VA | U.S. Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
FY 2022 ANNUAL EVALUATION PLAN

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BACKGROUND AND APPROACH

The Foundations for Evidence-based Policymaking (EBP) Act of 2018 (P.L. 115-435, "Evidence Act") requires cabinet-level agencies including the Department of Veterans Affairs (VA) to create and use Learning Agendas, Evaluation Plans and Capacity Assessments. In guidance documents, the Office of Management and Budget (OMB) specified requirements for these deliverables.

During fiscal year (FY) 2021, Federal agencies were required to develop (non-public) Interim Learning Agendas and (non-public) Interim Capacity Assessments and provide an Annual Evaluation Plan which is a public document. The Learning Agenda and Capacity Assessment will become part of the quadrennial strategic planning process as public documents to be released February 2022.

Since the Evidence Act became law in early 2019, the chartered VA Foundations for Evidence-Based Policymaking Working Group (FEBPWG) has superintended efforts to meet the statutory requirements of the Evidence Act across VA. The FEBPWG has over 190 representatives from the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), National Cemetery Administration (NCA) and staff offices supporting implementation of the Evidence Act.

CRITERIA FOR SIGNIFICANCE AND TOPIC SELECTION

The Evidence Act requires agencies to identify "significant" evaluations and address them in its Annual Evaluation Plan, as well as provide a definition of "significant." Since the passage of the Evidence Act, VA has viewed the opportunity of publicizing its most significant evaluation and research priorities as fully consistent with its vital mission on behalf of Veterans and their families, and welcomes the chance to further advocate for them by focusing attention on important issues.

VA engages in thousands of peer-reviewed evaluations and research studies each year, and none of them are considered insignificant. All are used to advance service delivery, improve access, enhance quality and contribute to their respective fields of inquiry both within VA and for Veterans and others. For example, as part of the internal solicitation protocol for research and evaluation proposals across the Office of Research and Development (ORD), VHA has a well-established set of criteria to verify significance:

- programmatic or policy importance or value of the evaluation, and its value to Veterans health care and health outcomes
- whether the evaluation addresses a new topic or topic that has not been resolved
- whether it addresses a critical question related to barriers to optimal service
- whether if completed successfully, there is a pathway for the results to inform improvements

On the basis of these criteria proposals are identified for implementation after peer review, and the results and findings are likewise peer-reviewed.

To select those evaluations most suited to the requirements of the Annual Evaluation Plan, and the intent of the Evidence Act, OMB provided criteria (Memorandum 19-23, footnotes 21 & 61) for identification of significance of evaluations:

- Importance of a program or funding stream to the agency mission
- The size of the program in terms of funding or people served
- The extent to which the study will fill an important knowledge gap regarding the program, population(s) served, or the issue(s) that the program was designed to address

To maximize the value of implementing the Evidence Act provisions on behalf of Veterans, their families and caregivers the VA FEBPWG considered these criteria and identified several VA-specific criteria consistent with guidance to further narrow down our most significant issues and evaluations.

VA Criterion #1: Existing Lines of Inquiry (Consistent with guidance criterion #3)

VA's current efforts entail hundreds of evaluations every year, conducted with a variety of means and for many reasons, including statutory requirements. Evaluation practitioners therefore seek to focus on existing lines of inquiry embodied in current evaluation studies and efforts. Practitioners think that all areas of national importance are currently being addressed at some point in the evaluation lifecycle.

Those identifying potential evaluations were required to attest that their pursuit of those questions could be completed using existing funds under current services, whether by reprioritization of existing budgets, or identification of evaluations that were already anticipated. In subsequent fiscal years, evaluations requiring new resources will be appropriately prioritized in established budget processes.

VA Criterion #2: Mission Focus on Veterans (Consistent with guidance criterion #1)

VA acknowledges that there are a number of challenges it faces both with respect to our direct mission-driven care and services, as well as our administrative functions. However, VA chooses to focus the initial effort under the Evidence Act on purely Veteran-facing topics. By doing so, efforts to address the requirements of the Evidence Act will additionally stimulate internal VA interest, and external stakeholder attention, on the most important issues facing Veterans and their families.

In addition, as organizations outside of VHA (which is highly mature in its capacity to build and use evidence based on VA's forthcoming Capacity Assessment) build their own evaluation capacity, VA will broaden its focus to include administrative and other program offices that are not primarily Veteran-facing.

VA Criterion #3: Underserved and Vulnerable Veterans (Consistent with all guidance criteria)

VA's existing Strategic Plan for FY 2018 – FY 2024, and the upcoming version for FY 2022 – FY 2028, encompass myriad areas in which VA impacts Veterans – truly every

aspect of the life journeys of Veterans – requiring a focus on a meaningful subset of our Strategic Objectives. An immediate consensus emerged that in order to rally attention and effort to VA's public evaluation activities under the Evidence Act we would focus on the most compelling of our Objectives, namely enhancing care and services for underserved, at risk, marginalized and vulnerable Veterans, such as those facing addiction, suicide, or homelessness. In early deliberations, there was no second-place issue that presented so stark a priority. This emphasis is fully consistent with the new administration's focus on diversity, equity and inclusion, and will highlight and address the challenges faced by our Veteran subpopulations.

This focus aligns, as discussed below, the VA Learning Agenda (forthcoming) with this Annual Evaluation Plan.

VA Criterion #4: Alignment of Learning Agenda with Evaluation Plans by Topic and Over Time (Consistent with all guidance criteria)

Early in VA's deliberations, it became clear that the virtues of pursuing a rigorous set of evaluations that would be showcased to many stakeholders due to the very public nature of the Evidence Act requirements, such as wide public dissemination of findings, meant that our longer-term Learning Agenda should be closely tied to Evaluation Plan studies. In this way, both documents would focus attention on issues of wide public concern and be complementary in the information they will convey and which will help generate (both within VA and by partners, external stakeholders and researchers) new discoveries and insights touching on the most important issues for Veterans. The goal is to provide preliminary evaluation findings to policymakers early in the span of the Strategic Plan to address initial, broader questions while providing further details as a result of evaluations later in the cycle.

Therefore, a critical criterion in VA for "significance" is an evaluation which directly supports VA's Learning Agenda.

A related issue is one of timing. The Learning Agenda spans the time horizon of the Strategic Plan and evaluations begin annually in FY 2022, but not every issue of great concern fits neatly into those time frames. For example, the pandemic of Corona Virus Disease - 2019 (COVID-19) emerged during the planning for completion of the Evidence Act deliverables, and certainly is one of the most pressing issues affecting Veterans at this time. However, the immediate urgency of that challenge, and the need for exceptionally agile responses, could not await studies beginning in FY 2022, and so that grave challenge was not addressed in VA's initial Evaluation Plan. Alternatively, some studies began earlier than FY 2022 and will continue to be highlighted in this and future Annual Evaluation Plans because they impact Learning Agenda topics.

VA Criterion #5: Nomination Using Administrations' Existing Prioritization (Consistent with all guidance criteria)

The working group decided that those individuals who were responsible for carrying out such Agendas and Plans should use their existing, documented priorities (which align to VA's Strategic Plan) to nominate a set of questions and research topics. Those

professionals are located organizationally within the major VA Administrations – the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA) and the National Cemetery Administration (NCA). The FEBPWG worked with the Administrations to focus the Administrations' nominations based on the overarching VA criteria.

