Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Progress in Implementing the Veterans Health Administration's Uniform Mental Health Services Handbook

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Contents

Page

Executive Summary i

Introduction 1

Purpose 1

Background 1

Scope and Methodology 3

Results and Conclusions 7

A. Review of VHA's Continued Progress in Implementing the Handbook 7

B. Assessment of the Metrics Developed by VHA to Ensure Implementation of Handbook Requirements 25

C. Assessment of System Developed to Track Use of Evidence-Based PTSD Therapies 33

D. A Determination of Whether the Department has Sufficient Inpatient Capability Available for Substance Use Treatment 40

E. Identification of any Barriers to Full Implementation 50

Appendixes

A. Patient Utilization 53

B. Under Secretary for Health Comments 60

C. OIG Contact and Staff Acknowledgments 66

D. Report Distribution 67

Executive Summary

Introduction

As directed in House of Representatives Report 111-188 to accompany H.R. 3082, the Military Construction, Veterans Affairs, And Related Agencies Appropriations Bill, 2010, the VA Office of Inspector General (OIG) conducted (1) a review of the Department of Veteran Affairs continued progress in implementing Veterans Health Administration (VHA) Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (the Handbook); (2) an assessment of the metrics developed by the Department to ensure implementation of Handbook requirements; (3) an assessment of the system developed to track use of evidence-based post traumatic stress disorder (PTSD) therapies; (4) a determination of whether the Department has sufficient inpatient capability available for substance use treatment; and (5) identification of any barriers to full implementation.

Results

Review of VHA's Continued Progress in Implementing the Handbook

From the Handbook we selected 15 items to review based on clinical relevance; whether implementation of the item could be reliably measured; and whether implementation of the item could be objectively validated.

To assess implementation we queried the OIG Austin Data Analysis Section in Austin, Texas for diagnostic data using the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) system, data pertaining to VHA Decision Support System (DSS) administrative stop code usage, and treatment data using the Current Procedural Terminology system for October 2009; reviewed relevant documentation; and made on-site visits.

The scope of this inspection included VA Medical Centers (VAMCs) and Very Large Community Based Outpatient Clinics (VL CBOCs).

The items for which implementation is near universal or universal across VAMCs are provision of specialized individual and/or group clinics for PTSD; individual psychotherapy for patients with major depression; pharmacotherapy for depression; 24/7 on-call mental health emergency department coverage; and evening clinics to expand access to mental health care.

The items for which implementation is prevalent to a substantial degree but for which uniform implementation has not been achieved across VAMCs include Mental Health in Primary Care Integrated Programs; Grant and Per Diem or alternative residential treatment for homeless veterans with mental illness; telemental health; treatment for

opioid dependence with either buprenorphine or an opioid replacement treatment program (demand for this service is minimal at some sites); and the availability of secure bedrooms for women veterans on acute inpatient units.

Although neuropsychological (cognitive) testing is not an explicit Handbook requirement, we believe it to be an implicit requirement in order to provide a full range of services for patients with traumatic brain injury (the explicit Handbook requirement). Committee on Accreditation of Rehabilitation Facilities (CARF) accreditation of residential programs is dependent on preparation for and timing of the CARF inspection process for which several VHA sites are on the queue.

We are concerned regarding the provision of intensive substance abuse treatment services either in an intensive outpatient treatment program or through care in a residential program. Although one or both of these services are available at more than 80 percent of VAMCs, because substance use issues are common primary and co-morbid conditions we would expect universal implementation at VAMCs.

The provision of either PTSD specific programming or consultation by outpatient PTSD specialists for patients on acute inpatient units; and the implementation of psychosocial recovery and rehabilitation outpatient centers (PRRCs) at VAMCs with more than 1500 patients on the national psychosis registry are additional areas of concern.

At VL CBOCs the provision of psychotherapy and pharmacotherapy for patients with depression is near universal. However, the degree of implementation of specialized PTSD clinics (99% versus 79%); the availability of evening clinic hours (94% versus 43%); and the presence of Mental Health in Primary Care Integrated Programs (84 versus 31) significantly lags implementation of these items at the VAMC level. This suggests that as a whole, implementation of items at VL CBOCs for which provision is required (as opposed to elements that must be made available) is generally occurring in series rather than in parallel to implementation at the VAMC level.

Looking forward, as system-wide implementation of the Handbook continues to progress, the focus should naturally shift toward efforts to measure the impact and outcomes of select Handbook items, and modifications or adjustments in delivery of care based on these health evaluations research efforts.

In addition to ascertaining the extent of implementation of the 15 Handbook items across the system, for a sub-set of items we used administrative data to review the number of unique patients who received a particular service at each VAMC and in each Veterans Integrated Service Network (VISN). A discussion of this analysis can be found in Appendix A of this report.

Assessment of Metrics Developed by VHA to Ensure Handbook Implementation

The VA Office of Mental Health Services (OMHS) utilizes an electronic implementation checklist to survey facility progress with Handbook implementation which is hierarchically organized into sections for VISN requirements, VAMC requirements, and CBOC requirements. Considering the size of the system, the breadth of the Handbook, and variation in requirements for facilities of different sizes or characteristics, this seems to be a reasonable approach by which to initially identify items and locations for which implementation is lagging.

Respondents to the OMHS' internal implementation checklist indicated that 85.6 percent of requirements had been implemented at more than 80 percent of VAMCs and 71.1 percent had been implemented at more than 90 percent of VAMCs. At VL CBOCs 85 percent of items on the checklist had been implemented at more than 80 percent of VL CBOCs and 74 percent had been implemented at more than 90 percent of VL CBOCs.

For certain mental health services, the OMHS has begun comparing data from 22 stop codes to data for related responses from the internal survey and is developing efforts to quantify the level of each activity (the average number of encounters per veteran for a service) provided at facilities.

VHA uses performance monitor data to track provision of a few Handbook items relevant to mental health care access. VHA performance monitor data indicates that facilities are providing timely access to follow-up evaluation or treatment following initial new patient mental health encounters but continue to struggle with ensuring follow-up within 7 days of inpatient discharge.

In October 2009, the Secretary of the Department of Veterans Affairs directed VHA to implement a PTSD outcome measure for Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. VHA will use the 17 item PTSD Checklist (PCL). As of January 2010, at PTSD clinical team (PCT) clinics, the PCL will be administered to new OEF/OIF veterans on initial evaluation and on quarterly follow-up during active treatment. Administration of the PCL will be strongly encouraged but not required for use with other PCT clinic patients. The OMHS is presently working toward implementation of the Public Health Questionnaire (PHQ-9) and the Brief Assessment Module (BAM) respectively for outcomes measurement in patients with depression and substance use disorders.

Assessment of the System Developed to Track Use of Evidence-Based PTSD Therapies

VHA clinical leaders have made progress in developing electronic medical record based templates which will facilitate tracking the provision and utilization of evidence-based therapies (EBT) for PTSD and which promote fidelity with which cognitive processing therapy (CPT) and prolonged exposure (PE) therapy are provided. VHA will be better

able to track the delivery of EBT when templates are fully operational and disseminated as the templates will provide uniform and easily retrievable documentation of the selection, course, and outcome of treatment.

Mandatory use of EBT templates may be impractical for some providers or at some locations. When piloting the templates, OMHS will ascertain whether the templates take less or more time than traditional medical record documentation and whether the templates are user friendly.

The OMHS has undertaken a large-scale effort to train mental health practitioners in EBT. As of November 17, 2009, the total number of mental health practitioners (VAMCs and CBOCs) who have completed either the CPT or the PE workshop training is 3,086. A small number of providers may have completed both CPT and PE training. Because these clinicians would be counted separately in both the CPT and PE training totals, the combined number of clinicians trained in either CPT or PE (3086) may exceed by a small margin the number of unique providers who have been trained.

We used the ratio of VHA clinicians trained in CPT or PE to the number of unique patients seen for an individual PCT clinic or non-PCT specialized PTSD clinic visit as a metric by which to assess the availability of trained providers to those patients most likely seeking intensive treatment for PTSD during the 1-month period following the Handbook implementation deadline. By VISN, ratios ranged from 1:5 to 1:25. At specialized PTSD clinics, we believe that VHA should ensure that a sufficient number of trained clinicians are available to provide adequate capacity to deliver CPT and PE for patients with PTSD treated in these settings.

Determination of Whether the Department has Sufficient Inpatient Capability Available for Substance Use Treatment

Primary or co-morbid substance use is common among patients utilizing VA residential treatment. For the system as a whole, the Department's overall capability to provide residential substance use treatment services appears grossly in line with demand based on average occupancy rate and Office of Strategic Planning and Analysis' adaptation of the VA Model projections data. However, using these analytic perspectives, potential gaps exist on the VISN and/or facility level.

At the VISN and facility level we are unable to come to a clear conclusion because of methodologic limitations, the lack of available data on the use of non-VHA residential program beds, the potential impact of initiatives to outreach and engage homeless veterans, and the impact of current economic circumstance.

Expanded implementation of intensive outpatient substance use treatment programs may impact utilization for residential substance use treatment and could modulate length of stay by facilitating transition to an alternative level of intensive services. In addition,

comparative outcomes research for residential treatment programs and intensive outpatient substance use programs would further inform needs analysis.

Identification of Barriers to Full Implementation

From Handbook exception/modification requests and interview of facility mental health leaders, the most commonly identified barriers to implementation across VISNs were need for additional space; need for additional staff; and recruitment of staff.

A few sites requested extensions for staff training in evidence-based therapies (for PTSD, depression, or Social Skills Training). Two of these sites listed availability of training slots and/or local training funds as additional resource needs.

The final push to hire Mental Health Enhancement Initiative (MHEI) funded mental health full-time equivalent employee (MH FTEE) during the second half of FY 2009 was accompanied by a decrease in Veterans Equitable Resource Allocation (VERA) funded MH FTEE, perhaps reflecting a natural time lag inherent in recruitment and hiring processes but raising concerns that VISN and facility leadership were able to fill MHEI positions with existing MH staff but will not sufficiently recruit or hire to fill vacated VERA funded positions. Mental health leaders expressed their hope that this trend will reverse in order to optimize gains in MH FTEE from the MHEI funding.

We made the following recommendations:

Recommendation 1. We recommended that the Under Secretary for Health in conjunction with the OMHS review the data from this report along with internal VHA data and take steps to prioritize implementation of Handbook requirements as deemed appropriate.

Recommendation 2. We recommended that the Under Secretary for Health in conjunction with the OMHS should evaluate the potential benefits, costs, and/or unintended consequences of implementing new or refining existing administrative data sources or documentation to improve tracking of services relevant to management of VHA mental health care.

Recommendation 3. We recommended that the Under Secretary for Health in conjunction with VISN and facility senior managers should ensure that specialized PTSD clinics have sufficient capacity to provide CPT and PE to patients with PTSD treated in that setting.

Recommendation 4. We recommended that the Under Secretary for Health ensure that the OMHS in conjunction with VISN Directors conduct a facility by facility tracking and analysis of bed need for residential substance use treatment, utilization of contract and other non-VA residential substance use treatment beds, and utilization for substance use treatment of residential program beds located at other VAMCs.

Recommendation 5. We recommended that the Under Secretary for Health review barriers to implementation and take appropriate actions to address these barriers.

Comments

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and conclusions (See Appendix B for the complete text of the Under Secretary's comments).

Assistant Inspector General for Healthcare Inspections Comments

The Under Secretary for Health's comments and implementation plan are responsive to the recommendation. We will continue to follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Purpose

As directed in House of Representatives Report 111-188 to accompany H.R. 3082, the Military Construction, Veterans Affairs, And Related Agencies Appropriations Bill, 2010, the VA Office of Inspector General (OIG) conducted a review of the Department of Veteran Affairs continued progress in implementing VHA (Veterans Health Administration) Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (the Handbook); an assessment of the metrics developed by the Department to ensure implementation of Handbook requirements; an assessment of the system developed to track use of evidence-based post traumatic stress disorder (PTSD) therapies, a determination of whether the Department has sufficient inpatient capability available for substance use treatment; and identification of any barriers to full implementation.

Background

The Handbook specifies the bundle of required mental health services that must be accessible to patients at Veterans Affairs Medical Centers (VAMCs), very large Community Based Outpatient Centers (VL CBOCs), large CBOCs, mid-size CBOCs and small CBOCs. Required Handbook elements must either be provided (delivered when clinically needed to patients receiving health care at a facility by appropriate staff located at that facility) or available (made accessible when clinically needed to VA patients). Whether a required element is to be provided or available depends on the nature of the requirement itself, and on the facility size (VAMC, VL CBOC, and large CBOC). Several of the elements required in the different sections of the Handbook incorporate a recovery based focus, best practices, and/or evidence-based treatments.

The mental health services required by the Handbook represent the next step in the process that began with approval of VHA's Mental Health Strategic Plan in 2004. The Handbook is positioned to be a "bridge to the future" for VA mental health care.[1] The Handbook sets the expectation that facilities will have implemented the applicable requirements by September 30, 2009. The Mental Health Enhancement Initiative (MHEI), a special purpose fund (centralized fund for specific programmatic activities), was created in 2005 to support implementation of the mental health strategic plan. The MHEI grew from $100 million in FY 2005 to $557 million in FY 2009. After FY 2009, MHEI funding is to be rolled over into the Veterans Equitable Resource Allocation

[1] VA Mental Health: *Looking Ahead*, Zeiss, Antonette, PhD, Power Point presentation, VA Psychology Leadership Meeting, 2009.

(VERA) funding. [2] VHA instituted the initial VERA system in April 1997 to allocate funds to Veterans Integrated Service Networks (VISNs). VERA provides a methodology to distribute funds based on veteran use of the VA health care system rather than on reimbursement of cost. General purpose funds are distributed to VISNs at the beginning of each fiscal year based on the VERA model.

The VA Office of Policy and Planning in conjunction with RAND is presently in the final phase of completing a $9 million program evaluation of services for Veterans with PTSD, Major Depression, Bipolar Disorder, Schizophrenia, and Substance Use Disorder. The study was undertaken by VHA in response to the Government Performance and Results Act (GPRA). The evaluation started in 2006, and will be completed in mid-2010. It was designed to be prospective and to analyze in part, the impact of implementation of the mental health strategic plan. Phase 1 consisted of a survey of VA VISNs and facilities conducted in 2007 to establish a rough baseline of services reported by VA facilities. The survey is being repeated in FY 2010. In addition, the study will include an evaluation of patient charts, and a telephone survey of about 8,000 veterans.

The April 2009 OIG Healthcare Inspection report, *Implementation of VHA's Uniform Mental Health Services Handbook*, looked at the extent to which selected elements from the Handbook had been implemented at VAMCs. This review occurred at approximately the midpoint of the deadline for Handbook implementation. Overall, we found mixed results with approximately one-half of the selected elements implemented in more than 90 percent of facilities but one-third of the selected elements implemented in less than 80 percent of facilities.

We expressed the concern that a system was not in place by which VHA could reliably track provision and utilization of evidence-based PTSD therapies on a national level. A system, whether based on use of specific administrative data codes, chart documentation, or other means, would allow VHA to assess the extent to which these therapies are provided to patients, would facilitate analysis of treatment outcomes, and aid comparative effectiveness research. We identified representative items/areas of risk for not meeting the system-wide implementation goal, and we suggested that VHA develop metrics and outcome measures to facilitate dynamic adjustment of handbook requirements in response to changing mental health care needs of the veteran population.

[2] Testimony of the American Association for Geriatric Psychiatry for the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, U.S. House of Representatives, Hearing on FY 2010 Appropriations for the Department of Veterans Affairs, April 23, 2009.

Scope and Methodology

1. Review of VHA's Continued Progress in Implementing the Handbook

The universe of VAMCs consisted of 139 facilities.[3] In addition to VAMCs, the scope of this inspection also included assessing implementation of select items at 48 VL CBOCs.[4]

The Handbook contains more than 200 items. For some items the wording is manifest (such as, "In all cases, veterans treated on acute inpatient psychiatry units must be seen for face-to-face evaluations within 2 weeks of discharge"). For other items the wording is conceptually based and interpretable (such as, "inpatient units must promote a positive therapeutic and least restrictive environment and strive to be restraint-free").

VHA uses outpatient mental health Decision Support System (DSS) identifiers or "stop codes" to administratively capture provision of services by VHA providers.[5] Use of DSS identifiers pre-dates development of the Handbook by several years. Some identifiers are more general in nature than others. There are a small number that correspond directly to items in the Handbook, some that correspond generally but not specifically, and others which do not correspond at all. A few DSS specifiers were recently added to align with specific elements in the Handbook (such as, 591-incarcerated veterans re-entry used to record interventions for incarcerated veterans exiting correctional institutions and re-entering community living.)

While use of some stop codes across VHA is relatively uniform, other or newer stop codes may not be utilized in a consistent fashion which affects the sensitivity and completeness of data collected for these codes. For example, in the winter of 2009, an analysis by the mental health leadership in one VISN found that providers in only two of eight facilities were consistently using the 534 (mental health in primary care stop code) to capture care delivered by mental health clinicians in an integrated primary care clinic setting. The VISN urged uniform use of the stop code, and reportedly by the fall of 2009

[3] Administratively, separate campuses or divisions are considered part of one unified VAMC system with a unitary leadership team (such as the University Hospital, Highland Drive, and Heinz divisions of the Pittsburgh VAMC). For internal purposes VHA tracks implementation based on VAMC systems. In addition we included the Columbus, Ohio ambulatory care center since this facility functionally resembles a VAMC more than a VL CBOC.

[4] Very Large CBOCs are those that serve more than 10,000 unique veterans in a year. In FY 2009, as a component of the OIG CBOC Project Reviews, inspectors looked at compliance with annual PTSD screening and compliance with screening for suicidal ideation in those patients who screened positive for PTSD. For FY 2010, the OIG CBOC Project Review team is reviewing whether patients who are assessed to be high risk for suicide have safety plans that provide strategies that help mitigate or avert suicidal crisis, and how CBOCs address the mental health needs of OEF/OIF veterans.

[5] The VHA DSS is a managerial cost accounting system that is based on commercial software named Eclipsys. Introduced in 1994, full implementation of the VHA DSS in all facilities was completed in 1999. The VHA DSS data files comprise a longitudinal, secondary relational database combining selected clinical data and fiscal (cost) data. DSS provides a mechanism for integrating expenses, workload, and patient utilization.

all VAMCs in the VISN were using this code.[6] In considering items for which to query and collect stop code related data, we interviewed clinicians who were the point of contact or "champions" for particular stop codes, in order to assess the specificity with which a code was being used by providers (whether a stop code was being used by providers to capture one specific type of activity or a general range of activities) and whether providers throughout the system were actually using the code.

As noted in the April 2009 OIG report, there are no DSS specifiers, other administrative codes, or special electronic medical record documentation that directly corresponds to provision of evidence-based psychotherapies for PTSD or Depression.

For assessing implementation of Handbook requirements, randomly sampling implementation of a set number of Handbook requirements would potentially lack clinical meaning. Different requirements in the Handbook are applicable to different universes of facilities (such as VAMCs versus VL CBOCs, VAMCs with more than 1500 seriously mentally ill veterans, and facilities with inpatient units). Some are to be provided at a site and others are to be made available. Some are either/or requirements, that can be satisfied by provision of more than 1 mode of treatment. Consequently, employing a statistically representative sample of Handbook requirements would be problematic and also potentially lack clinical meaning.

