



Department of Veterans Affairs

Office of Inspector General

AUDIT OF DEPARTMENT OF VETERANS AFFAIRS FISCAL YEAR 2001 SPECIAL DISABILITIES CAPACITY REPORT

With the exceptions noted herein, VA's Special Disabilities Capacity Report fairly and accurately presents the staffing, workload, costs, and other data required by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001.

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Executive Summary

Introduction

The Office Inspector General (OIG) conducted an audit of the Department of Veterans Affairs (VA) Fiscal Year (FY) 2001 Special Disabilities Capacity Report. Congress has required the Capacity Report on an annual basis since 1999 as a means to measure compliance with Title 38 United States Code, Section 1706. This statute requires that the Veterans Health Administration (VHA) maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans to a level not below that which was available as of October 9, 1996.

The audit was conducted to comply with the VA's Health Care Programs Enhancement Act of 2001 (Public Law 107-135) which requires that the OIG audit each annual Capacity Report and submit a certification to Congress as to its accuracy. This statute requires that VA's capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans be measured and reported for the following programs: (1) spinal cord injury/disorders; (2) traumatic brain injury; (3) blindness; (4) prosthetics and sensory aids; and, (5) mental health. The measures of capacity as specified in the statute vary by program and include such areas as program costs, staffing, patients treated, number of beds, and recidivism.

Audit Results

We reviewed the reasonableness and consistency of supporting special disabilities capacity data for the 26 tables VA included in the Capacity Report to support the information required by Public Law 107-135 for the following programs:

- Mental Health – Tables A through G1 (22 tables)
- Spinal Cord Injury/Disorders – Table H1 (1 table)
- Blindness – Table I1 (1 table)
- Prosthetics and Sensory Aids – Table J (1 table)
- Traumatic Brain Injury – Table K (1 table)

We found that adequate subsidiary records existed and supported 21 tables (three of which were found by the audit to contain incorrect data because of programming errors, but which VHA agreed to correct and re-issue). Of the remaining five tables, one contained reported staffing data that was confusing and unreliable, and four were found to contain significant inaccuracies in the reported number of staff (*Details of the audit results are presented in Appendix C on pages 6-11.*). The five tables we identified with data reporting deficiencies are listed below:

- Specialized Mental Health Programs – Number and Type of Staff and Full Time Equivalent Employees (FTEE) by Facility, and Veterans Integrated Service Network (VISN) (Table E)
- Outpatient Psychosocial Rehabilitation Programs – Number and Type of Mental Health Staff by Clinic, Facility, and VISN (Table F1c)

- Outpatient Homeless Mental Health Programs – Number and Type of Mental Health Staff by Clinic, Facility, and VISN (Table F1d)
- Outpatient Post Traumatic Stress Disorder Programs – Number and Type of Mental Health Staff by Clinic, Facility, and VISN (Table F1e)
- Outpatient Mental Health Intensive Case Management Programs – Number and Type of Mental Health Staff by Clinic, Facility, and VISN (Table F1f)

Conclusion

With the exception of the five tables identified above, we concluded that VA's FY 2001 Special Disabilities Capacity Report fairly and accurately presents the staffing, workload, costs, and other data required by the VA Health Care Programs Enhancement Act of 2001.

Under Secretary for Health Comments

During the course of the audit, we issued an Advisory Letter to VHA program officials outlining the data reporting deficiencies identified. On August 27, 2002 the Under Secretary for Health provided a response to the Advisory that agreed with the audit results and discussed actions VHA will take to address the data reporting deficiencies identified. *(See Appendix D on page 12 for the Under Secretary's comments.)*

(original signed by:)
MICHAEL SLACHTA, JR
Assistant Inspector General for Auditing

Results and Conclusion

Department Subsidiary Records Support The Accuracy Of Twenty-One Of The Twenty-Six Tables Containing The Special Disabilities Capacity Data Required By Public Law 107-135

The audit found that 21 of the 26 tables of data specifically required by the VA Health Care Programs Enhancement Act of 2001 (Public Law 107-135.) had adequate supporting data, including three tables that we initially found that had inaccurate data due to programming errors. *(Details of the audit results are presented in Appendix C on pages 6-11.)* During the course of the audit, VHA program officials agreed to correct the erroneously reported data and re-issue the three tables. The following briefly describes the data reporting deficiencies found in the three tables:

