



DEPARTMENT OF VETERANS AFFAIRS  
Office of Inspector General  
Washington DC 20420

APR 30, 2001

Acting Principal Deputy Assistant Secretary for Management (004)

**Subject: Attestation of the Department of Veterans Affairs "Detailed Accounting Submission" for Fiscal Year 2001 (Report No. 01-00750-56)**

We have reviewed the accompanying "Detailed Accounting Submission" of the Department of Veterans Affairs (VA) for Fiscal Year (FY) 2001 relating to obligations on National Drug Control Program activities. Our review was conducted consistent with standards for attestation engagements established by the American Institute of Certified Public Accountants.

A review is substantially less in scope than an examination, the objective of which is the expression of an opinion on the "Detailed Accounting Submission." Accordingly, we do not express such an opinion.

We concluded that:

Estimated obligations reported for FY 2000 are reliable based on the approved change in the methodology used to calculate drug treatment expenditures limited by our concerns relating to the unreliability of cost accounting data produced by VA's financial systems and the inconsistent application of depreciation when presenting costs and computing per diem rates.

Except for the preceding qualification, nothing came to our attention that caused us to believe that the accompanying "Detailed Accounting Submission" is not presented in conformity with Office of National Drug Control Policy criteria.

For the Assistant Inspector General for Auditing

*(Original signed by:)*

STEPHEN L. GASKELL  
Director, Central Office Operations Division (52CO)

APPENDICES

## **BACKGROUND, SCOPE, AND RESULTS**

### **Background**

21 United States Code, Section 1704, requires that agencies responsible for implementing any aspect of the “National Drug Control Strategy” submit to the Director, Office of National Drug Control Policy (ONDCP) a detailed accounting for all funds expended by the agency for National Drug Control program activities during the previous year. The statute requires that such accounting be authenticated by the agency’s Inspector General (IG) prior to submission.

“ONDCP Circular: Annual Accounting for Drug Control Funds,” dated December 17, 1999, implements the statutory requirement and defines IG authentication as an attestation review, consistent with the Statements for Standards of Attestation Engagements, promulgated by the American Institute of Certified Public Accountants.<sup>1</sup> The ONDCP circular also identifies specific assertions required in the “Detailed Accounting Submission,” and criteria for the assertions.

### **Scope**

We reviewed the VA “Detailed Accounting Submission” for Fiscal Year (FY) 2001 including the “Table of Prior Year Drug Control Obligations” and required assertions relating to “Drug Methodology,” “Application of Methodology,” and “Financial Plan - Including Reprogramming and Transfers.” We expanded our review to include an examination of the three prior year’s obligations because VA received authority to change its drug cost reporting methodology from ONDCP. As a condition to changing the methodology, ONDCP requested that VA submit data back to the beginning of the ONDCP program (1981) that reflected the changed methodology. VA was able to provide actual cost data back to 1998. Years prior to 1998 were based on a reverse extrapolation that estimated annual drug expenditures. The “Detailed Accounting Submission” is the responsibility of VA management. Our responsibility is to express a conclusion about the reliability of the assertions made in the “Detailed Accounting Submission.”

### **Results**

#### **Required Agency Assertions**

ONDCP requires that reporting agencies make explicit assertions regarding: (1) the reasonableness and accuracy of the drug methodology used to calculate obligations of prior year budgetary resources, (2) application of the drug methodology to the annual accounting, and (3) changes to the agency financial plan affecting drug control obligations. Specifically, ONDCP requires the following:

---

<sup>1</sup> An attest engagement is one in which the practitioner is engaged to express conclusions regarding the reliability of written assertions. An assertion is any declaration, or set of related declarations, taken as a whole, by the party responsible for making the assertion.

