United States Government Accountability Office

Report to Congressional Committees

February 2023

VA MENTAL HEALTH

Additional Action Needed to Assess Rural Veterans' Access to Intensive Care

GAO-23-105544

February 2023

VA MENTAL HEALTH

Additional Action Needed to Assess Rural Veterans' Access to Intensive Care

GAO Highlights

Highlights of GAO-23-105544, a report to congressional committees

Why GAO Did This Study

Serious mental illness is a persistent and growing concern for our nation's veterans. Research shows veterans with serious mental illness who live in rural areas can face challenges accessing this care, such as long drive times to facilities.

The Sgt. Ketchum Rural Veterans Mental Health Act of 2021 included a provision for GAO to study the intensive mental health care that VHA makes available to rural veterans. Among other objectives, this report examines the information VHA uses to monitor access to such care, what these data show about rural veterans' access, and the guidelines VHA uses to establish programs for rural veterans.

GAO reviewed VHA documentation and policies on its intensive mental health care programs and fiscal year 2021 data (most recent available) on utilization and performance for these programs. GAO also interviewed VHA officials and officials from three health care systems selected for geographic and program variation.

What GAO Recommends

GAO is making four recommendations, including that VHA analyze intensive mental health care utilization and performance data by rurality and assess and update, as appropriate, guidelines for establishing outpatient intensive mental health programs. The Department of Veterans Affairs concurred with the recommendations and identified steps it would take to implement them.

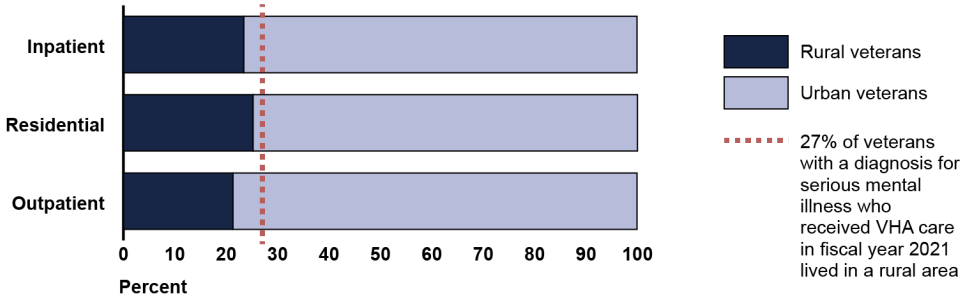
View GAO-23-105544. For more information, contact Alyssa M. Hundrup at (202) 512-7114 or hundrupa@gao.gov.

What GAO Found

The Veterans Health Administration (VHA) provides intensive mental health care for veterans with serious mental illness—disorders resulting in serious function impairment, such as schizophrenia or bipolar disorder. To monitor veterans' access to its inpatient, residential, and outpatient intensive mental health care programs, VHA analyzes the extent to which veterans use these programs. It also analyzes performance data, such as how long veterans wait for residential care and the ratio of patients to program staff. However, VHA does not analyze its data by rurality to compare program utilization and performance for veterans living in rural areas with those living in urban areas. Doing so would help VHA understand the extent to which programs effectively reach rural veterans.

In analyzing VHA's fiscal year 2021 data, GAO found rural veterans used intensive mental health care programs at lower rates than their urban counterparts. For example, the rate at which rural veterans used outpatient care was approximately 21 percent, compared with a utilization rate of 79 percent for urban veterans (see figure). VHA data show 27 percent of veterans with serious mental illness who received VHA care lived in a rural area in the same year. According to VHA officials, there may be various reasons rural veterans use care less than urban veterans, such as other demographic differences.

Proportion of Rural and Urban Veterans Using VHA Intensive Mental Health Care, Fiscal Year 2021



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105544

Note: Inpatient programs, such as a hospital stay, are for veterans experiencing acute mental health crisis. Residential programs provide residential and treatment services. Outpatient programs provide treatment services to veterans. GAO uses the term "rural veteran" to include veterans living in rural, highly rural, and insular island areas.

In 2021, VHA updated its guidelines for establishing inpatient and residential intensive mental health care programs to account for projected demand and geographic data, such as the location of where veterans live. However, guidelines for its outpatient intensive mental health care programs do not account for where veterans live. For example, guidelines for establishing rural-focused programs "strongly encourage" establishment in rural areas but do not otherwise identify parameters facilities should use in doing so, such as where veterans live or drive times for reaching a facility. Assessing and updating, as appropriate, its guidelines for establishing outpatient programs to include such parameters would be consistent with the Department of Veterans Affairs' goals of improving access to care for rural veterans and veterans with serious mental illness.

Contents

Letter		1
	Background	6
	VHA Uses Models and Utilization Data to Estimate Veterans' Demand for Intensive Mental Health Care	15
	VHA Analyzes Various Data to Monitor Access to Intensive Mental Health Care, but Does Not Examine Data by Rurality	19
	Some VHA Data Suggest Rural Veterans Use Mental Health Programs at Lower Rates than Urban Veterans	25
	VHA Developed Targeted Guidelines for Establishing Residential and Inpatient Intensive Mental Health Care Programs, but Not for Outpatient Programs	33
	Conclusions	40
	Recommendations for Executive Action	41
	Agency Comments	42
Appendix I	Supplemental Information on Methodology	44
Appendix II	Comments from the Department of Veterans Affairs	50
Appendix III	GAO Contact and Staff Acknowledgments	54
Tables		
	Table 1: Veterans Who Used Veterans Health Administration (VHA) Health Care by Rurality, Fiscal Year 2021	6
	Table 2: Veterans Who Used Any Veterans Health Administration (VHA) Care and Veterans on the National Psychosis Registry by Rurality, Fiscal Year 2021	9
	Table 3: Number of Veterans Health Administration (VHA) Health Care Systems with Intensive Mental Health Care Programs and Number of Veterans Who Used Them, Fiscal Year 2021	12
	Table 4: Veterans Health Administration (VHA) Health Care Systems by Rurality of Populations Served, Fiscal Year 2021	15

Table 5: Veterans Health Administration (VHA) Projection of Change in National Demand for Intensive Mental Health Care from Fiscal Year 2019 to 2029 17
Table 6: Key Data Veterans Health Administration (VHA) Uses to Monitor Access to Intensive Mental Health Care Programs 21
Table 7: Number of Veterans Who Used Veterans Health Administration (VHA) Intensive Mental Health Care Programs per 10,000 Veterans Who Used VHA Care by Rurality, Fiscal Year 2021 27
Table 8: Guidelines for Establishing Veterans Health Administration (VHA) Outpatient Intensive Mental Health Programs 36
Table 9: Veterans Health Administration (VHA) Health Care Systems by Rurality of Populations Served, Fiscal Year 2021 44

Figures

Figure 1: Challenges for Rural Veterans in Accessing Intensive Mental Health Care Identified by Veterans Health Administration (VHA) Officials 8
Figure 2: Veterans Health Administration (VHA) Intensive Mental Health Care Programs 11
Figure 3: Basic Components of VHA's Enrollee Health Care Projection Model 16
Figure 4: Proportion of Rural and Urban Veterans Who Used One or More of VHA's Intensive Mental Health Care Programs, Fiscal Year 2021 26
Figure 5: Average Wait Times across Mental Health Residential Rehabilitation Treatment Programs, Fiscal Year 2021 31

Abbreviations

OMHSP	Office of Mental Health and Suicide Prevention
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

February 9, 2023

The Honorable Jon Tester
Chairman
The Honorable Jerry Moran
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Mike Bost
Chairman
The Honorable Mark Takano
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Serious mental illness—mental, behavioral, or emotional disorders resulting in serious functional impairment—has been a persistent and growing issue for our nation's veterans.[1] Veterans with serious mental illness often need a higher level of mental health care and are generally at greater risk for worse health outcomes, including the risk of suicide. From 2006 through 2020, the number of veterans who received all types of mental health care from the Veterans Health Administration (VHA) grew by 85 percent—an increase of more than three times the rate for all other Department of Veterans Affairs (VA) health care services.

Our past work and other research have raised questions about access to intensive mental health care, particularly for veterans with serious mental illnesses living in rural areas.[2] This work highlights a variety of factors that may affect access to intensive mental health care for rural veterans, such as transportation, distance from health care facilities, and staffing

[1]See U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *2019 National Survey on Drug Use and Health: Veteran Adults* (Sept. 2020).

[2]For example, see GAO, *Veterans Health Care: Services for Substance Use Disorders, and Efforts to Address Access Issues in Rural Areas,* GAO-20-35 (Washington, D.C.: Dec. 2, 2019) and National Academy of Sciences, Engineering, and Medicine, *Evaluation of the Department of Veterans Affairs Mental Health Services* (Washington, D.C.: 2018).

shortages. For example, more than half of rural Americans lived in a mental health professional shortage area in 2022.[3]

VHA provides intensive mental health care to veterans with serious mental illness through inpatient, residential, and outpatient programs.[4] Some of these programs are targeted to veterans in rural areas and offer services such as delivering mental health care in veterans' homes located in remote areas. Of the 8.3 million veterans enrolled in VHA in fiscal year 2021, about one-third lived in a rural area. Comparatively, about one-fifth of Americans lived in a rural area.[5] Recognizing the needs of veterans living in rural areas, VA's Fiscal Years 2022-28 Strategic Plan includes a goal to increase health care access for rural veterans and veterans with serious mental illness.[6]

The Sgt. Ketchum Rural Veterans Mental Health Act of 2021 included a provision for GAO to study the intensive mental health care that VHA makes available to rural veterans.[7] In this report we

1. describe how VHA estimates veterans' demand for intensive mental health care,
2. examine the types of information VHA uses to monitor access to intensive mental health care for rural veterans,
3. describe what VHA data show about rural veterans' access to intensive mental health care, and

[3]The Health Resources and Services Administration designates geographic areas with shortages of primary care, dental, and mental health care providers to meet population needs. See U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Areas Statistics as of September 30, 2022* (Dec. 5, 2022).

[4]For the purposes of this report, we refer to VHA's intensive mental health care services and programs as intensive mental health care programs. Inpatient programs, such as a hospital stay, are for veterans experiencing acute mental health crisis. Residential programs provide residential and treatment services for veterans with mental health and substance use disorders. Outpatient programs provide case management and other services to veterans outside of a hospital or residential setting.

[5]VA defines veteran rurality using the U.S. Census-derived Rural Urban Commuting Code for the veteran's home census tract. We use the term "rural veteran" to include veterans living in rural, highly rural, and insular island areas.

[6]Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan* (Apr. 18, 2022).

[7]Pub. L. No. 117-21, § 3, 135 Stat. 292, 292-293 (2021).

4. examine the guidelines that VHA uses to establish and provide seed funding for intensive mental health care programs for rural veterans.

To describe how VHA estimates veterans' demand for intensive mental health care, we reviewed VHA demand projection policies and documents, including policies VHA used for its annual Enrollee Health Care Projection Model. We reviewed data from the Enrollee Health Care Projection Model's projection of demand for intensive mental health care in 2029 based on 2019 utilization data (the most recent reliable data available at the time of our review) and calculated the difference in demand from 2019 to 2029.[8] To identify any differences between rural and urban veterans, we sorted VHA's demand projections by market rurality using data from VA's National Planning Strategy–Rural Health.[9] We also interviewed officials from VHA's Office of Mental Health and Suicide Prevention (OMHSP) and Chief Strategy Office who are responsible for developing projection models and determining demand for VHA services.

To examine the types of information VHA uses to monitor access to intensive mental health care for rural veterans, we reviewed VHA policies and performance assessments for each of its inpatient, residential, and outpatient intensive mental health programs, as well as other documentation about the programs. We also reviewed research on serious mental illness and veteran rurality published from 2012 to 2022 to provide context to our work. In addition, we interviewed officials from OMHSP who are responsible for overseeing mental health care programs and their performance. We also interviewed officials from VHA's Office of Integrated Veteran Care who are responsible for community care provided to veterans.[10] We assessed VHA's efforts to analyze access to intensive mental health care against VA's strategic goals and policies for

[8]We used 2019 data for our analysis because VHA officials told us that the COVID-19 pandemic depressed utilization of these services in 2020.

[9]Department of Veterans Affairs, *National Planning Strategy–Rural Health* (Washington, D.C.: Mar. 2021).

[10]In order to meet the needs of the veterans it serves, VA is authorized to pay for community care for eligible veterans. As required by the MISSION Act, VA implemented the Veterans Community Care Program in June 2019, consolidating many of VA's existing community care programs into a permanent program. See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395 (2018) (codified as amended at 38 U.S.C. § 1703).

its intensive mental health care programs.[11] Additionally, we examined VHA's efforts against best practices for management decision making that we identified in prior work.[12]

To describe what VHA data show about rural veterans' access to intensive mental health care, we obtained data that VHA collects related to veterans' access to such care. Specifically, we obtained intensive mental health care program utilization and performance data on population coverage, wait times, and capacity for fiscal year 2021, the most recent data at the time of our review.[13] We then disaggregated and analyzed these data by rurality to examine any differences between veterans living in rural areas and veterans living in urban areas. To assess the reliability of VHA data we obtained for all of our objectives, we interviewed relevant agency officials, reviewed related documentation, and performed electronic and manual testing to identify any missing data and obvious errors. On the basis of these steps, we determined that the data were sufficiently reliable for the purposes of our audit objectives. See appendix I for additional details on the methodology we employed in analyzing VHA utilization and performance data.

