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Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review to assess elements of the Veterans Health Administration's (VHA) Intensive Community Mental Health Recovery (ICMHR) programs, which provide intensive community-based outpatient care to veterans with serious mental illness.[1] The number of visits with a veteran, or visit frequency, is a key element of ICMHR and a measure of service intensity. This review examined the visit frequency for ICMHR-enrolled veterans April 1, 2019, through March 31, 2021, which represents one year prior to and one year after the onset of the COVID-19 pandemic (pandemic).[2] Additionally, the OIG reviewed VHA healthcare systems' contingency planning for veteran medication access during emergencies, to include long-acting antipsychotic injectable medications.[3]

ICMHR is a recovery-oriented, evidence-based approach for veterans with serious mental illness. ICMHR is an adaptation of Assertive Community Treatment, a well-known, evidence-based model of intensive case management originating outside the VHA and provided in communities and homes.[4] The visit frequency expectation for Assertive Community Treatment is four or more visits weekly, compared to the ICMHR visit frequency expectation of an average of two to three visits weekly.

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[1] For the purpose of this report, the use of ICMHR refers to Intensive Community Mental Health Recovery programs and related services. Mental Health Intensive Case Management (MHICM), Rural Access Network for Growth Enhancement (RANGE), and Enhanced Rural Access Network for Growth Enhancement (E-RANGE) are VHA programs for veterans with serious mental illness, and they are collectively referred to as ICMHR. VHA Handbook 1163.06, *Intensive Community Mental Health Recovery Services*, January 7, 2016. Serious mental illness includes diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorders, and other non-organic psychoses. DSM-5-TR, "schizophrenia spectrum and other psychotic disorders," accessed March 31, 2022, https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787.

"Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms." A person with a psychotic disorder may experience mood changes such as depression, anxiety, or anger.

[2] Although VHA released its COVID-19 Response Plan on Monday, March 23, 2020, for this review, the OIG used Sunday, March 29, 2020, as the date of the onset of the pandemic since the OIG calculations are based on encounter frequency per calendar week. VA, Managerial Cost Accounting Office Program Documents, *Business Process for Stop Codes*, May 2021. "An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition." VHA Office of Emergency Management, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, ver. 1.6, March 23, 2020.

[3] VHA, MIRECC/CoE, accessed February 2, 2022, https://www.mirecc.va.gov/visn22/schizoaffective_disorder_education.asp. Long-acting injectable antipsychotic medications are used in the treatment of psychosis. Some antipsychotic medications are available as long-acting injectables. These medications are typically administered once every few weeks.

[4] Susan D. Phillips, M.S.W. et al, "Moving Assertive Community Treatment Into Standard Practice, " *Psychiatric Services* 55 (June 2001): 6.

High-intensity mental health services beyond those available through traditional approaches, such as outpatient mental health therapy, are provided to enable veterans to live meaningful lives in their community of choice.[5] When the intensity of service elements is rigorously maintained, programs like ICMHR have been shown to reduce mental health hospitalizations and are "no more expensive than traditional care," reduce suicidality, improve medication adherence, improve housing stability, and improve quality of life for individuals enrolled in these programs.[6]

ICMHR staff are expected to provide high-intensity services by meeting with ICMHR-enrolled veterans an average of two to three times weekly, in the veteran's community or home. The OIG reviewed ICMHR encounter data from VHA to determine the frequency of visits for each veteran enrolled in ICMHR during the review period. The OIG calculated the weekly average number of encounters by reviewing the total number of encounters for each calendar week in a veteran's treatment period, both in person and with virtual care, before and since the onset of the pandemic.[7] The OIG found ICMHR programs did not meet VHA's required visit frequency for high-intensity services.

The OIG determined the average number of ICMHR visits prior to the onset of the pandemic, per week per veteran, was 1.18. Since the onset of the pandemic, in an effort to ensure staff and veterans safety, VHA adjusted the requirements related to in-person ICMHR visits and allowed them to take place through either virtual or in-person care. The OIG determined virtual care was used more frequently after the onset of the pandemic, and the average number of ICMHR visits since the onset of the pandemic, per week per veteran, was 1.23. The increased use of virtual care did not substantially increase ICMHR visit frequency.

The OIG interviewed VHA leaders from the Office of Mental Health and Suicide Prevention, and the Northeast Program Evaluation Center, and reviewed national ICMHR policies to gain an understanding of national expectations and oversight of ICMHR practices.[8] VHA leaders confirmed that VHA policy allows up to 20 percent of an ICMHR team's caseload to be veterans

[5] VHA, *VA Office of Mental Health and Suicide Prevention Guidebook*, June 2018. In VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019, recovery-oriented care is an approach to mental health care that is strength-based, focuses on a veteran's self-directed goals and preferences, and encourages shared decision-making between the veteran and mental health provider. According to the Agency for Healthcare Research and Quality, evidence-based practice is "a way of providing health care that is guided by thoughtful integration of the best available scientific knowledge with clinical expertise." Agency For Healthcare Research and Quality, "Topic: Evidence-Based Practice," accessed August 11, 2022.

[6] Susan D. Phillips, M.S.W. et al, "Moving Assertive Community Treatment Into Standard Practice," *Psychiatric Services,* 55 (June 2001): 6.

[7] For the purpose of this report, the OIG defines virtual care as the use of telehealth video technology or telephone for visits between VHA staff and veterans.

[8] The Northeast Program Evaluation Center, often referred to as NEPEC, is organizationally positioned in the VHA Office of Mental Health and Suicide Prevention and has a significant role in the evaluation and monitoring of ICMHR program performance.

with low-intensity needs. Veterans receiving low-intensity ICMHR may have less intensive clinical needs and may be seen less than once per week. However, veterans who receive high-intensity ICMHR should comprise 80 percent or more of an ICMHR team's caseload. VHA leaders informed the OIG that there is no requirement to distinguish between low- and high-intensity visits. Therefore, VHA is unable to monitor whether veterans are getting the required visit frequency based on their clinical needs.

The OIG distributed a questionnaire to 153 ICMHR coordinators identified from the 131 health care systems included in this review to obtain perspectives from the field. The questions assessed their perception of resources needed to meet ICMHR visit frequency requirements, and the role of virtual care since the onset of the pandemic. A total of 123 ICMHR coordinators responded. A majority of ICMHR coordinators noted their perception that they had the resources needed to meet visit frequency requirements. Of the ICMHR coordinator responses that indicated resources are needed to meet visit frequency expectations, staffing and technology needs were reported most frequently.[9] The OIG found that VHA did not meet visit frequency requirements regardless of whether ICMHR coordinators indicated they did or did not have enough resources. Additionally, ICMHR coordinators indicated through written responses that virtual care should continue to have some role in the delivery of care moving forward, representing an opportunity for VHA to assess the ongoing role of virtual care in ICMHR.

Due to the onset of the pandemic, along with the community-based nature of ICMHR and the medication needs of veterans with serious mental illness, the OIG evaluated VHA's contingency planning for medication access during emergencies. VHA has established procedures and provided guidance regarding emergency planning for VHA healthcare systems. According to VHA guidance, community-based programs, such as ICMHR, should have program-specific emergency response procedures in place.[10] The guidance indicates contingency planning for ICMHR should include veteran access to medications during emergencies.

The OIG requested the healthcare systems provide their ICMHR-specific contingency plans for veterans' access to medications during emergencies, including access to long-acting injectable antipsychotic medications.[11] A disruption of access to this type of medication could be destabilizing for a veteran with a serious mental illness. The OIG reviewed the provided documentation and determined 57 (44 percent) of 131 healthcare systems had ICMHR-specific contingency plans for veterans' general medication access during emergencies. Thirty-eight (29

[9] For the purpose of this report, technology refers to internet connectivity, VA Video Connect training or technical support, technology equipment access, and training for ICMHR staff regarding VHA virtual care initiatives.