### **Required Assertion**

*“An assertion shall be made regarding the reasonableness and accuracy of the drug methodology used to calculate obligations of prior year budgetary resources. The criteria associated with this assertion are as follows:*

*Data -- If workload or other statistical information supports the drug methodology, then the source of these data and the current connection to drug control obligations should be well documented. If these data are periodically collected, then the data used in the drug methodology must be clearly identified and will be the most recently available.*

*Other Estimation Methods -- If professional judgment or other estimation methods are used as part of the drug methodology, then the association between these assumptions and the drug control obligations being estimated must be thoroughly explained and documented. These assumptions should be subjected to periodic review, in order to confirm their continued validity.*

*Completeness -- All activities conducted by the agency or bureau that have a drug-related nexus shall be reflected in the drug methodology.*

*Financial Systems -- Financial systems supporting the drug methodology should yield data that fairly present, in all material respects, aggregate obligations from which drug-related obligation estimates are derived.”*

### **Conclusion**

#### **Data and Estimation Methods**

VA includes a thorough explanation of the assumptions used for estimating drug-related costs and associates those assumptions with the drug methodology.

VA asserted that the FY 2000 drug control-related obligations reported in the FY 2001 “Resource Summary” were based on a methodology that uses information from the Inpatient Treatment File (PTF) and the Outpatient Treatment File (OPTF) compiled from data imputed at the VA Medical Center level.

VA considers substance abuse to include both alcohol abuse and drug abuse. Both conditions are treated in VA substance abuse clinics. The ONDCP has requested that VA provide information only on drug abuse patients. To that end, VA has determined the percentage of patients treated in substance abuse settings for Domiciliary Substance Abuse, Inpatient Treatments in Specialized Substance Abuse Clinics, and Outpatient Substance Abuse Clinics. VA relies on its Cost Distribution Report (CDR) to determine costs in various clinical settings. The following table lists the CDR cost totals and drug abuse treatment percentages for each year that the IG was required to attest.

## APPENDIX I

Department of Veterans Affairs  
Revised Detailed Accounting Reports  
For Fiscal Years 1998, 1999, and 2000  
Dollars in thousands of dollars (000)

DESCRIPTION	1998 – CDR			1999 -- CDR			2000 -- CDR		
	1998 CDR	Drug Abuse %	1998 Report	1999 CDR	Drug Abuse %	1999 Report	2000 CDR	Drug Abuse %	2000 Report
<b><u>Specialized Treatment Costs</u></b>									
Domiciliary Substance Abuse	\$18,456	72.10%	\$13,307	\$28,409	72.72%	\$20,659	\$34,932	75.72%	\$26,451
Total Inpatient Substance Abuse Clinic Costs	\$197,212	66.97%	\$132,077	\$146,513	65.49%	\$95,953	\$123,412	64.08%	\$79,083
Total Outpatient Substance Abuse Clinic Costs	\$172,885	89.3%	\$154,386	\$174,657	89.4%	\$156,144	\$177,484	89.8%	\$159,380
<b>Total Specialized Treatment Costs</b>			<b>\$299,770</b>			<b>\$272,756</b>			<b>\$264,914</b>
<b><u>Non-Specialized Treatment Costs</u></b>									
Inpatient Substance Abuse Costs in a Non-Substance Abuse Setting			\$49,142			\$46,304			\$55,442
Outpatient Substance Abuse Costs in a Non-Substance Abuse Setting			\$213,325			\$222,255			\$226,475
<b>Revised Total Based on New Methodology</b>			<b>\$562,237</b>			<b>\$541,315</b>			<b>\$546,831</b>
<b>Research</b>			\$4,923			\$7,345			\$7,797
<b>Total Costs</b>			<b>\$567,160</b>			<b>\$548,660</b>			<b>\$554,628</b>

We ascertained that the information above accurately represents reported values from the CDR. Patient counts used to determine various per diem rates were computed by VA from the same CDR data, and patient counts used to calculate per diem rates came from independent sources.

For the specialized treatment clinics, VA used un-adjusted CDR data. The Veterans Health Administration (VHA) allocated on a proportional basis, indirect expenses including Education & Training-Trainee Salary, Education & Training-Instructional Support, Education & Training-Administrative Support, Education & Training-Continuing Education Medical Research Support, Prosthetic Research Support, administration, environmental management, and engineering. Although VA accounting policy requires inclusion of depreciation expenses in consideration of cost accounting systems, VA did not allocate depreciation expenses to the associated cost centers, but chose to ignore depreciation in calculating expenses for specialized treatment programs. (The effect of this understatement is discussed below.)