From the Handbook we therefore selected 15 items to review based on clinical relevance; whether implementation of the item could be reliably measured; and whether implementation of the item could be objectively validated. Qualitative considerations in selection of items to assess included the following:

- Would provision of the Handbook item be clinically salient to the direct care of a veteran presenting to a facility for a particular or set of mental health concerns.
- Is there a DSS stop code or other administrative data that would allow for system-wide measurement and is there information to suggest that clinicians actually use the administrative code to capture the service provided?
- Could the item be reliably and sufficiently validated during an onsite visit?
- Could the item be reliably and sufficiently validated through document review?
- For particular (not all) items, was there reason to believe that implementation would be significantly lagging?

For eight of the requirements for which we assessed implementation, we queried the OIG Austin Data Analysis Section in Austin, Texas for diagnostic data using the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) system, data pertaining to VHA DSS administrative stop code usage, and treatment data using the

[6] Relative non-usage of the MST stop code is discussed in detail in the February 2010 OIG report, *Healthcare Inspection Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma*.

Current Procedural Terminology system for October 2009. We chose October 2009 because the VHA Office of Mental Health Services' (OMHS) expectation for implementation of the Handbook was September 30, 2009. We reviewed and analyzed the data to assess how many sites had implemented the requirement and the number of unique patients receiving the service.

During mid-December, 2009 and early January 2010, inspectors conducted site visits to 20 VAMCs to assess implementation of Handbook requirements pertaining to the safety and security of women veterans on acute inpatient mental health units; PTSD programming or provision of consultation by outpatient PTSD specialists to patients on acute inpatient mental health units; and after-hours coverage of emergency departments by on-call or onsite mental health providers. We used a stratified sample design to select a probability-based representative sample for on-site inspection. From a universe of all VAMC campus locations, 20 VAMC sites with inpatient units and emergency/urgent care clinics were selected. To further assess on-call mental health coverage of emergency/urgent care clinics, in January 2010 we requested pertinent documentation from 11 additional facilities that were selected as a component of the initial representative sampling procedure.

On October 14, 2009, we requested each unique VAMC and all VL CBOCs to provide us with information and documentation related to implementation of evening mental health clinics; availability of pharmacotherapy with appropriately-regulated opiate agonists for patients diagnosed with opiate dependence; and Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation of mental health residential rehabilitation treatment programs (MH RRTP). Our review also included document requests to CARF to validate MH RRTP accreditation and the Joint Commission to confirm accreditation of VHA Opioid Treatment Programs. Additionally, we interviewed VA telemental health services program leadership and reviewed telemental health utilization data.

2. An Assessment of the Metrics Developed by VHA to Ensure Implementation of Handbook Requirements

We interviewed VA OMHS leadership, obtained and reviewed internal VHA data from the Handbook implementation checklist survey process that OMHS leadership uses to track facility implementation. We ascertained which VHA performance measures and monitors are used to track required Handbook items. Data for specific measures is presented in this section of the report. We reviewed how OMHS leadership is utilizing and/or planning to utilize the information gathered from the implementation checklist and performance measure/monitors. In addition, we reviewed metrics under development and the recent implementation of a PTSD outcome measure for use in assessing and treating Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans.

3. Assessment of the System Developed to Track Use of Evidence-Based PTSD Therapies

We interviewed clinicians who are leaders in PTSD assessment, treatment, and research. We interviewed VHA informatics staff responsible for adapting templates developed to facilitate tracking of evidence-based PTSD therapies (EBT) for use with VHA's computerized medical record system. We obtained and reviewed OMHS data indicating the number of mental health clinicians who underwent VHA training in cognitive processing therapy and prolonged exposure therapy. Using data from the OIG Austin Data Analysis Center, we analyzed by VISN, the number of clinicians trained as a percentage of the number of patients with a primary PTSD diagnosis seen for individual visits at specialized PTSD stop codes during October 2009. In addition, we looked at the number of unique PTSD patients by VISN who received any kind of individual therapy for 25–30, 45–50, and 75–80 minute sessions and group therapy at specialized PTSD clinic stop codes.

4. A Determination of Whether the Department has Sufficient Inpatient Capability Available for Substance Abuse Treatment

We interviewed staff of VHA's Office of Enrollment and Forecasting (E&F) and VHA's Office of Strategic Planning and Analysis in the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning (ADUSH/PP). We looked at projected MH RRTP bed need based on Office of Strategic Planning adaptation of the output from the Office of Policy and Planning actuarial model used to project demand for VHA services. The Office of Strategic Planning adapts the output and projects the need for residential beds at VAMC sites. We compared the projected bed need to actual beds in service and interviewed VISN mental health directors to explore potential gaps. We analyzed FY 2009 residential facility occupancy rate data that is tracked by the Northeast Program Evaluation Center (NEPEC) and also interviewed VISN mental health directors to better understand drivers of occupancy rate at a VISN specific level. We obtained residential bed utilization data and substance use diagnosis (ICD-9) data for FY 2009 from the OIG Austin Data Analysis Section.

5. Identification of Any Barriers to Full Implementation

VISNs were required to provide the OMHS with requests by facilities for exceptions or modifications to implementation of Handbook requirements. The requests specify the justifications as to why facilities were unable to implement specific required items. The OMHS received exception/modification requests from 10 VISNs (1,5,8,9,10,15,18,19,21,23). We obtained the exception requests from the OMHS. From a random sample of 25 VAMC locations in the remaining VISNs we interviewed mental health directors regarding barriers to implementation. Finally, we requested OMHS data used to track aggregate mental health clinician positions that were funded through the MHEI and those that were funded through VERA.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results and Conclusions

A. Review of VHA's Continued Progress in Implementing the Handbook

In this section, we review system-wide implementation of the 15 items that we selected from the Handbook. Table 1-1 summarizes our findings. A more detailed discussion of each item follows the table.

Item	Percentage
Outpatient Services for PTSD	
VAMCs: Specialized Outpatient PTSD Clinics-individual or group treatment	**99***
VL CBOCs: Specialized Outpatient PTSD Clinics-individual or group treatment	**79**
Outpatient Services for Major Depression	
VAMCs: Provision of Individual Psychotherapy for Patients with depression	**100**
VAMCs: Provision of Pharmacotherapy for Depression	**99**
VL CBOCs: Provision of Individual Psychotherapy for Patients with Depression	**100**
VL CBOCs: Provision of Pharmacotherapy for Depression	**98**
Treatment of Substance Use Disorders	
VAMCs: Residential Treatment Program or Intensive Outpatient Substance Use Treatment Program	**83**
Intensive Outpatient Substance Use Treatment **53**	
VAMCs: Buprenorphine or Opioid Treatment Program	**74**
Buprenorphine Treatment for Opioid Dependence **71**	
Opioid Replacement Treatment Program for Opioid Dependence **23**	
Recovery and Rehabilitation/Serious Mental Illness	
VAMCs: NEPEC Approved Psychosocial Rehabilitation Recovery Centers at VAMCs with > than 1500 Seriously Mentally Ill	**33**
Either a PRRC or Alternative Outpatient Rehabilitation Program at VAMCs with > than 1500 Seriously Mentally Ill **55**	
Services for Homeless Veterans with Mental Health Issues	
VAMCs: Grant-Per-Diem/Health Care for Homeless	**86**

Vets or Alternative Residential Treatment Program		
Grant-Per-Diem/Health Care for Homeless Vets at VAMCs with > 100 Homeless Veterans	**70**	
General Ambulatory Mental Health Services		
VAMCs: Mental Health in Primary Care Integrated Programs		**84**
VAMCs: Evening Mental Health Clinics		**94**
VAMCs: Neuropsychological Testing for evaluating cognitive function in TBI Patients		**73**
VAMCs: 24/7 On-Call Mental Health Coverage for Emergency/Urgent Care ; Onsite ED Coverage for Level 1A Sites from 7AM to 11PM		**100†**
VAMCs: Telemental Health		**78**
VL CBOCs: Mental Health in Primary Care Integrated Programs		**31**
VL CBOCs: Evening Mental Health Clinics		**43**
Acute Inpatient Mental Health Services		
VAMCs: Security of Bedrooms for Women Veterans on Acute Inpatient Mental Health Units		**65†(90)‡**
VAMCs: PTSD Track on Inpatient Unit or Consultation from PCT or PTSD Specialists while on Inpatient Unit		**70†**
Residential Treatment		
VAMCs: CARF Accreditation of Residential Treatment Programs		**30**

Table 1-1. Handbook requirements selected for review in this inspection and the percentage of VAMCs at which these elements have been implemented. † Indicates estimation for all applicable VAMCs based on site visit findings. *For sites for which administrative data did not support provison of a specialized individual PTSD clinic, review of training data indicates the presence of providers trained in evidence-based therapies. ‡ With inclusion of close proximity to nursing station, 90 percent of inpatient units met the requirement. Green=items for which implementation is near universal or universal across VAMCs or VL CBOCs. Yellow=items for which implementation is prevalent to a substantial degree but for which uniform implementation has not been achieved across VAMCs. Red=areas of lagging implementation or concern.

Outpatient PTSD Specialty Services

Specialized Outpatient PTSD Clinics

The Handbook indicates that all VAMCs and VL CBOCs must have: specialized outpatient PTSD programs and the ability to provide care and support for veterans with PTSD… and either a PTSD clinical team (PCT) or PTSD specialists based on locally-determined patient population needs.

Administrative data indicate the occurrence of individual PCT clinic visits at 79 percent of VAMCs. Some facilities do not have PCT clinics. Some sites with PCT clinics have other mental health clinics at which patients may also be seen for an individual (non-

group) visit for specialized PTSD care. The data indicate individual treatment at non-PCT specialized PTSD clinics occurred at 49 percent of VAMCs. Factoring out double counting of VAMCs with both PCT and non-PCT specialized PTSD clinics, the data indicates provision of specialized individual outpatient PTSD treatment at 96 percent of VAMCs.

For the 4 percent of sites without use of these stop codes, patients may be seen by PTSD specialists in a general mental health clinic. At the sites for which administrative data did not support the presence of specialized individual PTSD clinic care, a review of evidence-based therapy training data (discussed in a later section of this report) shows the presence of EBT trained therapists at each site.

For the same time period, we looked at group visits to PTSD specialty clinics. The administrative data indicate occurrence of group PCT clinics at 76 percent of VAMCs. Factoring out double counting at sites with treatment at both PCT and non-PCT specialized PTSD clinics, the data indicate the presence of group clinics at 94 percent of VAMC sites.

Overall, data support provision of specialized PTSD individual or group clinics (the Handbook requirement) at **99** percent of VAMC sites.

During October 2009, administrative data indicates patients were seen for individual visits in specialized PTSD clinics at 48 percent of VL CBOCs and for group visits in specialized PTSD clinics at 79 percent of VL CBOCs. Overall the data indicates the presence of specialized PTSD or group clinics (the Handbook requirement) at **79** percent of sites.

A later section of this report reviews the availability of clinicians to provide evidence-based therapy for patients seen at specialized PTSD clinics.

Outpatient Services for Major Depression

Provision of Psychotherapy for Patients with Depression

The Handbook indicates that all veterans with depression must have access to evidence-based psychotherapy for depression.

Although it is not possible through analysis of administrative data or chart review to accurately determine whether and to what extent facilities are specifically providing evidence-based therapies for depression, as a marker (proxy measure) we are able to characterize the provision of any type of psychotherapy to VA patients with major depression.

Using administrative data, for clinical encounters coded for individual psychotherapy of 20–30, 45–50 or 75–80 minutes duration we found that some type of individual

psychotherapy was provided to patients with major depression at **100** percent of VAMCs during October 2009.

We also determined the number of unique patients with a primary diagnosis of depression who received some form of group therapy. Data indicate group psychotherapy was provided to patients with a primary diagnosis of major depression at **96** percent of VAMCs.

Patients with a primary diagnosis of major depression were seen for individual psychotherapy at **all** VL CBOC sites and patients with a primary diagnosis of depression received group therapy at 92 percent of VL CBOC sites.

Provision of Pharmacotherapy for Depression

The Handbook also states that all care sites, medical centers and CBOCs need to provide evidence-based pharmacotherapy when indicated for mood disorders.

We ascertained by site, the number of unique patients with a primary diagnosis of depression for whom a provider had coded an encounter for medication management during October 2009. The data indicate provision of medication management to patients with a primary diagnosis of major depression at **99** percent of VAMCs.

During October 2009, patients with a primary diagnosis of major depression were seen for medication management at **98** percent of VL CBOC sites.

Treatment of Substance Use Disorders

Intensive Substance Use Treatment Programs

The Handbook states that coordinated and intensive substance use treatment programs must be available for all veterans who require them to establish early remission from substance use disorders (SUD). These coordinated services can be provided through either (a) Intensive Outpatient services at least 3 hours per day at least 3 days per week in a designated program delivered by staff with documented training and competencies addressing SUD **or** (b) A MH RRTP either in a facility that specializes in SUD services or a SUD track in another MH RRTP that provides a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regimen.

After factoring out double counting for VAMCs that provide treatment for patients with substance use disorders at both an intensive outpatient substance use program and a mental health residential rehabilitative treatment program, we found that **83** percent of VAMCs satisfied the requirement in October 2009.

Because intensive outpatient substance use treatment and/or residential care are often considered "best practices" for substance dependence, we are concerned as to the absence

of full implementation. In addition, the Veteran's Mental Health and Other Care Improvements Act mandates provision of intensive outpatient substance use care services at VAMCs. A later section of this report reviews the availability of residential treatment services in detail.

Provision of intensive substance use treatment is not required at VL CBOCs.

Pharmacotherapy for Treatment of Opioid Dependence

Individuals at risk for developing substance use issues include not only users of illicit drugs, but also those under the care of a physician and who require lengthy courses of prescription pain medication. The Handbook requires VAMCs to provide or to make available pharmacotherapy for treatment of opioid dependence via the following settings: an Opioid Treatment Program (OTP) **and/or** office-based buprenorphine (opiate agonist) treatment.

An OTP is a setting of care that involves a formally-approved and regulated opioid substitution clinic wherein patients receive opioid maintenance treatment typically using methadone. Public health regulations, (42 CFR Part 8), require that all OTP programs are accredited. The Joint Commission, an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States, is the accrediting body for all VHA OTPs.

Office-based buprenorphine treatment can be prescribed as office based treatment in non-specialty settings (such as primary care), but only by a "waivered" physician.[7] While buprenorphine treatment is not subject to all of the Drug Enforcement Agency (DEA) regulations required in an officially-identified OTP, the treatment must be prescribed or dispensed by a qualified physician, who must complete specialized training and receive a "waiver" of the special registration requirements. The qualified physician is then assigned a specific DEA number to prescribe buprenorphine, in addition to their usual DEA number for prescribing other controlled medications.

We asked all VAMC locations if they provided onsite OTP and/or buprenorphine treatment.[8] Those who responded affirmatively were asked to provide us with the dates of OTP accreditation and/or physical evidence of physician DEA buprenorphine waivers. We also requested facilities that provide buprenorphine treatment to tell us how many

[7] The drug addiction treatment act of 2000 (DATA 2000) enables *qualifying physicians* to receive a *waiver* from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid therapy. This waiver allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the **Food and Drug Administration (FDA)**. On October 8, 2002, Subutex® (buprenorphine hydrochloride) and Suboxone® tablets (buprenorphine hydrochloride and naloxone hydrochloride) received FDA approval for the treatment of opioid addiction.

[8] Our review did not include offsite or non-VA fee basis care for either OTP or office-based buprenorphine treatment.

physicians provided buprenorphine treatment and the number of patients each treated. To validate OTP accreditation, we requested documentation from the Joint Commission.

We found that **74** percent of VAMC locations provided either onsite accredited OTPs or buprenorphine treatment (met the either or requirement). Seventy-one percent of VAMCs offered buprenorphine treatment and 23 percent offered OTP. We found all VA medical centers that offer buprenorphine treatment have at least one waivered physician. The number of participating physicians ranged from 1 per VAMC location to 22 physicians at one site. VAMC program sizes ranged from 1 to 344 patients in treatment. See Figure 1-1 below.

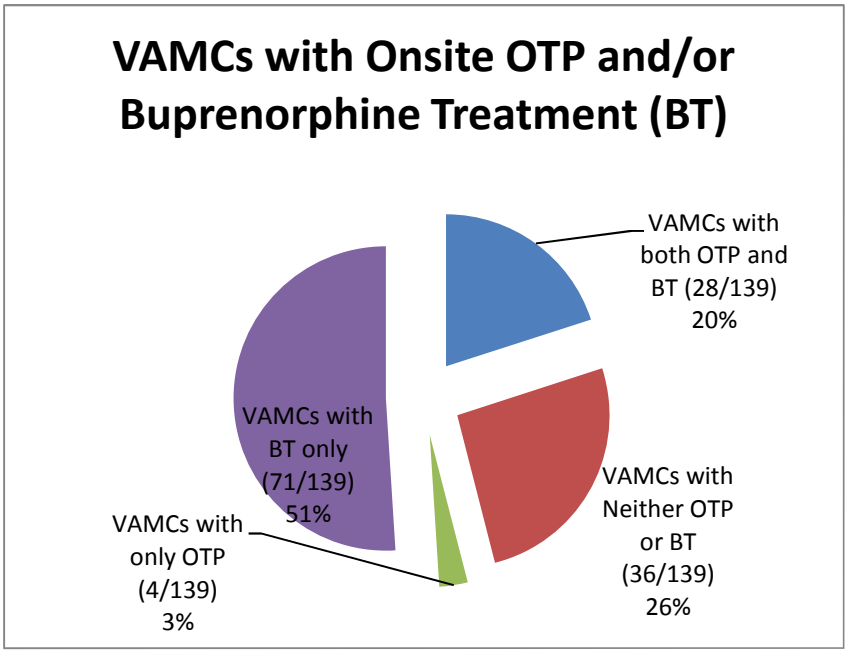

Figure 1-1. VAMCs with an onsite opioid treatment program or that provide buprenorphine treatment.

Recovery and Rehabilitation/Serious Mental Illness

Psychosocial Rehabilitation Recovery Centers Programs

The Handbook states that medical centers with 1,500 or more current patients included on the National Psychosis Registry (NPR) must have an outpatient psychosocial rehabilitation recovery center (PRRC).

PRRC programs treat patients with serious mental illness (primarily schizophrenia and other psychosis) following stabilization of an acute phase of illness. PRRCs offer a range of evidence-based psychosocial rehabilitative services such as development of individual recovery goals, development of natural supports for community integration, individual and family psychoeducation, personal wellness strategies, social and life skills training, in

addition to a variety of self-help and peer support resources. Facilities currently having day treatment centers, day hospitals, partial hospitals, or analogous programs must transform their existing programs into PRRCs.

From interviews with VA mental health clinicians, we are aware that on one end of the spectrum some facilities have made little progress to conversion to a PRRC, while at the other end of the spectrum there are sites which function largely as a PRRC but have not yet attained OMHS approval to be officially recognized as a PRRC. Barriers to approval include an OMHS space requirement and a requirement that PRRC's are first CARF accredited. Several programs are reportedly in the queue for CARF accreditation. Administrative data for October 2009 data indicate the presence of OMHS approved PRRCs at **33** percent of VAMCs with more than 1,500 seriously mentally ill (SMI) patients.

We cannot distinguish which other psychosocial rehabilitation programs are functionally non-approved PRRCs and which other psychosocial rehabilitation programs have not progressed toward functioning as PRRCs. By quantifying the total number of VAMCs at which either an approved PRRC or other psychosocial rehabilitation programs were provided, we can estimate the absolute maximum percentage of sites functionally meeting the requirement. Administrative data support provision of either an approved PRRC or other psychosocial rehabilitation program at **55** percent of VAMCs with more than 1,500 SMI patients during October 2009.

