

The Threat to Veterans' Mental Health Care of Renewing or Expanding the Choice Program Without Supplemental Funding

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The bipartisan 2016 Commission on Care Final Reportⁱ declared that: "Veterans Health Administration (VHA)'s behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled" (p. 22). This unparalleled Veterans' healthcare could be at risk depending on how the Veterans Choice Program is extended. The original 2014 Choice Act provided \$10 billion in supplemental funds to pay for outsourced care. The program is up for renewal in August 2017. If it is renewed as is -- or if Choice options are expanded -- without supplemental funding, money to pay for Choice care will be siphoned straight out of VHA facility budgets. Shrinking allocations for VHA care would lead to incrementally fewer VHA mental health (MH) providers and programs, and the superior mental health care for Veterans would fade.

Below we elaborate on the manifold superiority and innovations of the VHA mental health care not readily available in the community, including: (1) unique expertise in treating Veterans, (2) seamless integration of medical care and mental health, and (3) training and adherence procedures that ensure state-of-the art, evidence-based treatment. All of this would be impacted detrimentally if funding is diverted from the VHA to private sector care.

VHA expertise in treating Veterans with Post Traumatic Stress Disorder (PTSD) and depression is missing in the private sector.

More than 6,300 VHA MH providers have received extensive training and supervision in the most effective evidence-based therapies (EBP) for PTSD -- Prolonged Exposure and/or Cognitive Processing Therapy. More than 1,800 VA providers have received extensive training and supervision in one of three EBPs for depression.ⁱⁱ Veterans who received these EBPs in the VA have experienced clinically meaningful and robust improvement in their PTSD and depressive symptoms.^{iii iv v vi vii viii ix}

By contrast, RAND's *Ready to Serve*^x national study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA or DoD, "a psycho-therapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions" (page 21). Only 18% of Tricare and 6% of non-Tricare community therapists were trained in and used an EBP.

VHA MH patients are more likely to receive recommended psychiatric medication than are patients in the community.

Recent publications comparing the VHA to private sector care's medication treatment for mental disorders found that for all seven indicators, VHA performance was superior to that of the private sector by more than 30%.^{xi xii} Another study found that only 1-12% of private sector patients treated with antidepressants are treated in a manner that is consistent with American Psychiatric Association guidelines (with care of ethnic minorities tending to be on the lower side of this range).^{xiii}

The VHA achieves better quality of care because, as a unified system, it has the organizational ability to implement and monitor adherence to assessment and treatment standards. The private healthcare system is not capable of this kind of oversight and accountability. When care is diffused across the community, coordination and quality lessen.

The VHA’s approach to preventing suicides is more comprehensive than is commonly found in the private sector.

Each of the ~150 VHA medical centers has one or more Suicide Prevention Coordinator (SPC) dedicated positions. SPCs provide enhanced care coordination for Veterans identified at high risk for suicide and collaborate with VHA’s integrated network of care providers and community partners to reduce suicide risk among vulnerable Veterans. VHA Suicide Prevention policies also include follow ups to missed appointments, safety planning, and wraparound services, and for high risk Veterans a medical record flagging and monitoring system that includes mandatory mental health appointments. VHA also uses predictive analytics to identify Veterans at risk for suicide and other adverse outcomes and offers enhanced care to these Veterans according to their needs. Some of these Veterans may not have been identified as at risk based on clinical signs -- this novel big data approach allows VHA to identify and help vulnerable Veterans before a crisis occurs.

Veterans with Serious Mental Illness (SMI) who use the VHA have greater life expectancy and reduced inpatient bed days of care.

Veterans with SMI conditions who receive VHA care live much longer on average than their counterparts in the U.S. population.^{xiv} Veterans with SMI who drop out of VHA health care but then resume have significantly lower rates of mortality than Veterans who do not return.^{xv} Building on this success, VHA implemented the SMI Re-Engage Program, an outreach to Veterans with SMI who have a 12-month gap in VHA service utilization. For Veterans contacted between March 2012 and March 2016, 24% returned to VHA care within 4 months.^{xvi}

In the VHA’s Intensive Community Mental Health Recovery (ICMHR) program, MH staff visit Veterans with SMI multiple times weekly to provide recovery oriented interventions, typically in the Veteran’s place of residence, which ensures more routine follow up and alleviates the burden to present to a medical facility. Veterans enrolled in ICMHR services had 27 fewer bed days of care and 1.4 fewer admissions on average as compared to the year prior to admission to the program.^{xvii}

VHA’s comprehensive and integrated health care response to military sexual trauma (MST) has no comparable program in the private sector.

When screened by a VA healthcare provider, 1 in 4 women Veterans and 1 in 100 men report that they experienced MST.^{xviii} Although women experience MST in higher proportions, because of the fact that most servicemembers are men, men constitute 40% of all MST survivors seen in VHA. MST is associated with a wide range of mental and physical health conditions, as well as lasting impairment in occupational and life functioning.^{xix xxxxi}

Given that many survivors never talk about their MST experience unless asked directly, VHA’s screening, sensitivity and attentive efforts are crucial ways to proactively reach survivors who might not otherwise seek out care. Each VHA facility has a dedicated MST coordinator position, mandatory MST training for primary and mental health care providers, free MST-related treatment and outreach efforts. All Veterans enrolled in the VHA are

screened for experiences of MST, and survivors who are in need of mental health care get tailored treatment plans. Over 938,000 outpatient MST-related mental health visits were provided to Veterans with a positive MST screen in FY14.^{xxii} Comparable screening and treatment programs do not widely exist in the community, where providers are less likely to have experience or recognize that it is important to even ask Veterans about MST.

