



December 2022

# VETERANS HEALTH CARE

## Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services

Accessible Version

# GAO Highlights

Highlights of [GAO-23-105372](#), a report to congressional committees

## Why GAO Did This Study

VHA has seen a significant increase in demand for mental health services and expects that demand to continue to grow. One way VHA meets such demand is by integrating certain mental health services within primary care settings.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 included a provision for GAO to review VHA's integration of primary and mental health services. Among other objectives, this report examines the extent to which facilities have met VHA requirements to integrate mental health care into primary care. It also discusses challenges that have affected such integration and steps VHA has taken to mitigate them.

GAO reviewed VHA documentation and policies on integration efforts and annual survey data from 2011 to 2022. GAO also interviewed VHA officials and providers from nine VHA facilities. These facilities were selected based on geographic location and other factors, such as the percentage of veterans receiving integrated mental health services in fiscal year 2020.

## What GAO Recommends

GAO is recommending that VHA (1) monitor the development and implementation of corrective action plans and (2) evaluate and implement strategies to help mitigate staffing challenges affecting the integration of mental health and primary care services. VA concurred with GAO's recommendations and described steps it has or plans to take to implement them.

View [GAO-23-105372](#). For more information, contact Alyssa M. Hundrup at (202) 512-7114 or [hundrupa@gao.gov](mailto:hundrupa@gao.gov).

December 2022

## VETERANS HEALTH CARE

### Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services

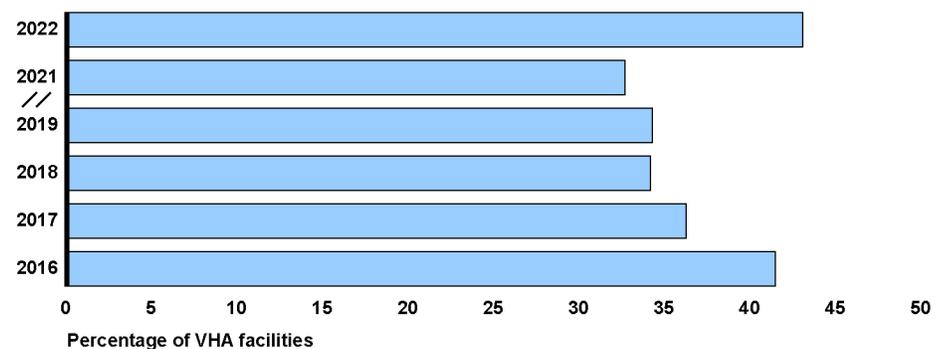
## What GAO Found

The Veterans Health Administration (VHA) requires its medical facilities serving at least 5,000 veterans annually to integrate mental health services into the primary care services they provide. Specifically, facilities are required to have mental health providers, such as psychologists, psychiatrists, and social workers, available within primary care settings to work collaboratively and share responsibility with primary care providers to (1) assess and treat veterans with mental health symptoms and conditions, such as anxiety or depression; and (2) follow up with those veterans to monitor symptoms and adherence to medications, and provide education and referral services.

VHA data show that as of February 2022, about 79 percent of 455 VHA facilities reported they met both requirements, with the remainder meeting one or none of the requirements. VHA officials said that regional networks are responsible for monitoring their facilities' adherence to the requirements and developing corrective action plans. However, VHA does not monitor implementation of corrective action plans. Doing so would ensure facilities are taking appropriate actions to comply. Veterans at those facilities would then have better access to mental health care services in primary care settings, as VHA intends.

VHA facilities reported that persistent staffing challenges have adversely affected their efforts to integrate mental health services into primary care settings from 2016 through February 2022 (see figure).

**Percentage of VHA Facilities That Reported Staffing As Their Most Significant Challenge, 2016 through 2022**



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

**Data table for Percentage of VHA Facilities That Reported Staffing As Their Most Significant Challenge, 2016 through 2022**

	2016	2017	2018	2019	2021	2022
Percent of VHA facilities reporting staffing as the most significant challenge	41.5%	36.3%	34.2%	34.3%	32.7%	43.1%

Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Note: Data were reported in VHA annual surveys. According to VHA officials they did not administer a 2020 annual survey due to the COVID-19 pandemic.

To address staffing challenges, officials from the selected facilities in GAO's review reported taking steps such as offering more flexible work schedules and providing additional technology to reduce workloads. Regional network officials identified several additional strategies that VHA could consider, such as providing additional guidance on recruiting and retaining staff and increasing funding for certain positions. Evaluating and implementing these strategies, and any others as appropriate, may help facilities mitigate staffing challenges. Doing so would help ensure that veterans receive the most appropriate and timely mental health care services available.

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**Abbreviations**

OMHSP	Office of Mental Health and Suicide Prevention
PCMHI	Primary Care Mental Health Integration
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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December 15, 2022

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

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

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) has seen a significant increase in demand for mental health services over time. From 2006 through 2020, the number of veterans who received mental health care from VHA grew by 85 percent—an increase of more than three times the rate for all other VA health care services. Veterans may receive mental health care through a continuum of outpatient and inpatient health care settings depending on the severity of their mental health conditions and other factors. However, the majority of veterans receive such care in an outpatient setting. For example, VHA data indicate that in fiscal year 2021, about 96 percent of the approximately 2 million veterans who received mental health care received it in an outpatient mental health setting.

VHA projects that demand for outpatient mental health services will continue to grow by about 32 percent over the next decade. This growth in demand poses challenges for VHA in providing timely access to mental health services, especially given that it has already faced challenges in meeting veterans' mental health needs due to issues such as staffing shortages and burnout for mental health professionals.<sup>1</sup>

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<sup>1</sup>See Congressional Research Service, *Veterans Health Administration: Behavioral Health Services* (Washington, D.C.: Dec. 3, 2019).

In 2007, VHA began implementing a Primary Care Mental Health Integration (PCMHI) model to integrate care for veterans' physical and mental health conditions, improve access to and quality of care across the spectrum of illness severity, and allow treatment in mental health specialty settings to focus on veterans with more severe mental illnesses.<sup>2</sup> As a part of this implementation, in 2008, VHA began requiring that all VA medical centers and community-based outpatient clinics serving at least 5,000 unique veterans annually (collectively referred to as VHA facilities in this report) meet both of the following two PCMHI requirements:<sup>3</sup>

1. Facilities must offer co-located collaborative care in which dedicated PCMHI providers (e.g., psychologists, psychiatrists, social workers) work directly within primary care settings. The providers are to work collaboratively and share responsibility with primary care providers to assess and treat a variety of mental health symptoms and conditions, such as anxiety or depression.
2. Facilities must offer collaborative care management in which PCMHI collaborative care managers use structured protocols to follow up with veterans diagnosed with mental health conditions to monitor symptoms, adherence to treatment and treatment outcomes, and any side effects of medication. They also provide education and referral management services.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 included a provision for us to review and report

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Staffing shortages are not specific to VHA—the Substance Abuse and Mental Health Services Administration reported, in November 2016, that rural areas have few behavioral health practitioners, and half of U.S. counties have no mental health professionals. See Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Rural Behavioral Health: Telehealth Challenges and Opportunities* (Rockville, Md.: Nov. 2016).

<sup>2</sup>Edward P. Post and William W. Van Stone, "Veterans Health Administration Primary Care Mental Health Integration Initiative," *North Carolina Medical Journal*, vol. 69, no. 1 (2008): 49-52.

<sup>3</sup>Community-based outpatient clinics are stand-alone clinics that are geographically separate from VA medical centers and provide outpatient primary care, mental health care, and, in some cases, specialty care services. These outpatient clinics are administratively assigned to a VA medical center or health care system.

See Department of Veterans Affairs, Veterans Health Administration, Uniform Mental Health Services in VA Medical Centers and Clinics, VHA Handbook 1160.01 (Washington, D.C.: Sept. 11, 2008, amended Nov. 16, 2015).

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on VHA's integration of mental health care into primary care services. In this report we examine

1. the extent to which VHA facilities have met requirements to integrate mental health care into primary care services and examine how VHA monitors adherence to these requirements;
2. VHA's efforts to collect and make available information on the agency's performance in integrating mental health care within primary care settings; and
3. any challenges that have affected VHA's integration of mental health care within primary care settings and examine steps VHA has taken to mitigate them.

To address all three objectives, we reviewed relevant VHA documentation and interviewed and collected information from VHA's Office of Mental Health and Suicide Prevention (OMHSP), which is responsible for monitoring and improving the quality and availability of mental health services, and other relevant VA and VHA program offices. For example, we reviewed OMHSP's annual PCMHI survey results from 2011 through 2022 to determine the extent to which VHA facilities reported meeting PCMHI requirements and challenges related to implementing or sustaining the services over time and results from 2018 through 2022 to determine how these services were provided.<sup>4</sup>

We also interviewed officials and providers who oversee, administer, or help facilitate PCMHI services from a total of nine VHA facilities. These included three VA medical centers and six community-based outpatient clinics (two associated with each of the three VA medical centers). We also reviewed documentation that these VA medical centers provided.<sup>5</sup>

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<sup>4</sup>VHA facilities are required to complete annual surveys to indicate the extent to which they met VHA's requirements to provide co-located collaborative care and collaborative care management services and provide other information on PCMHI implementation efforts from year to year. According to OMHSP officials, these surveys serve as a point-in-time assessment rather than measuring a specific year-to-year fiscal or calendar year period. As such, survey data represent VHA facilities' adherence to the PCMHI requirements as of a certain date each year (e.g., February 1, 2022, for the 2022 annual survey). However, a longitudinal review could provide different results. According to OMHSP officials, since the office began requiring that VHA facilities complete annual surveys in 2011, its reporting period has changed over time. As such, we refer to the year in which the data were collected for each annual survey. According to OMHSP officials, they did not administer an annual survey in 2020 due to the COVID-19 pandemic.

<sup>5</sup>VHA provides enrolled veterans with a full range of inpatient and outpatient services through VA medical centers, which typically provide primary care and some specialty care services, and their affiliated community-based outpatient clinics.

Among other factors, we selected these facilities for geographic variation as they are located in three different Veterans Integrated Service Networks (VISN). These networks are responsible for managing and overseeing day-to-day functions of VA medical centers and other VHA facilities within their defined regional geographic areas. Information and perspectives we obtained from individuals from the nine facilities in our review cannot be generalized, but rather provide illustrative examples of local efforts to implement and sustain PCMHI programs. In addition, we reviewed research articles related to VHA's PCMHI integration efforts and outcomes. These research articles were either provided by OMHSP or identified through our search in research databases for articles published from January 2007 to December 2021. We also interviewed six VHA researchers who have published studies on VHA's PCMHI integration efforts and outcomes. In addition, we obtained the perspectives of the chief mental health officers from each of the 18 VISNs to determine how they oversee PCMHI programs within their regions.

To describe the extent to which VHA facilities have met VHA's requirements to integrate mental health care into primary care services and examine how they monitor adherence to them, we reviewed annual PCMHI survey data from 2011 through 2022. We also reviewed documentation related to integration requirements and interviewed VHA officials to assess their monitoring efforts against VHA policies and federal internal control standards related to monitoring.<sup>6</sup>

To describe VHA's efforts to collect and make information available on the agency's performance in integrating mental health care within primary care settings, we reviewed OMHSP's 2022 annual survey results. We also reviewed three PCMHI related performance measures that are derived from VHA's clinical data to identify potential changes in trends over time at the national, regional, and individual facility level.<sup>7</sup> In addition, we interviewed VISN and VA medical center officials to determine the

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<sup>6</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

<sup>7</sup>The three PCMHI performance measures are captured in either VHA's Strategic Analytics for Improvement and Learning system or VHA's Corporate Data Warehouse. VHA publishes data in the Strategic Analytics for Improvement and Learning system on a quarterly basis about each VHA facility. Each facility in turn can compare its performance with other facilities, and those staff with medical record-level access can view information on patients with a particular medical condition. VHA's Corporate Data Warehouse is a database that stores and makes accessible up-to-date data from VHA's electronic health record and other VA systems. In this report, we refer to these data sources collectively as "clinical data."

extent to which they reported using these data to implement quality improvement efforts on a local level.

To describe challenges that have affected VHA's integration of mental health care within primary care settings and examine steps it has taken to mitigate them, we reviewed OMHSP's annual PCMHI survey data from 2016 through 2022 to identify challenges VHA facilities reported over time. We also interviewed both VA medical center officials and OMHSP officials to determine steps VHA has taken on a facility and national level to mitigate them. In addition, we reviewed VHA documentation related to recommended staffing levels and our prior work that identifies key practices for strategic human capital management.<sup>8</sup>

For all data sources, we interviewed VHA officials and reviewed relevant documentation about how the data were collected and used. We assessed the reliability of these data in several ways, including conducting checks for missing or erroneous data and interviewing VHA officials knowledgeable about the data's reliability. Based on these activities, we determined that the data we used were sufficiently reliable for our audit objectives. See appendix I for additional details on our objectives, scope, and methodology.

