



October 2015

VA MENTAL HEALTH

Clearer Guidance on Access Policies and Wait-Time Data Needed

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GAO Highlights

Highlights of [GAO-16-24](#), a report to congressional requesters

Why GAO Did This Study

Between 2005 and 2013, the number of veterans receiving mental health care from VHA increased 63 percent, outpacing overall growth in veterans receiving any VHA health care. In fiscal year 2014, VHA spent more than \$3.9 billion providing outpatient specialty mental health care (mental health care) to more than 1.5 million veterans.

GAO was asked to examine VHA's efforts to provide timely access to mental health care for veterans. This report examines, among other things, (1) veterans' access to timely mental health care, and (2) VHA's related oversight. GAO conducted site visits to five VAMCs selected to provide variation in factors such as location and mental health care utilization rates; reviewed a randomly selected, nongeneralizable sample of 100 medical records (20 from each of the five selected VAMCs) for veterans new to mental health care who received treatment between July 1, 2014, and September 30, 2014; and interviewed VHA and VAMC officials on VHA's measures and oversight of access to mental health care. GAO evaluated VHA's oversight of access to mental health care against relevant federal standards for internal control.

What GAO Recommends

GAO recommends that VHA issue clarifying guidance on (1) access policies; (2) definitions used to calculate wait times; and (3) how open-access appointments are to be managed. VHA concurred with GAO's recommendations but disagreed with certain of its findings, for example, GAO's calculation of overall wait-times. GAO maintains its findings, as discussed in the report, are valid.

View [GAO-16-24](#). For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

October 2015

VA MENTAL HEALTH

Clearer Guidance on Access Policies and Wait-Time Data Needed

What GAO Found

The way in which the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) calculates veteran mental health wait times may not always reflect the overall amount of time a veteran waits for care. VHA uses a veteran's preferred date (determined when an appointment is scheduled) to calculate the wait time for that patient's full mental health evaluation, the primary entry point for mental health care. Of the 100 veterans whose records GAO reviewed, 86 received full mental health evaluations within 30 days of their preferred dates. On average, this was within 4 days. However, GAO also found

- veterans' preferred dates were, on average, 26 days after their initial requests or referrals for mental health care, and ranged from 0 to 279 days. Further, GAO found the average time in which veterans received their first treatment across the five VA medical centers (VAMC) in its review ranged from 1 to 57 days from the full mental health evaluation.
- conflicting access policies for allowable wait times for a full mental health evaluation—14 days (according to VHA's mental health handbook) versus 30 days (set in response to recent legislation) from the veteran's preferred date—created confusion among VAMC officials about which policy they are expected to follow. These conflicting policies are inconsistent with federal internal control standards and can hinder officials' ability to ensure veterans are receiving timely access to mental health care.

VHA monitors access to mental health care, but the lack of clear policies on wait-time data precludes effective oversight. GAO found VHA's wait-time data may not be comparable over time and between VAMCs. Specifically

- data may not be comparable over time. VHA has not clearly communicated the definitions used, such as how a new patient is identified, or changes made to these definitions. This limits the reliability and usefulness of the data in determining progress in meeting stated objectives for veterans' timely access to mental health care.
- data may not be comparable between VAMCs. For example, when open-access appointments are used, data are not comparable between VAMCs. Open-access appointments are typically blocks of time for veterans to see providers without a scheduled appointment. GAO found inconsistencies in the implementation of these appointments, including one VAMC that manually maintained a list of veterans seeking mental health care outside of VHA's scheduling system. Without guidance stating how to manage and track open-access appointments, data comparisons between VAMCs may be misleading. Moreover, VAMCs may lose track of patients referred for mental health care, placing veterans at risk for negative outcomes.

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Abbreviations

CBOC	community-based outpatient clinic
CMHC	community mental health clinics
HHS	Department of Health and Human Services
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
PTSD	post-traumatic stress disorder
SAIL	Strategic Analytics for Improvement and Learning
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VCP	Veterans Choice Program
Choice Act	Veterans Access, Choice, and Accountability Act of 2014
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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October 28, 2015

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
House of Representatives

The Honorable Richard Burr
United States Senate

The Honorable Joni K. Ernst
United States Senate

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has seen a significant increase in demand for mental health services. Between 2005 and 2013, the number of veterans who received mental health care from VHA increased 63 percent, more than 3 times the rate of increase seen in the overall number of veterans using any VHA health care services. 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 estimated that more than 1.5 million veterans obtained outpatient mental health care for conditions such as PTSD, depression, and substance abuse.¹ VHA provides mental health care in its more than 1,200 facilities in both specialty settings—those that primarily provide mental health care—and in other settings, such as

¹Department 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.).

primary care. Additionally, VHA may pay for mental health care provided by non-VA providers in the community. 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.²

In recent years, we and others have expressed concerns about veterans' ability to access timely mental health care, and VHA's oversight of patient scheduling practices.³ For example, we previously identified the reliability of reported wait times and patient scheduling oversight as areas for improvement.⁴ Also, 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 new and follow-up appointments for mental health treatment. An August 2012 Executive Order directed VHA to improve mental health 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.⁵ In addition, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), enacted in August 2014, provided additional

²See Department of Veterans Affairs, *Volume II Congressional Submission Fiscal Year 2016 Funding*. 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.

³See 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). 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).

⁴See [GAO-13-130](#). We made recommendations to improve oversight of the process for scheduling veterans for outpatient health care, which, along with VHA's actions to address them, are discussed later in this report.

⁵Executive Order No. 13625, 3 C.F.R. 302 (Aug. 31, 2012): *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*.

non-VA care options for veterans facing long waits or lengthy travel distances to obtain VHA health care services.⁶

You asked us to examine issues related to VHA's efforts to provide timely access to mental health care for veterans. This report examines

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, if any, of that hiring on access to mental health care, and
4. VHA's community provider pilot program's effects, if any, on veterans' access to mental health care.

We limited our scope to outpatient specialty mental health care, which we refer to as mental health care for the purposes of this report, because the majority of veterans with either a possible or a confirmed mental illness, about 70 percent and 85 percent respectively, are treated by VHA through outpatient mental health.⁷ To address all four objectives, we conducted site visits to five VA medical centers (VAMC): 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).⁸ These VAMCs were selected for variation in facility complexity level, geographic location, mental health care utilization, mental health appointment wait times, the number of mental health staff hired since 2012, and participation in the community provider pilot program.⁹ At each site, we visited the VAMC as well as one affiliated community-based outpatient clinic (CBOC) that provided mental health

⁶Pub. L. No. 113-146, 128 Stat. 1754 (Aug. 7, 2014).

⁷Outpatient 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) for mental illnesses including schizophrenia, bipolar disorder, PTSD, and substance abuse.

⁸We will refer to the selected VAMCs as VAMCs A through E.

⁹VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

care.¹⁰ Additionally, at the two sites that participated in the community provider pilot program, we visited two of the community-based providers that participated in the program. The results from our five VAMC visits cannot be generalized to all VHA facilities.

To examine veterans' ability to access timely mental health care and VHA's oversight of this access, we reviewed relevant VHA and VAMC documents, and interviewed staff from VHA's central office, the five selected VAMCs, and the five Veterans Integrated Service Networks (VISN) that oversee the selected VAMCs about the current policies and guidance for scheduling mental health appointments.¹¹ We also interviewed stakeholders from other key organizations, such as Vet Centers and veteran service organizations, to gain their perspectives on mental health care access.¹² Further, for each of the five VAMCs we visited, we reviewed a randomly selected sample of medical records to assess the timeliness in which veterans received mental health appointments.¹³ Our sample included 100 new veteran records, 20 for each VAMC, generally composed of 10 records for veterans who had a diagnosis of PTSD and 10 records for veterans who had any other (i.e., non-PTSD) mental health diagnoses. We considered veterans with PTSD separately because PTSD is considered one of the signature injuries of the conflicts in Iraq and Afghanistan. For new veterans, we examined the timeliness in which they received comprehensive mental health evaluations and follow-up mental health appointments as defined in VHA's policies, and, for new veterans with PTSD, we evaluated whether or not they were referred to, and completed, evidence-based therapies for PTSD—treatments specified by VHA as shown to be effective—in

¹⁰In addition to VAMCs, VHA operates CBOCs that are located in areas surrounding VAMCs and provide primary care, and some specialty care services that do not require a hospital stay.

¹¹Each of VA's 21 VISNs is responsible for managing and overseeing medical facilities within a defined geographic area.

¹²Vet Centers are community-based centers, owned and operated by the VA, that provide a broad range of counseling, outreach, and referral services to eligible veterans. Veteran service organizations are private, non-profit groups that advocate on behalf of veterans.

¹³Specifically, we sampled veterans who were new to mental health care (new veterans) between July 1 and September 30, 2014. New veterans are individuals who have not received mental health care through VHA within the past 24 months.

accordance with VHA's policies.¹⁴ Four of the five VAMCs we visited offered inpatient mental health care. For those four VAMCs, we also reviewed 20 records, 5 from each VAMC, of recently discharged inpatients to assess the timeliness of their first follow-up mental health appointments following discharge.¹⁵ Additionally, we reviewed a random sample of 15 records from a list one of the VAMCs we visited used to track veterans outside of VHA's scheduling system.¹⁶ We reviewed these records to see whether the veterans received mental health care. 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. Lastly, we evaluated VHA information on veteran wait times for mental health appointments and VHA's oversight of access to mental health care against the federal internal control standards related to control activities, information, and monitoring.¹⁷

To examine VHA's hiring of mental health staff since 2012 (the year of the relevant Executive Order) and any effects on access to mental health care, we analyzed national VHA mental health workforce data from fiscal year 2010 through fiscal year 2014, as well as the number of full-time-equivalent staff providing outpatient mental health care, before and after the hiring initiative. We also analyzed VHA data on hires by position type to determine the number and types of mental health staff hired as a result of the hiring initiative. Additionally, we reviewed vacancy rate data for mental health staff at each of the five VAMCs we visited and across VHA as of March 2015. We reviewed relevant VHA and VAMC documentation related to staffing and hiring initiatives and interviewed VHA, VISN, and VAMC officials about recruitment, hiring, and retention of outpatient specialty mental health staff, any effects these initiatives had on access to care, and the challenges to hiring or placing new staff. To determine the

¹⁴We reviewed the timeliness in which veterans received follow-up mental health appointments in the three main mental health clinics: psychiatry, psychology, and substance abuse. Some veterans may receive ongoing care from multiple providers.

¹⁵We randomly sampled veterans who were discharged from inpatient mental health stays between July 1 and September 31, 2014.

¹⁶Based on the most recent data available, as of May 2015, a total 644 veterans were placed on this list in fiscal year 2014 and through February 2015.

¹⁷See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-23.3.1](#) (Washington, D.C.: Nov. 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

reliability of the workforce and vacancy data, we reviewed related documentation; performed manual and electronic tests of the data to identify any outliers or anomalies; and followed up with officials as necessary, incorporating the corrections we received. We determined that the data were sufficiently reliable for the purposes of our review. Finally, we reviewed a random, nongeneralizable sample of 30 records from VAMC transfer lists—15 from each of the two VAMCs we visited that were using them—that track veterans waiting for mental health care appointments at preferred locations.¹⁸ We reviewed the records to identify whether these veterans were receiving care while waiting to be transferred to their preferred locations.

