



December 2019

VETERANS HEALTH CARE

Services for Substance Use Disorders, and Efforts to Address Access Issues in Rural Areas

Accessible Version

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Highlights of [GAO-20-35](#), a report to congressional committees

View [GAO-20-35](#). For more information, contact Mary Denigan-Macauley at (202) 512-7114 or deniganmacauleym@gao.gov.

Why GAO Did This Study

Substance use and illicit drug use are a growing problem in the United States. SUDs occur when the recurrent use of alcohol or drugs causes significant impairment, such as health problems. The veteran population has been particularly at risk. Veterans are 1.5 times more likely to die from opioid overdose than the general population, according to VA and Centers for Disease Control and Prevention data. Furthermore, veterans live in rural areas at a higher rate than the general population, which may affect their ability to access SUD services. VA is the largest integrated health care system in the United States, providing care to about 6.2 million veterans. VA provides SUD services through outpatient, inpatient, and residential care settings and offers various treatment options, including individual and group therapy, medication-assisted treatment, and naloxone kits to reverse overdoses.

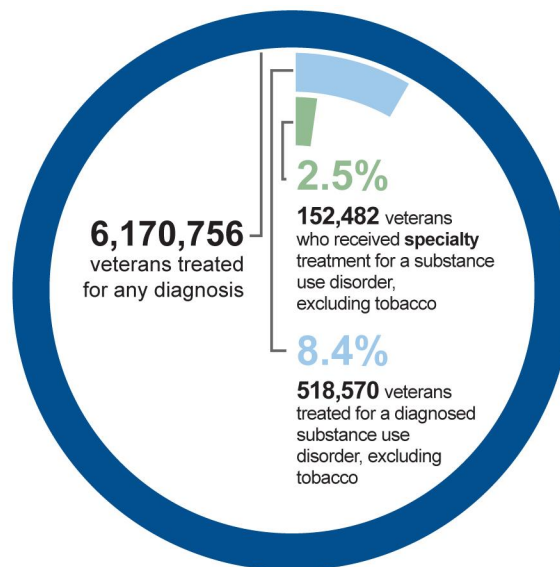
Senate Report 115-130 included a provision for GAO to study VA's capabilities to treat veterans with SUDs. This report describes (1) trends in the number of and expenditures for veterans receiving SUD services, including specialty SUD services; and (2) any differences between veterans' use of SUD services in rural and urban areas, and the issues affecting access to those services in rural areas. GAO reviewed VA policies and data from fiscal years 2014 through 2018. GAO also interviewed officials from six VA health care systems, selected for their high percentage of veterans with an opioid use disorder and to achieve variation in geography and locations VA has designated as urban and rural.

VA provided technical comments, which GAO incorporated as appropriate.

What GAO Found

The Department of Veterans Affairs (VA) treated 518,570 veterans diagnosed with a substance use disorder (SUD) in fiscal year 2018, a 9.5 percent increase since fiscal year 2016. Of these, 152,482 veterans received specialty SUD services in fiscal year 2018, a number that has remained relatively unchanged since fiscal year 2014. Specialty SUD services are those provided through a clinic or program dedicated to SUD treatment. Expenditures for VA's specialty SUD services increased from about \$552 million in fiscal year 2014 to more than \$600 million in fiscal year 2018. In the same year, VA expended about \$80 million to purchase SUD services from non-VA community providers for more than 20,000 veterans, an increase since fiscal year 2014. The number receiving this care from non-VA providers may include veterans who also received services in VA facilities.

Veterans Treated for Substance Use Disorders, Fiscal Year 2018



Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

Note: Specialty SUD services are those provided through a clinic or program dedicated to substance use disorder treatment. SUD services include services provided by any type of provider.

VA data show that overall there was little difference in the percentage of veterans using SUD services, including specialty services, in rural and urban areas in fiscal year 2018. However, there were differences for some specific services. For example, in rural areas, 27 percent of veterans with an opioid use disorder received medication-assisted treatment—an approach that combines behavioral therapy and the use of medications—compared to 34 percent in urban areas. In providing SUD services in rural areas, VA faces issues similar to those faced by the general population, including lack of transportation. The agency is taking steps to address these issues, such as using local service organizations to transport veterans for treatment.

Contents

GAO Highlights	2
Why GAO Did This Study	2
What GAO Found	2
Letter	1
Background	5
Number of Veterans Receiving, and Expenditures for, VHA Specialty SUD Services Have Remained Unchanged in Recent Years; Community Care SUD Services Have Increased	10
Veterans' Usage Differed Between Urban and Rural Areas for Some Specialty SUD Services; VHA Is Taking Steps to Address Access Issues in Rural Areas	22
Agency Comments	31
Appendix I: Map of 140 Veterans Health Administration Health Care Systems, Fiscal Year 2018	32
Appendix II: Site Selection Methodology and Selected Health Care System Characteristics	34
Appendix III: Veterans Health Administration Substance Use Disorder Residential Rehabilitation Treatment Programs	36
Appendix IV: Comments from the Department of Veterans Affairs	40
Text of Appendix IV: Comments from the Department of Veterans Affairs	43
Appendix V: GAO Contact and Staff Acknowledgments	46
Related GAO Products	47

Tables

Table 1: Veterans Health Administration’s Provision of Specialty Substance Use Disorder (SUD) Services to Veterans, Fiscal Years 2014-2018	11
Table 2: Outpatient Specialty Substance Use Disorder (SUD) Services in Veterans Health Administration (VHA) Health Care Systems, Fiscal Years 2014-2018	13
Table 3: Veterans Health Administration (VHA) Residential Rehabilitation Treatment Programs for Substance Use Disorders (SUD), Fiscal Years 2014-2018	16
Table 4: Medication-Assisted Treatment among Veterans with Opioid Use Disorder within the Veterans Health Administration (VHA), Fiscal Years 2015-2018	18
Table 5: Substance Use Disorder (SUD) Services Purchased by the Veterans Health Administration through Community Care Programs, Fiscal Years 2014-2018	21
Table 6: Selected Veterans Health Administration (VHA) Health Care Systems, by Location with Site Selection Criteria and Additional Characteristics, Fiscal Year 2018	34
Table 7: Veterans Health Administration’s (VHA) 67 Substance Use Disorder (SUD) Residential Rehabilitation Treatment Programs, Fiscal Year 2018	36

Figures

Figure 1: Number of Veterans Receiving Any Treatment from the Veterans Health Administration (VHA) for a Diagnosed Substance Use Disorder (SUD) by Type of Disorder, Fiscal Years 2014 through 2018	6
Figure 2: Settings and Types of Services Offered by the Veterans Health Administration for Substance Use Disorders	8
Figure 3: Veterans Health Administration’s (VHA) Residential Rehabilitation Treatment Programs Dedicated to Substance Use Disorders (SUD), Fiscal Year 2018	15
Figure 4: Veterans Health Administration Health Care Systems, Fiscal Year 2018	33

Abbreviations

SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	substance use disorder

VA
VHA

Department of Veterans Affairs
Veterans Health Administration

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December 2, 2019

The Honorable John Boozman
Chairman
The Honorable Brian Schatz
Ranking Member
Subcommittee on Military Construction, Veterans Affairs, and Related
Agencies
Committee on Appropriations
United States Senate

The Honorable Debbie Wasserman Schultz
Chairwoman
The Honorable John Carter
Ranking Member
Subcommittee on Military Construction, Veterans Affairs, and Related
Agencies
Committee on Appropriations
House of Representatives

Substance use and illicit drug use is a growing problem in the United States. Veterans are at particular risk for substance use disorders (SUD), as veterans may use drugs or alcohol to help cope with the effects of stressful events experienced during deployment or with difficulties they encounter in readjusting from wartime military service to civilian life.¹ For example, the largest portion of drug overdose deaths in the United States are attributed to opioids, and veterans are 1.5 times more likely to die from opioid overdose than the general population, according to 2016 data from the Department of Veterans Affairs (VA) and the Centers for Disease

¹According to the Substance Abuse and Mental Health Services Administration (SAMHSA), SUD occurs when the recurrent use of alcohol or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. SAMHSA is the agency within the Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. Although tobacco use disorder is considered a substance use disorder, we excluded it from this report, as tobacco cessation treatment is generally not provided in substance use disorder treatment facilities.

Control and Prevention.² Access to SUD services—a subspecialty of mental health services—is important because of the harmful consequences of untreated SUDs on veterans’ physical, psychological, and social well-being. However, veterans may face greater issues obtaining quality medical care, including SUD services and medicine, because they live in rural areas at a higher rate than the general population.³ Rural areas have traditionally experienced shortages of health care professionals.

The Veterans Health Administration (VHA), which operates one of the nation’s largest health care delivery systems, offers specialty SUD services—services delivered in programs specifically dedicated to SUD treatment in either a residential or outpatient setting—as well as non-specialty SUD services delivered in, for example, primary care or in general mental health clinics. The majority of veterans who access health care services through VHA, including SUD services, receive those services in VA-operated medical facilities; however, veterans may also obtain services that VHA purchases from non-VA providers in the community either via specific programs, known as community care, or via local contracts.⁴

Senate Report 115-130 included a provision for us to examine VHA’s capabilities and capacity for treating veterans with SUDs.⁵ In this report, we describe:

²The comparison of the veteran population to the general population was calculated by comparing VA-reported data on veterans to Centers for Disease Control and Prevention nationwide data on age-adjusted rates of opioid overdose deaths per 100,000 in 2016, the latest data available at the time of our audit. Centers for Disease Control and Prevention, *Multiple Cause of Death (Detailed Mortality)*, CDC WONDER, accessed June 10, 2019, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.

³Depending on the method used to define rural areas, an estimated 22 to 30 percent of veterans enrolled in the Veterans Health Administration live in rural areas, compared to an estimated 15 to 20 percent of the U.S. population. Michael E. Ohl, et al., “Availability of Healthcare Providers for Rural Veterans Eligible for Purchased Care under the Veterans Choice Act,” *BMC Health Services Research* (2018).

⁴In fiscal year 2018, a total of 6,170,756 veterans received health care services provided or purchased by VHA for any diagnosis. See Department of Veterans Affairs, *Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2020 Funding and FY 2021 Advance Appropriations* (Mar. 11, 2019).

⁵S. Rep. No. 115-130, at 55 (2017).

1. trends in the number of and expenditures for veterans receiving SUD services, including specialty SUD services; and
2. any differences between veterans' use of SUD services in rural and urban areas and the issues affecting access to those services in rural areas.