We conducted this performance audit from August 2021 to December 2022 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 findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>8</sup>Department of Veterans Affairs, Veterans Health Administration, *Productivity and Staffing in Clinical Encounters for Mental Health Providers*, VHA Directive 1161 (Washington, D.C.: Apr. 28, 2020).

See GAO, *A Model of Strategic Human Capital Management*, [GAO-02-373SP](#) (Washington, D.C.: Mar. 2002).

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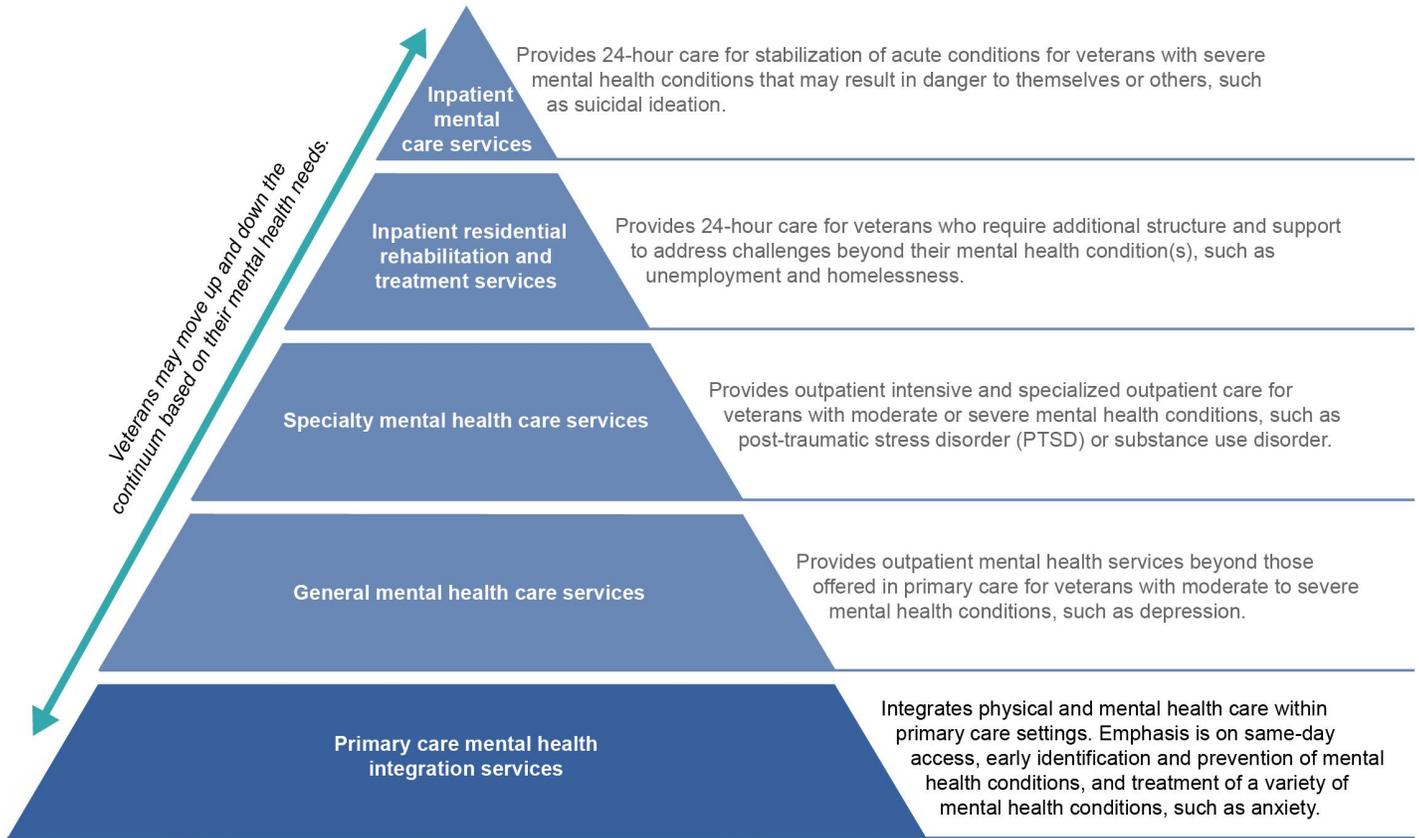
## Background

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### VHA Continuum of Mental Health Care Services

VHA policy states that veterans are entitled to timely access to mental health care services wherever they obtain care in VHA's healthcare system. Depending on the severity and complexity of their mental health conditions, preferences, and other factors, veterans can receive mental health care through a continuum of mental health care services. This continuum is based on five levels of care, with each level increasing in intensity of services. The least intensive level is care provided within the primary care setting, and the most intensive level is inpatient mental health care. (See figure 1.) VHA aims to treat veterans at the lowest appropriate intensity of care, while preserving more intensive mental health services for those who need them. However, veterans who receive mental health care may move up or down levels depending on their needs.

**Figure 1: Veterans Health Administration Continuum of Mental Health Care Services**



Source: GAO summary of Veterans Health Administration documents. | GAO-23-105372

**Text of Figure 1: Veterans Health Administration Continuum of Mental Health Care Services**

Arrow	Triangle pieces	Text on right
Veterans may move up and down the continuum based on their mental health needs	Inpatient mental health programs	Provides 24-hour care for stabilization of acute conditions for veterans with severe mental health conditions that may result in danger to themselves or others, such as suicidal ideation.
	Inpatient residential rehabilitation and treatment programs	Provides 24-hour care for veterans who require additional structure and support to address challenges beyond their mental health condition(s), such as unemployment and homelessness.

Arrow	Triangle pieces	Text on right
	Specialty mental health programs	Provides outpatient intensive and specialized outpatient care for veterans with moderate or severe mental health conditions, such as post-traumatic stress disorder (PTSD) or substance use disorder.
	General mental health care	Provides outpatient mental health services beyond those offered in primary care for veterans with moderate to severe mental health conditions, such as depression.
	Primary care mental health integration services	Integrates physical and mental health care within primary care settings. Emphasis is on same-day access, early identification and prevention of mental health conditions, and treatment of a variety of mental health conditions, such as anxiety.

Source: GAO analysis of Veterans Health Administration documents. | GAO-23-105372

## PCMHI Model of Care

VHA research has shown that integrating the PCMHI model of care within primary care settings is beneficial in detecting patients with mental health concerns early on and providing timely care.<sup>9</sup> VHA research also shows that by offering same-day access to co-located collaborative mental health care within Patient-Aligned Care Teams, veterans may be more likely to be receptive to services when they fall on the same day as their primary care appointment.<sup>10</sup> In addition, according to VHA, providing PCMHI services also helps reduce the stigma of seeking care for mental health conditions, improves patient satisfaction, and preserves access to

<sup>9</sup>See, for example, Kipling M. Bohnert et al., “Same-day Integrated Mental Health Care and PTSD Diagnosis and Treatment among VHA Primary Care Patients with Positive PTSD Screens,” *Psychiatric Services In Advance*, vol. 67, no.1 (2016): 94-100 and Brittany L. Cornwell et al., “Treatment Initiation Following Positive Depression Screens in Primary Care: A Propensity Score–Weighted Analysis of Integrated Mental Health Services,” *Journal of General Internal Medicine*, vol. 36, no. 2 (2021): 561-563.

<sup>10</sup>Cornwell et al., “Treatment Initiation Following Positive Depression Screens in Primary Care,” 563 and Kipling M. Bohnert et al., “Continuation of Care Following an Initial Primary Care Visit with a Mental Health Diagnosis: Differences by Receipt of VHA Primary Care Mental Health Integration Services,” *General Hospital Psychiatry*, vol. 35, no.1 (2013): 66-70.

Each veteran enrolled in VHA care is assigned to a Patient-Aligned Care Team that consists of a primary care provider, nurse care manager, clinical associate, and administrative clerk who work collaboratively to provide the veteran with health care services. Patient-Aligned Care Teams can also consist of other types of providers, such as PCMHI providers, as needed.

more intensive and specialized mental health care services for those veterans who need them.

According to VHA, the delivery of PCMHI services in the primary care setting differs significantly from other outpatient mental health services. For example, within general and specialty mental health programs, veterans typically schedule appointments in advance and see mental health providers outside of their primary care setting. However, PCMHI appointments are intended to be available on the same day as primary care appointments and are structured so that veterans view the meeting with a PCMHI provider as a routine primary care service, rather than a separate consult with a mental health provider.

According to OMHSP, the number of PCMHI providers that it recommends each VHA facility have to provide these services depends on the total number of veterans treated in that facility's primary care setting. Specifically, OMHSP recommends that each VHA facility have a clinical staffing ratio of 0.67 full-time equivalent PCMHI providers for every 1,200 veterans served in a primary care setting. Co-located collaborative care is provided in person or virtually, whereas collaborative care management is typically conducted by telephone, according to VHA. Depending on the facilities' structure and staffing of PCMHI programs, collaborative care management follow-up services may be performed by the same or different PCMHI providers who provided the initial co-located collaborative care.

In addition, so that PCMHI providers remain available for same-day appointments, the model is not designed to provide extended mental health care services. Specifically, PCMHI appointments are generally limited to one to six per veteran and are intended to be more brief (i.e., 20-30 minutes) than traditional mental health appointments, which generally last 50-60 minutes. Furthermore, general and specialty mental health providers normally have set scheduled appointments whereas PCMHI providers providing co-located collaborative care operate on a schedule that allows for same-day access. For example, PCMHI providers might have full open access in which patients are seen on a first-come-first-serve basis, or a schedule that alternates between scheduled and unscheduled 30-minute appointments. Multiple PCMHI providers may also share one open access pager that primary care providers can call for an immediate warm hand-off. This is a process for providing same-day access where a primary care provider directly introduces or "hands-off" a veteran to a PCMHI provider.

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A PCMHI provider with prescription privileges may provide consultation to a primary care provider to initiate or adjust mental health medications. A PCMHI provider may also initiate mental health medications in collaboration with a primary care provider, who will address medication renewals once the veteran is stabilized. The referring primary care provider would ultimately oversee the plan of care for the patient. If the veteran does not stabilize and requires additional care, PCMHI providers may also help with referrals to additional mental health services.

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## VHA Resources Supporting PCMHI Implementation

VHA's OMHSP is responsible for monitoring and improving the quality and availability of mental health services and programs across the agency's health care system, including PCMHI. OMHSP and other VHA program offices provide training and offer several resources, education and consultation services, and materials to support the model's implementation and address challenges or other factors. These include the following:

- **Required training.** OMHSP developed and leads a national PCMHI Ongoing Competency Training for PCMHI providers that focuses on providing the skills to maintain fidelity with the model and promote same-day access by keeping appointments with veterans to 30 minutes or less. In 2017, VA began requiring that all PCMHI providers complete this one-time training either as part of the initial national rollout or within one year of being hired.<sup>11</sup>
- **Community of practice calls.** OMHSP hosts four community of practice calls for PCMHI leaders, providers, trainers, and others that focus on different content (such as leadership, education, and training issues). According to OMHSP officials, these calls give PCMHI providers and leaders from VHA facilities a forum to discuss implementation issues, ask questions, and share best practices across locations.
- **Technical assistance.** OMHSP offers program support and technical assistance for PCMHI issues to VHA facilities that request it. Specifically, OMHSP officials told us that they provide technical consultation on a range of PCMHI related topics and also monitor implementation efforts by tracking performance metrics and other

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<sup>11</sup>PCMHI providers are also required to complete annual PCMHI continuing education activities such as completing and reviewing an annual self-assessment survey and reviewing annual PCMHI updates provided by OMHSP's Center for Integrated Healthcare.

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data. OMHSP offers multiple PCMHI self-help resources on its website and intranet and more intensive types of support and consultation services to specific facilities on a wide range of issues, such as how to promote same-day access and advice on what kinds of interventions should be provided.

