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Healthcare Inspection

Implementation of VHA's Uniform Mental Health Services Handbook

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To Report Suspected Wrongdoing in VA Programs and Operations

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Executive Summary

Introduction

As required by the Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year 2009 (FY09), the VA Office of Inspector General (OIG) conducted a review of the Veterans Health Administration's (VHA's) progress in implementing the recommendations of the Mental Health Strategic Plan. Additionally, the Committee was concerned that VHA policy on the identification and treatment of post-traumatic stress disorder (PTSD) has not been applied uniformly and directed the OIG to include a review of the compliance to these policies in the report.

The Mental Health Strategic Plan has over 200 initiatives; VHA's Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* translates this into an operational, point of service, programmatic package of approximately 400 mental health services provided or available to eligible veterans at VA medical centers and community based outpatient clinics (CBOCs) of varying size.

Results

Given the dimension of the handbook, a comprehensive review of the extent of implementation is challenging. We limited the scope of our review to the medical center level. Implementation at CBOCs will be reviewed through OIG's CBOC review process. In addition, we chose selected items from the handbook to evaluate for implementation. For each section, there may be items that were not chosen for which the extent of implementation is greater or less. In addition, implementation of the handbook is a dynamic and ongoing process during FY09 and the data presented in the findings do not capture partial implementation. We believe the items chosen reasonably estimate the present extent of handbook implementation at the medical center level at this time. A detailed table presents our findings, including findings on identifying and treating PTSD.

We would anticipate the extent of implementation at medical centers to exceed that seen at the CBOC level. Smaller and rural CBOCs may face obstacles to implementation including geographic distance to care and ability to recruit mental health providers, among others.

We found that some facilities were unclear as to facility level status and therefore were unclear whether onsite emergency department requirements have been met.

At present we are unaware of a system by which VHA reliably tracks provision and utilization of evidence-based PTSD therapies on a national level. Development of a national system to track provision of evidence-based PTSD therapies and utilization by

returning veterans would allow for a population based assessment of treatment outcomes with implications for the treatment of other veterans presenting for PTSD related care.

The handbook is an ambitious effort to enhance the availability, provision, and coordination of mental health services to veterans. The handbook notes that metrics will be used to ensure implementation of requirements. Program evaluation and development of mental health outcome measures can be challenging. As implementation further progresses, VHA should develop metrics and outcome measures where feasible to allow for dynamic refinement of program requirements in order to meet changes in mental health needs and care utilization patterns of veterans.

This inspection reports on the system-wide implementation status of VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*. Because facilities have until the end of FY09 to fully meet the handbook requirements, we made no recommendations at this time.

Comments

The Under Secretary for Health concurred with our findings and stated that he was optimistic about forecasts for full implementation by the end of FY09, given VHA's actions in process. See Appendix A, pages 24–25 for the full text of his comments.

(original signed by:)
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Introduction

Purpose

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year 2009 (FY09), the VA Office of Inspector General (OIG) conducted a review of the Veterans Health Administration's (VHA's) progress in implementing the recommendations of the Mental Health Strategic Plan. Additionally, the Committee was concerned that VHA policy on the identification and treatment of post-traumatic stress disorder (PTSD) has not been applied uniformly and directed the OIG to include a review of the compliance to these policies in the report.

Background

The VHA Mental Health Strategic Plan (MHSP)[1] was finalized in 2004 in the context of a growing veteran population with unmet mental health care needs and the transformational emphasis of the 2003 report of the President's New Freedom Commission on Mental Health.[2] The New Freedom Commission identified 6 broad goals:

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment and referrals to services are common practice.
- Excellent mental health care is delivered and research is accelerated.
- Technology is used to access mental health care.

In 2003, the VA Under Secretary for Health convened a work group to review the President's New Freedom Commission on Mental Health Report, to determine the relevance of the Commission's goals and recommendations to veterans' mental health programs, and to develop an action plan tailored to the special needs of the enrolled veteran population. In December 2003, this work group developed and published an action agenda report: *Achieving the Promise: Transforming Mental Health Care in VA.*

The action agenda report prompted VHA to organize a workgroup to develop a comprehensive strategic plan for mental health care services. The workgroup ultimately incorporated multiple talking points into a 5-year strategic plan with more than 200

[1] More formally known as *A Comprehensive VHA Strategic Plan for Mental Health Services.*

[2] *Achieving the Promise: Transforming Mental Health Care in America*, The President's New Freedom Commission on Mental Health, 2003.

initiatives. The MHSP was initially approved by the Under Secretary in July 2004, finalized in November 2004, and revised in May 2005.

The purpose of the MHSP was to present a new approach to mental health care, focused on recovery versus pathology and the integration of mental health care into overall health care for veteran patients. The MHSP action items were grouped to align with the goals and recommendations of the New Freedom Commission Report.

Since the MHSP is organized by New Freedom Commission Goals and Recommendations rather than by mental health program or operational focus, some MHSP initiatives do not clearly delineate what specific actions should be carried out to achieve these goals and are not easily measureable. In addition, several items are administrative in nature, such as establishing a workgroup. Although implementation of these items may indirectly facilitate provision of care, point of service delivery is not directly addressed.

VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (the handbook), issued on June 11, 2008, and updated in September 2008 establishes minimum clinical requirements for VHA mental health services. The handbook specifies the essential components of the mental health program to be implemented nationally to ensure that all veterans have access to needed mental health services. The handbook delineates those services that must be provided at each VA medical facility and at very large, large, mid-sized, and small community based outpatient clinics (CBOCs).

Mental health services required by the handbook represent the next step in the process that began with approval of the MHSP in 2004 and the allocation of funding through the Mental Health Enhancement Initiative. As an extension of the MHSP, the handbook was also developed to further implement the goals of the New Freedom Commission Report.

Objectives of the handbook include:

- Expanding access and capacity.
- Integrating MH and primary care.
- Transformation toward a recovery and rehabilitation model.
- Implementing evidence-based care.
- Returning veterans.
- Suicide prevention.

Although there is overlap between MHSP items and the handbook items, the handbook more clearly defines specific requirements for services that must be provided (those services that must be delivered when clinically needed to patients receiving health care at a facility by appropriate staff located at that facility) and those that must be available (those that must be made accessible when clinically needed to patients receiving health

care from VHA). In contrast to the MHSP, the handbook has an operational focus and action items are organized by mental health program areas (e.g., Ambulatory Mental Health Care, Homeless Programs, and Substance Use Disorders, etc.) rather than by less specific New Freedom Commission goals.

Although the handbook contains over 400 elements, it does not intend to describe all mental health programming that could be effective, and it encourages sites to go beyond the specifications. In addition, specifications are not delineated with such detail as to preclude adjustments for local variation in clinical issues. The handbook stipulates that every veteran seen in mental health services will be assigned a principal mental health provider to help with continuity, care coordination, and treatment plan implementation and monitoring.