To examine the community provider pilot program's effects, if any, on veterans' access to mental health care, we reviewed relevant VHA documents related to the pilot program and other non-VA care programs and interviewed VHA, VISN, and VAMC staff on the use of these programs. We also collected information from the 10 VAMCs that referred veterans to community provider pilot sites to assess the extent to which VHA has referred veterans to these providers, and reviewed VHA's pilot program evaluation and related veteran satisfaction survey results.

We conducted this performance audit from September 2014 to October 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA provides a range of treatments and services to improve the mental health of veterans, including teaching coping skills and offering tailored programs to treat specific problems, such as depression, PTSD, and substance abuse disorders, and to promote recovery.¹⁹ When needed

¹⁸Transfer lists are lists that select VAMCs use to manage the transfer of veterans from one VHA facility to another.

¹⁹According to the Substance Abuse and Mental Health Services Administration, mental health recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. See Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Working Definition of Recovery* (Rockville, MD: Feb. 2012).

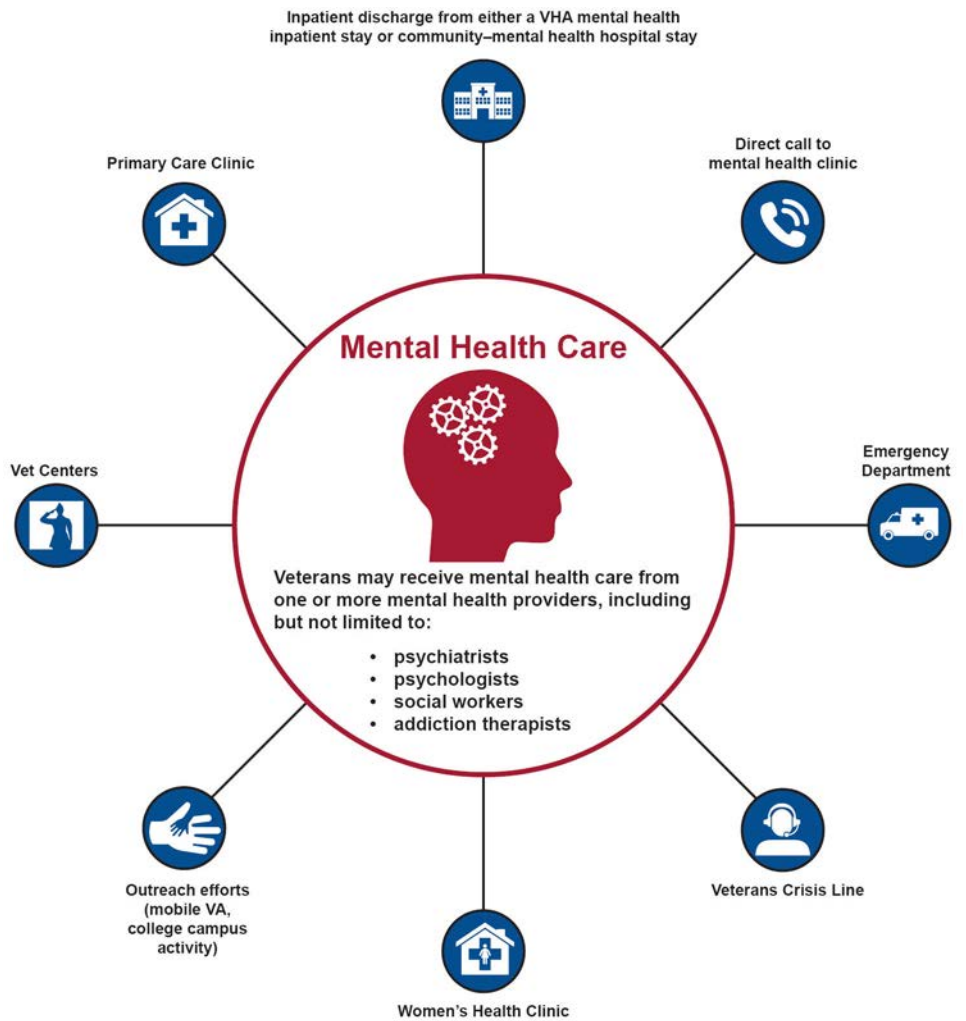
mental health care is not available through a local VHA provider, VHA has avenues by which veterans may obtain care from non-VA providers in the community.

Veterans' Access to Mental Health Care

VHA policy states that veterans are entitled to timely access to mental health care. There are a number of ways a veteran may seek access to mental health care. (See fig. 1.) Upon initial referral or request for mental health care, veterans new to mental health care (those not seen by a mental health provider within the past 24 months through VHA) are to receive initial assessments from either referring providers (such as primary care physicians) or mental health providers; these assessments identify those who need urgent or immediate access to mental health care.²⁰ Following the initial assessment, a veteran is to receive timely access to a comprehensive mental health evaluation that includes a diagnosis and a plan for treatment. The comprehensive evaluation—referred to as a full mental health evaluation—serves as a veteran's main entry point to mental health care.

²⁰Department 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).

Figure 1: Common Pathways through Which Veterans Can Access Mental Health Care within the Veterans Health Administration (VHA)



Sources: VHA (information) and GAO (illustration). | GAO-16-24

Additionally, established veterans (those who already have received mental health care within the past 24 months through VHA) are to receive timely access to follow-up care. Follow-up care may be provided by a single provider or, for those veterans who need a range of services, by multiple providers. For example, a veteran may receive ongoing care from both a psychiatrist and a psychologist to manage their symptoms. Veterans with specific diagnoses, such as PTSD, are to be considered for

evidence-based therapies, such as cognitive processing therapy or prolonged exposure therapy, as clinically appropriate.²¹ Furthermore, veterans discharged from inpatient mental health stays are to receive timely access to follow-up outpatient mental health care.

VHA's scheduling policy establishes processes and procedures for scheduling medical appointments, including mental health appointments.²² This policy requires schedulers to obtain and correctly record the preferred date—the date on which the veteran wants to be seen—in VHA's Veterans Health Information Systems and Technology Architecture (VistA).²³ VistA's scheduling component was implemented in 1985 and VA is considering several options for updating or replacing this scheduling component.

VHA Wait Time and Performance Data

In 1995, VHA established a policy of scheduling specialty care appointments, including mental health appointments, within 30 days of the date the veteran would like to be seen. In fiscal year 2011, based on reported improved performance, VHA shortened its wait-time policy to 14 days for new veterans. In fiscal year 2015, VHA set a new policy for new veterans in response to the Choice Act that veterans should be seen within 30 days of the date the veteran wants to be seen.²⁴ Currently, VHA

²¹Cognitive processing therapy helps patients gain an understanding of, and modify the meaning attributed to their traumatic events. Prolonged exposure therapy is characterized by re-experiencing a traumatic event in order to become less sensitive to the traumatic memories, and reducing the stress and avoidance behaviors associated with remembering the traumatic events.

²²VHA outpatient medical appointment scheduling policy is documented in Department of Veterans Affairs, *VHA Outpatient Scheduling Processes and Procedures*, VHA Directive 2010-027, (Washington, D.C.: June 9, 2010). For the purposes of this report, we refer to the directive as "VHA's scheduling policy".

²³VistA is the single integrated health information system used throughout VHA in all of its health care settings. VHA officials said they revised the previously used term "desired date" to "preferred date," although these terms refer to the same field within VistA.

²⁴The Choice Act defines wait-time goals for VHA as not more than 30 days from the date on which the veteran requests an appointment for services unless VA submits a report and public notice of an alternative policy. On October 17, 2014, VHA specified in the Federal Register a wait-time policy of "not more than 30 days from either the date that an appointment is deemed clinically appropriate, or, if no such determination has been made, the date a veteran prefers to be seen for hospital care or medical services." Previously, VHA referred to this as desired date but now refers to it as preferred date. See 79 Fed. Reg. 62519 (Oct. 17, 2014).

also has a policy of providing outpatient mental health care to a veteran discharged from an inpatient mental health stay within 7 days and for providing follow-up care to an established veteran within 30 days of the clinically indicated date, commonly referred to as the return-to-clinic date.

To facilitate accountability for achieving its wait-time policies, VHA includes wait-time and other performance data, such as the “missed opportunity” rate—the percentage of scheduled appointments that were not used because veterans did not show up for their appointments—in several internal and external reports. VHA also makes publicly available on its website its patient access reports (including monthly average wait times for completed and pending mental health appointments for each VAMC), and its Strategic Analytics for Improvement and Learning (SAIL) reports, which assess VAMC performance across 25 quality measures, including death and medical complication rates, customer satisfaction, and access (based on wait-time data).

VHA Mental Health Providers

To meet the needs of veterans seeking mental health care, VHA has sought to increase its mental health staff, including the number of psychiatrists, psychologists, social workers, peer specialists and other mental health professionals.²⁵ In 2012, VHA began 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 and filling existing vacancies starting in June 2012; and (2) Executive Order 13265, issued in August 2012, 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.

Non-VA Medical Care

Generally, eligible veterans may utilize the Non-VA Medical Care Program when a VAMC is unable to provide certain specialty care services, or when the veteran would have to travel long distances to obtain care at a VAMC. Non-VA providers generally treat veterans in non-VA facilities, such as physicians’ offices or hospitals in the community, and are commonly paid by VHA using a fee-for-service arrangement.

²⁵Peer specialists are veterans with mental health conditions who are in recovery and have been trained to help others with mental health conditions.

There are several ways veterans can obtain care from non-VA providers.²⁶ For example, the August 2012 Executive Order required VHA to establish partnerships with community-based providers, such as community mental health clinics (CMHCs), under a pilot program, to help meet veterans' mental health needs in a timely manner. The goal for the pilot program was to decrease wait times and increase the geographic reach of VHA mental health services. The Executive Order required VHA to establish at least 15 pilot sites by February 27, 2013. In addition, in 2013, VA established the Patient Centered Community Care (PC3) program to deliver care to veterans when local VAMCs and CBOCs cannot provide the care due to demand exceeding capacity, geographic inaccessibility, or other factors.²⁷ More recently, the Choice Act authorized non-VA care, including mental health care, for veterans with certain access challenges. Under this authority, VHA created the Veterans Choice Program (VCP) with the goal of meeting demand for health care in the short term. Beginning in November 2014, for example, certain veterans were able to receive non-VA care if the next available medical appointment with a VA provider was more than 30 days from their preferred date or if they lived more than 40 miles from the nearest VA facility.²⁸ Recently passed legislation requires VHA to submit a plan to Congress by November 1, 2015 for consolidating its Non-VA Medical Care programs under a single program.²⁹

²⁶VA is authorized to obtain health care services from non-VA providers through both the Non-VA Medical Care Program and clinical contracts. VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

²⁷PC3 is a nationwide VA program that established two nationwide contracts with Health Net and TriWest 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.

²⁸Pub. L. No. 113-146, § 101 (a), (b), 128 Stat. 1754, 1755-1756 (Aug. 7, 2014).