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## Most VHA Facilities Have Met Integration Requirements, but OMHSP Does Not Monitor Corrective Actions at Facilities That Do Not

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### About 79 Percent of VHA Facilities Reported Meeting VHA's Requirements to Integrate Mental Health and Primary Care as of February 2022

According to VHA's 2022 annual PCMHI survey results, about 79 percent of its facilities reported having implemented the two PCMHI requirements.<sup>12</sup> (See figure 2.) Because only VHA facilities that serve at least 5,000 veterans annually have these two requirements, the number of facilities subject to meeting them can vary from year to year.<sup>13</sup> However, the percentage of facilities that reported meeting both requirements generally remained consistent or increased from 2011 through 2022.<sup>14</sup>

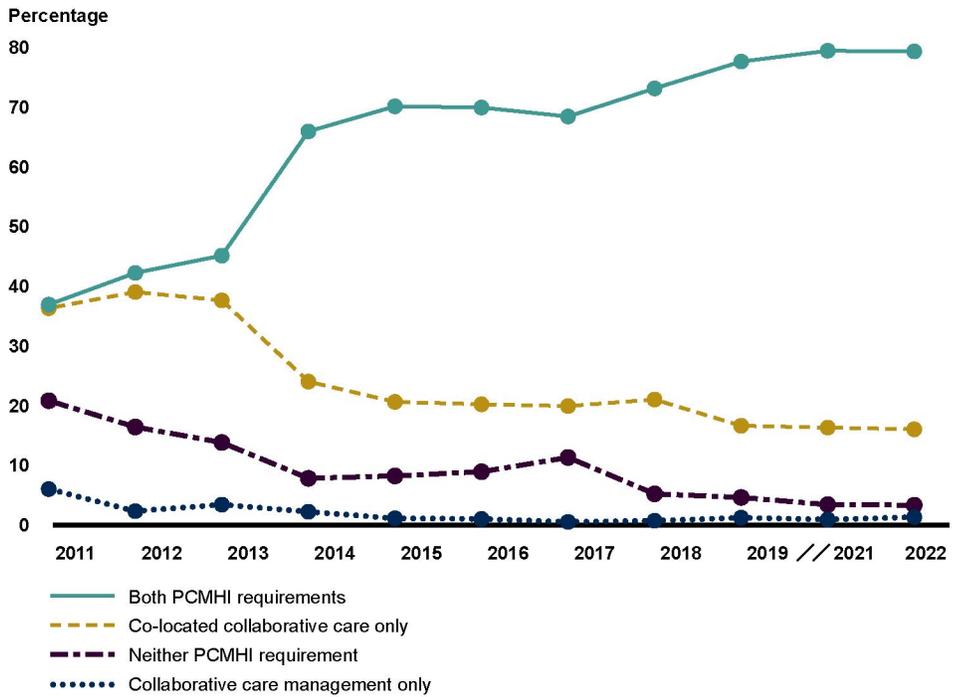
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<sup>12</sup>VHA requires that facilities serving at least 5,000 veterans annually have mental health providers embedded within the primary care setting to treat a variety of mental health symptoms and conditions, provide follow-up with those veterans to monitor symptoms and treatment, and provide education and referral services. See Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1160.01.

<sup>13</sup>For example, in 2011, 336 VHA facilities were required to have both co-located collaborative care and collaborative care management. That number increased every year over the following decade and as of the 2022 annual survey, had increased to 455 VHA facilities.

<sup>14</sup>According to OMHSP officials, they did not administer an annual survey in 2020 due to the COVID-19 pandemic. PCMHI surveys serve as a point-in-time assessment that captures services that VHA facilities provide as of a certain date. For example, the date for the 2022 annual survey was February 1, 2022.

**Figure 2: VHA Facilities' Reported Implementation of Primary Care Mental Health Integration (PCMHI) Requirements, 2011-2022**



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

**Data table for Figure 2: VHA Facilities' Reported Implementation of Primary Care Mental Health Integration (PCMHI) Requirements, 2011-2022**

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Both PCMHI requirements	36.9%	42.2%	45.1%	65.9%	70.1%	69.9%	68.4%	73.1%	77.6%	N/A	79.4%	79.3%
Co-located collaborative care only	36.3%	39.0%	37.6%	24.0%	20.6%	20.2%	19.9%	21.0%	16.6%	N/A	16.3%	16.0%
Collaborative care management only	6.0%	2.3%	3.4%	2.2%	1.1%	1.0%	0.5%	0.7%	1.2%	N/A	0.9%	1.3%
Neither PCMHI requirement	20.8%	16.4%	13.8%	7.8%	8.2%	8.9%	11.3%	5.2%	4.6%	N/A	3.4%	3.3%

GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Notes: VHA facilities serving at least 5,000 unique veterans annually are required to provide both co-located collaborative care and collaborative care management. For co-located collaborative care, facilities must make mental health providers available within primary care settings to assess and treat veterans with mental health symptoms and conditions. For collaborative care management, facilities must follow up with those veterans to monitor symptoms and adherence to and any side effects of

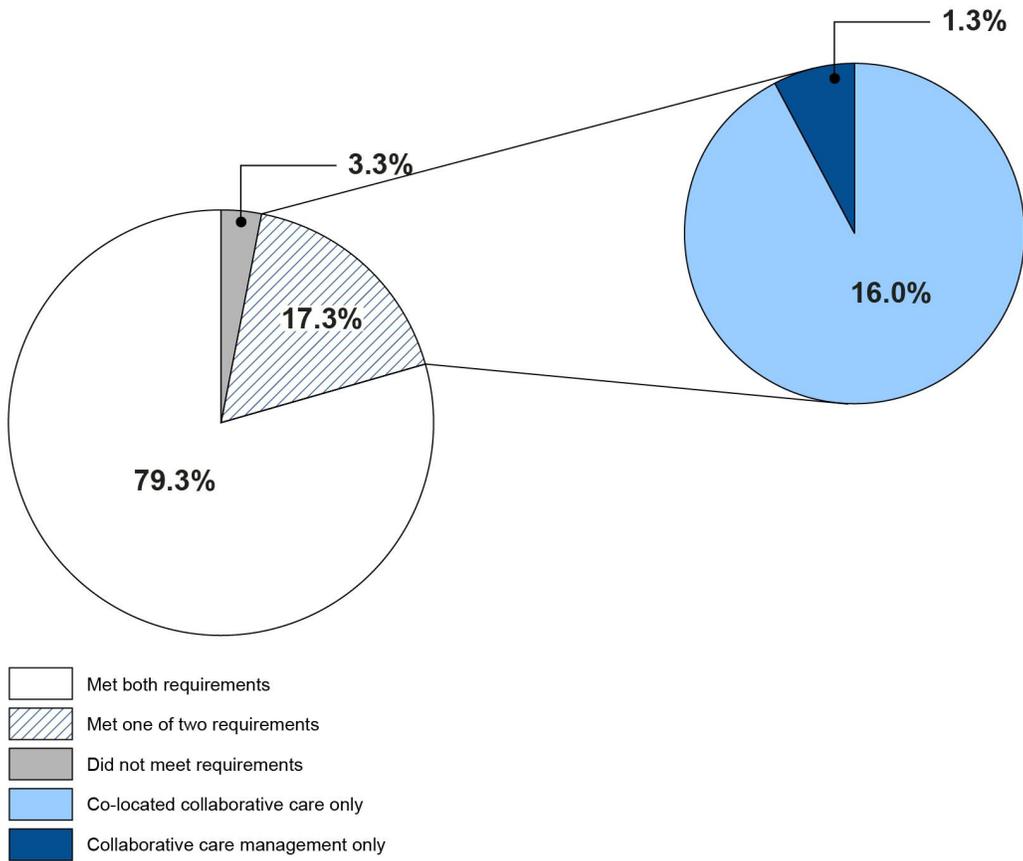
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medication and provide education and referral services. The number of VHA facilities required to provide these PCMHI services may vary depending on whether they serve at least 5,000 unique veterans annually. For example, in 2011, 336 facilities were required to have both co-located collaborative care and collaborative care management. That number increased every year over the following decade and as of the 2022 annual survey, had increased to 455 facilities.

According to VHA's Office of Mental Health and Suicide Prevention (OMHSP) officials, certain VHA facilities have been required to complete an annual PCMHI survey since 2011. However, they did not administer the 2020 annual survey because of the COVID-19 pandemic. According to OMHSP, these surveys serve as a point-in-time assessment that captures services that VHA facilities provide as of a certain date. For example, the date for the 2022 annual survey was February 1, 2022.

Of the VHA facilities that reported providing one of the two PCMHI requirements in the 2022 annual survey, more facilities reported providing co-located collaborative care by embedding PCMHI providers in the primary care setting. Specifically, of the 455 facilities required to provide PCMHI services, approximately 17 percent (79 facilities) reported having only one of the requirements, 16 percent (73 facilities) reported implementing co-located collaborative care only, and about 1 percent (6 facilities) reported only implementing collaborative care management. (See figure 3.)

**Figure 3: VHA Facilities' Reported Implementation of Primary Care Mental Health Integration (PCMHI) Requirements in 2022**



Source: Veterans Health Administration (VHA) data. | GAO-23-105372

**Data table for Figure 3: VHA Facilities' Reported Implementation of Primary Care Mental Health Integration (PCMHI) Requirements in 2022**

	Percentage
Met both requirements	79.3
Met one of two requirements	17.3
Did not meet requirements	3.3
Co-located collaborative care only	16
Collaborative care management only	1.3

GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Notes: Percentages do not add to 100 due to rounding. VHA facilities serving at least 5,000 unique veterans annually are required to provide both co-located collaborative care and collaborative care management. For co-located collaborative care, facilities must make mental health providers available within primary care settings to assess and treat veterans with mental health symptoms and conditions. For collaborative care management, facilities must follow up with those veterans to monitor symptoms and adherence to and any side effects of medication and provide education and

referral services. The number of VHA facilities required to provide these PCMHI services may vary depending on whether they serve at least 5,000 unique veterans annually. For example, in 2011, 336 facilities were required to have both co-located collaborative care and collaborative care management. That number increased every year over the following decade and as of the 2022 annual survey, had increased to 455 facilities.

According to VHA's Office of Mental Health and Suicide Prevention, PCMHI surveys serve as a point-in-time assessment that captures services that VHA facilities provide as of a certain date. The date for the 2022 annual survey was February 1, 2022.

According to OMHSP officials and VHA researchers, the absence of one or both PCMHI requirements may contribute to inefficiencies in the delivery of care through the model. For example, according to three VHA researchers, in the absence of co-located collaborative care, veterans are less likely to receive same-day access to mental health services.<sup>15</sup> In addition, these researchers said that when PCMHI providers are not co-located within the primary care setting, other primary care providers who screen for common mental health conditions may be less aware of PCMHI and therefore less likely to refer veterans to its services. They noted that veterans receiving mental health care in a PCMHI program without collaborative care management may not receive adequate follow-up and may be less likely to adhere to treatment protocols. Furthermore, VHA officials told us that the absence of collaborative care management can diminish the ability of co-located collaborative care providers to meet same-day demand if those providers have to conduct the follow-up services typically provided by collaborative care managers.

VHA officials and some VA medical center officials we spoke with said that they are working to help support the implementation of both PCMHI requirements. For example, one VHA researcher and PCMHI providers from three VA medical centers said that to help bolster co-located collaborative care, PCMHI providers across VHA facilities develop and maintain relationships with primary care providers and encourage referrals to PCMHI. In addition, VHA officials told us that they continue to emphasize collaborative care management as part of the training that all PCMHI providers are required to complete within one year of their hire. However, VHA officials said that for the training to be effective, VHA facilities must first have sufficient collaborative care management staffing levels to provide those services. They said that VHA also provides

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<sup>15</sup>These VHA researchers have co-authored at least one research article related to VHA's PCMHI integration efforts and outcomes. See, for example, Lucinda B. Leung, et al., "Association of Integrated Mental Health Services with Physical Health Quality among VA Primary Care Patients," *Journal of General Internal Medicine*, vol. 37, no. 13 (2022): 3331-3337 and Brittany L. Cornwell et al., "Impact of the COVID-19 Pandemic on Primary Care Mental Health Integration Services in the VA Health System," *Psychiatric Services*, vol. 72, no. 8 (2021): 972-973.

guidance and assistance on implementing collaborative care management to facilities because research indicates that providing collaborative care management makes a facility's PCMHI program more successful.<sup>16</sup>

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### VHA Collects Information on the Extent to Which Facilities Reported Meeting Integration Requirements, but Does Not Monitor Implementation of Corrective Action Plans

OMHSP collects information on the extent to which VHA facilities meet PCMHI requirements through its annual survey. OMHSP officials reported they then use survey information to provide each VISN with an annual report of the responses specific to its facilities, as well as a summary of PCMHI implementation on a national level. These VISN-specific reports include information on the extent to which the facilities met VHA's PCMHI requirements and any changes in survey results from the previous year. In addition, the reports provide contact information for VHA program offices that are available to provide technical assistance to support implementation.

According to OMHSP officials, the annual reports do not include specific guidance or recommendations on how to remedy any deficiencies or improve adherence. The officials explained that each VISN is responsible for monitoring and overseeing their facilities' adherence to PCMHI requirements. However, OMHSP officials reported that VISN officials may use annual PCMHI survey results, including national and VISN-specific summaries, to help with these efforts. All 18 VISN chief mental health officers stated that they find the summaries about annual survey results useful, but reported taking different actions or approaches based on their review. For example, some reported developing corrective action plans and others providing enhanced support to specific facilities to help them meet one or both of the requirements the following year. Specifically, the VISN chief mental health officers reported the following:

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<sup>16</sup>For research regarding collaborative care management services, see, for example, Brittany L. Cornwell et al., "Primary Care Mental Health Integration in the Veterans Affairs Health System: Program Characteristics and Performance," *Psychiatric Services*, vol. 69, no. 6 (2018): 696-702 and David W. Oslin et al., "A Randomized Clinical Trial of Alcohol Care Management Delivered in Department of Veterans Affairs Primary Care Clinics Versus Specialty Addiction Treatment," *Journal of General Internal Medicine*, vol. 29, no. 1 (2014):162-168.