- Dual Diagnoses - Individuals and Dollars – Table C *(The number of patients treated annually and the amounts expended for dual diagnosis mental health patients annually by VISN since FY 1996.)* The audit found that a programming error resulted in FY 1997 data that were incorrect. The error resulted in the under-reporting of both the number of unique individuals and costs for all VISNs.
- Total Seriously Mentally Ill and Non-Seriously Mentally Ill Non-Pharmacy Treatment Expenditures – Table G1 *(The total amount expended for mental health during the year.)* The audit found that a programming error had resulted in FY 2001 costs for one VISN that were approximately twice what should have been reported.
- Blindness - FTEE and Operating Beds – Table I1 *(The number of staffed beds and the number of FTEE assigned to provide care at Blind Rehabilitation Centers.)* The audit found that a programming error resulted in staffing data for two facilities that were incorrect. The error resulted in the over-reporting of staffing at one facility and the corresponding under-reporting of staffing at another facility.

Five Tables Contain Unreliable Or Inaccurate Data Or Do Not Address The Specific Staffing, Workload, Costs, And Other Data Required By Public Law 107-135

Five of the 26 tables included in the audit were found to contain unreliable or inaccurate data. All five of these tables address mental health staffing and are based on VHA Cost Distribution Report (CDR) information, which is the common underlying weakness. The following briefly describes the nature of the data inaccuracies identified for each table:

- Specialized Mental Health Programs – Table E *(The number and type of staff that are available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison*

from FY 1996 through FY 2001.) Table E was constructed by VHA using the CDR information to identify staffing charged to five cost centers associated with mental health treatment. These cost centers included psychiatry, psychology, social work, mental health nursing, and psychosocial rehabilitation. We found that the use of the CDR does not allow for the identification of the specific types of staff required by the statute. CDR cost centers are comprised of personnel “types” that are not solely mental health specific. For example, personnel charged to the psychiatry cost center can include clinical staff as well as administrative staff and staff from other services since each facility decides how to distribute its own staff costs. As a result, we noted severe increases and decreases in staffing levels among mental health, nursing, psychiatry, etc., which are not necessarily a reflection of actual staffing level changes but of accounting procedures. VHA program officials also explained that facility consolidations severely affect the validity of any attempt at staffing analysis from year to year.

VHA recognizes the limitations in using the CDR to construct staffing tables and states in the Special Disabilities Capacity Report that “...staffing representations are not solely comprised of the staff category listed. Often different categories of staff are contained within any given staff category because the cost center for any one discipline may include several categories of staff. As an example, some VISNs transferred mental health professionals from all disciplines to psychiatry when they moved from the traditional discipline specific organizational structure to a mental health care line structure. As a result of these inconsistencies in reporting, Table E should be viewed as an overall representation of staffing trends rather than as a specific portrayal for any specific discipline or any specific facility.”

The following four tables represent a subset of the staffing data included in Table E and, as a result, include the problems affecting the accuracy of the data presented. However, we found additional data accuracy problems for these four tables beyond the issues identified for Table E. Specifically, Tables F1c through F1f present the number of staff associated with the number of clinics and type of mental health programs at each clinic identified in corresponding Tables F2c through F2f. As a result, the two groups of tables should be consistent. Specifically, if Table F2c shows that a program exists at a clinic, Table F1c should show staff charged to that program. We found numerous examples where facility programs were reported in Tables F2c through F2f, but no staff were charged to those programs in Tables F1c through F1f as follows:

- Outpatient Psychosocial Rehabilitation Programs – Table F1c (*The number and type of mental health staff at each clinic.*) Twenty facilities reported that “0” staff were charged to these programs while also reporting in related Table F2c (Outpatient Psychosocial Rehabilitation Programs – The number of clinics and type of mental health programs at each clinic.) that these programs existed. We found that the numbers of programs shown in Table F2c were counted using clinic stop codes from the CDR in accordance with the instructions in the “data definitions” section of the Special Disabilities Capacity Report. However, the instructions for Table F1c excluded some of the cost centers where these staff were charged by many facilities. As a result, the reported number and type of staff dedicated to Outpatient Psychosocial Rehabilitation Programs is not accurate.