To examine the guidelines that VHA uses to establish and provide seed funding for intensive mental health care programs, we reviewed VHA handbooks, directives, and other policy documents for each of its inpatient, residential, and outpatient intensive mental health care

[11]Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan*. The plan includes a strategic objective specifying that VA emphasizes the delivery of benefits, care, and services to underserved, marginalized, and at-risk veterans to prevent suicide and homelessness; improves their economic security, health, resiliency, and quality of life; and achieves equity. The plan includes veterans living in rural areas as an at-risk population for focus. See also Veterans Health Administration, *VHA Handbook 1160.01, Uniform Mental Health Services in VA Centers and Clinics* (Washington D.C.: Sept. 11, 2008).

[12]GAO, *Managing for Results: Enhancing Agency Use of Performance Information for Management Decision Making,* GAO-05-927 (Washington D.C.: Sept. 9, 2005).

[13]VHA's OMHSP completes performance assessments for each of VHA's intensive mental health care programs. The assessments include various data including program wait time and capacity data.

programs.[14] We reviewed VHA's funding application documentation for its rural-focused outpatient treatment programs and obtained and analyzed data on funding provided to these programs from fiscal year 2010 through fiscal year 2021. See appendix I for additional details on the methodology we employed in analyzing VHA funding and other data for this objective. In addition, we interviewed officials from OMHSP and the Office of Rural Health about guidelines for establishing programs. We assessed VHA's guidelines for establishing programs against VA's strategic and policy goals for improving access to care for veterans in rural areas and veterans with a serious mental illness.[15]

Additionally, for all objectives, we interviewed officials at three selected VHA health care systems for information on how they implement policies regarding access to intensive mental health care for rural veterans at local facilities. We also interviewed them regarding any challenges the Veterans Integrated Services Networks and VHA health care systems may face providing care to rural veterans.[16] Specifically, at each selected health care system, we interviewed health care system leadership, officials responsible for intensive mental health care programs, and Veterans Integrated Service Network officials. We selected health care systems for variation by geography, number of rural veterans served, intensive mental health care programs offered, and prevalence of

[14]For example, see Veterans Health Administration, *Market Area Health Systems Optimization, National Planning Strategy, Inpatient Mental Health* (Mar. 2021); *VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services* (Washington D.C.: Aug. 13, 2019); *VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program* (Washington D.C.: July 15, 2019); *VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services* (Washington D.C.: Jan. 7, 2016); *VHA Handbook 1160.06 Inpatient Mental Health Services* (Washington D.C.: Sept.16, 2013); and *VHA Handbook 1160.01*.

[15]Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan* and *VHA Handbook 1160.01*.

[16]VHA's delivery of health care is divided into geographic regions called Veterans Integrated Services Networks. Each Veterans Integrated Services Network is responsible for managing and overseeing the health care systems within a defined area. A VHA health care system is an integrated health care delivery system under the direction of one administrative parent facility—such as a VHA medical center—and comprised of multiple health care facilities, such as community-based outpatient clinics, offering an array of health care services to veterans in a defined geographic area.

veterans with serious mental illness.[17] Information we obtained from these interviews is not generalizable across health care systems. In addition, we spoke to representatives from two veterans service organizations (the American Legion and the Wounded Warrior Project) to obtain veterans' perspectives on our audit objectives.

We conducted this performance audit from November 2021 to February 2023 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 based on our audit objectives.

Background

Veterans Living in Rural Areas

VHA data show that in fiscal year 2021, 2.7 million of the 8.3 million veterans enrolled in VHA lived in a rural area, and of those that lived in a rural area, approximately 2 million used VHA care. See table 1.

Table 1: Veterans Who Used Veterans Health Administration (VHA) Health Care by Rurality, Fiscal Year 2021

	Number	Percent
Rural veterans	2,011,350	34
Urban veterans	3,903,672	66
All veterans	5,918,036[a]	100

Source: GAO analysis of VHA data. | GAO-23-105544

Notes: For the purposes of this report, the term ''rural veteran'' means a veteran who lives in a rural, highly rural, or insular island area using the U.S. Census-derived Rural Urban Commuting Code for the veteran's home census tract.

This table reflects veterans who used VHA services in fiscal year 2021. About 2.4 million additional veterans were enrolled in VHA but did not use services in that year.

[a]Numbers do not sum due to missing rurality information for some veterans.

[17]We interviewed officials from the Eastern Oklahoma Health Care System (Muskogee, Oklahoma), Maine Health Care System (Augusta, Maine), and Jackson Health Care System (Jackson, Mississippi). We also spoke to officials from the Veterans Integrated Services Networks for each health care system—Veterans Integrated Services Networks 19, 1, and 16, respectively.

Research we reviewed and VHA officials we interviewed indicated that rural veterans may face unique barriers to accessing mental health care compared with urban veterans. For example, rural veterans tend to live farther away from VHA facilities than urban veterans and have challenges securing transportation.[18] Further, according to VA, rural veterans are older, tend to be more medically complex, and often have limited internet access at home.[19] Additionally, research shows that rural adults experience higher rates of serious mental illness and higher risk for suicide than urban adults.[20] According to VHA officials, their facilities located in rural areas also experience challenges maintaining adequate staffing, which can affect access to care. See figure 1 for additional information on challenges rural veterans face accessing mental health care, as identified by VHA officials.

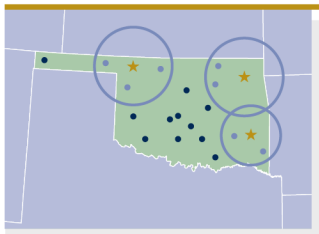
[18]See John F. McCarthy et al., "Suicide Among Patients in the Veterans Affairs Health System: Rural-Urban Differences in Rates, Risks, and Methods," *American Journal of Public Health*, vol. 102, no. S1 (2012): S111-S117. Also see Hillary D. Lum et al., "Anywhere to Anywhere: Use of Telehealth to Increase Health Care Access for Older, Rural Veterans," *Public Policy & Aging Report*, vol. 30, no. 1 (2019): 12-18.

[19]U.S. Department of Veterans Affairs, Office of Rural Health, *Rural Veterans* (Washington, D.C.: Mar. 31, 2022), accessed September 18, 2022, https://www.ruralhealth.va.gov/aboutus/ruralvets.asp.

[20]See for example McCarthy et al., "Suicide Among Patients in the Veterans Affairs Health System" S111-S117 and Carlee J. Kreisel et al., "Reducing Rural Veteran Suicides: Navigating Geospatial and Community Contexts for Scaling up a National Veterans Affairs Program," *Suicide and Life Threatening Behavior*, vol. 51, no. 2 (2021): 344-351.

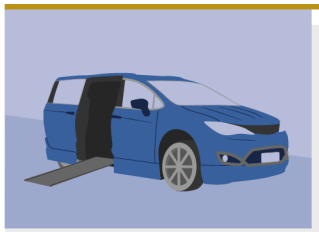
Figure 1: Challenges for Rural Veterans in Accessing Intensive Mental Health Care Identified by Veterans Health Administration (VHA) Officials

Location of programs



The location of VHA programs often acts as a barrier to care for veterans in rural areas, according to officials from the three health care systems in our review. The officials stated that in particular it can be more difficult for rural veterans to access intensive mental health services that are delivered at frequent and face-to-face visits. For example, VHA's outpatient intensive mental health care programs require frequent visits and necessitate veterans or staff to travel for care, making the geographic location of these programs important. Additionally, officials from VHA's Office of Mental Health and Suicide Prevention said that inpatient programs and residential programs are considered regional resources and may not be readily available for all rural veterans.

Transportation

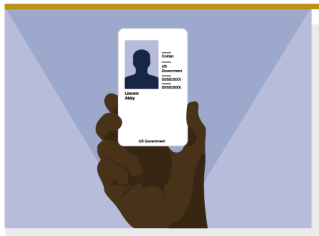


Officials from the three health care systems in our review said **transportation, both for rural veterans and VHA staff traveling to veterans' homes, can be a challenge.** For example, veterans in rural areas may live farther from VHA facilities, and public transportation or ride sharing may not be an option in these areas. Additionally, long drive times required by staff are time-consuming and limit the number of veterans that can receive direct care in their homes.

Access to telehealth

VHA can use telehealth as a strategy to help ensure rural veterans have access to outpatient intensive mental health care programs, according to VHA officials; **however, telehealth cannot address all access challenges.** Officials from the three health care systems reported that veterans can face challenges in accessing telehealth. For example, many veterans living in rural areas do not have reliable cell phone service or broadband internet access, according to the officials. The officials said that some veterans also experience cognitive and organizational difficulties related to mental illness, which may limit the effectiveness of telehealth.

Staffing



Maintaining adequate staffing levels is challenging, according to officials from the three health care systems. The officials said that recruiting staff and providers to work in rural areas is difficult. An official from one health care system said that recruiting for positions requiring a higher education level is especially challenging. With limited staff, it can be difficult to provide care for every veteran in need of intensive mental health care.

Source: VHA information. | GAO-23-105544

Veterans with Serious Mental Illness

VHA estimates that in fiscal year 2021, about 4 percent of veterans who received its care suffered from serious mental illness—such as schizophrenia, bipolar disorder, or psychosis—as defined by VHA's National Psychosis Registry.[21] The National Psychosis Registry indicates that fewer veterans in rural areas received intensive mental health care for serious mental illness in fiscal year 2021 than urban veterans compared with their overall population distributions.[22] Additionally, the percentage of rural veterans who used any VHA care was higher than the percentage of rural veterans on the National Psychosis Registry, while the opposite held true for urban veterans. See table 2.

Table 2: Veterans Who Used Any Veterans Health Administration (VHA) Care and Veterans on the National Psychosis Registry by Rurality, Fiscal Year 2021

	Veterans who used any VHA care		Veterans on National Psychosis Registry	
	Number	Percent	Number	Percent
Rural veterans[a]	2,011,350	34	62,385	27
Urban veterans	3,903,672	66	170,283	73
All veterans	5,918,036	100	232,874	100

Source: GAO analysis of VHA data. | GAO-23-105544

Note: The National Psychosis Registry identifies veterans who received VHA care in a given year for a serious mental illness diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder diagnoses.

[a]For the purposes of this report, the term ''rural veteran'' means a veteran who lives in a rural, highly rural, or insular island area using the U.S. Census-derived Rural Urban Commuting Code for the veteran's home census tract.

[21]The National Psychosis Registry identifies veterans who received VHA care in a given year for a serious mental illness diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder diagnoses. Although VHA uses the National Psychosis Registry to identify veterans with certain serious mental illness, it does not include all diagnoses associated with serious mental illness. As a result, the registry serves as a proxy for serious mental illness, but does not capture the full extent of veterans with such illnesses.

[22]Within the general population, 5.8 percent of adults living in rural areas experienced serious mental illness compared with 4.1 percent of adults living in urban areas in 2018, according to research from the American Psychiatric Association. See American Psychiatric Association and Substance Abuse and Mental Health Services Administration, *Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities* (Aug. 2021).

It is important that veterans with serious mental illness are able to access intensive mental health care because research indicates that inadequate access to mental health care leads to under treatment and negative health consequences.[23] Moreover, veterans with serious mental illness have a lower life expectancy than veterans who do not have such illness. For example, research indicates that on average, the lives of veterans with serious mental illness are shortened by approximately 10 years.[24]

VHA Intensive Mental Health Care Programs

VHA policy states that all veterans, wherever they obtain care in VHA, are to have access to needed mental health services.[25] VHA has established several intensive mental health programs for veterans with serious mental illness who need high-frequency or acute mental health care, as described in figure 2.

[23]See for example, Young Shin Park et al., "Evaluation of Neighborhood Resources and Mental Health in American Military Veterans using Geographic Information Systems," *Preventive Medicine Reports,* vol. 24, (2021).

[24]See for example Benjamin R. Szymanski et al., "Facility-Level Excess Mortality of VHA Patients with Mental Health or Substance Use Disorder Diagnoses," *Psychiatric Services*, vol. 72*,* no. 4 (Apr. 2021): 408-414.

[25]Veterans Health Administration, *VHA Handbook 1160.01.*

Figure 2: Veterans Health Administration (VHA) Intensive Mental Health Care Programs

Source: GAO analysis of Veterans Health Administration information. | GAO-23-105544

[a]Mental Health Residential Rehabilitation Treatment Programs include several programs with differing services for specific populations, including Domiciliary Care for Homeless Veterans, Domiciliary Substance Use Disorder Programs, Domiciliary Posttraumatic Stress Disorder Programs, General Domiciliary Programs, and Compensated Work Therapy-Transitional Residence.

The number of VHA health care systems that offer intensive mental health care programs varies. For example, in fiscal year 2021, most of the systems (129 of 139) offered an outpatient intensive community mental health recovery program, but the type of program varied. See table 3. The two programs designed for rural veterans—Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement—were located at fewer health care systems and used by fewer veterans than the other intensive mental health care programs, VHA data show. We refer to these two programs as VHA's rural-focused treatment programs for the purposes of this report.

Table 3: Number of Veterans Health Administration (VHA) Health Care Systems with Intensive Mental Health Care Programs and Number of Veterans Who Used Them, Fiscal Year 2021

VHA intensive mental health care program	Number of health care systems with one or more programs	Number of veterans who used the program
Psychosocial Rehabilitation and Recovery Centers	97	18,584
Intensive Community Mental Health Recovery	129	9,895
• Mental Health Intensive Case Management	99	n/a[a]
• Rural Access Network for Growth Enhancement	47	n/a[a]
• Enhanced Rural Access Network for Growth Enhancement	14	n/a[a]
Mental Health Residential Rehabilitation Treatment Programs	92	18,080
Inpatient mental health care programs	111	44,399

Source: GAO analysis of VHA information. | GAO-23-105544

Notes: There were 139 VHA health care systems in fiscal year 2021 and 5,918,036 total veterans who used VHA services in that year. Veterans could have used more than one program in fiscal year 2021.