- **Corrective action plans.** Eight of the 18 VISN chief mental health officers reported they have required from facilities in their regions that have not met one or both of the requirements some type of corrective action plan, which they said they developed in collaboration with their facilities. For example, three officers reported they required facilities not meeting one or both of the requirements to outline steps for improvement or develop a timeline so that progress could be reviewed on a recurrent basis. One of these officers said that such steps have included developing standard operating procedures for collaborative care management and requesting additional PCMHI staff.

One chief mental health officer reported that the VISN allowed facility leadership to present its proposed action plan and to make changes based on initial feedback from the leadership on that proposed action plan to solidify facility-level efforts. Further, two VISN chief mental health officers reported that they shared their facilities' action plans with other facilities in their region to share implementation strategies.

- **Facility-level PCMHI support.** The remaining 10 VISN chief mental health officers reported that they offer various types of support to facilities that do not meet PCMHI requirements. For example, four officers reported that they offer facilities PCMHI consultations, and two officers reported meeting with their facility's leadership to discuss and mitigate identified barriers in providing services. Two VISN chief mental health officers reported that they have supported additional training efforts at non-adherent facilities to increase fidelity to the PCMHI model of care. Furthermore, five chief mental health officers reported dissemination of best practices to facilities to encourage adherence to the requirements.

In July 2022, VHA sent VISN officials the results of the 2022 annual survey. At that time, it also notified them that OMHSP planned to follow up with VISN chief mental health officers regarding implementation status and the development of action plans for those facilities that did not meet one or both of the requirements. According to VA, as of November 2022, OMHSP was in the process of developing a checklist to document what a facility needs to meet PCMHI requirements. They said this will provide VISNs additional means by which to conduct their annual assessments and develop their specific action planning steps to address any areas of noncompliance.

According to VHA policy, OMHSP is responsible for working with entities (like other headquarters-based program offices) and periodically assessing or monitoring VISNs to ensure that noncompliance with VHA

requirements is remedied.<sup>17</sup> VHA policy also states that program offices, such as OMHSP, are responsible for identifying deficiencies and ensuring corrective actions are taken.<sup>18</sup> Through the annual surveys, OMHSP identifies facilities that do not adhere to the requirements.<sup>19</sup> OMHSP officials told us that facilities and VISNs will continue to be responsible for monitoring their VHA facilities' adherence to PCMHI requirements as well as any corrective action plans to address noncompliance. However, OMHSP could help ensure adherence to the PCMHI requirements if it monitored VISNs' development and implementation of corrective action plans. Such actions would align with VHA's policy regarding OMHSP's monitoring function.

Further, in monitoring VISNs' development and implementation of any needed corrective action plans, OMHSP would be better positioned to provide support to them and help ensure they are taking appropriate steps to address any deficiencies. In turn, this would help VISNs and VHA facilities fully implement the PCMHI model of care, ensuring veterans have access to mental health care services in primary care settings, as VHA intends.

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<sup>17</sup>Department of Veterans Affairs, Veterans Health Administration, *VHA Integrity and Compliance Program*, VHA Directive 1030(2) (Washington, D.C.: Dec. 29, 2020).

<sup>18</sup>Department of Veterans Affairs, Veterans Health Administration, *VHA Central Office Operating Units*, VHA Directive 1217 (Washington, D.C.: Sept. 10, 2021).

Monitoring compliance is also consistent with federal standards for internal control, which state that management should evaluate and document deficiencies and determine appropriate remediation actions to help ensure they are completed on a timely basis. [GAO-14-704G](#).

<sup>19</sup>According to a VA notice, any facility or VISN that does not adhere to PCMHI requirements must request a waiver from OMHSP. This provides OMHSP with another way to identify facilities that do not adhere to PCMHI requirements. According to VA, facilities and VISNs that apply for these waivers are responsible for monitoring compliance with corrective action plans and ensuring implementation of them. Department of Veterans Affairs, Veterans Health Administration, *Waivers to VHA National Policy*, VHA Notice 2022-01 (Washington, D.C.: Feb. 10, 2022).

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## VHA Has Efforts to Collect and Make PCMHI Performance Data Available to VISNs and Its Facilities

VHA collects PCMHI-related performance data and makes them available to VISNs and its facilities to help provide information on how well facilities are integrating mental health services into primary care and to identify areas for quality improvements. Such data are collected through two sources—VHA clinical data and OMHSP’s annual surveys.

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### VHA Clinical Data

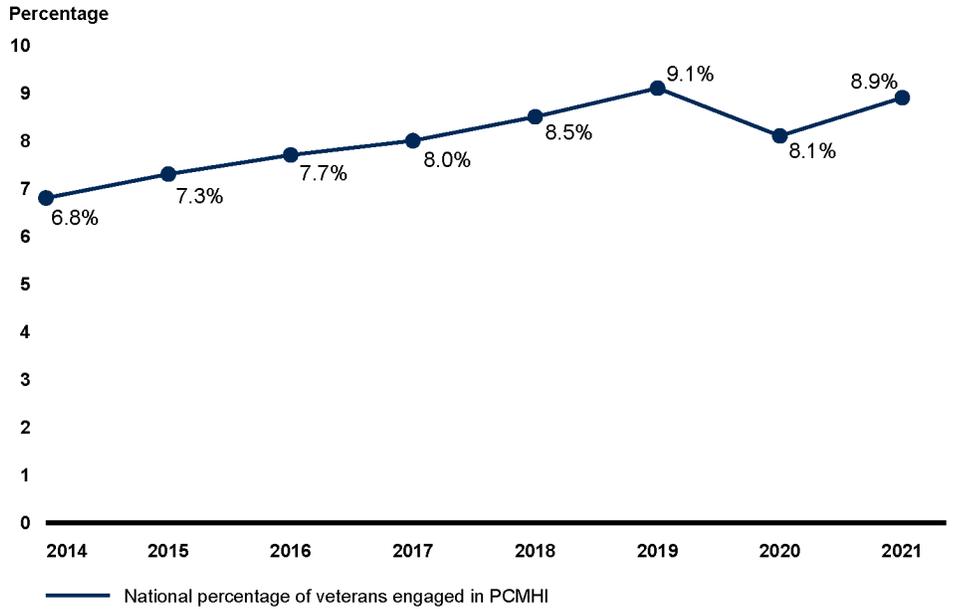
OMHSP officials reported that they collect VHA clinical data on three PCMHI-related performance measures related to veterans’ access to care.<sup>20</sup> These data are made available to VISNs and VHA facilities on a quarterly basis and may be evaluated on a national, network, and facility level.

- **Number of veterans engaged in PCMHI.** To track the extent to which veterans are using PCMHI services, this measure captures the total number of veterans who had a PCMHI encounter within the past 12 months compared with the total number of veterans assigned to primary care. From fiscal years 2014 through 2021, the number of veterans who used PCMHI services either increased slightly from year-to-year or remained relatively stable. (See figure 4.)

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<sup>20</sup>These clinical data are derived from either VHA’s Strategic Analytics for Improvement and Learning system or its Corporate Data Warehouse.

**Figure 4: Percentage of Veterans Engaged in PCMHI in VHA Facilities, Fiscal Years 2014 through 2021**



PCMHI = Primary Care Mental Health Integration  
 Source: Veterans Health Administration (VHA) data. | GAO-23-105372

**Data table for Figure 4: Percentage of Veterans Engaged in PCMHI in VHA Facilities, Fiscal Years 2014 through 2021**

	2014	2015	2016	2017	2018	2019	2020	2021
National percentage of veterans engaged in PCMHI	6.8	7.3	7.7	8	8.5	9.1	8.1	8.9

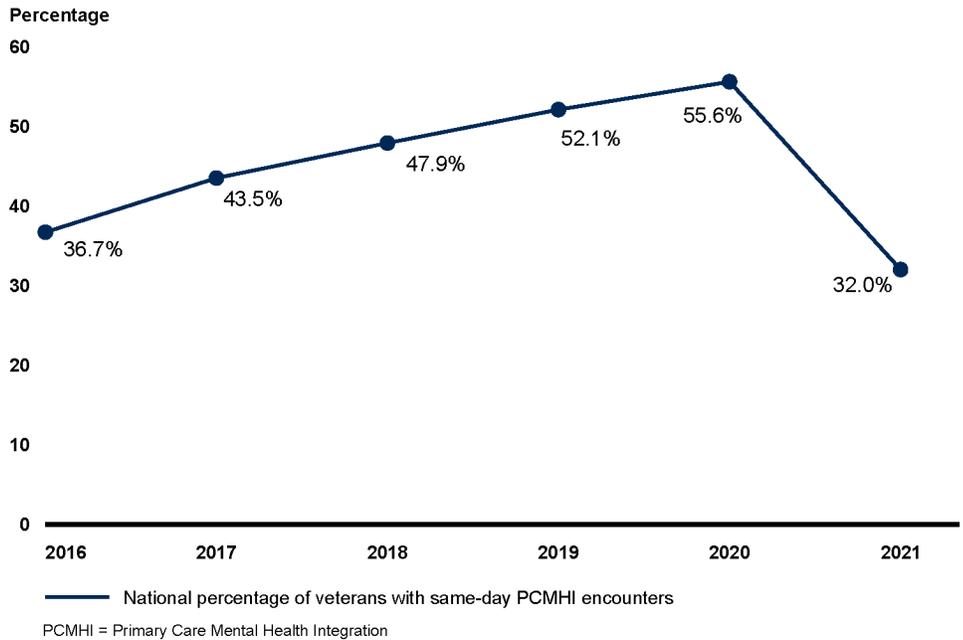
GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Note: This figure reflects national-level information on the percentage of veterans who had a PCMHI encounter within the past 12 months compared with the total number of veterans assigned to primary care.

- PCMHI same-day access for initial care.** This measure captures the percentage of veterans who had a primary care, emergency department or urgent care, or select other non-mental health encounter on the same day as their initial PCMHI encounter. The percentage of veterans for whom this was the case increased from about 37 percent in fiscal year 2016 to about 56 percent in fiscal year 2020. Same-day access declined from about 56 percent to 32 percent between fiscal years 2020 and 2021. OMHSP officials attributed this decrease to a change in the definition of what the measure captures

as a result of, and effects related to, the COVID-19 pandemic.<sup>21</sup> (See figure 5.)

**Figure 5: Percentage of Veterans with Same-day PCMHI Encounters in VHA Facilities, Fiscal Years 2016 through 2021**



Source: Veterans Health Administration (VHA) data. | GAO-23-105372

<sup>21</sup>According to OMHSP, the PCMHI same-day access for initial care measure changed between fiscal years 2020 and 2021. Specifically, for fiscal year 2020, it included only in-person face-to-face and video telehealth encounters at a VHA facility that provided treatment (thereby excluding telephone and other encounters). For fiscal year 2021, the measure was revised to include telephone and other encounters that became more common during the COVID-19 pandemic. According to OMHSP, this expanded what the measure includes and PCMHI teams needed to develop procedures to conduct virtual warm hand-offs. They reported that many VHA facilities had difficulties scheduling same-day virtual encounters as well as encountered other challenges to providing PCMHI services as a result of the pandemic.

**Data table for Figure 5: Percentage of Veterans with Same-day PCMHI Encounters in VHA Facilities, Fiscal Years 2016 through 2021**

	2016	2017	2018	2019	2020	2021
National percentage of veterans with same-day PCMHI encounters	36.7	43.5	47.9	52.1	55.6	32.0

GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Notes: This figure reflects national-level information on the percentage of veterans who had a primary care, emergency department or urgent care, or select other non-mental health encounter on the same day as their initial PCMHI encounter.