[10] VHA Office of Emergency Management, *Program Guide for VA Medical Facility Assessments, Emergency Management Capability Assessment Program, EMCAP – PG – VAMC*, December 8, 2016.

[11] Antipsychotic medications are used in the treatment of serious mental illness, particularly schizophrenia and psychotic disorders, and are available as both oral (pills or tablets) and injectable medications, often referred to as long-acting injectable antipsychotic medication. For veterans enrolled in ICMHR and prescribed long-acting injectable antipsychotic medications, injections may occur in veterans' homes or at a VA medical center or clinic.

percent) of 131 healthcare systems had ICMHR-specific contingency plans that included veterans' access to long-acting injectable antipsychotic medications during emergencies. Even though there were a low number of contingency plans provided, ICMHR coordinator responses on the questionnaire indicated most programs did not have issues or disruptions to medication access during the pandemic. However, some responses did note that the absence of a formal plan or process, as well as the lack or loss of staff, made it more difficult to ensure veterans got their long-acting injectable antipsychotic medications.

The OIG made three recommendations to the Under Secretary for Health. The recommendations address ICMHR visit frequency and intensity of care provided; the ongoing role of virtual care in the delivery of ICMHR; and ICMHR-specific contingency planning related to medication access during emergencies, with a focus on long-acting injectable antipsychotic medications.

Comments

The Under Secretary for Health concurred in principle with recommendation 1, concurred with recommendations 2 and 3, and provided an action plan. Given the low number of visits identified in this report for veterans enrolled in ICMHR, the OIG has concerns with VHA's response and action plan for recommendation 1. The OIG expects VHA to adhere to all relevant policies and ensure the level of care provided is in the best interest of veterans and aligned with fundamental aspects of evidence-based treatment. See appendix A for the OIG's full response to VHA's action plan. The OIG will follow up on planned actions until they are completed.

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Contents

Abbreviations

ACT	Assertive Community Treatment
ICMHR	Intensive Community Mental Health Recovery
NEPEC	Northeast Program Evaluation Center
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted this review to assess elements of the Veterans Health Administration's (VHA) Intensive Community Mental Health Recovery (ICMHR) programs.[1] The OIG reviewed the frequency of veteran visits with ICMHR staff, and healthcare system contingency planning for veteran medication access during emergencies, to include long-acting antipsychotic injectable medications.[2] This review assessed these focus areas April 1, 2019, through March 31, 2021, a period that began approximately a year before the onset of the COVID-19 pandemic and continued through a year after the onset. For this review, the OIG used March 29, 2020, as the date of the pandemic onset. Although VHA released its COVID-19 Response Plan on March 23, 2020, the OIG used March 29, 2020, as the date of the onset of the pandemic since the OIG calculations are based on encounter frequency per calendar week.[3]

Background

For veterans seeking mental health care, VHA provides a continuum of treatment and services that include outpatient, inpatient, residential, and community-based care.[4] This review focuses exclusively on ICMHR, which typically occurs in community-based locations versus medical offices or clinics. According to VHA, mental health services provide "timely access to high-quality, recovery-oriented, evidence-based mental health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Service members into their

[1] For the purpose of this report, the use of ICMHR refers to Intensive Community Mental Health Recovery programs and related services.

[2] For the purpose of this report, the OIG defines visits to include in-person, telehealth video, and telephone encounters between a veteran and ICMHR staff. VHA, MIRECC/CoE, accessed February 2, 2022, https://www.mirecc.va.gov/visn22/schizoaffective_disorder_education.asp.

Long-acting injectable antipsychotic medications are used in the treatment of psychosis, a disorder with symptoms of hallucinations or delusions and impairments in cognition that can lead to social and occupational dysfunction. There are some antipsychotic medications available in a long-acting injectable form. These medications are typically given once every few weeks.

[3] VHA Office of Emergency Management, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, ver. 1.6, March 23, 2020.

[4] VHA, *VA Office of Mental Health and Suicide Prevention Guidebook*, June 2018. Community-based care is identified as the provision of VA mental health care provided by VA providers primarily in the community rather than in office settings. The continuum of mental health services available through VHA include outpatient and inpatient mental health care, substance use disorder treatment, psychosocial rehabilitation and recovery centers, mental health residential rehabilitation treatment programs, posttraumatic stress disorder (PTSD) treatment, integrated geriatric mental health services, suicide prevention, veterans crisis line, treatment for the effects of military sexual trauma, women's mental health, and intensive community mental health recovery services.

communities."[5] In 1987, VHA initiated its first intensive community-based program for veterans with serious mental illness, now known as ICMHR. The purpose of ICMHR is to help "veterans define and pursue a personal mission and vision, based on their self-identified strengths, values, interests, personal roles, and goals."[6] For veterans who experience serious mental illness, such as schizophrenia or bipolar disorder, with severe functional impairments and high mental health service utilization, ICMHR provides intensive, community-based mental health services.[7] ICMHR is intended for veterans who "need additional services beyond those available in traditional approaches," such as outpatient mental health therapy, to "enable them to live meaningful lives in the community of their choice."[8]

Table 1 shows the number of veterans served by ICMHR for fiscal years (FY) 2019, 2020, and 2021.[9]

[5] VHA, *VA Office of Mental Health and Suicide Prevention Guidebook*. In VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019, recovery-oriented care is defined as an approach to mental health care that is strength-based, focuses on the veteran's self-directed goals and preferences, and encourages shared decision-making between the veteran and mental health provider. According to the Agency for Healthcare Research and Quality, evidence-based practice is "a way of providing health care that is guided by thoughtful integration of the best available scientific knowledge with clinical expertise." Agency For Healthcare Research and Quality, "Topic: Evidence-Based Practice," accessed August 11, 2022. https://www.ahrq.gov/topics/evidence-based-practice.html.

[6] VHA, *VA Office of Mental Health and Suicide Prevention Guidebook*.

[7] VHA Handbook 1163.06, *Intensive Community Mental Health Recovery Services*, January 7, 2016. Serious mental illness includes diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorders, and other non-organic psychoses. Patients with diagnoses such as schizophrenia and bipolar disorder can have episodes of psychosis. DSM-5-TR, "schizophrenia spectrum and other psychotic disorders," accessed March 31, 2022, https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787.

"Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms." A person with a psychotic disorder may experience mood changes such as depression, anxiety, or anger. They may also lack awareness of their illness and poor psychosocial functioning. VHA Handbook 1163.06. Intensive services are defined by visit frequency as well as clinical complexity of visits.

[8] VHA, *VA Office of Mental Health and Suicide Prevention Guidebook*.

[9] The OIG defines a fiscal year to be from October 1st through September 30th.

Table 1. Veterans Receiving ICMHR

Fiscal Year	Number of Veterans Served
FY 2019	14,583
FY 2020	14,420
FY 2021	13,910

Source: Totals provided by VHA.

ICMHR Program Types

ICMHR encompasses three programs: "Mental Health Intensive Case Management (MHICM), Rural Access Network for Growth Enhancement (RANGE), and Enhanced Rural Access Network for Growth Enhancement (E-RANGE)."[10] MHICM and RANGE programs both provide community-based intensive case management to veterans with serious mental illness; however, the RANGE program focuses more specifically on rural and less densely populated areas. The E-RANGE program serves veterans with serious mental illness experiencing homelessness. All three ICMHR programs assist with resource needs, community integration, advocacy, and access to medication management. The expected staff to veteran ratios, as well as staffing requirements, differ between the three programs (see table 2).

[10] VHA Handbook 1163.06.