²⁹See the Surface Transportation and Veterans Health Care Choice Improvement Act. Pub. L. No. 114-41, § 4002, 129 Stat. 443, 461 (Jul. 31, 2015).

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

Most Veterans Received Full Mental Health Evaluations within 30 Days of Their Preferred Dates, though VHA’s Access Policies Conflict

Most veterans included in our review received full mental health evaluations, which provide new veterans with an entry point to access mental health care, in an average of 4 days of their preferred dates. 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. (See table 1.)

Table 1: Time Frames for which Veterans Received Full Mental Health Evaluations for Selected Veterans Affairs Medical Centers (VAMC)

VAMC	Average number of days from preferred date to full evaluation	Number of veterans seen within 14 days of preferred date	Number of veterans seen within 30 days of preferred date
A	0	20	20
B	0	16	16
C	9	16	18
D	7	14	16
E	3	15	16

Source: GAO analysis of Veterans Health Administration data. | GAO-16-24

Note: We reviewed 100 medical records (20 from each VAMC we visited) to determine how much time elapsed between a veteran’s preferred date and the date of their full mental health evaluation.

VHA has two policies that conflict in their definitions of timely access to a full mental health evaluation for a veteran new to VHA mental health care: (1) a 14-day policy established by VHA’s *Uniform Handbook for Mental*

Health Services,³⁰ and (2) a 30-day policy set by VHA in response to the Choice Act.³¹ 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.³² VHA officials told us they are aware of the discrepancy and that there is an internal group working to revise the access policies for mental health care, as well as the *Uniform Handbook*, to ensure consistency, but the officials could not provide a timeline for completion. When we assessed the veteran records included in our sample against these two policies, we found that, across all five VAMCs, 86 of the 100 veterans included in our review received a full mental health evaluation within 30 days of the preferred date and 81 veterans received this evaluation within 14 days. As a result of the conflicting policies, 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 may make it difficult for them to ensure timely access in light of increasing demand for mental health care. By not clarifying which access policy currently applies to mental health care, VHA is limited in its ability to effectively manage timely access to mental health care.

³⁰The *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.

³¹VHA 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 these assessments can be completed by a number of providers, including the referring provider, and that VHA does not have a way to consistently track them. As a result, VHA does not have a measure to assess whether these initial assessments are being completed in a timely manner.

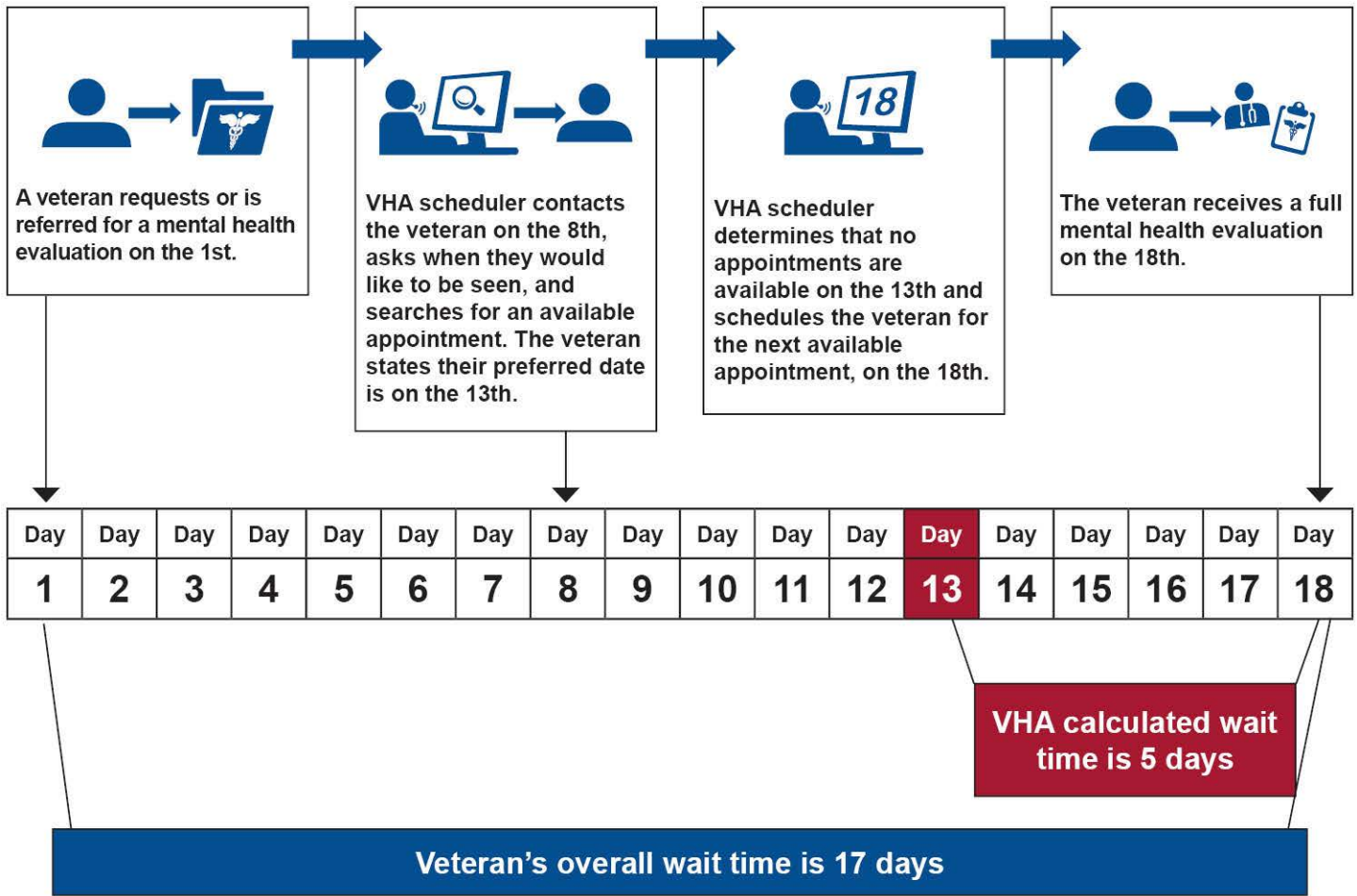
³²[GAO/AIMD-00-21.3.1](#).

VHA's Method of Calculating Wait Times Does Not Always Reflect Veterans' Overall Wait Times for Appointments and Services

Although the averages for the time between veterans' preferred dates and their full mental health evaluations were generally within several days, they may not reflect overall wait times. We found that because VHA uses veterans' preferred appointment date—not the date veterans initially request or are referred for mental health care—as the basis for its wait-time calculations, these calculations may only reflect a portion of veterans' overall wait time. This occurs because veterans generally are not asked for their preferred dates until some period of time after they request or are referred for mental health care.³³ (See fig. 2.)

³³Most of the veterans whose records we reviewed, 59 of 100, accessed mental health through a primary care referral.

Figure 2: Illustration of How Overall Wait Time May Differ from Veterans Health Administration's (VHA) Calculated Wait Time



Sources: VHA (information) and GAO (illustration). | GAO-16-24

On average, our review of 100 new veteran records found that a veteran's preferred date was 26 days after their initial request or referral for mental health care, though this varied by VAMC.³⁴ (See table 2.)

³⁴A veteran is to be contacted after an initial request or referral in order to set up an appointment. Part of the appointment scheduling process includes the veteran providing a preferred date for their appointment.

Table 2: Time Frames between Initial Date of Request or Referral for Mental Health Care and Veterans' Preferred Dates, by Selected Veterans Affairs Medical Centers (VAMC)

VAMC	Average number of days	Minimum number of days	Maximum number of days
A	28	0	104
B	41	0	279
C	15	0	57
D	27	0	181
E	18	0	74

Source: GAO analysis of Veterans Health Administration data. | GAO-16-24

Delays between initial request or referral date and a veteran's preferred date may be due to a veteran not wanting to start treatment immediately. However, based on our review of records, we also found that some patients were delayed in receiving care because a facility did not adequately handle a referral to mental health care.

- For example, one veteran received a referral to psychology in November 2013 when the referring provider noted that the veteran should be evaluated for PTSD. However, no contact was made with the veteran until the veteran called back in July 2014 and asked for an evaluation. As a result, the veteran's preferred date was 279 days after the initial referral.
- Another referral led to a veteran waiting 174 days between their initial referral for mental health care and their preferred date. The veteran's primary care provider was supposed to have placed a referral to psychology in March 2014, but we could not find evidence of the referral ever being placed. Despite not placing a proper referral, 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 documented correctly). The veteran was then able to schedule a full mental health evaluation approximately 1 week later.
- One veteran called the suicide prevention hotline in August 2014 expressing suicidal thoughts and then hung up. The hotline staff contacted the VAMC and the local authorities who found the veteran intoxicated and took him to a local jail to stabilize. The VAMC contacted the veteran a couple days later to discuss mental health

treatment (which the veteran declined at the time) but did not follow up again with the veteran until February 2015, when the veteran contacted a VHA social worker to say he was suffering from severe depression and continued to have suicidal thoughts. As a result, the veteran's preferred date was 181 days after the initial contact for mental health care.

Veterans who receive a full mental health evaluation may experience additional delays in receiving treatment. Our review found that veterans do not always begin treatment specific to their mental health condition (such as a prescription for medication or a course of psychotherapy) at the appointment in which they receive their first full mental health evaluation. We found this for 50 of the 100 new veterans whose records we reviewed.

- One veteran called into a VAMC expressing suicidal thoughts and was seen the same day for a full mental health evaluation, but no appointment for treatment was made at that time as the veteran was starting a new job. The veteran did not receive treatment for more than 7 months and the mental health providers at the facility did not document any attempts to contact the veteran during that time.³⁵
- Two veterans with PTSD, both initially referred in March 2014, received their full mental health evaluations in April 2014, within 30 days of their initial requests or referrals. However, neither received treatment until August 2014, nearly 4 months after their full mental health evaluations.
- Another veteran was initially referred to mental health care in September 2014 after a screening for veterans returning from the recent conflicts in Iraq and Afghanistan. While the veteran was seen for a full mental health evaluation within 30 days and subsequently seen in a PTSD orientation group, the veteran did not receive treatment until December 2014, nearly 80 days from the time of the full mental health evaluation. The veteran's file provided no indication of the reason for the treatment delay.

³⁵The veteran's request to receive mental health care was not reflected in the preferred date for the appointment 7 months later. The preferred date for that appointment was documented as being the same day as the appointment, reflecting a wait time of 0 days.

Based on our records review, we found that whether veterans received treatment for their mental health conditions during their full evaluation appointments was generally dependent on the type of mental health professional who conducted the evaluation. Generally speaking, veterans who were evaluated by a psychiatrist received some type of mental health treatment during their full evaluation appointments, while veterans who were evaluated by a psychologist or substance abuse professional often did not receive treatment specific to their mental health condition at their full evaluation appointments. We found that the timeliness in which veterans received this first treatment varied by VAMC included in our review. (See table 3.)