Each Administration has their own strategy and business documents that tie directly to the VA-level Strategic Plan, and they are familiar with the most significant issues they face that address the above criteria. In addition, VHA enters the Evidence Act process already recognized as a thought leader in program evaluation and implementation sciences, while VBA begins with a substantial process-analytic foundation but not one focused heretofore on evaluation. (For VBA and other offices needing to develop their evaluation and evidence-building and -use capacity, VA's forthcoming Capacity Assessment and related budget initiatives will address such gaps.)

This federated approach ensures that policymakers are able to obtain the most salient findings addressing the most significant issues they are likely to face, while the Administrations are able to pursue questions they are capable of addressing in this Annual Evaluation Plan using the current and likely state of knowledge, expertise and analytic capacity they encompass.

In the following sections, VHA identifies the means they used to nominate evaluation topics which were subjected to the above criteria for inclusion in this VA FY 2022 Annual Evaluation Plan, while VBA provides a plan to leverage their existing evidence to enable them to subsequently address the Learning Agenda questions that VA has prioritized.

VHA TOPIC NOMINATION PROCESS

VHA's Existing Approach to Evaluation Identification Linked to VA's Significance Criteria

In the case of VHA, the following long-range goals are aligned with overall VA goals for improvement and modernization of Veteran health services, and strengthening VHA as a high-reliability organization, namely:

- Make VHA the provider and care coordinator of choice for Veterans
- Deliver comprehensive and integrated whole health care
- Innovate as a learning and teaching organization
- Increase the effective and efficient use of resources across the enterprise.

Annually, VHA issues a call for topics and research/evaluation topics to address VHA and VA goals. Based on existing scoring criteria and rigorous peer review, proposals are ranked for support. Those efforts which are identified for support were then subjected to the VA criteria for significant evaluations by the FEBPWG and constitute the VHA portion of the FY 2022 Annual Evaluation Plan.

VHA EVALUATION PLANS

VHA will address care for vulnerable and underserved Veterans with focused evaluations on suicide prevention, opioids usage, and enhancing access.

A. Suicide Prevention: Caring Letters

Learning Agenda Question: *"What strategies work best to prevent suicide among Veterans?"*

Evaluation Question: *Are Caring Letters an effective and sustainable intervention to reduce suicide behaviors among Veterans?*

Timeline: Ongoing; intervention and evaluation began in FY 2020.

Background: Reducing rates of Veteran suicide is a top clinical priority for VA. Executive Order 13861, signed in 2019, established the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). This is a three-year effort that takes an all-inclusive, public health approach to suicide prevention. This roadmap prioritizes suicide reduction research, implementation strategies, and emphasizes the need for program evaluations to ensure better suicide prevention for Veterans. The recently signed Commander John Scott Hannon Veterans Mental Health Care Improvement Act also expands VA and VHA efforts to prevent Veteran suicide and improve mental health outcomes. To this end, there are a number of ongoing suicide prevention programs and interventions being evaluated for their effectiveness in the Veteran population.

Suicide is a leading cause of death in the Veteran population. Veterans accounted for 13.5% of all deaths by suicide among U.S. adults in 2017, according to the 2019 National Veteran Suicide Prevention Annual Report. Suicide rates vary depending on service branch, age, sex/gender, and other factors, according to a 2012 study in the Journal of Suicide and Life-Threatening Behavior. Reducing rates of Veteran suicide is VA's top clinical priority and a significant priority for the current administration. Previous studies, including a 1976 randomized control trial of Caring Contacts in the civilian population, and later, more targeted studies in the Veteran population, have shown that Caring Contacts is a proven and effective method of suicide prevention. Caring Contacts involve caring, non-demanding messages of support that are sent to high-risk individuals. Contacts can be digital (text messages) or physical (postcards or letters).

Caring Contacts was adapted for implementation in the Veteran population in 2019 for emergency department visits and piloted at one VA facility with positive feedback. The Veterans Crisis Line (VCL) Caring Letters initiative is expected to have the largest reach of all Caring Contact implementations yet, and targets all Veterans who call VCL, VA's suicide telephone hotline. While the Quality Enhancement Research Initiative (QUERI) funded partnered evaluation of this program is planned for three years (FY2020 – FY

2023), the Caring Letters program, in which Veterans will receive letters over the course of a year after their call, is intended to become a permanent part of VCL care for callers.

Objective: The primary aim of this evaluation is to evaluate the effects of Caring Letters on clinical outcomes (including incidence of VA documented suicide attempts) and clinical utilization rates (including VA inpatient mental health hospitalization and outpatient mental health utilization). An additional exploratory aim will be to examine rates of all-cause mortality and suicide for Veterans who receive Caring Letters compared to the comparison cohort of Veterans from the two years prior to the launch of the Caring Letters campaign. Since this is a new population for the use of the intervention, the project will also evaluate the effects of two different Caring Letter signatories (VA Counselor and a Peer Veteran) by randomizing each enrolled Veteran to one of two conditions. The evaluation will also examine facilitators and barriers to implementing the Caring Letters program using the Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) framework and will include budget impact analyses.

Study design and data sources: As an effectiveness-implementation hybrid design this evaluation focuses on both clinical effectiveness and implementation goals. All Veterans who meet the inclusion criteria will receive nine caring, non-demanding letters over the course of a year following their call to VCL, randomized by signatory (by provider or by peer). Participants will be included in the evaluation cohort if they call VCL during the evaluation period (estimated to be 6/22/2020 – 6/30/2021) and are an identifiable VCL caller (e.g., not an anonymous caller); have a valid mailing address on file with the VA; and are calling about themselves (e.g., not calling about a loved one). Quantitative and qualitative analyses will be conducted. Quantitative data sources will consist of secondary VA data that are collected as a part of routine care and/or clinical management. These include the VCL data repository, Corporate Data Warehouse (CDW), suicide attempt data and DOD-VA Suicide Data Repository, and mortality data. Qualitative data sources include program documentation content analysis for implementation evaluation, as well as surveys and stakeholder interviews that include Veterans perspectives. All surveys and interview documents involving 10 or more patients per site will be reviewed by the VA Office of the Chief Data Officer to ensure compliance with the PRA.[1]

In a non-randomized portion of the study, clinical outcomes and clinical utilization will be compared among Veterans who called the VCL after June 2020 (when Caring Contacts

[1] VA's Chief Data Officer will oversee coordination of the Paperwork Reduction Act of 1995 (PRA) approval process for surveys and interviews of greater than nine patients or other members of the public, where applicable. It is expected that the majority of required data for the Evaluation Plans will be obtained from electronic health records of administrative (claims) data or involve nine or fewer patients in mixed-methods interviews and surveys (qualitative and quantitative primary care collection). For the Evaluation Plans that involve greater than nine VA patients for primary data collections from surveys and interviews, the VA Chief Data Office will review them to ensure compliance to the PRA requirements.

began to be mailed) and among Veterans who called the VCL from June 2018 – May 2020. This pre-post design will provide data on differences in outcomes among VCL callers who do and do not receive letters.

Analysis: Evaluators will complete baseline analyses using secondary data from a comparison cohort of VCL callers from 2 years prior to the program's launch in 2020. Differences in outcomes for pre-post and signatory comparisons will be analyzed with chi-square tests, a Wilcox rank-sum test, logistic regression, zero-inflated Poisson, or negative binomial models. Analysis for this intervention utilizes the RE-AIM framework.

