



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

NOV 04 2020

The Honorable James M. Inhofe
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to section 720 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92) is enclosed. The Secretary of Defense is required to provide a report on shortages of mental health providers; the reasons for, and impact of, such shortages; and the Military Departments' strategies to better recruit and retain these providers.

Multiple variables contribute to the number of mental health providers and mental health provider availability, including clinical workload (e.g., hours per week, shifts per month, weeks per year), non-clinical workload (e.g., charting, administrative duties), and provider demand exceeding supply of graduating students. The ability to adequately meet the mental health care needs of Active Duty Service members may be evaluated by assessing access to care, patient demand, quality of care, and timeliness of care.

Preliminary analysis indicates that the Department of Defense (DoD) met or exceeded current access standards. Further studies, which assess the quality of care or outcomes of those enrolled in care, is required for additional insight on the ability of the military medical treatment facilities to provide adequate and timely follow-up care once patients gain access to it. To address potential shortages and maintain standard of care, the DoD engages in the full range of recruiting and retention efforts for hard-to-fill physicians and health care professional positions.

Thank you for your continued strong support of the health and well-being of our Service members, veterans, and their families. I am sending an identical letter to the House Armed Services Committee.

Sincerely,

//SIGNED//

Matthew P. Donovan

Enclosure:
As stated



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The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

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Dear Senator Reed:

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The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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NOV 04 2020

The Honorable William M. "Mac" Thornberry
Ranking Member
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thornberry:

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Matthew P. Donovan

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REPORT TO THE COMMITTEES ON ARMED SERVICES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES



Section 720 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92) Strategy to Recruit and Retain Mental Health Providers

November 2020

The estimated cost of report or study for the Department of Defense (DoD) is approximately \$11,000 for the 2020 Fiscal Year. This includes \$0 in expenses and \$11,000 is DoD labor. Generated on 11 AUG 2020. RefID: 6-BAEFEO

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EXECUTIVE SUMMARY

This report is in response to section 720 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2020 (Public Law 116-92) requiring the Secretary of Defense (SecDef) to submit a report on “Strategy to Recruit and Retain Mental Health Providers.” Specifically, the report is to describe the shortage of mental health (MH) providers of the Department of Defense (DoD); explain the reasons for such shortage; explain the effect of such shortage on members of the Armed Forces; and describe a strategy to better recruit and retain MH providers in a manner that addresses the need for cultural competence and diversity among such mental health providers.

The DoD recognizes the importance of decreasing barriers to MH services and offers a full spectrum of MH care to Service members. Thus, this report defines “shortage” as the number of MH providers (licensed professionals, such as psychiatrists, psychologists, MH nurse practitioners (NPs), licensed clinical social workers, and other licensed MH providers) required to adequately provide access to quality MH care services, which meets the needs of Active Duty Service members (ADSMs).

It is difficult to quantitatively identify “shortages” and reasons thereof until it is more adequately defined; thus, this report discusses “shortages” as a whole, and not by MH provider specialty. Multiple variables may contribute to MH provider shortages, including but not limited to: (1) a nationwide shortage of MH providers, including psychiatrists and psychologists; (2) competition with the private and public sectors; and (3) awareness of DoD health professions programs and scholarships.

Shortages may affect the ability to adequately meet the MH care needs of ADSMs; specifically affecting access to care, quality of care, and/or timeliness of care. Preliminary analysis indicates that the DoD met or exceeded current DoD access standards (1.0 days or less for urgent/acute care; seven days or less for routine care; 28 days or less for initial specialty appointment; and 28 days or less for wellness or preventative care). Further study, which assesses the quality of care or outcomes of those enrolled in care, is required for additional insight on the ability of the military medical treatment facility (MTF) to provide adequate and timely follow-up care once patients gain access.

Efforts associated with recruitment and retention for health care professionals, especially providers in critical specialties (e.g., MH), are ongoing, and include coordination between Health Affairs (HA), the Defense Health Agency (DHA), and the Military Departments to develop incentivizing criteria that align with the evolving health care landscape. The Military Health System (MHS) maximizes the use of authorized incentives to recruit a diverse workforce. The DHA recruiting team assesses hard-to-fill lists, posts flyers, purchases ads, and presents exhibits and recruits at over 70 continuing medical education conferences a year. Although the recruitment team does not directly address cultural competence and diversity among MH providers, the team presents exhibits and recruits at minority specialty conferences.

