DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

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BEFORE THE
SUBCOMMITTEE ON HEALTH,
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
COMBATTING A CRISIS: PROVIDING VETERANS ACCESS TO LIFE-SAVING SUBSTANCE ABUSE DISORDER TREATMENT
APRIL 18, 2023

Chairwoman Miller-Meeks, Ranking Member Brownley, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Veterans Health Administration's (VHA) domiciliary substance use disorder treatment program. The OIG's Office of Healthcare Inspections reviews the quality and safety of health care provided across VHA and communicates the findings through a variety of public reports. These include results from hotline inspections, national reviews, comprehensive healthcare inspections, vet center inspections, and Veterans Integrated Service Network (VISN) reviews. For each of these reports, OIG clinical review teams provide recommendations for improving processes or further reducing risks to the veterans who entrust their health care to VHA.

VHA faces significant challenges in meeting the needs of individuals with substance use disorders. The devastating effects on veterans, their families and caregivers, and communities cannot be overstated. Veterans with substance use disorders often have co-occurring mental health issues that can place them at higher risk for suicide. Given that VHA's top clinical priority is to reduce veteran suicide, evidence-based substance use disorder treatment programs are imperative to addressing the clinical needs of these high-risk patients. When both VHA and community care providers are engaged in managing these patients, the coordination must be seamless and collaborative.

This testimony focuses on OIG reports that have identified challenges with community care access and coordination for high-risk patients. The OIG believes the findings and recommendations should be considered by all VHA providers and leaders managing patients with complex mental health needs including substance use disorders.

NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM

In August 2021, the OIG hotline received allegations that staff for the domiciliary substance use disorder treatment program (DOM SUD) at the VA North Texas Health Care System (VA North Texas) placed patients on waitlists for two to three months and failed to offer non-VA community residential care referrals for substance use disorder treatment.[1] The complainant also alleged that VA North Texas staff denied patients' requests for community residential care referrals, whereas patients from another VISN 17 facility, the Central Texas Veterans Health Care System (Central Texas VA), received community residential care treatment. During the course of the OIG staff's review of the allegations (including examining 15 VA North Texas DOM SUD consults (referrals) and electronic health records for 10 patients), the team identified additional concerns related to compliance with required scheduling procedures and the assignment of mental health treatment coordinators to patients awaiting admission. To understand the context for the resulting report's findings, it is important to consider VHA's program goals and requirements.

Background

Mental health residential rehabilitation treatment programs (MH RRTPs) provide 24-hour treatment and rehabilitative services to patients with a range of treatment needs and include domiciliary substance use disorder programs. MH RRTP is an umbrella term for the range of residential programs that provide treatment to patients experiencing homelessness, substance use disorders, posttraumatic stress disorder, as well as other medical and mental health conditions. To be eligible for an MH RRTP referral, veterans must need a higher level of care than an outpatient program but not be at imminent risk to themselves and others, and not meet criteria for a medical or acute mental health admission. VHA requires that each facility provide access to care at MH RRTPs through service agreements with other VA facilities or through referral to non-VA community residential care facilities.

VA North Texas, part of VISN 17, includes a 40-bed DOM SUD at the Dallas VA Medical Center and a 69-bed DOM SUD at the Sam Rayburn Memorial Veterans Center in Bonham, Texas. The Central Texas VA is in Temple, Texas, and has a 169-bed general domiciliary that offers substance use disorder treatment as a "track."

According to VHA's requirements, patients referred to MH RRTPs must be screened within seven business days by a team that includes a licensed mental health professional and a medical provider to determine whether admission is appropriate. If accepted, the patient must receive a tentative admission date and a point of contact at the MH RRTP.[2] So VHA can track admission wait times, the patient must

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[1] VA OIG, *Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System*, January 31, 2023.

