STATEMENT OF OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
TO THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
HONORING THE COMMITMENT: OVERCOMING BARRIERS TO QUALITY MENTAL HEALTH CARE FOR VETERANS
FEBRUARY 13, 2013

Mr. Chairman, Ranking Member Michaud, and members of the Committee, thank you for the opportunity to provide information to the Committee on the work of the Office of Inspector General (OIG) regarding the delivery and efficacy of mental health care by the Department of Veterans Affairs (VA).

VA provides medical care to eligible veterans throughout the United States through VA medical centers, VA community based outpatient clinics, and private providers in the community under the Non-VA Fee Care Program ("Fee Basis"). The activation of National Guard and Reserve units from across the country and the duration of the conflicts in Iraq and Afghanistan, combined with the increased utilization of VA mental health services by prior service-era veterans have stressed the ability of VA to provide ready and reliable access to necessary mental health care for returning veterans. The OIG has continued to report on the challenges that VA faces in delivering health care to address complex mental health issues including preventing suicides among returning veterans, addressing post traumatic stress and related clinical issues that result from prolonged combat, assisting female veterans to overcome the issues related to military sexual trauma, and providing appropriate treatment for substance use disorders while treating chronic pain conditions. Attached is a list of selected OIG reports dealing with these issues, which can be found on our website, www.va.gov/oig.

The Committee requested the OIG comment on five areas:

- **Fulfilling the promise to hire additional mental health personnel and fill the large number of existing vacancies** - In April 2012, VA announced a hiring initiative for mental health providers. As of December 26, 2012, which is the most recent information that VA provided to the OIG, less than half of the desired psychiatrists (260 of 558) have been hired and less than 70 percent of the desired psychologists (507 of 854), social workers (686 of 981) and mental health nurses (688 of 1032) have been hired. The goals identified in VA's plan are very ambitious given the limited number of mental health professionals trained each year and the increased competition for qualified mental health providers as economic and related conditions increase the non-governmental need for mental health professionals.

  VA has exceeded the hiring goal for non-clinical support staff (341 against a goal of 300). However, hiring more non-clinical staff than required does not compensate for the lack of clinical staff and may not improve efficiency.

- **Implementing the Executive Order on "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families"** – The OIG has not reviewed VA's actions related to the requirements in the Executive Order.

- **Addressing the recommendations of the recent VA Inspector General and Government Accountability Office reports** – As of today, all four recommendations from the OIG report, *Veterans Health Administration - Review of Veterans' Access to Mental Health Care* (April 23, 2012) remain open. The recommendations relate to improving the metrics used by VA to measure appointment wait times and the utilization of related metrics designed to effectively reflect the patient experience of access to mental health care and to improve management oversight of these clinical activities. In addition, VA committed to performing a staffing analysis to determine the personnel needs to provide the required mental health services. VA indicates that progress has been made toward accomplishing these goals but VA has not provided evidence of those efforts to the OIG to verify.

- **Correcting lengthy wait times, misleading access measures, and cumbersome scheduling processes and procedures** – As the OIG reports have indicated, VA mental health access times are not accurately reported and may not be the most useful measures to monitor clinical performance. While workgroups have been established and move ahead, changes to these metrics have not been finalized and/or implemented.

  The OIG has reported on the inefficiencies of the current patient appointment system for many years. The business rules of the current system also limit the usefulness of management data derived from the system. The installation of a new patient appointment system will take many months if not years to occur.

- **Effectively partnering with non-VA resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes** – VA has an inconsistent record of contracting effectively with non-VA providers to obtain health care for veterans. At present, the procurement of specialty medical services through Fee Basis does not provide a seamless compliment to in-house VA medical care. The use of the current Fee Basis business rules is cumbersome for VA facilities, and in practice, the business rules do not create certainty in the minds of veterans or Fee Basis providers that the goal of timely, appropriate health care will be delivered and paid for.

  The OIG has consistently reported on contracting issues with both in-patient and out-patient fee care. Weaknesses include reviewing bills to ensure the proper payment is made and ensuring clinical data is easily incorporated within the VA medical record. OIG has reported on instances of improper payment and/or inadequate integration of the treatment through purchased care into the veteran's medical records.

With the return of servicemen and servicewomen from our ongoing conflicts and the aging veteran population, VA faces a number of critical challenges in order to improve current performance and increasingly and consistently meet the complex mental health needs of veterans. The OIG will continue to review and report on VA actions at this critical time. Our veterans deserve no less.

SELECTED OIG REPORTS

Healthcare Inspection – Appointment Scheduling and Access Patient Call Center, VA San Diego Healthcare System, San Diego, California - 1/28/2013

Healthcare Inspection – Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma- 12/5/2012

Healthcare Inspection – Alleged Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California - 11/19/2012

Healthcare Inspection – Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas - 10/23/2012

Healthcare Inspection - Delay in Treatment, Louis Stokes VA Medical Center, Cleveland, Ohio - 10/12/2012

Healthcare Inspection – Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington - 9/25/2012

Healthcare Inspection – Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, South Dakota - 9/11/2012

Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas - 8/22/2012

Healthcare Inspection – Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic, Calais, Maine - 8/21/2012

Healthcare Inspection – Service Delivery and Follow-up After a Patient's Suicide Attempt, Minneapolis VA Health Care System, Minneapolis, Minnesota -7/19/2012

Homeless Incidence and Risk Factors for Becoming Homeless in Veterans - 5/4/2012

Healthcare Inspection – Suicide of a Veteran Enrolled in VA Supported Housing, Bay Pines VA Healthcare System, Bay Pines, FL - 4/18/2012

Healthcare Inspection – Alleged Mental Health Access and Treatment Issues at a VA Medical Center - 3/21/2012

Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas - 1/6/2012

Healthcare Inspection – Clinical and Administrative Issues in the Suicide Prevention Program Alexandria VA Medical Center Pineville, Louisiana - 8/30/2011

Healthcare Inspection – Attempted Suicide During Treatment West Palm Beach VA Medical Center, West Palm Beach, Florida - 7/25/2011

Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia - 7/12/2011

Healthcare Inspection – A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) - 6/22/2011

Healthcare Inspection – Prescribing Practices in the Pain Management Clinic, John D. Dingell VA Medical Center, Detroit, Michigan - 6/15/2011

Healthcare Inspection – Post Traumatic Stress Disorder Counseling Services at Vet Centers - 5/17/2011

Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits - 12/16/2010