Overall, facilities are expected to implement handbook requirements by the end of FY09. Potential barriers to implementation include: space limitations within facilities; difficulty recruiting mental health clinicians in some rural areas; limited availability of community providers with whom to arrange a sharing or contract agreement and/or the time needed to forge such agreements; and distance to travel to VA care. Each Veterans Integrated Service Network (VISN) must request approval from the Deputy Under Secretary for Health for Operations and Management for modifications and exceptions for requirements that cannot be met in FY09 with available and projected resources.

The handbook notes that "when fully implemented these requirements will complete the patient care recommendations of the Mental Health Strategic Plan, and its vision of a system providing ready access to comprehensive, evidence-based care."

Scope and Methodology

The scope of this review was limited to implementation at the VA medical facility level. VA facilities likely pursue full implementation at the facility level prior to the CBOC level. Accordingly, the extent of implementation presented in the findings likely represents the highest level currently attained for the system as a whole. OIG plans are that the Office of Healthcare Inspections, CBOC Project Group will inspect implementation at the CBOC level at a later date. Pursuant to Public Law 110-387, the OIG is presently conducting a review of VHA residential treatment programs. Implementation items related to residential programs were therefore excluded from the scope of this review. This review does include some items related to suicide prevention. As part of onsite visits for OIG combined assessment program (CAP) reviews, OIG inspectors have been conducting a focused, chart based review of implementation of suicide prevention related items from the handbook. This focused review began in January 2009 and will run through June 2009, after which a roll-up report will be issued.

We interviewed VA Central Office, Office of Mental Health Services leadership. In addition we spoke to several VISN mental health liaisons/directors. We obtained VHA

Deputy Under Secretary for Health for Operations and Management monitor data pertaining to timely access for all new veterans who need mental health care, mental health care transitions follow-up to inpatient mental health hospitalization, and follow-up for high risk hospitalized mental health patients. We obtained data from the VHA Office of Mental Health Services monthly tracking report for Suicide Prevention Coordinators, VISN Homeless Health Care for Reentry Veterans Specialists, and VISN homeless coordinator positions. This report monitors filling by the field of positions funded from the Office of Mental Health Services for specific initiatives (e.g., suicide prevention coordinators, re-entry specialists, network homeless coordinators). We obtained a list of facilities with greater than 1,500 seriously mentally ill patients from the VA Serious Mental Illness Treatment and Evaluation Center (SMITREC). We obtained data on locations, clinical staffing, and case load on the mental health case management program (MCHIM) and on MCHIM-RANGE (Rural Access Network for Growth Enhancement) units from the VA Northeast Program Evaluation Center (NEPEC). In addition, data and information on dissemination of training in evidence-based psychotherapies was obtained from the Office of Mental Health Services.

From August 11, 2008, to September 25, 2008, we conducted a web based mental health point of service inventory survey to be completed by all VA medical facilities. We received responses from 149 of 171 VA medical center campus sites. If a VA facility had more than one campus, then both campuses were individually surveyed. The inventory included questions related to availability of certain specific clinical mental health services or clinics (e.g., an Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) specialty clinic, evening mental health clinic hours) at VA medical facilities and CBOCs; location of CBOCs, satellite, and contract sites; and availability of evidence-based treatments.

From March 5–19, 2009, we conducted structured phone interviews with mental health directors and/or designees at 138 VA medical centers. The structured interview tool consisted of select items from VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*. Some sections of the handbook were omitted because we obtained data from other sources pertaining to implementation of items from these sections or because of exclusions (e.g., residential programs) described in the scope of this report. Each interview consisted of 39 index questions. OIG inspectors asked intermittent follow-up queries to enhance clarity and validity of interviewee responses. For facilities with more than one campus, only the mental health director responsible for the facility as a whole was interviewed. In addition, the interview process afforded the opportunity for mental health directors to apprise our inspectors on their progress on initiatives that are in process but not yet implemented. Also, we had the opportunity to obtain feedback and to hear about potential barriers to implementation.

From the VA-OIG Data Center in Austin, Texas, we obtained national patient treatment data on all unique clinical encounters at each VA facility and associated CBOCs and the

total number of these unique encounters with a primary ICD-9 diagnostic code of 309.81 (PTSD). We also obtained the number of all unique encounters for PTSD stop codes (516,540,561,519,542,562,580,581) and all unique encounters for PTSD stop codes for which the primary diagnosis was PTSD. This data was aggregated by VISN.

The inspection was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results and Conclusions

Issue A: Community Mental Health

According to the handbook, VISNs and facilities must collaborate with Vet Centers in outreach to returning veterans. Outreach can include presentations at National Guard and Reserve sites and Post Deployment Health Reassessment events as well as outreach involving veteran families.[3]

> During the structured interview, we were looking for evidence of active, collaborative outreach activities. We found that 87 percent of facilities affiliated with at least one Vet Center reported activities consistent with the handbook item. Five percent of facilities were not affiliated with a Vet Center and the question was therefore non-applicable.[4]

Issue B: Gender-Specific Care and Military Sexual Trauma

The handbook states that all inpatient and residential care facilities must provide separate and secured sleeping accommodations for women. Mixed gender units must ensure safe and secure sleeping and bathroom arrangements, including door locks and proximity to staff.

> Of the facilities with inpatient mental health units, 97 percent reported providing separate and secure sleeping and bathroom arrangements.

According to the handbook, a nationwide tracking system should be used to ensure consistent data on screening and treatment of victims of Military Sexual Trauma (MST).

> While facilities uniformly indicated that they perform MST screening and referral, 82 percent reported informally tracking the treatment of affected patients.

The handbook also requires that each Medical Center Director is responsible for ensuring that evidence-based mental health care is available to all veterans diagnosed with mental health conditions resulting from MST.

> In response to the web based mental health point of service inventory, 96 percent of medical centers reported availability of outpatient treatment for MST.

[3] Note that in this section, the material which begins at the left margin is what is stated or required in VHA's Handbook; the indented material which follows is what we found during this review.

[4] The importance of collaboration between medical centers and Vet Centers was raised in a January 2008 OIG report: *Healthcare Inspection, Alleged Premature Discharge of a Veteran, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania*, No. 07-01622-62, 1/24/2008. All OIG reports and testimony cited in this report are available on http://www.va.gov/oig/.

Issue C: 24/7 Care and Emergency Department Care

The handbook requires that all VHA emergency departments have mental health coverage by an independent, licensed mental health provider either onsite or on-call, on a 24/7 basis. For level 1A VA medical centers (those facilities that have higher utilization, higher risk patients, specialized intensive care units, and research, educational, and clinical missions) mental health coverage must at a minimum be onsite from 7am to 11pm. For non level 1A facilities, coverage must be onsite or on-call at all times. VA facilities with urgent care centers must have mental health coverage during their times of operation; the coverage may be onsite or on-call.