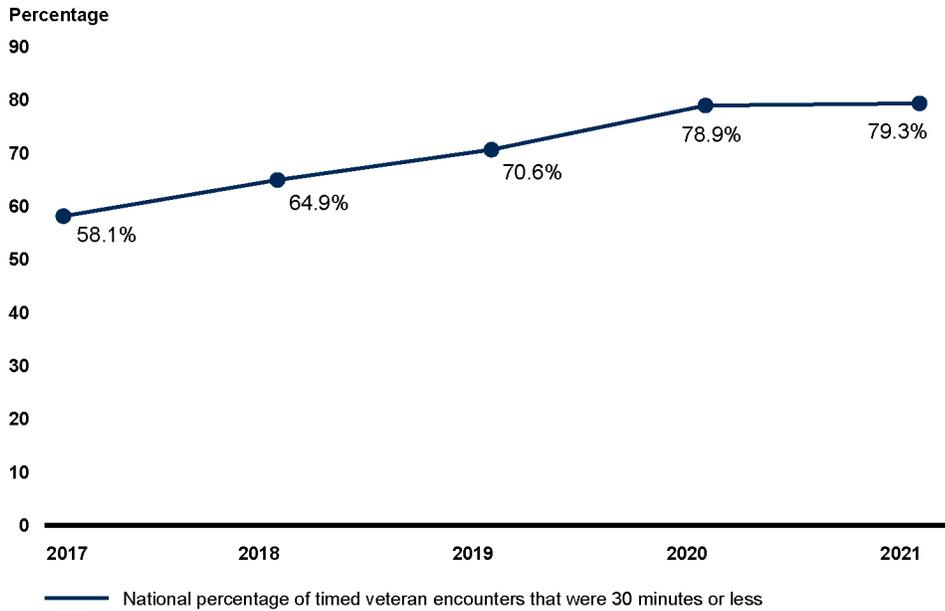
Office of Mental Health and Suicide Prevention (OMHSP) officials attributed the decline in same-day encounters between fiscal years 2020 and 2021 to a change in the type of information captured and effects related to the COVID-19 pandemic. Specifically, for fiscal year 2020, the measure included only in-person, face-to-face, and video telehealth encounters at a VHA facility that provided treatment (thereby excluding telephone and other encounters). For fiscal year 2021, the measure was revised to include telephone and other encounters that became more common during the COVID-19 pandemic. According to OMHSP officials, this expanded what the measure includes, and PCMHI teams needed to develop procedures to conduct virtual warm hand-offs. They reported that many VHA facilities had difficulties scheduling same-day virtual encounters as well as encountered other challenges to providing PCMHI services as a result of the pandemic.

- Percentage of encounters with PCMHI providers that are 30 minutes or less.** This measure tracks the extent to which PCMHI providers who are trained to provide brief, problem focused encounters are maintaining fidelity to the model by keeping encounters brief (i.e., 30 minutes or less).<sup>22</sup> The percentage of encounters lasting 30 minutes or less increased by about 20 percent from fiscal year 2017 through fiscal year 2021. (See figure 6.) OMHSP officials attributed this increase to the implementation of VA’s requirement that all PCMHI providers complete national PCMHI competency training beginning in 2017.<sup>23</sup>

<sup>22</sup>This measure captures all PCMHI encounters that were timed and the percent of those timed encounters that were 30 minutes or less. Although PCMHI encounters are expected to be brief and problem focused, in some situations, longer appointments are necessary and may not be timed. PCMHI encounters that were not timed are excluded from this measure.

<sup>23</sup>According to a July 17, 2017, memorandum from the Deputy Under Secretary for Health for Operations and Management, VHA facilities are required to train all new PCMHI providers on the model of care within one year of their hire. See Department of Veterans Affairs Veterans Health Administration, *Facility PCMHI Lead for Competency Training Rollout*, (Washington, D.C.: July 17, 2017).

**Figure 6: Percentage of PCMH Encounters That Were 30 Minutes or Less in VHA Facilities, Fiscal Years 2017 through 2021**



Source: Veterans Health Administration (VHA) data. | GAO-23-105372

**Data table for Figure 6: Percentage of PCMH Encounters That Were 30 Minutes or Less in VHA Facilities, Fiscal Years 2017 through 2021**

	2016	2017	2018	2019	2020
National percentage of timed veteran encounters that were 30 minutes or less	58.1	64.9	70.6	78.9	79.3

GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Note: This figure reflects national-level information on the percentage of all Primary Care Mental Health Integration (PCMH) encounters that were timed and the percentage of those timed encounters that were 30 minutes or less. Although PCMH encounters are expected to be brief and problem focused, in some situations, longer appointments are necessary and may not be timed. PCMH encounters that were not timed are excluded from this measure.

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## Annual PCMHI Survey Performance Data

OMHSP also collects information from VHA facilities through its annual surveys.<sup>24</sup> OMHSP officials told us that the annual surveys collect and summarize data that are not captured in VHA's clinical data and are intended to provide updates on the extent to which facilities are implementing their PCMHI programs as of a specific date from year-to-year. For example, the 2022 annual survey collected information on the extent to which PCMHI providers were available as of February 1, 2022, for warm hand-offs and how often they included consultation questions or specific requests.

- **PCMHI providers' availability for warm hand-offs.**<sup>25</sup>
  - About 63 percent of VHA facilities reported that their PCMHI providers were available to complete a warm hand-off for every PCMHI encounter;
  - About 27 percent of VHA facilities reported that their PCMHI providers were available to complete a warm hand-off for between 70 and 90 percent of PCMHI encounters;
  - About 6 percent of VHA facilities reported that their PCMHI providers were available to complete a warm hand-off for between 40 and 60 percent of PCMHI encounters; and
  - About 3 percent of VHA facilities reported that their PCMHI providers were available to complete a warm hand-off for between 10 and 30 percent of PCMHI encounters.<sup>26</sup>

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<sup>24</sup>OMHSP officials noted that they review the facilities' responses to each annual survey to identify any potential discrepancies and follow-up with them for any needed clarifications. Those officials told us that common discrepancies include respondent error or conflicting responses.

<sup>25</sup>Warm hand-offs are preferred because research suggests that warm hand-offs increase the likelihood that a veteran will continue to seek mental health treatment.

<sup>26</sup>In the 2022 annual survey, VHA facilities reported that less than 1 percent of their PCMHI providers were not available or they did not know the percent that they were available for warm hand-offs.

- **How often primary care providers included consultation questions or specific requests for warm hand-offs.**<sup>27</sup>
  - VHA facilities reported that primary care providers always included consultation questions or specific requests (e.g., provide depression care management, problem solving training) for about 16 percent of warm hand-offs to PCMHI providers;
  - VHA facilities reported that such information was often included for 41 percent of warm hand-offs;
  - VHA facilities reported that such information was included half of the time for about 14 percent of warm hand-offs;
  - VHA facilities reported that such information was sometimes included for about 26 percent of warm hand-offs; and
  - VHA facilities reported that they either did not know or primary care providers did not include explicit consultation or specific requests for about 3 percent of warm hand-offs.

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## VISNs and VHA Facilities' Use of Performance Data

According to OMHSP officials, PCMHI performance data are intended to help VHA facilities interpret and assess performance measures and examine changes in trends over time. OMHSP officials told us that they have not established specific benchmarks or targets for PCMHI performance. Rather, their focus is to promote higher PCMHI utilization among veterans and increase same-day access to PCMHI services. According to OMHSP officials, one way VISNs and VHA facilities can identify areas for improvement is by reviewing their performance data and comparing them with data from facilities within and outside of their VISNs to identify areas in which they are not performing as well as others. OMHSP officials said VISNs are responsible for overseeing and monitoring PCMHI performance.

Based on information we collected from the 18 VISN chief mental health officers, we found that VISNs generally reported using information from

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<sup>27</sup>VHA officials reported that annual PCMHI surveys collect information on consultation questions and specific requests because it is preferable for providers to include this information when conducting a warm hand-off. Consultation questions and specific requests may include a wide range of topics, depending on the providers' expertise and veteran population. Such examples include questions about the most appropriate level of mental health care, diagnostic clarification, risk assessments, and medication recommendations.

VHA's clinical data and annual PCMHI surveys to assess facilities' performance. For example, 16 VISN chief mental health officers, VA medical center officials, and providers from the three sites in our review told us that they hold regular meetings to discuss PCMHI performance measures.<sup>28</sup> In addition, VISN chief mental health officers and VA medical center officials gave us examples describing how they use these data as part of their efforts to monitor PCMHI and identify and implement quality improvements. This included the following:

- **Identifying and sharing best practices.** Ten VISN chief mental health officers told us that they use PCMHI performance data to identify and share best practices. For example, one VISN chief mental health officer said that he compiles and color codes these data on a spreadsheet to highlight facilities with good to outstanding performance. He may then ask those facilities to provide consultation and best practices for other facilities experiencing PCMHI challenges. Another VISN chief mental health officer said that PCMHI supervisors use annual survey results to share best practices and strategies to implement or improve both co-located collaborative care and care management.
- **Making staffing decisions.** Three VISN chief mental health officers said they have used performance measure data to help increase PCMHI staffing or encourage filling vacant positions.
- **Setting performance goals for facilities.** Officials from two VA medical centers said they review and compare their individual facilities' performance measure data with the national average to set performance goals for their facilities. Specifically, officials from one VA medical center said that if any metric falls below the 50th percentile, they examine possible causes and develop solutions, such as providing additional education for providers, to improve their performance. Officials from another VA medical center said they use the national average for same-day PCMHI encounters as a goal for all of their facilities to meet. In addition, one VISN chief mental health

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<sup>28</sup>An example of regular meetings that VISN and VA medical center officials may hold are community of practice calls. According to a memorandum from the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, in April 2021, VHA began requiring that each VISN establish and conduct a VISN-wide monthly PCMHI community of practice call. According to that memorandum, the purpose of these calls is to ensure critical information reaches front-line PCMHI providers and to provide a forum to discuss quality improvement efforts. See Department of Veterans Affairs Veterans Health Administration, *Primary Care Mental Health Integration (PCMHI) Ongoing Competency Training*, (Washington, D.C.: Apr. 21, 2021).

officer told us that in fiscal year 2021, his VISN sets a goal for each facility to improve their same-day access rate by 10 percent.

- **Improving utilization of warm hand-offs.** Four VISN chief mental health officers told us that they have used PCMHI performance measure data to take action to improve utilization of warm hand-offs between primary care and PCMHI providers. For example, one chief mental health officer said that he works collaboratively with Patient-Aligned Care Teams and other specialty areas to stress the importance of and encourage warm hand-offs for same-day access.
- **Enhancing primary care provider referrals.** Four VISN chief mental health officers said they use PCMHI performance data to help encourage referrals from primary care providers. For example, one VISN chief mental health officer said that he uses the measure for the percentage of patients engaged in PCMHI to enhance primary care providers' referrals to PCMHI by reminding them that such services are available. Another VISN chief mental health officer said that he reviews the percentage of patients engaged in PCMHI to emphasize how engagement and collaboration with Patient-Aligned Care Teams directly impacts PCMHI engagement. The officer said this measure also provides opportunities to explore variation in the percentage of veterans who are engaged in PCMHI across facilities.
- **Identifying opportunities to improve PCMHI providers' performance.** Four VISN chief mental health officers told us that they review data on the percentage of timed encounters with PCMHI providers that are 30 minutes or less to identify opportunities for improving PCMHI providers' performance. For example, one VISN chief mental health officer said he uses this measure to provide feedback to providers on adherence to the fidelity of the PCMHI model. Another VISN chief mental health officer reported using that same measure to identify the need to train staff in providing brief therapies within the PCMHI setting.

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## VHA Facilities Report Persistent PCMHI Staffing Challenges and Some Steps Taken to Mitigate Them

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### VHA Facilities Report That PCMHI Staffing Challenges Have Persisted for Several Years

Through annual PCMHI surveys, VHA facilities reported that staffing challenges affected their efforts to implement PCMHI programs since at least 2016, reaching a peak in 2022.<sup>29</sup> Specifically, VHA facilities often reported that staffing-related challenges were one of their most significant challenges to implementing or sustaining PCMHI services.<sup>30</sup> Such reported challenges were: (1) insufficient staffing levels for PCMHI providers such as psychologists and psychiatrists (i.e., overall PCMHI staffing levels), (2) replacing staff who have left PCMHI (i.e., turnover among PCMHI staff who changed positions, retired, or left VA, and backfilling vacant positions), and (3) recruiting staff for new PCMHI staff positions (i.e., expanding the number of PCMHI staff).

According to the 2022 annual survey, 189 of 439 VHA facilities, or about 43 percent, reported that one of those three staffing issues was their most significant challenge in implementing or sustaining PCMHI services over the past year.<sup>31</sup> This was the highest percentage reported since 2016 but

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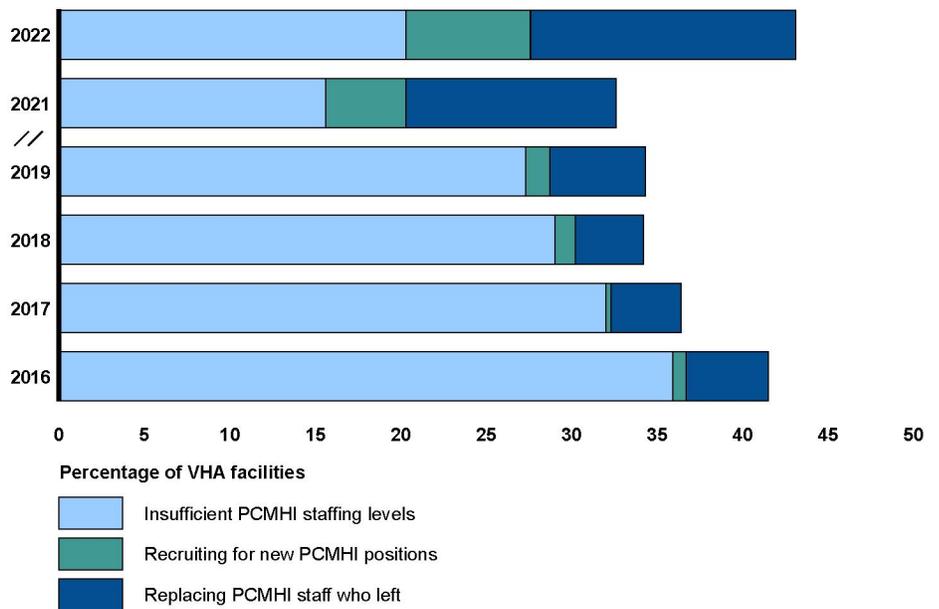
<sup>29</sup>According to OMHSP officials, OMHSP has required certain VHA facilities to complete annual surveys since 2011. According to OMHSP, the number of VHA facilities completing the survey can vary from year-to-year as only those that serve at least 5,000 veterans annually are required to provide both co-located collaborative care and collaborative care management. For example, 392 facilities were required to provide these services in 2016 compared with 455 facilities in 2022.