Table 3: Average Number of Days from Full Evaluation to First Treatment, by Selected Veterans Affairs Medical Centers (VAMC)

VAMC	Average number of days	Minimum number of days	Maximum number of days
A	20	0	77
B	57	0	218
C	4	0	53
D	10	0	70
E	1	0	14

Source: GAO analysis of Veterans Health Administration data. | GAO-16-24

The differences between the date of the initial request or referral to care and the preferred date are consistent with previous findings by the VA OIG, which found in 2012 that VHA's starting point for its wait-time calculation was not a meaningful measurement of a veteran's waiting time to receive an evaluation.³⁶ VHA officials agreed that the current calculation does not capture the time between when a veteran is referred to or requests mental health care and when the veteran is contacted to schedule a mental health appointment or to when a particular course of treatment starts, but also said there is currently no consensus on the appropriate standard or measure for when the calculation should begin or end.

³⁶See 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.

VHA Is Generally Meeting Access Policies for Other Types of Mental Health Appointments

VHA's *Uniform Handbook* also defines policies for timely access to other types of mental health appointments, such as follow-up appointments and outpatient appointments following discharge from an inpatient mental health stay.³⁷ In particular,

- established veterans should receive follow-up appointments within 30 days of their return-to-clinic dates;
- veterans recently discharged from inpatient mental health stays should receive outpatient appointments (either by phone or in-person) within 7 days of discharge; and
- veterans with PTSD should receive evidence-based therapies for PTSD.

Our review found that veterans generally received follow-up appointments and post-discharge appointments in accordance with the *Uniform Handbook*. Specifically, 126 of the 134 veterans' appointment records that we reviewed and included a return-to-clinic date documented by the provider received follow-up appointments within 30 days of that return-to-clinic date.³⁸ In addition, our review of 20 veterans discharged from inpatient mental health units at the four VAMCs we visited that provided inpatient mental health care found that these veterans received an outpatient follow-up within 2 days of discharge, on average, and all but one received this follow-up within 7 days of discharge.³⁹ However, our review found that not all veterans received evidence-based PTSD therapy. Out of the 51 veterans with a diagnosis of PTSD whose records we reviewed, 7 entered into PTSD evidence-based treatment and 44 did not. Mental health providers we interviewed said veterans with PTSD do not always receive these treatments because providers a) do not feel the veteran is appropriate for this intensive treatment, b) have limited

³⁷VHA has additional policies that are outside the scope of this engagement, including evidence-based therapies for substance abuse.

³⁸Each veteran may have multiple appointment records that included a return-to-clinic date. For the 100 veterans in our sample, we reviewed 77 psychiatry appointments, 52 psychology appointments, and 5 substance abuse appointments with return-to-clinic dates documented by the provider. Nearly all of these follow-up appointments were completed within 30 days of the return-to-clinic date and we found no significant variation between the specialties.

³⁹VHA performance data for the fourth quarter of fiscal year 2014 show that, nationwide, veterans received this follow-up within 7 days of discharge 83 percent of the time. VAMCs nationwide and the four sites we visited exceeded VHA's performance goal of 75 percent in the fourth quarter of fiscal year 2014.

availability in their schedule for this level of intensive treatment and, as a result, only select the candidates mostly likely to succeed, or c) the veteran declines.⁴⁰

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 through on-site reviews of clinic operations and sharing data, internally and externally, on mental health access, but the lack of clear policies for reliable data on veteran wait times and missed opportunities precludes effective oversight.⁴¹ Among other things, VHA's on-site reviews are to

- determine compliance with the policies for mental health care, as defined in the *Uniform Handbook*;
- reduce variability in access and quality of mental health care nationwide; and
- identify best practices and areas for growth at each VAMC.

We reviewed the findings of the most recent VHA on-site review for each of the five VAMCs we visited. VHA's recommendations included having one VAMC clarify local policies for referring veterans to mental health and establishing clear criteria on when veterans who have completed treatment should be discharged to primary care or other providers for ongoing monitoring and maintenance. VHA also recommended that another VAMC revise local policies for addressing veteran "no shows"—when a veteran did not attend their appointment and did not cancel in advance—to be consistent with VHA requirements. Following the visits, VHA requires VAMCs to submit corrective action plans that detail how the recommendations will be implemented. For example, one VAMC's action

⁴⁰Other research has shown relatively low receipt of evidence-based therapy among veterans with PTSD within VHA, due to a number of factors, including that such therapy is not available at some VAMCs and CBOCs, and not every veteran wants, needs, or meets the treatment criteria for such therapy. See RAND Health, *Veterans Health Administration Mental Health Program Evaluation: Capstone Report* (Santa Monica, Calif.: Rand Corporation, 2011) and Institute of Medicine of the National Academies, *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment* (Washington, D.C.: National Academies Press, 2014).

⁴¹In June 2014, VHA completed an access audit of all VAMCs and selected CBOCs, assessing scheduling staff's understanding of VA's policy, identifying any inappropriate scheduling practices used, and reviewing waiting list management. In addition, VHA's Office of Mental Health Operations conducts on-site reviews of VAMCs. Officials told us they visited all VAMCs in 2012, and after that time have visited about a third of all VAMCs each year.

plan stated that it revised the local no-show policy and trained relevant staff.

VHA officials said they also share data on mental health access, such as appointment wait times and VAMCs' missed opportunities rate, with VISN and VAMC staff through internal VHA websites and with the public through its SAIL and patient access reports. However, our previous work, as well as that of the VA OIG, has shown that VHA wait-time data is unreliable and prone to errors and interpretation.⁴² Among other things, we found in December 2012 that VAMCs were not implementing VHA's scheduling policies in a consistent manner, which led to unreliable wait-time data.⁴³ While VHA has taken steps to increase training in proper scheduling practices, we found three additional reasons contributing to the unreliability of VHA's mental health care wait-time data, which is inconsistent with federal internal control standards that state management should use and communicate, both internally and externally, quality information to achieve its objectives.⁴⁴ These include: (1) the wait-time data-entry process has the potential for errors, (2) data may not be comparable over time, and (3) data may not be comparable across VAMCs. In addition, we found that one VAMC was using a document outside of VHA's scheduling system to track veterans referred for a certain type of mental health clinic.

The wait-time data entry process has the potential for errors. Wait-time data relies on information entered at the time an appointment is scheduled, a process which we found has the potential for errors, including scheduler errors (e.g., entering an incorrect preferred date) that are compounded by high turnover in these positions, limitations with the scheduling system (e.g., the ability to view only appointments that follow a veteran's entered preferred date, not those that fall on the day(s) leading up to that date), and variation in how the preferred date is determined

⁴²See [GAO-13-130](#), [GAO-14-808](#), and Department of Veterans Affairs, Office of Inspector General, Review of Veterans' Access to Mental Health Care.

⁴³In response to these findings, we recommended that VHA take action to ensure VAMCs consistently implement the scheduling policy and ensure that all schedulers take the required training. VHA concurred with the recommendation and reported taking steps, such as drafting a standardized training on scheduling procedures that is to be taken by all schedulers. As of March 2015, VHA was in the process of revising scheduling guidance and training.

⁴⁴See [GAO/AIMD-00-21.3.1](#).

(e.g., providers basing their preferred return-to-clinic date on appointment availability instead of on the veteran's preferred date). For example, we found one case where VHA's system-generated wait-time data was calculated incorrectly, based on our review of the records. We identified that the scheduler did not properly search for the next available appointment and, as a result, the VistA scheduling system incorrectly used the date the appointment was created (as opposed to the veteran's preferred date) to calculate the VHA wait time. VAMC officials said this is an easy mistake to make because of the limitations of VHA's scheduling system.

Officials from all of the VAMCs we visited told us that there is the potential for scheduling errors. As result, they may not always be able to rely on VHA's aggregated wait-time data. Instead, some officials said they need to view individual-level information to monitor timely access, which can be time consuming and burdensome. Specifically, officials from one VAMC said that each day they review all scheduled appointments to identify and correct scheduling errors that may affect the accuracy of their data. We found in December 2012, that VHA's scheduling policy was unclear and subject to interpretation and this led to difficulty achieving consistent and correct application of the policy by schedulers. As a result, we recommended that VHA update its scheduling policy or identify wait-time measures that are not subject to interpretation or prone to scheduling error.⁴⁵ Until VHA clarifies its scheduling policy so that it is not as subject to interpretation or error, or develops new wait time measures, as we recommended, it is likely to continue to have data errors and may be missing an opportunity to improve the reliability, and thus usefulness, of its data.

Data may not be comparable over time. VHA has changed the definitions used to calculate various mental health wait-time measures; thus, these measures may not be comparable over time. For example, VHA officials said that in fiscal year 2014 the definition of a 'new mental health patient' changed from an individual who had not been seen within a specific mental health clinic, such as the general mental health clinic or

⁴⁵See GAO, *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). VHA concurred with this recommendation and has convened an internal group to revise the scheduling portion of the outpatient scheduling guidance, but as of March 2015, had not published revised guidance.

PTSD clinic, to an individual who had not been seen in any mental health clinic. According to VHA officials, this change was made because some veterans were being incorrectly flagged as new in the scheduling system if their appointments with their regular providers were scheduled in a different clinic (e.g., general mental health versus PTSD) than normal. A number of VHA officials, including VAMC and VISN officials, told us they were not sure which definitions were in effect at the time of our interviews or gave conflicting answers about which definitions were currently being used, which is contrary to federal internal controls standards that call for management to communicate relevant and reliable information in a timely manner. VHA has not clearly communicated the definitions used or changes to the definitions, which limits the reliability and usefulness of the wait-time data and VHA's ability to use these measures to determine progress in meeting stated objectives for veterans' wait times. Until VHA clarifies how different access measures are defined and calculated, and communicates any changes over time, local and VISN officials are likely to face difficulties accurately assessing wait times, and identifying needed improvements.

Data may not be comparable between VAMCs. In particular, data may not be comparable when VAMCs use open-access appointments (i.e. blocks of time where veterans may see providers without a scheduled appointment). Specifically, two VAMCs we visited often referred veterans to open-access appointments.⁴⁶ In these cases, because appointments were not scheduled until veterans came to the VAMC to be seen, the preferred and appointment dates were the same and wait times were calculated as 0 days, regardless of when veterans requested or were referred for mental health care.⁴⁷ Additionally in these cases, because appointments were not scheduled prior to veterans showing up for care, the VAMC's missed-opportunity rate may have been lower and may not be comparable to that of other VAMCs that did not use open-access appointments.

⁴⁶Officials from these VAMCs told us they refer veterans to open-access appointments who, based on a triage evaluation, are determined to be a low risk for harming themselves or others and who are not in need of an urgent appointment.

⁴⁷According to VHA officials, when aggregate wait times are calculated, appointments with a 0-day wait time are not included in the calculations.

We found that one of the VAMCs we visited had a list of veterans referred to open-access appointments rather than being given specific appointments. This list was maintained outside of VHA's scheduling system in a spreadsheet that was not systematically updated. Officials stated the spreadsheet was not used for clinical decision-making. However, the manual maintenance of the list raises concerns about the potential to lose track of veterans who may have needed mental health services more urgently. This VAMC's own documentation stated that there is no system in place to alert providers if a patient did not arrive for an open-access appointment, limiting officials' ability to follow up at least three times in accordance with VHA's policy to contact veterans at least three times if they miss an appointment without canceling, referred to as their no-show policy.⁴⁸ To mitigate the risk of lack of follow up for these veterans, VAMC officials told us that prior to being placed on this open-access appointment list, veterans receive a telephone screening by a mental health nurse who determines their risk level, but also to give veterans themselves an opportunity to determine if and when they should be seen.