A VHA health care system is an integrated health care delivery system under the direction of one administrative parent facility—such as a VHA medical center—and comprised of multiple health care facilities, such as community-based outpatient clinics, offering an array of health care services to veterans in a defined geographic area.

Data reflect the number of health care systems where at least one of the intensive mental health care programs was located in fiscal year 2021. A health care system could have more than one of the same type of program. For example, the health care system in Orlando, FL had two Psychosocial Rehabilitation and Recovery Centers associated with it in 2021, but the table counts that health care system once. Therefore, there were more intensive mental health care programs in fiscal year 2021 than the table reflects. According to VHA, there were 108 Psychosocial Rehabilitation and Recovery

Centers, 69 Rural Access Network for Growth Enhancement programs, 19 Enhanced Rural Access Network for Growth Enhancement programs, 111 Mental Health Intensive Case Management programs, and 251 Mental Health Residential Rehabilitation Treatment Programs in fiscal year 2021. With respect to Mental Health Residential Rehabilitation Treatment Programs, fiscal year 2021 utilization was suppressed due to COVID-19 relative to historic levels, according to VA.

[a]VHA does not collect unique veteran-level utilization data for the three Intensive Community Mental Health Recovery programs because veterans can access programs from multiple locations. Fewer veterans used the rural-focused treatment programs—Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement—than the Mental Health Intensive Case Management Programs, given the smaller number of health care systems with these programs available.

Community Care

When VHA cannot provide the care needed within its health care systems, veterans may obtain services from non-VHA providers, known as community care. VHA provides most of the care from non-VHA providers through its Veterans Community Care Program, which uses regional contracts with two third-party administrators. The Veterans Community Care Program—established by the VA MISSION Act of 2018 and implemented on June 6, 2019—is the most recent iteration of VA's long-standing practice of allowing veterans to receive care from community providers when they face challenges accessing care at VHA medical facilities.[26]

VHA Roles and Responsibilities for Intensive Mental Health Care

Multiple national, regional, and local VHA offices and entities are involved in setting policy, providing funding, and conducting oversight of intensive mental health care programs for veterans. The following are examples of national offices that are involved in helping to meet the needs of veterans with serious mental illness and rural veterans:

- **Office of Mental Health and Suicide Prevention.** This office is responsible for monitoring and supporting the implementation of mental health policies and the performance of mental health programs in VHA health care facilities. As part of this role, OMHSP is responsible for analyzing program data, setting polices for, and overseeing intensive mental health care programs. For example, the

[26]See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018), codified, as amended, at 38 U.S.C. § 1703, and implementing regulations at 38 C.F.R. §§ 17.4000 - 17.4040 (2021). For more information on VA's community care, see GAO, *VA Health Care: Incomplete Information Hinders Usefulness of Market Assessments for VA Facility Realignment*, GAO-22-104604 (Washington D.C.: Feb. 2, 2022).

office sets guidelines for when VHA health care systems have to or should establish new intensive mental health care programs.[27]

- **Office of Rural Health.** This office is responsible for conducting research on issues affecting rural veterans, developing innovations to address inequities, and disseminating these innovations across VHA. The office also provides "seed funding" to VHA health care systems to allow them to establish rural health programs, including Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement programs.
- **Office of Integrated Veteran Care.** This office is responsible for receiving and maintaining information on services provided by community providers, including intensive mental health care services.
- **Chief Strategy Office.** This office is responsible for providing information, analysis, and insight on VHA planning, policy, budget, performance, and system design decisions. These activities include developing and using projection models to estimate future demand for services, such as intensive mental health care programs.

At the regional level, VHA's Veterans Integrated Services Networks are responsible for managing and overseeing VHA health care systems within a defined geographic area. With respect to intensive mental health care programs, the networks are responsible for working with the health care systems in their areas to make decisions about where to establish new programs.

At the local level, VHA's 139 health care systems are responsible for delivering mental health care. Health care systems are also responsible for making decisions about where to establish outpatient programs within the parameters of program guidelines designated by OMHSP, according to VHA policy. Health care systems are generally responsible for funding intensive mental health care programs. They also make decisions about adjusting the capacity of intensive mental health care programs to help ensure veterans can access the care they need, according to VHA officials.

[27]Within OMHSP, there are program offices for inpatient mental health, residential rehabilitation and treatment, and outpatient services and psychosocial rehabilitation that are responsible for those respective programs. Additionally, OMHSP houses three program evaluation offices—the Northeast Program Evaluation Center; the Program Evaluation and Resource Center; and the Serious Mental Illness Treatment, Resource, and Evaluation Center. The Northeast Program Evaluation Center conducts program evaluation and monitoring of the VHA's intensive mental health care programs.

VHA data indicate that in fiscal year 2021, 28 percent (39 of 139) of health care systems had mostly rural veterans enrolled, as shown in table 4.

Table 4: Veterans Health Administration (VHA) Health Care Systems by Rurality of Populations Served, Fiscal Year 2021

Health care system population	Number of health care systems
Mostly rural veterans More than 50 percent of enrolled veterans lived in a rural, highly rural, or insular island area.	39
Some rural veterans 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, and 10,000 or more enrollees lived in a rural area.	63
Few rural veterans 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, and fewer than 10,000 enrollees lived in a rural area.	37
Total	**139**

Source: GAO analysis of VHA data. | GAO-23-105544

Note: A VHA health care system is an integrated health care delivery system under the direction of one administrative parent facility—such as a VHA medical center—and comprised of multiple health care facilities, such as community-based outpatient clinics, offering an array of health care services to veterans in a defined geographic area. GAO classified VHA health care systems as having mostly rural, some rural, and few rural veterans based on their number of enrolled veterans living in highly rural, rural, insular island, and urban areas. GAO used VHA policy as a basis for determining the 10,000 rural enrollees as the cutoff between some rural enrollees and few rural enrollees. Specifically, according to VHA policy, very large community-based outpatient clinics—which are required to have more robust programs and are encouraged to have Psychosocial Rehabilitation and Recovery Centers and Mental Health Intensive Case Management programs—serve over 10,000 or more unique veterans each year. Therefore, 10,000 or more rural enrollees indicates a rural presence similar to that of a very large community-based outpatient clinic.

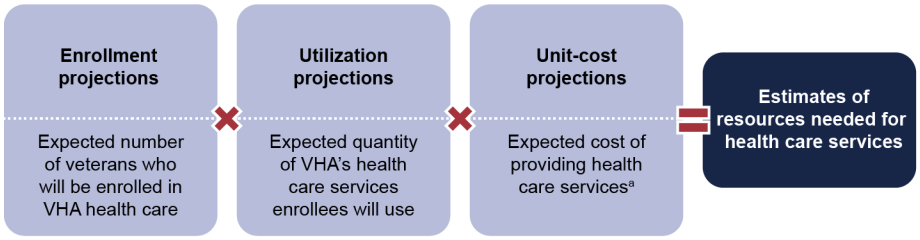
VHA Uses Models and Utilization Data to Estimate Veterans' Demand for Intensive Mental Health Care

Based on our review of VHA documentation and interviews with officials, we found that VHA uses multiple methods to estimate enrolled veterans' demand for intensive mental health care. These methods include using (1) a budget projection model, (2) a model specifically for its residential programs, and (3) program utilization assessments. In addition, we found that VHA uses public outreach efforts to improve its understanding of demand among veterans who have not accessed care through VHA, including those who have not enrolled in VA.

Budget projection model. VHA's Chief Strategy Office uses a model, called the Enrollee Health Care Projection Model, to help develop the majority of VA's health care budget requests. The office also uses it to conduct strategic and capital planning and assess the effect of potential policies and changes in a dynamic health care environment. VHA uses this model annually to project how many veterans will enroll in VHA, their

utilization of specific types of health care, and the costs of providing this care to estimate VHA's overall resource needs.[28] See figure 3 for the basic components of VHA's model.

Figure 3: Basic Components of VHA's Enrollee Health Care Projection Model



Source: GAO analysis of Veterans Health Administration (VHA) information. | GAO-23-105544

Note: The Enrollee Health Care Projection Model makes a number of complex adjustments to projections for VHA's health care to account for the characteristics of VHA health care and enrolled veterans. For example, the Enrollee Health Care Projection Model includes adjustments to account for reliance on VHA health care, that is, the extent to which enrolled veterans will choose to access health care through VHA as opposed to other health care programs or insurers. Additionally, the Enrollee Health Care Projection Model includes adjustments to incorporate the age, gender, priority level, and geographic location of enrolled veterans.

[a]VHA calculates the cost of providing a unit of service in different ways depending on the type of service provided. For example, unit costs for some pharmacy services reflect the cost of a 30-day supply of a prescription, and unit costs for inpatient services reflect the cost of a day of care at an inpatient facility.

VHA uses the Enrollee Health Care Projection Model to estimate veterans' utilization 5 and 10 years into the future for more than 140 types of health care, including intensive mental health programs provided through VHA health care systems and the care VA purchases from community providers. The model projects utilization by a range of

[28]For additional information on VHA's Enrollee Health Care Projection Model, see GAO, *VA Health Care: Estimating Resources Needed to Provide Community Care*, GAO-19-478 (Washington, D.C.: June 12, 2019).

geographic and demographic characteristics, such as by location (VHA facility or community provider), age group, and gender.[29]

According to the model, as of 2019, VHA projects that by 2029 there will be differences in the change in projected demand for intensive mental health care between rural and urban veterans.[30] See table 5. According to VHA, these differences could be due to various factors including shifts in demographic trends.

Table 5: Veterans Health Administration (VHA) Projection of Change in National Demand for Intensive Mental Health Care from Fiscal Year 2019 to 2029

Projected percent change in demand from 2019 to 2029		
VHA intensive mental health care	**Rural**	**Urban**
Intensive Community Mental Health Recovery	-8.83	-2.99
Psychosocial Rehabilitation and Recovery Centers	7.07	12.31
Mental Health Residential Rehabilitation Treatment Programs	-3.93	-3.82
Inpatient mental health care	-2.39	3.75

Source: GAO analysis of VHA Enrollee Health Care Projection Model data. | GAO-23-105544

Notes: The projections in this table are for intensive mental health care provided directly by VHA. VHA projected 2029 demand for VHA care based on 2019 data. The Enrollee Health Care Projection Model also projects demand for mental health care provided through community care. However, those projections include other types of mental health care in addition to intensive mental health care. GAO has not included community care projections in this table. GAO used 2019 data for this analysis because VHA officials said that the COVID-19 pandemic had depressed utilization of these services in 2020. According to VHA officials, these data do not reflect the extent to which programs meet veterans' current needs. Officials noted that even if demand declines, VHA may not be able to provide services to all veterans who need them.

VHA categorizes markets as rural when more than 50 percent of veterans live in rural areas. VHA categorizes markets with 50 percent or fewer rural veterans as urban.

[29]The Enrollee Health Care Projection Model projects utilization by market, priority, enrollee type, special conflict status, and eligibility status. VHA categorizes markets as rural when more than 50 percent of veterans live in rural areas. VHA categorizes markets with 50 percent or fewer rural veterans as urban. Enrollee type distinguishes between enrollees who used VA health care before the Veterans' Health Care Eligibility Reform Act of 1996 and enrollees who enrolled after eligibility reform. The model also includes projections for enrollees who are eligible for community care based on their proximity to primary and specialty care, and those grandfathered under the Veterans Access, Choice, and Accountability Act of 2014.

[30]We used 2019 data for our analysis because VHA officials told us that the COVID-19 pandemic depressed utilization of these services in 2020. VHA adapted this model to account for disruptions to the health care system caused by the COVID-19 pandemic. To do this, they used a hybrid approach that combined pre-pandemic assumptions about veterans' use of VHA care with updates to selected key inputs that include effects from the pandemic.

Residential demand model. In 2018, VHA began using a projection model for its residential program—Mental Health Residential Rehabilitation Treatment. Called the Demographic and Diagnosis-Based Demand Model, this model uses veteran diagnoses and demographic information to project how many veterans in a geographic area are expected to need residential mental health care. According to OMHSP officials, an advantage of this model is that it can estimate demand for geographic areas where care has not historically been available. In contrast, the Enrollee Health Care Projection Model depends on past usage trends to project future demand. Guidance from OMHSP states that VHA health care systems should use the residential demand model as a primary planning tool for determining residential program resource needs.

OMHSP officials told us they created this model because they wanted to understand veterans' needs for specific types of residential care, such as substance use disorder care and post-traumatic stress disorder care, which were not captured in the Enrollee Health Care Projection Model. They also said they wanted a tool that could help address geographic disparities in residential bed locations. According to the officials, residential care capacity has been historically concentrated in the northeastern and eastern United States.

According to OMHSP officials, they are working to locate programs closer to where veterans live in an effort to increase utilization. Expanding programs like residential care often requires the construction of new facilities and creates higher resource needs at facilities in order to provide care. These officials told us they used the residential demand model as part of VHA's market assessment, which used a process to evaluate its capacity to provide quality, accessible, and timely health care to veterans.[31] They said this helped them develop recommendations for additional residential care sites in VHA's March 2022 Asset and Infrastructure Review report.[32]

[31]We previously reported on VA's market assessment process. We found gaps and reliability issues in the data VA used to develop market assessments. We made two recommendations to improve the completeness of VA community care data and ensure VA communicates data reliability issues. VA concurred with our recommendations. See GAO-22-104604.