- Outpatient Homeless Mental Health Programs – Table F1d (*The number and type of mental health staff at each clinic.*) Fifteen facilities reported that “0” staff were charged to these programs, while also reporting in related Table F2d (Outpatient Homeless Mental Health Programs – The number of clinics and type of mental health programs at each clinic.) that these programs existed. As with Table F2c, the numbers of programs were counted using clinic stop codes from the CDR. However, we found that the staff for these programs were frequently charged to CDR cost accounts that were not included in the Special Disabilities Capacity Report. As a result, the reported number and type of staff dedicated to Outpatient Homeless Mental Health programs is not accurate.
- Outpatient Post Traumatic Stress Disorder Programs – Table F1e (*The number and type of mental health staff at each clinic.*) Thirty-seven facilities reported that “0” staff were charged to these programs, while also reporting in related Table F2e (Outpatient Post Traumatic Stress Disorder Programs – The number of clinics and type of mental health programs at each clinic.) that these programs existed. As with Tables F2c and F2d, we found that the numbers of programs were counted using clinic stop codes. However, the staff for these programs were not included in the Special Disabilities Capacity Report. As a result, the reported number and type of staff dedicated to Outpatient Post Traumatic Stress Disorder Programs is not accurate.
- Outpatient Mental Health Intensive Case Management Programs – Table F1f (*The number and type of mental health staff at each clinic.*) Nine facilities reported that “0” staff were charged to these programs, while also reporting in related Table F2f (Outpatient Mental Health Intensive Case Management Programs – The number of clinics and type of mental health programs at each clinic.) that these programs existed. As with Tables F2c, F2d, and F2e, we found that the numbers of programs were counted using clinic stop codes. However, the staff for these programs were not included in the Special Disabilities Capacity Report. As a result, the reported number and type of staff dedicated to Outpatient Mental Health Intensive Case Management Programs is not accurate.

Conclusion

With the exception of the five tables discussed, we concluded that VA’s FY 2001 Special Disabilities Capacity Report fairly and accurately presents the staffing, workload, costs, and other data required by the VA Health Care Programs Enhancement Act of 2001 (Public Law 107-135).

Objectives, Scope, and Methodology

Objectives

The purpose of the audit was to determine if the Special Disabilities Capacity Report accurately presents the information required by Public Law 107-135. Our objectives were to:

- Review and verify that the data presented in the Capacity Report addressed the information required by the Public Law 107-135.
- Verify that adequate support existed for the staffing, workload, costs, and other required data.

Scope And Methodology

The audit included the data required by Section 203 of Public Law 107-135, which VHA constructed from existing national VA databases and recurring reports, and which were then formatted into 26 data tables (*Details on each table are presented in Appendix C on pages 6-11.*) We did not review other data tables that were included in the Capacity Report because they contained information not required by the statute. VHA included additional tables in the Capacity Report to further describe the resources and workload devoted to the special disabilities programs. These tables included five summary tables, two supplemental tables, one mental health table (Table G2), two Spinal Cord Disorder tables (Tables H2a and H2b), and three Blind Rehabilitation tables (Tables I2, I3, and I4). We also did not address the narrative interpretations of the data since these contained elements of clinical and program judgment.

The multi-year nature of the Capacity Report required that our work include prior year data as a basis for comparative analysis. These data are included in the report because the criteria for which “capacity measures” are compiled have changed when compared with previous Capacity Reports.

In addition to performing a comparative analysis, we interviewed program officials and staff and conducted follow-up verification work at VA Central Office (VACO) and the following six VHA field locations:

- Northeast Program Evaluation Center (NEPEC), West Haven, CT
- Allocation Resource Center (ARC), Braintree, MA
- VISN 2 Headquarters, Albany, NY
- VISN 10 Mental Health Program Office, VA Medical Center (VAMC), Brecksville, OH
- VISN 18 Headquarters, Phoenix, AZ
- VISN 23 (formerly VISN 13) Headquarters, Minneapolis, MN

The audit was performed in accordance with generally accepted Government Auditing Standards.

