



Testimony  
Before the Committee on Veterans'  
Affairs, U.S. Senate

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# VA MENTAL HEALTH

## Action Needed to Improve Access Policies and Wait- Time Data

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Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

I am pleased to be here to discuss our report that is being released today on veterans' access to VA mental health care, the latest review from our extensive work in recent years on veteran's access to care.<sup>1</sup>

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has seen a 63 percent increase in the number of veterans receiving mental health care between 2005 and 2013. VHA reported a significant portion of this increase was due to an influx of veterans returning from the conflicts in Iraq and Afghanistan, and to its proactive screening to identify veterans with symptoms that may be associated with depression, post-traumatic stress disorder (PTSD), substance abuse disorder, or who may have experienced military sexual trauma. In fiscal year 2014, VHA spent more than \$3.9 billion providing outpatient specialty mental health care in its facilities, and more than \$34 million for outpatient specialty mental health care provided by non-VA providers.<sup>2</sup>

In recent years, we and others have expressed concerns about veterans' ability to access timely health care, including mental health care, and VHA's oversight of patient scheduling practices, particularly the reliability of reported patient wait times and weaknesses in appointment scheduling

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<sup>1</sup>GAO, VA Mental Health: *Clearer Guidance on Access Policies and Wait-Time Data Needed*, [GAO-16-24](#) (Washington, D.C.: Oct. 28, 2015). See also GAO, *VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care*, [GAO-14-808](#) (Washington, D.C.: Sept. 30, 2014); *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, [GAO-13-130](#) (Washington, D.C.: Dec. 21, 2012); *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, [GAO-12-12](#) (Washington, D.C.: Oct. 14, 2011); and *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, [GAO-10-294R](#) (Washington, D.C.: Mar. 10, 2010).

<sup>2</sup>See Department of Veterans Affairs, *Volume II Medical Programs and Information Technology Programs Congressional Submission Fiscal Year 2016 Funding and Fiscal Year 2017 Advance Appropriations Request* (Washington, D.C.). The 2014 federal fiscal year ended on September 30, 2014. As a result, recent programs that provide additional options for non-VA care to veterans are not included in this amount.

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oversight.<sup>3</sup> For example, in 2012, the VA Office of Inspector General (OIG) reported that VHA was not consistently providing new veterans with timely access to comprehensive mental health evaluations, and had overstated its success in providing veterans with timely appointments for mental health treatment. An August 2012 Executive Order directed VHA to improve mental health care access by, among other things, hiring additional staff and gauging the effectiveness of the use of community-based providers by establishing a community provider pilot program.<sup>4</sup> In addition, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), enacted in August 2014, provided additional non-VA care options for veterans facing long waits or lengthy travel distances to obtain VHA health care services.<sup>5</sup>

In this context, my testimony today summarizes the findings from our report being released today on veterans' access to mental health care services, which addresses

1. veterans' access to timely mental health care;
2. VHA's oversight of timely access to mental health care;
3. VHA's hiring of mental health staff since 2012 and the effects of that hiring on access to mental health care; and
4. VHA's community provider pilot program's effects on veterans' access to mental health care.

To examine these issues we conducted site visits to five VA medical centers (VAMC) and their affiliated community-based outpatient centers (CBOC), which were selected for variation in mental health utilization, geographic location, and participation in the community provider pilot program, among other factors.<sup>6</sup> For each of the five VAMCs we visited,

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<sup>3</sup>See [GAO-14-808](#), [GAO-13-130](#), [GAO-12-12](#), [GAO-10-294R](#). See also Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Review of Veterans' Access to Mental Health Care*, Report No. 12-00900-168 (Washington, D.C.: Apr. 23, 2012).

<sup>4</sup>Executive Order No. 13625, 3 C.F.R. 302 (Aug. 31, 2012): *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*.

<sup>5</sup>Pub. L. No. 113-146, 128 Stat. 1754 (Aug. 7, 2014).