As this represents a best case scenario, more work needs to be done to achieve system-wide implementation of PRRC programs at sites with more than 1,500 SMI patients.

Services for Homeless Veterans with Mental Health Issues

Grant-Per-Diem/Health Care for Homeless Veterans

The Handbook requires all medical centers with an estimated 100 homeless veterans or more in their Primary Service Area to have one Grant and Per Diem Program **or** alternative residential care setting for homeless veterans.

The same administrative code is used to record visits provided by clinical staff of Healthcare for Homeless Veterans (HCHV) and Grant and Per Diem programs to homeless chronically mentally ill veterans with mental and/or substance use disorders.

Although we cannot separate out at which sites using the code provide only a Grant and Per Diem Program versus only the HCHV program, homeless veterans with mental health issues are served by both programs and use of the administrative code therefore serves as an appropriate indicator of service to homeless veterans with mental illness. The data for October 2009 indicate provision at 70 percent of VAMCs with more than 100 homeless veterans. The Handbook requirement (alternative residential programs or

Grant and Per Diem/HCHV programs) was satisfied by **86** percent of VAMCs with more than 100 homeless veterans.

General Ambulatory Mental Health Services

Mental Health-Primary Care Integration

VA medical centers and VL CBOCs, (those seeing more than 10,000 unique veterans each year), must have integrated mental health services that operate in their primary care clinics on a full-time basis.

In FY 2007, specially funded mental health in primary care (MH-PC) pilot programs were initially implemented at 94 facilities. Subsequently additional sites have implemented MH-PC programs. Data for October 2009 indicate implementation of MH-PC clinics at **84** percent of VAMCs.

A caveat to these numbers include the possibility that some sites have implemented MH-PC services but have not yet adopted use of the administrative specifier used to code for provision of this service.

During October 2009, we found data to support the presence of MH-PC clinics at **31** percent of VL CBOCs.

Evening Mental Health Clinics

The Handbook requires mental health clinics in VAMCs and VL CBOCs to offer a full range of services during evening hours at least 1 day per week. Additional evening, early morning, or weekend hours need to be offered when they are required to meet the needs of the facility's patient population.

To evaluate implementation of the evening mental health clinic program component, we asked all VAMCs and VL CBOCs whether or not they provided evening mental health clinic appointments. We asked those sites that responded affirmatively to provide computerized patient appointment lists, including appointment times, for licensed mental health providers who had seen patients in evening hours[9] during the 2-week period of September 21, 2009–October 2, 2009.

During this review, some facilities told us that they provided evening mental health clinics by non-licensed providers, such as substance abuse counselors. Additionally, some facilities told us that they provided mental health care in emergency departments or urgent care clinics on a walk-in basis during evening hours or on weekends. Because we believe one purpose of the Handbook requirement is to expand access and promote continuity of care by extending usual daytime mental health services provided by

[9] Examples of a licensed MH provider include psychiatrists, psychologists, and licensed certified social workers.

licensed mental health providers, such as psychotherapy and medication management beyond traditional hours, (full range of services) we did not include clinics staffed by non-licensed providers or emergent/urgent care walk-in clinic arrangements when considering whether facilities met this Handbook requirement. Our criteria should not be misconstrued to diminish the valuable care provided by non-licensed mental health providers or emergent care walk-in clinics.

Of the 139 VAMC locations, **94** percent provided onsite mental health evening clinics that were serviced by a licensed MH provider at least one evening per week. We found most VAMC mental health clinics had evening hours more than the required one day per week. Although not mandated by the Handbook, 5 percent offered weekend mental health clinic hours. See Figure 1-2.

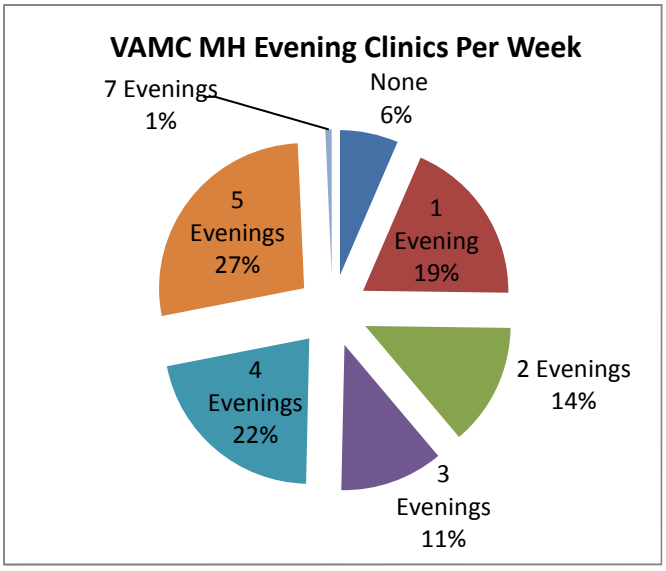

Figure 1-2. For VAMCs, the average number of mental health evening clinics per week.

The majority of locations offered hours past 7:00 p.m. Sixty-eight percent of clinic locations closed past 7 p.m. One-percent closed between 9 and 9:45 p.m. Ten percent extended clinic hours to between 5 and 6 p.m. See Figure 1-3.

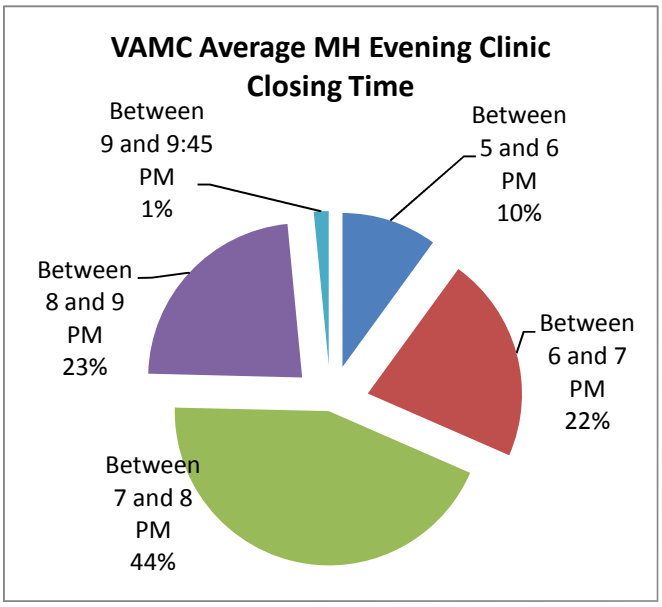

Figure 1-3. For VAMCs, average evening mental health clinic close time.

Because the Handbook does not define an evening MH clinic, we included clinics with extended hours to 6:00 p.m. in our analysis of CBOC evening MH clinic availability; however, it is our belief a clinic closed before 6:00 p.m. probably does not meet the intent of providing extended access to mental health care during the evening.

Our review revealed that 43 percent of VL CBOCs met the minimum 1 evening per week mental health evening clinic requirement. The majority of VL CBOCs that offer mental health evening clinic hours do so one day per week. Fourteen percent offer mental health evening clinics more than one evening a week. The majority of evening MH clinics are open until at least 7:30 p.m. See Figures 1-4 and 1-5.

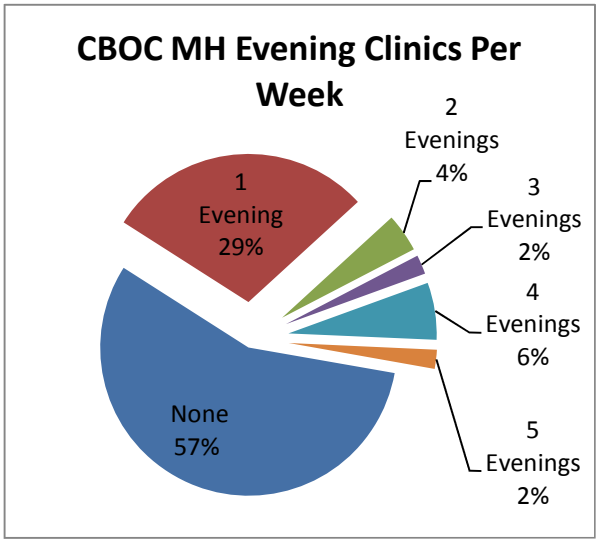

Figure 1-4. For Very Large CBOCs, average number of MH evening clinics per week.

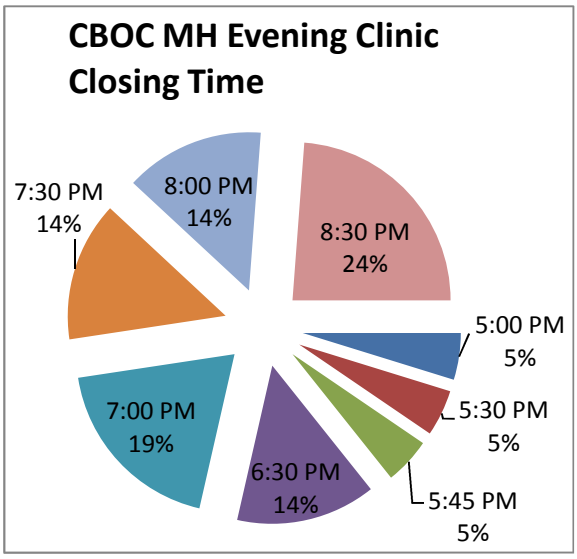

Figure 1-5. For Very Large CBOCs, average MH evening clinic closing time.

Neuropsychological Testing for Evaluating Cognitive Function in TBI

The Handbook states that mental health services including cognitive testing, diagnosis, evaluation, management of mental health and behavioral symptoms, and family consultations (when appropriate and when veterans with adequate decision-making capacity consent) must be available for all patients with Traumatic Brain Injury (TBI) who may require these services.

TBI and PTSD are often cited as signature OEF/OIF related injuries. Formal neuropsycholgical cognitive testing can provide information on a patient's cognitive, motor, behavioral, language, and executive functioning. When used along with clinical exam and other tests, neuropsycholgoical testing can provide information to aide diagnosis of cognitive deficit.

In addition, neuropsycholgical testing may indicate areas of impaired brain functioning and can be used in rehabilitation treatment planning for cognitively impaired patients.[10]

For October 2009, we looked at the number of VAMC sites for which encounters were administratively coded to indicate provision of neuropsychological testing and interpretation by a psychologist. Data indicate that patients received some form of neuropsychological testing at **73** percent of VAMCs. This does not take into consideration patients who were referred for neuropsychological testing through fee-basis arrangements.

[10] Malik, Atif B, MD, Turner, Megan E., Sadler, Craig, Neuropsychological Evaluation, e-medicine from WebMD, February 5, 2009.

Onsite/On-Call Mental Health Coverage for Emergency/Urgent Care Clinics

The Handbook requires that all VHA Emergency Departments (EDs) have mental health coverage by an independent, licensed mental health provider either onsite or on call, on a 24/7 basis. Level 1A facilities[11] must have mental health coverage onsite (based in the ED) from 7 a.m. to 11 a.m. At other times, it may be onsite or on-call.[12] For other facilities, coverage may be either onsite or on-call at all times.

Ten of the 20 sites we visited were Level 1A facilities. We visited the ED or Urgent Care Center (UCC) at these facilities after hours and met the mental health clinician onsite. For the remaining 10 sites visited, we went to the ED/UCC and verbally confirmed, from talking to ED/UCC staff and obtaining documentation (printed call schedule), that a mental health clinician was either onsite or on call. We found that **all** 20 sites visited complied with the Handbook regarding ED/UCC coverage for Level 1A and Non-1A facilities.

In addition to the 20 onsite visits, we also contacted 11 other sites by telephone and requested their on-call list for a specific day in December 2009. **All** 11 sites promptly provided documentation of having at least one, and in some cases two, on-call MH clinicians for coverage of their ED or UCC as required. Based on the 20 sites visited we estimate that all Level 1A VAMCs with emergency departments have onsite mental health coverage from 7 a.m. to 11 p.m. and that all VAMCs with emergency/urgent care clinics have 24/7 on-call mental health coverage. Table 1-2 shows the mental health disciplines for the first on-call mental health clinicians at the 20 sites visited.

Mental Health Discipline	1A Facility	Non-1A Facility
Psychiatrist	1	6
Resident with Attending Psychiatrist for Back-Up	4	3
Psychologist	1	
Social Worker	4	1

Table 1-2. Mental health disciplines for on-call mental health clinicians at the 20 sites visited.

Telemental Health

Facility size and geographic location can influence the ability facilities have to make available and/or to provide mental health services on site. Consequently, the Handbook allows and supports the utilization of telemental health to extend services when there are gaps between clinically required mental health services and those that are available at the

[11] As defined by VHA Handbook 1160.01: Facilities that have a higher utilization of services, higher risk patients, specialized intensive care units, research, educational and clinical missions.
[12] As defined by VHA Handbook 1160.01: On call coverage requires a telephone response within 20 minutes and the ability to implement onsite evaluations within a period of time to be established on a facility-by-facility basis.

VA facility nearest to the patient's home. Although provision of telemental health is not in itself a specific Handbook requirement, use of telemental health facilitates provision or availability of other mental health programming and treatment required in the Handbook.

Telemental health requires a qualified professional at the provider facility, support staff at the distal end who can arrange appropriate time and space for the veteran, staff who can provide technical support as needed, and necessary equipment and technical infrastructure. It can be an effective and satisfactory method for meeting select patient mental health care needs. Telemental health is particularly beneficial to facilities in rural communities and under-served locations that experience difficulty recruiting qualified care providers. Among other benefits, telemental health can improve access to specialty mental health providers for assessment and treatment and it may reduce wait times to access care when gaps arise.

We evaluated if and to what extent facilities are utilizing telemental health. To assess the extent that facilities are utilizing telemental health, we obtained data from VHA as to the number of unique patients who received mental health care of any type via telemental health services, and the total number of telemental health appointments completed during FY 2009. During the year, 39,753 patients received mental health care via telemental health. There were 91,660 total encounters. The data indicate that **78** percent of VAMCs provided telemental health services during FY 2009.

When telemental health encounters are classified as having occurred at urban, rural, or highly rural facilities the available FY 2009 data indicates that 54 percent were provided to patients at rural or highly rural locations and supports the idea that facilities are utilizing telehealth services to enhance patient access to mental health services. Table 1-3 depicts, by VISN, the number of patients and encounters utilizing telemental health services.

VISN	Number of Patients	Encounters
1	561	1824
2	1,302	2,666
3	333	610
4	975	2,542
5	631	1,885
6	1,441	3,274
7	1,724	4,370
8	2,064	7,255
9	843	1,417
10	675	838
11	1,479	4,068
12	6,487	13,776
15	2,941	8,696
16	3,498	7,288
17	2,220	4,088
18	1,868	3,714
19	3,168	5,630
20	606	991
21	1,078	2,570
22	1,597	4,357
23	4,262	9,799

Table 1-3. By VISN, the number of patients and telemental health encounters during FY 2009.

Acute Inpatient Mental Health Services

Security of Women Veterans on Acute Inpatient Mental Health Units

According to the Handbook, all inpatient facilities must provide separate and secured sleeping accommodations for women.

For the 20 facilities visited, we toured areas of the acute mental health inpatient unit designated for women veterans to see if and how bedrooms were secured. We found that facilities attempted to ensure safe accommodations in various ways. Most of the facilities used at least one, or a combination of methods to ensure a safe and secured environment. Some facilities utilized a staff member stationed outside of designated rooms at all times, some had a small designated wing. A few facilities used staffed video surveillance for monitoring the halls. At one facility, each room had an electronic touch key pad. We found that if rooms were lockable, all locks were the same and all inpatient staff had the key or ready access. For some rooms that were lockable, bathrooms were configured within the bedrooms as part of a private room or in a suite. For those facilities with suites, staff reported making only single gender assignments for the suites.

From the sites we visited, we estimate that **65** percent of VAMCs with inpatient mental health units have secure bedrooms for women veterans. At some sites, women veterans are placed in rooms that are located within close proximity to a nursing station. With

inclusion of sites at which women veterans are placed in close proximity to the nursing station, 90 percent of sites visited met the requirement. However, at times when staff attends to patients on the unit, the nursing station may be vacant.

We found that some facilities desired further guidance in terms of how to balance the task of providing a safe environment for patients with acute mental health concerns, while maintaining privacy for female veterans (some of whom may have previously experienced military sexual trauma). Facilities would likely benefit from clarification by OMHS regarding this issue.

Inpatient PTSD Programming

The Handbook states that all inpatient mental health units must have the capability to treat patients with PTSD. This can be accomplished by establishing units or tracks with staff trained to address the needs of acutely ill veterans with PTSD, including those from OEF/OIF; or making care or consultation by outpatient PCT clinicians or PTSD specialists available to inpatients.

At the 20 sites visited, we asked inpatient unit leaders about the availability of specialized inpatient PTSD programming. When applicable we asked for related programming documents (group schedules and brochures). Three (15 percent) of 20 facilities had a specialized inpatient PTSD track. Fifteen percent of the sites we visited offered informal (separate from a dedicated unit or formal track) inpatient PTSD programming. With inclusion of the sites visited at which clinicians from the PTSD Clinical Team (PCT) outpatient clinic or other outpatient PTSD specialists provide consultation but not necessarily treatment during the inpatient stay, **70** percent of sites met the Handbook requirement. Figure 1-6 depicts the percentage of VAMC inpatient units estimated to provide inpatient PTSD programming based on the 20 sites visited.

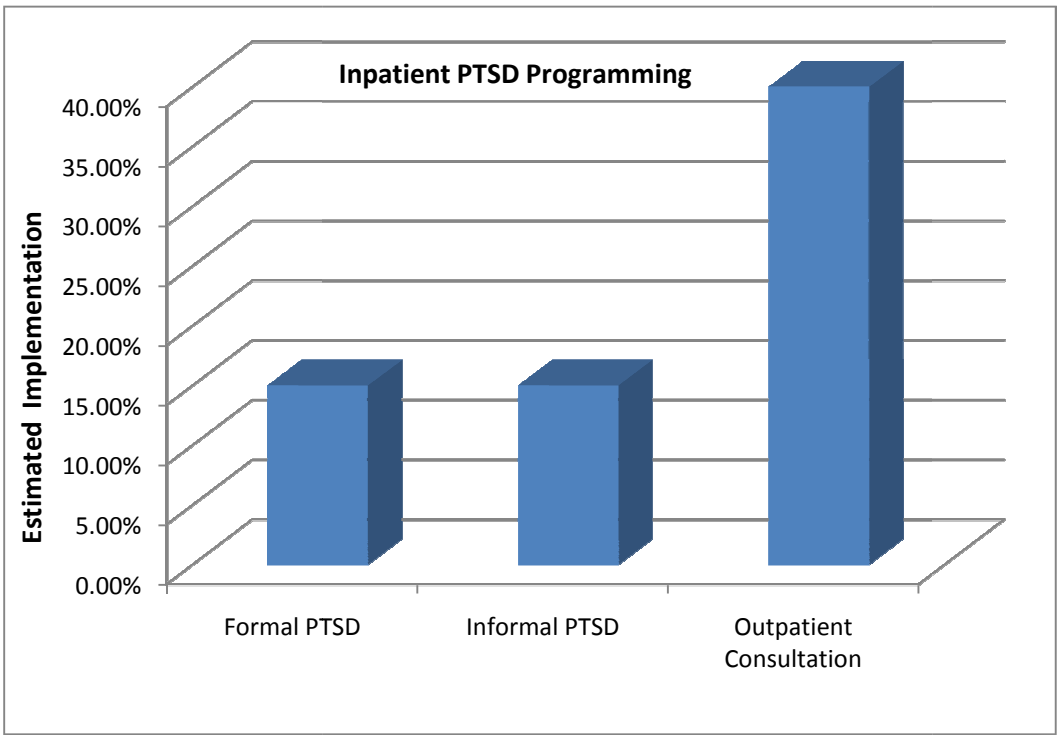

Figure 1-6. Percentage of VAMCs estimated to provide PTSD programming on acute inpatient mental health units.