Evaluators will assess the program's reach by measuring the total number of eligible Veterans as well as the number reached. Analyses will include the number of cards sent, the number of undeliverable cards, as well as the number of opt-outs. Data will be compiled into a master file in CDW, pulled from a backup of the VCL database (Medora), postal receipt information provided by the printing contractor, and opt-out feedback provided to the general e-mail or the VA311/VCL line.

Ongoing effectiveness analyses will examine increased use of resources, incidence and frequency of documented suicide attempts, rates of inpatient mental health hospitalization, emergency department visits, and engagement in mental health care. Upon completion of the evaluation period, effectiveness analyses will look at rates of suicide and all-cause mortality as well (suicide analyses will be delayed due to standard delays in the availability of national cause of death data). Maintenance analyses will determine guidance and recommendations for sustainability and future VA use of the Caring Letters program.

For the non-randomized portion of the evaluation (comparison of letters vs no letters), evaluators will compare outcomes among the randomized cohort to outcomes from a matched comparison cohort of VCL callers from 2 years prior to the program's launch in 2020. Outcomes will be assessed via VHA administrative data. Differences in outcomes will be analyzed with chi-square tests, Wilcoxon rank-sum tests, logistic regression, zero-inflated Poisson, or negative binomial models.

An additional budget impact analysis will incorporate the cost of materials, staff time devoted to launching and maintaining the program, and pre- and post-intervention comparisons of care utilization, to determine the mean costs of the program, measured by patient/month.

A qualitative analysis component will provide insight into the effectiveness of the intervention at different points in the evaluation and will be used to track implementation barriers and facilitators. As part of the stakeholder interview process evaluators will inquire about the perceived helpfulness of the letters and Veterans will self-report on their care and resources. This data will be provided to VCL for continued program quality improvement.

Anticipated challenges: A significant challenge of this intervention is being able to isolate the effect of COVID-19-related increases in VCL use. Pandemic aside, because this is the largest implementation of a Caring Contacts project to date, logistics of continuously enrolling a large number of patients into the intervention will require careful coordination between the different groups involved working on participant data design and tracking, program implementation, printing, and qualitative/quantitative evaluation.

Dissemination: Regular monthly reports on the intervention's reach will be compiled and provided to VA leadership, particularly the Office of Mental Health and Suicide Prevention (OMHSP). Insights on the program's impacts, as well as associated costs, can be used to guide future implementation at the VISN level. Once the program evaluation is complete, the evaluation team will share findings with key stakeholders. We will also tailor results reporting in consultation with communication leads to reach a broader audience of Veterans through media and publications. Since this will be the largest Caring Letters program to date, the results of this evaluation will also inform Caring Letters programs within and beyond the VCL and VA system. Additional dissemination activities will include peer-reviewed journal articles and promotional materials developed by the Center for Information Dissemination and Education Resources (CIDER), a QUERI resource center.

Milestones:

FY 2021 Quarters	**FY 2021 Suicide Prevention Milestones**
Q1 (Complete)	• Data collection, continued enrollment of participants • Monthly stakeholder reporting incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Ongoing data collection for program fidelity, implementation barriers and facilitators, and budget tracking

Q2 (Complete)	• Data collection, continued enrollment of participants • Monthly stakeholder reporting incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Conduct initial qualitative interviews with stakeholders. Note: given the likelihood that 9 or fewer patients will be interviewed, no PRA approval would be required • Ongoing data collection for program fidelity, implementation barriers and facilitators, and budget tracking
Q3 (Complete)	• Data collection, final enrollment of participants • Monthly stakeholder reporting, incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Ongoing data collection for program fidelity, implementation barriers and facilitators, and budget tracking
Q4	• Data collection, continued mailings for enrolled participants • Monthly stakeholder reporting, incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Ongoing data collection for program fidelity, implementation barriers and facilitators, and budget tracking

FY 2022 Quarters	**FY 2022 Suicide Prevention Milestones**
Q1	• Data collection, continued mailings for enrolled participants • Monthly stakeholder reporting, incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Ongoing data collection for program fidelity, implementation barriers and facilitators, and budget tracking • Conduct qualitative interviews with participants
Q2	• Data collection, continued mailings for enrolled participants • Monthly stakeholder reporting, incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Ongoing data collection for program fidelity, implementation barriers and facilitators, and budget tracking • Conduct additional qualitative interviews with participants

Q3	• Data collection, final mailings for enrolled participants • Monthly stakeholder reporting, incorporating total cards sent, undeliverable cards, number of opt-outs, percentage of target population reached • Conduct final qualitative interviews • Begin data analysis of outcomes/impact, program fidelity, implementation barriers and facilitators, and budget impact evaluation
Q4	• Continue data analysis of outcomes/impact • Complete data analysis for evaluation and begin final reporting to stakeholders

Point of Contact: This evaluation is being led by Dr. Mark Reger of VA Puget Sound Healthcare System in collaboration with the Partnered Evidence-based Policy Resource Center (PEPReC). PEPReC can be reached at peprec@va.gov and Dr. Reger can be reached at mark.reger@va.gov.

B. Opioids

VHA evaluators will examine two components of the effort to optimize opioids usage, thereby reducing the incidence and effects of opioid use disorders. Those programs are Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) and the Stratification Tool for Opioid Risk Mitigation (STORM).

B1. Stepped Care for Opioid Use Disorder – Train the Trainer (SCOUTT)

Learning Agenda Question: *"How can VHA provide clinically appropriate treatment for opioid use disorders for Veterans?"*

Evaluation Question: *Does the SCOUTT program improve access to Opioid Use Disorder (OUD) treatment and prevent intentional overdose deaths?*

Timeline: Estimated completion of initial pilot in FY21; evaluation extension anticipated through FY22.

Background: The VA Opioid Safety Initiative (OSI) has been associated with significant decreases in opioid prescribing and prescription opioid overdose among Veterans, according to studies in The Journal of PAIN (2017) and the American Journal of Preventative Medicine (2019). However, with rates of synthetic opioid and heroin overdoses on the rise, these trends underscore the importance of increasing access to medication treatment for opioid use disorder (MOUD) in non-substance use disorder specialty care settings. The focus of the Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) initiative, an evaluation project that is underway at the national level, is to increase access to MOUD in VA primary care, pain management and mental health care settings.

Study objective: The evaluation's objectives are to characterize and estimate the number of patients receiving OUD care at 18 VA facilities, and obtain clinicians' and

clinic leaderships' perspectives on OUD care. It will evaluate trends in the pharmacologic treatment of OUD and any adverse outcomes in the year prior and subsequent to SCOUTT's launch, relative to matched comparison clinics. Finally, it will assess the patient retention rate and compliance with the SCOUTT protocol.

Study design and data sources: The prospective evaluation of SCOUTT uses a mixed methods approach to evaluate the effectiveness of the SCOUTT initiative over a three-year period. Qualitative and quantitative data will include information obtained from surveys of SCOUTT participants regarding their perspectives of MOUD, interviews with providers, clinical leaders, and trainers, as well as patient and provider MOUD-related data and outcomes from the VA Corporate Data Warehouse. It will evaluate trends in the pharmacologic treatment of OUD and any adverse outcomes.