[32]Department of Veterans Affairs, *VA Recommendations to the Asset and Infrastructure Review Commission* (Washington, D.C.: Mar. 14, 2022).

Program utilization. OMHSP officials told us they analyze utilization data—data on the number of veterans who used intensive mental health care programs—to help them understand veterans' demand for these programs. For example, these officials said they compare veterans' use of mental health care at local VA facilities with a national average and examine facilities where use is lower than the national average. They said their office works to determine if use is lower because of less demand or because the facility does not have the staff to meet demand.

OMHSP officials added that they look for opportunities, where warranted, to help facilities better align their use of resources—such as staff and facility space—to fit veterans' needs. In addition, OMHSP officials said it is important to consider how accessible programs are when assessing utilization data because veterans who live far away may not use some intensive mental health care programs.

Officials from the Veterans Integrated Service Networks that include the three VHA health care systems in our review told us they believe there are veterans who could benefit from intensive mental health care, but have not sought treatment from VHA. These officials also said they engage in community outreach to help understand veterans' mental health needs and encourage them to seek care through VHA. This outreach helps connect rural veterans with VHA care, according to officials. For example, an official from one Veterans Integrated Service Network told us the network relies on community programs and word of mouth to understand veterans' needs. An official from another Veterans Integrated Service Network said VHA facilities partner with Vet Centers to share information and conduct direct outreach—such as bringing enrollment specialists to local festivals—so VHA can establish contact with veterans who might not otherwise interact with VHA.

VHA Analyzes Various Data to Monitor Access to Intensive Mental Health Care, but Does Not Examine Data by Rurality

VHA collects and analyzes utilization and performance data to monitor veterans' access to its intensive mental health care programs. However, VHA does not analyze these data by rurality to assess how access among veterans living in rural areas compares with access among those living in urban areas. In addition, we found that VHA analyzes some data on veterans' use of community care providers, but faces challenges in obtaining other data to monitor access to intensive mental health care in the community.

VHA Analyzes Utilization and Performance Data to Monitor Access to Care, but Does Not Analyze These Data by Veteran Rurality

VHA's OMHSP collects and analyzes utilization and performance data to help it monitor veterans' access to intensive mental health care. Specifically, OMHSP officials said they examine veterans' utilization of various intensive mental health programs to identify potential access challenges that could limit veterans' care. For example, officials told us they compare data showing the number of veterans who use intensive mental health programs for each health care system with the national average for all VHA health care systems, and for each facility within health care systems. According to VHA officials, this analysis is to identify any potential differences in the rates with which veterans access these programs. Officials noted that they analyze utilization data at different intervals—including monthly, quarterly, and annually—depending on the program. Additionally, OMHSP officials said they hold regular calls with health care system officials responsible for intensive mental health care programs to discuss any issues they identify in their analyses of utilization data.

OMHSP officials said they also use certain data in their performance assessments to help monitor access to care for the various intensive mental health care programs. These include data on how long veterans wait for appointments and data on staffing levels and the number of beds available. Officials said they use these assessments to monitor specific program performance, help ensure program budgets are used appropriately, and evaluate adherence to national policy and strategic priorities. If OMHSP finds that a health care system has difficulties with meeting certain program requirements, officials said they may offer technical assistance to help systems address these issues. For example, OMHSP officials may hold calls with health care system or Veterans Integrated Service Network officials to discuss and address any performance-related areas of concern. OMHSP officials also meet internally to discuss any gaps in service found through their performance assessments. See table 6 for information on the key utilization and performance data VHA analyzes to monitor access to intensive mental health care.

Table 6: Key Data Veterans Health Administration (VHA) Uses to Monitor Access to Intensive Mental Health Care Programs

Data	Programs where used	Description
Utilization	All VHA intensive mental health care programs, including • inpatient mental health care programs, • Psychosocial Rehabilitation and Recovery Centers, • Mental Health Residential Rehabilitation Treatment Programs, • Intensive Community Mental Health Recovery (including Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement, Enhanced Rural Access Network for Growth Enhancement).	Number of veterans who used the program
Population coverage	Psychosocial Rehabilitation and Recovery Centers and Intensive Community Mental Health Recovery	Number of veterans who used the program compared with number of veterans eligible for the program
Wait times	Mental Health Residential Rehabilitation Treatment Programs	How long veterans wait from the time they receive a screening decision to determine whether admission is appropriate to the time of admission for care
Capacity	Staffing levels: Psychosocial Rehabilitation and Recovery Center and Mental Health Intensive Case Management	Staffing levels (such as ratio of patients to program staff) or number of beds available
	Number of available beds: Inpatient mental health care programs[a]	

Source: GAO analysis of VHA information. | GAO-23-105544

[a]VHA also monitors bed availability and other measures for Mental Health Residential Rehabilitation Treatment Programs. However, VHA officials said they do not use bed availability as a key measure to understand access for these programs.

In its analyses, VHA has focused on comparing data on VHA health care systems with national averages but does not analyze its data to compare rates between rural and urban veterans. OMHSP officials said they do not analyze utilization or performance data by rurality because it is not required nor considered to be a priority by VHA. The officials stated that since there are few programs that are targeted to serving veterans in rural areas—with the exception of Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement—there is not a need to analyze access for rural veterans. The officials explained that they focus their analyses nationally to monitor access to intensive mental health care for all veterans, including rural veterans. In turn, VHA health care systems and regional Veterans Integrated Service Networks are responsible for addressing the unique needs of their rural patient populations.

However, officials from two of the three VHA health care systems we interviewed said that they do not have the expertise to analyze data on their patient population by rurality. Officials from all three health care systems told us they monitor access to their intensive mental health care

programs by reviewing data on overall utilization as well as wait times and capacity, which are tracked in performance assessments. Officials from two health care systems we interviewed said that receiving additional data broken out by rurality from a national VHA office could help in their monitoring efforts. OMHSP officials agreed that disaggregating utilization and performance data by rurality would help to identify and measure rural veterans' access to intensive mental health care since they use such data overall as indicators of access. They also stated that information about differences in utilization and performance data specific to rural veterans could be used to address identified access challenges.

Analyzing utilization and performance data for the intensive mental health programs by rurality would align with VHA's policies for OMHSP.[33] Specifically, VHA's policies governing its intensive mental health programs note that OMHSP is responsible for developing and analyzing relevant program data to monitor programs. Such analyses would also help support VA's goals to increase health care access for rural veterans and veterans with serious mental illness.[34]

By analyzing utilization and performance data by rurality and including the results in annual and other periodic program assessments, VHA would have information on the extent to which veterans' use of VHA mental health services differs by locality and whether any differences in access may exist by rurality. Analyzing these data by rurality would also help VHA determine whether programs designed for rural veterans are effectively reaching those veterans, as well as identify potential gaps in ensuring access to intensive mental health care programs for all veterans in need of such services.

VHA Analyzes Community Care Data to Monitor Access to Residential Care, but Not Inpatient and Outpatient Programs

OMHSP officials told us that reviewing data on community care is important for monitoring veterans' overall access to intensive mental health care. They said that they are working to improve their use of these data as a part of their overall monitoring efforts. The officials said they use community care data to monitor use of residential community care

[33]Veterans Health Administration, *VHA Handbook 1106.06; VHA Handbook 1163.06; and VHA Directive 1163*.

[34]Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan*. Additionally, such analyses would be consistent with best practices for management decision making that we identified in prior work. These practices specify that agencies should disaggregate data to identify specific aspects of performance. See GAO-05-927.

services, but do not have sufficiently complete data to monitor inpatient or outpatient services.

For residential care, officials said they analyze national-level community care data (i.e., referral and claims data) to monitor veterans' access to residential care in the community.[35] Officials said that they began analyzing community care referral data in mid-2022 for community residential programs, similar to their Mental Health Residential Rehabilitation Treatment Programs. The officials said that assessing these data—along with data on veterans' use of care at VHA facilities—helps them see a more complete picture of veterans' overall use of residential mental health care across the country. They added that these data could help them identify gaps in the types of residential mental health care VHA facilities provide.

Regarding inpatient and outpatient services provided through community care, OMHSP officials said that, on a case-by-case basis, they may obtain and analyze some community care data from the Office of Integrated Veteran Care. For example, OMHSP officials said they may obtain referral or claims data related to various inpatient or outpatient services in particular locations on an as-needed basis to help them answer specific questions such as identifying potential care for individual veterans. Officials said the data they obtain and analyze varies, depending on the type of mental health service.

However, OMHSP officials said they do not analyze national-level data on community care to monitor veterans' access to inpatient and outpatient intensive mental health care services. The officials said this is because they have not obtained complete community care utilization data for such services from the Office of Integrated Veteran Care. For inpatient care, OMHSP officials said they faced challenges accessing complete referral and claims data to monitor inpatient care provided through the community. Officials explained that they had been using claims data from one dataset but stopped using these data in 2022 when the Office of Integrated Veteran Care issued guidance stating that offices needed to rely on multiple datasets to ensure data reliability. OMHSP officials said they are unable to readily access these multiple datasets without

[35]Officials from VHA's Office of Integrated Veteran Care told us they collect community care data from two sources—referrals and claims. VHA uses electronic referrals to document why and when it refers veterans to community care, including referrals for intensive mental health care. Community providers submit claims for reimbursement to VHA after completing the care outlined in the referral.

assistance from the Office of Integrated Veteran Care and, therefore, have not tried to do so.

OMHSP officials who monitor access to outpatient intensive mental health care said they were interested in obtaining data on veterans' use of Assertive Community Treatment from community providers. Assertive Community Treatment is the closest community equivalent to VHA's intensive outpatient mental health care programs. However, their requests to the Office of Integrated Veteran Care for such referral or claims data have gone unfulfilled, according to OMHSP officials. Officials from the Office of Integrated Veteran Care told us these requests may have been misdirected during their office's recent reorganization that began in 2021.

Officials from the Office of Integrated Veteran Care told us that if requested, they could provide referral and claims data related to intensive mental health care services that are provided to veterans through community care. These officials told us they are developing a consolidated dataset that will bring all referral and claims data for community care into one place. They said that this project has been underway for three years and, when complete, will allow various offices—such as OMHSP—to generate data reports on community care utilization.

In November 2022, Office of Integrated Veteran Care officials told us they had built an initial version of the community care dataset and were working to make it available to VA offices. They said they expect to make the dataset available to VHA offices such as OMHSP in February 2023. OMHSP officials told us they plan to coordinate with the Office of Integrated Veteran Care to use this dataset. These officials said they intend to review the dataset once it is available and use it, as appropriate, to support their overall monitoring efforts of veterans' access to care. However, as of November 2022, OMHSP officials told us they had not determined if or how officials responsible for inpatient and outpatient intensive mental health care intended to use this dataset. They added that officials responsible for residential care were in the process of integrating community care data into their monitoring efforts, and this experience will guide OMHSP's use of the new community care dataset that will be available in February 2023.

VA's Fiscal Years 2022-28 Strategic Plan notes the importance of sharing data between offices that collect and manage data and offices that monitor health care programs. Specifically, the plan states that VA will collect data and provide these data to its offices to assess performance,

understand health outcomes, and improve the quality of medical care and programs.[36] Such data sharing would include the Office of Integrated Veteran Care providing community care data on intensive mental health care services to OMHSP.

Obtaining inpatient and outpatient intensive mental health community care data, once they are available from the Office of Integrated Veteran Care, would give OMHSP a more complete picture of veterans' use of these services. Further, in incorporating the analysis of such data into its monitoring efforts, the office would be able to better identify and address any access challenges to intensive mental health care. For example, OMHSP may be able to disaggregate these community care data by veteran rurality to help identify any potential gaps in access, which is consistent with the agency's strategic goal to improve health care access for rural veterans.

Some VHA Data Suggest Rural Veterans Use Mental Health Programs at Lower Rates than Urban Veterans

We disaggregated VHA's fiscal year 2021 utilization and performance data for its intensive mental health care programs and found some data show that rural veterans used these programs at lower rates or waited longer than urban veterans. This may indicate potential access challenges for rural veterans seeking intensive mental health care. Below are the results of our analyses for program utilization and performance data, including population coverage, wait times, and capacity.[37]

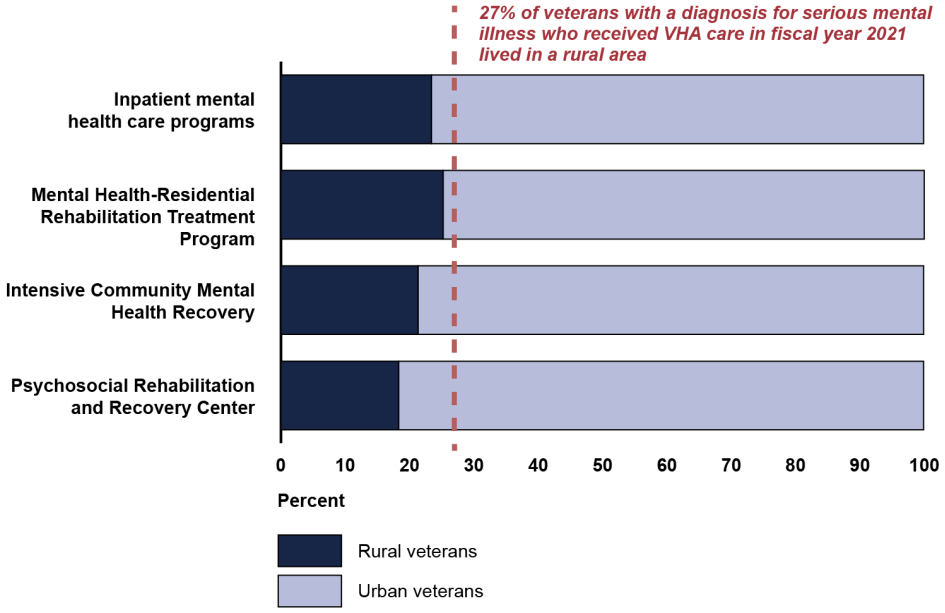
Utilization. This refers to the number of veterans who used the program. VHA data show that in fiscal year 2021, the proportion of veterans living in rural areas who used each of the intensive mental health programs was smaller than the proportion of veterans living in urban areas who used these programs. For example, about 21 percent of veterans who used outpatient Intensive Community Mental Health Recovery programs in fiscal year 2021 lived in a rural area, whereas the remaining 79 percent lived in an urban area. By comparison, 27 percent of veterans with a

[36]Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan.* Additionally, the Strategic Plan identifies a strategic goal to improve access for veterans living in rural areas.