To describe trends in the number of and expenditures for veterans receiving SUD services, we obtained VHA data for fiscal years 2014 through 2018 on 1) specialty SUD services (SUD services provided in outpatient settings and residential treatment programs specifically dedicated to SUD treatment) provided within VHA and 2) SUD services (both specialty and non-specialty) provided through community care.⁶ We analyzed these data to identify trends in the numbers of veterans receiving services, expenditures for those services, and relevant clinical staff providing those services. We also analyzed VHA data on veterans who received any treatment (specialty or non-specialty services) from VHA for a diagnosed SUD; we report these data in the background of this report. Furthermore, we reviewed VHA data on reported average and median wait times for admission to residential rehabilitation treatment programs dedicated to SUD treatment, as well as our previous reports on VHA wait times. VHA officials identified 12 residential rehabilitation treatment programs dedicated to SUDs that did not have reliable wait-time data, which we excluded from our wait-time analysis. VHA data on wait times for outpatient specialty SUD services were not available at the time of our review. We assessed the reliability of the data we used for these various analyses by interviewing officials responsible for overseeing the data sources and examining the data for obvious errors. We determined the data—with the exclusion of certain residential rehabilitation treatment programs' wait-time data, as described above—were sufficiently reliable for this reporting objective. In addition to our data analyses, we reviewed VHA documentation related to the number of and expenditures for veterans receiving specialty and non-specialty SUD

⁶Expenditures refers to the actual spending of money, such as the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate a federal obligation. According to VHA officials, VHA data do not allow identification of inpatient SUD services—specialty or non-specialty—provided by VHA, so data on these services are not included in this report. VHA's community care data on SUD services include both specialty and non-specialty services. Specifically, SUD services veterans received through community care include any care provided where the primary diagnosis was a SUD, regardless of the type of provider involved (e.g., primary care physician, SUD specialist) or setting (e.g., outpatient, inpatient).

services, such as agency budgetary submissions, and interviewed agency officials regarding the data and documents we reviewed.

To describe any differences between veterans' use of SUD services in rural and urban areas and the issues affecting access to those services in rural areas, we reviewed agency policies and other documents and interviewed agency officials regarding services for veterans with SUDs. We also analyzed data from VHA's 140 health care systems—that is, VA medical centers grouped together with their affiliated outpatient clinics and other medical facilities—by location to compare specialty SUD service use at health care systems designated by VHA as urban to those designated as rural.⁷ We assessed the reliability of these data by interviewing officials responsible for overseeing the data sources and examining the data for obvious errors. We determined the data were sufficiently reliable for this reporting objective. See appendix I for an interactive map of VHA's health care systems. In addition, we selected six VHA health care systems—three urban and three rural in various geographic regions, from among the health care systems with the highest percentages of veterans with an opioid use disorder diagnosis—and interviewed officials regarding their services for and issues serving veterans with SUDs. We selected VHA health care systems in Bath, New York; Cincinnati, Ohio; Coatesville, Pennsylvania; Lexington, Kentucky; Roseburg, Oregon; and White River Junction, Vermont. See appendix II for more information on our selection process and on selected site characteristics. We also identified and reviewed articles to corroborate the issues officials from the selected VHA health care systems identified in providing services to veterans with SUDs. We reviewed articles obtained via research databases such as ProQuest, as well as publications identified through citations in those articles and in agency documents, and reviewed their methodologies. The results of our analyses based on the six selected VHA health care systems cannot be generalized to all VHA health care systems.

⁷VHA has 141 health care systems. We excluded the Philippines and therefore refer to 140 systems in this report. VHA designates its facilities as urban if they are located in census tracts with at least 30 percent of their population residing in an urbanized area as defined by the Census Bureau (50,000 or more people). Facilities designated as highly rural are located in census tracts for which less than 10 percent of their working population commutes to any community larger than an urbanized cluster as defined by the Census Bureau (at least 2,500 and less than 50,000 people). Facilities designated as rural are located on all other land areas. Although each affiliated facility has its own designation, we referred to the relevant medical center's designation to determine the rurality of a health care system. Using this method, no health care systems were identified as "highly rural."

We conducted this performance audit from August 2018 to November 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

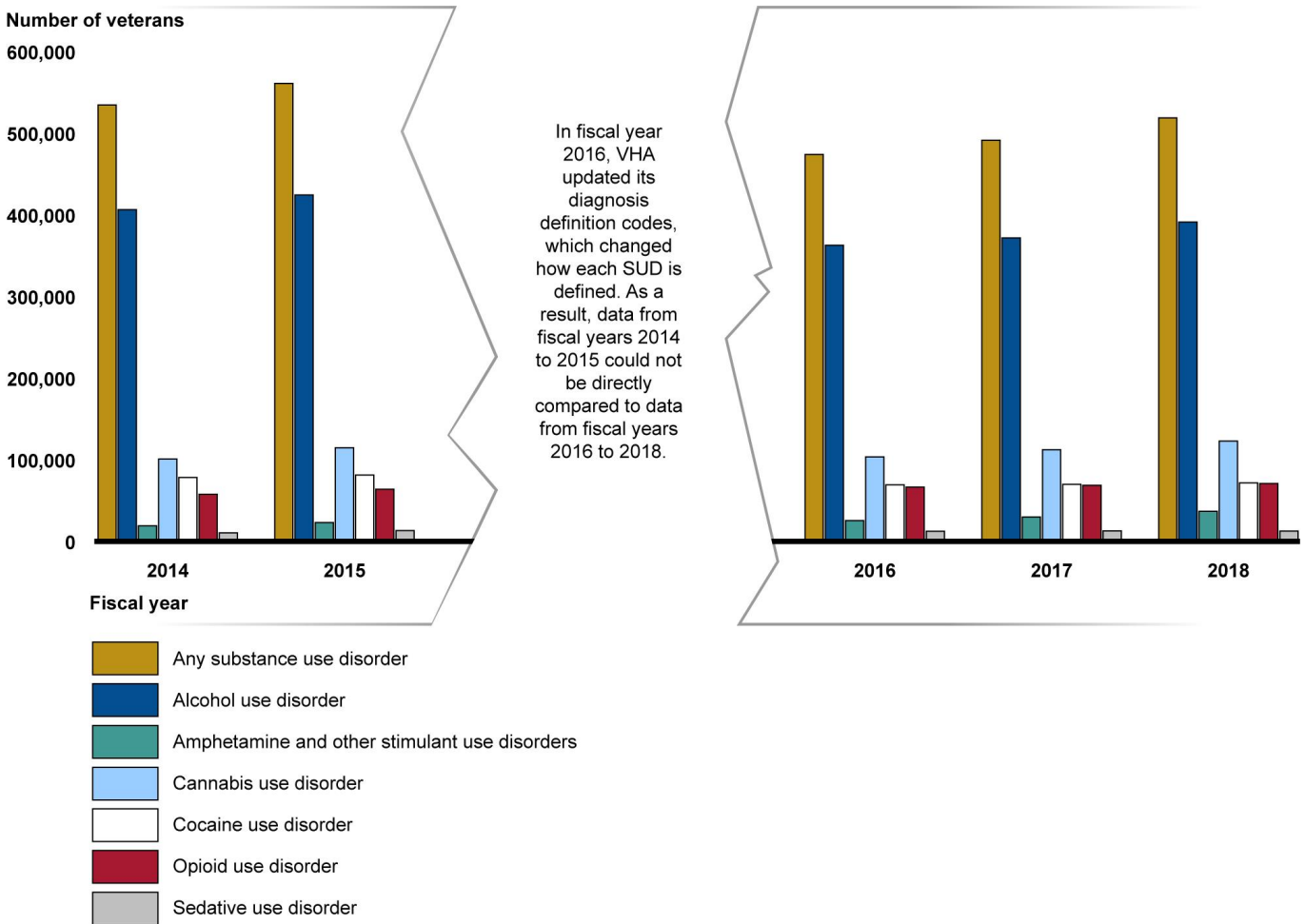
Background

Veterans with SUDs

In fiscal year 2018, VHA data show that 518,570 veterans received any treatment (specialty or non-specialty services) from VHA's health care systems for a diagnosed SUD, a 9.5 percent increase from fiscal year 2016 (see figure 1).⁸ Because these data include non-specialty services, the data do not indicate the extent to which the veteran received SUD services. For example, a provider briefly discussing the SUD of a veteran in long-term recovery during a primary care visit would be included in SUD treatment data. VHA data show that the majority of veterans who received any treatment from VHA's health care systems for a diagnosed SUD had an alcohol use disorder.

⁸Data on treatment from VHA's health care systems do not include services purchased from non-VA providers in the community. As noted previously, we excluded tobacco use disorder from this report. In fiscal year 2018, out of the 6,170,756 million veterans who received health care services provided or purchased by VHA for any diagnosis, 8.4 percent received any treatment for a diagnosed SUD from VHA's health care systems.

Figure 1: Number of Veterans Receiving Any Treatment from the Veterans Health Administration (VHA) for a Diagnosed Substance Use Disorder (SUD) by Type of Disorder, Fiscal Years 2014 through 2018



Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

Note: Some veterans may have multiple SUD diagnoses. Data include veterans receiving specialty SUD services delivered in outpatient settings and programs specifically dedicated to SUD treatment, as well as non-specialty SUD services delivered in, for example, primary care or in general mental health clinics. Data on any SUD exclude tobacco use disorders.

Veterans received any treatment from VHA for a diagnosed SUD at a higher rate than the general population. Data from the 2017 National Survey on Drug Use and Health indicate that 1.5 percent of individuals aged 18 or older nationwide received any SUD treatment in the past

year.⁹ In comparison, 8 percent of veterans getting health care provided or purchased by VHA received any treatment for a diagnosed SUD in fiscal year 2017, including individuals who received specialty SUD services as well as individuals who received non-specialty services in, for example, primary care or general mental health clinics.

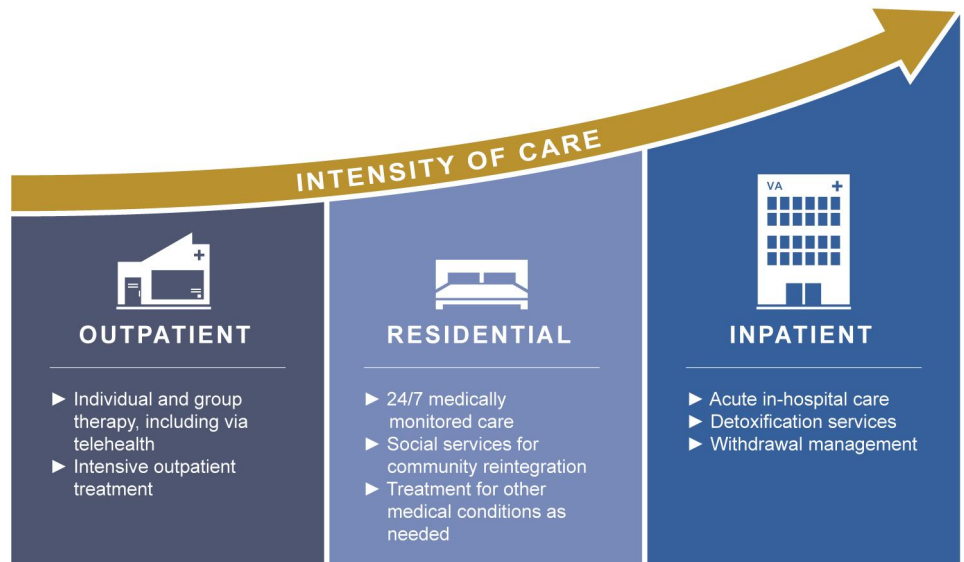
Specialty SUD Services

VHA's health care systems provide specialty SUD services in three settings increasing in intensity (see figure 2):

- **Outpatient services.** Individual and group therapy, either in person or via telehealth, among other services. VHA also offers intensive outpatient programs, which provide services for 3 or more hours per day, 3 days a week at a minimum.
- **Residential rehabilitation treatment programs.** Medically monitored, high-intensity care in a 24-hour supervised environment specifically dedicated to treating SUDs. These programs may also provide social services for community reintegration and treatment for other medical conditions during a veteran's stay.
- **Inpatient services.** Acute in-hospital care, which may include detoxification services.