<sup>6</sup>The sites visited were Atlanta VAMC (Decatur, Georgia); George H. O'Brien, Jr. VAMC (Big Spring, Texas); Hunter Holmes McGuire VAMC (Richmond, Virginia); Portland VAMC (Portland, Oregon); and Sioux Falls VA Health Care System (Sioux Falls, South Dakota).

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we reviewed a randomly selected sample of 20 outpatient medical records to assess the timeliness in which veterans received mental health appointments. Due to the small sample size of our medical record reviews, the results cannot be generalized across any single VHA facility or to all VHA facilities. We also reviewed relevant VHA policies, federal internal control standards, and other key documents, as well as interviewed staff from VHA's central office, the five selected VAMCs, and the five corresponding Veterans Integrated Service Networks (VISN) that oversee them, among others.<sup>7</sup> We limited our scope to outpatient specialty mental health care, which we refer to as mental health care, because the majority of veterans with either a possible or a confirmed mental illness, about 70 percent and 85 percent respectively, obtain outpatient mental health care through VHA.<sup>8</sup> Additional information on our scope and methodology is available in our report. The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards.

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<sup>7</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1999).

For example, we also interviewed staff from Vet Centers and veteran service organizations.

<sup>8</sup>Outpatient specialty mental health care generally refers to mental health services provided by a mental health specialist (e.g., psychiatrist, psychologist, social worker, or counselor) in an outpatient setting (i.e., receiving medical treatment without being admitted to a hospital).

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## Most Veterans in Our Review Received Care within 30 Days of Their Preferred Dates, but VHA's Method of Calculating Wait Times Does Not Always Reflect Overall Wait Times

The 100 veterans included in our review received a full mental health evaluation in an average of 4 days of the date they preferred to be seen (known as the preferred date). The full mental health evaluation is the primary entry point to mental health care. At the five VAMCs we visited, the average time in which a veteran received this full evaluation ranged from 0 to 9 days from the preferred date.

However, we identified conflicting VHA policies regarding how long it should take a new veteran to receive a full mental health evaluation: (1) a 14-day policy established by VHA's *Uniform Handbook for Mental Health Services*, and (2) a 30-day policy set by VHA in response to the Choice Act.<sup>9</sup> To date, VHA has not provided guidance on which policy should be followed, which is inconsistent with federal internal control standards that call for management to clearly document, through management directives or administrative policies, significant events or activities, such as ensuring timely access to mental health care, to help ensure management directives are carried out properly.<sup>10</sup> A number of VHA officials, including VISN and VAMC officials, told us they do not know which policy they are currently expected to meet, which makes it difficult for them to ensure timely access to care in light of increasing demand for mental health care. As a result, we recommended VHA issue clarifying guidance on the access standard for new veterans seeking mental health care. VA concurred with this recommendation, stating that it is in the process of revising the relevant policy in the *Uniform Handbook* to be consistent with the 30-day wait time goal established in response to the Choice Act. VHA stated that it is targeting issuance of the revised policy and clarifying guidance for March 2016.

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<sup>9</sup>Department of Veterans Affairs, *Uniform Mental Health Services in VA Medical Centers and Clinics*, Veterans Health Administration Handbook 1160.01 (Washington, D.C.: Sept. 11, 2008). The *Uniform Handbook* has an expiration date of September 30, 2013, however, VHA officials told us that it is still in effect and no update has been published.

VHA also has a policy that states that veterans who are new to mental health should receive initial assessments within 24 hours to identify those with urgent care needs. VHA officials told us that because these assessments can be completed by a number of providers, including the referring provider, they do not have a way to consistently track them. As a result, VHA cannot determine whether these initial assessments are being completed in a timely manner.

<sup>10</sup>[GAO/AIMD-00-21.3.1](#).