[37]We examined available VHA's fiscal year 2021 data at different levels and for different programs because the data sources and VHA's collection methods are different for each data source. We analyzed utilization and population coverage data at the individual veteran level. We analyzed wait time and capacity data at the health care system level. Moreover, our analyses are program specific based on the data VHA collects for each program.

diagnosis for serious mental illness who received VHA care in fiscal year 2021 lived in a rural area, a larger proportion than the proportion of rural veterans who used intensive mental health care.[38] See figure 4.

Figure 4: Proportion of Rural and Urban Veterans Who Used One or More of VHA's Intensive Mental Health Care Programs, Fiscal Year 2021



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105544

Notes: GAO disaggregated VHA's fiscal year 2021 utilization data for intensive mental health programs at the individual veteran level. However, GAO did not separately disaggregate data for the Intensive Community Mental Health Recovery programs—Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement, and Enhanced Rural Access Network for Growth Enhancement—because VHA does not collect unique veteran-level utilization data for these programs.

For the purposes of this report, the term ''rural veteran'' means a veteran who lives in a rural, highly rural, or insular island area using the U.S. Census-derived Rural Urban Commuting Code for the veteran's home census tract.

To help account for variations in population size, we analyzed VHA's fiscal year 2021 utilization data per 10,000 veterans to compare rural and urban veterans for each intensive mental health care program. This analysis also shows utilization differences between rural and urban

[38]Specifically, VHA data show that 27 percent of veterans on VA's National Psychosis Registry lived in rural areas in fiscal year 2021, with the remaining 73 percent living in urban areas. The National Psychosis Registry identifies veterans who received VHA care in a given year for a serious mental illness diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder diagnoses.

veterans. For example, urban veterans were over three times more likely to use inpatient mental health care programs within VHA than rural veterans. See table 7.

Table 7: Number of Veterans Who Used Veterans Health Administration (VHA) Intensive Mental Health Care Programs per 10,000 Veterans Who Used VHA Care by Rurality, Fiscal Year 2021

VHA intensive mental health care program	Rural veterans per 10,000[a]	Urban veterans per 10,000
Inpatient mental health care	17.5	57.4
Mental Health Residential Rehabilitation Treatment Program	7.7	22.8
Intensive Community Mental Health Recovery	3.6	13.1
Psychosocial Rehabilitation and Recovery Center	5.7	25.6

Source: GAO analysis of VHA data. | GAO-22-105544

Note: GAO disaggregated VHA's fiscal year 2021 utilization data for all intensive mental health programs at the individual veteran level. However, GAO did not separately disaggregate data for the Intensive Community Mental Health Recovery programs—Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement, and Enhanced Rural Access Network for Growth Enhancement—because VHA does not collect unique veteran-level utilization data for these programs.

[a]For the purposes of this report, the term ''rural veteran'' means a veteran who lives in a rural, highly rural, or insular island area using the U.S. Census-derived Rural Urban Commuting Code for the veteran's home census tract.

We also found differences in utilization for rural and urban veterans for each of VHA's three Intensive Community Mental Health Recovery Services programs.[39] According to fiscal year 2021 data, more urban veterans than rural veterans used two of the three programs, including one of the two programs designed for rural veterans. Specifically, in fiscal year 2021, VHA data showed the following:

- 90 percent of health care system facilities that offered Mental Health Intensive Case Management programs served mostly urban veterans through these programs;
- 67 percent of health care system facilities that offered rural-focused Rural Access Network for Growth Enhancement programs served mostly urban veterans through these programs; and

[39]We disaggregated VHA's fiscal year 2021 utilization data for the three Intensive Community Mental Health Recovery programs—Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement, and Enhanced Rural Access Network for Growth Enhancement—at the facility level to avoid double counting veterans who used more than one of these outpatient programs or visited more than one health care system in fiscal year 2021. See appendix I for more information.

- 17 percent of health care system facilities that offered the other rural-focused Enhanced Rural Access Network for Growth Enhancement programs served mostly urban veterans through these programs.

However, VHA officials added that the definitions of "urban" and "rural" used in analyzing VHA's data do not factor in less densely populated areas that are underserved.[40] Additionally, VHA officials said that although its rural-focused treatment programs may serve more urban veterans, they provide needed services to veterans who would otherwise not receive these services.

Officials from VHA's OMHSP said that several factors could contribute to differences in utilization between rural and urban veterans. For example, demographics like age, race, and sex may contribute to differences in utilization. Additionally, rural veterans may find participation in programs with an in-person emphasis, like Psychosocial Rehabilitation Recovery Centers, more challenging because of the burden of traveling to in-person locations. In addition, officials said that programs like Intensive Community Mental Health Recovery programs tend to have higher utilization in urban areas because they are located in areas with higher population density.

Population coverage. This refers to the number of veterans who used the program compared with the number of veterans eligible for the program. VHA's fiscal year 2021 population coverage data showed that urban veterans used certain intensive mental health programs more than rural veterans. Specifically, we looked at the population of veterans eligible to receive care (known as the target population) through Psychosocial Rehabilitation Recovery Centers and Intensive Community

[40]Specifically, VHA data define "rural" as "not living in an urban area, i.e., areas of 50,000 or more people or 2,500 - 49,999 people." For example, Cheyenne, Wyoming, with a population of 67,000 is considered urban. By comparison, Sheridan, Wyoming, with a population of 17,000 is considered rural, although both would lack intensive outpatient mental health care without VHA's Rural Access Network for Growth Enhancement or Enhanced Rural Access Network for Growth Enhancement programs. Moreover, for the purposes of our analyses, we excluded certain facilities that offered both Mental Health Intensive Case Management and Rural Access Network for Growth Enhancement programs because the data did not differentiate which program a veteran at that facility used.

Mental Health Recovery programs.[41] VHA data showed that 0.7 percent of urban veterans in the target population for Psychosocial Rehabilitation Recovery Centers used such programs compared with 0.3 percent of rural veterans in the target population, although use of the programs was low overall. For Intensive Community Mental Health Recovery programs, 4.5 percent of urban veterans in the target population used such programs compared with 3 percent of rural veterans in the target population.

Wait time. This refers to how long a veteran waits from receiving a screening decision to determine that admission for residential care is appropriate to the time of admission for care. On average, veterans seeking care from Mental Health Residential Rehabilitation Treatment Programs at VHA health care systems with mostly rural veterans waited longer for care than at systems with few rural veterans, according to VHA's fiscal year 2021 data.[42] See figure 5. According to VHA policy, veterans generally should not wait for Mental Health Residential

[41]VHA identifies the target population for Psychosocial Rehabilitation Recovery Centers to include veterans with mental health diagnoses reflected in the National Psychosis Registry, as well as those with post-traumatic stress disorder and major depressive disorder. This is broader than the target population for Intensive Community Mental Health Recovery programs, which includes veterans with mental health diagnoses reflected in the National Psychosis Registry.

[42]VHA measures the average wait time for specific services within each health care system. According to VHA officials, wait time data for residential care are collected through a standardized template and are reliable for the purposes of the performance assessments. Wait time is not a useful measure for outpatient or inpatient intensive mental health care programs, according to officials.

For the purposes of our analyses, we defined health care system rurality as follows. Mostly rural enrollees: more than 50 percent of enrolled veterans lived in a rural, highly rural, or insular island area. Some rural enrollees: 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, but 10,000 or more of these enrollees lived in a rural area. Few rural enrollees: 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, and fewer than 10,000 enrollees lived in a rural area.

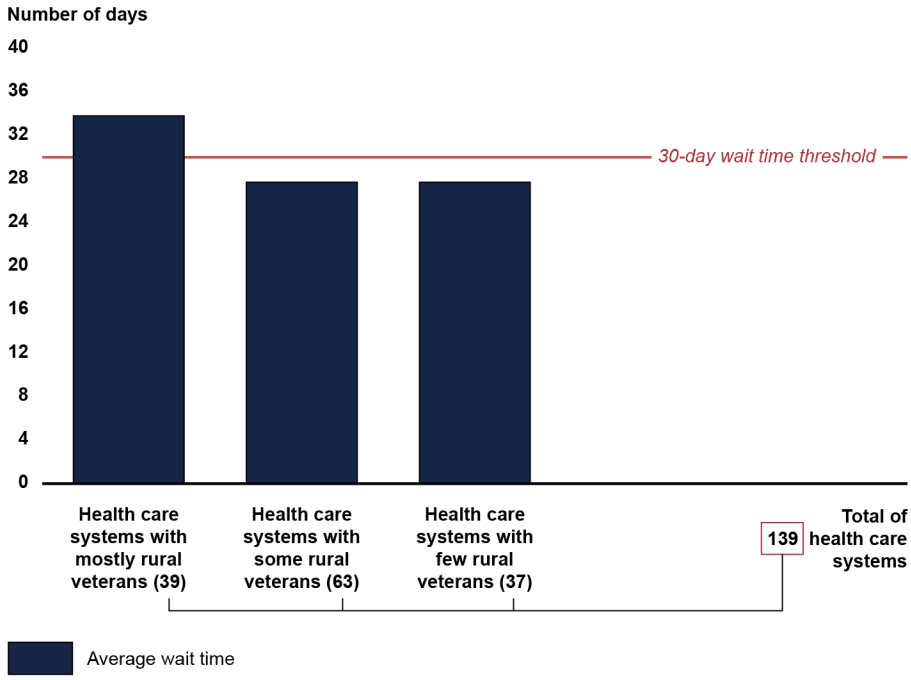
For more information, see appendix I. Although a health care system may have mostly rural veterans enrolled, it does not necessarily mean that mostly rural veterans use the programs offered by the health care system. It is important to consider these differences in utilization in review of VHA's wait time data because even at health care systems with mostly rural veterans, urban veterans may be using these programs at higher rates than rural veterans.

Rehabilitation Treatment care for more than 30 days.[43] However, the average wait time for any type of Mental Health Residential Rehabilitation Treatment Program at health care systems with mostly rural veterans was about 34 days, compared with about 28 days at health care systems with few rural veterans.[44] We found that about half of the health care systems serving mostly rural veterans had average wait times over the 30-day threshold. In comparison, about 29 percent of health care systems with few rural veterans exceeded the 30-day threshold.

[43]Specifically, VHA policy states that a veteran without priority access with a scheduled wait time of 30 calendar days must be offered alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening. See Veterans Health Administration, *VHA Directive 1162.02.* Additionally, veterans may elect to delay their admission for care, which may result in average wait times of greater than 30 days for those veterans without reflecting poorly on the 30-day threshold, according to VHA officials.

[44]A health care system may have more than one Mental Health Residential Rehabilitation Treatment Program at different facilities, with one in an urban location and one in a rural location, which could affect interpretation of the wait time data, according to VA. Some VHA health care systems offer several different programs within their Mental Health Residential Rehabilitation Treatment Programs, while other health care systems only offer one type of program. Types of programs within their Mental Health Residential Rehabilitation Treatment Programs include Domiciliary Care for Homeless Veterans, Compensated Work Therapy, General Domiciliary Programs, Domiciliary Substance Use Disorder Programs, and Domiciliary Posttraumatic Stress Disorder Programs. We present the wait time of all Mental Health Residential Rehabilitation Treatment Programs at a health care system combined because the wait times can differ by program type.

Figure 5: Average Wait Times across Mental Health Residential Rehabilitation Treatment Programs, Fiscal Year 2021



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105544

Notes: A VHA health care system is an integrated health care delivery system under the direction of one administrative parent facility—such as a VHA medical center—and comprised of multiple health care facilities, such as community-based outpatient clinics, offering an array of health care services to veterans in a defined geographic area. For the purposes of GAO's analyses, GAO defined health care system rurality as follows. Mostly rural enrollees: more than 50 percent of enrolled veterans lived in a rural, highly rural, or insular island area. Some rural enrollees: 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, but 10,000 or more of these enrollees lived in a rural area. Few rural enrollees: 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, and fewer than 10,000 enrollees lived in a rural area.

VHA measures the average wait time for each health care system. For each of the health care system groupings—health care systems with mostly, some, and few rural veterans—GAO summed the averages across health care systems and divided by the number of health care systems in the group to determine the average wait time across the group of health care systems.

GAO also examined the median wait times for all Mental Health Residential Rehabilitation Treatment Programs across health care systems and found a similar trend. Specifically, health care systems with mostly rural veterans had a median wait time of about 30 days; health care systems with some rural veterans had a median wait time of about 27 days; and health care systems with few rural veterans had a median wait time of about 23 days.

According to VHA Directive 1162.02, any veteran without priority access with a scheduled wait time of greater than 30 calendar days must be offered alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening.