Analysis: The evaluators will use the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework to study the effectiveness of SCOUTT in improving access to MOUD in non-substance use disorder specialty care settings and to identify patient, provider and system factors influencing its implementation, as well as several secondary outcomes.

This evaluation will include an estimate of the number and proportion of patients with OUD who fill prescriptions (buprenorphine or injectable naltrexone) to treat OUD by clinic type during the two years after the SCOUTT launch. Followed by a description of the variation in demographic and clinical characteristics of patients with and without receipt of MOUD.

Evaluators will then look at trends in percentages of patients diagnosed with OUD who filled prescriptions to treat OUD, received acute care services (emergency department, inpatient), and died by any cause by clinic type in the year before and year after SCOUTT's launch, relative to matched control clinics. They will describe the number of providers obtaining buprenorphine waivers and prescribing buprenorphine or injectable naltrexone in the implementation clinics in the years before and after SCOUTT implementation. Pre- and post-surveys of providers and clinical leaders will assess attitudes and beliefs about prescribing medications to treat OUD, organizational climate and barriers and facilitators to adoption.

Evaluators will assess patient retention in and compliance with treatment components (e.g., prescriptions filled, urine screens, psychosocial visits). After implementation, they will invite a sample of providers and clinical leaders to complete semi-structured interviews to identify barriers and facilitators to implementing OUD care and strategies used to address these barriers and will combine data sources to identify facilitators of optimal care implementation.

Maintenance at the implementation clinics will be assessed by changes across Years 1 and 2 in participation (number of waivered and prescribing providers) and compliance (retention in and compliance with stepped care). Evaluators will interview providers and leaders at the implementation clinics in Year 2, merging findings from these data with

changes in metrics to identify barriers and facilitators to maintaining OUD care. To identify factors that influence spread of OUD care to other clinics, evaluators will interview providers serving as trainers for spreading OUD care in Year 3.

Milestones:

FY 2021 Quarters	FY 2021 SCOUTT Milestones
Q1 (Complete)	• Disseminate Year 1 primary effectiveness outcomes to partners and scientific journal • Disseminate provider-level assessment of attitudes and beliefs about OUD treatment • Release national template to guide VA follow-up buprenorphine care to field • Complete coding and analysis of Year 1 qualitative interviews to assess implementation barriers and facilitators • Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams
Q2 (Complete)	Begin Year 2 qualitative data collection to identify barriers and facilitators to sustaining stepped care for OUD • Begin coding and analyses of Year 2 qualitative interviews • Describe characteristics of patients receiving MOUD and assess their representativeness of targeted population • Begin data management and analysis of secondary effectiveness outcomes over Years 1 and 2 after SCOUT launch, including receipt of acute care services and mortality • Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams
Q3 (Complete)	• Complete coding and analysis of Year 2 qualitative interviews • Disseminate secondary effectiveness outcomes over Year 1 and 2 after SCOUTT launch • Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams
Q4	• Begin Year 3 qualitative data collection to identify barriers and facilitators to spreading stepped care for OUD to other VISN clinics • Summarize proportion of patients retained in MOUD care and their receipt of core components of stepped OUD care over Years 1 and 2 after SCOUTT launch • Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams • Complete interim evaluation report and submit to national leadership – gather feedback

FY 2022 Quarters	FY 2022 SCOUTT Milestones
Q1	• Disseminate trends in primary effectiveness outcomes and adverse outcomes through Year 2. • Complete coding and analyses of third wave qualitative interviews • Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams
Q2	• Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams • Provide summaries of most common barriers and facilitators to maintaining stepped OUD among original implementation clinics and to spreading stepped care to other clinics
Q3	• Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams • Draft final evaluation report synthesizing qualitative and quantitative findings
Q4	• Disseminate monthly reports to operational partner and quarterly reports to SCOUTT implementation teams • Complete final evaluation report and submit to operations partner

Anticipated challenges: Preliminary findings suggest barriers to SCOUTT implementation include lack of buy-in and/or engagement of providers outside of the SCOUTT implementation team, lack of leadership support and resources (e.g., time, mental health care services), and credentialing and privileging issues related to buprenorphine prescribing. VHA substance use disorder leadership has been actively engaged in the SCOUTT initiative and evaluation and rapidly moved to address policy barriers impacting implementation with publication of VHA Notice 2019-18, Buprenorphine Prescribing for Opioid Use Disorder.

Dissemination: Evaluators summarize the numbers of patients with an OUD who receive MOUD and providers who prescribe MOUD and share this information with VA operational partners monthly and with SCOUTT teams quarterly. This information is used by operational partners to inform national VA leadership and external stakeholders on VHA efforts to increase access to MOUD. Further, evaluators meet regularly with the operational partners to disseminate key findings and to seek input. Evaluators will also draft and submit interim and final evaluation reports. Early project findings have been shared at national scientific conferences and will be published in academic journals.

Early project findings have been presented at the 2017 Academy Health National Health Policy Conference and as a VHA cyber-seminar. Evaluators presented preliminary results at the 2020 Conference. In addition, they have also published (and will continue to do so) research articles in peer-reviewed journals showcasing the impact of the dashboard and VHA's policy on opioid-related adverse events, and have presented findings, internally, to VA researchers, physicians, and policy makers. Additional

dissemination activities will include promotional materials developed by the Center for Information Dissemination and Education Resources (CIDER), a QUERI resource center.

Dr. Eric Hawkins is responsible for this evaluation. Dr. Hawkins can be reached at Eric.Hawkins@va.gov.

B2. The Stratification Tool for Opioid Risk Mitigation (STORM)

Learning Agenda Question: "How can VHA provide clinically appropriate pain management to Veterans while simultaneously decreasing dependence on opioids?"

Evaluation Question: *How did STORM improve opioid safety? How can the information obtained be used by leadership to refine opioid prescription related policy and practice?*

Timeline: Initial evaluation completed in FY20; evaluation extension anticipated.

Background: The opioid epidemic has ravaged communities in the United States, with Veterans facing an increased likelihood of developing opioid use disorder (OUD) due to a variety of unique military stressors. In 2018, over 900,000 Veterans treated in VHA had an opioid prescription. VA developed the Stratification Tool for Opioid Risk Mitigation (STORM) in 2017 to help clinical providers better identify Veterans who might be particularly vulnerable to negative opioid-related outcomes. VA issued a policy notice that required clinicians to conduct case reviews and identify appropriate risk mitigation strategies for patients who were identified as high-risk for opioid-related adverse events by STORM.

Study objective: The STORM evaluation is a multiyear effort that aims to determine if the use of the STORM tool decreases the rate of opioid-related adverse outcomes and whether the inclusion of consequences for failing to meet the minimum case review target would affect both the behavior of VHA providers and the opioid-related adverse event rate.

Study design and data sources: The evaluation is an interventional, cluster randomized trial that uses a stepped-wedge design to measure both the effectiveness of VHA's case review policy and the STORM dashboard in identifying patients at a high-risk of opioid-related serious adverse events (SAEs). Demographic, diagnostic, pharmacy, and health care utilization data are obtained from the VHA Corporate Data Warehouse (CDW).