Admissions to acute mental inpatient units are typically for psychiatric stabilization purposes with short lengths of stay. At some sites, clinicians did not feel that it was appropriate to initiate certain therapeutic modalities (evidence-based PTSD psychotherapies) due to the short length of stay for acute mental health inpatient admissions. They usually deferred initiation of psychotherapy or other evidenced-based treatment to outpatient follow-up, where the patient may form or continue an ongoing therapeutic relationship with a clinician or team specializing in PTSD. Optimal results for therapy are best achieved when a patient and mental health therapist can build adequate rapport and trust, as offered by outpatient follow-up or long-term residential treatment.

At one of the sites, patients diagnosed with PTSD are admitted to an acute inpatient PTSD team. When clinically appropriate, these patients receive evidenced-based therapy while on the inpatient unit. At this facility, assigned outpatient clinicians also follow patients while they are on the inpatient unit. Staff reported that this promoted greater continuity of care. At another site, a specific psychologist is notified by e-mail whenever a patient with PTSD is admitted to the inpatient mental health unit. The psychologist then meets with each PTSD patient during their stay and provides PTSD programming, education, and information about therapy options (pre-therapeutic programming) in order to set a foundation for further treatment on an outpatient basis.

Since PTSD is a significant program focus, VHA should persist in continuing efforts toward uniform provision of this service.

Residential Treatment

CARF Accreditation of MH RRTP Programs

The Handbook requires that mental health residential rehabilitation programs must be CARF accredited in behavioral health residential standards.

MH RRTPs provide residential rehabilitative and clinical treatment for patients who have a wide range of problems, illnesses, or rehabilitative care needs. Once accredited by CARF, a MH RRTP's accreditation term may be 1 or 3 years.

Documents provided by CARF indicate **30** percent of these programs were either accredited or were pending accreditation during our review period. This low level implementation is not surprising. Of the Handbook components reviewed over the course of this evaluation, it was our expectation that this component would be at the lowest level of implementation system-wide because, to some extent, CARF accreditation is not fully under the control of the facility. The accreditation process requires preparation and then placement on a queue to await an accreditation survey.

The VA OIG looked in depth at VA residential facilities during an inspection published in July 2009[13] and we plan to conduct a follow-up inspection during 2011. We included this item in our review to establish a baseline with which to compare during our follow-up review of residential programs. During the course of this review, many facilities informed us they either have 2010 surveys scheduled or plan to have them scheduled by 2011. It is our expectation that the percentage of CARF accredited facilities will increase significantly by that time.

Conclusions

The items for which implementation is near universal or universal across the 139 VAMCs are provision of specialized individual and/or group clinics for PTSD; individual psychotherapy for patients with major depression; pharmacotherapy for depression; 24/7 on-call mental health emergency department coverage; and evening clinics to expand access to mental health care.

The items for which implementation is prevalent to a substantial degree but for which uniform implementation has not been achieved across VAMCs include Mental Health in Primary Care Integrated Programs; Grant and Per-Diem or alternative residential treatment for homeless veterans with mental illness; telemental health; and treatment for

[13] *Healthcare Inspection – Review of Veterans Health Administration Residential Mental Health Care Facilities*, Report No. 08-00038-152, July 8, 2009.

opioid dependence with either buprenorphine or an opioid replacement treatment program (demand for this service is minimal at some sites); and the availability of secure rooms for women veterans on acute inpatient units.

Although neuropsychological (cognitive) testing is not an explicit Handbook requirement, we believe it to be an implicit requirement in order to provide a full range of services for patients with traumatic brain injury (the explicit Handbook requirement). CARF accreditation of residential programs is dependent on preparation for and timing of the CARF inspection process for which several VHA sites are in the queue.

We are concerned regarding the provision of intensive substance abuse treatment services either in an intensive outpatient treatment program or through care in a residential program. Although one or both of these services are available at more than 80 percent of VAMCs, because substance use issues are common primary and co-morbid conditions we would expect universal implementation at VAMCs.

The provision of either PTSD specific programming or consultation by outpatient PTSD specialists for patients on acute inpatient units; and the implementation of psychosocial recovery and rehabilitation outpatient centers (PRRCs) at VAMCs with more than 1500 patients on the national psychosis registry are additional areas of concern.

At VL CBOCs the provision of psychotherapy and pharmacotherapy for patients with depression is near universal. However, the degree of implementation of specialized PTSD clinics; the availability of evening clinic hours; and the presence of Mental Health in Primary Care Integrated Programs significantly lags implementation of these items at the VAMC level. This suggests that as a whole, implementation of items at VL CBOCs for which provision is required (as opposed to elements that must be made available) is generally occurring in series rather than in parallel to implementation at the VAMC level.

In addition to ascertaining the extent of implementation of the 15 Handbook items across the system, for a sub-set of items we used administrative data to review the number of unique patients who received a particular service at each VAMC and in each VISN. A discussion of this analysis can be found in Appendix A of this report.

Looking forward, as system-wide implementation of the Handbook continues to progress, the focus should naturally shift toward efforts to measure the impact and outcomes of select Handbook items, and modifications or adjustments in delivery of care based on these health evaluations research efforts.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health in conjunction with the OMHS review the data from this report along with internal VHA data and take steps to prioritize implementation as deemed appropriate.

B. Assessment of the Metrics Developed by VHA to Ensure Implementation of Handbook Requirements

The OMHS tracks implementation of Handbook requirements through use of an internal survey and performance measures and monitors. Recently, OMHS has initiated efforts to implement a PTSD outcome measure. In this section, we will review the processes and metrics developed by VHA to monitor implementation of the Handbook. We will also review implementation of the PTSD outcome measure.

OMHS Implementation Checklist

In April 2009, the OMHS sent an electronic survey to mental health leadership at VHA facilities. The survey instrument is formatted as a checklist with a format similar to that depicted in Table 2-1.

Handbook Element	Item	Implemented (Drop down menu)	Comments (Write in-Optional)	Plans (Write in-Optional)
Geriatric Programs				
Are the following services being provided in a timely manner to eligible veterans when required or clinically appropriate:				
The full range of integrated mental health services for older adults, including cognitive assessment, diagnostic evaluations, evidence-based interventions and family support (within existing legal authority)	22. d			
The full range of integrated mental health services in the facility's Community Living Center (CLC)	22.b			
At least 1 FTE psychologist per 100 CLC beds	22.b			
The full range of mental health services for all veterans in HBPC programs	22.c			

Table 2-1. From OMHS' internal survey checklist that was sent to facilities in April 2009.

The checklist is hierarchically organized into sections for VISN requirements, VAMC requirements, and CBOC requirements. Each section is sub-divided by Handbook topic headings (General requirements, Residential Treatment Services etc). The number of checklist items for each section decreases from the VAMC to the CBOC level. The OMHS organizes the results by VISN level, VAMC level, VL CBOC, Large CBOC, Medium Sized CBOC, and Small CBOC levels.

At CBOCs, respondents are also asked "among those CBOCs that provide this service, how is it delivered." A set of choices are given from which the respondent can then select (onsite, telemental health, telephone, referral to VAMC, contract or fee basis).

We obtained checklist results from the OMHS. Given the total number of data elements (16,128), the OMHS organizes results for each item by the percentage implementation for facilities across the system (all VAMCs) and the percentage implementation by VISN. Table 2-2 is an excerpt from the checklist depicting results from the General Requirements tab.

Handbook Element	Item	Percent of All Medical Centers that Implemented (N=144)	VISN 1 (N=9)	VISN 2 (N=5)	VISN 3 (N=5)	VISN 4 (N=9)	VISN 5 (N=4)	VISN 11 (N=7)
Has a mental health professional in its governance	7.a.	99%	89%	100%	100%	89%	100%	100%
Has a designated leader in each MH profession with responsibilities as outlined in the Handbook	7.c.1.	97%	100%	100%	100%	89%	100%	100%
Has an active local veteran Mental Health Council	8.h.	78%	100%	100%	100%	33%	75%	100%

Table 2-2. Excerpt of results compiled from OMHS spreadsheet Handbook implementation checklist.

The OMHS sent a repeat survey to facilities in late January 2010. Results were pending at the time of writing of this report.

To summarize overall Handbook compliance for the system as a whole, OMHS groups their results into the following categories: the percentage of total checklist items for which more than 90 percent of facilities reported implementation; the percentage of items for which more than 80 percent of facilities reported implementation; and the percentage of items for which less than 80 percent of facilities reported implementation.

Table 2-3 is an excerpt from the summary spreadsheet used by OMHS to tabulate overall implementation at the VAMC level for the system as a whole based on the April survey results (reformatted and resized to fit page). Results are as of August 31, 2009.

	Number of Checklist Items	Percent of Checklist Items
Total	**97**	
Compliant in >90% of VAMCs	**69**	**71.1%**
Compliant in >80% of VAMCs	**83**	**85.6%**

Table 2-3. Results from OMHS' summary of system-wide implementation for VAMCs.

OMHS tabulates overall compliance based on 97 of the items in the checklist. There are 112 items on the checklist. Some are not required by the Handbook but were included on the checklist for informational purposes. These items are not included in the tabulation of percentages. The OMHS survey found that 85.6 percent of requirements were reportedly implemented at more than 80 percent of VAMCs and 71.1 percent of the requirements were implemented at more than 90 percent of VAMCs.

OMHS's findings for VL CBOCs (as of August 31, 2009) are presented in Table 2-4.

	Number of Checklist Items	Percent of Checklist Items
Total	**38**	
Compliant in >90% of VAMCs	**28**	**73.7%**
Compliant in >80% of VAMCs	**34**	**89.5%**

Table 2-4. Results for VL CBOCs from OMHS' summary of system-wide implementation.

Table 2-5 below presents those Handbook items for which implementation by VISNs and VAMCs was reported at less than 80 percent on the OMHS checklist.

Item Description
Active Local Veteran Mental Health Council
Extended Observation in ED for up to 23 Hours
Specialized PTSD Inpatient Services either on PTSD unit or PTSD track on an inpatient unit
MH RRTP is CARRF Accredited
MH RRTP Safe Medication Management Procedures are Followed in MH RRTP Programs
Principle Mental Health Provider Assigned to Each Patient
Psychosocial Recovery and Rehabilitation Center (PRRC)
Peer Support Program
Methadone Maintenance or Buprenorphine Treatment for Opiate Dependence
Pharmacologic Treatment with Care Management for Depression/Anxiety in all Primary Care Clinics
The Full Range of Integrated MH Services in the Polytrauma Program
Geriatric Psychopharmacology in Home Based Primary Care Programs
Mental Health Services Integrated into the Geriatric Medicine Clinic
At Least one FTE Psychologist Per 100 Community Living Center Beds

Table 2-5. Handbook items for VISNs and VAMCs for which reported implementation was less than 80 percent.

More salient than collecting the survey data is what OMHS does with the data. Mental health leadership reported that data is used to identify lagging items (items that are less than 90 percent implemented across the system) and lagging facilities (facilities at which implementation does not appear in line with peer-sized facilities). The OMHS has designed a VISN specific spreadsheet report that has been sent to each VISN. For each item, the spreadsheet lists the percent implementation at applicable sites for the system as a whole, for that particular VISN, and for the facilities within that VISN. This will serve as a tool for informing facility and VISN leadership on how their progress compares to peer VISNs and facilities. Table 2-6 is an excerpt from the VISN specific spreadsheet developed by OMHS displaying results from the April survey for large CBOCs in VISN 23.

Handbook Element		Item	All VHA	VISN 23	LINCOLN
Geriatric:					
The full range of integrated mental health services for older adults, including cognitive assessment, diagnostic evaluations, evidence-based interventions and family support are available (within existing legal authority) (% Implemented)		22.d	92%	67%	YES
Number of CBOCs that Implemented =			99	2	1
Among those CBOCs that provide this service how is it delivered:	Onsite Staffing		64%	100%	YES
	Telemental Health		18%	50%	
	Telephone		7%	50%	
	Referral to VAMC		82%	50%	
	Contract or Fee-Basis		12%	0%	

Table 2-6. Excerpt from VISN specific spreadsheet tool developed by OMHS.

For certain mental health services, the OMHS has begun using data for 22 administrative stop codes for comparison to related responses from the checklist survey. The OMHS is developing efforts to quantitate the level of each activity (the average number of encounters per veteran for a service) provided at facilities. Inherent in the initial evaluation will be the determination by VHA whether facilities without evidence of activity are not using specific stop codes or whether they are not actually providing the service.

The OMHS reported also exploring development of ratios to compare activity levels at specific stop codes to the number of patients with diagnoses relevant to treatment at that stop code, once sites have achieved implementation and are universally using specific stop codes.

The OMHS is considering employing staff to periodically or on a rotating basis, visit facilities that seem to be struggling with implementation based on results from the internal checklist and use of administrative "stop code" data. The facilitators would help ensure consistent stop code usage and would determine how the OMHS could work with the facility and VISN to support implementation of lagging items.

Performance Monitors

VHA performance monitors that correspond to specific Handbook items are (1) follow-up evaluation or treatment within 14 days from initial mental health encounter

for patients new to mental health and (2) mental health follow-up within 7 days of discharge from an inpatient mental health unit.

VHA uses administrative data to track performance monitors. The Handbook requires that all new patient requesting or referred for mental health services must receive an initial evaluation within 24 hours (to identify patients with urgent needs) and more comprehensive evaluation and treatment planning within 14 days. In terms of care transitions, the Handbook also requires that veterans must receive follow-up mental health evaluations within 1 week of discharge from inpatient mental health units and must be seen for face-face evaluations within 2 weeks of discharge. Figures 2-1 and 2-2 (resized and reformatted) were provided by VHA and display results for the monitor that tracks follow-up evaluation within 14 days for new mental health patients and the monitor that tracks mental health follow-up within 7 day post discharge from an inpatient mental health unit.

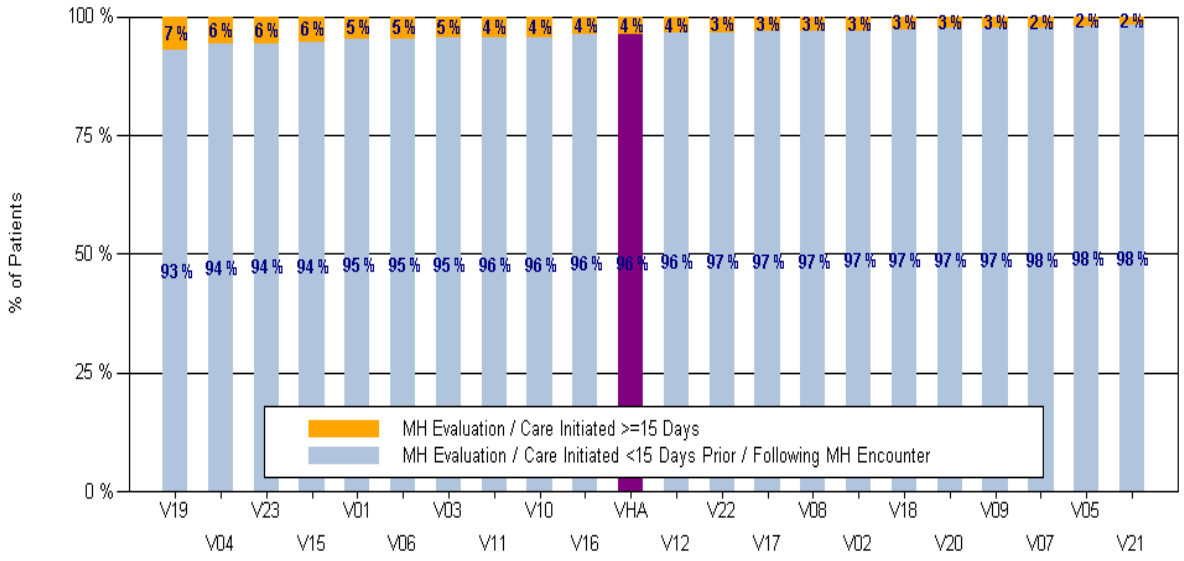

Figure 2-1. VHA Mental Health 14 Day Follow-Up Monitor by VISN, September FY 2009.

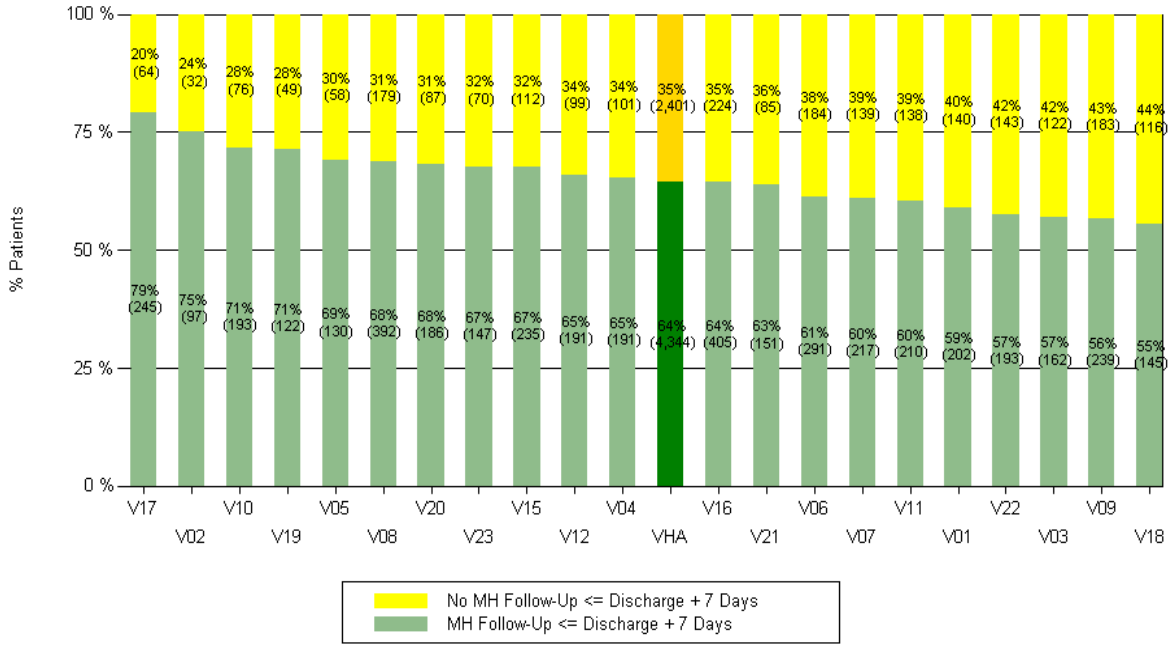

Figure 2-2. VHA FY 2009 Monitor-MH Inpatient 7 Day Follow-up Monitor, by VISN. Most Recent Discharge Date: November 27, 2009, Most Recent Encounter Date: November 19, 2009.

Figures 2-1 and 2-2 indicate that VHA facilities are providing timely access to follow-up evaluation or treatment following an initial new patient mental health encounter but continue to struggle with ensuring follow-up within 7 days of discharge from an inpatient mental health unit.