Capacity. This refers to the number of beds available or staffing levels (such as the ratio of patients to program staff). Based on our review of VHA's fiscal year 2021 data, we found mixed results in the relationship

between VHA health care system capacity—bed occupancy and staffing levels—and health care system rurality.[45]

- **Inpatient mental health care bed occupancy.** According to VHA's fiscal year 2021 data, health care systems with mostly rural veterans with inpatient mental health care programs had similar program capacity compared with health care systems with few rural veterans. Specifically, we found that health care systems serving mostly rural, some rural, and few rural veterans had similar average occupancy rates of around 50 percent.
- **Outpatient staffing levels.** VHA's fiscal year 2021 data on staffing levels—the ratio of patients to staff—for its Psychosocial Rehabilitation and Recovery Centers and Mental Health Intensive Case Management programs showed modest differences across health care systems with few, some, or mostly rural veterans.[46] Additionally, we analyzed the percentage of health care systems that had staffing ratios below the targeted staffing ratios defined by VHA policy.[47] VHA data showed modest differences in staffing ratios relative to target ratios by health care system rurality.

  However, we found some differences by rurality based on VHA data on the projected number of staff needed to ensure adequate

[45]We used VHA's enrollee fiscal year 2021 data to classify health care systems as having mostly rural, some rural, and few rural enrollees based on their number of enrolled veterans living in highly rural, rural, insular island, and urban areas. Although a health care system may have mostly rural veterans enrolled, it does not necessarily mean that mostly rural veterans use the programs offered by the health care system. It was important to consider these differences in utilization in review of VHA capacity data because even at health care systems with mostly rural veterans, urban veterans may be using these programs at higher rates than rural veterans.

[46]According to VHA OMHSP officials, capacity is a new metric used for performance assessments and should be interpreted cautiously. For example, the staffing ratio measure may be unreliable if a site does not enroll veterans in Northeastern Program Evaluation Center program evaluations.

[47]According to VHA policy, the target staffing ratio for Psychosocial Rehabilitation and Recovery Centers is one staff member for every six to 10 veterans; the target staffing ratio for Mental Health Intensive Case Management programs is one case manager for every seven to 15 veterans. See Veterans Health Administration, *VHA Directive 1163* and *VHA Handbook 1163.06*.

outpatient mental health care.[48] Specifically, VHA data showed that the 39 health care systems with mostly rural veterans would require 88 total additional staff members to reach the targeted staff-to-patient ratio for their population, according to VHA policy. Comparatively, the 37 health care systems with few rural enrollees would require 25 additional staff members to reach the targeted staff-to-patient ratio.[49]

VHA Developed Targeted Guidelines for Establishing Residential and Inpatient Intensive Mental Health Care Programs, but Not for Outpatient Programs

VHA Developed Targeted Guidelines for Establishing Residential and Inpatient Programs in 2021

In 2021, VHA updated its guidelines for establishing residential and inpatient mental health programs. Specifically, in developing its national planning strategies, VHA updated its guidelines to include targeted parameters for establishing these types of programs.[50] VHA developed the national planning strategies to inform its market assessment—a system-wide assessment of VHA's capacity to provide health care

[48]The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, also commonly known as the Hannon Act, improves mental health care and suicide prevention programs provided for veterans. In response to the Hannon Act, VHA's OMHSP collects data to help determine the number of staff needed to ensure adequate outpatient mental health care access for the full population of veterans actively receiving health care within a health care system. The office has developed a benchmark of 7.72 staff-to-patient ratio, which is intended to help indicate whether health care systems have the staff needed to supply adequate mental health care access to their population of veterans.

[49]These numbers indicate the projected need across VHA health care systems with mostly rural veterans and the projected need across health care systems with few rural veterans, based on VHA's OMHSP benchmark of a 7.72 staff-to-patient ratio. Some individual health care systems may not need additional staff to reach the benchmark.

[50]See Veterans Health Administration, *Market Area Health Systems Optimization, National Planning Strategy, Mental Health Residential Rehabilitation Treatment Programs* (Mar. 2021) and *Market Area Health Systems Optimization, National Planning Strategy, Inpatient Mental Health* (Mar. 2021).

services to veterans. As part of the market assessment, VA developed recommendations for modernizing and realigning the department's facilities and services. The market assessment includes recommendations to, for example, establish or relocate some residential and inpatient mental health programs.[51]

VHA's updated guidelines for establishing residential and inpatient mental health programs incorporated data from its demand projection models, in conjunction with geographic data, to identify conditions when health care systems should establish new programs. These guidelines also call for health care systems to take into account where veterans live by including drive time thresholds for establishing new programs.

For residential programs, VHA's guidelines include specific parameters that instruct health care systems to open a new Mental Health Residential Rehabilitation Treatment Program if the system meets certain parameters. Specifically, health care systems are to establish such programs if the residential demand model projects a need for 6,205 bed days of care in 10 years and if there are no other residential programs available within a 120-minute drive time of the health care system, among other parameters. According to OMHSP officials, historically residential programs have been concentrated in the Northeast and East with fewer programs in rural areas, especially in the Northwest and Midwest. Officials explained that using the updated guidelines, which now use the geographic location of veterans as the basis for projecting demand, may address some of the geographic differences that have developed over time.

For inpatient programs, VHA's guidelines instruct health care systems located in urban areas to open a program if they have a 10-year projected average daily census of 12 veterans using the program; those systems located in rural areas should open a new program if they have a 10-year projected average daily census of 9.6 veterans.[52] According to OMHSP

[51]VA published the market assessment recommendations in March 2022. VA's report to the Asset and Infrastructure Review Commission can be found at https://www.va.gov/aircommissionreport/, accessed December 8, 2022. For additional information on GAO's review of VA market assessments, see GAO-22-104604.

[52]VHA guidelines use, among other things, the Enrollee Health Care Projection Model to estimate these projections. This model projects utilization by a range of geographic and demographic characteristics such as service location (VHA facility or community care), age group, and gender. Average daily census refers to the average number of patients in the inpatient mental health unit per day over one year.

officials, some health care systems primarily use inpatient mental health care through the community for their veterans. As such, the new guidelines also instruct health care systems to consider the location of community care services when planning for the establishment of new inpatient mental health care programs. For example, veterans should have immediate access to an inpatient mental health care program, which could include a program in the community, targeted to be within a 60-minute drive time, according to the guidelines.

Guidelines for Establishing Outpatient Programs and Providing Seed Funding Do Not Factor in Where Veterans in Need Live

We found VHA has guidelines specific to each of its outpatient programs, but those guidelines are not targeted because they do not include specific parameters to factor in where veterans with serious mental illness live. We found this to be the case for guidelines on establishing new outpatient programs as well as for guidelines on providing seed funding for establishing rural-focused treatment programs (those programs that VHA's Office of Rural Health may provide seed funding to help establish new programs).

Establishing outpatient intensive mental health programs. VHA has guidelines for each of its outpatient programs, but those guidelines do not instruct health care systems to consider where veterans with serious mental illness live in establishing programs. See table 8. For example, for the rural-focused treatment programs, VHA guidelines "strongly encourage" health care systems to provide programs "for those who need them in smaller facilities, especially in more rural areas." These programs are intended to serve veterans living in less densely populated areas or rural areas with relatively few veterans on the National Psychosis Registry, according to VHA policy. But, VHA's guidelines do not identify parameters health care systems should use to determine where or when to establish these types of programs. For example, such parameters could include the number of veterans with serious mental illness living within a particular geographic area or who have driving times that exceed certain thresholds.

Table 8: Guidelines for Establishing Veterans Health Administration (VHA) Outpatient Intensive Mental Health Programs

Outpatient program	Guidelines
Mental Health Intensive Case Management	VHA health care systems serving 1,500 or more veterans identified on the National Psychosis Registry must have a program.[a]
Rural Access Network for Growth Enhancement	VHA "strongly encourages" health care systems to provide Rural Access Network for Growth Enhancement programs "for those who need them in smaller facilities, especially in more rural areas."
Enhanced Rural Access Network for Growth Enhancement	VHA "strongly encourages" health care systems to provide Rural Access Network for Growth Enhancement programs "for those who need them in smaller facilities, especially in more rural areas."
Psychosocial Rehabilitation and Recovery Centers	VHA health care systems serving 1,500 or more veterans identified on the National Psychosis Registry must have a Psychosocial Rehabilitation and Recovery Center.[a] VHA "strongly encourages" health care systems serving 1,000 to 1,499 veterans identified on the National Psychosis Registry to have a center. Centers should be located in the community with readily accessible public transportation. If centers are on VHA medical center grounds, efforts should be made to locate them in an outpatient area separate from the mental health clinic and separate from where other traditional mental health services are provided. Regardless of the location, adequate space should be available to support program operations. In addition, VHA guidelines require health care systems to transform any day treatment centers, day hospitals, partial hospitals, or analogous programs to Psychosocial Rehabilitation and Recovery Centers.

Source: GAO analysis of VHA Handbooks 1106.01, 1163 and 1163.06. | GAO-23-105544

[a]VHA's National Psychosis Registry identifies veterans who received VHA care in a given year for a serious mental illness diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder diagnoses. Although VHA uses the National Psychosis Registry to identify veterans with certain serious mental illness, it does not include all diagnoses associated with serious mental illness. As a result, the registry serves as a proxy for identifying veterans with serious mental illness, but does not capture the full extent of veterans with such illnesses.

The location of outpatient programs is an important factor in ensuring veterans' access to such care because in-person visits are frequent, such as weekly visits, and require veterans to travel to a facility or for case managers to travel to the veterans' homes. According to OMHSP officials, the location and geographic service radius for Intensive Community Mental Health Recovery programs—the area in which case managers can generally travel to a veteran's home—are decided by local officials who manage the programs. However, OMHSP officials said service radii typically form around a critical mass of veterans and are limited by program-specified caseload ratios. As such, case managers can only

reasonably visit a certain number of veterans to maintain the integrity of case management program models.[53]

OMHSP officials and officials from two of the health care systems we spoke to said rural veterans may not have many options for similar outpatient intensive mental health programs in the community. Specifically, these officials said the program in the community most like VHA Intensive Community Mental Health Recovery programs—Assertive Community Treatment—is limited in rural areas. Similarly, OMHSP officials said services similar to those offered under the Psychosocial Rehabilitation and Recovery Centers are not typically offered in the community. Therefore, veterans living in rural areas may need to use VHA-provided outpatient intensive mental health services to meet their needs.

Our review of VHA's fiscal year 2021 data showed that its outpatient programs may not be fully accessible to rural veterans with serious mental illness. Specifically, VHA data showed that over 84 percent of rural veterans on the National Psychosis Registry—those in the target population for these programs—did not live within a 60-minute average drive time of one of the rural-focused treatment programs.[54] Similarly, according to VHA's data, just over 29 percent of rural veterans on the National Psychosis Registry lived within a 60-minute drive of a Psychosocial Rehabilitation and Recovery Center, compared with about 74 percent of urban veterans.[55]

Additionally, as noted, VHA's fiscal year 2021 data showed that rural veterans used most of VHA's outpatient programs less than their urban counterparts, further suggesting that rural veterans may have less access

[53]According to VHA policy, integrity to service elements, such as low caseloads and frequent and clinically intense encounters, is essential to ensure desired program outcomes and positive results for veterans. Caseloads are limited to seven to 10 veterans per clinical case manager for teams in Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement programs respectively. Additionally, veterans must be seen frequently—typically two to three contacts per week, with at least one face-to-face visit per week. Veterans Health Administration, *VHA Handbook 1163.06*.

[54]Under the VA MISSION Act of 2018 and implementing regulations, if a veteran is not within a 60-minute average drive time for specialty care, they are eligible for community care. VA MISSION Act of 2018, Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395 (2018); 38 C.F.R. § 17.4040 (2021).

[55]VHA data on drive time is based on the average time to travel by car from a residence to the facility at 10AM on a weekday. VHA averages its drive time data over a 2-year period.

to these programs. For example, VHA data showed that 90 percent of health care system facilities that offered Mental Health Intensive Case Management Programs served mostly urban veterans. Regarding rural-focused treatment programs, VHA data showed that 67 percent of VHA facilities that offered Rural Access Network for Growth Enhancement programs served fewer rural veterans than urban veterans in fiscal year 2021. Additionally, our analysis indicated that about 18 percent of veterans who used Psychosocial Rehabilitation and Recovery Centers lived in a rural area compared with about 82 percent who lived in an urban area in fiscal year 2021.

OMHSP has not assessed the guidelines for their various outpatient programs to examine how well they reflect VA's goals to improve access for veterans living in rural areas and veterans with serious mental illness.[56] Regarding its rural-focused treatment programs, officials said that OMHSP developed the guidelines around the time the programs were created in 2007, and it may have been premature to establish more detailed guidelines at that time. For Psychosocial Rehabilitation and Recovery Centers and Mental Health Intensive Case Management Programs, OMHSP officials noted that their guidelines are focused on providing access for all veterans, and they defer to health care system officials to recognize the need for establishing new programs. For all programs, OMHSP officials said they are supportive of health care systems identifying the needs of their veterans with serious mental illness and initiating new outpatient programs to support those needs.[57]

However, without targeted guidelines that include specific parameters for establishing outpatient programs, the responsibility to justify the need for programs falls on individual health care systems. Justifying the need for new programs can be difficult, particularly for rural-focused treatment programs. For example, officials from one health care system said this has affected their ability to establish rural-focused treatment programs. Officials noted that it was clear to the local team responsible for the program that they needed rural-focused treatment services due to the number of referrals received that fell outside of their geographic service

[56]Department of Veteran Affairs, *FY 2022-2028 Strategic Plan*.