Of the 644 veterans who were placed on the referral list for open-access appointments at this VAMC in fiscal year 2014 and through February 2015, close to half (278) were reported as not having shown, and were generally either mailed a letter reminding them about the open-access clinic or had no action recorded.⁴⁹ We randomly selected 15 of these veterans' medical records for review, and found inconsistencies with the VAMC's application of VHA's no-show policy for veterans that did not attend an appointment. Just over half, 8 veterans, did not receive mental health care through the open access clinic or through an individual appointment. Of these 8 veterans, only 1 was contacted three or more times to remind them of the need to be seen—in accordance with VHA's no-show policy. The other 7 veterans were not adequately contacted and received phone calls, one letter, or no reminders. One of the veterans that did not receive any type of reminder was brought to the emergency department 1 month later by local police stating that he felt suicidal. The veteran was then admitted for inpatient mental health care. Another

⁴⁸Veterans Health Administration, *Guidance on Patient Failure to Attend Appointments (No Shows)*, VHA Memorandum (Washington, D.C.: Aug. 6, 2013).

⁴⁹The list noted that the remaining 366 veterans were seen in the VAMC's open-access clinic.

veteran was referred to an open-access appointment in January 2015, but did not attend an open access appointment and was not in contact with VHA again until the veteran called in May 2015.

VHA does not have guidance that clarifies how open-access appointments should be used, how such appointments should be scheduled, or how veterans referred for these types of appointments should be tracked. This 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 who 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. Officials from one of these VAMCs also said that while they referred some veterans to open-access appointments, they also began giving these veterans scheduled appointments after VHA officials told them that not providing scheduled appointments may not comply with VHA's scheduling policy.⁵⁰ In addition, VHA officials said they were not aware of uniform guidance about open-access appointments, and that this lack of guidance could explain why different VAMCs use different approaches. 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 leading to serious negative health outcomes for veterans that need mental health care.

⁵⁰Officials said that if patients came to open-access appointments for treatment, their scheduled appointments were generally canceled.

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's Hiring Initiative Met Its Goals, but VAMCs Reported Continued Challenges Hiring and Placing Mental Health Providers

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. As a result of this initiative, which included both inpatient and outpatient mental health positions, VHA hired about 5,300 new clinical and non-clinical mental health staff.⁵¹ In particular, VHA hired:

- 1,667 new mental health staff (as of June 30, 2013);
- 304 non-clinical support staff (as of June 30, 2013);
- 2,357 staff to fill existing mental health vacancies and any vacancies that opened during the initiative (as of June 30, 2013); and
- 932 peer specialists (as of December 31, 2013).⁵²

⁵¹VHA 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.

⁵²The total number of peer specialist hires includes staff hired as part of the hiring initiative, as well as staff that were hired as part of VHA's regular hiring process. VHA could not provide separate numbers for those hired as part of the hiring initiative, and those hired as part of the regular hiring process. The total also includes peer support apprentice hires. Peer support apprentices serve in a developmental capacity until they are certified as peer specialists.

VHA hired various types of mental health staff to fill positions under the agency's hiring initiative. (See table 4.) Many hires were for social workers and psychologists, positions that officials at VAMCs we visited reported hiring as part of the hiring initiative.

Table 4: Number of Mental Health Staff Hired under Veterans Health Administration's (VHA) Hiring Initiative, by Occupation Type, as of June 2013

Occupation	New position hires	Vacancy hires	Total hires
Social workers	412	584	996
Mental health nurse	372	616	988
Psychologists	437	321	758
Psychiatrists	155	250	405
Other: clinical ^a	291	413	704
Other: non-clinical ^b	304	173	477
Peer specialists ^c	932	N/A	932
Total	2903	2357	5260

Source: VHA. | GAO-16-24

Notes: 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.

N/A=Not available

^aOther: clinical positions include licensed marriage and family therapists, licensed professional mental health counselors, and other mental health professionals.

^bOther: non-clinical positions include occupations that provide services which facilitate care to the veteran, such as medical support assistants and scheduling clerks.

^cThe total number of peer specialist hires includes staff hired as part of the hiring initiative as well as staff that were hired as part of VHA's regular hiring process. Peer specialist data are as of December 31, 2013.

Officials at the five VAMCs we visited reported local improvements in access to mental health services due to the additional hiring. For example, officials at one VAMC reported being able to offer more evidence-based therapies as a result of the additional hiring. Officials at this VAMC, as well as officials at a second VAMC and two CBOCs, reported being able to provide mental health care at new locations where they were unable to do so prior to the hiring initiative. For example, prior to the hiring initiative, officials at one VAMC said one of their CBOCs had no capacity to provide mental health therapy services. As a result of the hiring, VAMC officials were able to add a psychologist at that CBOC who now provides mental health therapy and testing services for veterans who visit that location.

Further, officials at four of the five VAMCs we visited cited the benefits of having the additional peer specialist hires to assist mental health professionals in performing a variety of therapeutic and supportive tasks with fellow veterans. Peer specialists at the facilities we visited said they educate veterans on available mental health services, provide peer counseling, engage veterans who are resistant to discussing mental health issues, model effective coping techniques, and co-facilitate therapy groups. While VAMC officials cited the benefits of the peer specialists, they also said they initially did not receive clear guidance from VHA on their intended role and thus were unsure how to incorporate the position into the provision of mental health care. Consequently, officials said it took more time to take full advantage of these newly hired positions.

Although VHA considered their hiring initiative a success, officials at the five VAMCs we visited reported a number of challenges in hiring and placing mental health providers, including

- **Pay disparity with the private sector.** Officials at all the VAMCs we visited said that VHA salaries for mental health professionals were not competitive with private sector salaries. For example, officials at one VAMC said they experienced difficulties in recruiting mental health staff, such as psychiatrists, and lost prospective hires to the private sector.
- **Competition among VAMCs.** Officials at three of the five VAMCs we visited also stated that, because every VAMC across the country was trying to fill mental health staff positions at the same time during the hiring initiative, competition among the different VAMCs was high. For example, officials at one VAMC said they made offers to candidates who then used those offers as leverage to secure higher offers at other VAMCs.
- **Lengthy hiring process.** Even when candidates were available to fill positions, officials at four of the five VAMCs we visited stated that VHA's lengthy hiring process—which could take anywhere from 3 months to more than 1 year—was a challenge, possibly resulting in losing candidates who took positions elsewhere during that time. Officials at one VAMC attributed the delays to a lack of human resources staff to complete the administrative side of the hiring process. Despite the VAMC's staff growing significantly as a result of VHA's hiring initiatives, officials said the VAMC did not hire any additional human resources staff, which increased the workload of existing staff and contributed to hiring delays.

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- **Lack of space.** Once the hiring process was completed, officials at four of the five VAMCs and all five CBOCs we visited reported difficulties getting mental health hires in place to provide care due to a lack of sufficient space. All of the VAMCs we visited had either recently completed or were in the process of undergoing expansions of mental health space in their VAMC or CBOC buildings. Officials at one of the CBOCs we visited said that although they moved into their current facility in July 2014, by April 2015, they were already struggling with space constraints.
 - **Lack of support staff.** Four VAMCs we visited reported that a lack of non-clinical support staff resulted in providers taking on some of the administrative burden, which reduced their clinical availability. For example, officials at one VAMC said that while the recent hiring initiatives added staff to improve access, without a corresponding initiative for hiring support staff, providers are now also scheduling patient appointments, addressing office equipment issues, and handling phone calls about administrative issues, in addition to their clinical duties.
 - **Nationwide shortage of mental health professionals.** Officials at three VAMCs we visited reported that the nationwide shortage in mental health professionals also presented a hiring challenge. According to the Department of Health & Human Services' (HHS) Substance Abuse and Mental Health Services Administration, the nation faces a current shortage in the mental health and addiction services workforce, and that shortage is expected to continue.⁵³ As of July 2015, there were about 4,000 areas designated as having a shortage of mental health professionals, which HHS's Health Resources and Services Administration projected would require almost 2,700 additional mental health providers to fill the need in these underserved areas.⁵⁴

⁵³Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues* (Washington, D.C.: Jan. 24, 2013).

⁵⁴U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Clinician Recruitment and Service, *Designated Health Professional Shortage Area Statistics, as of July 29, 2015* (Washington, D.C.: Jul. 29, 2015).

Additional staff likely will be needed to meet VHA's continuing demand for mental health care. 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 2014-2017.⁵⁵ As of March 2015, VHA's mental health staff vacancy rate (14 percent) was similar to that of VHA's overall staff vacancy rate (16 percent), even though the vacancy rates were calculated differently.⁵⁶ Mental health staff vacancy rates varied widely among VAMCs we visited, from 9 to 28 percent.⁵⁷ Four of the five VAMCs we visited had mental health staff vacancy rates that were higher than the national average. (See table 5.)

Table 5: Mental Health Staff Vacancy Rates Nationally and at Selected VA Medical Centers (VAMC), as of March 2015

VAMC	Number of vacancies	Vacancy rate (percentage)
National	4,147	14
A	63	28
B	53	16
C	13	28
D	13	22
E	23	9

Source: Veterans Health Administration. | GAO-16-24

Note: Vacancies are measured in full-time equivalents. A full-time equivalent is a measure of staff hours equal to those of an employee who works 2,080 hours per year, or 40 hours per week for 52 weeks. Vacancies include both inpatient and outpatient staff positions, and only those administrative positions included in VHA's hiring initiative. The director of the 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.

⁵⁵Department 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.: April 17, 2015).

⁵⁶The mental health staff vacancy rate is calculated based on a survey of VAMC officials, while, according to VHA officials, the overall staff vacancy rate is calculated based on vacancy information entered into VHA's human-resources tracking database.

⁵⁷Vacancies 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.

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, hiring telehealth providers at VHA facilities outside of the region (e.g., a provider located in another state), and using internships and academic affiliations to find potential recruits. For example, officials at one VAMC reported using relocation and recruitment bonuses up to 15 percent of the base salary (usually around \$5,000) to recruit mental health clinicians. 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 when compared with the private sector.⁵⁸

VHA's Hiring Initiative Coincided with an Increased Demand for Mental Health Care That VAMCs Reported Being Unable to Meet

Officials at four of the five VAMCs we visited stated that they were still unable to meet overall demand for mental health care despite VHA's hiring initiative. In addition, an official from a VHA office tracking mental health staffing and access data had not observed any systemic reduction in wait times or staff-to-patient ratios nationally, in part because of simultaneous increased demand for mental health care. Nationally, VHA outpatient mental health staffing totals increased from 11,138 full-time equivalents in fiscal year 2010 to 13,795 in fiscal year 2014, a 24 percent increase.⁵⁹ Over the same time period, the number of veterans receiving outpatient mental health care increased from 1,259,300 to 1,533,600, a 22 percent increase. The 22 percent increase in veterans receiving outpatient mental health care has outpaced general growth in the number of veterans using VHA services overall. During the same time period, from fiscal year 2010 through fiscal year 2014, the total number of veterans who used any VHA services increased 9 percent, from 5,441,059 to 5,955,725.⁶⁰ VHA attributed the increased demand for mental health care to the influx of veterans returning from the recent

⁵⁸79 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.

