprehensive view of the ability with which new patients can access mental health treatment.

Furthermore, although VHA collects and reports mental health staffing and productivity data, the complexity of the computations and inaccuracies in some of the data sources limits the usability of productivity information to fully assess current capacity, determine optimal resource distribution, evaluate productivity across the system, and establish mental health staffing and productivity standards.

Private sector entities with whom we spoke reported that their managers use multiple measures to assess a range of access parameters. These entities disseminate their dashboard reports to all levels of management thereby facilitating timely response to changing access dynamics.

Beyond measures of timeliness (or delay) to mental health care, a dashboard of user friendly measures that incorporate aspects of patient demand, provider supply, clinic capacity, and provider productivity, anchored by a consistent set of business rules, might provide VHA decision makers with a more robust perspective from which to assess and timely respond to changes in access parameters.

## **Recommendations**

4. We recommend the Under Secretary for Health ensure that data collection efforts related to mental health access are aligned with the operational needs of relevant decision makers throughout the organization.

## **Under Secretary for Health Comments**

The Under Secretary for Health concurred with the OIG's findings and recommendation. VHA's Office of Mental Health Operations has developed a comprehensive mental health information system. This operations group will review available data and add other data elements as necessary, ensuring the information system is aligned to the operational needs of the organizational structure. We consider the planned actions acceptable and will follow up on the implementation.

## Appendix A Scope and Methodology

We conducted this review from December 2011 to March 2012. To address our review objective, we reviewed applicable laws, regulations, policies, procedures, guidelines, and studies. Additionally, we focused on measures contained with the FY 2011 PAR:

- Percent of eligible patient evaluations documented within 14 days of the new mental health patient index encounter.
- Percent of specialty care appointments completed within 14 days of the desired date.

To evaluate whether patients received full evaluations within 14 days, we obtained the VSSC data “Percent of Eligible Patient Evaluations Documented within 14 days of New Mental Health Patient Index Encounter (Formerly Mental Health 14-Day Follow-up Monitor)” report for FY 2011. VHA officials identified this as the source data used to support the 95 percent reported in VA’s FY 2011 PAR. We then obtained a statistically random sample to test the data. For further details on the sampling methodology, see Appendix B.

To evaluate whether patients received their mental health appointments within 14 days of the desired date, we obtained the VSSC Report “Wait Time Final Cube (Completed Appointments)” from VHA Systems Redesign. We received all new and established patient mental health appointments, excluding Compensation and Pension visits. We then obtained a statistically random sample of new patient appointments and established patient appointments to test the data. For further details on the sampling methodology, please refer to Appendix B.

We interviewed the directors of behavioral health services for three private sector health care organizations based in the Pacific Northwest, California, and the Southeast. The organizations included a large, national health care system and two regionally based systems. All three organizations have multiple mental health clinics distributed throughout their geographic service delivery area. These clinics vary widely in size, available resources, and patient demographics. Two of the organizations use electronic medical record systems for all aspects of patient care. All three have a mechanism to refer patients to providers outside their organizations to augment the capacity or range of services provided. During the review, we visited four VA medical centers located in:

- Denver, CO
- Milwaukee, WI
- Salisbury, NC
- Spokane, WA

## **Appendix A Scope and Methodology (cont)**

While on site at VA healthcare facilities, we conducted interviews with schedulers, providers and medical center management to identify the steps used to schedule appointments, the origins of return to clinic dates used by providers, and the clinic availability of the providers. The audit team used these interviews to determine if VHA personnel followed established scheduling procedures.

We assessed the reliability of automated data by comparing three selected data elements—create date of appointment, desired date of care, date of completed appointment—to the electronic medical records. To test completeness of the data, we captured and compared all completed appointments from Spokane found in VistA and confirmed the completed appointments were included in VHA's universes used to calculate and support the performance measures. We concluded that the data used to accomplish the audit objective was sufficiently reliable.

Our assessment of internal controls focused only on those controls related to the accuracy of veterans' waiting times and access to care. The Office of Audits and Evaluations and Office of Healthcare Inspections completed this review jointly in accordance with The Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation.

## Appendix B Statistical Sampling Methodology

To determine whether veterans can access the mental health care that they need in a timely manner, we reviewed three random samples to ensure veterans seeking VHA mental health services for the first time received timely evaluations, and to ensure accurate recording of waiting times for new and established mental health patients.