<sup>30</sup>According to OMHSP officials, since 2016, annual surveys have requested that facilities report their most significant challenge, if any, in implementing or sustaining PCMHI services over the past year. While the 2022 annual survey included a list of 24 possible options to select from, our analysis includes three specific PCMHI staffing challenges that were frequently reported between 2016 and 2022.

<sup>31</sup>According to OMHSP officials, the 2022 annual survey was sent to a total of 455 VHA facilities that were required to have both co-located collaborative care and collaborative care management. The 2022 survey included a section that asked VHA facilities to identify their most significant challenge to implementing or sustaining PCMHI services over the past year. According to OMHSP officials, 13 VHA facilities skipped this section because they had neither of the required PCMHI requirements and three skipped it because they reported that they did not have a significant challenge; as such, a total of 439 VHA facilities completed the section.

generally consistent with previous years. (See figure 7.) (See appendix II for a full list of all types of most significant challenges each VHA facility reported in the 2022 annual survey.)

**Figure 7: Percentage of VHA Facilities That Reported Staffing As Their Most Significant Challenge to Implementing or Sustaining Primary Care Mental Health Integration (PCMHI) Services, 2016 through 2022**



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

**Data table for Figure 7: Percentage of VHA Facilities That Reported Staffing As Their Most Significant Challenge to Implementing or Sustaining Primary Care Mental Health Integration (PCMHI) Services, 2016 through 2022**

	2016	2017	2018	2019	2020	2021	2022
	Percent						
Insufficient PCMHI staffing levels	35.9%	32.0%	29.0%	27.3%	0	15.6%	20.3%
Recruiting for new PCMHI positions	0.8%	0.3%	1.2%	1.4%	0	4.7%	7.3%
Replacing PCMHI staff who left	4.8%	4.1%	4.0%	5.6%	0	12.3%	15.5%

GAO analysis of Veterans Health Administration (VHA) data. | GAO-23-105372

Notes: According to VHA's Office of Mental Health and Suicide Prevention (OMHSP), the office did not administer a 2020 annual survey because of the COVID-19 pandemic. The number of VHA

facilities providing this information varied from year-to-year as only those serving at least 5,000 veterans annually are required to meet VHA's mental health integration requirements.

According to OMHSP, the three staffing-related challenges are: (1) insufficient PCMHI staffing levels addresses overall PCMHI staffing levels, (2) recruiting staff for new PCMHI staff positions addresses expanding the number of PCMHI staff, and (3) replacing staff who have left PCMHI addresses turnover among PCMHI staff who changed positions, retired, or left VA, and backfilling vacant positions. Examples of the types of PCMHI providers who may be affected by staffing-related challenges include psychologists and psychiatrists. Examples of other types of challenges reported from 2016 through 2022 include those related to competing demands (e.g., other new clinical priorities or programs) and insufficient administrative/clerical or scheduling support.

According to annual survey results from 2013 through 2022, between about 54 percent and 65 percent of VHA facilities reported that their PCMHI programs were not adequately staffed based on needed services that year. Not having adequate staffing to meet veterans' needs may adversely affect veterans' access to PCMHI services. For example, OMHSP reported shorter wait times for same-day access to PCMHI services and more PCMHI provider availability for warm hand-offs are associated with facilities that reported having adequate staff.

Sixteen of the 18 VISN chief mental health officers and several VA medical center officials indicated that PCMHI staffing has been a challenge for their facilities. VA medical center officials told us that several factors may contribute to PCMHI staffing issues, including

- national shortages of mental health providers;
- provider turnover;
- salary discrepancies for mental health care positions between VHA and the private sector;
- provider preferences to deliver care virtually rather than in person; and
- slow and complicated hiring processes.

Furthermore, VA medical center officials told us that staffing challenges can affect all PCMHI positions, but some positions are more difficult to fill than others. For example, officials from one VA medical center said that psychologist positions are especially difficult to fill because their VA medical center does not offer psychologists salaries that are competitive with the private sector or other incentives, such as retention or relocation

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bonuses or Education Debt Reduction Program benefits.<sup>32</sup> An official from another VA medical center told us that the medical center has difficulty hiring psychiatrists because psychiatrists can earn twice the salary in the private sector compared with VHA.

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### Officials from Selected VHA Facilities and VHA Reported Taking Some Steps to Mitigate Staffing Shortfalls, and VISN Officials Identified Additional Steps That Could Be Taken

Officials from the selected facilities in our review told us they are exploring or have implemented strategies at their local facilities to help mitigate staffing challenges. For example:

- VA medical center officials from two of the selected facilities said they offer hybrid positions in which PCMH providers can work a combination of in-person and virtual hours to allow more flexibility in work schedules.
- One VA medical center official said she is also looking at ways to better manage and reduce the amount of unnecessary administrative tasks providers must complete by offering additional support or technology because providers complain about this aspect of their workload most often. The official said that she is also working to restructure salaries and expedite hiring by immediately submitting a request to fill PCMH positions as soon as she knows that attrition will create an opening rather than waiting to begin the process until the position is actually available.
- Another VA medical center official said that he temporarily reassigned a person who was working on another unit to PCMH and trained the person to help provide more coverage.

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<sup>32</sup>Established in May 2002 by VA, the Education Debt Reduction Program is a student loan repayment program available to newly hired providers and is used as a recruitment tool by VA medical centers by reimbursing qualifying education loan debt for employees in hard-to-recruit positions. Providers apply for the program directly with their VA medical center, and applications are approved by VHA. For additional information, see GAO, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*, [GAO-18-124](#) (Washington, D.C.: Oct. 19, 2017).

- Officials from another VA medical center said that the VA medical center increased salaries for psychiatrists to be competitive with the local market.

According to OMHSP officials, they have tried to mitigate PCMHI staffing challenges by announcing a funding opportunity in October 2021 for VISNs to apply for one year of funding to hire PCMHI care managers. OMHSP offered this funding to support suicide prevention and be responsive to an anticipated significant increase in the workload for facility mental health providers as a result of a transition in the Veterans Crisis Line in the summer of 2022.<sup>33</sup>

OMHSP officials said they also provide guidance and consultation to VISNs and VHA facilities that can help the facilities develop local staffing priorities and allocations. However, OMHSP officials said they have not developed a plan to mitigate staffing challenges because recruitment and other staffing decisions are determined by individual VISNs and VA medical centers.

Additionally, VISN chief mental health officers we spoke with identified more that could be done. For example:

- **Providing additional guidance.** One VISN chief mental health officer said that OMHSP could provide guidance on strategies to help prevent PCMHI provider burnout and recruit and retain PCMHI staff.
- **Enhancing and increasing funding opportunities.** One VISN chief mental health officer said that, since nationwide challenges with human resources have interfered with rapid hires, OMHSP should provide VHA facilities a longer window to apply for special funding for PCMHI positions. Another officer recommended that OMHSP increase opportunities for funding PCMHI positions and fund additional internship and post-doctorate training to ensure a continuous influx of providers.
- **Engaging facility leadership.** Two VISN chief mental health officers said that OMHSP should hold facility leadership accountable for ensuring adequate PCMHI staffing levels. Another VISN chief mental health officer said that OMHSP could communicate directly with

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<sup>33</sup>The Veterans Crisis Line, a three digit number veterans can call, supports veterans in emotional crisis and helps implement VA's goal of improving mental health outcomes for service members, veterans, and their families through a number of actions—including reducing barriers to seeking mental health treatment and expanding access to VA services.

facility leadership and mental health leaders to emphasize the importance of adequate PCMHI staffing levels.

- **Supporting, reinforcing, or revising recommended PCMHI clinical staffing levels.** OMHSP recommends that each VHA facility have a clinical staffing ratio of 0.67 full-time equivalent PCMHI providers for each Patient-Aligned Care Team that treats 1,200 veterans in the primary care setting. However, according to OMHSP, the 2022 annual survey indicated that the overall clinical staffing ratio was 0.42 full-time equivalent PCMHI providers for each Patient-Aligned Care Team. Four VISN chief mental health officers said that OMHSP could do more to support, reinforce, or revise the recommended clinical staffing level it uses to help VHA facilities determine the appropriate number of PCMHI providers each facility should have.<sup>34</sup> Specifically, one VISN chief mental health officer said that none of the facilities in his VISN meets or comes close to the recommended clinical staffing level. As a result, he said that PCMHI functions as a triage service rather than providing the short-term treatment that could prevent veterans from having to go to another level of care and receive specialty mental health services. Another VISN chief mental health officer said that VISN officials have long wanted OMHSP to provide direct incentives to support core services, such as PCMHI, for VHA facilities that are struggling with vacancies. Two VISN chief mental health officers recommended that OMHSP shift the PCMHI staffing recommendation to a requirement for those facilities required to provide PCMHI services.<sup>35</sup>

OMHSP officials recognized that PCMHI-related staffing challenges have persisted for several years, but explained that VISNs and VA medical centers are responsible for staffing decisions. However, OMHSP is responsible for continuously monitoring, supporting, and evaluating the implementation of mental health policies in VISNs and VHA facilities.<sup>36</sup> Given this critical role, OMHSP (in partnership with other headquarters-based program offices) may be able to assist the VISNs and VHA facilities with their staffing efforts.

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<sup>34</sup>See Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1161.

<sup>35</sup>OMHSP officials said that the rationale for recommending rather than requiring PCMHI staffing ratios takes into consideration the potential for staffing ratios to evolve over time and that depending on site need and demand, facilities may need additional PCMHI staff.

<sup>36</sup>Department of Veteran Affairs, *Functional Organization Manual*, version 6 (2020).

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The strategies identified by VISNs are examples of opportunities that OMHSP has to help mitigate longstanding staffing issues. A comprehensive evaluation of strategies such as these and others, and implementing them as appropriate and feasible would be consistent with key practices for strategic human capital management that we identified. These practices state that effective organizations develop strategies to address human capital gaps and achieve programmatic goals and results.<sup>37</sup> Moreover, to the extent that such strategies are effective, they will help VISNs and facilities in their efforts to fully implement the PCMHI model of care.

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## Conclusions

VHA has seen a significant increase in demand for mental health services over time and projects that the demand for such services, including PCMHI, will continue to grow over the next decade. VHA has long recognized that integrating mental health services into primary care is critical in improving access to and the quality of mental health care veterans receive. Most VHA facilities report providing PCMHI services, but not all of the facilities have met both requirements. OMHSP is taking an important step in now creating guidance for VISNs on developing corrective action plans to address any areas out of compliance. By also monitoring the implementation of any corrective actions plans to bring facilities into compliance, OMHSP could help ensure that facilities implement the PCMHI model as the agency intends.

A full complement of mental health professionals is imperative for VA to be able to meet the rapid growth in demand for VA mental health services. The expected continued growth in demand for mental health services may only exacerbate longstanding and persistent PCMHI-related staffing challenges. By comprehensively evaluating and implementing strategies to help mitigate PCMHI-related staffing challenges, OMHSP can better fully implement the PCMHI model of care across VHA facilities and help ensure that veterans receive the most appropriate and timely mental health care services available.

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<sup>37</sup>See [GAO-02-373SP](#).

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## Recommendations for Executive Action

We are making the following two recommendations to VHA:

The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention monitors VISNs' development and implementation of corrective action plans for any VHA facilities that do not fully adhere to VHA's Primary Care Mental Health Integration program requirements. (Recommendation 1)

The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention comprehensively evaluate and implement strategies to help mitigate staffing challenges that affect VHA facilities' abilities to integrate mental health care within primary care settings. (Recommendation 2)

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## Agency Comments

We provided a draft of this report to VA for review and comment. In written comments, reproduced in appendix III, VA concurred with our two recommendations and described steps VHA has taken or plans to take to address them.