For treatments in non-substance abuse clinics, VA used the appropriate International Classification of Diseases (ICD-9-CM<sup>2</sup>) diagnostic codes to determine the numbers of patients

<sup>2</sup> ICD-9-CM is a Medical Industry standard listing of diagnostic codes for diseases and procedures for treatment of patients developed by the U.S. Department of Health and Human Services, Health Care Financing Administration. By using the standard codes, medical practitioners communicate the diagnosis of a patient and treatment procedures used with various patients to third parties. VA adopted this system in 1998 to ease the billing of third party insurers for medical care cost recovery. VA has maintained patient treatment files for several years. By incorporating the

treated and applied a per diem rate for each clinical setting to calculate the costs. We confirmed that the obligations reported for FY 2000 were prepared using patient counts and per diem rates calculated on information in the PTF and OPTF and in the CDR. Per diem rates were calculated using adjusted CDR costs including an allocation of depreciation amongst all cost centers.

The following is a description of the methodologies the Program Evaluation and Resource Center (PERC) uses to compute the costs and full-time equivalent employees (FTEE) associated with treating patients with substance abuse disorders in specialized and non-specialized treatment settings.<sup>3</sup> This is the revised methodology approved by ONDCP. We did not independently query either the PTF or the OPTF in order to validate the data used in the methodology described below.

### **Identifying Days Of Specialized Substance Abuse Inpatient Care For Patients With Drug Abuse Diagnoses**

The PTF Bed Section File was used to identify all bed section episodes of care for patients discharged from substance abuse bed sections with a drug abuse diagnosis during that treatment episode (i.e., ICD-9-CM coded discharge diagnosis of 292, 304, or 305). Substance abuse bed sections included the following: substance abuse residential rehabilitation, substance abuse compensated work therapy treatment, alcohol treatment, drug treatment, substance abuse, psychiatric substance intensive care, substance abuse domiciliary, and substance abuse sustained treatment and rehabilitation. Drug use disorder diagnoses included ICD-9-CM codes 292, 304, and 305.

All days of care for these bed section episodes were summed to calculate the total number of days of specialized substance abuse inpatient care for patients with drug diagnoses.

### **Inpatient Days Of Care For Patients With Drug Disorder Diagnoses Treated Outside Of Specialized Substance Abuse Treatment Units**

From the PTF, all bed section episodes of care in units other than specialized substance abuse treatment units (psychiatric units, medical units, surgical units, and intermediate units) were identified. Episodes in which the patients' primary discharge diagnosis was drug abuse was identified. "Primary diagnoses" were defined as the first of the five ICD-9-CM coded discharge diagnoses. The total number of days for each bed section type was calculated and the sum across bed sections was used to identify the total days of care of non-specialized substance abuse treatment for patients with drug abuse disorders.

---

ICD-9-CM diagnosis and treatment codes into the database for all medical centers and all patients, VA can track patient diagnosis and treatment in various clinical settings throughout the entire VA health care system, and can query the database to determine the numbers of patients and the treatments afforded patients on a national basis.

<sup>3</sup>Prepared by the Director, Department of Veterans Affairs Program Evaluation and Resource Center, March 29, 2001.

**Other Related Medical Costs For Inpatients With Drug Disorders**

The total number of days of care for patients with drug diagnoses treated in non-substance abuse bed sections was calculated as described above. VHA then multiplied the number of days of psychiatric, medical, surgical, and intermediate bed section care by their respective per diem rates as reported in the “Traditional Activity Table<sup>4</sup>” for the fiscal year to generate the cost of care in each bed section type. The sum of the cost of care across bed sections was reported as the other related medical costs for patients with primary drug diagnoses.

**Other Related FTEE For Inpatients With Drug Disorders**

The total number of episodes of psychiatric, medical, surgical, and intermediate bed section care for patients discharged with a drug diagnosis was calculated. Episodes are defined as separate discharges in the PTF file. The total number of episodes of care in each type of bed section type was then multiplied by the staffing ratios (FTEE/1000 patients treated) from the Traditional Activity Table. The products were then added to produce the total FTEE across all non-substance abuse bed sections. Episodes of care in specialized substance abuse units for patients with drug abuse diagnoses also were identified and the FTEE for these episodes of care were calculated using the ratio for psychiatric care.