⁹See SAMHSA, *Results from the 2017 National Survey on Drug Use and Health: Detailed Tables* (Rockville, Md.: Sept. 7, 2018). The 95 percent confidence interval for this percentage ranges from 1.36 to 1.64.

Figure 2: Settings and Types of Services Offered by the Veterans Health Administration for Substance Use Disorders



Source: GAO analysis of Veterans Health Administration information. | GAO-20-35

Medication-Assisted Treatment for Opioid Use Disorder

For veterans with opioid use disorder—a subset of SUDs—VHA’s health care systems provide medication-assisted treatment.¹⁰ Medication-assisted treatment combines behavioral therapy and the use of certain medications, including methadone and buprenorphine.¹¹ Medication-assisted treatment has proven to be clinically effective in reducing the need for inpatient detoxification services for individuals with opioid use disorder, according to SAMHSA.¹²

¹⁰Medication-assisted treatment can refer to treatment for a number of different SUDs. For the purposes of this report, we use the phrase to refer to medication-assisted treatment for opioid use disorders.

¹¹In addition to methadone and buprenorphine, naltrexone might be used in medication-assisted treatment. Naltrexone suppresses the euphoric effects of opioids.

¹²For more information on medication-assisted treatment, see GAO, *Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment*, [GAO-18-44](#) (Washington, D.C.: Oct. 31, 2017) and GAO, *Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access*, [GAO-16-833](#) (Washington, D.C.: Sept. 27, 2016).

- **Methadone.** This medication suppresses withdrawal symptoms during detoxification. It also controls the craving for opioids in maintenance therapy, which is ongoing therapy meant to prevent relapse and increase treatment retention.¹³ Methadone is a controlled substance and, when used to treat opioid use disorder, may generally be administered or dispensed only within a certified opioid treatment program to help prevent diversion.¹⁴
- **Buprenorphine.** This medication eliminates opioid withdrawal symptoms, including drug cravings, and it may do so without producing the euphoria or dangerous side effects of other opioids. It can be used for detoxification and maintenance therapy.¹⁵ Buprenorphine is also a controlled substance, and when used to treat opioid use disorder, may be administered or dispensed within an opioid treatment program, or prescribed or dispensed by a qualifying provider who has received a waiver to do so.¹⁶ Providers who receive this waiver are limited in the number of patients they may treat for opioid use disorder.¹⁷

In addition to medication-assisted treatment, VHA has initiatives aimed at preventing opioid-related overdose deaths. For example, VHA's Opioid Overdose Education and Naloxone Distribution program includes education and training regarding opioid overdose prevention as well as

¹³Methadone is available in tablet form or oral solution.

¹⁴The Controlled Substances Act establishes a framework through which the federal government regulates the use of these substances for legitimate medical, scientific, research, and industrial purposes, while preventing them from being diverted for illegal purposes. See Pub. L. No. 91-513, tit. II, 84 Stat. 1236, 1242-84 (1970) (codified, as amended, at 21 U.S.C. § 801 et seq.). Additional requirements apply to certain controlled substances when used to treat opioid use disorder, as opposed to pain management.

¹⁵Buprenorphine is available in tablet form or film for sublingual (under the tongue) administration both in a stand-alone formulation and in combination with another agent called naloxone, and as a subdermal (under the skin) implant.

¹⁶Under the Drug Addiction Treatment Act of 2000 and subsequent amendments of the Controlled Substances Act, qualified practitioners may apply for a waiver to treat a limited number of patients for opioid use disorder with approved buprenorphine products in any setting in which they are qualified to practice. See Pub. L. No. 106-310, § 3502, 114 Stat. 1101, 1222-27 (2000) (codified, as amended, at 21 U.S.C. § 823(g)).

¹⁷Qualified practitioners may prescribe buprenorphine to up to 30 patients in the first year of their waiver and may apply to treat up to 100 patients in the second year and up to 275 patients in the third year. Practitioners at the 275-patient level must meet additional qualifications and requirements.

naloxone distribution.¹⁸ Naloxone is a medication that can reverse opioid overdoses.

Care in the Community

Veterans may receive services from community providers via local contracts or community care. For local contracts, individual VA medical centers establish contracts with local community providers. For example, a VA medical center may develop a contract with a community residential rehabilitation treatment program provider to set aside a number of beds specifically for veterans.

For community care, veterans may be eligible if, for example, VHA does not offer the care or service the veteran requires or VHA cannot provide the care or services consistent with its access standards. In general, community care services must be authorized in advance of when veterans access the care. Prior to June 6, 2019, eligible veterans could receive community care via one of multiple VHA community care programs. In 2018, the VA MISSION Act required VA to implement a permanent community care program that consolidated several community care programs. On June 6, 2019, the consolidated community care program, the Veterans Community Care Program, went into effect.

Number of Veterans Receiving, and Expenditures for, VHA Specialty SUD Services Have Remained Unchanged in Recent Years; Community Care SUD Services Have Increased

Number of Veterans Receiving Specialty SUD Services in VHA's Health Care Systems and Related Expenditures

¹⁸VHA also has an Opioid Safety Initiative that aims to ensure that veterans are prescribed and use opioid pain medications in a safe and effective manner. For more information, see GAO, *VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed*, [GAO-18-380](#) (Washington, D.C.: May 29, 2018).

Were Relatively Unchanged Between Fiscal Years 2014 and 2018

Among the 518,570 veterans who received SUD services in fiscal year 2018, VHA provided specialty SUD services to 152,482 veterans in fiscal year 2018.¹⁹ This number has increased slightly but remained relatively unchanged since fiscal year 2014, as shown in table 1 below. These veterans received care in VHA’s health care systems—that is, in VA medical centers or in one of the medical centers’ affiliated outpatient clinics and other medical facilities. During the same time period, VHA expenditures for these specialty SUD services increased from \$552 million in fiscal year 2014 to \$601 million in fiscal year 2018.²⁰ Total specialty SUD expenditures per capita increased from \$3,691 to \$3,941 from fiscal years 2014 through 2018. Adjusted for inflation, however, per capita expenditures remained relatively unchanged between fiscal years 2014 and 2018.²¹

Table 1: Veterans Health Administration’s Provision of Specialty Substance Use Disorder (SUD) Services to Veterans, Fiscal Years 2014-2018

Fiscal year	Number of veterans receiving specialty SUD services	Total specialty SUD expenditures (dollars) ^a	Total specialty SUD expenditures per capita (dollars) ^b
2014	149,653	552,407,214	3,691
2015	152,613	543,439,394	3,561
2016	150,373	541,216,435	3,599
2017	150,910	576,336,138	3,819
2018	152,482	600,991,257	3,941

¹⁹In fiscal year 2018, among the 6,170,756 million veterans who received health care services provided or purchased by VHA for any diagnosis, 2.5 percent received care through specialty SUD services.

²⁰Total specialty SUD expenditures include services provided in outpatient settings and residential rehabilitation treatment programs dedicated to treating SUDs as well as some pharmacy services. Expenditures do not include care received in the community or inpatient SUD services. **Error! Bookmark not defined.** See Department of Veteran Affairs, *Capacity to Provide Services to Veterans with Disabilities of Spinal Cord Dysfunction, Amputations, Blindness, and Mental Illness – Fiscal Year 2018* (Washington, D.C.: March 2019).

²¹In fiscal year 2014, per capita expenditures were \$3,922 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures were \$3,941.

Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

^aTotal specialty SUD expenditures include services provided in outpatient settings and residential rehabilitation treatment programs dedicated to treating SUDs, and some pharmacy services. Expenditures do not include care received in the community or inpatient SUD services.

^bIn fiscal year 2014, per capita expenditures were \$3,922 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures were \$3,941.

Most Veterans Received Specialty SUD Services in Outpatient Settings; Medication-Assisted Treatment Has Increased for Opioid Use Disorders in Recent Years

Our analysis of VHA data shows that veterans received specialty SUD services from VHA's health care systems in multiple settings from fiscal years 2014 through 2018, with most veterans receiving these services in outpatient settings. Veterans may receive specialty SUD services across multiple settings within a year. Below, we provide information on utilization and expenditures for specialty SUD services in outpatient and residential treatment programs and for medication-assisted treatment for veterans with opioid use disorder.

Specialty Outpatient Settings

In fiscal year 2018, nearly all veterans who received specialty SUD services from VHA's health care systems received this care in outpatient settings at some point during the year. Of those veterans who received outpatient specialty SUD services, 17 percent received intensive outpatient specialty SUD services, with little change from previous years.²² Expenditures for outpatient specialty SUD services increased from fiscal years 2014 through 2018, as shown in table 2 below. During this time period, outpatient specialty SUD expenditures per capita increased from \$2,176 to \$2,348. Adjusted for inflation, per capita expenditures grew 1.5 percent between fiscal years 2014 and 2018.²³ In addition, we found little change in the number of full-time employee

²²Intensive outpatient services are a form of outpatient service and are defined as receiving services for 3 or more hours per day, 3 days a week at a minimum.

²³In fiscal year 2014, per capita expenditures for outpatient specialty SUD services were \$2,313 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures for outpatient specialty SUD services were \$2,348.

equivalents that actively provided outpatient specialty SUD services from fiscal years 2015 through 2018.²⁴

Table 2: Outpatient Specialty Substance Use Disorder (SUD) Services in Veterans Health Administration (VHA) Health Care Systems, Fiscal Years 2014-2018

Fiscal year	Number of veterans receiving outpatient specialty SUD services ^a	Number of veterans receiving intensive outpatient specialty SUD services ^b	Total outpatient specialty SUD expenditures (dollars) ^c	Outpatient specialty SUD expenditures per capita (dollars) ^d	Number of health-related staff dedicated to providing specialty SUD services in outpatient settings ^e
2014	149,637	n/a	325,646,669	2,176	n/a
2015	150,946	27,199	342,271,471	2,268	1,510.9
2016	148,860	26,830	349,377,391	2,347	1,513.8
2017	149,362	27,011	360,242,622	2,412	1,504.2
2018	150,920	25,672	354,357,347	2,348	1,470.6

Legend: n/a = Not available

Veterans Health Administration (VHA) Outpatient Wait Times

GAO has a body of work highlighting challenges VHA has with the reliability of its wait-time data. See below for recent reports about this issue in outpatient settings.

We have highlighted the importance of reliable outpatient wait-time data in a testimony regarding VHA’s efforts to address our previous recommendations on these issues. See GAO, *Veterans Health Care: Opportunities Remain to Improve Appointment Scheduling within VA and through Community Care*, [GAO-19-687T](#) (Washington, D.C.: July 24, 2019).

We have designated our past recommendations related to outpatient wait-time data as priorities for the agency. See GAO, *Priority Open Recommendations: Department of Veterans Affairs*, [GAO-19-358SP](#) (Washington, D.C.: Mar. 28, 2019).