[57]VHA policy outlines procedures for re-engaging veterans with serious mental illness in treatment. The policy requires OMHSP, Veterans Integrated Service Network, and health care system officials to take certain steps to work together to identify and re-engage veterans who have been lost to follow-up care. Veterans Health Administration, *VHA Directive 1160, Re-Engaging Veterans with Targeted Serious Mental Illness in Treatment* (Washington D.C.: Feb. 7, 2018).

radius for their existing program. But, without guidelines to help demonstrate their need to initiate a Rural Access Network for Growth Enhancement program, program staff said they were unable to convince their leadership to establish a program. Officials from another health care system said they were able to justify adding rural-focused treatment programs because their leadership started prioritizing mental health.

If VHA assessed its outpatient intensive mental health programs' guidelines, it could identify specific parameters to consider adding to its guidelines. In particular, VHA could determine whether it needs specific parameters to trigger when a health care system should establish a program, such as a specific number of veterans with serious mental illness living within a particular geographic area, a maximum driving distance veterans should have to travel to reach care, or a maximum distance case managers should have to drive to reach veterans with serious mental illness. Assessing and then updating, as appropriate, its guidelines would help ensure VHA is effectively reaching all veterans in need, including those in rural areas. This may be particularly important for the rural-focused treatment programs, which were designed specifically to provide services to rural veterans.

Seed funding for rural-focused treatment programs

VHA's Office of Rural Health provides seed funding to some VHA health care systems to support the initial establishment of Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement programs. Health care systems can use initial seed funding—up to $333,000 per year for each program—toward staff salaries for the first 3 years of the program. After 3 years, VHA generally expects health care systems to support their programs using their own funding.

Source: GAO analysis of Veterans Health Administration (VHA) information. | GAO-23-105544

Providing seed funding for rural-focused treatment programs. VHA's Office of Rural Health makes available seed funding to establish rural-focused treatment programs, but we found the guidelines for selecting VHA health care systems to fund do not consider where veterans with serious mental illness live. The Office of Rural Health provided about $33 million from fiscal year 2010 through fiscal year 2021 to health care systems to establish 27 Rural Access Network for Growth Enhancement and 23 Enhanced Rural Access Network for Growth Enhancement programs.[58] However, we found that more health care systems applied for seed funding than the office had monies to fund. For example, in fiscal year 2022, based on available funding, VHA provided funding to three of the 27 health care systems that applied for funding that year to establish programs.

[58]According to VHA, there were 69 Rural Access Network for Growth Enhancement and 19 Enhanced Rural Access Network for Growth Enhancement programs in fiscal year 2021. VHA noted that five of the 23 funded Enhanced Rural Access Network for Growth Enhancement programs were either closed by the health care system or converted to Rural Access Network for Growth Enhancement. One Rural Access Network for Growth Enhancement program did not use the funding due to hiring issues.

OMHSP is responsible for assessing and selecting health care system applicants for the Office of Rural Health to fund. According to OMHSP officials, the guidelines for deciding which systems to fund include consideration of the percentage of enrollees in a service radius who lived in a rural census tract, proposed staffing for the program, and other resources available for the program identified by the applicant, including the number of available vehicles. The officials said that the Office of Rural Health requires the rurality of veterans in the zip codes targeted to be served to be at least 50 percent. However, OMHSP's guidelines do not consider information on the population these programs are meant to serve—the locations of veterans with serious mental illness or locations with the highest concentration of such veterans potentially served by the programs. Officials said the guidelines do not specify including such information because they did not believe this was necessary when making funding decisions.

However, without considering information on the location of veterans with serious mental illness, VHA is at risk of not directing its resources to where they are most needed, especially when the number of applicants for seed funding well exceeds available funding. Officials from one health care system that did not receive seed funding for a program in fiscal year 2022 told us their existing Mental Health Intensive Case Management Program had too many veterans to reasonably service. They have had to rely on scarce community care resources to address veterans' unmet need. In contrast, another health care system that received seed funding for a Rural Access Network for Growth Enhancement program in fiscal year 2021 told us that their existing Mental Health Intensive Case Management Program had capacity to care for more veterans within its service radius, and the funding would help them increase their services to a larger geographic radius.

Incorporating information on the locations of veterans with serious mental illness into its guidelines for providing seed funding would be consistent with VA's goals to improve access for veterans living in rural areas and veterans with serious mental illness.[59] Moreover, incorporating such information would help ensure that OMHSP is able to best direct available seed funding to the areas with the greatest need.

Conclusions

VHA provides critical intensive mental health care to veterans with serious mental illness, a persistent and growing concern among veterans.

[59]Department of Veteran Affairs, *FY 2022-2028 Strategic Plan*.

VHA's OMHSP analyzes utilization and performance data to monitor veterans' access to its intensive mental health care programs. However, the office does not analyze data by rurality. By also analyzing utilization and performance data by rurality and including these analyses in its assessments of veterans' access to intensive mental health care, VHA would have better information about any differences in access for rural veterans. Further, by also analyzing available community care referral and claims data in conjunction with its other analyses, OMHSP would have more information about the extent to which veterans in need of intensive mental health care are accessing such care from community providers. This, in turn, would better position OMHSP to address any apparent differences in access for rural veterans and help achieve VA's strategic goals of improving access for rural veterans and veterans with serious mental illness. This is especially important because our review of VHA data shows that, in some instances, there were differences in utilization and wait times for rural veterans compared with their urban counterparts in fiscal year 2021, suggesting that rural veterans may have less access to important mental health care.

The availability of VHA's intensive mental health care programs is important for helping to ensure that all veterans who need care—including those living in rural areas—can access it. VHA's efforts to update its guidelines for establishing inpatient and residential intensive mental health care programs show the agency's commitment to providing needed services to veterans in rural areas. By also assessing and updating, as appropriate, its guidelines for establishing outpatient intensive mental health care programs to include parameters to help guide systems in establishing such programs, VHA could better ensure veterans in rural areas have access to these programs. Moreover, in updating its guidelines for providing seed funding to rural-focused treatment programs to include data on the locations of veterans with serious mental illness, VHA could more strategically target its available seed funding to those areas with the greatest need.

Recommendations for Executive Action

We are making the following four recommendations to VHA:

The Department of Veterans Affairs Under Secretary of Health should ensure that the Office of Mental Health and Suicide Prevention analyzes, by rurality, the utilization and performance data it uses to monitor access to intensive mental health care and include such analyses in program performance assessments. (Recommendation 1)

The Department of Veterans Affairs Under Secretary of Health should ensure that the Office of Mental Health and Suicide Prevention incorporates into its monitoring efforts, as appropriate, analysis of referral and claims data for intensive mental health care services provided through community care. (Recommendation 2)

The Department of Veterans Affairs Under Secretary of Health should assess and update, as appropriate, its guidelines for establishing outpatient intensive mental health care programs to incorporate parameters to factor in where veterans in need live. (Recommendation 3)

The Department of Veterans Affairs Under Secretary of Health should update its guidelines for providing seed funding to Rural Access Network for Growth Enhancement or Enhanced Rural Access Network for Growth Enhancement programs to include data on the locations of veterans with serious mental illness. (Recommendation 4)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix II, VA concurred with our recommendations and identified steps to implement them. Regarding our first recommendation, VA stated that the agency has begun exploring the feasibility of incorporating rurality data in its evaluations for intensive mental health care programs. For example, based on the population of veterans who use these services, VA stated that it can categorize veterans by home address into urban, rural, and highly rural categories and assess their proportional representation in the larger veteran population. VA noted that it will be important to examine whether differences observed between rural and urban areas are differences explained by geographic variation or other demographics such as race, ethnicity, gender, or age.

With respect to our second recommendation, VA stated that it has initiated efforts to incorporate community care data for intensive mental health care programs into its monitoring efforts. As noted in our report, OMHSP and the Office of Integrated Veteran Care have developed business rules to capture mental health residential care provided in the community when such data are available. VA stated that these two offices will continue to work together to identify opportunities to capture referral and claims data for other types of intensive mental health care.

For our third recommendation on assessing its guidelines for establishing outpatient intensive mental health care programs, VA stated that it will examine the geographic distribution of veterans on the National

Psychosis Registry, which it uses to approximate the population of veterans in need, as well as explore the availability of community care data.

Regarding our fourth recommendation related to updating guidelines for providing seed funding for its two rural-focused treatment programs, VA stated that it will examine the distribution of veterans on the National Psychosis Registry and that ongoing monitoring of veterans' enrollment by zip code is already being performed. VA further stated that the data available in the registry are an incomplete assessment of veterans who may need these services, and there may be many other local variables that may factor into a facilities' need for funding. We agree that the geographic location of veterans with serious mental illness may be one of many factors to consider in making funding decisions. VA also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of the Department 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 Alyssa M. Hundrup at (202) 512-7114 or hundrupa@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 III.

Alyssa M. Hundrup
Director, Health Care

Appendix I: Supplemental Information on Methodology

This appendix provides information regarding our categorization of Veterans Health Administration (VHA) health care systems by rurality, analyses of VHA data on rural veterans' utilization and performance of intensive mental health care programs, and analyses of data to inform VHA guidelines for establishing these programs. For all of our analyses, we used the term rural to include veterans living in rural, highly rural, and insular island areas.[1]

Categorization of VHA Health Care Systems by Rurality

We obtained VHA's fiscal year 2021 veterans' enrollee data to classify health care systems by rurality. We used the data to categorize systems based on the number of enrolled veterans living in highly rural, rural, insular island, and urban areas. We used VHA policy as a basis for determining 10,000 rural enrollees as the cutoff between some rural enrollees and few rural enrollees. See table 9.

Table 9: Veterans Health Administration (VHA) Health Care Systems by Rurality of Populations Served, Fiscal Year 2021

Health care system population	Number of health care systems	Percent of health care systems
Mostly rural veterans More than 50 percent of enrolled veterans lived in a rural, highly rural, or insular island area.	39	28
Some rural veterans 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, and 10,000 or more enrollees lived in a rural area.	63	45
Few rural veterans 50 percent or fewer of enrolled veterans lived in a rural, highly rural, or insular island area, and fewer than 10,000 enrollees lived in a rural area.	37	27
Total	**139**	**100**

Source: GAO analysis of VHA data. | GAO-23-105544

Note: A VHA health care system is an integrated health care delivery system under the direction of one administrative parent facility—such as a VHA medical center—and comprised of multiple health care facilities, such as community-based outpatient clinics, offering an array of health care services to veterans in a defined geographic area. GAO classified health care systems as having mostly rural, some rural, and few rural veterans based on their number of enrolled veterans living in highly rural, rural, insular island, and urban areas. GAO used VHA policy as a basis for determining 10,000 rural enrollees as the cutoff between some rural enrollees and few rural enrollees. Specifically, according to VHA policy, very large community-based outpatient clinics—which are required to have more robust programs and are encouraged to have psychosocial rehabilitation and recovery and Mental Health Intensive Case Management programs—serve over 10,000 or more unique veterans each year. Therefore, 10,000 or more rural enrollees indicates a rural presence similar to that of a very large community-based outpatient clinic.

[1]Department of Veterans Affairs defines veteran rurality using the U.S. Census-derived Rural Urban Commuting Code for the veteran's home census tract.

Analyses of Utilization and Performance Data for Intensive Mental Health Care Programs by Veteran Rurality

Utilization data. We obtained and analyzed VHA's fiscal year 2021 data on the number of veterans who used the following VHA intensive mental health care programs:

- inpatient mental health care,
- Mental Health Residential Rehabilitation Treatment Programs,
- Intensive Community Mental Health Recovery, and
- Psychosocial Rehabilitation and Recovery Centers.

We then disaggregated these data by veteran rurality. VHA determined veteran rurality using the U.S. Census-derived Rural Urban Commuting Code for veterans' home address in the VHA enrollment file. VHA used intensive mental health care program billing codes, known as stop codes, to disaggregate utilization data by veteran rurality. These billing codes reflect the type of outpatient care delivered. Our analyses do not control for veteran demographic factors. According to VHA, veterans of certain demographics living in rural areas may be less likely to use VHA care.

We also obtained and analyzed VHA's fiscal year 2021 utilization data for the Intensive Community Mental Health Recovery programs (Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement, and Enhanced Rural Access Network for Growth Enhancement).[2] VHA does not collect unique veteran-level data for these programs, so we disaggregated utilization data for these programs by veteran rurality at each health care system facility to avoid double counting veterans who may have used more than one program in fiscal year 2021.[3]

[2]VHA's utilization data for Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement, and Enhanced Rural Access Network for Growth Enhancement included some health care system divisions with program utilization values combined for two of the program types. We excluded these data from our analysis as we could not disaggregate the combined values to individual programs due to VHA data limitations.

[3]A VHA health care system is an integrated health care delivery system under the direction of one administrative parent facility—such as a VHA medical center—and comprised of multiple health care facilities, such as community-based outpatient clinics, offering an array of health care services to veterans in a defined geographic area.

Performance data. We obtained and analyzed VHA's available fiscal year 2021 performance data, disaggregated by veteran or health care system rurality.

- **Population coverage.** We calculated the population coverage by veteran rurality—the percentage of rural and urban veterans who used Psychosocial Rehabilitation and Recovery Centers and case management Intensive Community Mental Health Recovery programs compared with the number of veterans eligible for these programs—for fiscal year 2021.[4] VHA determined veteran rurality using the U.S. Census-derived Rural Urban Commuting Code for veterans' home address in the VHA enrollment file. Population coverage metrics are part of VHA's Strategic Analytics for Improvement and Learning metrics.[5]
- **Wait time.** We calculated the average and median wait times for Mental Health Residential Rehabilitation Treatment Programs in health care systems that had mostly rural, some rural, and few rural enrollees.[6] We used fiscal year 2021 wait time data from the

[4]For the purpose of the population coverage metrics, veterans in the target population for Psychosocial Rehabilitation and Recovery Centers include those with mental health diagnoses reflected in the National Psychosis Registry—schizophrenia, bipolar disorder, and psychosis—as well as those with post-traumatic stress disorder and major depressive disorder. This is broader than the target population for case management programs, which includes only veterans with mental health diagnoses reflected in the National Psychosis Registry.