Development of Outcome Measures

In October 2009, the Secretary of the Department of Veterans Affairs directed VHA to implement a PTSD outcome measure for OEF/OIF veterans. VHA will use the 17 item PTSD Checklist (PCL). At PTSD clinical team clinics, the PCL will be administered to new OEF/OIF veterans seen on initial evaluation and on quarterly follow-up during active treatment. Administration of the PCL will be strongly encouraged but not required for use with other PCT clinic patients.

"The PCL is a 17-item self-report measure of the 17 DSM-IV[14] symptoms of PTSD. Respondents rate how much they were "bothered by that problem in the past month." Items are rated on a 5-point scale ranging from 1 ("not at all") to 5 ("extremely").[15]

[14] This is the Diagnostic and Statistical Manual of Mental Disorders, fourth version.
[15] From the VA National Center for PTSD website: http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp.

In January 2010, the OMHS instituted a performance measure to track compliance with use of the PCL. Once the measure indicates sufficient compliance, the OMHS will begin to use PCL for outcome measurement.

The OMHS is exploring implementation of the Public Health Questionnaire-9 (PHQ-9), a 9 item self-report depression scale that can be used to aid in monitoring treatment of depression and the Brief Assessment Module (BAM) for use as outcome measures.

Conclusions

The OMHS utilizes an electronic implementation checklist to survey facility progress with Handbook implementation which is hierarchically organized into sections for VISN requirements, VAMC requirements, and CBOC requirements. Considering the size of the system, the breadth of the Handbook, and variation in requirements for facilities of different sizes or characteristics, this seems to be a reasonable approach by which to initially identify items and locations for which implementation is lagging.

Respondents to the OMHS' internal implementation checklist indicated that 85.6 percent of requirements had been implemented at more than 80 percent of VAMCs and 71.1 percent had been implemented at more than 90 percent of VAMCs. At VL CBOCs 85 percent of items on the checklist had been implemented at more than 80 percent of VL CBOCs and 74 percent had been implemented at more than 90 percent of VL CBOCs.

For certain mental health services, the OMHS has begun using data from 22 stop codes for comparison to related responses from the implementation checklist and is developing efforts to quantitate the level of each activity (the average number of encounters per veteran for a service) provided at facilities.

VHA uses performance monitor data to track provision of a few Handbook items relevant to mental health care access. VHA performance monitor data indicates that facilities are providing timely access to follow-up evaluation or treatment following initial new patient mental health encounters but continue to struggle with ensuring follow-up within 7 days of inpatient discharge.

In October 2009, the Secretary of the Department of Veterans Affairs directed VHA to implement a PTSD outcome measure for OEF/OIF veterans. VHA will use the 17 item PTSD Checklist (PCL).[16] As of January 2010, at PCT clinics, the PCL will be administered to new OEF/OIF veterans on initial evaluation and on quarterly follow-up during active treatment. Administration of the PCL will be strongly encouraged but not required for use with other PCT clinic patients. The OMHS is presently working toward implementation of the Public Health Questionnaire (PHQ-9) and the Brief Assessment

[16] An additional item was added from the Public Health Questionnaire (PHQ) to measure the impact of symptoms on function.

Module (BAM) respectively for outcomes measurement in patients with depression and substance use disorders.

Recommendations

Recommendation 2. We recommended that the Under Secretary for Health in conjunction with the OMHS should evaluate the potential benefits, costs, and/or unintended consequences of implementing new or refining existing administrative data sources or documentation to improve tracking of services relevant to management of VHA mental health care.

C. Assessment of System Developed to Track Use of Evidence-Based PTSD Therapies

In mid-2009, we evaluated certain aspects of VA's implementation of the Handbook. We found that VHA did not have a system that reliably tracked (or enabled others to reliably track) the provision and utilization of evidence-based PTSD therapies (EBT) on a national level.[17] Without a tracking system, it was not possible to definitively ascertain whether medical centers were offering patients EBT, whether trained staff was conducting therapy, and whether patients were completing or benefitting from EBT. VA's Under Secretary for Health (USH) agreed that a tracking system was essential to monitor implementation of the Handbook mandate regarding EBT. The USH indicated that the VA was in the process of developing templates that would allow tracking of the delivery of therapy and that would also serve as decision-making tools for clinicians.

Development of Computerized Patient Record System (CPRS) Templates for Tracking Provision of Cognitive Processing Therapy and Prolonged Exposure Therapy

CPT is a psychotherapy that closely follows a written manual and consists of twelve 50-minute sessions focusing on cognitive interventions that are designed to assist patients in identifying the connection between events, thoughts, and feelings.[18] The sessions are weekly or bi-weekly. The patient must complete homework assignments, and specific goals are set for each session. For example, the patient writes an impact statement after completion of Session 1 which is read and discussed during Session 2. Subsequent sessions include additional writing assignments and Socratic-style questioning[19] to challenge the patient's assumptions and maladaptive thoughts. The final five sessions are devoted to examining the patient's beliefs in the areas of safety, trust,

[17] *Healthcare Inspection – Implementation of VHA's Uniform Mental Health Services Handbook*, Report No. 08-02917-105, April 6, 2009.
[18] Monson, C. et al. *Cognitive Processing Therapy for Veterans with Military-Related Posttraumatic Stress Disorder.* J. Consulting Clin Psych, Vol. 74 (5), 2006, p. 901; National Center for PTSD: *CPT Fact Sheet for Clinicians*.
[19] A method of teaching that uses probing questions to foster critical thinking.

power/control, esteem, and intimacy.[20] CPT may be delivered in either an individual or group setting.

PE therapy is a psychotherapy that also closely follows a written manual with specific agendas and treatment procedures for each session.[21] PE sessions are longer (80–90 minutes) than CPT sessions. The treatment course ranges from 7 to 15 sessions. PE therapy is also a cognitive-based therapy that focuses on the emotional reaction associated with a traumatic event and involves four primary components: education, relaxation breathing exercises, exposure to trauma-related situations (in vivo exposure), and exposure to the trauma memory through repeated recounting of the traumatic event (imaginal exposure).[22]

A template is a pre-designed document that can be formatted for common purposes. It generally contains standard elements and may be customized after completing the blank fields with individual data.

Rather than developing a single template for the EBTs, mental health managers have developed multiple session-specific templates that correspond to the goal or activity that is to be accomplished during each session of CPT or PE therapy. All the templates will contain standard items such as location of the session (outpatient clinic, residential program etc.) and diagnosis, as well as unique items that will allow the provider to document the particular events that occur during the session.

The templates will be linked to reference materials, and elements of the template will be mapped to data factors that will allow future extraction of epidemiological information. They will also be linked to software that allows clinicians to access mental health assessment tools, such as the PTSD checklist (PCL) or Beck Depression scale, that are used to monitor aspects of a patient's progress. The results of the mental health tools may be downloaded into the template or stored in the software that requires an additional level of access to enter.

The CPT template will include 12 session-specific template notes. The notes will be titled by the activities that take place during each session (for example: Trauma Event Session or Challenging Questions Session). The provider will document factual information either by checklist (for example: session was face to face, by telephone, by video or other; patient read impact statement or completed an assigned worksheet) or by choosing an option from a drop down list (session took place in a clinic or domiciliary or community living center or other). If the patient fails to accomplish the session-specific goal or the provider wishes to document other additional observations, the provider may enter comments into a text box. The provider will also be prompted to assess the degree

[20] Monson, p. 901.
[21] US DHHS. *Prolonged Exposure Therapy for Posttraumatic Stress.* April, 2003.
[22] http://vaww.infoshare.va.gov/sites/pe/default.aspx, PE for PTSD. Accessed November 18, 2009.

of collaboration between the patient and therapist (low, medium, or high) and to include a plan for the next meeting.

The PE template will include six session-specific notes. The first note will be a general pre-treatment note that includes an assessment of the patient's motivation and ability to undergo PE. Three of the session-specific notes will address issues that are examined during the first three sessions of therapy. A fifth note will document the mid-sessions which involve the in vivo and imaginal exposure components of PE. The final note will summarize the results of therapy and include any further plans or recommendations for treatment. The means for documentation of PE session-specific notes will be similar to that of the CPT notes (checklists, drop-down boxes, and text boxes).

After developing template prototypes, mental health managers forwarded them to the VA informatics department for conversion into a specialized format that is compatible with the VA electronic medical record system (CPRS). The CPT template has not yet been converted. The PE template has been successfully converted and will be the first piloted template. It took approximately 160 hours to complete the conversion process. The CPT template is more complex and will require more than 160 hours to convert into a CPRS format.

According to the MH managers, piloting of the PE template began in January 2010 in several VA medical centers that have volunteered to participate. Piloting will continue for at least 10–12 weeks. It is anticipated that revisions to the template based on piloting results will be minimal, but it may take another 10–12 weeks to retest the template after revisions are made. Piloting of the CPT template will begin after the utility of the PE template has been determined.

Dissemination of the final version of the templates will be accomplished electronically. Training of EBT staff in the use of the template will be included in EBT training courses (see below) and facilitated by the local Evidence-Based Psychotherapy Coordinator[23] once the templates are available. We estimate that the minimal amount of time for piloting (including piloting of revisions), dissemination, and training for the PE templates will be 6–8 months. It is unclear whether piloting, dissemination, and training for the CPT templates will occur concurrently with the PE template or only after the PE templates are fully operational.

Training VHA Mental Health Providers in CPT and PE

The Handbook requirement that EBT is provided or available to veterans with PTSD presumes that appropriately trained practitioners are available to provide the therapy. Historically, however, CPT and PE therapies had not been routinely included in the

[23] Per the VHA Director of Psychotherapy Programs in the Office of Mental Health, the EBT coordinator position is a .3 position. Local Evidence-Based Psychotherapy Coordinators are required at all medical centers. All but 3 facilities had Evidence-Based Psychotherapy Coordinators appointed at the time this information was requested.

curricula of mental health practitioner programs in part because clinical research has only in recent years identified CPT and PE as evidence-based therapies. In order to ensure that appropriately-trained practitioners are available to deliver EBT, the VA Office of Mental Health Services launched a national initiative to provide such training to qualified mental health providers.[24]

Multi-day workshops were offered at training sites across the country for both CPT and PE throughout 2009 and continue into 2010. After completion of the workshop, the newly-trained provider may begin to deliver CPT or PE therapy independently or continue to consult with designated trainer-experts for assistance with initial cases. Post-workshop consultation is provided to help maintain fidelity to the manualized approach of the EBTs.

CPT or PE training is not mandatory for mental health providers. Because of limitations in how the training data is collated we could not separate providers at VAMC's from those stationed at CBOC's although per VA OMHS leadership EBT trained clinicians are largely stationed at VAMC's or VL CBOC's. In addition, on different days of the week, some trained practitioners provide services at both VAMC's and affiliated CBOC's.

The total number of mental health practitioners (VAMC's and CBOC's) who have completed CPT or PE workshop training based on the data provided to us on November 17, 2009, is 3,086 (see Figure 3-1). Of those, 311 had completed consultation training and another 1,089 were still participating in consultation training. A small number of providers may have completed both CPT and PE training. Because these clinicians would be counted separately in both the CPT and PE training totals, the combined number of clinicians trained in either CPT or PE (3086) may exceed by a small margin the number of unique providers who have been trained. Given that system-wide training in CPT started prior to the rollout of PE training, to date more practitioners have completed CPT workshops than the PE workshops.

[24] See VA Rolls Out PTSD Therapy Program. http://www.index.va.gov/search/va/va_search.jsp?SQ=&TT=1&QT=va+rolls+out+ptsd+therapy; Accessed December, 4, 2009.

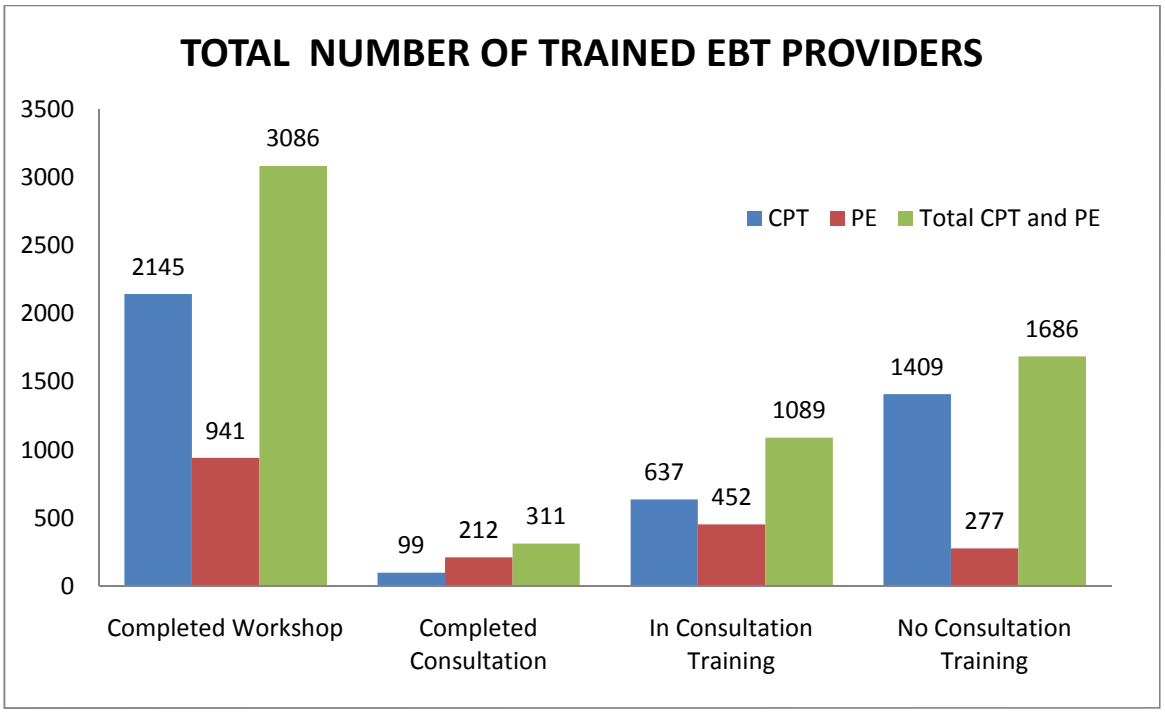

Figure 3-1. Total number providers trained by VHA in EBT for PTSD as of November 17, 2009.

The total number of providers in each VISN who have been trained by VHA in EBT for PTSD is shown in figure 3-2.

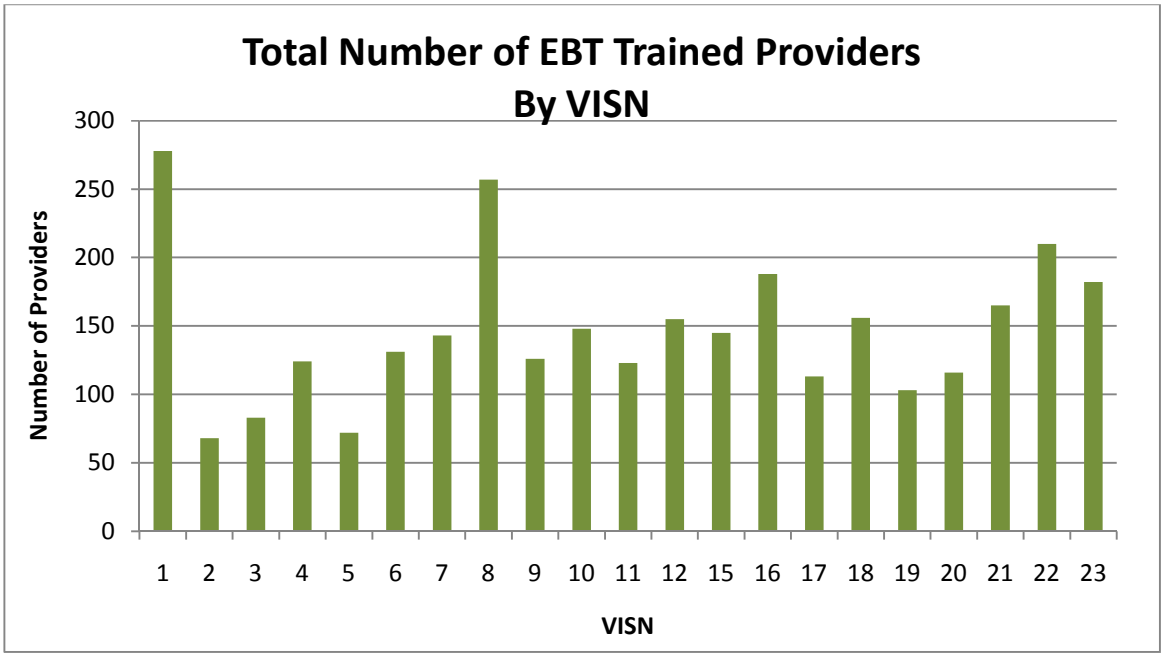

Figure 3-2. Total Number of EBT Trained Providers by VISN.

A large number of practitioners have undergone CPT workshop training in VISN 1 (particularly in the Boston VA where a core group of expert trainers are located) and a large number of practitioners have undergone PE training in VISN 8.

We recognize that the above figures do not definitively identify all practitioners available to provide EBT. For example, more recently graduated providers may have received training in CPT or PE during doctoral or post-doctoral training. Alternatively, providers may have undergone training in a non-VA setting.

Ratio of Clinicians Trained in EBT to Unique Patients with PTSD Seen for Individual Visits at Specialized PTSD Clinics during October 2009

In the absence, at the present time, of a reliable method to track the delivery of EBT to patients, we used the ratio of VA clinicians trained in CPT or PE to the number of unique patients seen for an individual (non-group) PCT or non-PCT specialized PTSD clinic visit as a metric by which to assess the availability of trained providers to those patients most likely seeking intensive treatment for PTSD during the 1 month period following the Handbook implementation deadline.

Because patients receiving CPT or PE are typically seen 1–2 times per week for 10–12 sessions, we felt that using a 1-month time period for the ratio would correspond well with the clinical aspect of these therapies. The presence of a trained EBT provider indicates availability of EBT, and therefore the potential for EBT to be delivered, but does not indicate that evidenced-based psychotherapy was provided. As a caveat, although most trained providers are stationed at VAMC sites, the training data does not separate out which EBT trained providers are stationed exclusively at CBOCs.

For October 2009, the ratio ranged from one provider per 5 unique patients seen for an individual PCT clinic visit or an individual non-PCT specialized PTSD clinic visit in VISNs 4 and 21 to one provider per 25 veterans in VISN 3. Table 3-1 displays the ratios by VISN.

VISN	Ratio of EBT Providers to Unique Patients Seen for Individual PCT and non PCT specialized PTSD Clinic Visits
1	1:10
2	1:17
3	1:25
4	1:5
5	1:12
6	1:14
7	1:20
8	1:13
9	1:12
10	1:9
11	1:12
12	1:16
15	1:13
16	1:15
17	1:10
18	1:10
19	1:6
20	1:16
21	1:5
22	1:6
23	1:7

Table 3-1. By VISN, the ratio of trained EBT providers to unique patients seen for individual PCT or non-PCT, specialized PTSD clinic visits in October 2009.

Conclusions

VHA clinical leaders have made progress in developing electronic medical record based templates which will facilitate tracking the provision and utilization of evidence-based therapies for PTSD and which promote fidelity with which cognitive processing therapy and prolonged exposure therapy are provided. VHA will be better able to track the delivery of EBT when templates are fully operational and disseminated as the templates will provide uniform and easily retrievable documentation of the selection, course, and outcome of treatment.

Mandatory use of EBT templates may be impractical for some providers or at some locations. When piloting the templates, OMHS will ascertain whether the templates take less or more time than traditional medical record documentation and whether the templates are user friendly.