**Visits To Specialized Substance Abuse Clinics For Patients With Drug Diagnoses**

Using the OPTF, all episodes of outpatient care in specialized substance abuse clinics were identified, and from these episodes, visits by patients with a drug abuse diagnosis during that clinic visit were counted. Substance abuse clinic visits include the following: drug dependency individual session (507), alcohol treatment individual session (508), substance abuse individual session (513), substance abuse home visit (514), compensated work therapy/substance abuse (517), compensated work therapy treatment substance abuse (518), substance abuse/PTSD (519), substance abuse HUD/VASH (522), methadone visit (523), intensive substance abuse (547), substance abuse day hospital (548), drug dependency group session (555), alcohol treatment group session (556), and substance abuse group session (560). Visits were counted when ever a drug abuse ICD-9 code was listed. The total number of specialized substance abuse clinic visits for drug abuse patients was then calculated.

**Visits To Other Clinics For Patients With Drug Diagnoses**

Using the OPTF, all episodes of outpatient care in clinics other than specialized substance abuse clinics were identified. From these episodes, visits by patients with a primary drug

---

<sup>4</sup> This is a per diem calculation table prepared by VHA that is used to determine individual activity per diem rates. In this table, VHA brings together the CDR adjusted obligations for various activities (bed sections, contract facilities, and outpatient clinics), the FTEE associated with each activity, the total patients treated, and the average daily census. By dividing the obligations for each activity by the patients treated, the activity per diem rate is calculated.

abuse diagnosis during that clinic visit were selected, where “primary” is defined as the first listed ICD-9 code. The total numbers of such visits were then calculated.

### **Other Related Medical Costs For Outpatients With Drug Disorders**

The total cost of non-substance abuse outpatient care for patients with a drug diagnosis was calculated by summing the number of visits to clinics other than substance abuse clinics in which a patient received a primary drug diagnosis, and multiplying that total by the per visit cost of outpatient care in the Traditional Activity Table.

### **Other Related FTEE For Outpatients With Drug Disorders**

“Other related FTEE” for outpatient care was calculated by multiplying the total number of non-substance abuse outpatient visits for patients receiving a primary drug diagnosis by the FTEE/1000 visits estimate in the Traditional Activity Table.

### **Revised Reporting Methodology Has Significantly Reduced Reported Expenditures**

For FY 2000 VA reported over \$1 billion in drug treatment expenditures. With implementation of the revised ONDCP reporting methodology, VA’s reported drug treatment expenditures for FY 2000 was reduced by \$556.8 million. Under the previous methodology, VA included as drug treatment expenditures the costs of treating secondary and tertiary diagnostic procedures. With the revised methodology, VA no longer includes secondary and tertiary expenditures.

For instance, if a patient with a drug diagnosis presents himself or herself for treatment of a broken leg caused by falling down the stairs while they were under the influence of a controlled substance, that treatment was included as a secondary drug treatment. Counting these treatments was cumbersome because it required scanning the treatment files for patients that were previously treated for substance abuse in a substance abuse setting and then counting each of their non-substance abuse treatments as secondary or tertiary drug treatment. Certainly there were instances where these treatments had a drug nexus, but it became counter productive to use this methodology.

### Completeness

All activities conducted by VA having a drug-related nexus were not reflected in the drug methodology, specifically workload and costs associated with:

- Accounting and inventory control of pharmaceuticals, narcotics, and controlled substances.
- Investigation of theft or losses of VA pharmacy inventory.
- Investigation of crime involving illegal drug use on VA property.
- Investigation of crime involving illegal drug use by VA employees.

## APPENDIX I

However, VA reported in its “Detailed Accounting Submission” that the cost of these activities was not material in relation to the aggregate VA costs reported.

### Reliability of VA Financial Systems

VA’s drug cost reporting methodology acquires drug control-related costs from VA’s CDR. This cost accounting system has been shown to produce inconsistent and unreliable data, and VA has approved, but has not yet fully implemented, a replacement cost accounting and management information system-the Decision Support System (DSS). VA has reported that DSS will be fully operational in FY 2001. In our opinion, DSS has the potential to produce more reliable and consistent data that would yield a more accurate accounting of drug control-related obligations. VA should disclose the reliability of cost data used to prepare the Resource Summary in future “Detailed Accounting Submissions.”