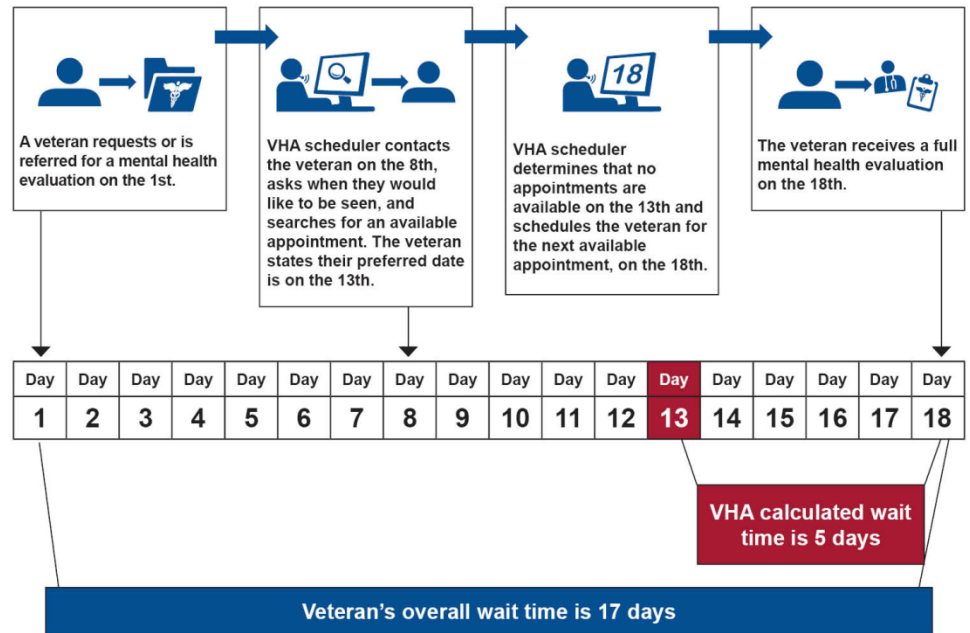
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Further, although the average time between veterans' preferred dates and their full mental health evaluations in our review were generally within several days, that time did not always reflect how long veterans may have actually waited for mental health care. Because VHA uses a veteran's preferred date as the basis for its wait-time calculations, rather than the date that the veteran initially requests or is referred for mental health care, these calculations only reflect a portion of a veteran's overall wait time.<sup>11</sup> While some of the delay in care may be attributed to a veteran not wanting to start care immediately, we also found that some delays were because a facility did not adequately handle a referral or request for mental health care. In our review of 100 veteran records, we found that significant delays can occur if the referral or request for an appointment is not processed correctly or in a timely manner. For example, one veteran in our review waited 174 days between the initial referral for mental health care and the veteran's preferred date due to a referral not being appropriately managed. The veteran's primary care provider was to have placed a referral to psychology in March 2014, but our review of the medical record found no evidence of the referral ever being placed. Nonetheless, the veteran's primary care provider alerted a VHA psychologist who reached out to the patient in March 2014, by phone, but did not leave a message. No VAMC mental health provider reached out again until September 2014, after the veteran's primary care provider made a referral (this time appropriately requested). The veteran was then able to schedule a full mental health evaluation approximately 1 week later. On average, our review of 100 new veteran medical records found that a veteran's preferred date was 26 days after his or her initial request or referral for mental health care, though this varied by VAMC. (See fig. 1.)

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<sup>11</sup>Most of the veterans whose records we reviewed, 59 of 100, accessed mental health through a primary care referral.