> Approximately 79 percent of facilities interviewed have emergency departments. Of the facilities with an emergency department of any level, 98 percent had at least 24/7 on-call coverage. For the number of facilities with urgent care centers, 88 percent reported onsite coverage and 100 percent had at least on-call coverage during their times of operation.
>
> Although we initially attempted to ascertain the extent of 1A facilities with onsite emergency department coverage from 7am to 11 pm, it became clear that many facilities do not have level 1A emergency departments. Although most facility mental health directors were aware of the facility level, some mental health directors were unsure of the facility level or the level had recently changed. One mental health director commented that it would be helpful for central office to send all facility mental health directors a list of up to date facility level designations in order to ensure that mental health directors are meeting the emergency department onsite requirements.

The handbook notes that all medical centers with emergency departments must have resources to allow extended observations or evaluations for up to 23 hours when clinically necessary. Observation beds offer an opportunity to further evaluate patients initially presenting in states of intoxication. This may be accomplished through observation beds in the emergency department or, when consistent with State and accreditation standards, through use of observation beds on inpatient units.

> We found that 54 percent of facilities with emergency departments had observation beds. Some facilities reported working toward implementation of this item. Some reported space as a notable barrier to implementation. One facility reported having had observation beds in the past, but converted the beds back to regular inpatient status because the patients in these beds were nearly uniformly admitted on subsequent evaluation.

Issue D: Inpatient Care

According to the handbook, inpatient care must be available to all veterans who require hospital admissions for a mental disorder, either at the VA medical center where they usually receive care, a nearby VA, or by contract, sharing agreement, or non-VA fee-basis referral to a community facility to the extent that the veteran is eligible. In addition, secured inpatient units in VA medical centers must be prepared when it is feasible to accept involuntary hospitalizations resulting from civil commitments for veterans for whom VHA provides health care services.

> From the structured interview, 79 percent of facilities reported providing inpatient mental health care onsite. Ninety-two percent of the facilities with inpatient units also admit involuntary patients. A few facilities with inpatient units that do not admit involuntary patients reported either having arrangements in place with other VA medical centers or private community facilities. At least one facility that does not admit involuntary patients and one facility that does not have an inpatient unit reported the de facto use of state facilities to provide for involuntary hospitalization.

Issue E: Ambulatory Mental Health Care

The handbook specifies that all new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days.

> In FY09, the Office of Mental Health Services, within the Office of Patient Care Services (PCS), established expectations for timely access to mental health specialty care consistent with the goals of the mental health strategic plan and the handbook. Veterans defined as new to mental health are to have further evaluation and the initiation of mental health care within 15 days of an initial trigger encounter. Based on the PCS monitor, for February 2009, 96.7 percent of new patients were seen within the 15 day time frame. The monitor target is 90 percent. The preliminary data for March 2009 indicate a range between VISNs of 89–98 percent. PCS and the Office of Quality and Performance state that they are collaborating to further develop and refine performance metrics (including formal Performance Measures for accountability, and monitors for ongoing tracking) to support system-wide goals.

In order to enhance access to ambulatory mental health care, the handbook requires that clinics in medical centers must offer a full range of services during evening hours at least 1 day per week. Additional morning, evening, or weekend hours need to be offered when required to meet the needs of a facility population. Evening hours may increase access for patients who work or attend college during usual business hours.

In the OIG August–September 2008 mental health point of service inventory, we asked facilities if evening hours were available for at least one outpatient mental health clinic. Eighty-seven percent of the facilities reported having evening hours. Similarly we asked about weekend hours and 18 percent of facilities reported offering one or more outpatient Saturday or Sunday mental health clinics or groups. In the March 2009 structured interview we also asked if facilities provide evening or weekend onsite outpatient mental health services at least 1 day per week; 99 percent of facilities reported affirmatively. As an anecdotal trend, some facilities indicated that evening substance use programs seemed well attended but the turnout for evening PTSD clinics has been mixed. One mental health director reported that an evening OIF/OEF clinic at his facility initially had poor turnout for months but has become increasingly utilized. In terms of weekend hours, anecdotally a few respondents from facilities that have implemented weekend hours reported that younger patients have indicated the desire for weekend hours but the turnout has been poor.

Issue F: Care Transitions

As per the handbook, facilities must ensure continuity of care during transitions from one level of care to another. When veterans are discharged from inpatient or residential settings, they must be given appointments for follow-up at the time of discharge, receive information about how they can access mental health care on an emergency basis, and receive follow-up mental health evaluations at least by phone within 1 week of discharge and face-face within 2 weeks of discharge.

From the structured interview, 97 percent of mental health directors of facilities with inpatient units reported giving patients mental health follow-up appointments at the time of discharge. A few facilities expressed the caveat that for unexpected discharges and discharges occurring during the weekend, this is not always possible. A few facilities reported having made wallet appointment cards which are given to patients along with the usual discharge paperwork. Of the facilities with inpatient units, 97 percent reported giving patients information about how to access mental health care on an emergency basis, including the number for the VA national suicide hotline. Some facilities also give patients cards with the suicide hotline number on it.

Consistent with the handbook requirements for timely follow-up after discharge from a mental health inpatient unit, the VHA Office of Quality and Performance, Office of Patient Care Services, and Office of Mental Health Services introduced a new quality monitor for FY09. The monitor measures the percent of inpatient discharges that include at least a bed day of care in a mental health bed-section of care during which the patient received a face-to-face, telehealth, or telephone encounter within 7 days following the discharge date; and if the initial follow-up

encounter was by telephone, a face to face follow-up encounter must occur within 14 days. VHA pulls the data for these measures from the VA National Patient Care Database Outpatient and Inpatient Workload files. In March 2008 prior to the handbook, 46 percent of total patient discharges were seen within 7 days. For February 2009, this increased to 57 percent. The monitor target is 85 percent.

Issue G: Specialized PTSD Services

Veterans with PTSD can be treated in specialized PTSD services, general mental health services, or primary care. The handbook requires that all VA medical centers have specialized outpatient PTSD programs, either a PTSD clinical team (PCT) or PTSD specialists based on locally determined patient population needs, and staff with training and expertise to serve the OIF/OEF veterans either through an OIF/OEF team or PTSD program staff.

In the OIG point of service inventory, 80 percent of VA medical centers indicated having a PCT and 91 percent of respondents reported having a specialized clinic for patients with PTSD. In addition, 61 percent reported having an OIF/OEF PTSD specialty clinic. Some small facilities may have a single PTSD specialist available in general mental health clinic.