- Eligible Patient Evaluations – New Mental Health Patient Index Encounter
- Completed mental health appointments for new patients
- Completed mental health appointments for established patients

### Population

The population of encounters (appointments) of veterans seeking mental health care at VHA for the first time (Sample 1) consisted of over 373,000 in FY 2011. These veterans have had no prior encounters in specific mental health clinics in the previous 24 months at that specific medical center, and require further evaluation and treatment in mental health. In the FY 2011 PAR, VHA reported 95 percent of these veterans received an extensive evaluation and initiation of appropriate mental health care within 14 days of a trigger encounter.

The population of appointments for veterans new to a specific mental health clinic (Sample 2) consisted of over 262,000 completed appointments in FY 2011. The definition of a new patient is someone not seen by a high-level qualified provider within the prior 24 month. A patient will only move into the “established” category once a high-level, qualified physician has seen them. The population of appointments for veterans established in the mental health clinic (Sample 3) consisted of over 10 million completed appointments in FY 2011.

In the FY 2011 PAR, VHA reported they completed 95 percent of new and established specialty care appointments within 14 days of the desired date. We obtained and reviewed only the mental health patient (all 500 series stop codes) appointments and separated them into universes of new and established patient appointments. VHA’s mental health appointment data showed 95 percent of the new patient and 98 percent of the established patient appointments were completed within 14 days of the desired date.

### Sampling Design

We used a simple random sampling approach to select the sample from each of the three populations, based on a design precision of no more than 8.2 percent of the estimated number of cases, a 90 percent confidence level, and an expected error rate of no more than 10 percent of the total. This sampling technique provided equal chance of selection of all records in the respective population. Based on this sampling criterion, we used a

## Appendix B Statistical Sampling Methodology (cont)

classical simple random formula to calculate the sample sizes.

We segregated the populations of records into two groups based on two judgmentally selected sites and all remaining sites. Each randomly selected sample was within the two groups. OIG statisticians used a random number generator to generate a random selection of appointments, which automatically selected records from the population.

<b>Table 3. Sampling Approach New Mental Health Evaluations</b>			
<b>Group</b>	<b>Total No. Of Sites</b>	<b>Total Evaluations</b>	<b>Sample Size</b>
Certainty Sites	2	5,700	53
Remaining Sites	139	367,600	93
<b>Total</b>	<b>141</b>	<b>373,300</b>	<b>146</b>

Source: VA OIG

<b>Table 4. Sampling Approach New Patient Completed Appointments</b>			
<b>Group</b>	<b>Total No. Of Sites</b>	<b>Total Appointments</b>	<b>Sample Size</b>
Certainty Sites	2	4,300	60
Remaining Sites	139	257,900	200
<b>Total</b>	<b>141</b>	<b>262,200</b>	<b>260</b>

Source: VA OIG

<b>Table 5. Sampling Approach Established Patient Completed Appointments</b>			
<b>Group</b>	<b>Total No. Of Sites</b>	<b>Total Appointments</b>	<b>Sample Size</b>
Certainty Sites	2	135,800	60
Remaining Sites	139	9,908,700	200
<b>Total</b>	<b>141</b>	<b>10,045,500</b>	<b>260</b>

Source: VA OIG

## Appendix B Statistical Sampling Methodology (cont)

### Sampling Methodology

The 146 sampled evaluations in Sample 1, and the 260 sampled appointments each in Samples 2 and 3 represented particular segments of the overall universes. We accounted for differences in the probability of selection between groups by weighting the sample results.

To evaluate access to mental health care and determine if veterans received a full evaluation within 14 days, we identified when the patient initially contacted mental health seeking services, or when another provider referred the patient to mental health. Specifically, we used VA's Compensation and Pension Records Interchange to review patients' visit dates, clinical notes, and consult records. We determined if the full evaluation contained patient history, diagnosis, and treatment plan. Based on that information, we calculated the number of days between initial contact in mental health and the full mental health evaluation.

To evaluate wait times for mental health appointments, we determined if VHA personnel followed established procedures when selecting the types of appointments and veterans' desired dates of care. Specifically, we reviewed the desired date of care requested by the provider and documented in medical records or the veteran's desired date of care as recorded in the VistA scheduling and consult packages by the scheduler. Based on that information, we calculated the number of days between the desired date and the completed appointment date.

