Statement of
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Before the Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives
Hearing on *Charting the VA's Progress on Meeting the Mental Health Needs of Our Veterans: Discussion of Funding, Mental Health Strategic Plan, and the Uniform Mental Health Services Handbook*
April 30, 2009

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today regarding VA's progress toward meeting the mental health needs of our veterans. I will focus on the results of two reports that we recently released in this area: *Healthcare Inspection – Implementation of Veterans Health Administration's Uniform Mental Health Services Handbook* and *Audit of Veterans Health Administration Mental Health Initiative Funding.* I am accompanied by Larry Reinkemeyer, Director of the Office of Inspector General's (OIG) Kansas City Audit Operations Division, who directed the audit project.

Background
The 2003 President's New Freedom Commission Report identified 6 goals and made 19 broad recommendations for transforming the delivery of mental health services in the United States. In 2004, the Veterans Health Administration (VHA) developed its 5-year Mental Health Strategic Plan (MHSP) that included more than 200 initiatives. Because the MHSP is organized by the goals and recommendations of the Commission's report rather than by a mental health program or operational focus, some MHSP initiatives do not delineate what specific actions should be carried out to achieve these goals and are not readily measureable.

The VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, issued in June 2008 and updated in September 2008, establishes minimum clinical requirements for VHA mental health services. The handbook outlines those services that must be provided at each VA Medical Center (VAMC), and services required by the size of community based outpatient clinics (CBOCs).

Although there is overlap between MHSP and handbook items, the handbook more clearly defines specific requirements for services that must be provided (i.e., 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 (i.e., those that must be made accessible when clinically needed to patients receiving health care from VHA). The handbook has an operational focus and is organized by mental health program areas (e.g., Homeless Programs) rather than by broader Commission goals. 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."

Overall, VA medical facilities are expected to implement the handbook requirements by the end of fiscal year (FY) 2009. Each Veterans Integrated Service Network (VISN) must request approval from the Deputy Under Secretary for Operations and Management for modifications and exceptions for requirements that cannot be met in FY 2009 with available and projected resources.

Healthcare Inspection – Implementation of VHA's Uniform Mental Health Services Handbook

Because there are over 400 implementation items in the handbook, we limited the scope of our review to the medical center level where full implementation is more likely to occur prior to CBOC level implementation. Accordingly, the extent of implementation presented in the findings represents the highest level currently attained for the system as a whole.

Given the dimension of the handbook, a comprehensive review of the extent of implementation is challenging. Based on our clinical judgment, we chose 41 items from the handbook to evaluate for implementation. We believe the items chosen reasonably estimate the present extent of handbook implementation at the medical center level. Implementation of the handbook is an ongoing process and the data presented does not capture partial implementation.

We found that 31 of the 41 items reviewed were implemented at more than 75 percent of VAMCs. For example, evening mental health clinic hours were in place at 99 percent of VAMCs. As another example, Mental Health Intensive Case Management programs were in place at 100 percent of facilities with more than 1,500 seriously mentally ill (SMI) patients from the VA National Psychosis Registry. A complete listing of items reviewed and implementation rates is included at the end of the statement.

We identified the following items indicative of areas in which VHA is at risk for not meeting the implementation goal:

- Ensuring a follow-up encounter within 1 week of discharge from an inpatient mental health unit.
- Accessing timely a VISN specialized post-traumatic stress disorder (PTSD) residential program.
- Providing Intensive Outpatient Services (at least 3 hours per day at least 3 days per week) for treatment of substance use disorders.
- Availability of 23-hour observation beds.
- Availability of substitution therapy for narcotic dependence.
- Providing a psychosocial rehabilitation and recovery center program at facilities with more than 1,500 SMI patients.
- Availability of peer support counseling for SMI patients.
- The presence of at least one full-time psychologist to provide clinical services to veterans in VA community living centers (formerly nursing home care units) with at least 100 residents.