VA’s cost accounting policy and its related handbook states that all costs associated with supplying goods and services must be included when computing the costs of those services. The policy handbook clearly discusses equipment and building and the costs associated with depreciation of those assets. Depreciation may be considered either a direct cost of that service if it can be clearly shown that the equipment or building directly reflects on the cost of providing a particular product or service. If it does not directly contribute to a singular product or service, depreciation should be considered overhead or indirect costs. Those costs must be allocated amongst all products or services provided by the cost center.

When determining the per diem rates for non-specialized treatment, VA included all of the costs associated with the providing both inpatient and outpatient treatments. On the other hand, for specialized treatments including Domiciliary Substance Abuse, Inpatient Substance Abuse and Outpatient Substance Abuse Clinics, VA choose to ignore depreciation when computing the costs of providing these services. This practice caused VA to understate each year’s cost of providing these services. We estimate these understatements are as follows:

In thousands of dollars (000)	1998	1999	2000
Restated Costs Including Depreciation	\$305,657	\$277,435	\$268,945
Expenses Reported To ONDCP	299,770	272,756	264,914
<b>Net Understatement Reported To ONDCP</b>	<b>\$5,887</b>	<b>\$4,679</b>	<b>\$4,031</b>

In future reporting to the ONDCP, VA should include appropriate depreciation costs to more accurately reflect all costs associated with treating patients with drug use disorders in specialized and non-specialized treatment settings.

### Required Assertion

*“Application of Methodology -- Each report shall include an assertion that the methodology disclosed in this section was the actual methodology used to generate the table required by Section 5a. Calculations will be sufficiently well documented to independently reproduce these data. Calculations should also provide a means to ensure consistency of data between reporting years.”*



### **Conclusion**

VA has asserted that the “Drug Methodology” described above was the actual methodology used to accumulate the data shown in the “Resource Summary.” The PERC prepared electronic worksheets after querying the PTF bed section files for periods of inpatient stays and the OPTF for clinical visits. By applying the per diem rates established by the Budget Office, we reconstructed costs associated with drug treatment patients. Nothing came to our attention that indicated we should be concerned with the data reported.

The ONDCP revised the VA accounting submission for FY 2000 to include two new paragraphs and to delete one paragraph VA previously submitted. The revised submission discusses the fact that VA changed its methodology to account more accurately for drug-related treatment funding. The following paragraphs were added to the report:

- “As displayed in this volume, the Department of Veterans Affairs’ (VA) drug control budget methodology has been changed to more accurately account for drug-related treatment funding. As a result of improved tracking mechanisms within the cost accounting system regarding drug patients, VA is now better able to account for the drug-related resources associated with medical treatment costs for patients with substance abuse disorders. Previously, VA included ‘other related treatment costs’ of patients treated with primary, secondary or associated drug diagnoses-various percentages of treatment costs were applied depending on the patient’s drug diagnosis. This data was then extrapolated from previous years to current years by applying the medical Consumer Price Index. This process resulted in capturing costs that were not directly related to anti-drug treatment. As a result, a change in drug methodology has been implemented that more accurately accounts for drug-related treatment.”
- “For fiscal year 2000, the revised methodology has resulted in a scorekeeping adjustment of \$556.8 million from the amount reported in last year’s *Budget Summary*. Adjustments have been made to the historical data series for all fiscal years in which VA has reported drug funding. This change reflects a technical scorekeeping adjustment only and has no adverse effect on the actual level of VA’s resources devoted to drug treatment.”

The changes made by ONDCP fairly represent the approved methodology. Since VA had not disclosed the impact of the methodology change in its original submission to ONDCP, the inclusion of the scorekeeping adjustment of \$556.8 million appropriately advises the reader of the magnitude of the downward revision of VA’s FY 2000 reported costs.