INTRODUCTION

This report describes the shortage of MH providers for the DoD, provides data on the number of MH providers, discusses recruitment challenges, and offers a strategy to better recruit and retain MH providers going forward, which addresses cultural competence and diversity.

DESCRIBE THE SHORTAGE OF MENTAL HEALTH PROVIDERS OF THE DEPARTMENT OF DEFENSE

The NDAA did not define “shortage;” thus, for the purpose of this report, “shortage” is defined as the number of MH providers required to adequately provide access to quality MH care services, which meets the needs of ADSMs.

The NDAA defined MH providers as psychiatrists, psychologists, MH NPs, licensed clinical social workers, and other licensed providers of the MHS. In order to provide MH care that adequately addresses MH needs of ADSMs, a provider must satisfy licensing, certification, and credentialing requirements to work independently. Therefore, this report defined MH providers as licensed professionals, such as psychiatrists, psychologists, MH NPs, MH registered nurses (RNs), licensed clinical social workers, and other licensed MH providers of the MHS.

To quantitatively identify a shortage based on the above definitions, this report examined the number of MH providers authorized (number an organization can afford) and the number of MH providers assigned (actually on board) as of quarter four of FY 2019 (4QFY19). The “staffing rate” was derived from the data, illustrating the percentage of providers at fiscal year-end compared to the number of providers authorized for the fiscal year. For example:

$$\begin{aligned} \text{Psychiatrist Staffing Rate} = & \\ & ([\text{total \# of psychiatrists on board at 4Q19}] / \\ & [\text{total \# of psychiatrist authorizations afforded by the DoD}]) \\ & \times 100 \end{aligned}$$

MH provider data for this report, such as authorized and assigned, was provided by the Services and DHA, and includes those providers who are still in training for the identified specialty. Preliminary analysis of MH providers is provided in the tables below. Table 1 illustrates the numbers of FY 2019 authorizations and Table 2 provides the number of MH providers on board at 4QFY19 with a comparison to FY 2019 authorizations (Table 2). In 2018, the Government Accountability Office (GAO) reported varying definitions of a shortage, “ranging from having less than 80 percent to less than 100 percent of authorizations filled” (GAO, 2018). Given the inclusion of providers in training, the analysis overestimates the total fill rate of fully credentialed and independently practicing MH providers in the given specialty. Thus, it is possible that the DoD MH provider shortage is greater than what is reflected below.

Table 1. MH Providers Authorized for FY19. Data illustrate the total number of MH providers afforded to the DoD, as collected by the Military Departments and maintained by the DHA.*

SPECIALTY	MIL	CIV	CTR	TOTAL
Psychologist	737	927	137	1801
Psychiatrist	495	215	36	746
Social Worker	587	1482	121	2190
MH Nurse Practitioner (NP)	112	60	12	184
Other Licensed MH Provider	0	183	28	211
TOTAL	1931	2867	334	5132

*Data are results from preliminary analysis.

Table 2. MH Providers Assigned at 4Q19. Data illustrate the total number on board and percentage of authorized military (MIL), civilian (CIV), and contractor (CTR) MH providers, as collected by the Military Departments and maintained by the DHA.*

SPECIALTY	MIL	CIV	CTR	TOTAL
Psychologist	713 (96.7%)	897 (96.8%)	106 (77.4%)	1716 (95.3%)
Psychiatrist	423 (85.5%)	197 (91.6%)	28 (77.8%)	648 (86.9%)
Social Worker	764 (130.2%)	1409 (95.1%)	89 (73.6%)	2262 (103.3 %)
MH Nurse Practitioner (NP)	74 (66.1%)	56 (93.3%)	6 (50.0%)	136 (73.9%)
Other Licensed MH Provider	0 (0%)	169 (92.3%)	26 (92.9%)	195 (92.4%)
TOTAL	1974 (102.2%)	2728 (95.2%)	255 (76.3 %)	4957 (96.6 %)

*Data are results from preliminary analysis.

This report focused on provider shortages associated with licensed, independently practicing professionals as required by the NDAA. The staffing rate for other behavioral health providers, such as Physicians Assistants (PAs), RN, Behavioral Health Techs and other unlicensed support staff (e.g. groups, triage, test administration and scoring), which provide important mental health care services, were not evaluated, and may affect the overall results presented in Tables 1 and 2.