Analysis: The evaluation includes two interventions. In the first intervention, VHA facilities are required to review patients with different risk levels as identified by the STORM tool. For the first nine months of the evaluation, the facilities include patients in the top 1% of risk. After that, half the facilities are randomly selected to increase their case review load to include patients identified in the top 5% of risk. All participating VHA facilities case review rates are reviewed using VHA administrative data 18 months after the initial start date.

In the second intervention, VHA facilities are randomly selected into two groups. One group will receive a policy memo indicating consequences if case review completion targets are not met, the other will receive a memo without any mention of the consequences. Like the first part of the evaluation, participants' case review rates are reviewed using VHA administrative data 18 months after initiation.

The primary outcome variables measured for both interventions are opioid-related SAEs – opioid overdose, accidental falls, and possible and confirmed suicide attempts – which will be identified using International Classification of Disease (ICD) -10 codes. The rate of opioid-related SAEs will be compared between a treatment group (high risk patients as identified by the STORM dashboard) and a control group (patients who were not displayed on the dashboard) over the course of two years. Patients are censored from the study if they experience one of the SAEs, die, or leave the study.

The data is analyzed using an intention-to-treat approach with patient-month-level survival analysis for both parts of the evaluation (effectiveness of policy memo and effectiveness of the STORM tool).

The evaluators will conduct quantitative analyses to evaluate the effects of the differing policy approaches and patient inclusion on the STORM tool's high-risk list on time to first opioid-related SAE, using data from the dashboard and VHA's CDW. They will also conduct surveys and qualitative interviews with key stakeholders to evaluate the implementation process of the STORM tool. In addition, the evaluators will examine the consequences of expanding the risk strata at each step wedge on patient load, case review rates, and risk mitigation rates. These findings will help inform future policy roll outs and implementation initiatives.

Anticipated challenges: Evaluators found that the expansion of case review requirements from the top 1% of high-risk patients to the top 5% of high-risk patients dramatically increased mental health providers' workload. If the STORM dashboard is implemented at this level with no additional changes (e.g. additional staffing), this could pose a challenge for mental health providers in the future, potentially leading to provider burnout.

Dissemination: Evaluators presented the evaluation protocol at the 2017 Academy Health National Health Policy Conference and as a VHA cyber-seminar and presented preliminary results at the 2020 Conference. In addition, they published research articles in peer-reviewed journals showcasing the impact of the dashboard and VHA's policy on opioid-related adverse events and have presented findings internally to VA researchers, physicians, and policy makers. Dissemination efforts will be updated as more results become available. Additional dissemination activities will include peer-reviewed journal articles, national conferences, and promotional materials developed by the Center for Information Dissemination and Education Resources (CIDER), a QUERI resource center.

Milestones:

FY 2021 Quarters	FY 2021 STORM Milestones
Q1 (Complete)	• Continue initial analyses on STORM's direct impact on patient outcomes, including serious adverse events and mortality outcomes • Continue initial analyses on STORM's case review process on provider practice patterns, including impact on patient load and provider attitudes • Results dissemination efforts of preliminary findings will continue through FY21
Q2 (Complete)	• Complete initial analyses on STORM's direct impact on patient outcomes, including serious adverse events and mortality outcomes • Complete initial analyses on STORM's case review process on provider practice patterns, including impact on patient load and provider attitudes • Continue results dissemination of initial analyses, as results become available
Q3 (Complete)	• Preliminary findings from STORM will be used to update OMHSP best practices • Continue collaboration with OMHSP as STORM dashboard evolves
Q4	• Disseminate reports to operational and implementation partners • Continue publication of findings in peer-reviewed journals

FY 2022 Quarters	FY 2022 STORM Milestones
Q1	• Continue data collection from STORM dashboard • Continue evaluations of STORM policy and dashboard over FY21 and FY22 • Perform secondary analyses of STORM intervention and impact on patient outcomes to inform VA best practices in pain management
Q2	• Update findings on STORM's impact on patient outcomes and private practice • Continue dissemination of reports to operational partners and implementation teams
Q3	• Draft updated evaluation report synthesizing qualitative and quantitative findings
Q4	• Continue publication of findings in peer-reviewed journals and presentation of findings at conferences

Point of Contact: The Partnered Evidence-based Policy Resource Center (PEPReC) is responsible for this evaluation. PEPReC can be reached at peprec@va.gov.

C. Access

VHA evaluators will examine two components of the effort to improve access by Veterans to healthcare under the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION) Act, including Section 401 on underserved facilities and Section 507 the Medical Scribes Pilot Program.

C1. Mission 401 Underserved Facilities and Populations

Learning Agenda Question: "How can VA ensure that Veterans have access to timely care in their preferred setting?"

Evaluation Question: *How effective are the underserved scores and subsequent mitigation strategies in addressing underserved facilities?*

Timeline: Ongoing.

Background: Most Veterans who are enrolled in VHA care live in areas with limited access to health care services. Approximately 16% of Veterans live within primary care shortage areas and 70.2% live in mental health care shortage areas. To improve Veteran access to quality care, VA implemented the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION). In compliance with Section 401 of the MISSION Act, the Office for Veterans Access to Care (OVAC), in collaboration with other research and operations offices, developed scoring algorithms to identify underserved VA medical facilities in both primary care and mental health services. Each year the top twenty underserved facilities are required to develop action plans explaining how they intend to improve Veteran access to care at their facilities.

Study objective: The objective of this evaluation is to study the effectiveness of the underserved scores and mitigation strategies at measuring and addressing facility-level underservedness.

Study design and data sources: Both a quantitative longitudinal cohort study and a qualitative study design will be employed. Data to be analyzed include administrative data on health care use (from VHA Corporate Data Warehouse), Veteran demographics, and facility and market characteristics, as well as interviews with key stakeholders (via email and phone).

Analysis: The evaluation will assess how well the scoring methodologies for primary care and mental health services measure underservedness. It will also evaluate individual variables to ensure they are important components in the measure of underservedness and worth keeping in the algorithms (e.g. wait times, capacity, Veteran demographics). Should the evaluation show that individual variables are no longer a good fit for the model, refinements will be made ahead of future underserved score calculations to either replace or improve those variables.

Evaluators will also interview local leadership to determine what mitigation strategies (e.g. personnel strategies, telehealth modalities, physical space) were employed to improve access to care. This information will then be used to assess how well those strategies worked by evaluating changes in access measures and underserved scores. Regression models will be used to control for potential confounding factors and to test the statistical significance of between-group differences. To reflect what mitigation strategies were implemented, evaluators will include a set of indicator variables in the models in place of the proposed action plan data. The analysis will also include a comparison of underservedness between the facilities required to submit action plans (top 20 most underserved) and those that were not. Evaluators will estimate the effectiveness of the program by measuring the extent to which the action planning group demonstrates greater improvement than the comparison group on various metrics.

Anticipated challenges: Evaluators anticipate that the newness of the underserved program may make evaluation difficult. With only two years of data, changes in underservedness may be hard to quantify. Thus, quantifying the program's overall impact may also prove difficult.

Dissemination: OVAC will have received annual evaluation reports from its research partners, with the first one in FY21Q2. The findings will also be shared with Congress in the program's annual congressionally mandated reports. Evaluators will share findings with local and national leadership as requested. Evaluators will also produce deidentified and/or aggregated results that can be shared with the public. This cycle of dissemination will continue through FY 2022 and beyond. Additional dissemination activities will include peer-reviewed journal articles, national conferences, and promotional materials developed by the Center for Information Dissemination and Education Resources (CIDER), a QUERI resource center.