Table 2. ICMHR Staffing Requirements

Program Type	Number of VHA Program Types Across VHA*	Expected Staff: Veteran Ratio	Clinical Case Manager Staffing Requirement	Nurse Staffing Requirement	Psychiatrist Staffing Requirement[11]
MHICM	96	1:7-15	Minimum of 4 full-time clinical case managers	1 full-time registered nurse	1 psychiatrist dedicated 20% time
RANGE	51	1:7-10	Minimum of 2 full-time clinical case managers	NA	1 psychiatrist dedicated 20% time
E-RANGE	17	1:7-10	Minimum of 3 full-time clinical case managers	NA	1 psychiatrist dedicated 20% time

Source: VHA Handbook 1163.06 and the OIG review of VHA healthcare systems' documents.
**Some healthcare systems have more than one program of each type.*

To initiate admission into ICMHR, ICMHR staff evaluate appropriateness for the services after a veteran has been referred to or requests ICMHR. The criteria for ICMHR eligibility is as follows:

- diagnosis of a serious mental illness, such as schizophrenia or bipolar disorder;
- inadequately served by clinic-based outpatient treatment;
- high use of mental health inpatient services (over 30 days per year, or three or more mental health hospitalizations per year); and
- clinically appropriate to manage in the outpatient setting.[12]

[11] VHA Handbook 1163.06. A staff to veteran ratio is the number of veterans assigned to a clinical case manager (i.e., a ratio of 1:7–10 means 1 clinical case manager for 7–10 veterans). A clinical case manager is a clinician who "focuses on all aspects of the physical and social environment through the utilization of community experiences as…treatment opportunities." The psychiatrist staffing requirement can be filled by a psychiatrist or other professional qualified to provide psychopharmacological treatment.

[12] The definition of clinically appropriate is not defined in VHA Handbook 1163.06. Therefore, the OIG defines clinically appropriate as the type of care needed to manage symptoms in the least restrictive manner. For ICMHR, "community-based" is considered a form of outpatient care as opposed to inpatient psychiatric hospital care. VHA Handbook 1163.06.

Assertive Community Treatment

ICMHR is an adaptation of Assertive Community Treatment (ACT), a well-known, evidence-based model of intensive case management originating outside the VHA and provided in communities and homes.[13] The American Psychiatric Association recommends that individuals with a diagnosis of schizophrenia who also have a history of poor engagement with mental health services receive ACT.[14] ACT has been shown to decrease inpatient mental health hospitalizations and is "no more expensive than traditional care," improve medication adherence, reduce suicidality, improve housing stability, increase treatment retention, and result in higher satisfaction for individuals receiving ACT.[15]

One factor that contributes to an increased risk of inpatient hospitalization is poor adherence with antipsychotic medication, which can be common among individuals with schizophrenia. A study on ACT concluded that ACT program enrollment was associated with higher levels of antipsychotic medication adherence among veterans with schizophrenia.[16] Improved adherence persisted over time and was impactful for veterans with higher frequency versus lower frequency of visits with ACT services. This study states, "These findings add to the growing literature suggesting that ACT has a strong and long-lasting impact on antipsychotic medication adherence."[17] According to an independent evaluation of ICMHR, veterans self-reported medication adherence increased between initial enrollment and follow-up.[18]

ICMHR Visit Frequency

ICMHR is considered a high-intensity service that entails providing frequent visits to support seriously mentally ill veterans in the community. More specifically, high-intensity services, a critical element of ICMHR, are defined in VHA policy as having an average frequency of two to

[13] Susan D. Phillips, M.S.W. et al, "Moving Assertive Community Treatment Into Standard Practice, " *Psychiatric Services* 55 (June 2001): 6.

[14] George A Keepers et al, "The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia," American Journal of Psychiatry 177:9, September 2020

[15] VHA Handbook 1163.06. Susan D. Phillips, M.S.W. et al, "Moving Assertive Community Treatment Into Standard Practice. " Marsha Valenstein, M.D, M.S. et al., "Assertive Community Treatment in Veterans Affairs Settings: Impact on Adherence to Antipsychotic Medication," *Psychiatric Services* (May 1, 2013). Somaia Mohamed, "Rates and Correlates of Suicidality in VA Intensive Case Management Programs," *Community Mental Health Journal* (May 04, 2021).

[16] Marsha Valenstein, M.D, M.S. et al., "Assertive Community Treatment in Veterans Affairs Settings: Impact on Adherence to Antipsychotic Medication."

[17] Valenstein, "Assertive Community Treatment in Veterans Affairs Settings: Impact on Adherence to Antipsychotic Medication."

[18] Aptive HTG, *Clay Hunt SAV Act Evaluation 2021 Report,* October 15, 2021.

three visits per week, which includes a minimum of at least one in-person visit per week.[19] Meeting that minimum in-person expectation does not fulfill the overall requirements for high-intensity care.[20] In comparison, the ICMHR visit frequency expectation is less than the ACT visit frequency expectation, which targets four or more visits per week.

Table 3. ICMHR Visit Frequency Expectations

Pandemic-specific Timeframe	High-Intensity Visit Frequency Expectations
ICMHR, Prior to the Onset of the Pandemic	Average of 2–3 visits/week (1 visit must be in person)
ICMHR, Since the Onset of the Pandemic	Average of 2–3 visits/week (in person or virtual)

Sources: VHA Handbook 1160.01, VHA Handbook 1163.06, and VHA Deputy Under Secretary for Health for Operations and Management memo, "Continuity in Mental Health Services and Suicide Prevention Activities," March 21, 2020.

Veterans nearing completion of ICMHR goals may decrease to low-intensity services, with "fewer than 1 community contact per week."[21] While ICMHR team caseloads are expected to have no more than 20 percent of veterans receiving low-intensity services, VHA leaders informed the OIG that there is no requirement to distinguish between low- and high-intensity visits.

ICMHR Cost Effectiveness

The Clay Hunt SAV Act Evaluation 2021 Report is an annual, third-party, independent evaluation of VHA mental health and suicide prevention programs to ensure efficacy and cost effectiveness of services.[22] The FY 2021 evaluation identified clinical outcomes and cost effectiveness of MHICM programs specifically. The evaluation reported a decline in admissions to inpatient mental health services for veterans fully engaged in an MHICM program.[23] The evaluation concluded the MHICM program prevented 0.04 inpatient mental health services admissions resulting in a savings of $1,579, per veteran in the 12 months after a veteran's initial MHICM service.

[19] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VHA Handbook 1163.06.

[20] VHA Handbook 1163.06.

[21] VHA Handbook 1163.06.

[22] *Clay Hunt SAV Act Evaluation 2021 Report.*

[23] *Clay Hunt SAV Act Evaluation 2021 Report.* VHA program leaders define "fully engaged" as veterans "having a completed program intake form . . . or 12 or more MHICM encounters in the 12 months following first MHICM service . . . "

The evaluation also looked at the impact of intensity, defined by visit frequency, analyzing veterans who had at least 26 MHICM visits in the 12 months following their first MHICM service. The analysis sample identified an additional cost savings of $2,058 per veteran. With respect to the RANGE and E-RANGE programs, VHA reported a reduction in inpatient mental health bed days and inpatient costs from the year prior to veteran enrollment in RANGE and E-RANGE programs compared to the year after program entry.

ICMHR Oversight and Monitoring

The Substance Abuse and Mental Health Services Administration, *Evidence-based Practices Kit: Building Your Program*, encourages ACT and ACT-inspired programs, such as ICMHR, to be monitored and for adjustments to be made as needed.[24] Within VHA, the Office of Mental Health and Suicide Prevention has the responsibility to oversee ICMHR. The Northeast Program Evaluation Center (NEPEC), organizationally positioned in the Office of Mental Health and Suicide Prevention, has a significant role in the evaluation and monitoring of ICMHR program performance. NEPEC leaders, during an interview, indicated that NEPEC staff collect data from internal VHA data sources and from ICMHR staff in the field, including veteran-specific data at the time of admission, at the six-month follow-up, annually, and at discharge. The data is analyzed by NEPEC, and then provided to ICMHR for the purpose of monitoring program outcomes and performance improvement. NEPEC also monitors ICMHR visit frequency by tracking whether veterans have at least four ICMHR visits each month. NEPEC collaborates on the development and management of ICMHR, and produces an annual report regarding ICMHR adherence to VHA policy.

