**STATEMENT OF**
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**DEPARTMENT OF VETERANS AFFAIRS (VA)**
**BEFORE THE**
**U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS**

**AUGUST 7, 2013**

Mr. Chairman, Senator Isakson, and Members of the Committee, thank you for the opportunity to appear here this morning to discuss mental health care at the Atlanta VA Medical Center (VAMC). I am accompanied today by Mr. Charles Sepich, Network Director, Veterans Integrated Service Network (VISN) 7, and Ms. Leslie Wiggins, Director, Atlanta VAMC.

VA is committed to ensuring the safety of our Veteran patients, especially when they are in crisis. VA and the Atlanta VAMC leadership take every Veteran death, especially suicide, seriously. Even one Veteran suicide is too many. Regrettably, there are times when a Veteran receiving VA care takes his or her life despite our intervention. Each time such a tragedy occurs, we reexamine our interactions with the Veteran and our processes in order to understand what we might have done differently. VA uses the information from these difficult individual situations to strengthen our treatment and suicide prevention efforts. We apply the lessons learned across the system, ideally, to prevent another Veteran's untimely death. We remain committed to continuous improvement and to providing Veterans with the high quality health care they have earned and deserve.

My written statement today will discuss the actions that VA and the Atlanta VAMC have taken in response to VA's Office of Inspector General (OIG) reports,

Patient Care Issues and Contract Mental Health Program Management and Mismanagement of Inpatient Mental Health Care. My testimony will also highlight a number of proactive initiatives that VA is currently implementing to improve the mental health program in all VA facilities.

In April 2013, OIG issued two reports concerning inpatient mental health care and contracted outpatient mental health care at the Atlanta VAMC. VA concurs with all of OIG's recommendations and remains dedicated to providing the highest quality of care to our Veterans. Leadership in VHA, VISN 7, and at the Atlanta VAMC has taken aggressive corrective actions to address all reported deficiencies identified in the reports. These actions include holding employees, as well as senior management accountable. As part of the facility's ongoing quality and patient safety program, the Atlanta VAMC fully investigated the care of the Veterans cited in the news report immediately after the incidents occurred. The facility identified the root causes and has either taken action or the action was already in process to resolve the identified deficiencies prior to OIG's investigations.

The Atlanta VAMC strengthened policies and developed a system improvement process to ensure patient safety. These actions included revisions of procedures for observing patients who are required to be off of the unit, providing a mental health staff escort as a means to strengthen the visitor policy, and implementing a hazardous item search policy. At the national level, VHA drafted a handbook on inpatient mental health services prior to OIG's report and is currently completing final concurrences. VHA expects to complete its national guidance for hazardous items, visitation, urine drug screens, and escort services and initial implementation in all inpatient mental health

units by September 30, 2013. Each facility will be required to adapt this guidance with site specific details and to confirm to the VISN the presence of new or updated local policies addressing these issues, and VA Central Office will provide follow-up technical assistance as necessary to ensure ongoing compliance and implementation.

All facilities already are required to meet the requirements for mental health services as outlined in VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics," and all facilities are required to ensure that care provided, whether by VA or through contract, meets the same quality of care standards. For example, VAMCs and very large community-based outpatient clinics (CBOC) which see more than 10,000 unique Veterans each year, must have integrated mental health services that operate in their primary care clinics on a full-time basis. These services need to utilize a blended model that includes co-located collaborative care and care management. Another requirement is that inpatient care must be available to all Veterans who require hospital admissions for a mental disorder, either in the VAMC where they are treated, a nearby facility, or by contract, sharing agreement, or non-VA fee-basis referral to a community facility to the extent that the Veteran is eligible. The Uniform Mental Health Services Handbook also requires that all Veterans with Post-traumatic Stress Disorder must have access to cognitive processing therapy or prolonged exposure therapy as designed and shown to be effective. VAMCs and very large CBOCs must provide adequate staff to allow the delivery of evidence-based psychotherapy when it is clinically indicated for their patients. Mid-sized CBOCs may provide these services through telemental health when necessary. VA Central Office monitors the implementation progress of the Uniform Mental Health Services Handbook,

first published in 2008, through quarterly surveys and at mental health site visits currently conducted at each facility once every 3 years. Facilities not in compliance with mental health policy are required to submit an action plan, which is monitored quarterly until compliance is obtained. The Atlanta VAMC is currently 89 percent compliant with VHA's Uniform Mental Health Services Handbook, up from 84 percent last quarter. The targeted performance is 95 percent.