We have previously made recommendations for VHA to improve the reliability of wait-time measures for outpatient care generally, and two of the four recommendations remain outstanding as of October 2019. See GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, [GAO-13-130](#) (Washington, D.C.: Dec. 21, 2012).

Source: GAO. | GAO-20-35

GAO-20-35

- ^aOutpatient specialty SUD services include individual and group therapy, which may be in person or via telehealth, as well as intensive outpatient therapy.
- ^bIntensive outpatient specialty SUD services are a form of outpatient specialty SUD service and are provided for 3 or more hours per day, 3 days a week at a minimum. According to VHA officials, intensive outpatient specialty SUD data for fiscal year 2014 were unavailable.
- ^cOutpatient specialty SUD expenditures include individual and group therapy, home visits, joint SUD and Post Traumatic Stress Disorder treatment, and SUD treatment via telehealth.
- ^dIn fiscal year 2014, per capita expenditures for outpatient specialty SUD services were \$2,313 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures for outpatient specialty SUD services were \$2,348.
- ^eThe number of staff was estimated by calculating full-time employee equivalents, which involved adding up all relevant employee hours and dividing by the total hours of a full-time employee in a fiscal year. For example, four employees (some part-time, some full-time) work 7,280 hours, and 2,080 hours is the equivalent of the hours a full-time employee works in a fiscal year. The full-time employee equivalent for that fiscal year is 3.5. Staffing data for fiscal year 2014 were not available due to a change in how VHA counted staff.

VHA did not provide specialty outpatient wait-time data because, according to VHA officials, the data do not reliably capture veterans’ wait times to receive SUD services in outpatient settings. VHA officials explained that veterans may receive non-specialty SUD services in various outpatient settings, including primary care and general mental

²⁴Staffing data for fiscal year 2014 were not available due to a change in how VHA counted staff. The number of staff was estimated by calculating full-time employee equivalents, which involved adding up all relevant employee hours and dividing by the total hours of a full-time employee in a fiscal year. For example, four employees (some part-time, some full-time) work 7,280 hours, and 2,080 hours is the equivalent of the hours a full-time employee works in a fiscal year. The full-time employee equivalent for that fiscal year is 3.5.

health clinics. Therefore, developing a wait-time measure for specialty SUD services would not accurately capture whether veterans are waiting for SUD services not previously provided or services that would continue ongoing treatment begun in a primary care or general mental health clinic. As a result, we did not analyze outpatient wait-time data. In prior work, we have made recommendations to VHA on ways it can improve its outpatient wait-time data (see sidebar).

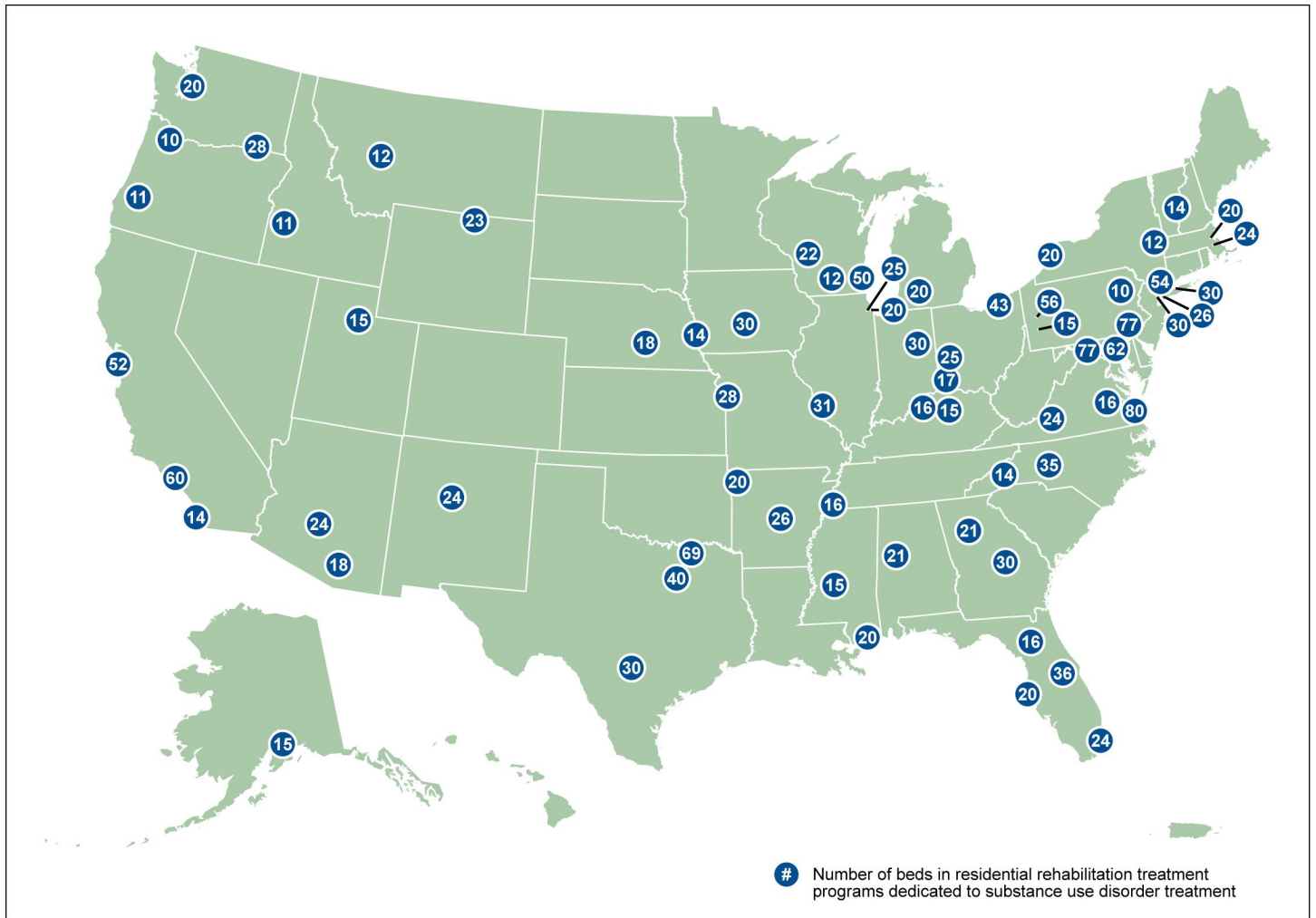
Specialty Residential Rehabilitation Treatment Programs

As of fiscal year 2018, VHA had residential rehabilitation treatment programs available for veterans with complex and long-term mental health needs at 113 facilities, and 67 of these programs were dedicated to SUD treatment.²⁵ The number of residential rehabilitation treatment programs dedicated to SUD treatment increased from fiscal years 2014 through 2018, as did the number of beds available. Figure 3 shows the location of all 67 residential rehabilitation treatment programs specifically dedicated to SUDs with the corresponding number of beds in fiscal year 2018.²⁶ See appendix III for more information on residential rehabilitation treatment programs dedicated to SUD treatment.

²⁵Facilities may have more than one program.

²⁶As of fiscal year 2017, the most recent data available, VHA had 25 additional residential rehabilitation treatment programs that did not specialize in SUD treatment but had designated tracks to treat veterans with SUD. These tracks had 287 dedicated beds plus additional beds “as needed” for veterans with SUD.

Figure 3: Veterans Health Administration's (VHA) Residential Rehabilitation Treatment Programs Dedicated to Substance Use Disorders (SUD), Fiscal Year 2018



Source: GAO analysis of Veterans Health Administration Data; MapInfo (map). | GAO-20-35

Note: VHA offers several different kinds of residential rehabilitation treatment programs, some of which are specific to SUD treatment. This map reports on the 67 residential rehabilitation treatment programs that are designated as specific to SUD treatment. However, veterans with SUDs can receive SUD services in other VHA residential rehabilitation treatment programs that are not specific to SUD.

The number of veterans participating in VHA's specialty SUD residential rehabilitation treatment programs (that is, those dedicated to SUD treatment) remained relatively stable from fiscal years 2014 through 2018,

as shown in table 3.²⁷ Of the veterans who received specialty SUD services in fiscal year 2018, approximately 10 percent participated in one of VHA's 67 residential rehabilitation treatment programs dedicated to SUD treatment, similar to previous years. Meanwhile, expenditures for VHA's residential rehabilitation treatment programs dedicated to SUD decreased from fiscal years 2014 through 2016, but increased in fiscal years 2017 and 2018. Similarly, specialty SUD residential expenditures per capita decreased from \$15,386 in fiscal year 2014 to \$12,526 in fiscal year 2016 and increased again to \$16,031 in fiscal year 2018. After adjusting for inflation, specialty SUD residential expenditures per capita in 2018 were about 2 percent less than what they were in 2014.²⁸

Table 3: Veterans Health Administration (VHA) Residential Rehabilitation Treatment Programs for Substance Use Disorders (SUD), Fiscal Years 2014-2018

Fiscal year	Number of veterans participating in residential rehabilitation treatment programs dedicated to SUD treatment	Total specialty SUD residential expenditures (dollars)	Specialty SUD residential expenditures per capita (dollars) ^a	Average length of stay (days) (minimum - maximum)	Number of residential rehabilitation treatment programs dedicated to SUD treatment	Total number of residential beds designated for veterans with SUDs
2014	14,738	226,760,545	15,386	39.8 (14 – 128)	62	1,702
2015	15,021	201,167,923	13,392	38.7 (14 – 128)	62	1,636
2016	15,315	191,839,044	12,526	36.1 (14 – 105)	63	1,668
2017	15,862	216,093,516	13,623	36.5 (14 – 104)	64	1,751
2018	15,385	246,633,910	16,031	35.8 (3 – 106)	67	1,853

Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

Note: VHA offers several different kinds of residential rehabilitation treatment programs, some of which are specifically dedicated to SUD treatment. This table reports on residential rehabilitation treatment programs that are designated as specific to SUD treatment. However, veterans with SUDs can receive SUD services in other VHA residential rehabilitation treatment programs that are not specifically dedicated to SUDs. VHA has residential rehabilitation treatment programs available for veterans with complex and long-term mental health needs at 113 facilities.

²⁷VHA offers several different kinds of residential rehabilitation treatment programs, some of which are specific to SUD treatment. We are reporting on residential rehabilitation treatment programs that are designated as specific to SUD treatment. However, veterans with SUDs can receive SUD services in other VHA residential rehabilitation treatment programs that are not specific to SUD. VHA has residential rehabilitation treatment programs available for veterans with complex and long-term mental health needs at 113 facilities.

²⁸In fiscal year 2014, per capita expenditures for specialty SUD residential services were \$16,350 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures for specialty SUD residential services were \$16,031.

²⁹In fiscal year 2014, per capita expenditures for specialty SUD residential services were \$16,350, adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures for specialty SUD residential services were \$16,031.