**Figure 1: Illustration of How Overall Wait Time May Differ from Veterans Health Administration's (VHA) Calculated Wait Time**



Sources: VHA (information) and GAO (illustration). | GAO-16-170T

In commenting on a draft of our report, VHA confirmed that they measure wait times from preferred date to when the appointment occurs. However, they disagreed with our calculations of the overall wait time for veterans to receive full mental health evaluations, noting that these calculations do not capture situations outside of their control, such as when a veteran wants to delay treatment. Our calculations illustrate that the use of the preferred date does not always reflect how long veterans are waiting for care or the variation that exists not only between, but within, VAMCs. During the period of time prior to establishing the preferred date, we found instances of veterans' requests or referrals for care being mismanaged or lost in the system, leading to delays in veterans' access to mental health care. Our current and previous work, along with the work of VA OIG, highlights the limitations of VHA's current scheduling

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practices, including wait time calculations.<sup>12</sup> In December 2012, we recommended that VHA take actions to improve the reliability of wait-time measures by clarifying the scheduling policy or identifying clearer wait-time measures that are not subject to interpretation or prone to scheduler error. VHA has not yet implemented this recommendation, and we continue to believe that implementation of this recommendation would improve the reliability of wait time measures.

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## VHA Monitors Access to Mental Health Care, but Current Policies Cannot Ensure Reliable Data, Which Precludes Effective Oversight

VHA monitors access to mental health care, but the lack of clear policies may contribute to unreliable wait-time data and precludes effective oversight. Among other reasons contributing to the potential unreliability of VHA wait-time data, we found VHA's wait-time data may not be comparable over time or between VAMCs.

- **Data may not be comparable over time.** VHA has changed the definitions used to calculate various mental health wait-time measures, and a number of VHA officials we interviewed, including VAMC and VISN officials, told us they were not sure which definitions for new mental health patients were in effect for calculating wait-time measures or gave conflicting answers about which definitions were being used. VHA has not clearly communicated the definitions used or changes made to these definitions used in its wait-time calculations, which is contrary to federal internal controls standards that call for management to communicate reliable and relevant information in a timely manner. This limits the reliability and usefulness of these data in determining progress in meeting stated objectives for veterans' timely access to mental health care. As a result, we recommended that VHA issue guidance about the definitions used to calculate wait times, such as how a new patient is defined, and communicate any changes in wait-time data definitions within and outside VHA. VHA concurred with our recommendation and stated that it plans to publicly provide an updated data definition document in October 2015 and will issue an information letter in November 2015 that contains sources where both internal and external stakeholders can locate the

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<sup>12</sup>Department of Veterans Affairs, Office of Inspector General, *Review of Veterans' Access to Mental Health Care*. The OIG recommended that VHA revise the full mental health evaluation measurement to better reflect the veteran's experience from the point of first contact with mental health care to the completion of the full mental health evaluation.



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definitions used to calculate wait times, including how a new patient is defined.

- **Data may not be comparable between VAMCs.** When VAMCs use open-access appointments, data may not be comparable across VAMCs. Open-access appointments are typically blocks of time for veterans to see providers without a scheduled appointment. In these cases, because appointments are not scheduled until veterans come to the medical center, the preferred and appointment dates are the same and wait times are calculated as 0 days, regardless of when veterans initially requested or were referred for mental health care. We found inconsistencies in the implementation of these appointments, including one VAMC that was referring veterans to these open-access appointments after an initial evaluation by phone rather than rather than being given specific appointments. Those veterans who were referred to the open-access appointments were tracked using a manually maintained list outside of VHA's scheduling system. We found that follow-up with these veterans was inconsistent, and nearly half never showed up to the open-access appointments. VHA does not have guidance that clarifies how to manage and track open-access appointments, which is inconsistent with federal internal controls that call for management to clearly document policies for significant activities to help ensure management's directives are carried out properly. As a result, officials at the VAMCs that used open-access appointments said they were unclear about how they could be used, how they should be entered into VHA's scheduling system, and whether local tracking mechanisms were compliant with VHA scheduling policies. Without guidance on how appointment scheduling for open-access clinics is to be managed, VAMCs can continue to implement these appointments inconsistently, and place veterans on lists outside of VHA's scheduling system, potentially posing serious risks to veterans needing mental health care.