Regarding our first recommendation, VA stated that it will explore the potential for VHA's Assistant Under Secretary for Health for Clinical Services and VHA's Assistant Under Secretary for Health for Operations to update mechanisms by which clinical program offices, such as OMHSP, share facility noncompliance information with VISNs and VHA leadership and request corrective actions be taken to address noncompliance.

With respect to our second recommendation, VA stated that ensuring OMHSP helps mitigate staffing challenges that affect VHA facilities' abilities to integrate mental health care within primary care settings is a top VHA leadership priority. VA described several actions OMHSP has taken at national and local levels, such as participating in monthly calls to discuss topics addressing recruiting and hiring strategies.

In its written comments, VA stated that VHA has completed work on this recommendation and requested GAO consider closing the recommendation as implemented. We agree that VHA has taken several

actions to help mitigate staffing challenges, and we describe many of those in our report. However, staffing challenges have persisted over several years. As such, we are recommending that OMHSP comprehensively evaluate the actions and strategies it has employed to date. Then, based on that evaluation, the office will be better positioned to implement the most effective strategies it identifies to mitigate longstanding staffing issues. 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 Veterans Affairs, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [hundrup@gao.gov](mailto:hundrup@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 IV.



Alyssa M. Hundrup  
Director, Health Care

## Appendix I: Objectives, Scope, and Methodology

The objectives of our report were to examine (1) the extent to which Veterans Health Administration (VHA) facilities have met requirements to integrate mental health care into primary care services and examine how VHA monitors adherence to these requirements; (2) VHA's efforts to collect and make available information on the agency's performance in integrating mental health care within primary care settings; and (3) any challenges that have affected VHA's integration of mental health care within primary care settings and examine steps VHA has taken to mitigate them.

To address all three objectives, we reviewed VHA's *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook and other relevant Primary Care Mental Health Integration (PCMHI) documentation.<sup>1</sup> We also interviewed PCMHI program officials and providers who administer and oversee services from a total of nine VHA facilities. These included three Veterans Affairs (VA) medical centers and two community-based outpatient clinics associated with each of the three VA medical centers.<sup>2</sup> Specifically, we interviewed VHA facility officials, PCMHI program managers, PCMHI providers and case managers, and primary care providers who refer veterans to PCMHI services. Among other factors, we selected these facilities for variation in (1) the extent to which they reported meeting one or both PCMHI requirements, (2) the percentage of primary care patients who received such services in fiscal year 2020 (the most recent data available at the time of site selection), and (3) geographic location. See table 1 for a list of the three VA medical centers and six community-based outpatient clinics we selected. Information and perspectives we obtained from individuals from the nine facilities in our review cannot be generalized, but rather provide

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<sup>1</sup>See Department of Veterans Affairs, Veterans Health Administration, *Uniform Mental Health Services in VA Medical Centers and Clinics*, VHA Handbook 1160.01 (Washington, D.C.: Sept. 11, 2008, amended Nov. 16, 2015).

<sup>2</sup>VHA provides enrolled veterans with a full range of inpatient and outpatient services through VA medical centers, which typically provide primary care and some specialty care services, and their affiliated community-based outpatient clinics.

illustrative examples of local efforts to implement and sustain PCMHI programs.

**Table 1: Selected Department of Veterans Affairs (VA) Medical Centers and Community-Based Outpatient Clinics**

VA medical center	Affiliated community-based outpatient clinics
East Orange VA Medical Center (East Orange, New Jersey)	James J. Howard Veterans' Outpatient Clinic (Brick, New Jersey)
	Hackensack VA Clinic (Hackensack, New Jersey)
Orlando VA Medical Center (Orlando, Florida)	William V. Chappell, Jr. Veterans' Outpatient Clinic (Daytona Beach, Florida)
	Deltona VA Clinic (Deltona, Florida)
West Los Angeles VA Medical Center (Los Angeles, California)	Los Angeles VA Clinic (Los Angeles, California)
	Oxnard VA Clinic (Oxnard, California)

Source: GAO analysis of Veterans Health Administration information. | GAO-23-105372.

To gain additional insights into all three objectives, we also obtained the perspectives of the chief mental health officers from each of VHA's 18 Veterans Integrated Service Networks (VISN). In addition, we interviewed officials from two veterans' service organizations, the Wounded Warrior Project, and Iraq and Afghanistan Veterans of America. We selected these organizations because their missions indicate they help veterans obtain mental health services. We also interviewed officials from three non-VA organizations that focus on integration of mental health services in primary care settings and interviewed six VHA researchers who have published studies on VHA's PCMHI integration efforts and outcomes.<sup>3</sup> Finally, we reviewed our own work related to veterans' mental health as well as relevant reports from the Department of Veterans Affairs' Office of Inspector General and the National Academies of Sciences, Engineering, and Medicine.<sup>4</sup>

<sup>3</sup>We interviewed officials from the National Alliance on Mental Illness, the National Council for Mental Wellbeing, and the University of Washington's Advancing Integrated Mental Health Solutions Center.

<sup>4</sup>For GAO reports we reviewed, see, *Veterans Health Care: Efforts to Hire Licensed Professional Mental Health Counselors and Marriage and Family Therapists*, [GAO-22-104696](#) (Washington, D.C.: Mar. 28, 2022); *Veterans' Growing Demand for Mental Health Services*, [GAO-21-545SP](#) (Washington, D.C.: May 17, 2021); and *VA Health Care: Goals and Related Measures Needed to Better Assess the Impact of Same-Day Services*, [GAO-19-546](#) (Washington, D.C.: Aug. 7, 2019).

To describe the extent to which VHA facilities have met requirements to integrate mental health care into primary care services and examine how they monitor adherence to them, we reviewed PCMHI requirements included in VHA's Office of Mental Health Uniform Services handbook. We also reviewed data from annual PCMHI surveys from 2011 through 2022 to determine the extent to which the number of facilities reported providing one, both, or neither of the two PCMHI requirements changed over time. In addition, we interviewed officials and providers from the three VA medical centers included in our review to examine the extent to which they reported variation in completing the annual surveys. We also interviewed VISN officials to determine the extent to which they track VHA facilities' adherence to the requirements and use information from the annual surveys to develop performance or action plans for their facilities. In addition, we reviewed documentation and interviewed VHA officials to determine the extent to which they monitor facilities' adherence in meeting the PCMHI requirements and assessed that information against VHA policies and federal internal control standards related to monitoring.<sup>5</sup>

To describe VHA's efforts to collect and make information available on the agency's performance in integrating mental health care within primary care settings, we reviewed data from annual PCMHI surveys from 2011 through 2022 and relevant VHA clinical data.<sup>6</sup> Among others, we reviewed the following PCMHI related performance measures: (1) the national percentage of veterans engaged in PCMHI; (2) the national percentage of veterans with same-day access to PCMHI encounters; and (3) the national percentage of timed veteran encounters that were 30 minutes or less. We also obtained information from all 18 VISN chief mental health officers to determine the extent to which they use annual

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For reports we reviewed from Veterans Affairs Office of Inspector General, see, for example, *Veterans Health Administration: OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022*, Report No. 22-00722-187 (Washington, D.C.: July 7, 2022) and *Veterans Health Administration: Review of Veterans Health Administration Staffing Models*, Report No. 20-01508-214 (Washington, D.C.: Aug. 19, 2021).

See National Academies of Sciences, Engineering, and Medicine, *Evaluation of the Department of Veterans Affairs Mental Health Services* (Washington, D.C.: Jan. 31, 2018).

<sup>5</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

<sup>6</sup>The three PCMHI performance measures are captured in either VHA's Strategic Analytics for Improvement and Learning system or its Corporate Data Warehouse.

PCMHI survey and performance data to implement quality improvement efforts on a regional level.

To describe challenges that have affected the integration of mental health care within primary care settings and examine steps VHA has taken to mitigate them, we reviewed VHA's Office of Mental Health and Suicide Prevention annual PCMHI survey data from 2016 through 2022 to identify VHA facilities' reported challenges over time. We also reviewed VHA's *Productivity and Staffing in Clinical Encounters for Mental Health Providers* directive and reviewed our prior work that identifies key practices for strategic human capital management.<sup>7</sup>

For all data sources—including annual PCMHI survey results and VHA clinical data—we interviewed VHA officials and reviewed relevant documentation about how VHA collected and used the data. We assessed the reliability of these data by reviewing VHA documentation about each source, conducting checks for missing or erroneous data, and interviewing VHA officials knowledgeable about the data. Based on these activities, we determined that the data we used were sufficiently reliable for audit objectives.

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<sup>7</sup>Department of Veterans Affairs, Veterans Health Administration, *Productivity and Staffing in Clinical Encounters for Mental Health Providers*, VHA Directive 1161 (Washington, D.C.: Apr. 28, 2020).

See GAO, *A Model of Strategic Human Capital Management*, [GAO-02-373SP](#) (Washington, D.C.: Mar. 15, 2002).

## Appendix II: Most Significant Challenge Reported by Veterans Health Administration (VHA) Facilities in the 2022 Annual Primary Care Mental Health Integration Survey

According to VHA's Office of Mental Health and Suicide Prevention (OMHSP) officials, certain VHA facilities have been required to complete an annual Primary Care Mental Health Integration (PCMHI) survey since 2011.<sup>1</sup> As part of the 2022 survey, OMHSP requested that PCMHI staff from each facility identify all challenges that affect their efforts to implement or sustain PCMHI services, as well as their most significant challenge.<sup>2</sup> In the 2022 annual survey, 439 VHA facilities selected one from among 24 types of challenges as their most significant.<sup>3</sup> (See table 2.)

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<sup>1</sup>In 2008, VHA began requiring that all Veterans Affairs medical centers and certain community-based outpatient clinics serving at least 5,000 unique veterans annually provide PCMHI services.

<sup>2</sup>According to VHA officials, the annual PCMHI surveys capture the perspectives of PCMHI staff that have a collaborative relationship with primary care team members. They said that one particular challenge related to primary care providers' reluctance to prescribe psychotropic medications has been a very important frustration of PCMHI staff as it challenges the effective adoption of the evidence-based collaborative care management requirement. Furthermore, officials said that this same concern likely affects other responses such as reluctance to utilize PCMHI collaborative care management. However, they noted that there is a potential causality dilemma in that primary care providers may be less willing or become less willing to prescribe psychotropic medications when PCMHI collaborative care management providers are not available.

<sup>3</sup>According to Office of Mental Health and Suicide Prevention officials, the 2022 annual PCMHI survey was sent to a total of 455 VHA facilities that were required to have both co-located collaborative care and collaborative care management. According to those officials, 13 VHA facilities skipped this section because they had neither of the PCMHI requirements, and three skipped it because they reported that they did not have a significant barrier; as such, a total of 439 VHA facilities completed the section.

**Appendix II: Most Significant Challenge  
Reported by Veterans Health Administration  
(VHA) Facilities in the 2022 Annual Primary  
Care Mental Health Integration Survey**

**Table 2: VHA Facilities Most Significant Challenge to Implementing or Sustaining  
Primary Care Mental Health Integration (PCMHI) Services in 2022**

<b>Challenge type</b>	<b>Number of facilities reporting as most significant challenge</b>	<b>Percent of total facilities selecting challenge</b>
Insufficient PCMHI staffing levels	89	20.3%
Replacing staff who have left PCMHI	68	15.5
Shortage of/turnover of specialty mental health providers	35	8.0
Competing demands on PCMHI staff time	34	7.7
Recruiting staff for new PCMHI staff positions	32	7.3
Primary care provider reluctance to prescribe psychotropic medications	24	5.5
Insufficient or inappropriate space for PCMHI staff members	21	4.8
Primary care staff turnover	19	4.3
Insufficient administrative/clerical or scheduling support	18	4.1
Insufficient primary care provider support or “buy-in”	13	3.0
COVID-19 pandemic - challenges in conducting warm-handoffs	13	3.0
Other	11	2.5
Insufficient primary care leadership support or “buy-in”	10	2.3
PCMHI staff turnover	9	2.1
Concerns that unscheduled open-access staff time is not captured by productivity reports	8	1.8
Competing demands for site (e.g., other new programs, other clinical priorities)	7	1.6
Primary care provider/staff reluctance to utilize PCMHI collaborative care management	5	1.1
Primary care staff more comfortable with specialty mental health services than PCMHI practice style	5	1.1
COVID-19 pandemic - patient reluctance to engage in remote care	5	1.1
PCMHI staff more comfortable with specialty mental health service practice style than PCMHI practice style	4	0.9
COVID-19 pandemic - reduced capacity for in-person care due to physical distancing requirements	4	0.9

**Appendix II: Most Significant Challenge  
Reported by Veterans Health Administration  
(VHA) Facilities in the 2022 Annual Primary  
Care Mental Health Integration Survey**

<b>Challenge type</b>	<b>Number of facilities reporting as most significant challenge</b>	<b>Percent of total facilities selecting challenge</b>
COVID-19 pandemic - patient computer and internet access	4	0.9
COVID-19 pandemic - patient concerns about physically entering a VA facility	1	0.2
COVID-19 pandemic - staff computer network issues	0	0
<b>Total</b>	<b>439</b>	<b>100</b>

Source: Veterans Health Administration (VHA) information. | GAO-23-105372

## Appendix III: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON

November 22, 2022

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: **VETERANS HEALTH CARE: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services** (GAO-23-105372).