VHA monitors a variety of visit frequency performance metrics, however, no measure collected by VHA targets the expected high-intensity two to three visits per week. Oversight of VHA's ICMHR is also provided by accrediting bodies such as The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.[25]

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[24] Substance Abuse and Mental Health Services Administration, *Evidence-based Practices Kit, Building Your Program: Assertive Community Treatment,* accessed March 25, 2022, https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-act_1.pdf.

[25] The Joint Commission *Hospital Standards Manual (e-edition)*, Emergency Management chapter, EM 02.02.03, January 2019. The Emergency Operations Plan describes "how the hospital will obtain and replenish medications and related supplies that will be required throughout the response and recovery phases of an emergency…", accessed May 5, 2021, https://e-dition.jcrinc.com/MainContent.aspx. Commission on Accreditation of Rehabilitation Facilities, *2019 Behavioral Health Standards Manual, Purposes*. The Commission on Accreditation of Rehabilitation Facilities develops and maintains "standards that improve the value and responsiveness of the programs and services delivered to people in need of life enhancement services." The 2019 Standards Manual has been replaced by subsequent manuals, most recently by the 2022 *Behavioral Health Standards Manual*. All manuals contain the same language regarding the Commission's purposes. From VHA Handbook 1163,06, "All ICMHR Services with 3 or more clinical team members must obtain accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) and maintain adherence to the CARF Behavioral Health Standards, Sections 1 and 2, psychosocial rehabilitation field category, and Case Management program standards."

ICMHR Since the Onset of the COVID-19 Pandemic

ICMHR faced new challenges during the pandemic. VHA and individual healthcare systems had to quickly pivot to ensure veterans received care and services did not lapse. VHA leveraged virtual care in lieu of in-person, face-to-face visits, when possible, to ensure the safety of veterans and staff after the World Health Organization's declaration of the pandemic in March 2020.[26] Due to the need for social distancing during the pandemic, VHA distributed a Deputy Under Secretary for Health for Operations and Management memorandum on March 21, 2020, regarding the continuity of mental health services and suicide prevention activities while limiting in-person visits.[27]

The memorandum included guidance for ICMHR to suspend non-essential in-person visits.[28] It also stated ICMHR clinical visits should be maintained at the frequency of the regular program standards while maximizing virtual care.[29] This flexibility meant the visit frequency standard remained an average of two to three visits each week; however, the weekly in-person visit could be conducted virtually. VISN Directors were instructed to use the memorandum to guide healthcare systems' decision-making to maintain continuity of mental health care.

Prior to the onset of the pandemic, ICMHR permitted video virtual care for up to 20% of visits per veteran per year. The pandemic created the need to shift ICMHR delivery to increased virtual care. The change was significant since care is traditionally delivered in person and in the community. According to the Substance Abuse and Mental Health Services Administration, the use of virtual care with individuals with serious mental illness has some possible benefits, such as improved provider experience (provision of timely delivery of care, coordination of care, management of workforce shortages), improved experience for individuals receiving care (increased access to providers and specialized care, reduced travel costs and removal of geographic barriers, less impact to employed individuals or individuals navigating childcare or caregiver responsibilities), improved population health (enhanced health outcomes such as quality of life, access to care, or reduced symptoms), and improved costs (positive financial impact to mental health organizations, especially in rural settings).[30]

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[26] For purpose of this report, the OIG defines virtual care as the use of telehealth video technology or telephone for visits between VA staff and veterans.

[27] VHA Deputy Under Secretary for Health for Operations and Management memo, "Continuity in Mental Health Services and Suicide Prevention Activities," March 21, 2020.

[28] VHA Deputy Under Secretary for Health for Operations and Management memo.

[29] VHA Deputy Under Secretary for Health for Operations and Management memo. VA Video Connect is a method for veterans to "meet with VA health care providers through live video on any computer, tablet, or mobile device with an internet connection," accessed April 6, 2022, at https://mobile.va.gov/app/va-video-connect.

[30] Substance Abuse and Mental Health Services Administration, *Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders,* accessed April 1, 2022, https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders?msclkid=897d0f9eb4db11ecbea043cde1aeb35c. This guide addresses virtual care for individual living with a severe mental illness.

Increasing virtual mental health care for individuals with a serious mental illness is not without challenges. The guide identifies technology and internet access as two possible barriers. Although several cost benefits are associated with increased virtual care, there are the added costs of technology equipment such as phones, computers, and internet access. Another concern regarding virtual care is that some individuals with psychotic disorders, such as schizophrenia, may have symptoms, such as delusions or suspiciousness, that interfere with the ability to use virtual care.

ICMHR Contingency Planning for Emergencies

The Emergency Management Capability Assessment Program (EMCAP) Program Guide for VA Medical Facility Assessments establishes procedures and provides guidance regarding emergency planning for VHA healthcare systems.[31] EMCAP focuses on "preparedness, resiliency, and continuity of mission essential functions to deliver health care services and continued access to VA patients, military personnel, and as appropriate, the public in the event of a disaster, emergency, or other contingency."[32]

EMCAP guidance states VHA community-based programs, including ICMHR, should have program-specific response procedures to implement when emergencies occur. More specifically, at a program level, there should be a plan that outlines the response strategies, actions, and staff responsibilities to ensure care continuity during an emergency.[33] Although many considerations are listed in the EMCAP as part of the program-level emergency plan, veteran access to medication is identified as a mandatory criterion. Additionally, the ICMHR Handbook states healthcare system administration, in collaboration with local ICMHR leaders, should establish policies to assist veterans with psychiatric medication use in the community.[34]

The Joint Commission standards for accredited hospitals include having a written emergency operations plan outlining "how the hospital will obtain and replenish medications and related supplies that will be required throughout the response and recovery phases of an emergency." [35] In addition, ICMHR teams with three or more members must be accredited by the Commission on Accreditation of Rehabilitation Facilities and maintain adherence to the Commission's

[31] VHA Office of Emergency Management, *Emergency Management Capability Assessment Program Guide for VA Medical Facility Assessments,* EMCAP – PG – VAMC, December 8, 2016.

[32] VHA Office of Emergency Management, EMCAP – PG – VAMC.

[33] VHA Office of Emergency Management, EMCAP – PG – VAMC. VHA Handbook 1163.06. Only MHICM is mentioned under community-based programs in the EMCAP. However, the EMCAP guidance was published the same year as the new ICMHR Handbook, which established ICMHR as the umbrella term for: MHICM, RANGE, and E-RANGE.

[34] VHA Handbook 1163.06.

[35] The Joint Commission, *Emergency Management chapter from Hospital Standards Manual*, e-edition, EM 02.02.03.

standards, one of which includes written emergency procedures to address the continuation of essential services such as medication access.[36]

Antipsychotic medications used in the treatment of serious mental illness, particularly schizophrenia and psychotic disorders, are available as both oral (pills or tablets) and injectable medications.[37] Long-acting injectable antipsychotic medications' effects remain in an individual's system up to several weeks after injection and are potentially unsafe for caregiver or self-administration. For veterans enrolled in ICMHR and prescribed long-acting injectable antipsychotic medications, injections may occur in veterans' homes or at a VA medical center or clinic.

For individuals with schizophrenia, poor adherence to oral antipsychotic medications is associated with increased odds of needing psychiatric hospitalization.[38] Alternatively, long-acting injectable antipsychotic medications provide an option that eliminates the need to remember to take daily doses of oral medications.