From fiscal years 2014 to 2018, veterans' average length of stay for VHA's specialty residential rehabilitation treatment programs specifically dedicated to SUD generally decreased, while wait times varied across programs. Across VHA's residential rehabilitation treatment programs dedicated to SUD treatment, veterans' average length of stay generally decreased from fiscal years 2014 to 2018, from nearly 40 days to nearly 36 days. VHA officials said that average length of stay may have decreased as a result of multiple factors, such as programs with longer lengths of stay adjusting their treatment approaches. The median wait times to enter residential rehabilitation treatment programs dedicated to SUD treatment varied considerably, ranging from 0 days to 56 days across the programs in fiscal year 2018, although not all residential rehabilitation treatment programs had sufficient—and therefore reliable—data on wait times.²⁹

Specifically, out of the 67 residential rehabilitation treatment programs dedicated to SUD, VHA officials identified 12 that did not have sufficient wait-time data, which we excluded from our analysis. VHA officials noted that some specialty residential rehabilitation treatment programs do not have sufficient wait-time data because the facilities do not consistently code whether a patient's visit included a screening for admission to the program. As such, VHA cannot tell when patients were initially screened for admission. In fiscal year 2019, officials implemented changes to address the lack of reliable data from some facilities.³⁰ However, it is too early to tell if the new changes will address the data reliability issues in wait-time data for residential rehabilitation treatment programs.

Medication-Assisted Treatment for Opioid Use Disorder

VHA health care systems offer veterans medication-assisted treatment for opioid use disorder in a variety of settings, including outpatient specialty SUD settings and residential rehabilitation treatment programs dedicated

²⁹Wait times for residential rehabilitation treatment programs are measured as the time between when a veteran is screened by a provider for admission to a residential rehabilitation treatment program to the date the veteran is admitted to the program.

³⁰Beginning in fiscal year 2019, VHA implemented a national template for admission screening. This template is designed to allow VHA to calculate wait times regardless of whether the facility correctly codes the screening services.

to SUD treatment, as well as in non-specialty settings, such as primary care and general mental health clinics. Our analysis of VHA data shows the number and proportion of veterans with an opioid use disorder who received medication-assisted treatment from VHA’s health care systems has risen in recent years, as shown in table 4. In fiscal year 2018, 23,798 veterans received medication-assisted treatment, which was 33.6 percent of veterans diagnosed with an opioid use disorder. Veterans with an opioid use disorder may receive medication-assisted treatment through VHA at a lower rate than individuals who received care through private insurance. According to a study by the Department of Health and Human Services, 50.6 percent of individuals diagnosed with an opioid use disorder and enrolled in private insurance received medication-assisted treatment in 2014 to 2015.³¹ Some veterans may also have private insurance and may have received their medication-assisted treatment through that private insurance.

Table 4: Medication-Assisted Treatment among Veterans with Opioid Use Disorder within the Veterans Health Administration (VHA), Fiscal Years 2015-2018

Fiscal year ^a	Number of veterans diagnosed with opioid use disorder	Number of veterans with opioid use disorder receiving medication-assisted treatment	Percentage of veterans with opioid use disorder receiving medication-assisted treatment
2015	63,877	18,785	29.4
2016	66,403	20,542	30.9
2017	68,505	21,937	32.0
2018	70,870	23,798	33.6

Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

Note: Veterans can receive medication-assisted treatment in specialty outpatient clinics and residential rehabilitation treatment programs specifically dedicated to substance use disorder treatment, as well as in non-specialty settings such as primary care and general mental health clinics.

^aVHA officials stated that fiscal year 2014 data were unavailable.

In fiscal year 2018, 9,132 (38 percent) of the veterans who received medication-assisted treatment received their care at one of VHA’s 33 opioid treatment programs, which is the only setting where methadone can be administered to treat opioid use disorder. Expenditures for these

³¹See Department of Health and Human Services, *Use of Medication-Assisted Treatment for Opioid Disorders in Employer-Sponsored Health Insurance – Final Report* (Washington, D.C.: Feb 2019).

opioid treatment programs increased from \$35.9 million in fiscal year 2014 to \$39.1 million in fiscal year 2018.³²

In fiscal year 2018, VHA had 2,036 providers with a waiver to prescribe buprenorphine, a 17.6 percent increase from fiscal year 2017.³³ According to VHA officials, VHA has encouraged its providers—including those who are not specialists in treating SUDs, such as primary care providers—to obtain the waiver required to prescribe buprenorphine to treat opioid use disorder. In fiscal year 2018, there were about 29 VHA providers with a waiver to prescribe buprenorphine for every 1,000 veterans with opioid use disorder, a 14 percent increase from fiscal year 2017.

Naloxone Distribution

VHA's naloxone kit distribution increased exponentially from 646 in fiscal year 2014 to 97,531 kits in fiscal year 2018. A total of 204,557 naloxone kits have been distributed through fiscal year 2018. VHA health care systems distributed naloxone kits to VA staff, including VA first responders and VA police officers, and veterans with opioid use disorder. Factors contributing to the increase may include:

- In 2014, VHA implemented the Opioid Overdose Education and Naloxone Distribution initiative to decrease opioid-related overdose deaths among veterans, with one of its key components focused on encouraging naloxone kit distribution. Since the program's implementation, all VHA health care systems dispense naloxone kits.
- The Comprehensive Addiction and Recovery Act of 2016 directed VHA to maximize the availability of naloxone to veterans and to ensure that veterans who are considered at risk for opioid overdose have access to naloxone and training on its proper administration.³⁴

³²Department of Veteran Affairs, *Capacity to Provide Services to Veterans with Disabilities – Fiscal Year 2018*.

³³VHA began collecting data on the number of providers with a waiver to prescribe buprenorphine in fiscal year 2017.

³⁴Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, § 911(e)(1), 130 Stat. 695, 759 (2016).

More Veterans Have Received SUD Services through Community Care in Recent Years; VHA Seeks to Collect Reliable Data on Usage by Community Care Settings

Through its community care programs, VHA purchased SUD services (specialty and non-specialty) for 20,873 veterans in fiscal year 2018, a significant increase since fiscal year 2014 (see table 5).³⁵ VHA officials noted that veterans can receive community care in addition to, or instead of, care at a VHA facility; therefore, the number of veterans served through community care cannot be combined with the number who received services within VHA to provide an overall number of veterans receiving care. Expenditures for these SUD services purchased by VHA also increased over time, from nearly \$6 million in fiscal year 2014 to over \$80 million in fiscal year 2018. Between fiscal years 2014 and 2018, on a per capita basis, SUD services purchased by VHA increased from \$3,021 to \$3,852. Per capita expenditures adjusted for inflation also increased during this time period.³⁶ These increases coincided with the establishment of the Veterans Choice Program in early fiscal year 2015, which expanded eligibility for community care.³⁷ Wait-time data for SUD services purchased through community care were not available because of data reliability issues, VHA officials told us. See sidebar for more information on our previous recommendations to VHA regarding community care wait-time data.

Veterans Health Administration (VHA) Community Care Wait Times

GAO has a body of work highlighting challenges VHA has with the reliability of its wait-time data. See below for recent reports about this issue.

We have highlighted the importance of reliable community care wait-time data in a testimony regarding VHA's efforts to address our previous recommendations on these issues. See GAO, *Veterans Health Care: Opportunities Remain to Improve Appointment Scheduling within VA and through Community Care*, [GAO-19-687T](#) (Washington, D.C.: July 24, 2019).

We have designated our past recommendations related to community care wait-time data as priorities for the agency. See GAO, *Priority Open Recommendations: Department of Veterans Affairs*, [GAO-19-358SP](#) (Washington, D.C.: Mar. 28, 2019).

We have previously made recommendations to VHA to capture the necessary information and improve the reliability of wait-time data for community care. These recommendations remain outstanding as of October 2019. See GAO, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs*, [GAO-18-281](#) (Washington, D.C.: June 4, 2018).

Source: GAO. | GAO-20-35

³⁵Specifically, SUD services veterans received through community care include any care provided where the primary diagnosis was a SUD, regardless of the type of provider involved (e.g., primary care physician, SUD specialist) or setting (e.g., outpatient, inpatient). These numbers do not include veterans that received care through local contracts or expenditures related to local contracts.

³⁶In fiscal year 2014, per capita expenditures for SUD services purchased in the community were \$3,210 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures for SUD services purchased in the community were \$3,852.

³⁷The Veterans Choice Program sunsetted on June 6, 2019, when the new Veterans Community Care Program went into effect. The Veterans Community Care Program was established by the VA MISSION Act and consolidated the Veterans Choice Program along with several other community care programs. Pub. L. No. 115-182, tit. I, 132 Stat. 1393 (2018).

Table 5: Substance Use Disorder (SUD) Services Purchased by the Veterans Health Administration through Community Care Programs, Fiscal Years 2014-2018

Fiscal year	Number of veterans receiving SUD services through community care	Total expenditures for SUD services provided through community care (dollars)	Per capita SUD expenditures for services provided through community care (dollars) ^a
2014	1,975	5,966,524	3,021
2015	2,479	8,523,209	3,438
2016	13,959	47,832,720	3,427
2017	18,548	61,958,321	3,340
2018	20,873	80,398,163	3,852

Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

Note: Community care data on SUD services include both specialty and non-specialty services. Specifically, SUD services veterans received through community care include any care provided where the primary diagnosis was a SUD, regardless of the type of provider involved (e.g., primary care physician, SUD specialist) or setting (e.g., outpatient, inpatient). These numbers do not include veterans that received care through local contracts or expenditures related to local contracts.

^aIn fiscal year 2014, per capita expenditures for SUD services purchased in the community were \$3,210 when adjusted for inflation by converting the fiscal year 2014 amounts to 2018 dollars. In fiscal year 2018, per capita expenditures for SUD services purchased in the community were \$3,852.

While VHA is able to report on the overall number of veterans receiving SUD services through community care, data limitations prevent VHA officials from reliably determining whether veterans received this care in residential or outpatient settings. These issues are as follows:

- **Residential rehabilitation treatment programs.** VHA uses billing codes on paid claims to track the settings in which veterans receive community care; however, according to agency officials, there is no specific billing code for a residential setting. VHA officials told us that community residential rehabilitation treatment programs may record treatment provided using inpatient or outpatient billing codes—or a combination of the two—in submitting claims to VHA. As a result, VHA is unable to use claims data to reliably identify veterans who received residential rehabilitation treatment through community care.
- **Outpatient settings.** Because some residential care data are coded using outpatient billing codes, outpatient data may contain residential services counted as outpatient services. As a result, VHA is unable to reliably identify veterans who received SUD services in community care outpatient settings.

Currently, VHA is taking steps to address these coding issues. VHA officials told us they are developing a payment code that will bundle together common residential program services, which will allow VHA to identify veterans receiving residential rehabilitation treatment for SUDs

through community care. Officials explained that using this code for residential SUD services will allow VHA to better distinguish between residential and outpatient community care because residential care will no longer need to be identified using outpatient codes.

In contrast to its community care programs, VHA does not centrally track SUD services provided via local contracts. Rather, the individual medical centers that established the contracts with local community providers are responsible for tracking and documenting SUD services provided to veterans. In fiscal year 2019, VHA began conducting market assessments, a broader agency initiative to better understand the supply and demand of all services at all VA medical centers, including both what is available within VHA as well as what is available in the local communities. We reviewed one of the data collection instruments the agency is using as a part of this work and found that it should allow VHA to identify, among other things, the number of community residential rehabilitation treatment beds contracted by individual medical centers to serve veterans with SUDs, as well as the number of veterans who received SUD services through local contracts or community care for SUDs. Agency officials said that they expect the market assessments to be completed in 2020.