[2] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, July 15, 2019. Tentative admission date refers to the MH RRTP staff's expected date of bed availability.

be added to the pending bed placement list.[3] Since 2018, VHA has required staff to include information in the patient's electronic health record to improve tracking of program wait times and capacity.[4]

Community Care Program Eligibility Criteria

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) mandated changes to VHA's community care program.[5] Those changes led to VHA's Office of Community Care issuing implementation guidance stating that "wait time and drive time access standards are only applicable to primary care, specialty care, and non-institutional extended care services." The guidance further said MH RRTPs "are considered institutional extended care services" and do not follow the same wait-time standards.[6] When MH RRTP care is not available within VA facilities for an eligible patient who "elects to receive care in the community," VHA will authorize community residential care. Further, for MH RRTP admission wait times greater than 30 calendar days, facility staff must offer the patient alternative care that addresses the patient's needs and preferences including a referral to community residential care or another VHA program. Additionally, facility staff should discuss outpatient care options with the patient while the patient awaits MH RRTP admission. It is important to note that the COVID-19 pandemic put additional stresses on VHA and that the Texas facilities were not alone in facing long wait times. In February 2021, VHA estimated that 3,500 patients nationally were pending admission with an average wait time of more than 150 days. At that time, VHA required MH RRTP staff to provide alternatives, including community residential care, if unable to admit patients within 30 days.[7]

VA North Texas DOM SUD Wait Times Exceeded Requirements and Staff Failed to Refer Patients to Community Residential Care as Required

The OIG team reviewed 15 VA North Texas DOM SUD consults to determine admission wait times and evaluate whether staff offered community residential care. The team substantiated the allegation that VA North Texas staff placed patients on waitlists for two to three months and failed to offer community residential care referrals during most of fiscal years 2020 and 2021, inconsistent with VHA

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[3] VHA Directive 1002, Bed Management Solution for Tracking Beds and Patient Movement Within and Across VHA Facilities, November 28, 2017.

[4] VHA Deputy Under Secretary for Health for Operations and Management (10N) memo, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) CPRS Note Templates Implementation," July 30, 2018.

[5] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

[6] VHA Office of Community Care, "Field Guidebook: Specialty Programs," updated November 3, 2021. The Office of Community Care determines a patient eligible for community mental health care when the wait time is greater than 20 days or the drive time is greater than 30 minutes for a VHA outpatient mental health appointment.

[7] VHA Assistant Under Secretary for Health for Clinical Services memorandum, "Ensuring Access to Residential Treatment for Veterans with Mental Health and Substance Use Disorders during the Pandemic," February 11, 2021.

requirements. It is important to note that the OIG did not identify any adverse clinical outcomes due to the patients' delayed access to residential care.

In March 2020, due to the pandemic, facility leaders restricted access to the Dallas DOM SUD to local veterans, in accordance with VHA guidance. The Dallas DOM SUD subsequently reopened to a broader group of patients but still with reduced capacity in September 2020. The Bonham DOM SUD remained open during the pandemic at reduced capacity until January 2022, when admissions were halted until June 2022 due to COVID-19 concerns. VHA data indicated that the Dallas and Bonham DOM SUDs' average wait time was 30 days or greater from the third quarter of fiscal year 2020 through the second quarter of fiscal year 2021, likely due to pandemic-related restrictions.

Of the 10 North Texas patients' records the OIG reviewed, five had one DOM SUD consult placed and the other five had two consults placed during the review period, resulting in a total of 15 consults examined. Of the 15 consults, 13 were referrals to the Bonham DOM SUD and two were referrals to the Dallas DOM SUD. Seven consults were closed when the patient was admitted within 30 days, declined screening, or was not approved for admission. Among the eight remaining consults, two were closed when the patients declined admission and six resulted in patients waiting an average of 79 days before VA North Texas staff offered DOM SUD admission or removed the patient from the pending bed placement list. For seven of the eight consults, staff documented that the "anticipated admission date exceeds 30 days; however, there is no available alternative to consider at this time."