The pandemic's disruption of in-person clinical visit availability potentially impacted the administration of long-acting injectable antipsychotic medications. Although the EMCAP highlights access to medications as a mandatory element, it does not specify requirements regarding long-acting injectable antipsychotic medications, which may require an additional layer of planning due to the need for in-person administration.[39]

The American Psychiatric Association issued guidance during the pandemic stating that long-acting injectable antipsychotic medications should be considered a clinically necessary treatment.[40] The guidance goes on to state, "While we recognize that there are some patients for whom it is clinically prudent to switch to an oral medication, there are others for whom that

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[36] VHA Handbook 1163.06. Commission on Accreditation of Rehabilitation Facilities, *2020 Behavioral Health Standards Manual*.

[37] *Merriam-Webster.com Dictionary*, "intramuscular", accessed April 15, 2022, https://www.merriam-webster.com/dictionary/intramuscular. Administration of an injection by "entering a muscle".

[38] Marsha Valenstein, M.D, M.S. et al., "Assertive Community Treatment in Veterans Affairs Settings: Impact on Adherence to Antipsychotic Medication."

[39] VHA Office of Emergency Management, EMCAP – PG – VAMC.

[40] The American Psychiatric Association, *COVID-19 Pandemic Guidance Document, Use of Long-Acting Injectables as a Clinically Necessary Treatment*, accessed January 25, 2021, https://www.psychiatry.org/File%20Library/Psychiatrists/APA-Guidance-Long-Acting-Injectables-COVID-19.pdf#:~:text=USE%20OF%20LONG-ACTING%20INJECTABLES%20AS%20A%20CLINICALLY%20NECESSARY,with%20high-risk%20chronic%20illness%20as%20a%20necessary%20procedure. The American Psychiatric Association is a professional organization of psychiatrists in the United States, with the goal of promoting "the rights and best interests of patients and those actually or potentially making use of psychiatric services for mental illness, including substance use disorders," *APA's Vision, Mission, Values, and Goals*, accessed March 1, 2021, https://www.psychiatry.org/about-apa/vision-mission-values-goals.

change would be deeply destabilizing."[41] In step with the American Psychiatric Association, the VHA Deputy Under Secretary for Health for Operations and Management memorandum specifically addressed the need for ICMHR staff to make plans for continuity of long-acting injectable antipsychotic medications for veterans enrolled in ICMHR during in-person restrictions due to the pandemic.[42]

Scope and Methodology

On March 3, 2021, the OIG initiated a review of VHA ICMHR to assess visit frequency and contingency planning for veteran medication access during emergencies, to include long-acting injectable antipsychotic medications. The OIG evaluated ICMHR visit frequency, including virtual care, from April 1, 2019, through March 31, 2021, capturing one year prior to and one year since the onset of the pandemic.

The OIG reviewed ICMHR encounter data to determine the frequency of visits for each veteran enrolled in ICMHR during the review period.[43] Stop codes were used to identify ICMHR encounters that took place in person or virtually.[44] As noted above, for the purpose of this review, the OIG used March 29, 2020, as the date of the onset of the pandemic.

Of the 140 VHA healthcare systems, 130 were represented in the data from prior to the onset of the pandemic and 131 were represented in the data from after the onset of the pandemic.[45] The OIG observed the total number of encounters for each calendar week in a veteran's treatment period, both in person and with virtual care, before and since the onset of the pandemic, and

[41] The American Psychiatric Association, *COVID-19 Pandemic Guidance Document, Use of Long-Acting Injectables as a Clinically Necessary Treatment*.

[42] VHA Deputy Under Secretary for Health for Operations and Management memo.

[43] VA, Managerial Cost Accounting Office Program Documents, *Business Process for Stop Codes*, May 2021. "An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[44] VA Managerial Cost Accounting Office Program Documents, *Stop Codes - Instructional Guide,* May 2021. A stop code is a VHA term used to identify workload for "outpatient encounters, inpatient appointments in outpatient clinics, and inpatient professional services." Stop codes "indicate the work group responsible for providing the specific set of clinical products." The primary stop code "designates the main clinical group responsible for the care." The secondary stop code "further define[s] the primary workgroup," providing "additional information about the clinic such as the provider type or a modality of care such as telehealth technology or secure messaging."

[45] This count includes VA Medical Centers and the VA Manila Outpatient Clinic in Pasay City, Philippines, designated as "other outpatient service" by VHA. For the purpose of this report, the OIG considers the term *healthcare systems* to include the parent facility and its associated medical centers, outpatient clinics, and other related VA services or programs.

calculated the average number of encounters by week.[46] The OIG found 1,228,380 ICMHR encounters after exclusions, representing 12,496 veterans who received treatment prior to the onset of the pandemic, and 12,849 veterans who received treatment after the onset of the pandemic.[47]

The OIG interviewed VHA Office of Mental Health and Suicide Prevention and NEPEC leaders regarding low- versus high-intensity veterans, visit frequency, and the changes related to conducting the required in-person visits by video telehealth or telephone. Leaders from the Office of Mental Health and Suicide Prevention and NEPEC confirmed that VHA policy allows up to 20 percent of ICMHR caseloads to be veterans with low-intensity needs, but low- and high-intensity ICMHR encounters are not distinguishable in encounter data. In an effort to account for possible low-intensity encounters within the encounter data, the OIG conducted two additional analyses. One analysis excluded veterans in the bottom 20 percent of average encounters per week. Another analysis excluded the final 20 percent of encounters in a veteran's treatment period as a veteran's case management needs are more likely to be low intensity as they approach the end of treatment. The results of each calculation fluctuated less than one tenth regardless of whether these encounters were excluded or included. The OIG determined attempts to exclude potential low-intensity veteran encounters did not affect the resulting summaries and chose not to delineate low-intensity veteran encounters for this review.

The OIG requested VHA documents and policies to evaluate requirements for ICMHR operations and emergency planning for administration of long-acting injectable antipsychotic medications as of March 31, 2021. The OIG also requested documentation from healthcare systems regarding expectations specific to healthcare system ICMHR contingency planning for emergencies for veteran access to medications, including long-acting injectable antipsychotic medications.

On August 23, 2021, the OIG distributed, via email, an online questionnaire to 153 ICMHR coordinators identified by the healthcare systems. The goal was to obtain perspectives from the field on resources needed to meet visit frequency requirements, as well as contingency plans for medications during emergencies.[48] The questionnaire had multiple choice, scale, and open-ended text-response questions, and the coordinators were asked to complete the questionnaire by September 3, 2021. Of the 153 questionnaires distributed, 123 (80 percent) were completed,

[46] The OIG considered visits at different healthcare systems as separate treatment periods, even if treatment at multiple healthcare systems overlapped. If more than 12 calendar weeks occurred between encounters, the weeks were not counted as the veteran's treatment period. Subsequent encounters after a break of more than 12 calendar weeks, were counted as a new treatment period. The OIG also split a veteran's treatment crossing March 29, 2020, as two treatment periods. Therefore, a veteran could be identified as having more than one treatment period.

[47] The OIG excluded test patient encounters, veterans with less than three ICMHR program encounters, and encounters representing supportive services to a veteran, such as services not provided by a healthcare practitioner.

[48] Some healthcare systems provided the name of more than one ICMHR coordinator.

analyzed, and included in the review. The team analyzed text responses in the questionnaire by counting the frequency of similar topics. The OIG analyzed the data for content, not meaning. The OIG does not verify or otherwise confirm the questionnaire responses.

In addition, the OIG reviewed professional practice guidelines from the American Psychiatric Association and Substance Abuse and Mental Health Services Administration, and standards of the accrediting bodies Commission on Accreditation of Rehabilitation Facilities and The Joint Commission. The OIG also reviewed professional literature on the topics of benefits and clinical considerations for intensive case management, serious mental illness, and access to long-acting antipsychotic injectable medications during the pandemic.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

The OIG determined ICMHR did not meet the expectations for overall visit frequency. Although ICMHR regularly met the expectation of at least one weekly in-person visit prior to the onset of the pandemic, they did not meet the expectation of an average of two to three visits weekly prior to or since the onset of the pandemic.