Veterans' Usage Differed Between Urban and Rural Areas for Some Specialty SUD Services; VHA Is Taking Steps to Address Access Issues in Rural Areas

Although overall use of SUD services was similar among veterans in rural and urban areas, VHA data show the utilization rates of some specialty SUD services differed. The literature and agency documents we reviewed and VHA officials consistently cited several issues, such as recruiting SUD providers and accessing necessary prescriptions for SUDs, which affect the use of services by veterans with SUDs in rural areas. According to agency documents and officials, VHA is taking steps to address these issues.

Overall Use of SUD Services Was Similar for Veterans in Rural Areas Compared to Urban Areas, but Use of Some

Specialty SUD Services Differed in Fiscal Years 2014 through 2018

Overall, veterans' use of SUD services was similar in rural areas compared to urban areas, but use of some specialty services differed. Our analysis of VHA data shows that across VHA's 140 health care systems, there was relatively little difference in the overall utilization of SUD services (specialty and non-specialty) in rural and urban areas from fiscal years 2016 through 2018.³⁸ In fiscal year 2018, for example, 7.5 percent of veterans in rural areas received any SUD services compared with 8.8 percent of veterans in urban areas. However, VHA data also show there were some types of specialty services, such as intensive outpatient specialty services, residential rehabilitation treatment programs, and medication-assisted treatment for opioid use disorder, that rural veterans with SUDs tended to use more or less of than their urban counterparts.

Intensive Outpatient Specialty SUD Services

Among veterans receiving specialty SUD services across all 140 VHA health care systems, those veterans in rural locations used intensive outpatient specialty SUD services at a slightly higher rate (19 percent) than veterans in urban locations (17 percent) in fiscal year 2018. While veterans' utilization of these specialty SUD services has decreased in both rural and urban locations in recent years, the decreases have been larger in rural areas. In rural locations, the percentage of veterans using intensive outpatient specialty SUD services decreased from 25 percent in fiscal year 2015 to 19 percent in fiscal year 2018. In comparison, in urban areas, the percentage of veterans using these services decreased from 18 percent to 17 percent during this same time period.

Officials from VHA health care systems in three urban locations and two rural locations we spoke with indicated that they offered intensive outpatient specialty SUD services in conjunction with either residential or outpatient services. According to officials from the rural VHA health care

³⁸VHA policy requires that veterans receive the same range of SUD services, whether via its health care systems or community care, regardless of location. The data we reviewed do not include community care, only care provided within VHA. In fiscal year 2016, VHA updated its diagnosis definition codes; as a result, data on SUD services (specialty and non-specialty) from fiscal years 2014 to 2015 cannot be directly compared to data from fiscal years 2016 to 2018.

system that did not offer this service, the location did not have sufficient staff to provide the additional hours of intensive outpatient specialty SUD treatment each week.

Specialty Residential Rehabilitation Treatment Programs

Veterans in rural locations using specialty SUD services participated in residential rehabilitation treatment programs dedicated to SUD treatment at a higher rate (17 percent) than veterans using these services in urban locations (10 percent) across all 140 VHA health care systems in fiscal year 2018. From fiscal years 2014 through 2018, there was a slight increase in the percentage of rural veterans using specialty SUD services who participated in residential rehabilitation treatment programs dedicated to SUD treatment, from 13 percent to 17 percent. VHA officials told us rural communities often face difficulties with transportation that may make residential programs more feasible than accessing intensive outpatient specialty SUD services, which are at least 3 days per week, at VHA health care systems. All six of the VHA health care systems we interviewed offered residential rehabilitation treatment programs.³⁹ VHA reported the agency is currently conducting market assessments that may help determine gaps in services for veterans with SUDs, including residential rehabilitation treatment, once the assessments are complete.

Medication-Assisted Treatment for Opioid Use Disorder

Across all 140 VHA health care systems, veterans with an opioid use disorder received medication-assisted treatment (in specialty and non-specialty settings) at a higher rate in urban locations (34 percent) than in rural locations (27 percent) in fiscal year 2018. We also found differences in the availability of medication-assisted treatment services between rural and urban areas:

- **Methadone.** The only setting in which methadone may be used to treat an opioid use disorder is an opioid treatment program. All of VHA's opioid treatment programs are located in urban areas. Only one of the six selected VHA health care systems in our review had an opioid treatment program. Officials from the other five VHA health care systems we spoke with told us they typically referred out to

³⁹Five of the health care systems offered residential rehabilitation programs specific to SUD. Officials from one system indicated that they offered a general residential rehabilitation program that provides SUD treatment as needed.

community providers if a veteran needed methadone. Regional VHA officials indicated that some locations, especially rural ones, may not have the number of veterans with opioid use disorder needed to justify the resources required to run an opioid treatment program.⁴⁰

- **Buprenorphine.** The number of waived providers per 1,000 veterans with opioid use disorder was slightly higher in rural areas (29.9 providers) than in urban areas (28.7 providers) in fiscal year 2018. Non-specialist rural providers, such as primary care providers, may feel a greater responsibility to obtain a waiver because there are fewer specialists for them to refer their patients to, according to VHA health care system officials. Despite the similar rates of waived providers in rural and urban areas, as previously mentioned, rural veterans with opioid use disorder use medication-assisted treatment at a lower rate.

VHA Taking Steps to Address Provider Shortage and Access Issues in Rural Areas for Veterans with SUDs

VHA requires that all rural and urban health care systems offer the same range of SUD services (specialty or non-specialty). However, rural areas have historically faced difficulties delivering all types of health care, including SUD services, according to literature, agency documents, and VHA health care system officials we spoke with. VHA is taking steps to address several issues that affect the delivery of health care services generally, and SUD services in particular, in rural areas.

Shortage of Qualified Providers

Officials from three of the six VHA health care systems we interviewed noted a shortage of SUD specialists in their area, including addiction therapists and providers with a waiver to prescribe buprenorphine. According to one study and agency documents we reviewed, veterans may reside in mental health professional shortage areas at a higher rate than the general population, therefore they may have less access to providers qualified to offer medication-assisted treatment or other mental

⁴⁰VHA's health care systems are organized into 18 regions within defined geographic areas. These regional offices manage the day-to-day function of VHA medical facilities and also provide administrative and clinical oversight of these facilities.

health treatment.⁴¹ One study found that efforts to improve access for veterans in rural areas by purchasing care from community providers may have limited effect, because these areas are relatively underserved generally.⁴²

Officials from two of the three VHA health care systems in rural areas we selected expressed difficulty hiring and retaining providers to provide SUD services. Because of the shortages, recruiting and retaining providers to deliver care to rural veterans is critical. Based on the literature reviewed and half of VHA health care system officials interviewed, rural communities struggle with recruiting and retaining providers, including SUD providers. Some rural areas report provider shortages with ongoing, long-term vacancies.⁴³

To respond to these provider shortages and hiring and retaining challenges, VHA has implemented new initiatives and practices to increase the supply of rural health professionals. A VHA official noted that these efforts include rural health training and education initiatives to provide rural health experience to health professions trainees, including those who provide SUD services. The agency also plans to use expanded recruitment tools, like greater access to an education debt reduction program, improved flexibility for bonuses for recruitment, relocation, and retention, as well as piloting a scholarship program authorized under the VA MISSION Act of 2018 to hire mental health professionals. However, recruiting health professionals in rural areas, including mental health providers and social workers, remains an issue for VHA and the community at large, and VHA officials noted that data are not yet available to understand the long-term effect of the newly trained providers on the availability of SUD services.

⁴¹Counties were classified as health professional shortage designations using criteria created by the Health Resources & Services Administration within the Department of Health and Human Services, based on provider-to-population ratios. Mental health care shortage areas were defined as those areas with either less than 1 psychiatrist per 20,000 individuals and less than 1 primary care provider per 6,000 individuals; less than 1 primary care provider per 9,000 individuals; or less than 1 psychiatrist per 30,000 persons.

⁴²Michael E. Ohl, et al., "Availability of healthcare providers for rural veterans eligible for purchased care under the Veterans Choice Act," *BMC Health Services Research* (2018).

⁴³Ian T. MacQueen, et al., "Recruiting Rural Healthcare Providers Today: a Systematic Review of Training Program Success and Determinants of Geographic Choices," *Journal of General Internal Medicine* (November 27, 2017). SUD specialists would generally fit within the broader category of mental health providers.

Availability and Use of Telehealth Services for the Delivery of SUD Services

Officials from two VHA health care systems we interviewed noted that providing services, such as medication-assisted treatment, through telehealth technology is difficult, especially when the SUD service requires monitoring for medication compliance.⁴⁴ However, a VHA official told us the use of telehealth services overall has grown exponentially at VHA's health care systems and goes beyond traditional video conference capabilities to include advanced technology that can be attached to computers or videoconference equipment like an exam camera to allow for an interactive examination. The official added that the provision of SUD services using telehealth can be supported by medical personnel located at the closest VA facility to complete necessary tests, such as urine screening, when the service is provided at a VHA location.

VHA officials from one health care system we spoke with and literature noted that providing medication-assisted treatment via telehealth technologies requires a cultural change within the profession. Officials from one VHA health care system we spoke with told us that delivering medication-assisted treatment using technology is risky. For example, buprenorphine is a controlled substance with a risk of misuse. This official added that many providers may not be open to the idea of delivering this level of treatment using telehealth. One study we reviewed confirmed that acceptance within the profession appears to be the main barrier to the successful implementation of telehealth services.⁴⁵ However, VHA's budget and strategic plan show continued support for the use of telehealth for SUD treatment. Studies have shown that telephone

⁴⁴Telehealth is the delivery of health care services using telecommunications technology. Using telehealth technologies, such as videoconferencing, changes the location where health care services are delivered and has alleviated some rural health issues related to access to mental health care.

⁴⁵Stephanie D. Wynn and Roy Ann Sherrod, "Providing Mental Health Care to Veterans in Rural Areas Using Telehealth Mobile Clinics," *Journal of Psychosocial Nursing*, Vol. 50, No. 6 (2012).

services, a type of telehealth service, potentially have the same outcomes as in-person services.⁴⁶

Officials from all six VHA health care systems we selected mentioned they had mental health telehealth services available to facilitate the delivery of care to veterans in both urban and rural areas for SUD services. To ensure adequate access to care, VHA has multiple telehealth initiatives underway. For example, between fiscal years 2017 and 2019, VHA allocated \$28.5 million for mental health telehealth hubs at 11 sites. In another instance, VHA allocated more than \$750,000 for rural facilities in fiscal years 2018 and 2019 toward a nationwide initiative to improve participation in a program that establishes video connections in the homes of rural veterans to receive mental health treatment, including for SUDs, with psychotherapy and psychopharmacology. While VHA has initiatives underway, the success of these efforts is contingent on rural areas having broadband and internet connectivity, which remains a challenge, according to agency documents and officials.