The OIG determined that the VA North Texas chief for Patient Administration Services, who oversees community care, misinterpreted community care guidance and provided inaccurate information to VA North Texas leaders and staff. Specifically, the Office of Community Care's guidance states that community care wait time standards were not applicable to MH RRTP. Facility staff should have instead followed VHA policy requiring a patient with a schedule wait time of greater than 30 days be offered alternative residential treatment or another level of care. Alternative residential treatment could include a referral to a community program, another program in the VISN, or another program in another VISN.[8]

However, the Patient Administration Services chief told the OIG team during the review that MH RRTPs are "excluded from the MISSION Act" and not eligible for community care based on access standards—reflecting an inaccurate understanding of the Act. In contrast, the national director of the MH RRTP reported that although drive time and wait time standards do not apply to DOM SUDs, community care referrals are expected when a patient is determined to require a residential level of care and VHA is unable to provide treatment within the required timeframe.

In September 2020, the MH RRTP national program office released guidance that included instructions for community care referrals. In February 2021, VHA provided guidance that VISN chief mental health officers and facility leaders must ensure that patients who require a residential level of care are offered a

[8] VHA Directive 1162.02.

VA MH RRTP bed or community residential care. VHA further required that each facility provide the operational status of MH RRTP beds and "information on the availability of community based residential treatment options."[9] VISN 17's response to the February 2021 guidance indicated that the Dallas and Bonham DOM SUDs were not making community residential care referrals.

In December 2021, the OIG informed VISN 17 and VA North Texas leaders of staff's failure to comply with community residential care referral expectations and requested corrective action be taken to address staff education and potential patient treatment needs. VA North Texas leaders communicated referral requirements to Office of Community Care and Mental Health Services staff and reviewed all community residential care consults placed from October 1, 2019, through November 30, 2021. Additionally, in response to the OIG's request, VA North Texas staff completed a clinical review to ensure appropriate follow-up for patients referred from October 1, 2019, through December 31, 2021, to the Dallas and Bonham DOM SUDs whose wait times were greater than 30 days.

The OIG made a total of five recommendations in this report.[10] The first recommendation is for the VA North Texas director to ensure that staff provide alternative treatment options, including community care when MH RRTP admission wait times exceed 30 days. The second recommendation calls on the director to conduct a comprehensive review of the management of community residential care referrals. They concurred in principle with this recommendation. The remaining three recommendations are described below.

VA Central Texas Compliance

In contrast to the VA North Texas's failures, the OIG's review of two patients referred to the Temple DOM SUD by VA North Texas staff indicated the VA Central Texas staff placed consults and scheduled patients in accordance with VHA policy. Further, VA Central Texas developed procedures for community residential care referrals when MH RRTP wait times were greater than 30 days.

Inadequate VISN Oversight

The OIG determined that VISN 17 leaders did not ensure VA North Texas leaders' adherence to the national MH RRTP policy. According to the MH RRTP directive, each VISN mental health lead is responsible for ensuring that all VISN MH RRTPs collect data sufficient for oversight related to VHA policy implementation.[11] Additionally, the national director of the MH RRTP confirmed the VISN has oversight responsibility to ensure eligible patients have access to a residential level of care, although

[9] VHA Assistant Under Secretary for Health for Clinical Services memorandum.

[10] The OIG considers all five recommendations currently open pending the submission of sufficient documentation that would support that adequate progress has been made on implementation to close them. The OIG requests updates on the status of all open recommendations every 90 days, which are then reflected on the recommendations dashboard found on the OIG website. For this report, the OIG will request the first update on or about May 1, 2023.

[11] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, July 15, 2019.

there are not defined expectations related to community care utilization monitoring. The VISN 17 chief mental health officer provided guidance to VA North Texas leaders on three occasions in 2021 regarding the use of community residential care. However, she reported that the VISN role did not have the authority to ensure policy adherence or "direct oversight" because "oversight is at the local facility management level." The third report recommendation is for the under secretary for health to make certain that VISN leaders provide adequate oversight to ensure that access to care for MH RRTPs is provided consistent with VHA policy.