The OMHS has undertaken a large-scale effort to train mental health practitioners in EBT. As of November 17, 2009, the total number of mental health practitioners (VAMC's and CBOC's) who have completed either the CPT or the PE workshop training is 3,086. A small number of providers may have completed both CPT and PE training. Because these clinicians would be counted separately in both the CPT and PE training totals, the combined number of clinicians trained in either CPT or PE (3086) may exceed by a small margin the number of unique providers who have been trained.

We used the ratio of VHA clinicians trained in CPT or PE to the number of unique patients seen for individual PCT clinic or non-PCT specialized PTSD clinic visits as a metric by which to assess the availability of trained providers to those patients most likely seeking intensive treatment for PTSD during the 1-month period following the Handbook implementation deadline. By VISN, ratios ranged from 1:5 to 1:25. At specialized PTSD clinics, we believe that VHA should ensure that a sufficient number of trained clinicians are available to provide adequate capacity to deliver CPT and PE for patients with PTSD treated in these settings.

Recommendations

Recommendation 3. We recommended that the Under Secretary for Health in conjunction with VISN and facility senior managers should ensure that specialized PTSD clinics have sufficient capacity to provide CPT and PE to patients with PTSD treated in that setting.

D. A Determination of Whether the Department has Sufficient Inpatient Capability Available for Substance Use Treatment

We approached the capability question from different perspectives through review and analysis of (1) projected MH RRTP bed need based on VHA Office of Strategic Planning adaptation of the output from the Enrollee Health Care Projection Model (VA Model) developed by the VHA Office of Enrollment and Forecasting (E&F) to project demand for VHA services[25] and (2) FY 2009 residential facility bed occupancy rate data summarized by NEPEC reports.[26]

In FY 2003 1,218,327 veterans received a mental health or substance use diagnosis in VA. Twenty-two percent of these patients received a substance use diagnosis and 18 percent were dually-diagnosed.

During the mid-1990's VA underwent transformation from a hospital, specialty care focus to a population-based, primary care focus. Although the focus was not specific to

[25] ProClarity Website: http://vaww.fcdm.med.va.gov/pas/en/src/proclarity.asp?uiConfig=hp;&book={74C453DC-AD9F-4F44-B88B-34D8366BDEB1}&page={3285F25B-4AD8-4768-B92A-39F1ED763541}&folder=root&LibID=.
[26] http://vaww.nepec.mentalhealth.med.va.gov/RRT/PRR/prrtp.htm.

mental health services, during these years VA mental health underwent significant transformation. Between 1995 and 2003, 96 percent of all inpatient substance abuse beds were closed. With the shift from inpatient to residential treatment VA began expanding residential program beds. By October 2000, traditional inpatient substance use treatment beds were almost eliminated at VAMCs and the number of residential beds more than doubled from 1994 to 2000, although this increase was not enough to offset the 91 percent decrease in traditional inpatient substance use beds.

Both in VA and non-VA settings, patients in need of medical detoxification are typically admitted for either a short stay on an acute inpatient medical unit or on an acute inpatient psychiatric unit. Assessment of the level of medical risk, the presence of co-morbid non-psychiatric medical issues, and the presence or absence of a prior history of detoxification complicated by delirium tremens or seizures helps determine the appropriate treatment setting. Once detoxification is completed, extended substance use treatment may occur in traditional outpatient settings, intensive outpatient treatment programs, or through an extended admission in a residential rehabilitation program.

Traditionally, inpatient substance use treatment can be defined as specialized substance use treatment in an acute care hospital program. Residential substance use treatment can be defined as treatment in specialized domiciliary and residential rehabilitation centers. Residential care has less intensive staffing and longer lengths of stay than acute inpatient settings.

Consistent with the shift in non-VA facilities, substance use treatment on acute inpatient units has been replaced by extended substance use treatment in residential treatment settings. In analyzing, whether VA has sufficient inpatient capability for substance use treatment, we therefore focused our review on VA residential programs.

Because of the converging patient populations, and therapeutic and rehabilitative goals of the psychosocial and domiciliary residential programs, in 2009, the VA Office of Residential Rehabilitation and Treatment Programs within the OMHS issued a Handbook that unified the domiciliary and psychosocial rehabilitation programs under a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) bed level of care and specified a common set of procedures and reporting requirements relating to VHA residential programs. At the end of FY 2009, there were 8,446 residential program beds.

Historical bed section descriptors retained in the MH RRTP bed level of care include general domiciliary, general psychosocial rehabilitation treatment program, Domiciliary Care for Homeless Veterans, Substance Abuse Residential Rehabilitation Treatment Program, Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program, and Compensated Work Therapy-Transitional Residence (CWT-TR). However, these bed section descriptors are somewhat of an artifact under the all-inclusive MH RRTP paradigm.

On interview, VA experts in the treatment of substance use and in the treatment of PTSD reported that use of residential facilities for substance use treatment is not limited to those MH RRTP programs with specialized substance use bed sections. Substance use diagnoses are frequently co-morbid with other mental health diagnosis regardless of what bed type is occupied by the patient. In practice, patients with primary substance use problems are often admitted to general MH RRTP programs at their local VAMC, and MH RRTP beds are used interchangeably to a great extent, their clinical practices and policies being fungible.

We queried the VA OIG Austin Data Center and found that during calendar year 2009, 30,512 unique patients occupied VA MH RRTP beds. Of these, 20,009 or nearly 66 percent had a substance use diagnosis. We therefore included bed availability in all MH RRTP programs in our review.

There is no single metric with which to definitively assess VA's capability for meeting the inpatient substance use needs of patients with substance use issues. Considerations include both the demand for this level of substance use treatment and the available supply of residential treatment services. Diagnosis is one measure of demand however, not all patients with a substance use diagnosis opt for or commit to residential substance use treatment, and residential treatment is not the appropriate level of care for all patients with substance use issues.[27] Waiting lists are an indicator of sufficient capacity but waiting lists are impacted by complex factors not necessarily in a facility's control; waiting lists are limited to referrals, a subset of total demand; and formal waiting lists are not universally maintained throughout the system.

Projected Demand for Substance Use Treatment Based on the VHA Enrollee Health Care Projection Model

Using data sources including the DoD and U.S. Census Bureau, the VA National Center for Veterans Analysis and Statistics' Veteran Population Model (VetPop) provides estimates and projections of the veteran population and their characteristics. Starting with VetPop data, E&F develops the VA model. Data from VHA's Health Eligibility Center provides historical information on the enrolled veteran population. Data from VHA's DSS is also utilized to determine historical workload and cost base. E&F applies assumptions from relevant program offices and subject matter experts to the model. For programs or services for which analogous programs are readily available in the non-VA sector ("bread and butter" health services) non-VHA healthcare utilization is factored into the modeling methodology.

For VHA specific programs which include residential treatment, historical VHA utilization data is modulated by changes in an array of drivers including geographic

[27] The American Society of Addiction Medicine Patient Placement Criteria (PPC-2R) provides guidelines for five levels of care: Early Intervention, Outpatient Treatment, Intensive Outpatient/Partial Hospitalization, Residential/Inpatient Treatment, and Medically-Managed Intensive Inpatient Treatment.

migration, regional utilization patterns, veteran demographics within geographic regions, and the impact of new programming and service initiatives such as the mental health Handbook. Through actuarial based modeling, E&F projects enrollment and workload by geographic location and priority level, for a range of health services. The VA model output is expressed in bed days of care for residential programs, stop codes for VHA special outpatient programs, and Current Procedural Terminology-based workload (i.e., office visits) for services readily available in the non-VA sector.

It is important to note that the VA model projects demand for different services, for example residential treatment rather than for physical assets, for example beds. The model projects expected bed days of care for residential programs as a whole and does not project enrollment for residential sub-types. A caveat to the VA model is that like any model, it is a *model* and therefore only as good as its underlying assumptions and the quality of the information available at the time that it is produced.

In turn, the Office of Strategic Planning and Analysis utilizes the VA Model projections data to derive an estimate of residential bed need in each market and at each VAMC. The simplest adaptation involves converting the VA Model bed days of care by a factor of 0.95 for sub-acute care which includes mental health residential rehabilitation programs. The Office of Strategic Planning and Analysis' estimates include those market areas without existing residential programs. For example, if historically patients in a market area where the closest facility does not have a residential program use a residential program at a nearby VAMC, the estimates will forecast bed need at the VAMCs where the workload is currently being delivered for that market area. VISNs and facilities have the opportunities each year in the Office of Strategic Planning and Analysis' Health Care Planning Model using projections data as well as other programmatic inputs to re-allocate residential rehabilitation workload to facilities closer to market areas where demand originates from and develop plans to implement these changes.

NEPEC collects VISN data on bed availability and occupancy from facility quarterly bed reports (QBR[28] – bed counts, gains and loss reports, average occupancy) and facility bed change request letters to modify the category of patient using each bed. The values are accumulated each quarter and reset at the start of each fiscal year.

We compared the present availability of MH RRTP beds in operation (from NEPEC) to projected bed utilization based on VHA Office of Strategic Planning and Analysis adaptation of VA Model output. System-wide, NEPEC QBR's indicate availability of 8,358 and 8,446 MH RRTP beds in FY 2008 and FY 2009 respectively. System-wide, the estimated bed need based on the adapted VA Model output was 7,721 and 7,956 for these years. For FY 2008 actual residential bed presence exceeded projected utilization by 637 beds and by 490 in FY 2009. However, these overall system-wide numbers do not reflect variances on a VISN and local level.

[28] Example: http://vaww.nepec.mentalhealth.med.va.gov/RRT/PRR/prrMH9Q3.pdf.

We compared actual bed presence to projected bed utilization on a VISN and facility level. Table 4-1 depicts by VISN, available MH RRTP beds and projected residential bed need for FY 2008 and FY 2009 based on adaptation of the VA Model.

VISN	Actual Beds FY 2008	Projected Utilization FY 2008	Actual Beds FY 2009	Projected Utilization FY 2009
1	302	387	301	379
2	375	285	381	288
3	410	428	420	418
4	485	524	485	529
5	566	583	566	591
6	257	269	274	292
7	410	455	410	473
8	293	240	293	295
9	371	315	356	315
10	514	420	514	418
11	180	221	240	234
12	616	530	616	538
15	338	344	363	359
16	271	234	271	268
17	891	776	891	802
18	257	205	267	220
19	112	132	119	131
20	763	684	769	691
21	221	200	223	211
22	321	199	321	199
23	405	290	366	305
Total	8358	7721	8446	7956

Table 4-1. Comparison of existing operating residential beds with projected residential bed need based on adaptation of the VA Model output for FY 2008 and FY 2009.

Figure 4-1 displays projected gaps (positive and negative) between actual residential bed presence and projected residential bed utilization need for FY 2009.

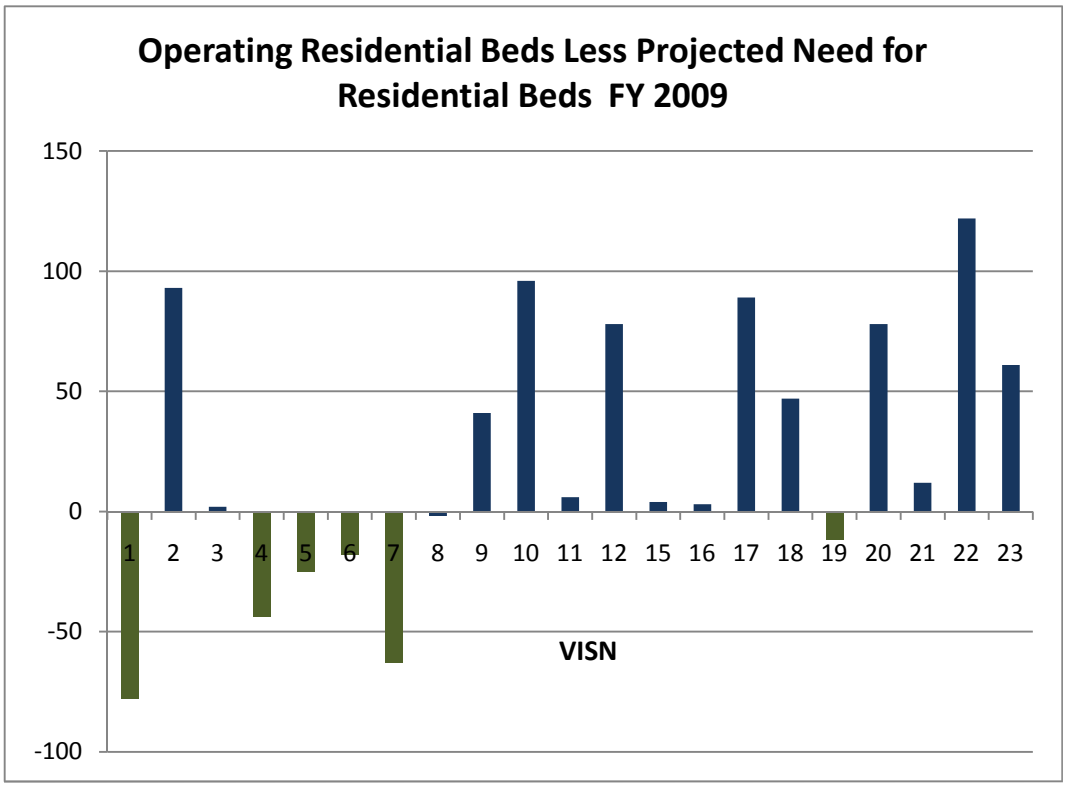

Figure 4-1. By VISN, projected gaps between residential beds in operation and the projected need for residential beds for FY 2009. Projected need is based on adaptation of VA Model output.

Using this analytic paradigm, nine VISNs in 2008 and seven VISNs in 2009 had a projected under-availability of residential beds. In 2009, almost one-third (32 percent) of available residential beds were located in VISNs 1, 4, 5, 6, and 7 (2,448/8,446). These VISNs account for up 94 percent of the projected undersupply nationwide (228/242).

Conclusions derived from comparison of system-wide and VISN level operating bed presence to projected bed need are limited in part by other factors including occupancy rates, geographic access, cohort based program structure, staffing patterns, referral patterns, contracts with non-VA facilities, and variability introduced by adaptation of the VA model projections data. For example, a VISN may have more operating residential beds that projected demand; however, if the VISN's only residential program is remotely situated, impediments to access may nonetheless exist.

To better understand factors which facilitate or adversely impact residential bed availability, we interviewed mental health leadership at 18 VISNs regarding potential gaps between residential beds in operation and projected residential bed need.

Most of the VISN mental health leaders indicated the availability and use of non-VA beds that are not accounted for in the NEPEC census. These include residential treatment programs run by contracted agencies operating on and off of VAMC campuses, private and non-profit programs accessed through fee-basis arrangements or other agreements.

In addition, some VISN mental health leaders reported access/participation in residential treatment programming by patients residing at night in grant per diem or HUD/VASH program housing. One VISN reported use of 150 residential beds for males and 30 for females owned by a contracted agency but located on campus with another 60 beds available to patients at that same facility through an arrangement with Fresh Start (a non-VA community based program). Another VISN reported access to 200 additional beds available to house patients participating in intensive outpatient treatment programs, and access to 100 beds in community based residential substance abuse treatment programs. That VISN also reported an additional 100 contract beds, 90 percent occupied by substance abuse patients, at a location for which NEPEC data would indicate no available beds.

Although these "ghost beds" may avoid delay or disengagement of treatment they have potential limitations to utilization by VA patients and are not a one to one replacement for on-campus residential rehabilitation under VA control. Use of available beds are not guaranteed, outside agencies may have greater restrictions to program acceptance (such as a minimum period of sobriety), treatment program content is not guided by VA standards, and there is no clear definition of the treatment intensity provided for the patients.

VISN 6 illustrates the local nature of projected under and over-availability. The Hampton VAMC, originally built as an old soldier's home, has a projected over-availability of 50 beds while the Salem VAMC has a projected deficiency of about the same number (59) of beds. There is a concentration of OEF/OIF veterans around Fort Bragg and Camp Lejeune, indicating potential residential bed need at the Fayetteville VAMC where there are no MH RRTP beds. The VISN is exploring alternative residential rehabilitation beds in the community; however, building or leasing space takes time and additional resource planning.

As a whole, VISN 7 had projected under-availability of 63 residential beds during 2009 and an overall average occupancy rate of 87 percent (discussed further under next subheading). The Charleston VA has no residential beds and reportedly contracts for 100 beds in the community, 90 percent of which are occupied by substance abuse patients. Building space is an obstruction to expansion there and in Columbia and Atlanta. Dublin on the other hand has available space but the beneficiary population is not increasing in this geographic area. In VISN 19, facilities are using telehealth to provide higher intensity treatment to patients near facilities where there are no residential beds.

NEPEC Average Occupancy Rate Data

NEPEC gathers data on MH RRTP programs that are owned and staffed by the VA. Residential treatment beds at non-VA facilities are not included in the data. NEPEC calculates average occupancy rates for each residential program.

Residential program census and the demand for residential beds can vary daily based on fluctuations in local patient need, referral patterns, availability of nursing staff, weather and other factors. Accounting for these fluctuations an average occupancy rate around 85 percent therefore translates in practical terms into near maximum capacity. For the system as a whole, average occupancy rates were 80 percent and 81.9 percent for FY 2008 and FY 2009 respectively. We reviewed NEPEC data for average occupancy rates at the VISN and facility level with focus on sites with greater than 85 percent average occupancy rates (near full to full capacity) and sites with less than 60 percent occupancy rates.

Table 4-2 below depicts the average residential program occupancy rate by VISN during FY 2008 and FY 2009.

VISN	Occupancy Rate FY 2009	Occupancy Rate FY 2008
1	0.8	0.76
2	0.8	0.72
3	0.79	0.78
4	0.87	0.87
5	0.89	0.91
6	0.7	0.77
7	0.87	0.9
8	0.86	0.86
9	0.83	0.81
10	0.85	0.82
11	0.78	0.84
12	0.88	0.79
15	0.84	0.81
16	0.78	0.68
17	0.85	0.83
18	0.86	0.73
19	0.94	0.89
20	0.82	0.89
21	0.78	0.78
22	0.5	0.43
23	0.75	0.66

Table 4-2. By VISN, average occupancy rate for residential treatment programs, FY 2008 and FY 2009.

Nine networks (VISN 4,5,7,8,12,18,19, and 20) exceeded 85 percent average occupancy rates in one or both years. Five networks (VISNs 4,5,7,8, and 19) exceeded an 85 percent average occupancy rate in both years.

Using this analytical paradigm, VISN 7 appeared the most constrained. Overall occupancy rate for VISN 7 was 90 percent in FY 2008 and 87 percent in FY 2009. On a

facility level, four of the six facilities within the VISN that have residential programs had average occupancy rates over 90 percent for either one or both years. Average occupancy rates in one or both years were over 85 percent for the other two VAMCs with residential programs. Some logistical and resource challenges particular to VISN 7 were discussed in a previous section.

To further understand factors that facilitate or adversely impact average occupancy rates, we interviewed VISN mental health leadership regarding average occupancy rates for the VISN as a whole and for individual facilities within the VISN.

Structural factors that affect occupancy rates include under or inappropriate referrals, geographic location, capacity constraints due to physical space limitations, cohort based scheduling (synchronized patient cohort starting dates versus individual patient starting dates), the presence of an uneven number of women in a program with two-person bedrooms, and units under renovation.

Temporary changes in the total number of operating beds (the denominator) may also influence average occupancy rates for the year. In calculating average occupancy rates for the year, the denominator is not changed to reflect temporary changes. Temporary changes include short term renovation and use of residential beds for swing beds when other sections of the hospital are under construction. For example, at one facility average occupancy went from 81 percent to 67 percent, because some beds are temporarily unavailable in reality but ultimately are counted in the denominator (total beds).