VHA does not use population coverage data for inpatient and residential programs because health care systems that do not have local VHA inpatient or residential services may be more likely to use community inpatient and residential services and send more patients to community care, which is not reflected in population coverage data.

[5]VHA uses the Strategic Analytics for Improvement and Learning system to measure, evaluate, and benchmark the quality, efficiency, and productivity of medical centers. These measures are available to VHA health care systems and Veterans Integrated Service Networks.

[6]Wait time refers to the time between a patient receiving a referral for care and receiving services. VHA health care systems complete a screening template, which indicates the start of a veteran's wait time. Health care systems with a screening template usage of 50 percent or below were excluded from our analyses due to unreliable data.

Northeast Program Evaluation Center performance assessment for Mental Health Residential Rehabilitation Treatment Programs.[7] VHA reported these data by health care system, so we were unable to disaggregate them by unique veteran rurality. Thus, we disaggregated these data by health care system rurality using our categorization of health care systems described above. VHA calculated an average wait time for any residential bed type for each health care system with a residential program in its annual performance assessment. We calculated the average and the median of the health care systems' residential programs' average wait times across health care systems that had mostly rural, some rural, and few rural enrollees.

- **Capacity.** We obtained and analyzed capacity data for inpatient mental health services, Psychosocial Rehabilitation and Recovery Centers and Mental Health Intensive Case Management Programs for health care systems with mostly rural, some rural, and few rural enrollees. We used fiscal year 2021 capacity data from the Northeast Program Evaluation Center performance assessments.[8] VHA reported these data by health care system, and we were unable to disaggregate them by unique veteran rurality. Thus, we disaggregated these data by health care system rurality using our categorization of health care systems described above. For inpatient mental health services, we calculated the average and median bed occupancy rates across health care systems with mostly rural, some rural, and few

According to VHA, wait time is not a useful measure for Psychosocial Rehabilitation and Recovery Centers and case management programs because there are no standard consults or referrals for these programs. Therefore, there are no data on the time between a veteran being screened and deemed appropriate for care and receiving that care through these programs. VHA also does not collect wait time data for inpatient programs because veteran admission into inpatient programs, either provided by VHA or by non-VHA facilities, should be immediate. Additionally, we have reported that outpatient medical appointment wait times reported by VHA are unreliable. For example, in 2013 we recommended VA improve the reliability of its wait time measures by clarifying the policy for recording the desired date for patient treatment. This recommendation remained unaddressed in 2022. 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).

[7]The Northeast Program Evaluation Center is responsible for conducting performance assessments of Mental Health Residential Rehabilitation Treatment Programs. These evaluations include program monitoring and outcome data.

[8]The Northeast Program Evaluation Center is responsible for conducting performance assessments of inpatient mental health services, Mental Health Intensive Case Management Programs, and Psychosocial Rehabilitation and Recovery Centers.

rural enrollees.[9] For Psychosocial Rehabilitation and Recovery Centers and Intensive Community Mental Health Recovery programs, we calculated the average and median staffing ratios across health care systems with mostly rural, some rural, and few rural enrollees.[10]

- **Staffing.** Through a policy directive, VHA specifies the number of staff needed to ensure sufficient capacity to provide adequate outpatient mental health care access. Based on this directive, we calculated the number of additional staff that would be needed to meet VHA's specifications in health care systems with mostly rural, some rural, and few rural enrollees during the second quarter of fiscal year 2021.[11] VHA collected and reported these data, among others, to Congress in VA's 2021 Staffing Improvement Plan, which it prepared in response to the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.[12]

Analysis of VHA's Guidelines for Establishing Intensive Mental Health Care Programs

To inform our review of the guidelines that VHA health care systems use to establish and provide seed funding to intensive mental health care programs, we obtained and analyzed data related to elements of the guidelines.

- **Drive time to outpatient intensive mental health care programs.** We collected drive time data from VHA that describe the time it took veterans to travel by car from their homes to VHA outpatient intensive

[9]Average occupancy rate for an inpatient mental health program is calculated by dividing the average daily census by actual operating beds. This value is calculated on a monthly basis, and then an annual value is generated by averaging across 12 months.

[10]Caseload ratios are calculated by dividing total active clients by total full-time equivalents at a point in time—September 2021. VHA does not collect caseload ratio data for the rural-focused treatment programs.

According to the performance assessments, caseload ratios should be interpreted cautiously because they may be unreliable if a site does not enroll veterans in Northeast Program Evaluation Center program evaluations or Northwest Program Evaluation Center discharge forms are not submitted.

[11]According to VHA calculations, if a health care system has a 7.72 staff-to-patient ratio in their outpatient mental health programs, they are able to supply adequate mental health care access to their population of veterans. According to OMHSP officials, Psychosocial Rehabilitation and Recovery Centers and case management programs are included in these data.

[12]Department of Veterans Affairs, *Staffing Improvement Plan for Mental Health Providers of the Department of Veterans Affairs* (October 2021). See Pub. L. No. 116-171, tit. V, § 501, 134 Stat. 778, 814-815 (2020).

mental health program locations in fiscal year 2021.[13] Using these data, we calculated the percentage of rural and urban veterans on the National Psychosis Registry within a 60-minute drive to facilities with Psychosocial Rehabilitation and Recovery Centers.[14] We also calculated the percentage of rural veterans on the National Psychosis Registry within a 60-minute drive to facilities with rural-focused treatment programs.

- **Seed funding for rural-focused treatment programs.** We obtained and analyzed data on the Rural Access Network for Growth Enhancement and Enhanced Rural Access Network for Growth Enhancement programs VHA had funded as of fiscal year 2021. We used these data to calculate the number of rural-focused treatment programs funded by VHA through 2021 and the total amount of funding VHA provided for fiscal years 2010 through 2021.

To assess reliability of the data we analyzed, we interviewed relevant agency officials, reviewed related documentation, and performed electronic and manual testing to identify any missing data and obvious errors. On the basis of these steps, we determined that the data were sufficiently reliable for the purposes of providing information on rural veterans' use of intensive mental health care programs, the performance of these programs, and VHA guidelines for establishing these programs.

[13]Drive time was based on the average time to travel by automobile from a residence to a facility at 10 AM on a weekday. Drive time data are averaged over a 2-year period.

[14]The National Psychosis Registry identifies veterans who received VHA care in a given year for a serious mental illness diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder diagnoses. Although VHA uses the National Psychosis Registry to identify veterans with certain serious mental illness, it does not include all diagnoses associated with serious mental illness, thus it serves as a proxy for serious mental illness.

Appendix II: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

January 19, 2023

Ms. Alyssa M. Hundrup
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Hundrup:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA MENTAL HEALTH: Additional Action Needed to Assess Rural Veterans' Access to Intensive Care*** (GAO-23-105544).

The enclosure contains technical comments and the action plan to implement the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya Bradsher
Chief of Staff

Enclosure

Enclosure

**Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*VA MENTAL HEALTH: Additional Action Needed to
Assess Rural Veterans' Access to Intensive Care*
(GAO-23-105544)**

Recommendation 1: The Under Secretary for Health should ensure the Office of Mental Health and Suicide Prevention analyzes, by rurality, the utilization and performance data it uses to monitor access to intensive mental health care and include such analyses in program performance assessments.

VA Response: Concur. The program evaluation protocols for Intensive Community Mental Health Recovery (ICMHR), acute inpatient, Mental Health Residential Rehabilitation Treatment Program (MH RRTP) and Psychosocial Rehabilitation and Recovery Center (PRRC) have already begun to explore the feasibility of incorporating rurality. By necessity, because VA must approximate measures of access with measures of utilization, VA does not have available data on a true denominator — the number and location of Veterans who may benefit from services (e.g., by virtue of having a particular disorder or a low level of dysfunction), and can only count those who have sought services at VA and have been assessed and diagnosed. However, given the population of Veterans who utilize these services, VA can categorize Veterans by their home address into urban, rural and highly rural categories and assess their proportional representation in the patient population compared to their proportional representation in the larger Veteran population. Similarly, VA can stratify performance assessment such as lengths of stay, readmission and clinical outcomes when they are available, by rurality, to determine if Veterans from rural areas have differences in their care, satisfaction with care or outcomes.

It will be important to examine closely whether differences that may be observed between Veterans in rural and urban areas are truly differences explained by geographic location and are not confounded with other demographics such as race, ethnicity, gender or age. Similarly, it is not necessarily the case that differences observed across rurality groups constitute a health disparity. The Office of Mental Health and Suicide Prevention (OMHSP) has a work group dedicated to the issues of assessing for disparities using records data, and we will consult with them on these program evaluations.

Target Completion Date: October 2023

Recommendation 2: The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention incorporates into its monitoring efforts, as appropriate, analysis of referral and claims data for intensive mental health care services provided through community care.

VA Response: Concur. The Veterans Health Administration (VHA) has already initiated efforts to incorporate data on the provision of intensive mental health services provided through community care. To date, OMHSP in collaboration with the Office of Integrated

Enclosure

**Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*VA MENTAL HEALTH: Additional Action Needed to
Assess Rural Veterans' Access to Intensive Care*
(GAO-23-105544)**

Veteran Care (IVC) has developed business rules to allow for the capture of mental health residential care provided in the community with a plan for quarterly review and sharing of information with the Veterans Integrated Service Networks. OMHSP will continue to work in collaboration with IVC to explore opportunities that will allow for the capture of referral and claims data for other types of intensive mental health care (e.g., assertive community treatment and acute inpatient mental health) and to develop business rules for capture of this information when data are available.

Target Completion Date: June 2023

Recommendation 3: The Under Secretary for Health should assess and update, as appropriate, its guidelines for establishing outpatient intensive mental health care programs to incorporate parameters to factor in where Veterans in need live.

VA Response: Concur. VHA relies on the National Psychosis Registry (NPR) to approximate the population of Veterans in need. Those who do not seek care from VA, or who have other diagnoses such as posttraumatic stress disorder or severe depression, are not counted in the NPR and thus would be missing from access measures. Given that limitation, there is much that OMHSP can do to examine the geographic distributions of Veterans on the NPR and to look for "pockets" of Veterans who may receive fewer services because they live farther away from program staff or a treatment program. OMHSP will look at the distribution of Veterans by location who would be considered appropriate for either ICMHR or PRRC services and work with local facilities to alert them to those Veterans so that the local facility can determine how best to serve them. Additionally, community care data could be examined to determine where Veterans may be getting inpatient, residential or assertive community treatment in their local communities and factor those data into considerations of capacity and unmet need. OMHSP will proceed with examining the geographic dispersion of Veterans on the NPR, both those using intensive services in VA and not. Additionally, OMHSP will explore the availability and specificity of community care data with IVC to determine whether such data are accurate and complete enough to factor into analyses of access and utilization.

Target Completion Date: October 2023

Recommendation 4: The Under Secretary for Health should update its guidelines for providing seed funding to Rural Access Network for Growth Enhancement or Enhanced Rural Access Network for Growth Enhancement programs to include data on the locations of Veterans with serious mental illness.

Enclosure

**Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*VA MENTAL HEALTH: Additional Action Needed to
Assess Rural Veterans' Access to Intensive Care*
(GAO-23-105544)**

VA Response: Concur in Principle. Although rurality data on those who are on the NPR are available, the NPR is an incomplete assessment of the locations of Veterans who need Rural Access Network for Growth Enhancement (RANGE) services. However, there is also little evidence that serious mental illness (SMI) disorders are unevenly distributed among Veterans across regions of the country. Furthermore, evidence from more than 100 RANGE and Enhanced-RANGE (E-RANGE) teams shows virtually 100% of participating Veterans have an SMI diagnosis (i.e., no teams have been funded where there are few Veterans with a SMI diagnosis being served). Monitoring ongoing enrollment in RANGE from zip codes is already being performed. Data on rurality by zip code, which is available, will suffice as a basis for selecting the location of new teams and data from VA's Northeast Program Evaluation Center's evaluation of these programs will allow continuous monitoring that the teams are reaching the intended SMI target population. VA cautions against exclusively using NPR numbers for the determination of where RANGE programs are needed. There are many local variables that figure into whether a facility will apply for funding for a team, and those factors may not be obvious purely by looking at the geographic distribution of Veterans on the NPR. However, OMHSP is aware that facilities would welcome data on the geographic distribution of Veterans identified by the NPR and will establish a process to provide this information.

Target Completion Date: October 2023

Page 3 of 6

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact:

Alyssa M. Hundrup, (202) 512-7114 or hundrupa@gao.gov.

Staff Acknowledgments:

In addition to the contact named above, Rebecca Rust Williamson (Assistant Director), Rebecca Abela and Elizabeth Dobrenz Johns (Analysts-In-Charge), Pamela Brown, Kaitlin Dunn, Catherine Parylo, Jeffrey Tamburello, and Christopher Zakroff made key contributions to this report. Also contributing were Jacquelyn Hamilton, Ying Hu, Ethiene Salgado-Rodriguez, and Ester Weir.

.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/about/what-gao-does/fraudnet

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

A. Nicole Clowers, Managing Director, ClowersA@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548