### Estimates and Margins of Error

Based on the results of our three samples, we projected nationwide totals and percentages of delays to evaluations, and waiting times for new and established mental health appointments. We used WesVar software to calculate the weighted population estimates and associated sampling errors. WesVar employs replication methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design. The margins of error and confidence intervals are indicators of the precision of estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time. The projected numbers are rounded to agree with the numbers in the report.

## Appendix B Statistical Sampling Methodology (cont)

### Sample 1

We projected that only 184,000 (49 percent) of over 373,000 new mental health patient evaluations were completed within VHA's goal of 14 days. Table 6 shows the results of our sample.

<b>Table 6. Projections New Mental Health Patient Evaluations</b>						
<b>Attribute</b>	<b>Projected Evaluations</b>	<b>Projected Percent</b>	<b>Margin of Error Based on 90 Percent Confidence Interval</b>			<b>Sample Size</b>
			<b>Margin of Error</b>	<b>Lower Limit</b>	<b>Upper Limit</b>	
Evaluation Within 14 Days	184,000	49.4	32,764	151,643	217,171	67
Evaluation Later Than 14 Days	161,000	43.1	32,206	128,784	193,195	68
Evaluation Not Completed	28,000	7.5	16,770	11,123	44,662	11
<b>Total</b>	<b>373,000</b>	<b>100</b>	<b>16,775</b>	<b>356,513</b>	<b>390,064</b>	<b>146</b>

Source: VA OIG

## Appendix B Statistical Sampling Methodology (cont)

### Sample 2

We projected that approximately 168,000 (64 percent) of new patient appointments were completed within 14 days of the desired date. Table 7 shows the results of our sample.

Table 7. Projections New Patient Completed Appointments						
Attribute	Projected Appointments	Projected Percent	Margin of Error Based on 90 Percent Confidence Interval			Sample Size
			Margin of Error	Lower Limit	Upper Limit	
Wait Time Within 14 Days	168,000	64.1	14,497	153,509	182,503	175
Wait Time Over 14 Days	94,000	35.9	14,497	79,734	108,728	85
<b>Total</b>	<b>262,000</b>	<b>100.0</b>				<b>260</b>

Source: VA OIG

### Sample 3

We projected that approximately 8.8 million (88 percent) of follow-up appointments within 14 days of the desired date. Table 8 shows the results of our sample.

Table 8. Projections Established Patient Completed Appointments						
Attribute	Projected Appointments	Projected Percent	Margin of Error Based on 90 Percent Confidence Interval			Sample Size
			Margin of Error	Lower Limit	Upper Limit	
Wait Time Within 14 Days	8,838,900	88.0	376,936	8,460,951	9,214,822	227
Wait Time Over 14 Days	1,207,000	12.0	376,936	829,665	1,583,536	33
<b>Total</b>	<b>10,045,000</b>	<b>100.0</b>				<b>260</b>

Source: VA OIG

## **Appendix C Previous OIG Reports Highlighting Need for Improved Appointment Scheduling and Performance Measures**

### **Audit of VHA's Outpatient Scheduling Procedures, Report No. 04-02887-169, July 8, 2005**

Schedulers did not follow established procedures when selecting the type of appointment when entering the desired appointment date, which affected how the waiting time was calculated. The then Under Secretary for Health agreed to ensure medical facility managers require schedulers to create appointments following established procedures and monitor the schedulers' use of correct procedures when creating appointments.

### **Audit of VHA's Outpatient Waiting Times, Report No. 07-00616-199, September 10, 2007**

Schedulers were not following established procedures for making and recording medical appointments, and schedulers were not receiving annual training. The then Under Secretary for Health agreed to establish procedures to routinely test the accuracy of reported waiting times and completeness of electronic waiting lists and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and documented in the VistA scheduling package. The Under Secretary also agreed to ensure schedulers received required annual training.

### **Audit of Alleged Manipulation of Waiting Times in VISN 3, Report No. 07-03505-129, May 19, 2008**

The U.S. Senate Committee on Veterans' Affairs requested we review allegations that leadership at VISN 3 was manipulating procedures to misrepresent patient waiting times. Schedulers were not following appointment scheduling procedures or inputting the correct desired appointment date. The then Under Secretary for Health did not agree with the recommendations to monitor compliance with established policies since the issues cited for VISN 3 reflected the need for national solutions that VHA was already addressing in response to previous reports.