From the structured interviews, mental health directors reported an OIF/OEF clinic with specialized mental health services at 65 percent of facilities. Even in the absence of a designated OIF/OEF clinic, 96 percent of facilities reported that they provide outpatient specialized PTSD services for OIF/OEF veterans.

The handbook also states that all VISNs must have specialized residential or inpatient care programs to address the needs of veterans with severe symptoms and impairments related to PTSD and that each VISN must provide timely access to residential care services to address the needs of those veterans with severe conditions.

Specialized inpatient PTSD programs are unusual, as most VA PTSD care was moved to a residential and outpatient basis. Mental health directors reported having a residential PTSD program or an inpatient PTSD program at 33 percent of facilities, excluding the stand alone facility in Columbus, Ohio, the Southeast Louisiana Veterans Hospital in New Orleans, and the medical center in Las Vegas which is presently in transition between locations. Of the facilities without a residential or inpatient PTSD program, 91 percent reported access to a program within the VISN (we counted as a positive response facilities in California that use another facility in California that is not within the VISN). Seventy-three percent reported the ability to reliably access the VISN program; some facilities reported

geographic distance to the VISN program and some reported that patients had to wait 4–8 weeks to start a program within the VISN.[5]

The handbook specifies that all PTSD or specialist programs must be able to address the care needs of veterans with both PTSD and substance use disorders (SUD) by having either distinct PTSD dual diagnosis program tracks or tracks that include providers with specific expertise in both PTSD and SUD; or by putting in place formal mechanisms to support coordination of care for PTSD with that provided by SUD programs.[6]

Mental health directors at 90 percent of facilities demonstrated efforts to address the care needs of veterans with concomitant PTSD and SUD and 76 percent described processes or mechanisms to support the coordination of care for PTSD with that provided in SUD programs. Several facilities have hired or are in the process of hiring a PTSD-SUD psychologist to spearhead efforts to bolster and coordinate PTSD-SUD care.

Although not a handbook requirement, in the OIG web based point of service inventory, 48 percent of facilities reported providing Seeking Safety/Seeking Strength groups. Seeking Safety is a specific form of therapy aimed at helping patients with co-morbid PTSD and SUD issues.

Issue H: Substance Use Disorders

The handbook notes that services addressing substance use conditions can be provided in VA facilities in SUD specialty care, primary care, programs integrating treatment for co-occurring mental health disorders and SUD, and other medical care settings. Regardless of setting, care must recognize the principle that SUDs are, in most cases, chronic or episodic, and recurrent conditions that require ongoing care.

For SUD treatment reluctant patients, the handbook indicates that motivational counseling needs to be available to patients in all settings who need it to support the initiation of treatment. When patients are appropriate for admission and willing to be admitted to inpatient or residential treatment settings for SUD related conditions, but admission is not immediately available, interim services must be provided to ensure patient safety and promote treatment engagement.

Motivational enhancement therapy is an empirically based psychosocial intervention that is more rigorous than motivational counseling. In the web based point of service inventory, 76 percent of facility respondents reported that they

[5] Monitoring and evaluation of a patient with PTSD related issues who was awaiting treatment at a VA residential program was explored in a May 2007 OIG Report: *Healthcare Inspection, Review of the Care and Death of a Veteran Patient, VA Medical Centers St. Cloud and Minneapolis, Minnesota*, No. 07-01349-127, 5/10/2007.
[6] The import of concomitant and coordinated care for patients with PTSD and SUD was highlighted in OIG testimony in front of a May 6, 2008, Committee on Veterans' Affairs, U.S. House of Representatives hearing.

provided some form of motivational enhancement therapy for patients with SUD who delay or resist treatment.

From the structured interview, 16 percent of facilities reported no wait for patients starting residential SUD programs at their facility. For the remaining facilities with some wait, 94 percent reported providing treatment in the interim.

The handbook also indicates that facilities must make medically-supervised withdrawal management available as needed, based on a systematic assessment of the symptoms and risks of serious adverse consequences related to the withdrawal process. Withdrawal management may take place at a VA facility, by referral to another VA medical center, or by a contract or fee-basis arrangement.

Ninety-five percent of facility mental health directors reported that inpatient withdrawal management was available to their patients either on the medical unit, mental health unit, through referral to a nearby VA medical center, or through a non-VA arrangement. Several directors reported follow-up via transfer to a residential, mental health inpatient, or intensive outpatient treatment program (IOP) at discharge.

The handbook specifies the provision of intensive outpatient services for SUD. Such programs must be at least 3 hours per day and at least 3 days per week. The nature of SUD related conditions including the risk for relapse and the frequent co-morbidity of other mental health conditions underscores the importance of available intensive outpatient services for SUD.

From the web based point of service inventory in late 2008, 62 percent of facilities reported having intensive outpatient services available for patients with SUD. By the time of the structured interview in March 2009, 71 percent of facilities reported having these services. Some facilities reported that for patients who live a considerable distance from the facility, temporary housing is arranged to facilitate participation in the program.

The handbook requires that a monitored pharmacotherapy program with approved, appropriately-regulated opioid agonists (e.g., buprenorphine, methadone) be an available option for appropriate patients diagnosed with opioid dependence for whom there are no medical contraindications.

Approximately half of facility respondents to the web based point of service inventory indicated that an opiate substitution program was available at the medical center. Outpatient buprenorphine agonist therapy was available at 38 percent of medical centers and outpatient methadone maintenance was available at 20 percent of sites. Some medical centers have both available. In

addition, some provide these services within a residential program which was not captured in this data.

Issue I: Seriously Mentally Ill and Rehabilitation and Recovery Services

The handbook states that based upon the evidence for the effectiveness of Assertive Community Treatment services as modified for use in the VA, Mental Health Intensive Case Management (MHICM) programs must be available to patients at all facilities with more than 1,500 patients on the Serious Mental Illness Research and Evaluation Center (SMITREC) psychosis registry. At least four full-time "on the street" employees are needed for each MHICM team. "On the street" staff are those who are non-administrative and are out seeing patients in the community.

MHICM is an intensive interdisciplinary, coordinated team approach to management of patients with severe mental illness, primarily psychosis. MHICM differs from usual case management in that clinician-patient interactions occur primarily in the community rather than in the office, a higher clinician to patient ratio, around the clock fixed responsibility over time for the team assigned to a patient, and multiple patient visits per week if needed.

We compared the data list from SMITREC of parent facilities with more than 1,500 seriously mentally ill (SMI) veterans based on the FY07 National Psychosis Registry with NEPEC data indicating staffing and caseload for sites with MHICM teams. We found that all 61 parent facilities with more than 1,500 SMI veterans had MHICM teams. In addition, there were 50 additional MHICM teams at several sites with less than 1,500 SMI veterans and some sites have more than one MHICM team.