Additionally, beds that cannot be fully staffed are counted as available, but in practice cannot be optimally used. For example, one VISN reported demand to fill beds they cannot functionally utilize because of difficulty recruiting trained staff at existing pay rates. Four of the residential programs in the VISN have occupancy rates less than 70 percent. Likewise, another VISN reported having a residential program in a remote location at which they perceive a need to utilize additional operating beds but cannot attract staff to support the increase. Conversely, a facility in a different VISN was able to increase their occupancy rate from 78 to 92 percent (2008 to 2009) by fully staffing available beds.

VISN mental health leaders also reported that the addition of new residential programs or the addition of beds to existing programs may initially lower facility occupancy rates until referrals pick-up and additional patients are captured in the data for subsequent reporting periods.

Grouping residential treatment patients into cohorts can waste available treatment days if the cohort ends on a Friday and the next one begins on the following Monday. If the duration of each program cohort is 6 weeks, approximately 17 days per year for each bed are not useable. Ending a class on a Wednesday or increasing the number of days in a month that cohort classes are started increases bed availability. On the other hand,

starting new cohorts on Mondays may be more convenient for patients traveling from long distances.

Other Considerations

The demand for residential substance use services in upcoming years may be influenced by recent policy initiatives. By impacting the number of homeless veterans who access care, the Secretary of the Department of Veterans Affairs' initiative to end veteran homelessness may also increase the number of patients able to access residential substance use treatment. The Department of Veterans Affairs estimates that "…about 45 percent of homeless veterans suffer from mental illness and (with considerable overlap) slightly more than 70 percent suffer from alcohol or other drug abuse problems."[29] Although assumptions arising from new initiatives are factored into the VA Model, the actual size effect on residential substance use treatment demand can only be determined over time.

The potential for increased utilization of VA mental health services by male and female OEF/OIF veterans, may impact residential treatment capacity.

Expanded implementation of intensive outpatient substance use treatment programs may impact utilization for residential substance use treatment and could modulate length of stay by facilitating transition to an alternative level of intensive services. In addition, comparative outcomes research for residential treatment programs and intensive outpatient substance use programs would further inform needs analysis.

Conclusions

Primary or co-morbid substance use is common among patients utilizing VA residential treatment. For the system as a whole, the Department's overall capability to provide residential substance use treatment services appears grossly in line with demand based on average occupancy rate and the Office of Strategic Planning and Analysis' adaptation of the VA Model projection data. However, using these analytic perspectives, potential gaps exist on the VISN and/or facility level.

At the VISN and facility level we are unable to come to a clear conclusion because of methodologic limitations, the lack of available data on the use of non-VHA residential program beds, the potential future impact of initiatives to outreach and engage homeless veterans, and the impact of current economic circumstance.

Expanded implementation of intensive outpatient substance use treatment programs may impact utilization for residential substance use treatment and could modulate length of stay by facilitating transition to an alternative level of intensive services. In addition,

[29] http://www4.va.gov/ASSETMANAGEMENT/MissionHomeless/index.asp.

comparative outcomes research for residential treatment programs and intensive outpatient substance use programs would further inform needs analysis.

Recommendations

Recommendation 4. We recommended that the Under Secretary for Health ensure that the OMHS in conjunction with VISN Directors conduct a facility by facility tracking and analysis of bed need for residential substance use treatment, utilization of contract and other non-VA residential substance use treatment beds, and utilization for substance use treatment of residential program beds located at other VAMCs.

E. Identification of any Barriers to Full Implementation

The Handbook asks VISNs to submit to the OMHS requests for full exceptions, temporary exceptions or modifications to Handbook requirements. A review of submitted requests provides insight into common barriers to implementation, and barriers unique to a particular facility. Requests were to be submitted by September 30, 2009. Additionally, we interviewed mental health leaders at a sample of VAMCs from the VISNs that had not submitted exception requests.

Barriers to Implementation

The OMHS received requests for exceptions or modifications from 10 VISNs. These 10 VISNs (1,5,8,9,10,15,18,19,21,23) requested 222 total exceptions or modifications on behalf of 30 parent VAMCs and their affiliated CBOCs. This total includes duplication of specific items at different facilities within a VISN. For example, VISN 21 requested a total of 23 exceptions for sites in the VISN corresponding to 9 distinct Handbook items.

Exceptions often listed more than one barrier to implementation (such as "additional staffing and space). The most commonly identified barriers to implementation across VISNs were need for available space, need for additional staff, recruitment of staff.

Across VISNs, exception/modification requests pertaining to PRRCs and Peer Support/Counseling were common. For these programs, need for additional space and staffing, were the most common barriers cited.

A small number of sites requested time extensions to allow for training of staff in evidence-based therapies for PTSD, depression and a few sites requested extensions for training of staff in delivery of Social Skills Training for seriously mentally ill patients. Two of these sites listed availability of training slots and/or local training funds as additional resource needs.

Facility mental health leaders that we interviewed also largely identified space, staffing, and recruitment as barriers to full implementation. Some mental health leaders expressed concern regarding delays in posting of new positions or delays in processing of new hires

by human resource departments. A few noted difficulty recruiting providers to rural sites. Some reported lack of funds for re-modeling or expansion of space to accommodate specific programs.

Core Mental Health Staffing

The OMHS provided us with MHEI and VERA core mental health staffing data from September 30, 2005 to September 30, 2009. During this time period, the total number of core VHA mental health (MH) full time employee equivalents (FTEE) increased from 13,950 to 19,282 (a 38.2 percent increase). During this time period, MHEI funded MH FTEE grew from under 1,000 to 6,592. However VERA funded MH FTEE decreased from 13,166 to 12,690. Figure 5-1 below depicts MHEI and VERA funded MHFTEE over this time period.

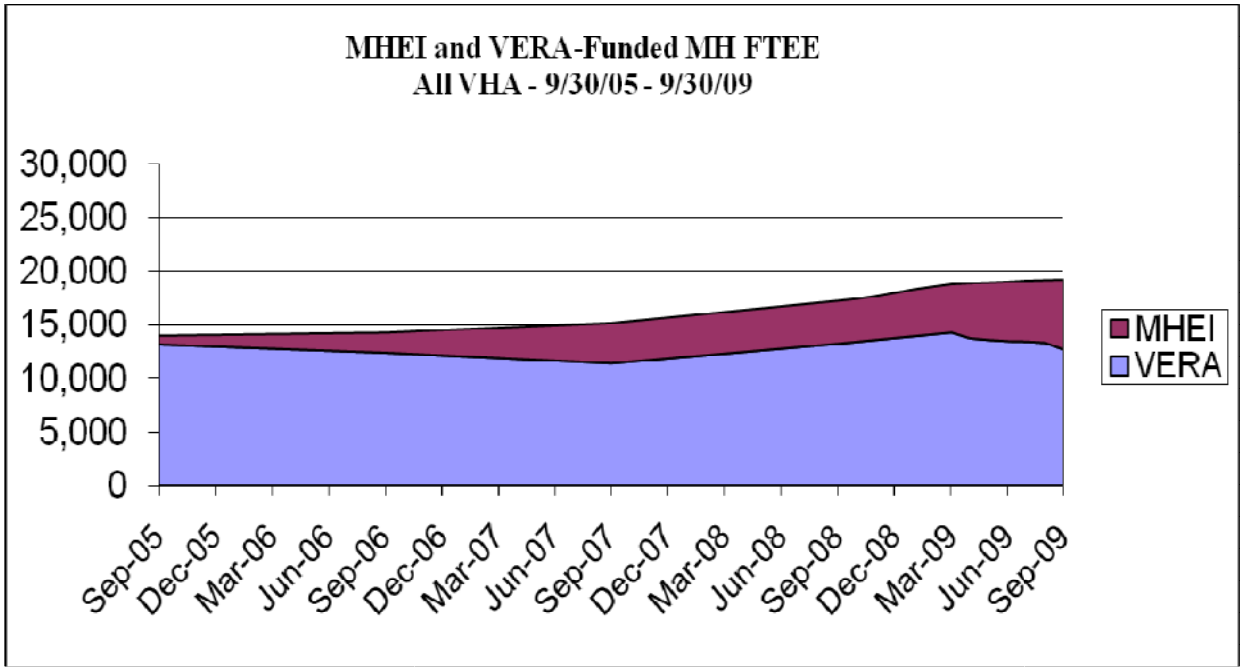

Figure 5-1. MHEI and VERA funded Mental Health FTEE from September 2005 to September 2009.

From September 2005 through September 2007, VERA funded MH FTEE declined from 13,166 to 11,366 as MHEI funded MH FTEE increased. After September 2007 until March 2009, VERA funded MH FTEE rebounded and steadily increased peaking at 14,082 MH FTEE while MHEI MH FTEE continued to gradually increase.

From the beginning of April 2009 through September 2009, MHEI positions increased from 4,593 to 6,592 as facilities made a final push to hire before expiration of the MHEI

funding. Concomitantly, from the beginning of April 2009 through September 2009, VERA funded MH FTEE decreased to 12,690, partially offsetting the gain in MHEI positions. This may reflect a natural time lag inherent in recruitment and hiring processes but raises concerns that VISN and facility leadership were able to fill MHEI positions with existing MH staff but will not sufficiently recruit or hire to fill vacated VERA funded positions.

As MHEI funding expires, mental health leaders expressed their hope that the trend in VERA MH FTEE experienced during the second half of FY 2009 will reverse in order to optimize the gains in MH FTEE from the MHEI funding. VHA should continue to track trends in total core MH FTEE.

Conclusions

From Handbook exception/modification requests and interview of facility mental health leaders, the most commonly identified barriers to implementation of specific items were need for additional space; need for additional staff; and recruitment of staff.

A few sites requested extensions for staff training in evidence-based therapies (for PTSD, depression, or Social Skills Training). Two of these sites listed availability of training slots and/or local training funds as additional resource needs.

The final push to hire MHEI funded MH FTEE during the second half of FY 2009 was accompanied by a decrease in VERA funded MH FTEE, perhaps reflecting a natural time lag inherent in recruitment and hiring processes but raising concerns that VISN and facility leadership were able to fill MHEI positions with existing MH staff but will not sufficiently recruit or hire to fill vacated VERA funded positions. Mental health leaders expressed their hope that the trend in will reverse in order to optimize gains in MH FTEE from the MHEI funding.

Recommendations

Recommendation 5. We recommended that the Under Secretary for Health review barriers to implementation and take appropriate actions to address these barriers.

Appendix A

Patient Utilization

As a summary, we developed ratios to serve as indicators for the number of patients who opted for and received a specific service (Handbook item) compared to the potential number of patients with a diagnosis relevant to that treatment service.[30]

Although we are not aware of relevant standards for these ratios in VA or non-VA treatment settings, we believe these metrics further inform the analysis. Table A-1 summarizes these comparison ratios.

Numerator	Denominator	Ratio (in percent)
# of Unique Patients Seen for Specialized PTSD Individual Clinic Visits	**# of Unique Patients with a Primary Diagnosis of PTSD Seen at any Mental Health Clinic**	**36**
# of Unique Patients Seen for Specialized PTSD Group Clinic Visits	**# of Unique Patients with a Primary Diagnosis of PTSD Seen at any Mental Health Clinic**	**22**
# of Unique Patients with a Primary Diagnosis of Major Depression who Received Individual Psychotherapy	**# of Unique Patients with a Primary Diagnosis of Major Depression Seen at any Mental Health Clinic**	**21**
# of Unique Patients with a Primary Diagnosis of Major Depression who Received Medication Management	**# of Unique Patients with a Primary Diagnosis of Major Depression Seen at any Mental Health Clinic**	**13**
# of Unique Patients Seen in an Intensive Substance Use Treatment Program	**# of Patients with a Primary Substance Use Diagnosis Seen at any Mental Health Clinic**	**9**

Table A-1. For select Handbook related items, ratios comparing the number of unique patients who received a particular service to the number of patients with a relevant diagnosis seen at any mental health clinic during October 2009.

[30] As a caveat, included in the denominator are those patients who have been seen once during the month for an initial evaluation and opted out of further referral or treatment; those with co-morbid diagnosis who are dually treated at another relevant mental health clinic (for example: patients with substance use and PTSD who are treated for both in a special dual diagnosis substance use clinic), and those patients who do not require more specific mental health treatment (such as patients with a history of depression in remission who are periodically followed/evaluated in a general mental health or mental health in primary care integrated clinic who do not presently need psychotherapy or active medication management).

All data presented is for the month of October 2009. Because some patients receive both individual and group therapy, or both therapy and medication management, ratios cannot be meaningfully summed. A more detailed discussion follows.

Patients Seen at Specialized Outpatient PTSD Clinics

During October 2009, we found that 92,229 unique patients with a primary diagnosis of PTSD were seen at any VAMC outpatient mental health clinic. System-wide, a total of 33,048 unique patients were seen for an individual PCT (28,268) or non-PCT, specialized PTSD clinic visit (4780).

Figure A-1 depicts, by VISN, the combined number of patients seen for an individual PCT or non-PCT specialized PTSD clinic visit as a ratio to the number of unique patients with a primary diagnosis of PTSD seen at any mental health outpatient clinic during October 2009. Although not all patients seen at a PCT or PTSD clinic may have a PTSD diagnosis, because the focus of treatment in PCT or non-PCT PTSD clinic visits is PTSD the comparison ratio is a reasonable metric.

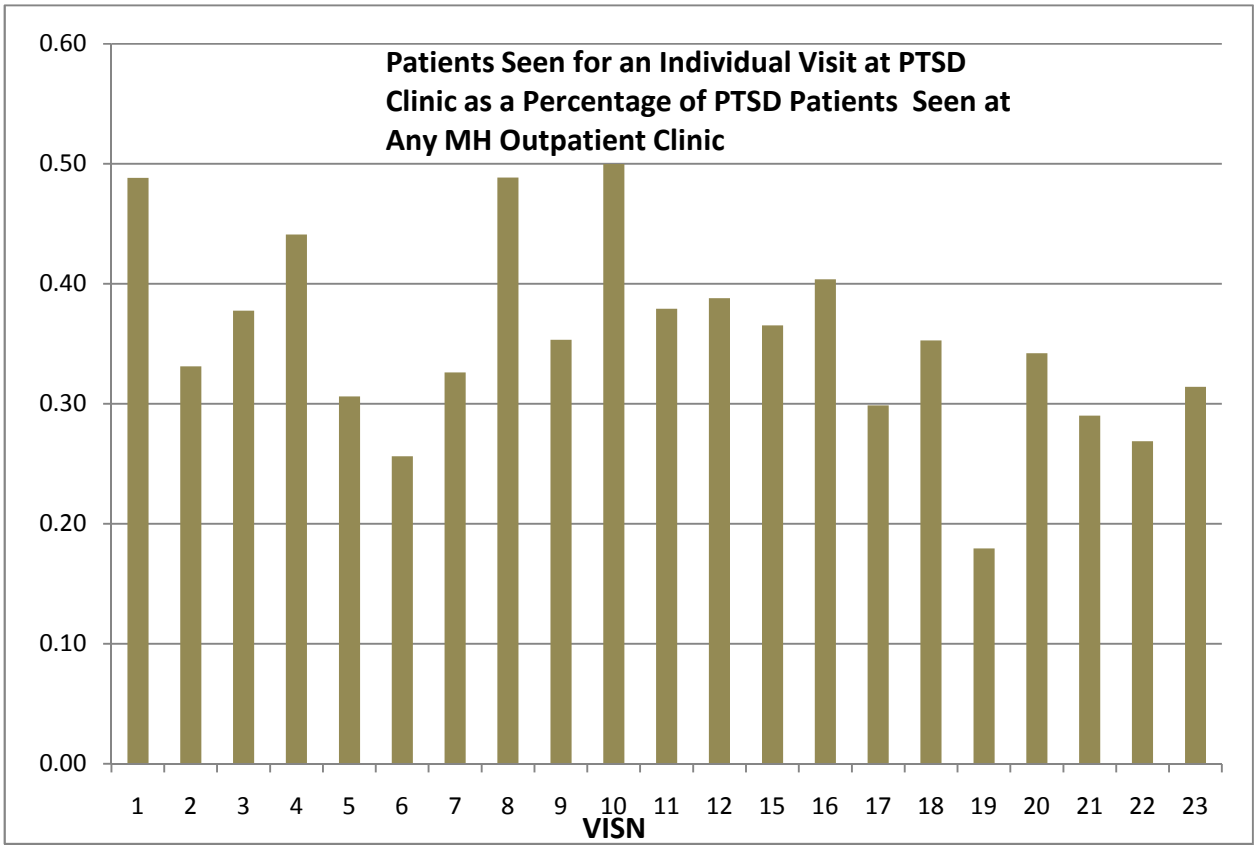

Figure A-1. By VISN, the ratio (in percent) of the number of patients seen for either an individual PCT or individual non-PCT specialized PTSD clinic visit to the number of patients seen at any VAMC outpatient mental health clinic with a primary diagnosis of PTSD during October 2009.

Additionally, we looked at group visits to PTSD specialty clinics. A total of 20,330 unique patients were seen for PCT (15,959) or non-PCT specialized PTSD (4380) group clinic visits compared to 92,229 unique patients with a primary PTSD diagnosis seen at any VAMC outpatient clinic during October 2009.

Provision of Psychotherapy to Patients with PTSD at PCT Clinics

For October 2009, we looked at the subset of unique VAMC patients seen for an individual PCT clinic visit who had a primary diagnosis of PTSD, and who had visits coded for any form of psychotherapy. Because PCT clinic is the most specialized venue for outpatient PTSD treatment, we chose to look at the provision of psychotherapy at these clinics.

System-wide, 11,163 unique patients with a primary diagnosis of PTSD were provided any kind of individual psychotherapy. Figure A-2 compares by VISN, the number of unique patients diagnosed with PTSD who received some form of individual psychotherapy in PCT clinic to the number of unique patients seen for an individual PCT clinic visit during the month. System-wide, the 11,163 unique patients with a diagnosis of PTSD who were provided individual therapy (not limited to EBT) in PCT clinic represent 39.5 percent of the 28,268 unique patients seen for an individual (non-group) visit at PCT clinics during this time period. These 11,163 patients represent 12.1 percent of all patients with a diagnosis of PTSD seen at any outpatient mental health clinic during October 2009.[31]

[31] As a caveat, the denominator includes patients seen for evaluation or 1 visit at other clinics and who have opted out of referral or further treatment, and patients who are being primarily treated for a co-morbid diagnosis in another clinic (such as joint treatment in a substance use clinic).