## **Appendix C Previous OIG Reports Highlighting Need for Improved Appointment Scheduling and Performance Measures (cont)**

### **Healthcare Inspection of Access to VA Mental Health Care for Montana Veterans, Report No. 08-00069-102, March 31, 2009**

VHA needed to increase the availability of evidence-based psychotherapy for mental health services in rural Montana. The then Under Secretary for Health agreed with the findings and took action to expand evidence-based psychotherapy with additional resources and developing contracts with providers throughout the state.

### **Healthcare Inspection of Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center, Report No. 10-02986-215, July 12, 2011**

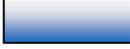
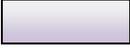
The inspection suggested that VHA improve performance measures for mental health care waiting times because medical centers may be compliant with current performance measures but may not be providing timely treatment.

### **Review of Select Patient Care Delays and Reusable Medical Equipment Review, Central Texas Veterans Health Care System, Report No. 11-03941-61, January 6, 2012**

Appointments were routinely made incorrectly by using the next available appointment date instead of the patient's desired date. The Director agreed to ensure staff follow VA policy for scheduling outpatient appointments and monitor compliance.

## Appendix D Detailed Legend for Figures

For the figures in this report:

- The color green is used to illustrate primary care venues  and the flow of patients seeking care at VA facilities who have not received a completed comprehensive diagnostic and treatment planning evaluation by a specialized mental health (MH) provider. 
- The color blue is used to denote specialized MH venues  and the flow of patients once they have received a completed comprehensive diagnostic and treatment planning evaluation. 
- Light purple is used to denote care at VA readjustment counseling centers (Vet Centers). 
- Light red is used to denote care at non-VHA settings including private MH providers, community MH services, and MH services accessed via other agencies (e.g. Tricare-DOD, Indian Health Service) or fee basis care arranged through VHA. 
- Orange is used to denote VHA inpatient/residential treatment venues. 
- A small square containing the number 1 is used to denote VHA access measure 1 (percent of eligible patient evaluations documented within 14 days of new MH patient index encounter). Placement of the small square completely within the lower corner of a MH treatment venue box is used to indicate that the MH index encounter and completed comprehensive evaluation have occurred within the same day at the same MH venue. The color inside the small square therefore shifts from green (non-MH) to blue (specialty MH) to indicate that the measure 1 clock essentially starts at point in time 1 and end at point in time 1.  The arrow that precedes the small square is green while the arrow following the small square to reflect the transition to specialty MH treatment.
- Placement of a small, completely blue square partly above and partly within an upper corner of a MH venue box is used to denote VHA access measure 1 when the initial MH trigger encounter precedes the encounter within which a comprehensive diagnostic evaluation is completed. The completed evaluation may occur within the same specialty MH venue as the trigger MH encounter, for example, general MH clinic (MHC) at point in time 1 and MHC at point in time 2 or within different MH venues, for example, MH walk-in clinic at point in time 1 and a Women's Stress Disorders Treatment Team (WSDTT) clinic at point in time 2.  The arrow between the trigger encounter MH venue and the MH venue at

## Appendix D Detailed Legend for Figures (cont)

which the comprehensive evaluation is completed is shaded from green to blue to indicate capture by the measure of the time frame between encounters at each venue and the transition to specialty MH care.  The arrow subsequently following the MH venue box would then be shaded completely blue. 

- A small, blue square containing the number 2 is used to denote VHA access measure 2, MH follow-up within 7 days of discharge from an inpatient or residential treatment unit.  The measure captures the time between the point at which a discharge is entered into the system, and the point in time at which the follow-up MH encounter occurs. 
- A small, blue and yellow square containing the number 3 is used to denote VHA access measure 3, OEF/OIF veterans new to MH receiving 8 weeks of psychotherapy within 14 weeks. 
- Blue ovals are used in figure 2 to represent specific types of MH treatment services; medication management (Med Mgmt, Evidence based psychotherapy (EBT), other psychotherapies (Other Therapy), case management (Case Mgmt), counseling, and education groups. 