⁵⁹A full-time equivalent is a measure of staff hours equal to those of an employee who works 2,080 hours per year, or 40 hours per week for 52 weeks. Full-time equivalent data include time spent on clinical, research, teaching, and administrative activities.

⁶⁰Department of Veterans Affairs, *Volume II Medical Programs and Information Technology Programs Congressional Submission Fiscal Year 2012 Funding and Fiscal Year 2013 Advance Appropriations Request* (Washington, D.C.); and VA *Volume II Congressional Submission Fiscal Year 2016 Funding*.

conflicts in Iraq and Afghanistan, increased proactive screening efforts, and VHA's increased capacity to provide mental health care.

Officials at the five VAMCs we visited described strategies they used to manage demand for mental health care in light of staffing challenges:

- **Changing the type of mental health care offered.** To maintain access given the increased demand, VAMC officials told us they increased the use of telehealth, group therapy (rather than individual therapy), and lengthened the time between therapy appointments. Officials at three of the five VAMCS we visited stated they have increased the use of telehealth to meet the increased demand for mental health services that exceeds their capacity, particularly in rural areas where it is more difficult to hire staff. For example, officials at one VAMC stated that a psychiatrist position has remained open for 2 years at a rural CBOC that has experienced significant increased demand for mental health care. Because of the difficulty in getting that position filled, VAMC officials hired a psychiatrist located in another state to provide mental health care via telehealth to veterans visiting that CBOC. Further, officials at four VAMCs we visited said they refer veterans to group therapy due to shortages in the availability of individual therapy appointments. Finally, officials at three VAMCs and two CBOCs we visited reported shortening appointments or spacing out follow-up individual therapy appointments at longer intervals than what providers preferred. For example, officials at one VAMC we visited said that when they are short staffed, they use shorter appointment times than they would prefer (e.g., 30 minutes) or extend the time between follow-up appointments, which means they did not see patients as often as the providers would prefer.
- **Countering space and staffing constraints.** VAMC officials reported using several strategies to address space shortages such as office sharing, increased teleworking or altering provider schedules, and converting closets into small offices. Officials at one VAMC told us they had designated one provider just for new patient intake appointments. This provider's schedule was made up of 90 minute time slots devoted to assessing the acuity of new patients and referring them to the appropriate source of care. Officials at another VAMC we visited told us they made use of limited office space for individual therapy appointments by having their providers record patient notes in common areas.
- **Referring veterans to other VA locations when a preferred CBOC is not available.** Officials at two VAMCs we visited said that when

veterans are unable to receive timely care at their preferred CBOC location, they refer that veteran to the VAMC or another CBOC for care until space becomes available at their preferred location. These two VAMCs had a total of 175 veterans on their transfer lists at the time of our visits. We reviewed 30 of these 175 veterans' records and found 26 veterans were waiting for care at a preferred location and 4 veterans were placed on this list in error. Of the 26 veterans that were waiting for care at a preferred CBOC, 17 were receiving care at other VAMCs or CBOCs until capacity became available at their preferred CBOC and 9 were not. Of the 9 veterans not receiving care at another location, 7 veterans' records clearly documented that they refused care at an alternative location and 2 veterans' records did not clearly document if they refused alternate care. According to officials at one CBOC, VAMC social workers followed up every month with veterans who opted not to receive care at the VAMC and instead wait for an opening at the preferred CBOC to assess their current mental health status.

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

VHA's Community Provider Pilot Program Provided Mental Health Care for a Limited Number of Veterans

In 2013, 10 VAMCs across VHA 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.⁶¹ The over 2,400 mental health appointments that veterans received through the CMHCs accounted for approximately 2 percent of the total mental health care provided across the 10 VAMCs. 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 (including intensive outpatient treatment and 28-day residential programs).

Veterans were generally satisfied with the care they received from the CMHCs in the pilot, according to VHA's survey. Veterans who were referred between January 2013 and December 2013 were surveyed retrospectively and 61 percent were completely or somewhat satisfied with the care they received and 19 percent were completely or somewhat dissatisfied.

Most of the 10 VAMCs established partnerships with one or two CMHCs, although one of the participating VAMCs, Atlanta, established seven partnerships.⁶² As such, nearly half of the care provided through the pilot program was through partnerships with the Atlanta VAMC.⁶³ The Atlanta CMHCs provided 1,150 appointments to veterans, while the partnerships with other VAMCs generally provided far fewer appointments. For example, the Indianapolis and Mountain Home VAMCs' partnerships provided the next highest number of appointments, with 664 and 170 appointments respectively, while certain CMHCs that partnered with the Sioux Falls VAMC provided fewer than 10 appointments. (See table 6 for additional information on the community provider pilot sites.)

⁶¹While 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.

⁶²Atlanta initially established partnerships with five CMHCs but expanded to two additional CMHCs during the course of the pilot program.

⁶³Over 90 percent of the 808 veterans surveyed by VHA for the pilot evaluation received services through one of the CMHCs that partnered with the Atlanta VAMC.

Table 6: Details of the Community Provider Pilot Program

VA Medical Center	Number of Community Mental Health Clinic pilot partnerships	Number of unique veterans referred for care	Number of veteran appointments
Alaska	1	20	61
Atlanta	7	1418	1150
Biloxi	1	10	20
Central Iowa	1	60	39
Indianapolis	1	Not available ^a	664
Lexington	1	33	168
Mountain Home	2	141	170
Sioux Falls	5	84	63
Tomah	1	13	82
Nebraska- Western Iowa	3	1	12
Total	23	1780	2429

Source: Veterans Health Administration. | GAO-16-24

^aThe Indianapolis VAMC was not able to provide the number of referrals because it did not begin specifically tracking these referrals until recently.

The most common partnership between VAMCs and CMHCs was for the CMHC to provide care on a fee basis. This type of arrangement was used for 12 CMHCs. Payments under fee-basis care are made to non-VA health care providers on an individual veteran basis. The seven CMHCs that partnered with the Atlanta VAMC provided care through locally negotiated contracts, which established the specific services to be provided to veterans. Finally, four CMHCs established partnerships through which VHA mental health providers, located elsewhere, provided telemental health care to veterans at designated CMHCs that were closer to veterans' homes than either the nearest VAMC or CBOC.

While the pilot program has ended, some VAMCs continued their partnerships with affiliated CMHCs.⁶⁴ When the pilot ended, the funding for the partnerships ended as well. VAMCs that continued their partnerships had to identify new funding sources, and in general, staff reported that they funded the ongoing partnerships through their normal

⁶⁴Many pilot partnerships began in February or March 2013, though some partnerships were not established until late 2013.

funding mechanisms. For example, officials from the Atlanta VAMC said that they used money from their discretionary budget to fund the care provided by the CMHCs after the pilot ended. VAMC officials who ended their relationship with CMHCs generally reported that they did so due to a perceived lack of veterans' interest.

Officials Identified Successes and Challenges of the Community Provider Pilot Program

VHA and CMHC officials described a number of successes and challenges related to the pilot program. Improved capacity and communication were among the community provider pilot successes:

Improved capacity. Officials at one VAMC said they would not be able to maintain mental health 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. Specifically, officials from one of these VAMCs said that, prior to their telemental health partnership with a CMHC, some veterans traveled 2 or more hours to receive care, but using the CMHC drastically reduced veterans' travel times and the VAMC's travel reimbursement costs.⁶⁵ Similarly, many veterans reported that they were able to receive care at CMHCs that were much closer than the nearest VAMC or CBOC, according to a VHA survey. VHA's survey also found that approximately 80 percent of veterans reported travel times of more than 30 minutes to the nearest VAMC, while approximately 50 percent reported that traveling to the nearest CMHC took less than 30 minutes.

Improved communication. Both VAMC and CMHC officials said that having a VAMC liaison on site or a dedicated point of contact improved communication. Specifically, one VAMC used previously established relationships with CMHCs to identify pilot sites, and used the pilot program to embed liaisons, who are VAMC employees, which helped facilitate communication between the VAMC and CMHCs. Embedded liaisons, who were registered nurses, were responsible for veteran outreach, the resolution of complaints, and ensuring veterans

⁶⁵Veterans are eligible to receive reimbursement for some travel expenses associated with medical appointments, such as mileage, if they meet certain criteria, generally related to whether they have a service-connected disability or low income level.

were receiving care comparable to that provided by the VAMC. Officials at two other VAMCs improved communication by identifying key points of contact. These points of contact worked to improve communications by centralizing information sharing within the VAMCs and CMHCs and addressing veterans' or other concerns, such as billing confusion.

Challenges with the community provider pilot included a number of administrative issues, as well as concerns about the appropriateness of care:

Medical documentation and billing. Officials at two VAMCs noted difficulty receiving timely medical documentation and CMHC officials we spoke with also described difficulty receiving timely payments from VAMCs. VAMC officials reported that delays in receiving medical documentation could limit the ability of VHA to provide quality care if a veteran returned to the VAMC for care prior to the VAMC receiving their medical documentation. CMHC officials reported waiting, at times for months, for payments or resubmitting paperwork multiple times because the VAMC appeared to have misplaced it. VHA recommends including incentives for timely documentation in their contracts with CMHCs as a best practice, but some VAMC officials noted that they had little leverage when trying to create or use such incentives. For example, officials at one facility said they had very little leverage in obtaining documentation because they could not withhold billing while waiting for documentation.

Technical challenges. Both VAMC and CMHC officials in our review also reported experiencing technical challenges, particularly related to the transfer of medical files and the use of telemental health technology. Two VAMCs reported depending on secure fax to exchange information because the VAMCs and the CMHCs used different computer systems. VHA officials said they plan to provide an internal report to VAMCs recommending, among other things, that VAMCs and CMHCs establish standards and plans for sharing information to reduce the impact on care and workload while ensuring confidentiality.

Confusion among available non-VA programs. Some VAMC officials expressed confusion about the different non-VA medical programs, including the CMHC partnerships, available to veterans. Some of the VAMCs in the pilot program extended their partnerships

with the CMHCs after the pilot program's end. A VHA document and VHA officials indicated that PC3 and VCP are now the primary programs for obtaining non-VA care of all kinds, including mental health care, although VAMC officials reported it is not always clear which option should be used. Veterans at a facility that continues to fund ongoing partnerships with CMHCs after the pilot program ended would have at least three options for non-VA care (with PC3 and VCP being the primary options). VAMC officials also reported that some providers and patients were unaware of the CMHCs as a treatment option for mental health care and that there is also confusion among patients regarding which services VHA will pay for at non-VA facilities. VHA officials said that veterans generally work with providers to identify the most appropriate non-VA option for mental health care. VHA central office officials said they leave non-VA care decisions up to the individual VAMCs and generally do not review their non-VA care coordination decisions. Previous reports from us and others have highlighted inefficiencies in non-VA care delivery.⁶⁶

Concern about appropriateness of care. VAMC and VISN officials also expressed concern about the appropriateness and effectiveness of referring to community providers for mental health care, and had concerns about the ability of community providers to provide culturally competent and high-quality care to veterans.⁶⁷ VAMC and CMHC officials noted the importance of having providers provide culturally competent mental health care for veterans, and some VAMCs were reported to have provided such training to community providers. Some VHA officials expressed concern about whether sufficient

⁶⁶See GAO, *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, [GAO-14-175](#) (Washington, D.C.: Mar. 6, 2014) and *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, [GAO-13-441](#) (Washington, D.C.: May 31, 2013). We made several recommendations to improve (1) data on wait times and cost-effectiveness of non-VA medical care; and (2) VA's oversight and monitoring of claims processing. VA agreed with these recommendations, and has taken action on some, but has yet to fully implement others. See also, Department of Veterans Affairs Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, 08-02901-185 (Washington, D.C.: Aug. 3, 2009). See also National Academy of Public Administration, *Veterans Health Administration Fee Care Program* (Washington, D.C.: Sept. 2011).