Even if mental health services remain fully resourced in the VHA, but primary care (PC) services are outsourced to the private sector, the VHA's state-of-the-art integration of care will unravel and overall quality will be reduced.

Comprehensive psychological screening and integrated care interventions in medical settings for MH conditions has been the VHA model since 2008, but are not the norm in the private sector, where services typically focus upon episodic, acute care.^{xxiii} VHA providers proactively screen Veterans for PTSD, alcohol misuse, depression, tobacco use, MST and traumatic brain injury (TBI), and when problems are identified, are able to deliver a warm handoff to mental health providers on their team. Same day access to PC-MH services reduces stigma and leads to early identification of and intervention with Veterans' MH conditions.^{xxiv} Studies show that Veterans receiving these integrated services are more likely to initiate future specialty MH psychotherapy and medication treatment, remain engaged in those services, and show improvement in MH symptoms, general mental health, life functioning and subjective well-being.^{xxv}

The VHA's evidence-based interdisciplinary approach to pain management hardly exists outside of the VHA.

Approximately 50% of Veterans treated in PC report one or more chronic pain complaints, disproportionately higher than American non-Veterans.^{xxvi} CDC Guidelines^{xxvii} specifically recommend avoiding the use of opioids in favor of cognitive behavioral psychotherapy, exercise therapy and non-opioid medications as first-line treatments for chronic pain. Instead of routinely triaging Veterans with chronic pain to specialists, the VHA introduced in 2009 a Stepped Care Model in which patients receive biopsychosocial chronic pain care first within VHA primary care. These interdisciplinary clinics collocate and integrate PCPs, psychologists, pharmacists and/or physical therapists to provide multi-modal pain care. Preliminary results show decreased self-reported pain, opioid risk and daily opioid use.^{xxviii xxix}

Interdisciplinary pain management continues to grow in the VHA but is very rare in the U.S. private sector where healthcare tends to be fragmented and truncated. VHA accounts for 40% of the U.S. interdisciplinary pain programs even though it serves 8% of the adult population.^{xxx} The importance of effective pain management, including behavioral interventions, is further underscored by the fact that pain is the most commonly identified risk factor analyses are conducted after a Veteran has died from suicide.^{xxxi}

In large sections of the country, access to mental health professionals, especially psychiatrists, is quite limited. Expanding Veterans Choice is unlikely to solve access challenges.

A 2013 SAMHSA report indicated that 77% of U.S. counties had a severe shortage of practicing psychiatrists, psychologists or social workers; 55% of U.S. counties, all rural, have none at all.^{xxxii} Even in geographic locations with available private sector psychiatrists, many are unwilling to accept insurance or government payments.^{xxxiii xxxiv} That's a contributing factor to the January 2017 VA OIG Report^{xxxv} finding: "Choice's inadequate network of providers created barriers for veterans trying to access care outside of VHA medical facilities"

(p. iii). Being unable to find a local Choice provider has been a major source of frustration to our Veterans, as voiced by VHA Veteran-run Mental Health Councils and yearly Mental Health Summit participants. By contrast, VHA actively works against regional shortages with innovative programs reaching out to even the most rural Veterans.

No other healthcare system is as Veteran-centric and Veteran-sensitive as the VHA.

VHA care is Veteran-centric in many ways not found in general community settings. The VHA has hired 1100 Peer Specialists who are Veterans in successful recovery from mental health challenges and are integrated in programs as staff members providing mental health care. Peer specialists are uniquely suited to engage Veterans in ongoing care and to instill hope. Across the system, 31% of VHA employees are Veterans themselves. RAND's *Ready to Serve* evaluation found that the Veteran and military cultural competency of VHA/DoD providers far outstripped that of community providers. VHA providers' cultural expertise comes not just from required trainings but also from an ardent commitment to the mission of serving those who served and from careers in a system that is by, for and about Veterans. Finally, there is something profound and healing when a band of Veterans in VHA therapy groups share experiences they have not discussed with anyone else in their lives.

The VHA is the main system of preparing our national healthcare workforce.

The VHA trains 70% of all U.S. physicians (as well as 40 other healthcare professions). Significant reductions in the number of VHA attending supervisors would disrupt healthcare education nationally. Given the costs of establishing and maintaining training programs and residencies, the private sector will not be able to compensate for the loss of VHA training opportunities for the next generation of providers.

This White Paper focuses on the potential impact of siphoning funds from the VHA to pay for the Choice Program on Veterans' mental health care. The same concern can be raised about the effect on VHA primary and specialty care, whose quality has also been generally found to outperform non-VA care.^{xxxvi xxxvii xxxviii} Diverting VHA funds to Choice would incrementally deconstruct the integrated VHA healthcare system.

We recognize that when timely access to VHA services isn't feasible that the VHA could purchase services from outside partners via VHA High Performance Networks. But this should be paid for with supplemental allocations. **The extension of Choice and other efforts to reform the VHA can best serve Veterans by ensuring that funding for existing VHA services be sustained and strengthened.**

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ENDNOTES

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