As a result, we recommended VHA issue clarifying guidance on how open-access appointments are to be managed. VHA concurred with our recommendation, stating that it conducted training during the summer of 2015 for schedulers based on existing VHA policy that included instructions on how to schedule same-day appointments, which VHA considers to include open-access appointments. VHA further stated its plans to aggressively monitor appointment management and identify areas of local inconsistency in scheduling procedures. However, VHA's description of same-day appointments does not capture the circumstances we observed during our review, in which veterans who would normally be given an appointment were instead referred to an

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open-access clinic. We reviewed the training that VHA said was provided to schedulers, but it did not address the circumstances we described. Given differences between types of same-day appointments (e.g., walk-in clinics where no prior evaluation may be required and open-access clinics that include an evaluation prior to referral), issuing specific guidance for open-access appointments would help to ensure veterans are getting their needs served and to improve data comparability across VAMCs.

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## VHA's Hiring Initiative Met Goals, but VAMCs Reported Continued Challenges in Hiring Mental Health Staff and Meeting the Growing Demand for Mental Health Care

VHA hired about 5,300 new clinical and non-clinical mental health staff between June 2012 and December 2013 for both its inpatient and outpatient programs, meeting the goals of its hiring initiative.<sup>13</sup> Officials at the five VAMCs we visited reported local improvements in access to mental health care due to the additional hiring. For example, officials at one VAMC reported being able to offer more evidence-based therapies. Officials at this VAMC, as well as officials from another VAMC and two CBOCs, cited the ability to provide mental health care at new locations where they were previously unable to do so.

Although VHA considered their hiring initiative a success because it met its goals, the five VAMCs we visited still had mental health staff vacancy rates ranging from 9 to 28 percent, and 4 of the 5 VAMCs were unable to meet overall demand for mental health services.<sup>14</sup> Officials at the five VAMCs reported a number of challenges in hiring and placing mental health providers, including

- pay disparity with the private sector;
- competition among VAMCs filling positions at the same time;

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<sup>13</sup>VHA increased mental health staff at its facilities nationwide through a two-part hiring initiative: (1) VHA's recruitment effort focused on hiring 1,600 new mental health professionals, 300 new non-clinical support staff (such as scheduling clerks), and filling existing vacancies starting in June 2012; and (2) Executive Order 13265, issued in August 2012, which authorized the hiring of 800 peer specialist positions by December 31, 2013, along with reiterating VHA's goal of hiring 1,600 new mental health professionals by June 30, 2013. VHA officials told us total staff hired does not reflect the total number of staff on board in their positions as of June 30, 2013, as some staff may have left their positions prior to the end of the hiring initiative, necessitating additional hiring.

<sup>14</sup>Vacancies include both inpatient and outpatient staff positions, and only those administrative positions included in VHA's hiring initiative. The director of the VHA office responsible for maintaining the vacancy data told us that these data may include some staff time used for clinical, research, teaching, and administrative activities.

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- lengthy VHA hiring process;
  - lack of space for newly hired mental health staff;
  - lack of support staff to assist providers; and
  - nationwide shortage of mental health professionals.

Despite VHA's hiring initiative, additional staff likely will be needed to meet VHA's growing demand for mental health care.<sup>15</sup> In an April 2015 report, VHA projected a roughly 12 percent increase in mental health staff would be needed to maintain the current veteran staffing ratios for fiscal years 2014-2017.<sup>16</sup>

To address some of the mental health hiring challenges, VAMCs reported using various recruitment and retention tools, including hiring and retention bonuses, student debt repayment, and using internships and academic affiliations to find potential recruits. In November 2014, VHA raised the annual salary ranges for all physicians system-wide, including psychiatrists, to enhance the agency's recruiting, development, and retention abilities.<sup>17</sup> Officials at the five VAMCs we visited also described strategies they used to manage demand for mental health care in light of staffing challenges, including (1) increasing the use of telehealth and group therapy (rather than individual therapy); (2) addressing space and staffing constraints by sharing offices or altering provider schedules; and (3) referring veterans to other VA locations when a preferred CBOC was not available.