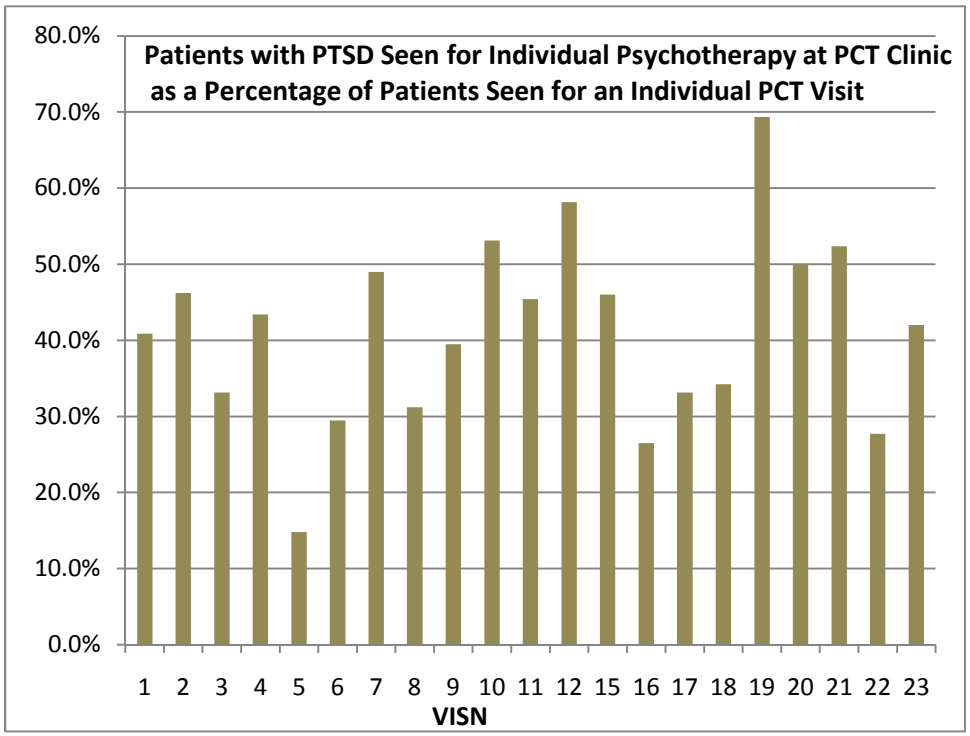

Figure A-2. By VISN, the number of unique patients diagnosed with PTSD who received some form of individual psychotherapy in PCT clinic as a ratio to the number of unique patients seen for an individual PCT clinic visit during October 2009.

Psychotherapy, including cognitive processing therapy may be delivered in a group setting. Some patients are offered or choose therapy in an individual setting, a group setting or both. Because of the re-experiencing component, PE therapy at VA facilities is only delivered in an individual setting. At VAMCs, we reviewed the number of unique patients with a primary diagnosis of PTSD seen for any kind of group psychotherapy (at a PCT group clinic visit. System-wide 13,096 unique PCT patients with a primary diagnosis of PTSD were seen for group psychotherapy. These 13,096 patients represent 82.1 percent of the 15,950 VAMC patients seen for a group visit at PCT clinic and 14.2 percent of the 92,229 unique patients with a primary diagnosis of PTSD seen at any VAMC outpatient mental health clinic during October 2009. Because some patients are seen in both individual and group therapy, the percentages for individual and group therapy cannot be meaningfully summed.

Estimating the Potential Extent of PE Delivered to PTSD Patients Seen in PCT Clinic

In the absence of a PE template, or administrative code specific for individual PE, for October 2009, we looked at unique patients who were seen for an individual visit at PCT clinic, who had a primary diagnosis of PTSD, and whose visits were coded using the current procedural terminology code 90808 which is a code used in both VA and non-VA settings to indicate provision of a session of any kind of psychotherapy for more than

75–80 minutes duration. Because a PE session is typically 90 minutes in duration, pragmatically a provider could use the 90808 code or could code back-to-back sessions using the 90806 (45–50 minutes) code. However, from interview, we found that PE providers typically use the 90808 code. In addition, other than for PE therapy or a crisis visit, a 90 minute visit for individual psychotherapy would be atypical (other CPT codes are used for initial patient evaluation or consultation). Table A-2 below displays, by VISN, the number of patients with a primary diagnosis of PTSD who seen for an individual PCT clinic visit for which a 90808 code was used.

VISNs	Unique Patients with a Primary Diagnosis of PTSD Seen in PCT Clinic for which the 90808 Individual Psychotherapy Code was Used
1	39
2	17
3	12
4	21
5	8
6	30
7	180
8	114
9	57
10	56
11	45
12	28
15	47
16	47
17	38
18	60
19	36
20	45
21	27
22	21
23	26
All	954

Table A-2. By VISN, the number of patients with a primary diagnosis who were seen for an individual PCT clinic visit for which a 90808 current procedural terminology code was used.

The numbers represent the upper limit of unique patients with a primary diagnosis of PTSD who received PE at PCT clinic in October 2009, if all psychotherapy sessions coded 90808 were for PE. The total number of patients in this category was 954. This represents 8.5 percent of unique patients (all service eras) with a primary diagnosis of PTSD who were seen for individual therapy at PCT clinic and 3.4 percent of unique patients (all service eras) seen for an individual visit at PCT clinic. Because PE sessions are typically 90 minutes in duration and are provided exclusively as individual therapy, cognitive processing therapy (60 minute sessions, group or individual) is more commonly

provided. The non-existence of specific Current Procedural Terminology time specifiers for group therapy, and the combinations by which providers could code for individual 60 minute therapy preclude similar analysis for trying to estimate the upper limit of CPT provision.

Provision of Psychotherapy for Patients with Depression

In October 2009, 72,638 unique patients with a primary diagnosis of major depressive disorder were seen at any VAMC outpatient mental health clinic. A total of 15,574 unique patients with depression were seen for individual psychotherapy comprising 21 percent of the 72,638 unique patients with a primary diagnosis of major depression seen at any VAMC outpatient mental health clinic during this time frame.

Figure A-3 presents, by VISN, the number of unique patients with depression for which with visits coded for individual psycotherapy as a ratio to the total number of patients with a primary diagnosis of major depression seen at any mental health clinic during October 2009.

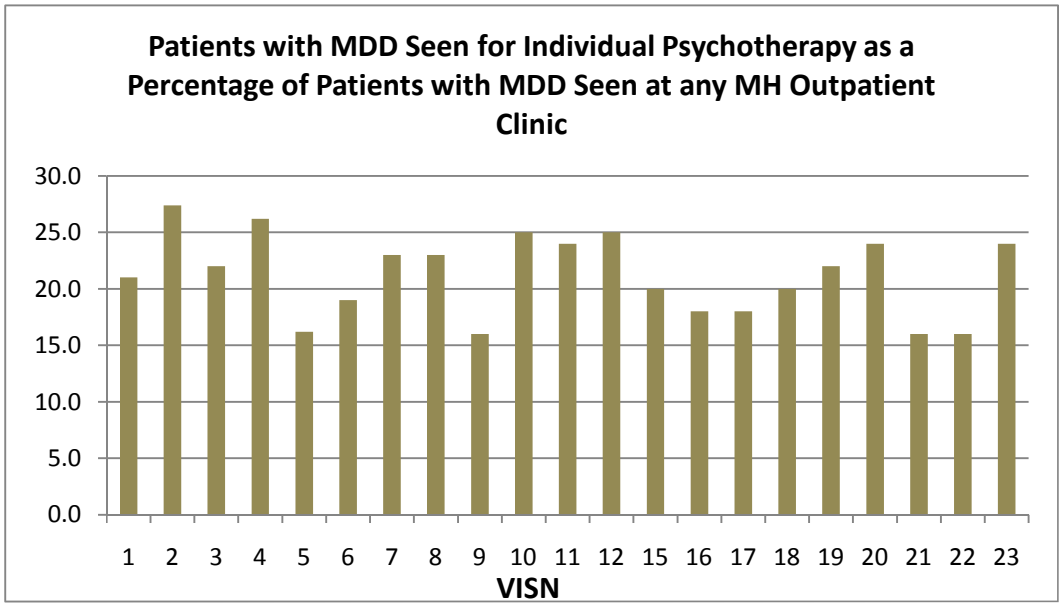

Figure A-3. By VISN, the ratio (in percentage) of unique patients with depression for which providers coded encounters for individual psychotherapy to the total number of unique patients with a primary diagnosis of major depression seen at any mental health clinic during October 2009.

System-wide, a total of 5,100 unique patients with major depression were seen for group psychotherapy comprising 7 percent of the unique patients with a primary diagnosis of major depression seen at any VAMC outpatient mental health clinic (500 series stop code) during this time frame.

Provision of Pharmacotherapy for Patients with Depression

System-wide, a total of 9,774 unique patients with a primary diagnosis of major depression were seen for medication management. These 9,774 patients comprise 13 percent of the patients with a primary diagnosis of major depression who were seen at any outpatient mental health clinic during the period. Because visits for active therapy should typically occur on a more regular basis, we would expect the number of patients with depression who were provided medication management in October 2009 to be less than the number of unique patients with depression who received some form of individual psychotherapy during the month.

Intensive Outpatient Substance Use Services

During October 2009, intensive outpatient substance use treatment services were provide to 3,339 unique patients, compared to 36,841 patients with a primary substance abuse diagnosis seen at any mental health outpatient clinic during the month.

Appendix B

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2010

From: Under Secretary for Health (10)

Subject: **Healthcare Inspection – Progress in Implementing the Veterans Health Administration Uniform Mental Health Services Handbook (WebCIMS 451876)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed and concur with the draft report. I am pleased that the report confirms the Veterans Health Administration's (VHA) efforts to fully implement the Uniform Mental Health Services Handbook, which remains a priority of VHA.

2. Thank you for the opportunity to respond to the report, which will be useful in guiding VHA's continued efforts for full implementation of the Uniform Mental Health Services Handbook. A complete action plan to address the report recommendations is attached. If you have questions, please contact Ms. Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

Appendix B

Under Secretary for Health Comments

Recommendations	Responsible Offices and Point of Contacts (POC)	Action Plan
Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with the OMHS, review the data from this report along with internal VHA data and take steps to prioritize implementation of Handbook requirements as deemed appropriate.	Patient Care Services (PCS), Office of Mental Health Services (OMHS), Deputy Under Secretary for Health for Operations and Management (10N) POC: OMHS	**Concur**. Patient Care Service's Office of Mental Health Service (PCS OMHS) will collaborate with Deputy Under Secretary for Health for Operations and Management (10N) to continue communication to the field about the mandate to fully implement the Uniform Mental Health Services Handbook (UMHSH). Specifically, a memo will be prepared for the USH's signature, to be distributed by 10N, re-affirming the Department of Veterans Affairs' (VA) and Veterans Health Administration's (VHA) commitment to full and sustained implementation of the UMHSH and re-stating the requirement that Veterans Integrated Service Networks (VISN) fully support this effort. **Due Date:** May 1, 2010
	OMHS, 10N POC: OMHS	In addition, these offices will coordinate technical assistance to the VISNs and their facilities to guide further implementation. To support this effort, 30 Technical Assistance (TA) staff will be hired and based in the field, but will report to OMHS and will work closely with OMHS leadership in planning and delivering technical assistance toward full implementation of the Handbook. **Due Date:** August 30, 2010
	PCS, OMHS, (10N) POC: OMHS	OMHS will continue to review and analyze data to identify gaps in implementation, and will forward this information to the Technical Assistants. **Due Dates:** • April 30, 2010. The next phase of monitoring will be completed • September 1, 2010. New staff to support technical assistance.
	OMHS, Principal Deputy Under Secretary for Health (PDUSH) (10A), Under Secretary for Health (USH) POC: OMHS	The PDUSH will directly monitor progress and report to the USH on progress as well as any experienced barriers. The first report will be submitted NLT June 30, 2010 and then twice a year thereafter. OMHS will continue to review and analyze data to identify gaps in implementation that persist after the first cycle of technical assistance, and will guide the Technical Assistants in their further efforts. **Due Date:** June 30, 2010, First report and then annually thereafter.

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with the OMHS, should evaluate the potential benefits, costs, and/or unintended consequences of implementing new or refining existing administrative data sources or documentation to improve tracking of services relevant to management of VHA mental health care.	PCS, OMHS, VHA Office of Health Information (OHI), 10N (including the Decision Support System (DSS) & VHA Support Services Center (VSSC), Employee Education System (EES) POC: OMHS	**Concur**. Patient Care Service's Office of Mental Health Service (PCS OMHS) will collaborate with the Deputy Under Secretary for Health for Operations and Management (10N) and the Office of Health Information (OHI) to identify essential coding practices needed to capture clinical activities in the field with the greatest possible degree of accuracy, and then will provide guidance on these practices to the field. OMHS will continue to review and analyze cross-validation data produced by the VHA Support Services Center (VSSC) to determine the accuracy and completeness of the administrative data. The goal is to eliminate the need to ask for self-reports on program activity, once the administrative data is valid and complete. " **Ongoing**
	PCS, OMHS, Office of Health Information (OHI), 10N, Office of Quality and Performance (OQP) POC: OMHS	Establish a inter-office work group to review the adequacy of codes used to capture services described in the Handbook, using cross-validation analyses produced by VSSC and Northeast Program Evaluation Center (NEPEC), performance measure and monitor data (including from chart abstraction), and other data sources as identified. The work group will be fully formed and engaged with this task by due date shown. **Due Date:** June 30, 2010
	PDUSH, OMHS, EES	Identify training needed for the field to better utilize current codes. **Due Date:** June 30, 2010
	PCS, OMHS; OHI, 10N	Final recommendations will be made for whether new codes are needed for better monitoring of these services and for training needed for the field regarding use of such new codes. **Due Date:** September 30, 2010
	PCS, OMHS; OHI, 10N	Oversight actions to determine how well prior codes and any newly added codes are capturing service delivery will continue and become standard practice and reported to the PDUSH and USH two times each year. **Due Date:** September 30, 2010

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, should ensure that specialized PTSD clinics have sufficient capacity to provide CPT and PE to patients with PTSD treated in that setting.	OMHS, PCS, (10N) POC: OMHS"	**Concur**. OMHS will lead the design of strategies to determine sufficient capacity and to respond appropriately where sufficient capacity is not present. OMHS will work with the Deputy Under Secretary for Health for Operations and Management (10N) on these processes.
	OMHS	OMHS will develop a pop-up clinical reminder to alert clinicians to offer Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) as first-line treatment for Post-Traumatic Stress Disorder (PTSD) when that diagnosis is made, as either a primary or secondary diagnosis. The clinician will note whether the offer was made; if not, why it was not offered (including non-availability of a clinician to provide the treatment); and if offered, what was the patient's response. If the patient accepted the treatment, administrative data can then be accessed to determine whether treatment was initiated within a reasonable time period (likely about 2 weeks) and was conducted per protocol, with sessions approximately weekly for at least 9 to 12 sessions. The first step is underway in this development; one site is already piloting this pop-up reminder. **Underway**
	OMHS, OHI, VA Office of Information Technology (VAOIT), VHA Support Service Center (VSSC)	After experience with and refinement of the clinical reminder, OMHS will work with OHI and then OIT to make this a national feature and to educate providers about its use. **Due Date:** January 1, 2011
	OMHS, PCS, Office of Quality and Performance (OQP) POC: OMHS	Once the reminder is nationally utilized, OMHS will work with PCS and OQP to define a performance monitor, which should develop into a performance measure in the following year with an appropriate target to demonstrate capacity. **Due Date:** June 1, 2011
	OMHS	In the interim, while the clinical reminder system is being finalized, OMHS will monitor capacity using a similar metric used by the OIG. Steps to accomplish this are outlined below.
	OMHS, PCS POC: OMHS	OMHS will lead the design of surveys to gather data allowing us to calculate the current ratio of trained providers to unique patients served in specialty PTSD outpatient settings, and collect other data relevant to determining that there is sufficient capacity to deliver these services, such as information to confirm that providers who have been trained remain in clinical positions in which they can deliver these psychotherapies. **Due Date:** May 1, 2010
	OMHS, PCS, (10N)	OMHS will work with 10N to request responses from VISNs

	POC: OMHS	for an initial survey. **Due Date:** May 28, 2010, Survey distributed NLT
	OMHS, PCS, (10N) POC: OMHS	OMHS and 10N will review and evaluate results. OMHS, PCS and 10N will determine a minimum ratio of staffing to uniques served by the facility in PTSD specialty treatment settings (following the OIG suggestion for a way to organize capacity information, but supplemented with the information ensuring that trained staff are in job positions where they can consistently deliver evidence-based psychotherapy) that meets the criterion of sufficient capacity. **Due Date:** June 30, 2010
	OMHS, with involvement of others as needed	Actions to be taken to meet need. One specific step is that CPT and PE staff training will increasingly be targeted to emphasize training for staff in VISNs/facilities below the established capacity ratio. **Due Date:** Begin July 1, 2010 and ongoing
	OMHS, PCS, (10N) POC: OMHS	Report to the PDUSH/ USH on an annual basis re capacity to deliver CPT and PE. **Due Date:** December 31, 2010 and ongoing.
Recommendation 4. We recommended that the Under Secretary for Health ensure that the OMHS, in conjunction with VISN Directors, conduct a facility by facility tracking and analysis of bed need for residential substance use treatment, utilization of contract, and other non-VA residential substance use treatment beds, and utilization for substance use treatment of residential program beds located at other VAMCs.		**Concur**. The Northeast Program Evaluation Center currently conducts a facility by facility tracking of mental health residential rehabilitation treatment program (MH RRTP) capacity through a quarterly bed report that lists the cumulative occupancy rate for each program. Data from this report is provided to VISNs and medical centers for analyzing bed utilization. Also, the Program Evaluation and Resource Center (PERC) conducts the Drug and Alcohol Program Survey (DAPS) at three year intervals. This survey is completed for every specialty substance use disorder (SUD) program, including all SUD intensive outpatient programs and all MH RRTPs specifically designated to treat SUD or which offer a distinct SUD treatment track. DAPS assesses availability of and intensity of specialty residential and outpatient SUD treatment services at all VA facilities, captures specialty SUD services that are available by contract or on a fee-basis, and examines the availability of housing options for Veterans while they are participating in intensive outpatient services. **Ongoing**
	OHI Health Information Management (HIM) (19), OMHS, (10N), Business Office (16) POC: OMHS	In April 2010, a work group will be established to analyze the reports listed above and additional information to determine a best strategy for analyzing and monitoring bed need and utilization, including services provided in the community on a fee or contract basis. **Due Date:** April 30, 2010
	OHI HIM (19), OMHS, (10N), 16 POC: OMHS	The work group will report to the PDUSH/USH re next steps and amend this action plan on the basis of the work group findings. **Due Date:** July 30, 2010

Recommendation 5. We recommended that the Under Secretary for Health review barriers to implementation and take appropriate actions to address these barriers.	OMHS, PCS, (10N), PDUSH, USH POC: OMHS	**Concur**. PCS will continue to coordinate with 10N re technical assistance and guidance to the VISNs and their facilities for further implementation. The PDUSH, to which both PCS and 10N report, will have direct oversight of these efforts and will report to the USH on progress as well as any experienced barriers. Plans to address these barriers will be developed and implemented through collaboration of 10N, PCS, and OMHS. **Ongoing**
	OMHS, PCS, (10N), PDUSH, USH POC: OMHS	Initial actions to identify barriers and provide technical assistance in addressing them will be completed by June 30, 2010. An ongoing process will evolve that will include feedback obtained from the Technical Assistants, analysis of administrative data, and input from local and network leadership. Periodic briefings to the USH will be made, and consideration of the need for further actions and strategies will be reviewed, with particular attention to any needed communication from the USH to VISN Directors regarding addressing barriers to implementation. **Due Date:** June 30, 2010
	OMHS, PCS, (10N), PDUSH, USH POC: OMHS	Continuing oversight actions will become standard practice, with a report to the USH on an annual basis. **Ongoing**

OIG Contact and Staff Acknowledgments

OIG Contact	Michael Shepherd, MD Office of Healthcare Inspections (202) 461-4660
Acknowledgments	Limin Clegg, PhD Melanie Cool Linda DeLong Joey Foley Kathy Gudgell Stephanie Hensel Jerome Herbers, MD Jeanne Martin Tishanna McCuthchen Rayda Nadal Glenn Pickens Reba Ransom James Seitz Prabu Selvam, MHS Kathleen Shimoda Barry Simon Mary Toy

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