We inspected filled clinical FTE data for December 2008 from NEPEC's MHICM monthly FTE Caseload Report. Of the 111 programs, there were 24 with less than 4 "on the street" FTE. For the 61 parent facilities with more than 1,500 SMI patients, 7 had less than 4 "on the street" FTE.

The handbook directs each medical center to maintain the Local Recovery Coordinator Position first authorized in FY07 to help transform local VA mental health services to a recovery-oriented model. The Local Recovery Coordinator's responsibilities include leading the integration of recovery principles into all mental health services, promoting activities to eliminate stigma, providing training and consultation to staff, veterans, and family members, and being directly involved in the provision of recovery-oriented clinical services.

Ninety-three percent of mental health directors reported that a local recovery coordinator was in place at their facility.

According to the handbook, medical centers with more than 1,500 SMI patients on the National Psychosis Registry must have a Psychosocial Rehabilitation and Recovery Center (PRRC). These programs are ambulatory, non-residential day treatment programs aimed at providing a therapeutic and supportive learning environment to facilitate maximization of function. PRRCs provide a menu of daily treatment programming alternatives from which patients can choose to assist in their attainment of treatment goals. PRRC programs must provide an array of services including individual psychotherapy, social skills training, illness management and recovery groups, peer support services, and family educational programs, among others.

Mental health directors reported having a PRRC in place at 51 percent of the medical centers with more than 1,500 SMI patients.

The handbook specifies that Social Skills training, an evidence-based psychosocial intervention aimed at enhancing social functioning in patients affected by SMI and individual or group peer counseling from peer support technicians must be provided when clinically indicated at all medical centers. In addition, compensated work therapy with transitional work experience and supported employment services must be offered.

VHA recently began a rollout of system-wide provider training in the delivery of formal, evidence-based Social Skills training. In the interim, mental health directors reported providing a more general form of Social Skills training at 74 percent of medical centers. SMI peer counseling was in place at 60 percent of facilities and CWT at 90 percent.

Issue J: Homeless Programs and Incarcerated Veterans

The handbook indicates that each facility must develop and maintain collaborative formal or informal agreements with community providers for shelter, temporary housing, or basic emergency services. Also, each VA medical center with an estimated 100 or more homeless veterans in their primary service area must have one Grant and Per Diem Program or alternative residential care setting for homeless veterans.

Ninety-three percent of mental health directors interviewed reported having collaborative agreements in place with community providers for homeless veterans. Although not required, 52 percent of the facilities with agreements reported having at least one written agreement.

We also found that without taking into consideration (eliminating) facilities with less than an estimated 100 homeless veterans in the primary service area,

87 percent of facilities reported having a Grant and Per Diem arrangement in place.

A full-time VISN Health Care for Reentry Veterans Specialist (HCRV Specialist) to support veterans being released from prisons is mandated by the handbook. The HCRV Specialist is to work with point of contacts to engage with veterans being released from prison who are in need of mental health care.

We obtained monthly HCRV Specialist position tracking data (filled, date filled, mental health discipline etc) from the Office of Mental Health Services. As of the end of January 2009, 20 of 21 VISNs had filled the open HVCR positions with full time social workers. The remaining VISN filled the HVCR position with a Health Science Specialist and is advertizing for a social worker to be a HVCR specialist also. In addition, 15 VISNs had a supplemental HCRV Specialist in place at a second site.

Issue K: Integrating Mental Health into Medical Care Settings and in the Care of Older Veterans

As per the handbook, VA medical centers must have integrated mental health services that operate in primary care clinics on a full-time basis. The services need to utilize a blend of co-located collaborative care and care management. Integration of mental health services in primary care clinics directly facilitates access for patients and indirectly by reducing stigma and supporting the New Freedom Commission and MHSP goal of helping patients understand that mental health is an essential component to overall health.

Seventy-eight percent of mental health directors reported the presence of integrated mental health services at primary care clinics.

VA Community Living Centers (CLCs), previously known as Nursing Home Care Units, are required to have integrated mental health services, including at minimum 1 FTE psychologist, to provide services (cognitive testing, psychological assessment and treatment) for facilities with at least 100 beds. The handbook also specifies that each VA Home-Based Primary Care (HBPC) team must have a full-time psychologist or psychiatrist as a core member of the team.

Slightly more than 45 percent of facilities do not have either a CLC or one that is bigger than 100 beds. Of the sites with a CLC to which the requirement applies, two-thirds met the requirement at the time of the interview. From the structured interview, 81 percent of facilities reported having a full-time psychologist or psychiatrist as a core member of the HBPC team.

Issue L: Suicide Prevention

Suicide prevention and VHA's implementation of suicide prevention related items from the mental health strategic plan are discussed in detail in a May 2007 OIG report.[7]

According to the handbook, all patients on inpatient units must be evaluated as clinically indicated for warning signs of self-destructive and dangerous behaviors, including risks of suicide and violence.

> As expected, all facilities with inpatient units reported evaluating for risks of suicide. To explore the issue of evaluation for suicide risk further, we asked how many both completed and documented a formal, multifactor risk assessment on admission, to which 95 percent responded affirmatively. Several mental health directors reported the use of templates, some of which were being used by facilities in their VISN or are used at other VA facilities. Some referenced a template documented in the admission nursing assessment. Although VHA clinicians have developed some formalized risk assessment templates, health care evaluations research is ongoing. At present there is not a uniform, standard "best practices" VHA suicide risk assessment template in use throughout the system.[8]
>
> As discussed in the scope of this report, during onsite visits for OIG CAP reviews, OIG inspectors have been conducting a focused, chart based review of implementation of suicide prevention related items from the handbook. These chart based reviews began in January 2009 and are scheduled to run through June 2009.
>
> Because most suicide prevention related elements in the handbook are linked to the functions of facility suicide prevention coordinators (SPCs), we obtained monthly SPC position tracking data (filled, date filled, mental health discipline, etc.) from the Office of Mental Health Services. As of the end of January 2009, 146 of 154 positions were filled; 1 facility was awaiting human resources processing, 4 were interviewing applicants, 2 were recruiting, and 1 had recently posted the position.

[7] VAOIG Report: *Healthcare Inspection, Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*, No. 06-03706-126, 5/10/2007.
[8] A July 2007 OIG report reviewed a suicide that occurred on a VA inpatient unit. OIG Report: *Healthcare Inspection, Patient Suicide, VAMC Augusta, Georgia*, No. 07-00561-167, 7/11/2007.

Issue M: Uniformity of PTSD Diagnosis and Evidence-Based Treatments

We were asked to review the uniformity of compliance with VHA policies regarding the identification and treatment of post-traumatic stress disorder (PTSD). Initially, we obtained data on unique patient encounters with a primary diagnosis of PTSD for all unique patient encounters at medical centers and affiliated very large CBOCs (greater than 10,000 annual visits) within each VISN. Figure 1 depicts the percentage of unique patients with a primary encounter diagnosis of PTSD, by VISN, seen as a percentage of all unique patients seen at facilities with greater than 10,000 annual encounters. VISN percentages ranged from 4 to 8.8 percent of unique patients seen.