Additionally, we are concerned that while a section of the handbook addresses access to specific evidence-based psychotherapies and somatic therapies, it appears that VA does not have in place

a system to reliably track provision and utilization of these therapies on a national level. VHA's Office of Mental Health Services (OMHS) began a system-wide effort to train VA clinicians in core mental health disciplines in cognitive processing therapy for PTSD in the summer of 2007 and in prolonged exposure therapy in the fall of 2007. Evidence-based PTSD therapies are relatively time and labor intensive, requiring regular sessions for multiple and consecutive weeks. At a given facility, factors limiting provision and/or utilization of available evidence-based PTSD therapies may include the number of trained providers; availability of provider time, especially at medical centers in areas where there is a high concentration of returning Operation Iraqi Freedom/Operation Enduring Freedom veterans; geographic distance to care; availability of mental health providers in rural areas; and patient preference for other treatment choices. Implementation of a national system to track provision of evidence-based PTSD therapies and their utilization by returning veterans would allow for a population-based assessment of treatment outcomes with implications for treatment of other veterans presenting for PTSD-related care.

Program evaluation and development of mental health outcome measures can be challenging. While VA has relevant performance measures and systems in place to monitor handbook implementation, VA should develop outcome measures where feasible to allow for dynamic refinement of program requirements in order to meet changes in mental health needs and to optimize treatment efficacy.

While this review contains items related to suicide prevention, we began a separate review of implementation of suicide prevention items in the handbook in January 2009. During our combined assessment program reviews, OIG inspectors have been conducting a focused, chart-based review of implementation. We will conclude our review in June 2009 and then issue a roll-up report on our findings.

Audit of Veterans Health Administration Mental Health Initiative Funding

In the FY 2008 budget submission to Congress, VHA requested $27.2 billion for medical services which included $360 million for the mental health initiative (MHI). Congress appropriated $29.1 billion to VHA for medical services but did not specify an amount for the MHI. In FY 2008, VHA augmented the $360 million it requested for the MHI with funds received as part of its overall funding for medical services and allocated $371 million to medical facilities for the MHI.

OMHS refined their method of allocating the MHI funding over the years. In FYs 2005 and 2006, OMHS allocated MHI funds to medical facilities based on proposals that detailed the specific projects and how the facilities would spend those MHI funds. In FY 2007 and 2008, OMHS allocated funds to continue the initiatives started in prior fiscal years (primarily to pay the salaries of MHI staff already hired) and to implement selected new nationwide initiatives, such as having a Suicide Prevention Coordinator at each facility.

In the FY 2008 VA budget submission, VHA requested funding to provide resources to continue the implementation of the MHI. VHA allocated these funds to programs that covered the specific initiatives identified in the MHSP.

Our objective for this audit was to determine if VHA had an adequate process in place to ensure funds allocated for the MHI were tracked and used accordingly. We found that VHA staff adequately tracked $371 million allocated for the MHI in FY 2008. At the six locations reviewed (New York, NY; Miami, FL; Milwaukee, WI; Jackson, MS; Alexandria, LA; and San Diego, CA), medical facilities' fiscal staff established multiple fund control points and tracked salary and purchase order costs for the MHI. VHA's Office of Finance staff compared the amounts spent to the amounts allocated. OMHS staff used reports from medical facilities to track the hiring status of MHI positions. Although our review covered only FY 2008 processes, in FY 2009, the Office of Finance established standardized account classification codes for MHI funds that could further enhance transparency and accountability over how MHI funding is spent in the future.

We also found that medical facilities used funds allocated for MHI as intended. VHA allocated $19.4 million for the MHI to the six medical facilities we reviewed and confirmed that $18.2 million (94 percent) of the $19.4 million were used for the MHI. The remaining $1.2 million consisted of numerous small dollar purchases; therefore, we reviewed those purchases only to the extent we were able to confirm the funds were used for mental health.

Conclusion

We believe that VHA Handbook, *Uniform Mental Health Services in VA Medical Centers and Clinics*, is an ambitious effort to enhance the availability, provision, and coordination of mental health services to veterans and that VHA has made progress in implementation at the medical center level. Because our review was limited to medical centers, we plan to conduct a review in FY 2010 on implementation at the CBOC level where such factors as geographic distance to care and ability to recruit mental health providers may pose greater obstacles to implementation. In regard to MHI funding, we found that VHA adequately tracks and uses MHI funding as intended.

Mr. Chairman, thank you again for this opportunity to appear before the Subcommittee. We would be pleased to answer any questions that you or members of the Subcommittee may have.

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

VHA Mental Health Services	Extent of Implementation (%)
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