Bonham MH RRTP Nonadherence with VHA Scheduling Requirements

During the inspection, the OIG team also identified that the Bonham MH RRTP standard operating procedure was inconsistent with VHA's minimum scheduling effort requirements, as it instructed schedulers to close a consult after three failed scheduling contact attempts rather than the four required. Since 2016, VHA has required providers to document a request for other services in the referred patient's electronic health record. The second attempt must use a different method of contact and can be completed the same day as the first attempt, while the third and fourth attempts must be on different days. To allow the patient time to respond, staff must wait a minimum of 14 calendar days from the second contact attempt before determining the action on the consult request, such as closing the consult. Additionally, the Bonham MH RRTP staff were attempting to contact patients by phone and not using other modes of contact. Failure to adhere to VHA minimum scheduling requirements may hinder efficient patient scheduling and contribute to the barriers patients experience in accessing DOM SUD services. The fourth recommendation is for the VA North Texas director to ensure that Bonham MH RRTP scheduling procedures are consistent with VHA minimum scheduling effort requirements.

Mental Health Treatment Coordinator Assignment

Finally, the OIG found that VA North Texas policy did not include information about the requirement for MH RRTP staff to assign a mental health treatment coordinator for patients awaiting admission to a residential program. Since 2012, VHA has required facility staff to assign a mental health treatment coordinator to patients who are receiving treatment in an outpatient mental health setting, have been admitted to an inpatient mental health setting, or are "waiting to engage in a different level of care" including an MH RRTP bed. However, in an interview, the national director for the MH RRTP acknowledged not having an assignment process for patients pending MH RRTP admission. This failure to develop a national-level process likely contributed to the VA North Texas MH RRTP leaders' lack of knowledge that the VA North Texas policy should address the identification and assignment of a mental health treatment coordinator for accepted patients awaiting admission. This lack of policy awareness may not only contribute to a coordinator not being assigned but can also diminish the likelihood of patients' engagement in outpatient care while awaiting admission. The fifth report recommendation relates to strengthening coordinator assignment procedures for patients waiting for an MH RRTP bed.

OTHER OIG REPORTS CITING CONCERNS WITH COMMUNITY CARE COORDINATION OF VETERANS WITH COMPLEX MENTAL HEALTH NEEDS

Coordinating medical care between the VHA care system and community providers remains a challenge, particularly for managing patients with complex mental health needs. The OIG has identified persistent administrative and communication errors or failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These deficiencies challenge the considerable efforts of VHA personnel to ensure a seamless experience for veterans. Many OIG reports have described the frustrations and, most importantly, the risks associated with patients referred to the community. The following reports exemplify the consequences that poor care coordination contributes to for high-risk patients.

In a report on the deficiencies found in the care and administrative processes for a patient who died by suicide, the review team found that administrative errors and confusion in the Phoenix VA health care facility's community referral process delayed specialized psychological testing for a veteran. The veteran died by suicide never having received the appropriate testing and resulting targeted treatment.[12]

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the patient's care between the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.[13] In addition, the patient suffered from hyperthyroidism, a condition that can aggravate anxiety. The patient declined a referral to endocrinology at the facility, due to the distance from home, but was never offered a referral to the community.

CONCLUSION

High-quality care demands that patients receive the necessary care provided by qualified clinicians in a timely manner. This is even more critical for individuals deemed to be at high risk due to their mental health and substance use conditions. The pandemic disrupted healthcare delivery in all settings, including addiction treatment, yet at the same time increased the demand for such interventions. VHA will continue to rely on community providers to deliver care when a veteran's needs cannot be met within VA's own facilities. The reports highlighted in this testimony call attention to the risks introduced when that care is not offered and even more concerning, when the care is not coordinated.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

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[12] VA OIG, *Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona*, March 31, 2021.

[13] VA OIG, *Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee*, September 3, 2020.