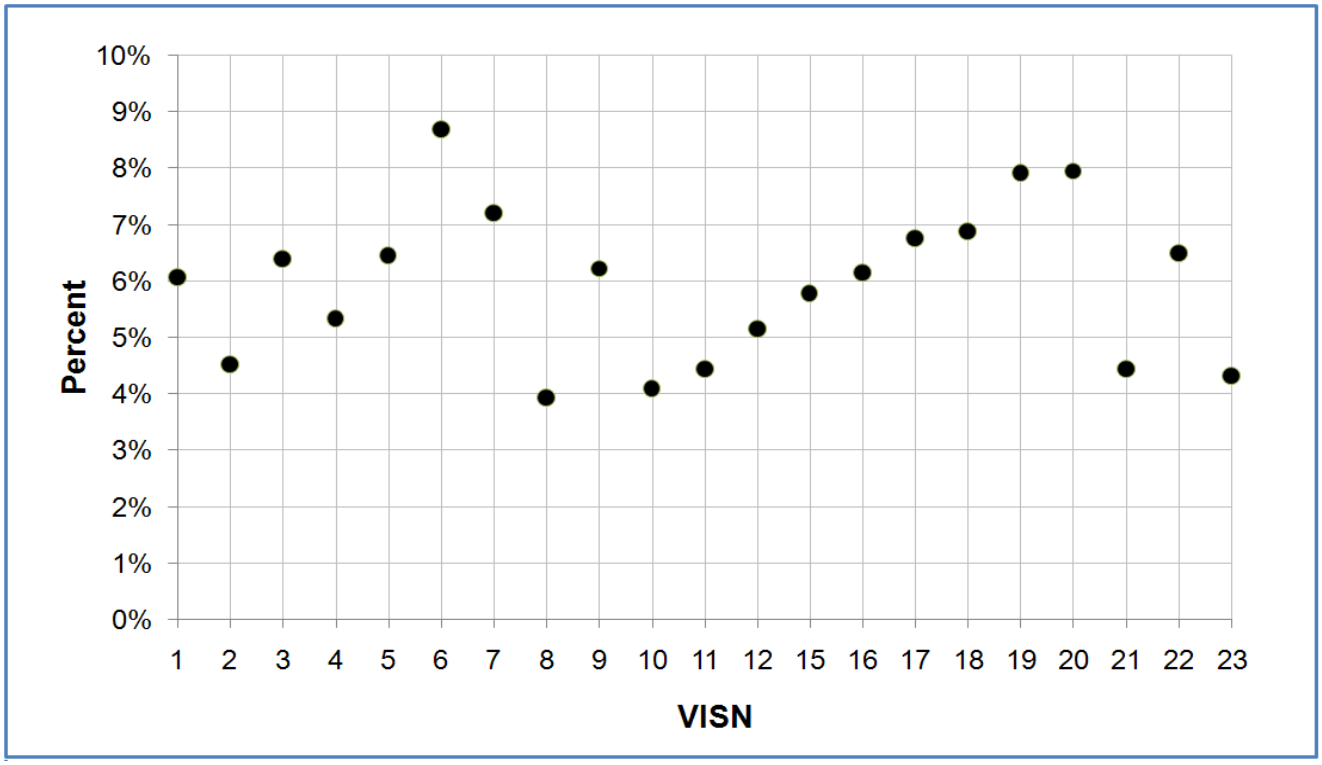

Figure 1. Patients with a primary encounter diagnosis of PTSD, by VISN, as a percentage of all patients seen at facilities with greater than 10,000 annual encounters.

To explore this issue further, we looked at data pertaining to PTSD clinic stop codes. These are clinics or programs that largely serve patients with PTSD and at which we would expect a high concentration of patients with a PTSD diagnosis. Figure 2 depicts patients with a primary encounter diagnosis of PTSD at clinics with PTSD stop codes, by VISN, as a percentage of all patients seen at clinics with PTSD stop codes, for facilities with greater than 10,000 annual encounters.