Milestones:

FY 2021 Quarters	FY 2021 Underserved Facilities and Populations Milestones
Q1 (Complete)	• Model development • Calculate this year's underserved scores • Quantitative evaluation data analysis – assess variable integrity and effectiveness at measuring underservedness • Qualitative evaluation data collection and analysis – disseminate email surveys to and conduct phone interviews with local leadership, analyze impact of implemented mitigation strategies
Q2 (Complete)	• Submit underserved scores to national/local leadership • Compile and submit evaluation report

Q3 (Complete)	• Debrief with national/local leadership to improve model and evaluation process – conduct phone interviews upon request, provide scoring breakdowns for specific facilities, incorporate feedback into model refinement in Q4
Q4	• Model refinement – incorporate leadership feedback from Q3 into model, update data sources and datasets when available, include new variables where appropriate • Quantitative evaluation data analysis – assess variable integrity and effectiveness at measuring underservedness • Qualitative evaluation data collection and analysis – disseminate email surveys to and conduct phone interviews with local leadership, analyze impact of implemented mitigation strategies • Compile and submit interim evaluation report

FY 2022 Quarters	**FY 2022 Underserved Facilities and Populations Milestones**
Q1	• Model development • Calculate this year's underserved scores • Quantitative evaluation data analysis – assess variable integrity and effectiveness at measuring underservedness • Qualitative evaluation data collection and analysis – disseminate email surveys to and conduct phone interviews with local leadership, analyze impact of implemented mitigation strategies
Q2	• Submit underserved scores to national/local leadership • Compile and submit evaluation report
Q3	• Debrief with national/local leadership to improve model and evaluation process – conduct phone interviews upon request, provide scoring breakdowns for specific facilities, incorporate feedback into model refinement in Q4
Q4	• Model refinement – incorporate leadership feedback from Q3 into model, update data sources and datasets when available, include new variables where appropriate • Quantitative evaluation data analysis – assess variable integrity and effectiveness at measuring underservedness • Qualitative evaluation data collection and analysis – disseminate email surveys to and conduct phone interviews with local leadership, analyze impact of implemented mitigation strategies • Compile and submit interim evaluation report

Point of Contact: The Partnered Evidence-based Policy Resource Center (PEPReC) is responsible for this evaluation. PEPReC can be reached at peprec@va.gov.

C2. Mission 507 Medical Scribe Pilot Program

Learning Agenda Question: *"How can VA ensure that Veterans have access to timely care in their preferred setting?"*

Evaluation question: *How do medical scribes affect clinic function and patient satisfaction?*

Timeline: Estimated to be completed in FY 2022.

Background: Most Veterans who are enrolled in VHA care live in areas with limited access to health care services. Approximately 16% of Veterans live within primary care shortage areas and 70.2% live in mental health care shortage areas. To improve Veteran access to quality care, VA implemented the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION). In compliance with Section 507 of the MISSION Act, the Office for Veterans Access to Care (OVAC), in collaboration with other research and operations offices, implemented a two-year medical scribes pilot in 12 selected emergency departments and specialty care clinics to help improve provider productivity and, in turn, improve Veteran access to care. The pilot started in 2020 (delayed due to COVID-19) and included up to 48 scribes (four at each site; two VA-hired and two contract-hired).

Study objective: The objective of this evaluation is to study the implementation and impact of the scribes pilot program to determine the effect of scribes on clinic function and provider and patient satisfaction, as well as compare outcomes between VA-hired and contract-hired scribes.

Study design and data sources: During implementation interested sites were randomized into treatment (scribe) and control groups. Quantitative and qualitative analyses will be conducted. Data will be collected from the VHA Corporate Data Warehouse, Veteran satisfaction surveys (e-mailed from Veterans Experience Office), site visits, and stakeholder interviews.

Analysis: Evaluators will measure the impact of medical scribes on provider efficiency, wait times, patient volume, and provider and patient satisfaction. Differences in outcomes between VA- and contract-hired scribes will also be evaluated, as will the hiring and implementation processes. The RE-AIM evaluation framework will be followed where appropriate.

Quantitative evaluators first computed a 12-month baseline series of data (organized by facility-month) and conducted a power analysis for each outcome to determine the minimum effect size that could be detected with 80% power. They will conduct retrospective data analysis (multivariable linear regression models at the facility-pay period level) on administrative data, including Veteran surveys, to assess the impact of medical scribes on outcomes of interest.

To evaluate the impact of medical scribes on provider efficiency, evaluators will compare physician productivity before and after the pilot by using work relative value units as well as visit volume. Average wait times will be analyzed on the provider- and clinic-levels with two measures as well: days to completed consult and days to scheduled consult. Evaluators will study changes in patient volume by looking at the average number of patients seen per day. Lastly, patient satisfaction will be analyzed with two Veteran surveys developed and administered by the Veterans Experience Office.

The qualitative evaluation team will complement the quantitative analysis with site visits and interviews with providers, scribes, and Veterans. Interviews will be recorded, transcribed, and analyzed using Archive for Technology, Lifeworld and Everyday Language (ATLAS).ti 8 technology. They will study implementation barriers and facilitators, factors impacting reach and adoption, perceived scribe and provider efficiency and effectiveness, adoption, maintenance (perceived feasibility and sustainability), and patient and provider satisfaction, guided by the RE-AIM framework. Differences between urban and rural sites, VA-hired and contract-hired scribes, and across care settings will be noted.

Anticipated challenges: Evaluators anticipate it may be difficult to draw quantitative conclusions from the data given the small size of the pilot. With less than 50 scribes participating, reaching statistical power is unlikely. Additionally, completing an adequate number of interviews may be difficult, limiting the reach of the qualitative analysis.

Dissemination: Evaluators will submit regular reports to OVAC. Additionally, the researchers will submit regular reports to the Office of Rural Health as a funding requirement. OVAC will submit annual congressionally mandated reports on the pilot's progress and impact. The results of the pilot will also be shared with local and national leadership as requested. Evaluators will also produce deidentified and/or aggregated results that can be shared with the public. Should the pilot be continued beyond FY 2022, additional dissemination requirements will need to be discussed. Additional dissemination activities will include peer-reviewed journal articles, national conferences, and promotional materials developed by the Center for Information Dissemination and Education Resources (CIDER), a QUERI resource center.

Milestones:

FY 2021 Quarters	FY 2021 Medical Scribe Pilot Program Milestones
Q1 (Complete)	• Start pilot program
Q2 (Complete)	• Data development and analysis planning – complete baseline analyses (including power analyses), prepare datasets and code • Develop site visit and interview guidance

Q3 (Complete)	• Qualitative data collection – begin site visits and stakeholder interviews • Quantitative data analysis – begin assessing impact on clinic efficiency, patient volume, wait times, and provider and patient satisfaction • Draft interim evaluation report – include both qualitative and quantitative interim analyses
Q4	• Complete interim evaluation report and submit to national leadership – gather feedback

FY 2022 Quarters	FY 2022 Medical Scribe Pilot Program Milestones
Q1	• Continue pilot program – integrate feedback from interim report
Q2	• Data development and analysis planning – integrate feedback from interim report • Qualitative data collection – continue site visits and stakeholder interviews • Quantitative data analysis – continue assessing impact on clinic efficiency, patient volume, wait times, and provider and patient satisfaction
Q3	• Qualitative data collection – continue site visits and stakeholder interviews • Quantitative data analysis – continue assessing impact on clinic efficiency, patient volume, wait times, and provider and patient • Draft final evaluation report – include both qualitative and quantitative analyses
Q4	• Complete pilot program • Compile final evaluation report and submit to national leadership

Point of Contact: The Partnered Evidence-based Policy Resource Center (PEPReC) is responsible for this evaluation. PEPReC can be reached at peprec@va.gov.