In addition, the OIG found that most healthcare systems lacked ICMHR-specific contingency plans for veteran access to medication.

1. ICMHR Visit Frequency

ICMHR staff are required to provide clinical visits to veterans an average of two to three times per week, which is reflective of high-intensity services according to VHA.[49] Of the two to three visits per week, one must be in person.[50] However, since the onset of the pandemic, virtual visits became an acceptable method for meeting visit frequency requirements for all ICMHR visits and

[49] VHA Handbook 1163.06, VHA Handbook 1160.01.

[50] VHA Handbook 1163.06.

were used more frequently than meeting with veterans in person. In addition, lower intensity services may be clinically appropriate for veterans who reach or are near reaching recovery goals; therefore, those veterans may need less frequent visits.

ICMHR Visit Frequency Before and Since the Onset of Pandemic

The OIG evaluated whether ICMHR provided high-intensity care to veterans at a frequency consistent with VHA requirements. The OIG determined ICMHR met the minimum of one in-person visit per week prior to the onset of the pandemic. However, ICMHR did not meet the frequency requirement of an average of two or more visits per week per veteran, prior to or since the onset of the pandemic. Prior to the onset of the pandemic, ICMHR-enrolled veterans had, on average, 1.18 visits per week. Since the onset of the pandemic, ICMHR-enrolled veterans had, on average, 1.23 visits per week. Even with the increased use of virtual care since the onset of the pandemic, ICMHR did not meet the expected frequency of an average two to three visits per week per veteran.[51]

Through communication with VHA leaders, the OIG determined that although VHA has several methods to monitor visit frequency, no monitor was provided that is specific to the required average of two to three ICMHR visits per week. According to VHA, veterans whose ICMHR visit frequency needs are low intensity can make up 20 percent of a team's caseload.[52] However, VHA leaders confirmed in interviews, there is no process or requirement in place to distinguish between low- and high-intensity visit frequency in encounter data. The inability to make that distinction may inhibit ICMHR from ensuring veterans get the needed intensity and associated visit frequency. Although more frequent visits are not an assurance of quality care, they are an important element in the provision of intensive case management.

ICMHR Coordinator Perceptions

A total of 123 (80 percent) coordinators responded to the questionnaire distributed by the OIG. Using a rating scale, four questions in the questionnaire elicited the respondents' perceptions on whether resources were needed to meet the visit frequency requirements, prior to and since the onset of the pandemic (table 4). A list of possible resources was provided in the questionnaire to the ICMHR coordinators to help identify program needs to meet visit frequency requirements. The OIG recognizes the responses were ICMHR coordinator opinions and should not be generalized across all ICMHR coordinators. However, the responses reflect perspectives on needed resources from those who responded.

[51] The OIG recognized that within the calculation of averages, some veterans did receive two or more visits per week.

[52] VHA Handbook 1163.06.

Table 4. ICMHR Coordinator Responses Regarding Needed Resources[53]

Statement in the Questionnaire	Resources Adequate	Resources Needed
Prior to the pandemic, ICMHR programs at my facility had enough resources to ensure veterans were seen:		
in person a minimum of one time per week.	99 (80%)	24 (20%)
two or more times per week.	75 (61%)	48 (39%)
Since the pandemic, ICMHR programs at my facility had enough resources available to ensure veterans were seen:		
in person or virtually a minimum of one time per week.	101 (82%)	22 (18%)
two or more times per week in person or virtually.	81 (66%)	42 (34%)

Source: OIG analysis of ICMHR coordinator questionnaire responses (N=123).

Although the majority of ICMHR coordinators reported sufficient resources to meet visit frequency expectations, this perception is surprising with the analysis of the ICMHR visit frequency data, which indicates an average of less than two visits per week per veteran. When respondents indicated additional resources were needed to meet the visit frequency expectations, staffing and technology-related needs were reported most often for both before and since the onset of the pandemic.

When responding regarding resources prior to the onset of the pandemic, staffing-related needs, such as more case managers and staff, increased staff retention and recruitment incentives and efforts, and smaller ICMHR caseloads were reported 208 times. Technology-related needs were reported 49 times, which included the items internet service or hotspots, tablets, laptops, and cell phones.

When responding regarding resources after the onset of the pandemic, the same staffing-related needs were reported 154 times, and technology-related needs were reported 207 times. Technology resources needed after the pandemic included veteran access to internet

[53] VHA Handbook 1163.06. For the purpose of this review, the category "resources adequate" is based on aggregated strongly agree and agree responses from ICMHR coordinators. "Resources needed" is based on aggregated neutral, disagree, and strongly disagree responses. The full statements in questionnaire were "Prior to [and since] the pandemic, ICMHR programs at my facility had enough resources to ensure veterans were seen two or more times a week when clinically needed." The specifier 'when clinically needed' was intended to reflect that up to 20% of patients may be receiving low-intensity ICMHR services and therefore may be appropriately receiving fewer visits. VHA's overarching requirement is for an average of 2–3 visits per week per veteran.

connectivity, improved training or technical support for veterans using VA Video Connect, veteran access to technology equipment to participate in virtual care, increased use of video telemental health, increased staff training or technical support for using VA Video Connect, increased availability of tablets for community-based staff, and increased information or training for ICMHR staff regarding VHA virtual care initiatives. Other resources cited included the availability of government vehicles, reimbursement for personally owned vehicles, frequency of staff supervision, access to personal protective equipment, and safety strategies for staff in the community.

The OIG could not determine whether program resources were sufficient or impacted ICMHRs' ability to meet visit frequency requirements. However, ICMHR coordinator responses suggest an opportunity exists for VHA to further assess factors that contribute to lower than required visit frequency, and ultimately ensure veterans receive the frequency and intensity of services that are the hallmark of ICMHR care.

The questionnaire sent to ICMHR coordinators also asked, via open-ended text-response questions, for their perspective on the use of virtual care for ICMHR delivery in the future (table 5). The comment with the highest response frequency was that virtual care is helpful, but should only play a limited role in ICMHR and supplement in-person visits. The ICMHR coordinators identified both benefits and limitations related to the use of virtual care in their ICMHR. Multiple respondents stated that virtual care could not replace in-person visits, particularly clinical telephone visits where the clinician cannot conduct a visual assessment of the veteran. Respondents also commented that virtual care visits should be based on veteran preference and clinical appropriateness.

Table 5. ICMHR Coordinator Perceptions on Future Use of Virtual Care

Questions and Top Five Response Categories	Frequency*
From your perspective, after the pandemic is over, what role, if any, would you like VA Video Connect (VVC) to play in ICMHR program services?	
Ongoing use should be limited, and/or a supplement to in-person visits	99
Ongoing use should be based on veteran preferences	26
Ongoing use increases ICMHR program access or visit frequency	25
Ongoing use is beneficial in inclement weather or other hazardous situations (pandemics, bedbugs, infectious disease)	22
Ongoing reduces travel time and/or distance	21
From your perspective, after the pandemic is over, what role, if any, would you like clinical telephone visits to play in ICMHR program services?	