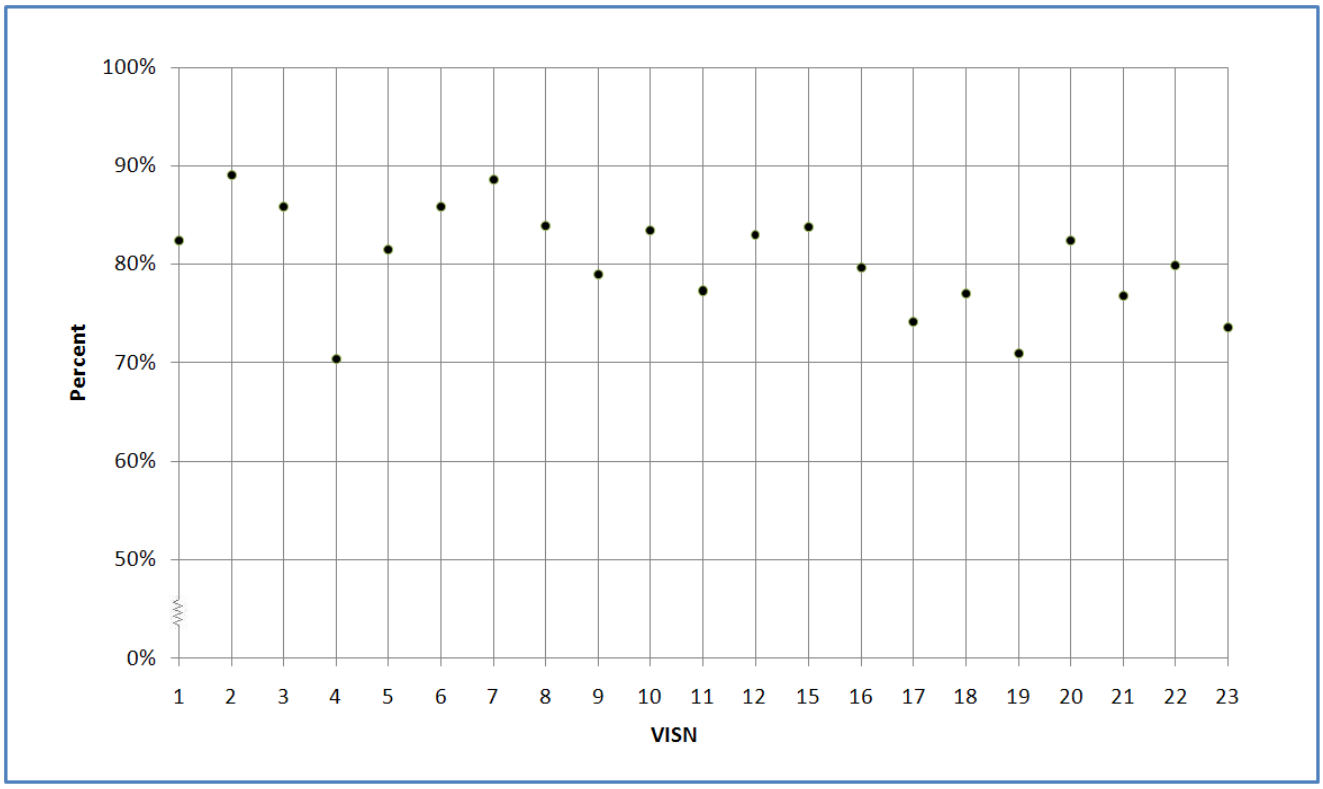

Figure 2. Patients with a primary encounter diagnosis of PTSD at clinics with PTSD stop codes, by VISN, as a percentage of all patients seen at clinics with PTSD stop codes, for facilities with greater than 10,000 annual encounters.

Among VISNs the percentage of unique encounters with a primary diagnosis of PTSD ranged from 71–88 percent. In a recent OIG report, we reviewed multiple charts from a facility's PCT clinic. We found that most patients had more than one diagnosis from encounter to encounter. In addition, although most unique patients seen in the PCT clinic had a diagnosis of PTSD, not all patients had this diagnosis. Some patients had clinical presentations and encounter diagnoses consistent with major depression, adjustment disorders, generalized anxiety disorder, and other non-PTSD anxiety disorders.[9]

There are a few important considerations to keep in mind when interpreting the PTSD diagnosis proportions. It is expected that there is some underlying variation across VISNs in terms of what patients are treated for and their propensity for a PTSD diagnosis. This is likely to be a function of differences in age distribution, gender, and service era, among other major factors. Thus, proportions of patients seen for a PTSD diagnosis are likely to vary as a result of a range of factors, and are not exclusively a function of differences in diagnostic consistency among mental health providers. The analysis is subject to and limited by confounding factors, and interpretation of PTSD

[9] *Healthcare Inspection, Allegations of Mental Health Diagnosis Irregularities at the Olin E. Teague VA Medical Center, Temple Texas*, No. 08-02089-59, 1/28/2009.

diagnosis proportions should be conducted in the context of underlying variability in the patient populations.

A section of the handbook addresses access to specific evidence-based psychotherapies and somatic therapies. It should be noted however, that attention to evidence-based care is present throughout the handbook. The handbook states that all veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) and medical centers must provide adequate staff to allow the delivery of evidence-based psychotherapy when clinically indicated. Additionally, all veterans with depression must have access to Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy.

The Office of Mental Health Services began a system-wide effort to train VA clinicians in core mental health disciplines in CPT in the summer of 2007 and in PE starting in the fall of 2007. System-wide training in CBT and ACT began in the summer of 2008. The Office of Mental Health Services has also begun a formalized system-wide training for social skills therapy. Although mental health clinicians have often been trained in some of the therapies like CBT during their doctoral education or post-doctoral residency training, and may use these therapies in their practices, the Office of Mental Health Service's intent is to provide a more comprehensive training and to promote fidelity to principles and delivery of specific evidence-based psychotherapies. The first step in the training process entails provider participation in experientially based workshops. The second step in the process involves weekly phone consultation with training consultants who are experts in that therapy.

> CPT can be delivered in a group or individual format and PE therapy on an individual basis. In the web based point of service inventory, 89 percent and 63 percent of respondent facilities reported that CPT and PE were available for patients with stress related disorders.

Evidence-based PTSD therapies are relatively time and labor intensive. For example PE sessions may last 90 minutes, and CPT and PE require regular session visits for multiple weeks. At a given facility, factors limiting provision and/or utilization of available evidence-based PTSD therapies may include the number of providers with at least step 1 training; availability of provider time, especially at medical centers in areas where there is a high concentration of returning OIF/OEF veterans; geographic distance to care, availability of mental health providers in rural areas, and patient preference (some patients may opt for other treatment choices.)[10]

[10] Evidence-based PTSD therapy is discussed further in an August, 2008 OIG report: *Healthcare Inspection Post-Traumatic Stress Disorder Program Issues, VA San Diego Healthcare System, San Diego California,* No. 08-01297-187, 8/26/2008. In this report, we commented on the need for the medical center to develop a mechanism to track whether returning OIF/OEF veterans are being offered and provided evidence-based PTSD

At present we are unaware of a system by which VHA reliably tracks provision and utilization of these therapies on a national level. We are aware of at least one residential PTSD program that enters a special progress note template into the electronic medical record that denotes the type of PTSD therapy provided and the session number for each visit. Development of a national system to track provision of evidence-based PTSD therapies and utilization by returning veterans (via template electronic note, special stop code, or other mechanism) would allow for a population based assessment of treatment outcomes with implications for the treatment of other veterans presenting for PTSD related care.[11]

Conclusions:

The President's New Freedom Commission Report laid the conceptual groundwork for the transformation of Mental Health Care in America. The 2004 VHA *Mental Health Strategic Plan* adopted the goals and strategies of the New Freedom Commission Report, adapted these to the VA system, and developed over 200 related initiatives. Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* attempts to further translate the New Freedom Commission Goals and MHSP initiatives into an operational, point of service, programmatic package of approximately 400 mental health services provided or available to eligible veterans at VA medical centers and CBOCs of varying size.

Given the dimension of the handbook, a comprehensive review of the extent of implementation is challenging. We limited the scope of our review to the medical center level. In addition, we chose selected items from the handbook to evaluate for implementation. For each section, there may be items that were not chosen for which the extent of implementation is greater or less. In addition, implementation of the handbook is a dynamic and ongoing process during FY09 and the data presented in the findings do not capture partial implementation. We believe the items chosen reasonably estimate the present extent of handbook implementation at the medical center level at this time.

The following table summarizes our system-wide findings regarding the level of implementation of handbook items at the medical center level:

therapies, whether they opt for treatment with these therapies, how many sessions are utilized by returning veterans, and whether those who start evidence-based therapies complete them.

[11] A recent OIG report: *Healthcare Inspection, Access to VA Mental Health Care for Montana Veterans*, No. 08-00069-102, 3/31/2009, reviews the provision of general mental health treatment, substance use treatment, and evidence-based PTSD therapies to veterans in a large rural state.