⁶⁷Culturally competent care, for our purposes, refers to the delivery of services by providers that are respectful of and responsive to the experiences, views, and needs of veterans.

providers in certain areas have the necessary training and experience to treat certain types of veterans and one VAMC established guidelines regarding which veterans were eligible to be referred for non-VA care and which were not.⁶⁸ VAMC officials said that some veterans preferred receiving care through VHA rather than through a CMHC. Together these factors may have contributed to veterans generally choosing to remain within the VHA system for mental health care. Finally, veterans referred to a CMHC did not always receive care, for a variety of reasons, including that some veterans did not want to receive mental health care once they were referred or veterans did not show up for scheduled appointments.⁶⁹

Conclusions

Our review found that veterans at the selected sites were generally receiving mental health care within 30 days of their preferred dates. A veteran's preferred date is the basis for how VHA calculates wait times, although this approach may not accurately reflect veterans' overall wait times. In particular, the way in which VHA calculates the key wait-time measure for new veterans generally does not account for the full amount of time it takes veterans to receive their full mental health evaluations, which we found ranged from 0 days to more than 200 days from their initial requests or referrals. VHA officials told us they are aware that the wait-time calculation does not include some portions of a veteran's wait, but said there is not currently consensus on what standard should be used to begin or end this calculation.

In addition, we found that VHA management of mental health care, as demonstrated through the use of clear policies and accurate measurement of performance, could be improved in three areas. First, the existence of two conflicting access policies (14 days versus 30 days) for a full mental health evaluation, the primary entry point for mental health care, creates confusion among VAMC officials and providers about which policy they are expected to meet. By issuing clarifying guidance, VHA would eliminate confusion and improve VAMC officials' ability to make

⁶⁸While officials acknowledged they made exceptions for certain patients, they generally did not refer patients for non-VA care if they were at a high risk for suicide, had combat veteran status, or had been recently hospitalized for mental health care, among other factors.

⁶⁹Officials at one VAMC noted that they tracked no shows to CMHCs and conducted outreach via telephone and letter to ascertain the veteran's interest and need for mental health care.

decisions to prioritize and improve access. Second, VHA lacks guidance on open-access appointments, which has caused confusion about these appointments at the local level and may have contributed to some VAMCs not complying with VHA's scheduling policies. The lack of guidance on open-access appointments also could lead to inconsistent application of VHA's access policies, hinder VHA's ability to assure all veterans are getting their needs served, and may skew the performance measurements of VAMCs that use them—specifically wait-time data and no-show rates—which would result in data that is not comparable across VAMCs. Third, a key way in which VHA measures access to mental health care is through the use of wait-time data. However, our interviews with local and VISN officials confirmed confusion about what definitions are in effect when calculating wait-time measures. The lack of guidance on the calculation of these measures limits their reliability and usefulness. Until VHA clarifies how different access measures are defined and calculated and communicates any changes over time, local and VISN officials are likely to face difficulties accurately assessing wait times and identifying needed improvements.

Finally, our interviews with mental health appointment schedulers and review of medical records confirmed our previous findings about how the wait-time measures are subject to error. As a result, we are reiterating our previous recommendation 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.

Recommendations for Executive Action

To enhance VHA's oversight of veteran mental health care and, in particular, improve and ensure the accuracy, reliability, and usefulness of its mental health data, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following three actions:

- Issue clarifying guidance on which of its access policies (e.g., 14 day or 30 day) should be used for scheduling new veterans' full mental health evaluations.
- Issue guidance on how appointment scheduling for open-access appointments are required to be managed.
- 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.

Agency Comments and Our Evaluation

VHA provided written comments on a draft of this report, which we have reprinted in appendix I. In its comments, VHA concurred with our three recommendations and described the agency's plans to implement each, but disagreed with certain findings.

In its comments, VHA stated that with regard to our first recommendation, the agency is in the process of revising the relevant access policy in the *Uniform Handbook* for scheduling full mental health evaluations to be consistent with the 30-day wait time goal the agency established in response to the Choice Act. VHA stated that it has already changed its data metrics and processes for measuring wait time to align with the 30-day goal, is in the process of revising the policy, and has plans to issue clarifying guidance about the policy revisions, metrics, and expectations for scheduling mental health evaluations. VHA plans to publicize this information through national calls and set a target completion date of March 2016.

With regard to our second recommendation, VHA stated that it conducted training in summer 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. However, VHA's description of same-day appointments for individuals who need an initial mental health evaluation, which is to occur within 24 hours of a request or referral for mental health services, does not accurately represent what we observed at two VAMCs during our review. At one of these VAMCs, veterans that expressed a desire or were referred for mental health services received their initial mental health evaluation over the phone, and then, rather than being given a scheduled appointment for the full mental health evaluation, were referred to the open-access clinic to subsequently seek care. We found that close to half of the veterans at this VAMC who were referred to the open-access clinic never showed up at the clinic and follow-up was often inadequate. At the second VAMC, we found that veterans were referred to the open-access clinic, but also were given scheduled appointments for a future date. We have reviewed the training provided to schedulers, as provided by VHA, and it was unclear whether the type of same-day, walk-in appointments addressed by the training would apply to what we observed in the field. Moreover, given potential differences between certain types of walk-in 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 ensure veterans are getting their needs served and that data are comparable when VAMCs use different approaches.

With regard to our third recommendation, VHA provided an overview of the different places that data pertaining to wait times are released. VHA stated that it plans to provide an updated data definition document in October 2015 for the SAIL data and will issue an information letter in November 2015 that contains sources where the general public and VHA employees can find the definitions used to calculate wait times, including how a new patient is defined.

More generally, VHA stated that the draft report does not capture the many ways in which VHA ensures veterans receive the care they need when they want it. In particular, VHA commented that our approach did not highlight an initial assessment which veterans are to receive within 24 hours of initial contact. Although this assessment is discussed in the report, we did not use this measure because, according to VHA officials with whom we spoke, this information is not tracked consistently in VHA's medical record system. We clarified this point in the final report. We believe the report captures various ways VHA provides mental health care, including care provided in outpatient and inpatient settings.

In addition, VHA commented that the use of the preferred date provides meaningful data on wait times because it differentiates between the ideal date a veteran wants to be seen and those dates that are either before or after the veteran's preferred date. VHA commented further that they disagreed with our calculations of the overall time it takes for veterans to receive full mental health evaluations, because it would not capture situations outside of their control such as when a veteran wants to delay treatment. The preferred date is intended to take into account veterans' preferences. However, 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. The report recognizes that many factors could impact a veteran's wait time, including the veteran's preference. Further, we do not recommend a specific method for calculating wait times. Rather, our calculations included the time that a veteran waited after initially requesting or being referred for care, but before an appointment is scheduled, at which time the preferred date is set. 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. Given the potential vulnerability of veterans seeking mental health care, we believe this time is an important part of the veteran's overall experience that provides meaningful information for VHA. Our current and previous work, along with the work of VA OIG, highlights the limitations of VHA's current scheduling

practices, leading us to reiterate our previous recommendation 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 also commented that the full mental health evaluation should be considered the start of a veteran's treatment, and that therefore there is no delay in care between this evaluation and the delivery of specific interventions. However, during the course of our work, we found a lack of consensus among VHA officials on the appropriate standard or measure for calculating the beginning of treatment. Further, given the wide variation we found across VAMCs in the average number of days between a veteran receiving a full evaluation and their first treatment, as discussed in the report, we believe this presents an important opportunity for VHA to improve veterans' experiences in accessing mental health care.

Finally, VHA commented that our review did not extend to a clinical medical record review to assess quality of care. A full clinical medical record review was beyond the scope of our work. Our objectives in reviewing a selection of veterans' files were to examine veterans' access to and VHA's oversight of timely mental health care. Our review allowed us to address both objectives and provide recommendations for improving veterans' access to mental health care.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Debra A. Draper
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

October 7, 2015

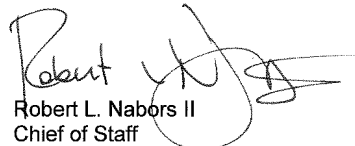
Ms. Debra A. Draper
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA MENTAL HEALTH: Clearer Guidance on Access Policies and Wait-Time Data Needed**" (GAO-16-24).

The enclosure provides detailed comments on the draft report and specifically addresses GAO's recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,


Robert L. Nabors II
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA MENTAL HEALTH: Clearer Guidance on Access Policies and
Wait-Time Data Needed”***
(GAO-16-24)

GAO Recommendation: To enhance VHA’s oversight of veteran mental health care and, in particular, improve and ensure the accuracy, reliability, and usefulness of its mental health data, GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following three actions:

Recommendation 1: Issue clarifying guidance on which of its access policies (e.g., 14 day or 30 day) should be used for scheduling new veterans’ full mental health evaluations.

VA Comment: Concur. The Veterans Health Administration (VHA) is in a dynamic situation where metrics and policy are not perfectly aligned with each other. For new patients needing to start mental health care, VHA Handbook 1160.01 establishes that all new patients requesting or referred to mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs, and to trigger hospitalization or the immediate initiation of outpatient care when needed. The initial 24-hour evaluation can be conducted by primary care, other referring licensed independent providers, or by licensed independent mental health providers.

Most importantly, VHA’s policy ensures patients needing mental health care receive clinically indicated care as quickly as possible.

In August 2014, Congress passed the Veterans Access, Choice and Accountability Act of 2014, which authorized VA to set wait-time goals for the Veterans Health Administration. These goals were published in a Notice in the Federal Register, 79 FR 62519, which can be accessed at

<https://www.federalregister.gov/articles/2014/10/17/2014-24897/wait-time-goals-of-the-department-for-the-veterans-choice-program>

The notice states:

Unless changed by further notice in the Federal Register, the term ‘wait-time goals of the Veterans Health Administration’ means not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a Veteran prefers to be seen for hospital care or medical services. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely. The Department anticipates that

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA MENTAL HEALTH: Clearer Guidance on Access Policies and
Wait-Time Data Needed”***
(GAO-16-24)

the Under Secretary for Health periodically will consider changes to the wait-time goals of VHA as appropriate.

As part of implementing the Notice, VHA has revised its metrics and processes for collecting appointment data per the 30-day standard. Now that metrics and data management processes have been revised and tested, VHA is ready to update its policy including the 14-day goal discussed above.