### **Required Assertion**

*“Financial Plan -- Including Reprogramming or Transfers -- Further, each report shall include an assertion that the data presented are associated with obligations against a financial plan that, if revised during the fiscal year, properly reflects those changes, including ONDCP’s approval of reprogramming or transfers affecting drug related resources in excess of \$5 million.”*

**Conclusion**

We confirmed that PL 106-113 removed \$79.5 million from government-wide budget authorities to meet discretionary spending caps for FY 2000. However, this did not specifically affect drug control-related funding because drug control expenditures are reported on the basis of patients served in various VA clinical settings. Nothing came to our attention indicating that the reprogramming had an affect on drug control-related activities or aggregate obligations.

## DEPARTMENT OF VETERANS AFFAIRS

DETAILED ACCOUNTING SUBMISSION FOR FY 2001<sup>5</sup>I. RESOURCE SUMMARY

	(Budget Authority in Millions)		
	2000 Final	2001 Enacted	2002 Request
<b>Drug Resources by Goal</b>			
Goal 3	\$554,628	\$572,915	\$580,766
<b>Drug Resources by Function</b>			
Treatment	\$546,831	\$564,363	\$571,358
Treatment Research	<u>7,797</u>	<u>8,552</u>	<u>9,408</u>
Total	\$554,628	\$572,915	\$580,766
<b>Drug Resources by Decision Unit</b>			
Medical Care	\$546,831	\$564,363	\$571,358
Research	<u>7,797</u>	<u>8,552</u>	<u>9,408</u>
Total	\$554,628	\$572,915	\$580,766
<b>Drug Resources Personnel Summary</b>			
Total FTEs (direct only)	3,621	3,661	3,616
<b>Information</b>			
Total Agency Budget	\$45,505.0	\$47,442.0	\$51,652.5
Drug Percentage	1.22%	1.21%	1.12%

II. METHODOLOGY

- Specialized Treatment Costs – Includes all costs generated by the treatment of patients with drug use disorders treated in specialized substance abuse treatment programs.
- Other Related Treatment – Includes all costs generated by the treatment of patients with a primary drug use diagnosis treated in any other treatment setting. No “other costs” associated with secondary and associative diagnosis is factored into the drug budget. A primary drug abuse diagnosis suggests that a drug use disorder was the focus of treatment in the non-specialized setting.
- This summary accounts for drug-related costs for VHA Medical Care and Research. It is not all encompassing of drug-related costs for the agency. VA incurs costs related to accounting and security of narcotics and other controlled substances and costs of law enforcement related to illegal drug activity; however, these costs are assumed to be relatively small and would not have a material effect on the aggregate VA costs reported.

<sup>5</sup> The Detailed Accounting Submission for FY 2001 is the responsibility of VA management.

## APPENDIX II

- As displayed in this volume, VA's drug control budget methodology has been changed to more accurately account for drug-related treatment funding. As a result of improved tracking mechanisms within the cost accounting system regarding drug patients, VA is now better able to account for the drug-related resources associated with medical treatment costs for patients with substance abuse disorders. Previously, VA included "other related treatment costs" of patients treated with primary, secondary or associated drug diagnoses - various percentages of treatment costs were applied depending on the patient's drug diagnosis. This data was then extrapolated from previous years to current years by applying the Medical Consumer Price Index. This process resulted in capturing costs that were not directly related to anti-drug treatment. As a result, a change in drug methodology has been implemented that more accurately accounts for drug-related treatment.
- For FY 2000, the revised methodology has resulted in a scorekeeping adjustment of \$556.8 million from the amount reported in last year's *Budget Summary*. Adjustments have been made to the historical data series for all fiscal years in which VA has reported drug funding. This change reflects a technical scorekeeping adjustment only and has no adverse effect on the actual level of VA's resources devoted to drug treatment.