VHA Mental Health Services	Extent of Implementation (%)
Community Mental Health	
Collaboration with Vet Centers for Outreach	87
Gender-Specific Care and MST	
Separate and Secure Sleeping and Bathroom	97
Tracking of MST Treatment	82
Availability of evidence-based care for MST	96
24 Hours a Day, 7 Days a Week (24/7) Care	
24/7 ED On-Call MH Coverage	98
Urgent Care On-Call Coverage	100
Availability of 23 Hour Observation Beds	54
Inpatient Care	
Onsite Inpatient Care	79
Ability to Admit Involuntary Patients	92
Ambulatory Mental Health Care	
Follow-Up for new MH Patients	97
Evening MH Clinic Hours	99
Care Transitions	
Set MH Appointment Provided at Discharge	97
Seen for Follow-Up within 1 Week Post- Discharge	57
Specialized PTSD Services	
PCT or Specialized Clinic for Patients with PTSD	91
OIF/OEF Outpatient Clinic Specialized MH Clinic	65
(or) Specialized PTSD Services for OIF/OEF	96
Access to a VISN Specialized PTSD Program	91
Ability to Reliably Access the VISN Program	73
Efforts to Address Concomitant PTSD and SUD	90
Coordination of PTSD and SUD Care	76
Substance Use Disorders	
Available Motivational Counseling	76
Treatment of Patients Awaiting Admission to Residential SUD Settings	94
Inpatient Withdrawal Management	95
Intensive Outpatient Services for SUD	71
Buprenorphine Opioid Agonist Therapy	38
(or) Methadone Opiate Substitution Therapy	20

SMI and Rehabilitation and Recovery Oriented Services	
MHICM Program if More than 1,500 SMI Patients	100
At Least 4 FTE MHICM Team Members	88
Presence of a Local Recovery Coordinator	93
PRRC Program if More than 1,500 SMI Patients	51
Social Skills Training	74
SMI Peer Counseling	60
Compensated Work Therapy	90
Homeless Programs and Incarcerated Vets	
Arrangements with Community Providers for Temporary Housing	93
At Least One Grant and Per Diem Arrangement	87
VISN Health Care for Reentry Veterans Specialist	95
Integrating Mental Health into Medical Care Settings and in the Care of Older Vets	
Integrated MH in Primary Care Clinics	78
At least 1 FTE Psychologist for 100 Bed CLC	67
FT Psychologist /Psychiatrist HBPC Core Team Member	81
Suicide Prevention	
Documentation of a Formal Risk Assessment	95
Suicide Prevention Coordinator in Place	95
Evidence Based Treatment	
Availability of CPT for PTSD	89
Availability of PE for PTSD	63

We would anticipate the extent of implementation at medical centers to exceed that seen at the CBOC level. Smaller and rural CBOCs may face obstacles to implementation including geographic distance to care and ability to recruit mental health providers, among others.

We found that some facilities were unclear as to facility level status and therefore were unclear whether onsite emergency department requirements have been met.

At present we are unaware of a system by which VHA reliably tracks provision and utilization of evidence-based PTSD therapies on a national level. Development of a national system to track provision of evidence-based PTSD therapies and utilization by

returning veterans would allow for a population based assessment of treatment outcomes with implications for the treatment of other veterans presenting for PTSD related care.

The handbook is an ambitious effort to enhance the availability, provision, and coordination of mental health services to veterans. The handbook notes that metrics will be used to ensure implementation of requirements. Program evaluation and development of mental health outcome measures can be challenging. As implementation further progresses, VHA should develop metrics and outcome measures where feasible to allow for dynamic refinement of program requirements in order to meet changes in mental health needs and care utilization patterns of veterans.

This inspection reports on the system-wide implementation status of VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*. Because facilities have until the end of FY09 to fully meet the handbook requirements, we made no recommendations at this time.

Department of Veterans Affairs **Memorandum**

Date: April 6, 2009

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, *Implementation of VHA's Uniform Mental Health Services Handbook*, Project No. 2008-02917-HI-0179 (WebCIMS 426570)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I appreciate the thoughtful review of VHA's progress in implementing the Uniform Mental Health Services Handbook. I concur with the draft report and agree on the importance of the Handbook in ensuring that the initiatives outlined in the VHA Mental Health Strategic Plan are translated into providing the necessary comprehensive, evidence-based mental health services for our Nation's Veterans.

2. Considering that VHA facilities have until the end of Fiscal Year (FY) 2009 to implement the handbook's requirements, I am generally encouraged by our progress as reported in your draft report. While acknowledging that VHA still needs to improve implementation in certain areas and ensure implementation of the Handbook at community-based outpatient clinics as well, I am optimistic about forecasts for full implementation.

3. In regards to the report's finding that VHA lacks a system that reliably tracks provision and utilization of evidence-based post-traumatic stress disorder (PTSD) therapies on a national level, I want to emphasize that, currently, there is no standard mechanism for doing this in any health care system. Nonetheless, VA is taking actions at multiple levels to promote the dissemination of evidence-based psychotherapies (EBPs) throughout VHA, and I strongly agree with the report's conclusion on the importance of tracking the provision and utilization of EBPs.

4. VHA is developing specific mechanisms to track the utilization and delivery of EBPs for PTSD and other mental disorders. Chief among these efforts is the development of EBP templates for different evidence-based therapies that will be input into the electronic medical record system. Clinicians will use the

templates to enter progress notes when one of the EBPs is delivered, and the templates will mark the service being delivered as an EBP service. Additionally, the templates also provide a heuristic device to help guide clinical decision making for the clinician. Full availability of the templates at all sites is targeted for completion by the end of FY 2009. Moreover, VHA has placed a Local EBP Coordinator at each medical center that will facilitate the implementation of evidence-based psychotherapies at the local level. The Local EBP Coordinators will help to implement and track the use of these templates. In addition to the development of the EBP templates, VHA has initiated a survey process to track the availability and delivery of EBPs.

5. I also agree with your report's statement that as implementation of the handbook progresses, VHA needs to further develop metrics and outcome measures where feasible to allow for program evaluation and dynamic refinement of program requirements. As your report mentions, VHA has multiple performance measures already in place related to implementation of the Uniform Mental Health Services Handbook. In addition to those you reviewed for the report, another relevant measure that VHA currently utilizes is an extensive check list capturing program coverage at all facilities and community-based outpatient clinics. This checklist was developed by the Office of Mental Health Services (OMHS) to provide formative evaluation for use in an extensive process of providing technical assistance to the Veterans Integrated Service Networks regarding implementation of the handbook. This checklist also will be used to monitor ongoing progress in implementation. Lastly, OMHS is currently working to develop additional measures to provide summative evaluation.

6. In closing, my staff has informed me that they have already discussed and resolved certain issues with members of your review team. Thank you for the opportunity to review this report and your willingness to collaborate with my staff to ensure that the final report is accurate and clear. If you have any questions, please contact Margaret Seleski, Director, Management Review Service (10B5) at (202) 461-8470.

(original signed by:)
Michael J. Kussman, MD, MS, MACP

Appendix A

OIG Contact and Staff Acknowledgments

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Appendix B

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