EXPLAIN REASONS FOR SUCH SHORTAGE

Multiple variables contribute to MH provider shortages. Briefly, the ability to adequately meet the MH care needs of ADSMs is a function of access to care, patient demand, quality of care, and/or timeliness of care. These variables are likely affected by the number of MH providers and MH provider availability, which is directly impacted by recruitment, retention, promotion, and attrition (turnover rate and reasons thereof). Additionally, MH provider availability is affected by elements including, but is not limited to MH provider clinical workload (e.g., hours/week, shifts/month, weeks/year), MH provider non-clinical workload (e.g., charting, administrative duties), and provider demand exceeding supply of graduating students.

Barriers to recruitment, retention, promotion, and attrition include: (1) a nationwide shortage of MH providers, including psychiatrists, psychologists and nurses; (2) competition with the private

and public sectors for talent; and (3) awareness of DoD health professions programs and scholarships. As previously reported by the GAO, physician cash compensation is generally less than private sector civilians, which may be partially due to budget and statutory limitations that hinder the Military Departments' ability to change the rate of special and incentive pays (GAO, 2020). Further, MH providers may weigh non-compensation factors into their decision-making, which include the number and frequency of deployments, administrative requirements associated with service (e.g., officer responsibilities, case management), promotion potential, and family and employment stability. Finally, system and budgetary constraints inhibit formal recruiting efforts, and pose a challenge for the Military Departments and the Uniformed Services University of the Health Sciences to promote program awareness.

EXPLAIN THE EFFECT OF SUCH SHORTAGE ON MEMBERS OF THE ARMED FORCES

Provider shortages affect access to care, which impact diagnosis and treatment of MH conditions and prevention of negative health outcomes. Specific to MH, access to care is important for promoting and maintaining MH, managing MH conditions, preventing stigma, and reducing unnecessary disability and premature death. Thus, assessing access to care provides important insights on the effects of MH provider shortages.

The DoD access standards in the direct care system include: 1.0 days or less for urgent/acute care; seven days or less for routine care; 28 days or less for initial specialty appointment; and 28 days or less for wellness or preventative care (TRICARE, 2020). For private sector care, mental health visits are considered specialty care, and therefore the 28 day standard applies.

Data from the West TRICARE Region are pending, however in the East Region the private sector care system on average met or exceeded these standards for both 2018 and 2019. The most recent data, for May 2020 continues to show this trend, with behavioral health at 10.3 days on average and psychiatry (which is reported separately) at 9.5 days

Preliminary data indicated that MH provider productivity, a function of patient demand and access to care, increased slightly in 2019 across all provider types. The data additionally illustrated a slight decline in access to care metrics for direct care, which included increased time from referral to appointment, increased time from book to appointment, and increased time between appointments. Although access to care metrics slightly declined, the DoD continued to meet access to care standards for ADSMs, and it can be reasonably concluded that this is a direct result of increased proportion of ADSMs seeking and receiving care, which is a positive outcome of DoD policies to improve MH care outcomes and combat stigma.

The above results differ from a recent report published by the DoD Office of the Inspector General. This is potentially due to evaluation of a seven-day standard for self-referred routine mental health care appointments to future (FTR) appointment types. FTR appointment types are used for both routine and follow-up care, and there is currently no access standard for follow-up care because the timing of appointments is based on the clinical judgment of the provider and the patient's symptoms and care plan.

Challenges and limitations to quantitatively evaluate the effect of access to care, patient demand, and timeliness of care include the use of variables beyond the markets' control (e.g. patient does not answer phone, not ready to book the appointment). Consequently, it is not optimally aligned to assess outcomes of DoD health care strategy within DoD, DHA, or MTF control. The DHA intends to further assess access to care by adjusting the measure definition to include, "Specialty Care: Percent Referral Disposition in One Business Day," which enables the use of an available data source, eliminates time beyond markets' control, and supports the MHS strategy for providing timely access to quality care.

Additionally, although assessing specialist appointment within a 28-day timeframe is an acceptable measure, it may not accurately measure appropriate access to care or type of care received. Further studies, which assess the quality of care or outcomes of those enrolled in care, is required for additional insight on the ability of the MTF to provide adequate and timely follow-up care once patients gain access.