VBA EVALUATION PLANS

Topic Nomination: In FY 2022, VBA will focus its evaluation efforts on military-to-civilian transition and its impact on Veteran overall well-being. This area of study directly supports VBA's priorities and commitment to improving the transition experience. The FEBPWG accepted VBA's nominated topic based on VA significance criteria (see above).

Current State: VBA currently undertakes a number of studies and evaluations which are used to support program and policy improvements. VBA will consider future studies and enhancements in the context of the Evidence Act. For VBA, the capability and capacity to conduct program evaluations is limited and requires time and effort to properly

develop. The initial focus will be on understanding and improving the transition experience and outcomes. As the quality of data improves, and as VBA is able to mature its evaluative capacity, future Annual Evaluation Plans will include substantive plans for the specific topic.

While the following does not explicitly detail a plan for answering any empirical questions, VBA outlines its efforts towards developing its data, processes, and partnerships so that it can deliver evaluations that are rigorous and help to effect strategy, policy, resource allocation, and program operations.

Programmatic Focus: VBA will focus its evaluation planning and capacity development efforts on the transition experience and post-transition outcomes.

Program Context: The Transition Assistance Program (TAP) provides a cohesive and outcomes-based program that standardizes the transition processes and better prepares Servicemembers to achieve successful outcomes in their post-military lives. TAP provides information on benefits and services available and is delivered through the U.S. Department of Defense (DoD) in cooperation with VA, the Department of Labor (DOL), Education (ED), Homeland Security (DHS), Small Business Administration (SBA), and Office of Personnel Management (OPM).

Current Data Gathering Efforts: VBA sponsors the Post Separation Transition Assistance Program Assessment (PSTAP) Outcome Study which assists VBA and its interagency partners in improving TAP. PSTAP collects outcome data for transitioning Service members. PSTAP was initiated in 2018 and conducted the first of the multiyear studies in 2019. PSTAP is designed to track Veterans long-term outcomes as they continue to transition through civilian life across a host of life domains. The study consists of two assessments, a longitudinal portion to provide annual snapshots of Veterans at the 6 months, 12 months, and 36 months post separation and a longitudinal portion to track Veterans who opt in as they progress through their transition journey. In its 2019 inaugural execution, a cross-sectional assessment was administered to over 160,000 participants. Starting in 2020, both the cross-sectional and longitudinal assessments were administered annually.

Data-Building Efforts: VBA will continue to refine the data incorporated into the PSTAP outcomes study, with the following specific actions:

A. Ensure sufficient participation: VA's initial survey (2019 cross-sectional) produced only a 2.9% response rate; additional outreach methods were added in 2020 and the response rate improved four-fold, resulting in a 50% reduction in the margin of error*.
B. VA will continue to develop approaches to increase the response rate, as well as develop any necessary revision to the Cross-Sectional and/or Longitudinal surveys to facilitate the evaluation of the transition space.

Cross – Sectional Surveys

Year	Pop. Size (N)	Respondents (n)	Rate	MoE*
2019	165,236	4,834	2.9%	1.39%
2020	139,834	18,721	13.4%	0.67%

* Measure of Effectiveness (MoE) at 95% Confidence Level

Longitudinal Surveys

Year	Pop. Size (N)	Respondents (n)	Rate	MoE*
2019	N/A	N/A	N/A	N/A
2020	3,001	1,876	62.5%	1.39%

* Measure of Effectiveness (MoE) at 95% Confidence Level

C. Collect additional administrative data to examine the effects of different demographic groups: As part of its evaluation plan, VBA will assess the extent to which it collects sufficient administrative data within its benefits programs. The assessment should determine the extent to which VBA collects key demographic variables, e.g., race, ethnicity, gender, education level. This will aid VBA in evaluating program outcomes and to better understand the needs of Veteran sub-populations.

D. Partner with the Departments of Labor and Health and Human Services: Although VA has commissioned the PSTAP outcomes study, many different agencies administer different aspects of the TAP program. VBA will work with the Department of Labor, with a plan to specifically identify focused questions that can isolate the effect of the TAP on employment outcomes for transitioning Servicemembers who participate. In addition, VBA will work with the Department of Health and Human Services to gain access to the National Database of New Hires, to gain comprehensive access to employment data, as authorized in Public Law 116-315, §4301.

Milestones:

FY 2021 Quarters	FY 2021 Military-To-Civilian Transition Milestones
Q4	• Identify any demographic data gaps in the current PSTAP outcomes study. Execute 2021 PSTAP Assessments

FY 2022 Quarters	FY 2022 Military-To-Civilian Transition Milestones
Q1	• Refine strategy for increasing respondent rate of PSTAP outcomes study, Analyze PSTAP 2021 Assessment results
Q2	• Propose revised PSTAP Outcome Study methodology
Q3	• Publish 2021 PSTAP Report
Q4	• Execute 2022 PSTAP Assessment

FY 2023 Quarters	FY 2022 Military-To-Civilian Transition Milestones
Q1	• Analyze 2022 PSTAP Assessment results
Q2	• Analyze 2022 PSTAP Assessment results
Q3	• Release 2022 PSTAP Report
Q4	• Execute 2023 PSTAP Assessment

APPENDIX

Overview of VA Evaluation Activities

As noted above, VHA conducts over 2000 evaluations each year, focusing on answering questions that impact the health and well-being of Veterans. Specifically, the vast majority of these evaluations are conducted through the VHA Office of Research and Development (ORD), which funds research evaluations across the translational research spectrum, from basic science to clinical, rehabilitation and health services research, to inform advancements of knowledge and generation of evidence to improve Veteran's health and well-being. ORD is administratively managed in four research service areas and several supporting program offices. VA research is an intramural program; VA investigators who apply for funding from ORD are located at VA facilities across the country. This makes VA one of the only cabinet-level agencies with an in-house program that generates evidence for clinical and policy use. This aspect led to an increased demand for evaluation once VA programs and policies were deployed nationally. As a result, ORD's Health Services Research and Development program leads a significant portion of evidence- generating evaluations to inform programs and policies. In addition, the ORD Quality Enhancement Research Initiative (QUERI) program has focused on broad national evaluations of programs and policies identified by VA national leadership or by Congressional mandate in order to improve their real-world use in VA.

There are two types of evaluation in VHA: clinically- and/or research-focused evaluation that is used to generate evidence and operations-focused quality improvement evaluation that focuses on assessing the effectiveness and sustainment of new programs or policies in real-world settings. The table below provide a sample of ongoing research and development studies.