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<sup>15</sup>For example, from fiscal year 2010 through fiscal year 2014, the number of veterans receiving outpatient mental health care increased from 1,259,300 to 1,533,600, a 22 percent increase that also outpaced the general growth in the number of veterans using VHA services overall. VHA attributed the increased demand for mental health care to the influx of veterans returning from the recent conflicts in Iraq and Afghanistan, increased proactive screening efforts, and VHA's increased capacity to provide mental health care.

<sup>16</sup>Department of Defense and Department of Veterans Affairs, *DOD/VA Report to the Congress in Response to Senate Report 113-44, pg. 133, Accompanying S. 1197, the National Defense Authorization Act for Fiscal Year 2014: Mental Health Counselors for Service Members, Veterans, and their Families* (Washington, D.C.: Apr. 17, 2015).

<sup>17</sup>79 Fed. Reg. 56125 (Sept. 18, 2014). See 38 U.S.C. § 7431, which sets forth requirements for setting salary ranges for VHA physicians and dentists.

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## VHA's Community Provider Pilot Program Expanded Access to Mental Health Care for a Limited Number of Veterans; VAMCs Reported Successes and Challenges

In 2013, 10 VAMCs across VHA participated in a pilot that established partnerships with 23 community mental health clinics (CMHCs), as required by an August 2012 Executive Order in an effort to help VHA meet veterans' mental health needs; these CMHCs provided mental health care to a limited number of veterans.<sup>18</sup> Veterans received approximately 2,400 mental health appointments through the CMHCs, which accounted for approximately 2 percent of the total mental health care provided across the 10 participating VAMCs. Nearly half of the care provided through the pilot program was through partnerships with the Atlanta VAMC. The most common service veterans received was individual therapy or counseling, but other commonly provided services included group therapy, medication management, and treatment for substance abuse. According to VHA's survey of veterans who received care through the CMHCs during the pilot, veterans were generally satisfied with the care they received.

VHA and CMHC officials in our review described a number of successes and challenges related to the pilot program. Successes included improved capacity and communication. For example, officials at one VAMC said they would not have been able to maintain mental health care access at current levels without the capacity provided by the pilot sites. Additionally, officials at three VAMCs said their partnerships allowed them to expand access by providing additional and more convenient care to veterans living in rural areas. VAMC and CMHC officials also said that having a VAMC liaison on site or a dedicated point of contact improved communication, which helped facilitate veterans' access to care.

Challenges with the community provider pilot included a number of administrative issues, including challenges with the timely receipt of medical documentation and payment for services, as well as technical challenges, particularly related to the transfer of medical files and the use of telemental health technology. Other challenges included confusion among some VAMC officials about the different non-VA programs available to veterans and concerns about the appropriateness of care, including whether there were a sufficient number of community providers

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<sup>18</sup>While VHA reported that 12 VAMCs established partnerships with CMHCs, the pilot program at one VAMC was never fully implemented and no veterans were referred to care. Similarly, another VAMC identified two potential sites, but never referred any patients for care.

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with the necessary training and experience to provide culturally competent and high-quality care to veterans.<sup>19</sup>

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Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, this concludes my prepared statement. I would be pleased to answer any questions that you may have at this time.

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## GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Debra A. Draper at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Lori Achman, Assistant Director; Jennie F. Apter; Jacquelyn Hamilton; Eagan Kemp; Vikki L. Porter; and Malissa G. Winograd.

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<sup>19</sup>Some of the VAMCs in the pilot program extended their partnerships with the CMHCs after the pilot program's ended, but VHA has indicated that the Patient Centered Community Care (PC3) program and the Veterans Choice Program (VCP) are now the primary programs for obtaining non-VA care, including mental health care. PC3 is a nationwide VA program to establish networks of providers that can provide care through the Non-VA Medical Care Program in a number of specialties—including primary care, inpatient specialty care, and mental health care. Under its Choice Act authority, VHA created the VCP with the goal of meeting short-term demand for health care.

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