## Appendix E Under Secretary for Health Comments

### Department of Veterans Affairs

### Memorandum

**Date:** April 12, 2012

**From:** Under Secretary for Health (10)

**Subj:** OIG Draft Report, Veterans Health Administration: Review of Veterans' Access to Mental Health Care

**To:** Assistant Inspector General for Audits and Evaluations (52)

1. The Veterans Health Administration (VHA) is unequivocally committed to providing the best care possible for Veterans and will act rapidly on all findings that may improve Veterans' access to mental health care. I have reviewed the draft report and generally agree with the report recommendations. VHA leadership and staff will continue to review the data, findings, and conclusions drawn in this draft report carefully to identify how best to meet Veterans' needs.
2. VHA is currently reviewing several issues that affect the ability to evaluate patient wait time performance measurement. These issues include provider and team behavior, scheduler system practices, as well as methodology.
3. The Office of Inspector General (OIG) assessed documentation at four VHA facilities. VHA will conduct a more extensive review of all VISNs using the approach developed by OIG. Based on the time needed to do these reviews and the value of the information obtained, VHA may expand the analysis to additional facilities in at least some VISNs. The goal is to develop a comprehensive set of information about how policies and practices work and what needs to be done to accurately assess wait times.
4. Attachment A provides our observations about the metrics that OIG reviewed.

5. Thank you for the opportunity to review the draft report. A complete action plan is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

*(original signed by:)*

Robert A. Petzel, M.D.

Attachments

## ATTACHMENT A DESCRIPTION OF MEASURES

### A. Metric: First-Time Patient's Access to a Full Mental Health Evaluation

1. The first metric, labeled in the report as "First-Time Patient's Access to a Full Mental Health Evaluation," was developed in 2007. It assesses the time that it takes for a Veteran to receive a full mental health evaluation and treatment initiation if they have never previously had such a mental health service at VA. VHA mandated this be completed within 14 days after an initial 24-hour period in which a triage evaluation was completed (i.e., a total of 15 days from initial referral). This distinction is important because in the first 24 hours after the determination that a Veteran without mental health treatment in the last 24 months needs mental health care, a triage evaluation is required, but this often is done without a specific appointment; the mental health provider typically sees the Veteran in Primary Care, the Emergency Department, at a walk-in clinic, or in some other way for this triage evaluation within 24 hours. After triage, the patient may be immediately admitted to an inpatient service if the need is urgent. If not, the appointment must be made at that time and occur within the next 14 days.
2. The OIG reports (page i) that this measure "is not a meaningful measure of waiting time." We agree with this finding. This was never intended to measure wait time, but rather, as the OIG suggests, it was intended to "measure how long it took VHA to conduct the evaluation."

### B. Metric: New Patient Waiting Time

1. The second metric, "New Patient Waiting Time" as measured per the scheduling directive, refers to appointments for patients who are new to a specific mental health clinic. That is, they may already have contact in one or more other mental health clinics, so they are not *new* to VA mental health care in general. The VHA scheduling directive requires schedulers to ask Veterans when they want to be seen for a new appointment. This is the *Desired Date*. The report indicates that OIG did not use that prescribed VHA methodology to assess the accuracy of this waiting time metric. Rather, OIG assessed waiting time based on the time that the appointment was actually entered into the system - the *Create Date*.
2. We agree with OIG's concerns that use of the *Desired Date* leads to ambiguity of the interaction between the patient and the scheduler. A simplified methodology would significantly improve the reliability of the new patient scheduling data. This is one of the issues that VHA is currently reviewing.

### C. Metric: Follow-up Appointments.

The third metric, "Follow-up Appointments" uses a similar method as described for the second metric "New Patient Waiting Time." We generally agree that some revision of the metric is required. This is one of the issues that VHA is currently reviewing.

**VETERANS HEALTH ADMINISTRATION  
Action Plan**

**OIG Draft Report, Veterans Health Administration: Review of Veterans' Access to Mental Health Care**

**Date of Draft Report: March 23, 2012**

<b>Recommendations/ Actions</b>	<b>Status</b>	<b>Completion Date</b>
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**Recommendation 1: We recommended that the Under Secretary for Health revise the current full mental health evaluation measurement to ensure the measurement is calculated to reflect the veteran's wait time experience upon contact with the mental health clinic or the veteran's referral to the mental health service from another provider to the completion of the evaluation.**

VHA Comment

Concur

The Veterans Health Administration (VHA) concurs with the Office of Inspector General (OIG) about the importance of ensuring that VHA's measurement of waiting times is meaningful and reflective of the Veteran's wait time experience. VHA leadership has consistently emphasized the critical importance of ensuring Veterans have timely access to mental health care with Veteran Integrated Service Networks (VISN) and facilities. While VHA changed its definition of access and designated measures in Fiscal Year (FY) 2012 to capture information about timely follow up care for specific high risk populations, these new measures do not directly address the "wait time experience" for all Veterans seeking mental health services.