Questions and Top Five Response Categories	Frequency*
Ongoing use should be limited, and/or a supplement to in-person visits	106
Ongoing use when clinically appropriate and meets needs of veterans	27
Ongoing use should count towards performance metrics, workload credit	23
Ongoing use gives flexibility in options to connect with veterans	20
Ongoing use is beneficial in inclement weather or other hazardous situations (pandemics, bedbugs, infectious disease)	16

Source: OIG analysis of ICMHR coordinator questionnaire responses.
**Some of the 123 responses were sorted into more than one category.*

Examples of ICMHR coordinator comments that supported future use of virtual care for the delivery of ICMHR included:[54]

- "I would like [VA Video Connect] to have some role, though the heart and soul of E-RANGE . . . is helping veterans live their best lives in their own communities. Doing so often necessitates . . . face to face visits";
- "It is a good tool for increasing veteran access to their providers, shows flexibility in support options, shows immediate access to providers in crisis situations, should not be primary over face to face, but will continue to have a place in care, should be left to the clinical decision of each provider and input from their veteran"; and
- "I would like to see a larger percentage of overall visits be allowed to be [VA Video Connect]. We could much more easily pick up a second visit during the week if we did not have to account for drive time and most of our veterans have told us they like using it. It would also eliminate the weather and bed bug infestations being a barrier to treatment."

Examples of ICMHR coordinator comments that highlighted concerns about future use of virtual care for the delivery of ICMHR included:[55]

- "The technology is too difficult for some of our Veteran population to manage";
- "[VA Video Connect] could potentially be utilized for veterans who need additional support (more than 2 [times] a week visits). [VA Video Connect] will not be able to replace face to face interactions due to the importance of care being provided in the home to the [serious chronic mental illness] population";

[54] The statements listed are not a comprehensive listing of statements by respondents. The OIG made edits to statements to write out abbreviations.

[55] The statements listed are not a comprehensive listing of statements by respondents. The OIG made edits to statements to correct spelling and write out abbreviations.

- "Definitely use in some capacity for increased access, continuity of care during times Veterans are away or unable to be visited and for increased frequency of visits, but not completely in place of face-to-face";
- "There is certainly a place for telephone visits within the care we provide, but do not believe it should be the primary method of communication if we want to maintain the level of care and integrity of an intensive program such as MHICM"; and
- "Many of our veterans do not have the technology for [VA Video Connect] due to lack of access/resources. We live in a highly rural area where internet/Wi-Fi is often very limited."

The pandemic highlighted the value, as well as the complexities, of utilizing virtual care in lieu of in-person visits for veterans receiving ICMHR during times of emergency. Many respondents indicated that regardless of the status of the pandemic, limited use of virtual care was preferable and allowed flexibility for veterans and ICMHR staff to stay connected. However, some respondents highlighted the financial, technological, and clinical challenges with use of virtual care for ICMHR. Of note, VHA's increased use of virtual care since the onset of the pandemic did not substantially increase ICMHR visit frequency. VHA has the unique opportunity to assess and clarify the role of virtual care in ICMHR moving forward.

2. Veteran Access to Medications During Emergencies

VHA programs providing veteran healthcare services outside the hospital or clinic setting, such as ICMHR, are expected to have a contingency plan for veterans' medication access during emergencies.[56] The pandemic highlighted the relevance of this expectation with periods of social distancing, community lockdowns, and suspension of non-essential in-person visits. The veteran population served by ICMHR is complex, and contingency planning for emergencies helps ensure there are no disruptions to medication access.

Medication Access

The OIG requested ICMHR policies and guidance related to veterans' access to medications during emergency situations, such as natural disasters or pandemics, from the 131 healthcare systems reviewed. ICMHR contingency plans can be a program-level plan or policy, or an annex to the healthcare system's emergency operations plan. Therefore, the OIG reviewed all of the provided documents, regardless of type or title, for required content related to emergency preparedness guidance, policies, or plans for ICMHR.

[56] VHA Office of Emergency Management, EMCAP – PG – VAMC.

The OIG determined that not all of the healthcare systems have an ICMHR-specific policy or guidance for veteran access to medications during emergencies. Of the 131 healthcare systems, fifty-seven (44 percent) provided ICMHR-specific documents inclusive of a process for veteran access to medications during emergencies.[57]

The OIG also requested each healthcare systems' ICMHR policies and guidance related to veteran access to and administration of long-acting injectable antipsychotic medications during emergencies. While veteran access to long-acting injectable antipsychotic medications is not a specific VHA requirement for ICMHR contingency plans, access to medications is required.[58] The pandemic highlighted how this class of medication may require special consideration and forethought when in-person visits are restricted, or when healthcare systems are experiencing staff shortages.

The OIG determined that not all of the healthcare systems had an ICMHR-specific policy or guidance for veteran access to long-acting injectable antipsychotic medications during emergencies. Of the 131 healthcare systems, 38 (29 percent) provided ICMHR-specific documents inclusive of a process for veteran access to long-acting antipsychotic injectable medications during emergencies.

ICMHR Coordinator Perceptions

The questionnaire sent to ICMHR coordinators included four questions to assess perspectives on their program's approach for veteran access to medications, including long-acting injectable antipsychotic medications, during emergencies. Two of the questions had *yes*, *no*, or *unsure* response options, and two had a text-response option. When asked if their programs had plans or processes prior to the pandemic to ensure veterans medication access during emergencies, 105 (85 percent) of 123 respondents selected the *yes* response, 7 (6 percent) selected the *no* response, and 11 (9 percent) selected the *unsure* response. ICMHR coordinator responses were inconsistent with the low number of healthcare systems providing documented ICMHR plans for veteran access to medications during emergencies.

In comparison, when asked specifically about plans or processes related to ensuring veteran access to long-acting injectable antipsychotic medications during emergencies, 99 (80 percent) of 123 respondents selected *yes*, 12 (10 percent) selected *no*, and 12 (10 percent) selected *unsure*. These ICMHR coordinator responses are also inconsistent with the low numbers of healthcare systems providing documented plans for veteran access to long-acting injectable antipsychotic medications during emergencies.

[57] The remaining health care systems either provided no documents or documents that were missing key elements requested by the OIG (some examples include documents not specific to ICMHR, written after the review time frame, or covered patient access to medications but not during emergencies).

[58] VHA Office of Emergency Management, EMCAP – PG – VAMC.

ICMHR coordinators were asked their perspectives regarding what went well and what hindered access to long-acting injectable antipsychotic medications during the pandemic (table 6). The largest percentage of responses indicated there were no issues or disruptions to administration of long-acting injectable antipsychotic medications, though some responses noted the lack of a formal plan or process made it more difficult to ensure veterans got their injections. Respondents also identified that a lack or loss of staff presented difficulties.

Table 6. Long-Acting Injectable Antipsychotic Medication Processes During the Pandemic

Questions and Top Five Response Categories	Frequency*
From your perspective, during the pandemic, what went well regarding the approach your ICMHR program took to ensure access to long-acting injectable antipsychotic medication for veterans?	
No disruptions in long-acting injectable antipsychotic medication administration	52
Using COVID precautions, good PPE [personal protective equipment] availability	45
Good coordination with other service lines and/or leadership	29
Changed to oral medication or longer-acting injectable antipsychotic medication	20
Change in injection administration setting	19
From your perspective, what hindered the approach your ICMHR program took to ensure access to long-acting injectable antipsychotic medication for veterans?	
Staffing	13
COVID precautions, PPE [personal protective equipment] availability	12
Policy or guidance issues	12
Disruptions in usual process for long-acting injectable antipsychotic medication administration	9
Changed to oral or longer-acting injectable antipsychotic medication	8
Communication problems with veterans	7

Source: OIG analysis of ICMHR coordinator questionnaire responses.
**Responses could fall into multiple response categories and not all respondents provided narrative responses, so frequency of response categories will not add up to the total 123 responses.*
Note: Some responses provided were unrelated to the question and were not included in the table. Most responses for Question 2 were either 'no issues' or 'N/A'. Because these responses did not answer the question, they were omitted; therefore, the frequency of responses in the remaining categories was substantially less than the frequency of responses to Question 1.