VHA is already revising the relevant policy and will issue clarifying guidance regarding intended policy revisions and other relevant information about metrics and national expectations for scheduling new patient mental health evaluations. VHA will also announce this information on appropriate national calls to ensure it is clearly communicated to all relevant stakeholders.

For patients who already have a mental health provider needing follow-up mental health care VHA's current policy establishes that waiting times for all mental health services for established patients must be less than 30 days from the desired date of appointment. VHA's policy is consistent with the Department's wait-time goals specified as not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a Veteran prefers to be seen for hospital care or medical services. (Federal Register Notice, 79 FR 62519, <https://www.federalregister.gov/articles/2014/10/17/2014-24897/wait-time-goals-of-the-department-for-the-veterans-choice-program>)

VHA finds that current policy for follow up appointments for established mental health patients is clear and consistent with The Veterans Access, Choice and Accountability Act. VHA will not be changing policy for follow-up appointments for established mental health patients. Target Completion Date: March 2016.

Recommendation 2: Issue guidance on how appointment scheduling for open-access appointments are required to be managed.

VA Comment: Concur. As explained by the Agency for Healthcare Research and Quality, open access, also known as same-day scheduling, is a method of scheduling in which all patients can receive an appointment slot on the day they call-in or walk-in.

VHA's ability to schedule patients for a same-day appointment (i.e., open access) is an essential component of VHA's standard of care for conducting an initial mental health evaluation within 24 hours of a Veteran's request for care. For the purpose of same-day initial mental health evaluation, licensed independent practitioners have been included as authorized to conduct the same day evaluation in order to address the varied access points to care such as, walk-ins, emergency rooms, or other specialty care clinics.

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The identification of a Veteran who may need or request mental health services can occur at several entry points to care. As a result, each facility must have a defined process that identifies a “warm hand-off” to a professional qualified to conduct the same-day initial mental health evaluation and arrange follow-up as appropriate. The facility process should, at a minimum, address the following:

- a. Apply to Veterans who are new to the facility, new to mental health, or current recipients of mental health and/or substance abuse service.
- b. Address the specific process for same day mental health evaluation.
- c. Require a “warm hand-off” to the assigned office or provider responsible for conducting the mental health evaluation. (Patients can decline a “warm hand-off.”)
- d. Ensure that a Veteran’s decision to undergo or not undergo the same day evaluation and any additional follow up is documented in the medical record.

Same-day appointment scheduling for initial mental health evaluation ensures that, if during a visit to a treatment facility, a Veteran requests or is identified as needing a mental health and/or substance abuse assessment, it will be provided (or at least offered) prior to the Veteran’s departure from the facility.

VHA policy in paragraph 4c(1) of VHA Directive 2010-027 establishes requirements for scheduling same-day appointments (e.g., walk-in appointments). VHA conducted extensive training for schedulers this year. The training included specific instruction on how to schedule same day appointments, specifically for call-ins or walk-ins. These same day scheduling procedures apply to all care settings, including for mental health care. To date, more than 23,000 schedulers have undergone training. VHA finds that the combination of current policy and training constitutes clear guidance on how to manage and schedule same-day appointments (i.e., open access appointments). Completed July 2015. We note that at this time, many schedulers are still developing proficiency with the training and are still prone to occasional errors. VHA continues to aggressively monitor appointment management and identify areas of local inconsistency in scheduling procedures.

We also agree with GAO’s finding that one VA Medical Center was using inappropriate processes for scheduling same-day appointments. VA continues to work with this facility to ensure their processes adhere to VHA same-day scheduling requirements.

Recommendation 3: 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.

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VA Comment: Concur. As discussed above, VHA communicated its standard for determining wait times by publishing a Notice in the Federal Register. If VHA changes the wait-time goals currently described in the Federal Register Notice, VA will communicate that information with a new Federal Register Notice.

VHA publically releases wait time reports for every facility and service every 2 weeks. The reports can be found at: <http://www.va.gov/health/access-audit.asp>. Each report contains the definitions and methods used to report wait-times including preferred date.

VHA issued clarification to all Network Directors on June 8, 2015. The clarification was in the form of memo titled “CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance.” The memo states: “VHA measures patient wait times using preferred date or clinically indicated date (CID) as the first reference point and the pending or completed appointment date as the second reference point.”

VA’s Strategic Analytics for Improvement and Learning Value Model or SAIL, is a system for summarizing hospital system performance within VHA. SAIL assesses 25 Quality measures in areas such as death rate, complications, and patient satisfaction, as well as overall efficiency at individual VAMCs. SAIL includes both an internal (Intranet) and external (Internet) scorecard component.

VHA publically releases a SAIL scorecard table for every facility every quarter. The reports can be found at VA Quality of Care web site (http://www.va.gov/qualityofcare/measure-up/Strategic_Analytics_for_Improvement_and_Learning_SAIL.asp).

The public-facing SAIL scorecard includes the same measures, including completed appointments, 30-day wait times for new primary care, specialty care, and mental health patients reported on the internal site.

VHA’s Completed Appointments Summary report (currently only available internally) includes a data definition document where a user may find the definitions of each wait-time measure, data sources, methodology, and time when a measure definition is updated. The design of the report includes features that allow a user to look at wait-time measures over multiple time periods (in months), make comparisons with VA overall, Veterans Integrated Service Networks (VISNs) and other clinics, and drill down the data to the stop code level. Detailed information such as new and established appointment methodology and clinical stop code grouping are embedded on the data definition document.

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An updated data definition document will be posted on the VA Quality of Care public site along with the fourth quarter fiscal year 15 SAIL scorecard tables expected to be posted by the end of October 2015.

VHA feels that the combination of our internal and external information provides staff with ready access to guidance about the definitions used to calculate wait times.

VHA will issue an information letter that contains sources where the public and VHA employees can find the definitions used to calculate wait times, such as how a new patient is defined, and announce the publication of the information letter to all staff. VHA information letters are publicly accessible at <http://www.va.gov/vhapublications/>. Target Completion Date: November 2015.

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General Comments:

The Department of Veterans Affairs (VA) appreciates GAO’s attempt to describe Veterans’ overall experience with obtaining Mental Health Care. It is clear that GAO shares the Veterans Health Administration’s (VHA) concern and commitment to ensure Veterans have timely access to appropriate high quality mental health services. However, the model GAO generated does not capture the many ways VHA ensures Veterans receive the care they need when they want it.

For example, VHA policy requires an initial assessment of the Veteran’s mental health needs within 24 hours of initial contact. The purpose of the initial assessment is to determine whether the Veteran needs treatment urgently, or whether it can be arranged through usual, routine scheduling based on the Veteran’s preference. In some circumstances, the initial contact is made by the Veteran’s primary care provider who may either complete the evaluation him/herself, or walk the Veteran directly over to a mental health provider located within the primary care team or in a mental health clinic within the same building in order to provide immediate mental health evaluation before the patient finishes with his or her appointment. In some circumstances, the provider personally transports a Veteran needing emergent mental health evaluation directly to the Emergency Department. In some circumstances, as GAO described, VHA obtains assistance from community law enforcement agents to locate and assist an anonymous Veteran who is in so much mental distress that he/she calls the Veterans Crisis Line, but hangs up without leaving essential information. GAO’s illustration of overall wait time does not capture these Veteran experiences.

For Veterans who do not need emergent or urgent treatment, VHA offers Veterans the opportunity to select an appointment time that works within their personal schedules. Some Veterans rely on others to transport them to appointments, so they want to coordinate an appointment that works for their companion. Some Veterans prefer mornings, while others prefer afternoons. Some Veterans relocate to southern states in the winter and call many months in advance to arrange future appointments. If VHA were to use GAO’s model for counting the “overall wait time” our wait time data would be uninterpretable.

To obtain meaningful data on wait times, VHA measures appointment wait times by confining the measure to the period of time between two reference points: the date a Veteran wants his/her appointment and the date the appointment is scheduled or completed. VHA aims ideally to offer appointments on the exact date the Veterans want to be seen. Any time before or after their preferred date reflects undesirable scheduling. This means if a Veteran wants to be seen today and cannot be scheduled until tomorrow, the Veteran experiences one day of undesirable scheduling, or “wait

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time.” If a Veteran wants to be seen 6 months from today and is scheduled for an appointment on the date they requested, the Veteran experiences no undesirable scheduling or “wait time.” If a Veteran wants to be seen next Tuesday and the scheduler insists on a same-day appointment to “make the wait time numbers look good” then the Veteran has been inappropriately inconvenienced to accommodate VHA’s needs.

By differentiating between ideal scheduling (i.e., the date the patient wants to be seen) and undesirable scheduling (i.e., before or after the patient’s preferred date), VHA has established a metric that respects Veterans’ preferences for when they receive care while also measuring deviation from the ideal schedule. The Veterans Access, Choice and Accountability Act of 2014 allows scheduling no more than 30 days after the patient’s preferred date.

VHA finds that GAO’s recalculation of wait-time data is uninterpretable and prone to unintended consequences for patients. Measures that do not differentiate between ideal and undesirable scheduling, such as the overall wait time described by GAO, do not appropriately address the problem identified.

VHA does not agree with GAO’s inference that a course of treatment has been delayed if it doesn’t begin at the time of the full mental health evaluation. All non-emergent outpatient medical and mental health care begins with an assessment which leads to the development of treatment options which the patient then considers and selects. Specific interventions may begin at that time of the initial evaluation or at a later date, as determined by multiple factors including patient preference. It would be erroneous to conclude that there is a delay in care if the patient does not receive or start all specific treatments in which they elect to participate at the time of an initial evaluation. Equally erroneous would be concluding that prescriptions for medication or a course of psychotherapy would be the only intervention(s) that constitute mental health outpatient treatment. Mental health providers and interdisciplinary teams work with patients to optimize the timing for initiating any additional treatments beyond those that may have begun during the initial evaluation.

Establishing a therapeutic relationship is the first and, often, the most critical step in treatment. This step begins during the initial mental health evaluation. The American Psychiatric Association practice guidelines for the psychiatric evaluation of adults establishes, “... the psychiatric evaluation is the start of a dialog with patients about many factors, including diagnosis and treatment options. Further goals of these guidelines are to improve collaborative decision making between patients and clinicians about treatment-related decisions as well as to increase coordination of psychiatric treatment with other clinicians who may be involved in the patient’s care.” The strength

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of the therapeutic relationship has been shown to predict compliance with treatment and successful treatment outcomes.

VHA finds that evidence presented in this report, and the scope of this review did not extend to a clinical medical chart review to assess for quality of care, and, in particular, whether VHA met professional standards of mental health care. This report does not provide sufficient evidence to conclude that Veterans experienced anything other than appropriate, mental health care consistent with professional quality of care standards.

Importantly, GAO describes two cases where the mental health referral was mis-handled. GAO’s review demonstrates that these isolated examples are not representative of most Veterans’ experiences with VA mental health care. Nonetheless, we will use this information in evaluations of our referral systems.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Jennie F. Apter; Robin Burke; Jyoti Gupta; Jacquelyn Hamilton; Sarah Harvey; Eagan Kemp; David Lichtenfeld; Vikki L. Porter; Brienne Tierney; and Malissa G. Winograd made key contributions to this report.

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