

GAO Highlights

Highlights of [GAO-15-55](#), a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

In 2013, VA estimated that about 1.5 million veterans required mental health care, including services for MDD. MDD is a debilitating mental illness related to reduced quality of life and productivity, and increased risk for suicide. VA also plays a role in suicide prevention. GAO was asked to review how VA tracks veterans prescribed antidepressants and what suicide data VA uses in its prevention efforts.

This report examines (1) VA's data on veterans with MDD, including those prescribed an antidepressant; (2) the extent that veterans with MDD who are prescribed antidepressants receive recommended care and the extent to which VA monitors such care; and (3) the quality of data VA requires VAMCs to collect on veteran suicides. GAO analyzed VA data, interviewed VA officials, and conducted site visits to six VAMCs selected based on geography and population served. From each of these six VAMCs, GAO also reviewed five randomly selected medical records for veterans diagnosed with MDD and prescribed an antidepressant in 2012, as well as all completed BHAP templates. The results cannot be generalized across VA but provide insights.

What GAO Recommends

GAO recommends that VA identify and address MDD coding discrepancies; implement processes to review data and assess deviations from recommended care; and implement processes to improve completeness, accuracy, and consistency of veteran suicide data. VA concurred with GAO's recommendations and described its plans to implement them.

View [GAO-15-55](#). For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

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VA HEALTH CARE

Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data

What GAO Found

GAO's analysis of Department of Veterans Affairs (VA) data for fiscal years 2009 through 2013 shows that about 10 percent of veterans who received VA health care services were diagnosed with major depressive disorder (MDD). MDD is characterized by depressed mood or loss of interest along with other symptoms for 2 weeks or more that represent a change in the way individuals function from their previous behaviors. Because GAO found diagnostic coding discrepancies in 11 of the 30 veterans' medical records it reviewed from six VA medical centers (VAMC), VA's data may understate the prevalence of MDD among veterans being treated through VA, to the extent that such discrepancies may permeate VA's data. One treatment for MDD is the use of medications such as antidepressants. According to GAO's analysis, 94 percent of veterans diagnosed with MDD were prescribed at least one antidepressant.

VA policy states that antidepressant treatment must be consistent with VA's current clinical practice guideline (CPG); however, GAO's review of 30 veterans' medical records identified deviations from selected MDD CPG recommendations for most veterans reviewed. For example, 26 of the 30 veterans were not assessed using a standardized assessment tool at 4 to 6 weeks after initiation of treatment, as recommended in the CPG. Additionally, 10 veterans did not receive follow up within the time frame recommended in the CPG. GAO found that VA does not have a system-wide process in place to identify and fully assess whether the care provided is consistent with the CPG. As a result, VA does not know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG and whether appropriate actions are taken by VAMCs to mitigate potentially significant risks to veterans.

The demographic and clinical data that VA collects on veteran suicides were not always complete, accurate, or consistent. VA's Behavioral Health Autopsy Program (BHAP) is a quality initiative to improve VA's suicide prevention efforts by identifying information that VA can use to develop policy and procedures to help prevent future suicides. The BHAP templates are a mechanism by which VA collects suicide data from VAMC's review of veteran medical records. GAO's review of 63 BHAP templates at five VAMCs found that 40 of the templates that VAMCs submitted to VA Central Office had incomplete data. Also, GAO found that the BHAP templates VAMCs submitted contained inaccurate data. For example, 6 BHAP templates included a date of death that was incorrect based on information in the veteran's medical record, and 9 BHAP templates included an incorrect number of outpatient VA mental health visits in the last 30 days. Moreover, GAO found that VAMCs submitted inconsistent information because they interpreted VA's guidance on completing the BHAP templates differently. This situation was further exacerbated because BHAP templates prepared by VAMCs are generally not being reviewed at any level within the Department for completeness, accuracy, and consistency. Lack of complete, accurate, and consistent data and poor oversight can inhibit VA's ability to identify, evaluate, and improve ways to better inform its suicide prevention efforts.