### III. PROGRAM SUMMARY

- The Department of Veterans Affairs, through its Veterans Health Administration, operates a network of substance abuse treatment programs located in the Department's medical centers, domiciliaries, and outpatient clinics. VA plays a major role in the provision of services to veterans who are "service connected" or indigent. (The term "service connected" refers to injuries sustained while in military service, especially those injuries sustained as a result of military action). All of the drug-related resources support Goal 3 of the *Strategy*.
- The investment in health care and specialized treatment of veterans with drug abuse problems identified as funded by the resources in Medical Care helps avoid future health, welfare and crime costs associated with illegal drug use.
- In coordination with the Center for Substance Abuse Treatment (CSAT) on how to best employ outreach models, VA has been a participant in the Treatment Improvement Protocol (TIP) initiative. A component of this project is the specific development of TIP number 27, relating to case management and the associated facilitation of access to treatment.
- The dollars expended in research help to acquire new knowledge to improve the prevention, diagnosis and treatment of disease, and acquire new knowledge to improve the effectiveness, efficiency, accessibility and quality of veterans' health care.
- The Department of Veterans Affairs, in keeping with modern medical practice, continues to improve service delivery by expanding primary care and shifting treatment services to lower cost settings when clinically appropriate. Included in this shift to more efficient and cost effective care delivery has been VA's substance abuse treatment system. Initial data suggest these shifts in care delivery may impact budgets in future years. The exact nature of the impact, if any, cannot be determined until additional trend data becomes available.

#### IV. BUDGET SUMMARY

##### **FY 2001 Program Level by Strategy Goal**

##### **Goal 3: Reduce health and social costs to the public of illegal drug use.**

- In FY 2001, VA will spend \$572.9 million for treatment activities that support Goal 3 of the *Strategy*. This includes \$564.4 million for medical care; \$264.6 million for specialized treatment; \$299.8 million for other related treatment that provides treatment of patients with a primary drug use diagnosis treated in any other treatment setting; and \$8.6 million for research and development to be applied towards drug abuse related research.

##### **FY 2002 Significant Program Changes**

- The FY 2002 request is \$580.8 million, which consists of \$571.4 million for medical care and \$9.4 million for drug abuse related research. This represents a \$7.9 million increase over FY 2001 enacted levels.
- In conjunction with the Department of Health and Human Services (HHS) and the Department of Justice (DOJ), VA will make available to communities its expertise in drug treatment theory and program development. The emphasis will be on the establishment of a treatment continuum, the implementation of patient/treatment matching and methods of evaluating treatment outcome and implementing and assessing the effectiveness of clinical practice guidelines. VA will be able to accomplish this within existing resources, primarily through its Center of Excellence in Substance Abuse Treatment and Education (CESTATE) and its Program Evaluation and Resource Center (PERC). These two entities already provide these services within VA and will be made available for integration into similar activities within HHS and DOJ.
- Increase treatment efficiency and effectiveness. Provide information on successful methods in various programs and the number of referrals that enter treatment. The dollars expended in research help to meet this goal and objective by (1) acquiring new knowledge to improve the prevention, diagnosis and treatment of disease, and (2) acquiring new knowledge to improve the effectiveness, efficiency, accessibility and quality of veterans' health care.
- Use effective outreach referral and case management efforts to facilitate early access to treatment. In coordination with CSAT on how best to employ outreach models, VA has been and will continue to be a participant in the Treatment Improvement Protocol (TIP) initiative developed by CSAT of SAMHSA, Department of Health and Human Services. A component of this project is the specific development of a TIP relating to case management and the associated facilitation of access to treatment. Previously issued TIPs have been made available to VA treatment programs, and have been used in VA's continuing education activities. This effort will continue in the future.