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

Sincerely,

A handwritten signature in blue ink that reads "Tanya J. Bradsher".

Tanya J. Bradsher  
Chief of Staff

Enclosure

Appendix III: Comments from the Department  
of Veterans Affairs

Enclosure

Department of Veterans Affairs (VA) Response to the  
Government Accountability Office (GAO) Draft Report  
**VETERANS HEALTH CARE: Staffing Challenges Persist for Fully Integrating  
Mental Health and Primary Care Services**  
(GAO-23-105372)

**Recommendation 1:** The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention monitors VISNs' development and implementation of corrective action plans for any VHA facilities that do not fully adhere to VHA's PCMH requirements.

**VA Response:** Concur. The Veterans Health Administration (VHA) Office of Mental Health and Suicide Prevention (OMHSP) provides Primary Care Mental Health Integration (PCMHI) policy, guidance, training, monitoring and implementation consultation in support of policy compliance.

OMHSP has a robust, ongoing monitoring process in place to aid Veterans Integrated Service Networks (VISN) and facilities in implementing PCMHI in accordance with policy. OMHSP provides a comprehensive annual program assessment that aggregates data from multiple sources (e.g., dashboards, site self-assessments) to inform the VISNs' compliance and improvement efforts. Multiple monthly Community of Practice (COP) calls provide constructive space for staff, PCMHI leadership, implementation consultants and subject matter experts to discuss best practices, strategies and tactics to address implementation challenges. Weekly forums between OMHSP leaders and VISN Chief Mental Health Officers (CMHO) provide opportunities for compliance-related discussion and planning as needed. OMHSP maintains dashboards that provide facilities and VISNs with easily accessible and regularly updated program performance information. Additionally, OMHSP has National Mental Health Quality Improvement and Implementation Consultants assigned to specific VISNs and facilities who are available to work closely with sites in developing action plans to address noncompliance and ensure those plans are informed by best practices and implementation science. Also, per VHA Notice 2022-01, Waivers to VHA National Policy, any facility or VISN not able to comply with official VHA policies must request a waiver for noncompliance to the policy owner, OMHSP in this case. This process affords OMHSP a mechanism by which to monitor VISNs' development of action plans for addressing temporary or ongoing noncompliance given these are a required part of the waiver process. The VISN is then responsible for ensuring implementation of those action plans and taking corrective action for remediation if not implemented.

GAO's evaluation has revealed an opportunity for strengthening collaboration across the VHA Assistant Under Secretary for Health (AUSH) for Clinical Services and the AUSH for Operations offices in support of 1) clinical program offices' (such as OMHSP) ability to monitor VISN implementation of corrective action plans and 2) VISNs ability to ensure implementation of those plans through corrective action and remediation when necessary. To close this recommendation, OMHSP will explore the potential for the offices of the AUSH for Clinical Services and AUSH for Operations to jointly engage in process improvement efforts to update mechanisms by which clinical program offices

**Appendix III: Comments from the Department  
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to the  
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***VETERANS HEALTH CARE: Staffing Challenges Persist for Fully Integrating  
Mental Health and Primary Care Services***  
(GAO-23-105372)

share facility noncompliance information with VISNs and AUSH for Operations leadership and request corrective actions taken to remediate non-compliance.

Target Completion Date: December 2024

**Recommendation 2: The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention comprehensively evaluate and implement strategies to help mitigate staffing challenges that affect VHA facilities' abilities to integrate mental health care within primary care settings.**

**VA Response:** Concur. VHA appreciates GAO's recommendation and concurs with ensuring the organization helps mitigate staffing challenges that affect VHA facilities' abilities to integrate mental health care within primary care settings. Addressing these issues is a top VHA leadership priority.

OMHSP evaluates program staffing as part of its ongoing, annual PCMHI program evaluations. Recent evaluations show insufficient PCMHI staffing levels, challenges replacing staff who have left PCMHI and shortages of or turnover of specialty Mental Health providers as top barriers to implementing PCMHI at facilities. In addition to Mental Health staffing data presented in aggregate on leadership calls, these PCMHI-specific results are shared or presented to leaders (including but not limited to VISN CMHOs) through reports and presentations and inform OMHSP's strategy to help mitigate staffing challenges that affect VHA facilities.

OMHSP's strategy to help mitigate staffing challenges is comprised of both national and locally tailored tactics to aid facility, VISN leadership and VHA Operations in determining staffing priorities and taking action to mitigate their staffing challenges. In compliance with VHA's enterprise-wide framework for integrity and compliance and the associated roles and responsibilities outlined in policy (VHA Directive 1030(2), VHA Integrity and Compliance Program); OMHSP contributes to this effort nationally through actively collaborating with Workforce Management and Consulting on the Mental Health Hiring Sustainment Initiative (MHH-SI). MHH-SI offers monthly "Best Practice Calls" with topics addressing "Compensation, Incentives and Scheduling Flexibilities for a Competitive Market;" "Trainee Recruitment and Hiring Strategies;" "Workforce Succession Strategic Plan;" "Recruitment and Retention of Clinicians from Diverse Backgrounds" and "Recruitment and Retention Bonuses." In addition to national efforts, OMHSP also provides resources and tailored consultation to aid facilities and VISNs in addressing locally identified barriers if needed (such as lack of space, limited leadership buy-in, competing programmatic priorities). Updated facility staffing data are provided quarterly. The Mental Health Management Summary System provides data on PCMHI patient-to-staff ratios and other key information that can aid facilities with staffing

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**Appendix III: Comments from the Department  
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to the  
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***VETERANS HEALTH CARE: Staffing Challenges Persist for Fully Integrating  
Mental Health and Primary Care Services***  
(GAO-23-105372)

decisions. Lastly, PCMHI policy guidance provides staffing ratios considered the minimum necessary to adequately provide PCMHI services to help inform facility staffing priorities and decisions.

Collectively, VHA is fully engaged in a fiercely competitive clinical recruitment market and employs a multi-faceted strategy to attract qualified candidates to support the unique staffing needs of clinical programs, including PCMHI. VHA continues to assess critical staffing needs, aggressively recruit the most needed specialties and leverage all flexibilities and incentives to successfully meet workforce needs.

VHA has completed work on this recommendation and requests GAO consider closing this recommendation as implemented.

Completion Date: September 2022

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## Text of Appendix III: Comments from the Department of Veterans Affairs

November 22, 2022

Ms. Alyssa M. Hundrup Director

Health Care

U.S. Government Accountability Office

441 G Street, NW Washington, DC 20548

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

Sincerely,

Tanya J. Bradsher Chief of Staff

Enclosure

Recommendation 1: The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention monitors VISNs' development and implementation of corrective action plans for any VHA facilities that do not fully adhere to VHA's PCMH requirements.

**VA Response: Concur. The Veterans Health Administration (VHA) Office of Mental Health and Suicide Prevention (OMHSP) provides Primary Care Mental**

**Health Integration (PCMHI) policy, guidance, training, monitoring and implementation consultation in support of policy compliance.**

OMHSP has a robust, ongoing monitoring process in place to aid Veterans Integrated Service Networks (VISN) and facilities in implementing PCMHI in accordance with policy. OMHSP provides a comprehensive annual program assessment that aggregates data from multiple sources (e.g., dashboards, site self-assessments) to inform the VISNs' compliance and improvement efforts. Multiple monthly Community of Practice (COP) calls provide constructive space for staff, PCMHI leadership, implementation consultants and subject matter experts to discuss best practices, strategies and tactics to address implementation challenges. Weekly forums between OMHSP leaders and VISN Chief Mental Health Officers (CMHO) provide opportunities for compliance-related discussion and planning as needed. OMHSP maintains dashboards that provide facilities and VISNs with easily accessible and regularly updated program performance information. Additionally, OMHSP has National Mental Health Quality Improvement and Implementation Consultants assigned to specific VISNs and facilities who are available to work closely with sites in developing action plans to address noncompliance and ensure those plans are informed by best practices and implementation science. Also, per VHA Notice 2022-01, Waivers to VHA National Policy, any facility or VISN not able to comply with official VHA policies must request a waiver for noncompliance to the policy owner, OMHSP in this case. This process affords OMHSP a mechanism by which to monitor VISNs' development of action plans for addressing temporary or ongoing noncompliance given these are a required part of the waiver process. The VISN is then responsible for ensuring implementation of those action plans and taking corrective action for remediation if not implemented.

GAO's evaluation has revealed an opportunity for strengthening collaboration across the VHA Assistant Under Secretary for Health (AUSH) for Clinical Services and the AUSH for Operations offices in support of 1) clinical program offices' (such as OMHSP) ability to monitor VISN implementation of corrective action plans and 2) VISNs ability to ensure implementation of those plans through corrective action and remediation when necessary. To close this recommendation, OMHSP will explore the potential for the offices of the AUSH for Clinical Services and AUSH for Operations to jointly engage in process improvement efforts to update mechanisms by which clinical program offices share facility noncompliance information with VISNs and AUSH for Operations leadership and request corrective actions taken to remediate non-compliance.

Target Completion Date: December 2024

Recommendation 2: The Under Secretary for Health should ensure that the Office of Mental Health and Suicide Prevention comprehensively evaluate

and implement strategies to help mitigate staffing challenges that affect VHA facilities' abilities to integrate mental health care within primary care settings.

**VA Response: Concur. VHA appreciates GAO's recommendation and concurs with ensuring the organization helps mitigate staffing challenges that affect VHA facilities' abilities to integrate mental health care within primary care settings. Addressing these issues is a top VHA leadership priority.**

OMHSP evaluates program staffing as part of its ongoing, annual PCMHI program evaluations. Recent evaluations show insufficient PCMHI staffing levels, challenges replacing staff who have left PCMHI and shortages of or turnover of specialty Mental Health providers as top barriers to implementing PCMHI at facilities. In addition to Mental Health staffing data presented in aggregate on leadership calls, these PCMHI- specific results are shared or presented to leaders (including but not limited to VISN CMHOs) through reports and presentations and inform OMHSP's strategy to help mitigate staffing challenges that affect VHA facilities.

OMHSP's strategy to help mitigate staffing challenges is comprised of both national and locally tailored tactics to aid facility, VISN leadership and VHA Operations in determining staffing priorities and taking action to mitigate their staffing challenges. In compliance with VHA's enterprise-wide framework for integrity and compliance and the associated roles and responsibilities outlined in policy (VHA Directive 1030(2), VHA Integrity and Compliance Program); OMHSP contributes to this effort nationally through actively collaborating with Workforce Management and Consulting on the Mental Health Hiring Sustainment Initiative (MHH-SI). MHH-SI offers monthly "Best Practice Calls" with topics addressing "Compensation, Incentives and Scheduling Flexibilities for a Competitive Market;" "Trainee Recruitment and Hiring Strategies;" "Workforce Succession Strategic Plan;" "Recruitment and Retention of Clinicians from Diverse Backgrounds" and "Recruitment and Retention Bonuses." In addition to national efforts, OMHSP also provides resources and tailored consultation to aid facilities and VISNs in addressing locally identified barriers if needed (such as lack of space, limited leadership buy-in, competing programmatic priorities). Updated facility staffing data are provided quarterly. The Mental Health Management Summary System provides data on PCMHI patient-to-staff ratios and other key information that can aid facilities with staffing decisions. Lastly, PCMHI policy guidance provides staffing ratios considered the minimum necessary to adequately provide PCMHI services to help inform facility staffing priorities and decisions.

Collectively, VHA is fully engaged in a fiercely competitive clinical recruitment market and employs a multi-faceted strategy to attract qualified candidates to support the unique staffing needs of clinical programs, including PCMHI. VHA continues to assess critical staffing needs, aggressively recruit the most needed specialties and leverage all flexibilities and incentives to successfully meet workforce needs.

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**Appendix III: Comments from the Department  
of Veterans Affairs**

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VHA has completed work on this recommendation and requests GAO consider closing this recommendation as implemented.

Completion Date: September 2022

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## Appendix IV: GAO Contact and Staff Acknowledgments

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### GAO Contact

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

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### Staff Acknowledgments

In addition to the contact named above, Jill Center (Assistant Director), Michelle Paluga (Analyst-in-Charge), Leslie McNamara, and Meghan Shrewsbury made key contributions to this report. Also contributing were Joycelyn Cudjoe, Jackie Hamilton, Ying Hu, Roxanna Sun, Cathy Hamann Whitmore, and TyKera Marrow.

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