The OIG determined the majority of VHA ICMHR programs lacked contingency plans or guidance on maintaining veteran access to medications, including long-acting injectable antipsychotic medications, during emergencies. The lack of a contingency plan may impact or delay an ICMHR team's response to veterans' medication needs, increase the risk of veterans

missing doses of critical medications during emergencies, and may ultimately put a veteran's well-being at risk.

Conclusion

Veterans with serious mental illness can benefit from intensive case management through VHA's ICMHR. Studies have shown intensive case management is associated with fewer psychiatric hospitalizations, reduced suicidality, improved medication adherence, housing stability, and better quality of life for those with serious mental illness.

An important element of high-intensity case management is visit frequency. The OIG determined that ICMHR did not meet the required two to three visits per week per veteran, on average. The OIG was unable to determine whether program resources were sufficient or impacted ICMHR staffs' ability to meet visit frequency expectations. However, ICMHR coordinator questionnaire responses suggest an opportunity for VHA to further assess factors and resource needs that contribute to fewer than required ICMHR visits.

VHA allows up to 20 percent of a team's caseload to include veterans whose ICMHR visit frequency needs are low intensity. VHA leaders confirmed in interviews that there is no requirement to distinguish between low- and high-intensity visits.

The pandemic highlighted the value and complexities of virtual care used in lieu of in-person visits for veterans receiving ICMHR; however, VHA's increased use of virtual care since the onset of the pandemic did not increase ICMHR visit frequency. The OIG determined VHA has a unique opportunity to assess and clarify the role of virtual care for ICMHR moving forward.

ICMHR is expected to have program-specific contingency plans for veterans' medication access during emergencies. The OIG determined most healthcare systems lacked ICMHR-specific contingency plans or guidance regarding veteran access to medications, in general, and long-acting injectable antipsychotic medications during emergencies. In contrast to the low number of contingency plans provided, ICMHR coordinators' reported, via the questionnaire, that most veterans received medications without disruption.

Recommendations 1–3

1. The Under Secretary for Health ensures the Office of Mental Health and Suicide Prevention develops, implements, and monitors action plans to meet Intensive Community Mental Health Recovery visit frequency requirements, to include program resource needs and the ongoing role for virtual care.

2. The Under Secretary for Health requires the Office of Mental Health and Suicide Prevention to develop a process for Intensive Community Mental Health Recovery programs to ensure veterans receiving low-intensity services do not represent greater than 20 percent of caseloads and to distinguish between veterans receiving high- and low-intensity services for accurate and effective program oversight.

3. The Under Secretary for Health identifies barriers and ensures healthcare systems develop, implement, and maintain contingency plans specific to Intensive Community Mental Health Recovery programs regarding veteran access to medications during emergencies, including long-acting injectable antipsychotic medications.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: November 29, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs

To: Program Director, Office of Healthcare Inspections (54MH00)

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs. The Veterans Health Administration concurs in principle with recommendation 1, concurs with recommendations 2 and 3, and provides an action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)
Shereef Elnahal, M.D., MBA

Office of the Under Secretary for Health Response

Recommendation 1. The Under Secretary for Health ensures the Office of Mental Health and Suicide Prevention develops, implements, and monitors action plans to meet Intensive Community Mental Health Recovery visit frequency requirements, to include program resource needs and the ongoing role for virtual care.

VHA Comments: Concur in Principle.

VHA concurs in principle because development and implementation of facility level action plans must be performed by the facility. The role of the Office of Mental Health and Suicide Prevention (OMHSP) is to coordinate with Veterans Integrated Service Networks as they monitor facilities' progress toward completion of action plans.

VHA appreciates the Inspector General's attention to its Intensive Mental Health Recovery (ICMHR) Program that provides care to a vulnerable population of Veterans. An essential program function is to fluctuate its visit frequency and type with the fluctuating care needs of the Veteran. Some life events require increased contact for limited periods of time, such as hospital discharges, transitions in living environments, initiation or changes in psychopharmacological treatment, or times of personal loss.

VHA finds Veterans are more engaged in recovery when providers merge clinical needs with patients' preferences on contact type and frequency. For high-intensity mental health recovery, VHA providers must have at least one in-person contact with the patient each week. Additional contacts during the week may occur in-person, by telephone, or using VA Video Connect according to patients' clinical need or preferences.

The ICMHR program will clarify national policy regarding contact type (including virtual care) and frequency for high-intensity services. Upon publication of updated VHA Handbook 1160.01, VHA will be positioned to determine whether any health care facilities need action plans related to visit frequency, type, and resourcing. ICMHR will identify and advocate for facility resource needs in support of mental health recovery.

Status: In progress Target Completion Date: November 2023

OIG Comments:

Current VHA policy requires low veteran-to-case manager ratios allowing ICMHR staff to provide high-intensity visit frequency to veterans served. Low caseloads for case

managers and high visit frequency are hallmarks of the evidence-based practice aligned with ICMHR.

VHA policy specific to ICMHR states veterans with high-intensity needs should have an average of two to three weekly visits, with at least one weekly visit being in-person. As this visit frequency is described as an average, some veterans may have less and some veterans may have more than two to three visits weekly, depending on veterans' fluctuating needs and preferences. The overall weekly visit frequency average of less than two, identified in this report, is not in compliance with current VHA policy or in alignment with literature regarding this evidence-based practice. Resolving this recommendation by reducing visit frequency expectations is not in the spirit of current ICMHR-related policies or the evidence-based practice for individuals with serious mental illness that ICMHR is adapted from.

The OIG recognizes that the manner in which visit frequency is calculated may need updating to reflect all the efforts made by ICMHR staff in the delivery of care. Additionally, the OIG recognizes the dedicated and hard work of ICMHR staff. With that in mind, the OIG included an opportunity in this recommendation to further evaluate needed resources, such as staffing or technology needs, that may improve the delivery of care and frequency of visits. Additionally, the OIG recommended further assessment of the use of virtual care in the delivery of ICMHR to ensure all veteran needs are met and that staff have avenues to capture workload accurately and deliver services that are individualized and meet veteran needs.

Any updates to VHA policy should serve the best interests of ICMHR-enrolled veterans who have complex, high-intensity needs and not serve to legitimize low visit frequency while maintaining low caseloads for ICMHR staff. The OIG is concerned, based on VHA's written response and other communication regarding this recommendation, that VHA will resolve this recommendation by re-writing policy to reduce visit frequency expectations instead of identifying resources needed, improving workload capture, and assessing the ongoing and future utilization of virtual care.

To consider closure of this recommendation, the OIG would expect VHA to submit evidence that all VHA ICMHR programs meet the visit frequency specified in both current policies and the evidence-based practice for individuals with serious mental illness from which ICMHR is adapted.

Recommendation 2. The Under Secretary for Health requires the Office of Mental Health and Suicide Prevention to develop a process for Intensive Community Mental Health Recovery programs to ensure veterans receiving low-intensity services do not represent greater than 20 percent of caseloads and to distinguish

between veterans receiving high- and low-intensity services for accurate and effective program oversight.

VHA Comments: Concur.

To resolve the recommendation, OMHSP will develop an informatics solution to identify and monitor Veterans receiving low-intensity ICMHR services. Visit frequency status options will include high and low intensity. Once implemented, OMHSP will be positioned to monitor and oversee program requirements regarding visit frequency relative to program status and caseload percentages.

Status: In progress Target Completion Date: November 2023

Recommendation 3. The Under Secretary for Health identifies barriers and ensures healthcare systems develop, implement, and maintain contingency plans specific to Intensive Community Mental Health Recovery programs regarding veteran access to medications during emergencies, including long-acting injectable antipsychotic medications.

VHA Comments: Concur.

VHA OMHSP will consult with OIG related to information gathered for this report on facilities that meet the contingency plan requirement. Using this information, VHA will develop and release guidance to the field on strong practices. To resolve this recommendation, VHA will then require facilities to submit a plan to comply with this requirement.

Status: In progress Target Completion Date: February 2023

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