Sample of Health Services Research and Development (HSR&D) studies

Study Title	Study End Date
Impact of COVID-19 and Social Distancing on Mental Health and Suicide Risk in Veterans	March 3, 2021
Piloting a Self-Help Intervention to Improve Veteran Mental Health During the Covid-19 Pandemic	March 30, 2021
COVID-19 in the VA Community Living Centers	Feb. 28, 2021
Incidence, Risk Factors, and Prognosis of COVID-19 Associated Acute Kidney Injury	March 31, 2021
Adapting Caring Contacts to Counteract Adverse Effects of Social Distancing Among High-Risk Veterans During the COVID-19 Pandemic	Dec. 31, 2020
Impact of the COVID-19 pandemic on chronic disease care within the VA	April 30, 2021
Strategies to Reduce Unnecessary Noninvasive Imaging	Sept. 30, 2023

Women Veterans' VA Maternity Care Utilization, Satisfaction, and Health Outcomes	June 30, 2021
Evaluating and Improving Osteoporosis Care for Male Veterans	Dec. 31, 2020
Implementing and Evaluating Computer-Based Interventions for Mental Health	June 30, 2021
Evaluating Cash Benefit Programs for Veterans' Long Term Care	Sept. 30, 2021
Improving Primary Care Anxiety Treatment Engagement and Effectiveness	March 3, 2022
Improving Health Care for Women Veterans: Addressing Menopause and Mental Health	May 31, 2023
An RCT of a Primary Care-Based PTSD Intervention: Clinician-Supported PTSD Coach	Sept. 30, 2021
Effects of VHA opioid policy on prescribing and patient-centered outcomes	April 30, 2021
Improving Diabetes Care through Effective Personalized Patient Portal Interactions	Jan. 31, 2021
Cannabis Use and Health among VHA Primary Care Patients	Sept. 30, 2021
Self-management of blood pressure medication for hypertensive veterans	July 31, 2022
Improving the Measurement of VA Facility Performance to Foster a Learning Healthcare System	Sept. 30, 2021
Effectiveness of Treatment and Outcomes for Veterans Infected with Resistant Gram-negative Organisms.	June 30, 2021
Effectiveness of a Rescue Medication in Preventing Opioid Overdose in Veterans	Nov. 30, 2021
Evaluating the Use of Peer Specialists to Deliver Cognitive Behavioral Social Skills Training	Jan. 31, 2023
Aligning policy and healthcare services with Veterans' values and preferences for results from Whole Genome Sequencing	April 30, 2021
Prediction and Prevention of Hypoglycemia in Veterans with Diabetes	Aug. 31, 2023

Each year, VA receives numerous recommendations and requirements to conduct evaluations from legislation, Congressional requests, Office of Inspector General (OIG) and Government Accountability Office (GAO) reviews. These evaluations sometimes arise in processes separate and distinct from our research and Learning Agendas; however, they serve to build the body of evidence policymakers use to determine future actions related to Veteran benefits and services. Below is a table depicting a sample of these required ongoing evaluations that are presented with additional detail in VA's forthcoming FY 2022 – FY 2028 Capacity Assessment. In this context, it serves to provide examples of the scope and breadth of VA's evaluative and evidence-building efforts as required by oversight functions.

Examples of Required Ongoing Evaluations

Source	Brief Description
Congressionally required	Caregiver Program Annual evaluation report
Congressionally required	Evaluation of impact of staffing shortages on VA patients
Congressionally required	Evaluation of effectiveness of education program
Congressionally required	Evaluation of the quality and timeliness of care
Congressionally required	Evaluate the needs of the Veteran and the family caregiver(s) to determine of additional instruction, preparation, training or technical support are needed
Congressionally required	Evaluate the effectiveness of the use of scribes at medical centers
Congressionally required	Homelessness: VA to work with HUD to report on the effectiveness of measures taken to address homelessness of Veterans at the US-Mexico border as it relates to HUD-VASH vouchers (Veterans Affairs Supportive Housing)
Congressionally required	MH and Suicide Prevention: Conduct a study to detail the findings on the outcomes and efficiency of the Veteran Crisis Line
Congressionally required	Substance Use Disorder Care: Plans to scale successful evidence-based, integrated SUD care model programs
Congressionally required	Homelessness: VA to assess the benefits of expanding the Homeless-Patient Aligned Care Teams (H-PACT) program, the expansion to additional locations (including rural areas) and additional services to improve the program
Congressionally required	Homelessness: Assess how best serve homeless or unstably housed women Veterans
Congressionally required	Women Veterans: Conduct a feasibility study re: establishing women-only clinics in order to reduce harassment
Congressionally required	Small, Minority and Women-Owned Businesses: Conduct an analysis detailing which contractors successfully implemented subcontracting plans and recommendations on how VA could better achieve its prime and subcontracting goals for small businesses
Congressionally required	Biomarkers for Brain Conditions: Devise a longitudinal study to identify and validate two non-survey diagnostic tools or biomarkers for brain health conditions including TBI and PTSD

Congressionally required	Equine Therapy: Conduct a comprehensive program evaluation to ensure the continued effectiveness of equine therapy in addressing the mental health needs of Veterans that participate in these programs
Congressionally required	Rare Cancer Research: Evaluate the health status of servicemembers from their time of deployment to Iraq and Afghanistan over many years to determine their incidence of chronic diseases including cancers that tend to not show up for decades
Congressionally required	Gulf War Illness Studies: continue to conduct epidemiological studies regarding the prevalence of Gulf War illness, morbidity and mortality in Persian Gulf War Veterans and the development of effective treatments, preventions and cures
Congressionally required	Hep C: Conduct outreach testing campaign while evaluating point-of-care testing opportunities that can reach Veterans outside the VA system
Congressionally required	Overmedicating: Conduct an assessment of the potential overmedication of Veterans that led to suicides, deaths, mental disorders and combat-related traumas
Congressionally required	Pressure Ulcer Transparency: Conduct an assessment of VA's efforts to 1) monitor the incidence and impact of unintended Hospital-Acquired Conditions, 2) reduce the incidence of pressure ulcers/injuries and 3) expand public reporting on hospital comparisons to include total pressure ulcer/injury incidence
Congressionally required	Rural Health: Develop evidence-based policies and innovative practices to bring healthcare to rural areas
Congressionally required	Tobacco Use Among Veterans: Continue promoting cessation and evidence-based tobacco interventions for our Veterans
Congressionally required	Hyperbaric Therapy: Support for the continued study of the use of hyperbaric oxygen treatments for Veterans suffering from PTSD
GAO/OIG required	Veterans First Program: conduct a fraud risk assessment for the Veterans First program (High Risk List)
GAO/OIG required	Acquisition Management: assess duplication between VA's FSS and MSPV programs to determine of this duplication is necessary or if efficiencies can be gained
GAO/OIG required	Cybersecurity: conduct an organization-wide cybersecurity risk assessment
GAO/OIG required	Succession Planning: VBA should work to close workforce gaps and monitor and evaluate VBA's succession planning
GAO/OIG required	Specialty Care: Complete a specialty care needs assessment for highly rural community-based outpatient clinics to include internet bandwidth and telehealth equipment and develops options for the delivery of safe patient care

GAO/OIG required	Rural Care: Complete an assessment to determine whether highly rural community-based outpatient clinics that are located in a non-VA community hospital or health care center are fully utilizing the resources available at the non-VA facilities and takes action as indicated
GAO/OIG required	EHRM: Evaluate the impact of the new electronic health record implementation on productivity and provide operational guidance and required resources to facilities prior to go-live