**V. PROGRAM ACCOMPLISHMENTS**

- Specialized substance abuse treatment services are available at 153 VA medical facilities. These are predominantly ambulatory treatment programs.
- VA continues to provide inpatient treatment services to veterans with significant substance abuse and psychosocial problems: 54 percent are 50 and older, 75 percent are not married, 37 percent are members of an ethnic minority, and 31 percent have service-connected disabilities. Among patients with drug diagnoses treated in specialized inpatient substance abuse units, 50 percent abuse cocaine, 34 percent abuse opioids, and 38 percent have coexisting psychiatric diagnoses.
- Improved rates of treatment retention: The PERC, Palo Alto Healthcare System, is conducting a major process-outcome evaluation of substance abuse treatment programs. PERC is focusing on substance abuse treatment programs at 13 VA Medical Centers that follow a traditional 12-step and/or a cognitive-behavioral (C-B) treatment approach. These are the two most prevalent treatment orientations in VA programs. Intake and discharge data have been collected on over 3,000 patients; one- and two-, and five-year follow-ups have been conducted. Findings obtained include:
  - A total of 40 percent of the patients were abstinent from alcohol and drugs in the three months before the 1-year follow-up compared with only 2 percent in the three months before treatment intake. Additionally, at follow-up, 30 percent of the patients had no problems due to substance use, whereas at intake only 3 percent had no such problems. Psychological, legal and employment functioning also improved, but less substantially.
  - Casemix-adjusted (statistically controlled for differences in patient characteristics across the different types of programs) 1-year outcomes showed that patients in 12-step programs were most likely to be abstinent, free of substance abuse problems, and employed. Patients who obtained more regular and more intensive outpatient mental health care, and those who participated more in 12-step self-help groups, were more likely to be abstinent and free of substance use problems.
  - With respect to treatment processes, patients in 12-step programs improved more between intake and discharge than did (C-B) patients on proximal. Outcomes assumed to be specific to 12-step treatment outcomes (e.g., disease concept beliefs, attending 12-step meetings), whereas patients in C-B programs made no greater change (and on a few variables, less change) than did 12-step patients on proximal. Outcomes assumed to underlie C-B treatment (e.g., sense of self-efficacy, coping skills).
  - No evidence was found that C-B or 12-step treatment is more beneficial for certain types of patients than is the other treatment approach.
  - Dually diagnosed patients and those with only substance use disorders had comparable substance use outcomes. However, patients with major psychiatric disorders fared worse on

## APPENDIX II

psychological symptoms and employment outcomes than did patients with personality disorders or only substance use disorders.

- PERC recently completed a prospective 1-year evaluation of a nationwide sample of more than 2,300 VA substance abuse patients seen in the Contract Residential Facilities (CRF) program. The findings are that:
  - Patients in the CRF program improve substantially between treatment intake and 1-year follow-up.
  - Patients who have longer episodes of care and participate more intensively in the CRF program have better casemix-adjusted 1-year outcomes.
  - The CRF program benefits diverse subgroups: substance abuse patients with psychiatric disorders, residually unstable and homeless patients, patients mandated to treatment, and patients admitted directly from outpatient care.
  - Patients in CRF care have better casemix-adjusted 1-year outcomes than comparable patients discharged directly from inpatient care to independent living in the community.
  - Patients who are clinically eligible to be admitted directly to CFRs from outpatient care have similar casemix-adjusted 1-year outcomes but lower costs than do comparable patients who first have an episode of inpatient care.
  - Patients who obtain more consistent outpatient mental health care during and after the CRF episode have better 1-year substance use and psychosocial outcomes than patients who obtain less consistent outpatient care.
- The PERC is working with Mental Health Strategic Healthcare Group to develop a system of indicators to monitor the provision of services to veterans with substance use disorders. The first phase of development will test monitors designed to assess the effectiveness of indicators measuring access to treatment and continuity of services. Later phases will evaluate treatment outcome using indicators such as changes in substance use, medical and psychiatric status, economic status, and social conditions after receipt of services.

**Department of Veterans Affairs**  
**Drug Control Funding by Goal and Function: FY 2000 – FY 2001**  
**(Budget Authority in Millions)**

**Drug Resources by Goal**

	<b>Strategy Goal</b>	<b>FY 2000 Final BA</b>	<b>FY 2001 Enacted</b>
Department of Veterans Affairs	3	\$554,628	\$572,915

**Drug Resources by Function**

	<b>Drug Function</b>	<b>FY 2000 Final BA</b>	<b>FY 2001 Enacted</b>
Department of Veterans Affairs	Treatment	\$546,831	\$564,363
	Research & Development	\$7,797	\$8,552
Total, Department of Veterans Affairs		\$554,628	\$572,915



**FINAL REPORT DISTRIBUTION**

**VA Distribution**

Acting Principal Deputy Assistant Secretary for Management (004)  
Chief Financial Officer, Veterans Health Administration (17)

**Non-VA Distribution**

Chief, Budget Branch, Office of National Drug Control Policy