STRATEGY TO RECRUIT AND RETAIN, ADDRESSING THE NEED FOR CULTURAL COMPETENCE AND DIVERSITY

The DHA assumed administration and management responsibilities from the Army, Navy, and Air Force for military hospitals and clinics in the United States on October 25, 2019; however, the Military Departments remain directly responsible for recruitment and retention of ADSMs. In conjunction with the Military Departments, DHA has begun an initiative to analyze current data collection methodology and review definitions of key requirements (e.g., shortage, requirements, and authorizations), to enable a data collection methodology that ensures consistency in data and the fidelity of data and data analysis, and inform recruitment and retention strategies.

In short, strategies for recruitment and retention take into account satisfying ADSM needs at the MTF, in garrison, and in theatre. Due to significant variability in patient acuity and fluctuating demand, "shortages" are best addressed as issues of demand and supply. Local demand and supply that is monitored centrally enables staffing plans which can be amended or developed to meet local patient care demands. These personnel requirements would then be augmented by the operational needs and requirements of the Military Departments.

Recruiting efforts for MH providers are ongoing. As noted in GAO-20-165, the DoD offers cash and noncash incentives (e.g., pension, health care coverage, tuition remission), some of which are uncommon in the private sector (GAO, 2020). However, data indicates that other factors may contribute to recruitment decision-making (e.g., number and frequency of deployments; practicing at administrative requirements; family considerations; non-selection for promotion). Currently, the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), the DHA and the Military Departments are coordinating to address MH provider recruitment and retention, which include efforts to develop educational incentivizing criteria that align with the evolving health care landscape (e.g., including opportunities long-term, part-time health education and training).

In addition to recruitment by incentives, the DHA established a recruiting team, which receives critical behavioral health and hard-to-fill lists on a weekly basis. The team immediately posts job flyers on the DHA recruiting website, which is relayed on multiple electronic job boards. Further, the team purchases ads in print and electronic medical journals, and presents exhibits and recruits at over 70 continuing medical education conferences a year, which target behavioral health specialties. Although the recruitment team does not directly address the need for cultural competence and diversity among MH providers, the team presents exhibits and recruits physicians and hard to fill medical occupations at minority specialty conferences.

The DHA recruitment team is completing an improved recruitment process instruction that will streamline recruitment through onboarding, by better forecasting anticipated critical losses/vacancies. The team will engage in key strategic discussions with selecting officials and staffers, tracking each step of the process using the recruiting applicant tracking system. An initial focus will be the recruitment of retiring or separating MH providers for civilian medical positions in DHA MTFs.

The DoD is an all-volunteer force with ADSMs that represent a wide range of creeds, religions, race, ethnicities, sexual orientations; thus, current efforts aim to recruit highly qualified MH providers to address cultural competence and diversity. At the direction of the SecDef, OASD(HA) performed a review of policy, programs, and procedures that may negatively impact equal opportunity, diversity, and inclusion, which includes “areas such as accessions, promotion boards, and associated processes; assignment and command opportunity and selection; and professional military education selection” (Secretary of Defense, 2020). The results of this effort are pending and will be used to inform policy and guidance for development and implementation.

CONCLUSION

Multiple variables contribute to the number of MH providers and MH provider availability, including clinical workload (e.g., hours/week, shifts/month, weeks/year), non-clinical workload (e.g., charting, administrative duties), and provider demand exceeding supply of graduating students. The ability to adequately meet the MH care needs of ADSMs may be evaluated by assessing access to care, patient demand, quality of care, and/or timeliness of care, and preliminary analysis indicates that the DoD met or exceeded current DoD access standards. To address potential shortages and maintain standard of care the DoD engages in the full range of recruiting and retention efforts for hard-to-fill physicians and health care professional positions.

REFERENCES

GAO. (2018). *Military Personnel: Additional Actions needed to Address Gaps in Military Physician Specialties*. US Government Accountability Office.

GAO. (2020). *Defense Health Care: DoD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists*. US Government Accountability Office.

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APPENDICES

Appendix A: List of Acronyms

(ACRONYM)	DESCRIPTION
ADSM	Active Duty Service member
CIV	Civilian
CTR	Contractor
DHA	Defense Health Agency
DoD	Department of Defense
FY	Fiscal Year
MH	Mental Health
MHS	Military Health System
MIL	Military
MTF	Military Medical Treatment Facility
NDAA	National Defense Authorization Act
NP	Nurse Practitioner
QFY	Quarter Fiscal Year
RN	Registered Nurse