VHA has convened a work group to specifically examine how best to measure Veterans' wait time experiences. This work group will develop an action plan to create new metrics about how long it takes to get care (such as wait time from referral to evaluation, or timeliness of treatment initiation) for Veterans using mental health treatment. The action plan will be provided to the Under Secretary for Health (USH) for review on or before July 1, 2012.

In process                      Work group plan will be provided to the Under Secretary for Health (USH) for review NLT July 1, 2012

**Recommendation 2: We recommended that the Under Secretary for Health reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments.**

VHA Comment

Concur

VHA is committed to developing a combination of measures that will reliably and accurately capture appointment scheduling performance for new and ongoing treatment.

Appointment scheduling measures should be sufficiently flexible to accommodate a Veteran's condition and the phase of treatment. For example, for Veterans who need weekly evidence-based psychotherapy training, a 14-day policy for time between appointments could be too long. At the other end of the spectrum, for a Veteran on a maintenance schedule after successful treatment, a return appointment in 14 days would be much too soon. Instead, a thoughtful, individualized maintenance plan should be developed to guide the timing of return appointments. The work group described in the response to Recommendation 1 will develop a set of options for measuring scheduling processes based upon Veterans' treatment needs considering the complexity and severity of problems identified and the phase of treatment.

In Process                      Work group plan to be provided to USH for review NLT July 1, 2012

**Recommendation 3: We recommended that the Under Secretary for Health conduct a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the Veterans Health Administration's ability to meet mental health timeliness goals, and if so, develop an action plan to correct the impediments.**

VHA Comment

Concur

VHA facility mental health staffing has historically been determined at the facility level to allow flexibility to staff based upon provider pools, types of programs offered, and Veteran demand.

VHA has recently developed a prototype staffing model for general mental health outpatient care using the same methodology as was used to successfully develop its Primary Care staffing model. The methodology included a literature review, interviews with other healthcare systems, and use of available productivity data. The prototype mental health staffing model is currently being piloted within three Veterans Integrated Service Networks (VISN) to validate its effectiveness prior to field implementation. National implementation of the model is targeted for September 30, 2012.

VHA began collecting monthly vacancy data about mental health direct care positions as of January 31, 2012. A survey collects information by facility and discipline on the

number of authorized positions for mental health and the number of vacant positions so that vacancy rates can be accurately calculated. VHA is currently assessing the impact of vacancies on operations and developing recommendations for improvement.

In Process                      National mental health staffing guidance to be implemented NLT September, 30, 2012.

VHA evaluation of vacancy data and related recommendations to be provided to USH NLT July 31, 2012

**Recommendation 4: We recommended that the Under Secretary for Health ensure that data collection efforts related to mental health access are aligned with the operational needs of relevant decision makers throughout the organization.**

VHA Comment

Concur

In March 2011, VHA established an Office of Mental Health Operations with operational oversight of the VHA Mental Health Program. Each VISN has identified a Mental Health Lead to collaborate with VHA Central Office and facility mental health providers. This VHA mental health organizational structure facilitates information sharing and best practices.

In FY 2011, VHA developed a comprehensive mental health information system. This system is available to all VHA staff to support management decisions and quality improvement efforts. Current VHA performance metrics and quantitative data are made available. The system provides normative information on utilization and penetration of VHA mental health services by facilities within each VISN, or nationally within treatment domains (e.g., substance abuse services, post-traumatic stress disorder, and general mental health). VHA will review existing available data and add other data elements related to access as developed by the work group referenced in the response to Recommendation 1 to ensure that the mental health information system is aligned to the operational needs of the established VHA mental health organizational structure.

In Process                      Data elements related to mental health access identified by the work groups referenced in the response to Recommendation 1 will be added to the mental health information system NLT September 30, 2012

Veterans Health Administration  
April 2012

## Appendix F OIG Contact and Staff Acknowledgments

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Larry Reinkemeyer, Director Dr. Michael Shepherd, Office of Healthcare Inspections Marilyn Barak Beverly Carter Lee Giesbrecht Dr. Monika Gottlieb Lance Kramer Brad Lewis Russ Lewis Claire McDonald Karen McGoff-Yost Daniel Morris Ken Myers Carla Reid Jason Schuenemann Nelvy Viguera Butler Sarah White Oscar Williams

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