The Atlanta VAMC serves nearly 89,000 Veterans and is experiencing a tremendous demand for services. The facility is closely monitoring mental health care and management of the mental health contract. The Atlanta VAMC continues to review staffing, training, and clinical care delivery to track the Community Service Boards (CSB) contracts. These are offered as another means to ensure timely access to mental health services. To enhance the facility's ability to track and monitor patients receiving contract care, the Atlanta VAMC has reduced the number of contracts with mental health organizations from 26 to 5 that, in collaboration with the Atlanta VAMC Mental Health Service Line, will work to provide outpatient services as needed. VA will monitor the quality of mental health care and contract management and will ensure that Veterans receive the highest quality medical care from either VA or its partners. Contract care will be reported quarterly to the executive committee of the medical staff, and new contracts will include a Quality Assurance Surveillance Plan with quality indicators such as appointment within 14 days of referral, treatment plan completed by the third visit, and complaints reported within 1 business day and resolved within 5 business days. These service contracts will also have extensions and "continuity of service" clauses, which allow for continuation of the contract pending award of a new

contract. VA licensed clinical social workers are embedded in the five CSB sites to coordinate care for Veterans and are available to Veterans and CSB staff. This will ensure that the Veteran receives an initial appointment. They then follow the care of the Veteran ensuring continuity of services with the Atlanta VAMC. Additionally, the facility created a database to track clinical and financial data for every Veteran referred to contract care. A comprehensive review of all patients (over 5,000) referred for contract care since 2009 was completed prior to implementing this new database. Currently, when a clinician inserts a contract referral into this tracking system, the clinical liaison will receive an automatic alert, and the data of referral will be uploaded into the database.

VA works closely with our Federal partners to implement President Obama's Executive Order 13625, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The executive order reaffirms the Administration's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts by increasing capacity at the Veterans/Military Crisis Line and supports recovery-oriented mental health services for Veterans by directing the hiring of 1,600 new mental health clinicians, 300 administrative personnel in support of the mental health programs, and 800 peer specialists. VA is on track to meet these goals nationwide. As of July 16, 2013, the Atlanta VAMC added 66 new mental health full-time equivalent employees including 50 clinicians, 6 administrative personnel, and 10 peer specialists.

VHA and the Atlanta VAMC are committed to improving access for Veterans seeking mental health services and have implemented new wait time measurement practices, policies, and technologies along with aggressive monitoring of reliability. New patient wait times for mental health services are based on measurement from the time the appointment was created until the time the patient visit was completed. Over the last few months, the facility has reduced appointment wait times; 89.6 percent of Atlanta VAMC Veterans receive a new non-urgent mental health appointment within 14 days. The average wait time for a new mental health appointment is 7 days.

The Executive Order calls for partnerships between VA and community providers to improve access to mental health services in pilot communities and to develop partnerships in hiring providers in rural areas. VAMCs began hosting Community Mental Health Summits on July 1, 2013, in order to bring together key stakeholders in the community to strengthen collaborative efforts that promote awareness and utilization of VA mental health resources. These summits, which also help Veterans gain access to community services and build healthy communities for Veterans and their families, will continue until September 15, 2013. The Atlanta VAMC's mental health summit is scheduled for August 16, 2013, and will allow community mental health providers to share resources, tools, and best practices.

As of May 31, 2013, VA has established pilot projects with 24 community-based mental health and substance abuse providers across 9 states and 7 VISNs. Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. Sites may include capabilities for telemental health, staff sharing, and space utilization arrangements to allow VA

providers to provide services directly in communities that are distant from a VA facility. The pilot project sites were established based upon community providers' available capacity and wait times, community treatment methodologies available, Veteran acceptance of external care, location of care with respect to the Veteran population, and mental health needs in specific areas.

The Atlanta VAMC is operating six pilot projects to enhance existing agreements or enter into new agreements with community providers. Enhanced agreements include additional coordination of care and the placement of VA staff persons in community locations to serve as liaisons for the Veterans and between the VAMC and the community providers. These specialized staff will address Veterans' access, acceptance, and engagement in mental health services with community partners. As a result, it is expected that an increased number of Veterans will complete a full course of care with the community providers. The Atlanta VAMC is also partnering with facilities in rural Georgia communities to further expand Veteran access.

VA has the opportunity, and the responsibility, to anticipate the health care needs of returning Veterans. As they reintegrate into their communities, we must ensure that all Veterans have access to quality mental health care. The facility has a long-term plan and new initiatives in place to expand mental health services and enhance access in the future. The Atlanta VAMC began offering expanded outpatient mental health services at the new Ft. McPherson Healthcare facility last month and anticipates opening a 40-bed homeless domiciliary there in late fall 2013. The activation of this new homeless domiciliary will assist in the medical center's compliance with VHA's Uniform Mental

Health Services Handbook. The VAMC also expects to open the Oakwood Community-Based Outpatient Clinic in September 2013 with dedicated mental health services.

## Conclusion

The Department regrets the failures in mental health care at the Atlanta VAMC. We have taken aggressive action to correct them. We are confident that these corrective measures and new initiatives have already improved the safety and quality of services offered to our Nation's Veterans in Atlanta and across the VHA's integrated health care system. The leadership and staff of the Atlanta VAMC continue to work with our local Veterans Service Organizations (VSO) and representatives to emphasize the Atlanta VAMC's commitment to providing the best quality care and services. VA will continue to work with our VSO partners to provide the world-class health care that Veterans have earned and deserve, and we continue to take every available action to improve access to mental health care services. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to your questions.