Access to Necessary Prescriptions

VHA's Clinical Practice Guidelines for SUDs recommends methadone and buprenorphine, among others drugs, to treat opioid use disorder. However, accessing these drugs in rural areas can be challenging, according to literature we reviewed and VHA officials we spoke with. For example, one national study found that opioid treatment programs providing methadone are generally absent from the treatment options in rural areas.⁴⁷ Within VHA, all of the opioid treatment programs are in

⁴⁶Kathryn McCollister, et al., "Cost-effectiveness analysis of a continuing care intervention for cocaine-dependent adults," *Drug and Alcohol Dependence*, (2015); James R. McKay, et al., "Extended telephone-based continuing care for alcohol dependence: 24-month outcomes and subgroup analyses," *Addiction*, (2011); James R. McKay, et al., "An Adaptive Approach for Identifying Cocaine Dependent Patients Who Benefit From Extended Continuing Care," *Journal of Consulting and Clinical Psychology*, Vol. 81, No. 6 (2013); James R. McKay, et al., "A Randomized Trial of Extended Telephone-Based Continuing Care for Alcohol Dependence: Within-Treatment Substance Use Outcomes," *Journal of Consulting and Clinical Psychology*, Vol. 78, No. 6 (2010); and James R. McKay, et al., "The Effectiveness of Telephone-Based Continuing Care for Alcohol and Cocaine Dependence," American Medical Association, *Arch Gen Psychiatry*, Vol. 62 (2005).

⁴⁷National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives*, (Washington, D.C.: The National Academies Press, 2019).

urban areas. In addition, in rural areas generally, a small percentage of providers nationwide have received waivers to prescribe buprenorphine.⁴⁸

VHA officials told us they are steadily expanding the availability of medication-assisted treatment for veterans with opioid use disorder. VHA had an interdisciplinary team of VA staff from a single facility within each region receive training on implementing medication-assisted treatment for opioid use disorder. These teams were responsible for spreading information to other facilities. Thus far, VHA reported it has trained over 300 providers using this model.⁴⁹ In a separate initiative, a VHA official reported that its Office of Rural Health provided over \$300,000 in fiscal year 2019 for a pilot program that trains primary care and mental health providers in the Iowa City VHA health care system on how to provide medication-assisted treatment for opioid use disorder.

Transportation

The availability of transportation is vital for veterans receiving medication-assisted treatment due to the necessity for frequent travel to the VHA health care systems for treatment. When using methadone for opioid use disorder treatment, the medication generally needs to be administered through an opioid treatment program at a specific location on a daily basis. In addition, during the initial stages of buprenorphine treatment, patients must also come into a facility frequently. Veterans living in rural areas who need this level of care may have to travel long distances every day to receive this medication.⁵⁰

Distance and lack of transportation impede access to care, including SUD services, for rural veterans. Specifically, the literature we reviewed noted

⁴⁸National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives*.

⁴⁹Department of Veterans Affairs, *Volume II: Medical Programs and Information Technology Programs Congressional Submission, FY 2020 Funding and FY 2021 Advance Appropriations*.

⁵⁰GAO has conducted previous work in this area. See *Drug Policy: Assessing Treatment Expansion Efforts and Drug Control Strategies and Programs*, [GAO-19-535T](#) (Washington, D.C.: May 9, 2019); and *Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access*, [GAO-16-833](#) (Washington, D.C.: Sept. 27, 2016).

distance, time, and access to transportation as barriers to care.⁵¹ Veterans may lack access to transportation or are no longer able to drive because of age, health status, or driving restrictions. Some rely on family, friends or vans available through community service organizations; however, they may have other difficulties like reaching pick-up locations or the organization not having vans that are wheelchair-equipped. Officials from all six VHA health care systems we selected noted the lack of transportation as a barrier to accessing SUD services. Officials from two rural locations of the six selected VHA health care systems mentioned that volunteers, including a local veteran service organization, assist with getting veterans from their homes to their appointments; however, they added that these services operate on an abbreviated schedule and veterans are sometimes subjected to riding in the vehicle for long periods of time (2 hours each way). Over the last 10 years, a VHA official told us that the agency has allocated between \$10 and \$12.9 million for its Veterans Transportation Service for new vehicles, drivers, and mobility managers to assist with rural transportation needs.

Additional VHA Plans to Address Rural Health Issues for SUD Services

The VA MISSION Act of 2018 includes provisions that specifically address the need to improve veterans' access to health care in areas with shortages of health care providers, including those providing SUD and mental health services. Based on this legislation, in June 2019, VHA published a plan organized in three areas: increasing personnel, using technology to connect veterans to care through public and private partnerships, and expanding VHA's infrastructure through the building or acquiring of space to address the problem of underserved facilities.⁵² For example, VHA has a pilot program with 11 Walmart sites and 15-20 additional sites planned with Philips Healthcare, the Veterans of Foreign Wars, and the American Legion to enable veterans who lack the necessary technology in their home and live far from a VHA facility to

⁵¹Colin Buzza, et al., "Distance is Relative: Unpacking a Principal Barrier in Rural Healthcare," *Journal of General Internal Medicine* 26 Suppl2 (2011): 648-54, and John A. Gale and Hilda A. Heady, "Rural Vets: Their Barriers, Problems, Needs," *Health Progress* (May-June 2013).

⁵²Department of Veterans Affairs, *VA Mission Act of 2018, Section 401 – Development of Criteria for Designation of Certain Medical Facilities of the Department of Veterans Affairs as Underserved Facilities and Plan to Address Problem of Underserved Facilities*, June 2019.

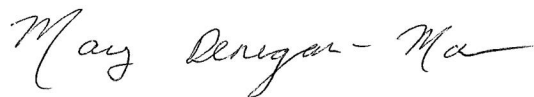
receive remote health care at a convenient location. VHA's plan indicates that while all VHA health care systems can use any of the strategies covered under this legislation, they will provide specific additional technical assistance for underserved facilities, monitor the effectiveness of these strategies, and share the findings of this work throughout the broader VHA system.

Agency Comments

We provided a draft of this report to VA for review and comment. VA provided written comments, which are reprinted in appendix IV, and technical comments, which we incorporated as appropriate. VA's comments note that the agency generally reports obligations and that the agency is unable to confirm some of our financial data.⁵³ However, the data provided by VA during the course of this engagement were regarding expenditures, and thus we report them as such.⁵⁴ VA's comments also provide information on additional efforts to expand mental health telehealth and ways the agency recruits providers in rural areas.

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

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



Mary Denigan-Macauley
Director, Health Care

⁵³An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States.

⁵⁴An expenditure is the actual spending of money (also known as an outlay).

Appendix I: Map of 140 Veterans Health Administration Health Care Systems, Fiscal Year 2018

Figure 4, an interactive graphic, shows the location and rurality of the Veterans Health Administration's health care systems, as well as information on veterans treated by these health care systems.

For an accessible version of the data used in this map, see <https://www.gao.gov/products/GAO-20-35>.

Figure 4: Veterans Health Administration Health Care Systems, Fiscal Year 2018

Appendix II: Site Selection Methodology and Selected Health Care System Characteristics

To describe any differences between veterans' use of substance use disorder (SUD) services in rural and urban areas and the issues affecting access to those services in rural areas, we selected six Veterans Health Administration (VHA) health care systems and interviewed officials regarding their SUD services and issues serving veterans with SUDs. Because opioid use disorders may pose a greater risk to veterans than the general population, we selected the six VHA health care systems from among those with the highest percentages of veterans with an opioid use disorder diagnosis in fiscal year 2018. We also selected these six health care systems to achieve variation in representation among VHA's five geographic regions and to include both urban and rural locations. See table 6.

Table 6: Selected Veterans Health Administration (VHA) Health Care Systems, by Location with Site Selection Criteria and Additional Characteristics, Fiscal Year 2018

Site selection criteria		Additional characteristics					
Location	Health care system	Percentage of total veterans treated with an opioid use disorder diagnosis (rank ^a)	Geographic region ^b	Number of veterans treated by the health care system for any diagnosis	Number of veterans receiving specialty substance use disorder (SUD) services ^c	Full-time employee equivalents actively delivering outpatient specialty SUD services ^d	Residential program dedicated to SUDs? ^e (Yes/No)
Urban	Cincinnati, Ohio	2.78 (5)	Midwest	35,579	2,043	25.9	Yes
	Coatesville, Pennsylvania	3.18 (2)	North Atlantic	16,049	965	9.2	Yes
	Lexington, Kentucky	2.08 (15)	Southeast	32,934	721	6.1	Yes
Rural	Bath, New York	2.02 (17)	North Atlantic	10,007	420	2.2	No

Appendix II: Site Selection Methodology and Selected Health Care System Characteristics

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	Roseburg, Oregon	1.56 (35)	Pacific	23,789	451	5.6	Yes
	White River Junction, Vermont	1.65 (28)	North Atlantic	22,084	724	5.3	Yes

Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

^aRankings are out of 140 health care systems with 1 being the highest percentage of veterans with an opioid use disorder diagnosis. We excluded data from the Philippines because it is not a U.S. state or territory but rather an independent nation that has treated few veterans.

^bThe North Atlantic region was frequently represented among the VHA health care systems with the highest percentage of veterans with an opioid use disorder diagnosis. As a result, half of our selected sites are located there.

^cSpecialty SUD services are those provided to veterans in outpatient clinics and residential rehabilitation treatment programs specifically dedicated to SUD treatment. Specialty SUD services do not include non-specialty SUD services provided, for example, via primary care or in general mental health clinics. We excluded tobacco use disorder, as tobacco cessation treatment is generally not provided in SUD treatment facilities.

^dCalculating full-time employee equivalents involved adding up all relevant employee hours and dividing by the total hours of a full-time employee in a fiscal year. For example, four employees (some part-time, some full-time) work 7,280 hours, and 2,080 hours is the equivalent of the hours a full-time employee works in a fiscal year. The full-time employee equivalent for that fiscal year is 3.5.

^eVHA offers several different kinds of residential rehabilitation programs, some of which are specific to SUD treatment. Veterans with SUD may receive SUD treatment in other VHA residential rehabilitation programs that are not specific to SUD.

Appendix III: Veterans Health Administration Substance Use Disorder Residential Rehabilitation Treatment Programs

The Veterans Health Administration had 67 residential rehabilitation treatment programs dedicated to substance use disorder treatment in fiscal year 2018. See table 7.

Table 7: Veterans Health Administration’s (VHA) 67 Substance Use Disorder (SUD) Residential Rehabilitation Treatment Programs, Fiscal Year 2018

Location	Program name (state abbreviation)	Number of veterans served	Number of beds	Cumulative occupancy rate (percentage)	Average length of stay (days)	Average wait time (days) ^a	Median wait time (days) ^a
Urban (59 programs)	Albany (NY)	114	12	85.8	31.3	n/a	n/a
	Albuquerque (NM)	86	24	60.8	61.8	63.8	51
	American Lake (WA)	234	20	81.0	24.5	36.8	29
	Anchorage (AK)	102	15	66.9	29.5	n/a	n/a
	Asheville (NC)	184	14	83.9	22.3	n/a	n/a
	Atlanta (GA)	156	21	78.7	44.8	37.2	25
	Battle Creek (MI)	246	20	85.5	23.6	37.9	26
	Bay Pines (FL)	281	20	91.2	24.1	86.7	51
	Biloxi (MS)	249	20	90.1	26.6	63.0	41
	Boise (ID)	127	11	78.7	25.3	46.8	23
	Bonham (TX)	419	69	63.1	32.7	53.1 ^b	32 ^b
	Boston (MA)	146	20	86.5	34.9	41.1 ^c	17 ^c
	Brockton (MA)	215	24	70.7	34.2	41.1 ^c	17 ^c
	Brooklyn (NY)	282	26	69.8	20.3	45.6	3
	Buffalo (NY)	211	20	71.2	23.0	n/a	n/a
	Chicago JB (IL)	189	20	85.4	33.9	24.1	6
	Cincinnati (OH)	237	17	74.5	18.4	53.9	29
	Cleveland (OH)	471	43	89.1	35.2	43.7	21

**Appendix III: Veterans Health Administration
Substance Use Disorder Residential
Rehabilitation Treatment Programs**

Location	Program name (state abbreviation)	Number of veterans served	Number of beds	Cumulative occupancy rate (percentage)	Average length of stay (days)	Average wait time (days)^a	Median wait time (days)^a
	Coatesville (PA)	935	77	87.9	26.0	40.9	8
	Dallas (TX)	396	40	74.9	29.1	53.1 ^b	32 ^b
	Dayton (OH)	346	25	n/a	45.2	37.8	14
	Des Moines (IA)	227	30	95.6	48.7	46.6 ^d	17 ^d
	East Orange (NJ)	330	30	85.6	24.2	n/a	n/a
	Fayetteville ^e (AR)	7	20	n/a	n/a	n/a	n/a
	Gainesville (FL)	117	16	89.6	46.8	40.0	27
	Grand Island (NE)	143	18	58.0	24.8	46.6 ^d	17 ^d
	Hampton (VA)	458	80	83.2	56.9	n/a	n/a
	Hines (IL)	281	25	73.6	21.9	29.7	9
	Jackson (MS)	195	15	87.3	25.1	n/a	n/a
	Kansas City (MO)	354	28	82.1	18.9	42.6	22
	Lexington (KY)	195	15	81.9	22.8	49.7	24
	Little Rock ^e (AR)	2	26	n/a	3.0	n/a	n/a
	Louisville (KY)	153	16	82.3	31.6	n/a	n/a
	Madison (WI)	143	12	92.7	26.7	25.2	6
	Martinsburg (WV)	553	77	93.0	41.3	44.2	22
	Memphis (TN)	154	16	86.5	31.6	n/a	n/a
	Miami (FL)	82	24	67.9	71.6	39.3	29
	Milwaukee (WI)	347	50	74.1	37.9	33.0	6
	Montrose (NY)	228	54	47.8	36.4	38.4	15.5
	Northport (NY)	109	30	91.5	106.4	26.8	20
	Omaha (NE)	153	14	70.4	20.6	46.6 ^d	17 ^d
	Orlando (Lake Baldwin) (FL)	272	36	66.1	56.0	41.9	18
	Palo Alto ^f (CA)	338	52	71.4 / 78.0	36.3	79.4	56
	Perry Point (MD)	227	62	93.3	60.7	35.9	13
	Phoenix (AZ)	146	24	87.8	57.1	41.0	16
	Pittsburgh-Heinz (PA)	229	15	80.0	18.6	15.7	2
	Portland (OR)	77	10	76.2	34.6	40.9	25.5
	Richmond (VA)	145	16	68.6	26.0	29.8	15
	Salem (VA)	258	24	82.0	23.5	37.8	11
	Salisbury (NC)	380	35	82.5	29.1	61.4	25
	Salt Lake City (UT)	123	15	91.7	39.1	40.5	21
	San Antonio (TX)	361	30	78.9	22.3	40.1	19

**Appendix III: Veterans Health Administration
Substance Use Disorder Residential
Rehabilitation Treatment Programs**

Location	Program name (state abbreviation)	Number of veterans served	Number of beds	Cumulative occupancy rate (percentage)	Average length of stay (days)	Average wait time (days) ^a	Median wait time (days) ^a
	San Diego (CA)	200	14	100	24.5	79.5	42
	St. Louis (MO)	445	31	64.4	14.8	18.6	0
	Tucson (AZ)	140	18	85.2	37.7	11.5	0
	Tuscaloosa (AL)	132	21	85.8	52.3	39.3	30.5
	Walla Walla (WA)	275	28	78.2	30.7	31.6	0
	West Los Angeles (CA)	323	60	80.8	65.8	36.6	13.5
	Wilkes-Barre (PA)	152	10	90.6	19.7	43.7	14
Rural (8 programs)	Butler (PA)	232	56	93.1	96.9	30.8	10
	Dublin (GA)	228	30	13.8	45.6	40.8	22
	Fort Harrison (MT)	93	12	90.9	38.6	52.7	30.5
	Marion IN (IN)	217	30	86.1	47.2	33.3	14
	Roseburg (OR)	75	11	90.9	34.2	n/a	n/a
	Sheridan (WY)	167	23	82.1	37.8	66.2	39.5
	Tomah (WI)	158	22	69.2	38.5	73.1	22
	White River Junction (VT)	135	14	80.2	29.4	42.8	20
Urban total or average		14,080	1,655	80.0	33.8	42.1	20.3
Rural total or average		1,305	198	75.8	46.0	48.5	22.6
Total or average		15,385	1,853	79.5	35.8	43.0	20.6

Legend: n/a = Not available

Source: GAO analysis of Veterans Health Administration data. | GAO-20-35

^aWait times for residential rehabilitation treatment programs are measured as the time between when a veteran is screened by a provider for admission to a residential rehabilitation treatment program to the date the veteran is admitted to the program. VHA officials noted that some residential rehabilitation treatment programs did not have sufficient—and therefore reliable—wait-time data because the facilities do not consistently code whether a patient’s visit included a screening for admission to the residential rehabilitation treatment program. As such, VHA cannot tell when patients were initially screened for admission. Programs without reliable wait-time data are indicated as n/a in the relevant columns.

^bWait-time data reported for Bonham and Dallas residential rehabilitation treatment programs dedicated to SUD treatment are combined because they belong to the same VHA health care system.

^cWait-time data for Boston and Brockton residential rehabilitation treatment programs dedicated to SUD treatment are combined because they belong to the same VHA health care system.

^dWait-time data for Des Moines, Grand Island, and Omaha residential rehabilitation treatment programs dedicated to SUD treatment are combined because they belong to the same VHA health care system.

^eIncomplete data are reflective of a new residential rehabilitation treatment program dedicated to SUD treatment.

**Appendix III: Veterans Health Administration
Substance Use Disorder Residential
Rehabilitation Treatment Programs**

^fPalo Alto has two residential rehabilitation treatment programs dedicated to SUD treatment. The data for the two programs were combined with the exception of the cumulative occupancy rate.

Appendix IV: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

November 6, 2019

Ms. Mary Denigan-Macauley
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Denigan-Macauley:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: "**VETERANS HEALTH CARE: Services for Substance Use Disorders and Efforts to Address Access Issues in Rural Areas**" (GAO-20-35).

The enclosure provides general and technical comments. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in blue ink, appearing to read "Pamela Powers".

Pamela Powers
Chief of Staff

Enclosure

Attachment

Department of Veterans Affairs
General and Technical Comments to the
Government Accountability Office's (GAO) Draft Report
**"VETERANS HEALTH CARE: Services for Substance Use Disorders
and Efforts to Address Access Issues in Rural Areas"**
(GAO-20-35)

General Comments:

In our reporting history, the Veterans Health Administration's (VHA) Office of Finance has regularly used obligation information as a representation of our budget execution. Throughout this report, the use of the term "expenditures" is ubiquitous, but consistent. We are unable to confirm some of the expenditure data. Other, non-financial data is consistent with other published documents such as information included in the Office of National Drug Control Policy and the President's budget.

VHA's Office of Rural Health (ORH) worked with the Office of Connected Care and Health Care Operations to develop 18 new Clinical Resource Hubs (CRH), funded for a total of \$115 million. Designed to address the Department of Veterans Affairs (VA) Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act access requirements, the CRHs deliver primary care and mental health care services via telehealth to hundreds of thousands of rural Veterans who might not otherwise have access to care.

VA finds that the most effective methods to recruit and retain in rural settings include:

- Offering Employee Referral programs;
- Ongoing Partnership with National Rural Recruitment and Retention Network, which provides visibility of VA practice opportunities to the rural patient care provider market;
- Participating in exhibits at regional health care career fairs and professional conferences to create awareness of and engagement with providers;
- Offering the Health Professions Scholarship Program;
- Leveraging targeted use of the Education Debt Reduction Program;
- Using the Transitioning Military Personnel program; and
- Having flexible work schedules.

Attachment

VA is also participating in a recruitment pilot program with the Department of Health and Human Services to share referral lists/certificates of highly qualified applicants for hiring consideration. Additionally, these other methods are most effective:

- Having competitive salaries;
- Utilizing student loan repayment program;
- Offering sign-on and retention bonuses;
- Ensuring adequate support staffing for providers to reduce burnout;
- Giving trainees rural health experience during their VA rotations; and
- Providing the opportunity to telework when appropriate.

Text of Appendix IV: Comments from the Department of Veterans Affairs

Page 1

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Pamela Powers Chief of Staff

Enclosure

Page 2

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Page 3

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- Providing the opportunity to telework when appropriate.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Mary Denigan-Macauley, (202) 512-7114 or
deniganmacauleym@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Hannah Marston Minter and Carolina Morgan, Analysts-in-Charge; Sam Amrhein; Amy Andresen; Shaunessye D. Curry; and John Tamariz made key contributions to this report. Also contributing were Giselle Hicks, Diona Martyn, Ethiene Salgado-Rodriguez, and Emily Wilson Schwark.

Related GAO Products

Veterans Health Care: Opportunities Remain to Improve Appointment Scheduling within VA and through Community Care, [GAO-19-687T](#). Washington, D.C.: July 24, 2019.

VA Health Care: Estimating Resources Needed to Provide Community Care, [GAO-19-478](#). Washington, D.C.: June 12, 2019.

Drug Policy: Assessing Treatment Expansion Efforts and Drug Control Strategies and Programs, [GAO-19-535T](#). Washington, D.C.: May 9, 2019.

Priority Open Recommendations: Department of Veterans Affairs, [GAO-19-358SP](#). Washington, D.C.: March 28, 2019.

Behavioral Health: Research on Health Care Costs of Untreated Conditions is Limited, [GAO-19-274](#). Washington, D.C.: Feb. 28, 2019.

Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs, [GAO-18-281](#). Washington, D.C.: June 4, 2018.

VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, [GAO-18-380](#). Washington, D.C.: May 29, 2018.

Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment, [GAO-18-44](#). Washington, D.C.: October 31, 2017.

Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access, [GAO-16-833](#). Washington, D.C.: September 27, 2016.

VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, [GAO-13-130](#). Washington, D.C.: December 21, 2012.

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