Background

Legislation has required the Special Disabilities Capacity Report since VHA's 1996 decentralization of its field management structure. Veterans Services Organizations and other advocates of special disability programs were concerned that the autonomy granted to local managers under decentralization would allow them to draw off resources from some specialized high-cost rehabilitation programs for the benefit of other clinical programs. As a result, Section 1706 of Title 38 United States Code requires that VHA maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans to a level not below that which was available as of October 9, 1996. Annual reports detailing various measures of capacity have been required since FY 1998. Although this reporting requirement was to have expired with the issuance of the FY 2000 Special Disabilities Capacity Report, the VA Health Care Programs Enhancement Act of 2001 (Public Law 107-135) extended this requirement through FY 2004.

Prior to Public Law 107-135, VHA was allowed to decide what data was to be reported as a measure of capacity and what programs were to be included in the definition of "Special Disabilities". However, the law now requires that capacity be measured and reported annually for the following programs: (1) spinal cord injury/disorders, (2) traumatic brain injury, (3) blindness, (4) prosthetics and sensory aids, and (5) mental health. The measures of capacity are also now specified in the statute for each program including costs and spending, staffing, patients treated, number of beds, etc. Another significant change brought about by the statute is the requirement that "Each report ... shall be audited by the Inspector General of the Department, who shall submit to Congress a certification as to the accuracy of each such report."

Results of Data Tables Reviewed

Audit of Department of Veterans Affairs Fiscal Year 2001 Special Disabilities Capacity Report

Table A - Mental Health Intensive Case Management - Individuals and Teams

Data Required By Statute	The number of discrete mental health intensive case management (MHICM) teams constituted to provide intensive community-based care to seriously mentally ill veterans and the number of veterans provided such care reported annually by VISN since FY 1996.
Description of Questionable Data	Two VISNs report that no MHICM patients were treated in 1996 or 2001.
Affected VISNs	15 and 18
Audit Work Performed	Site visit to NEPEC, and survey of VISN 18.
Results	The data were found to be accurate.

Table B - Opioid Substitution Programs - Individuals and Dollars

Data Required By Statute	The number of patients treated annually and the amounts expended for opioid substitution programs reported annually by VISN since FY 1996.
Description of Questionable Data	A complete absence of opioid substitution programs appeared questionable.
Affected VISNs	2, 7, 9, 14, 18, 19
Audit Work Performed	Site visits to NEPEC, ARC, VISN 2, and survey of VISN 18.
Results	The data were found to be accurate.

Table C - Dual Diagnoses - Individuals and Dollars

Data Required By Statute	The number of patients treated annually and the amounts expended for dual diagnosis mental health patients annually by VISN since FY 1996.
Description of Questionable Data	1997 data appeared too far out-of-line to be accurate.
Affected VISNs	All
Audit Work Performed	Site visit to ARC.
Results	The FY 1997 data were found to be inaccurate. A programming error resulted in the under-reporting of both the number of unique individuals and costs. VHA agreed to correct and re-issue the table

Substance Abuse Disorders Programs

Table Di - Occupied Beds in VA and Non-VA Substance Abuse Programs

Data Required By Statute	The number of beds (whether hospital, nursing home, or other designated beds) employed for substance abuse and the average occupancy of such beds.
Description of Questionable Data	Four VISN's reported large increases/decreases in spite of new Grant Per Diem Programs.
Affected VISNs	2, 3, 14, 22
Audit Work Performed	Site visits to NEPEC and VISN 2.
Results	The data were found to be accurate.

Table Dii - Outpatient Substance Abuse Services for Individuals

Data Required By Statute	The percentage of patients admitted directly to outpatient care during the fiscal year who had 2 or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison from FY 1996 through FY 2001.
Description of Questionable Data	None
Affected VISNs	N/A
Audit Work Performed	Site visit to NEPEC.
Results	The data were found to be accurate.

Appendix C

Table Diii - Substance Abuse Services for Inpatients

Data Required By Statute	The percentage of unique patients with substance use disorder diagnoses treated during the fiscal year who had one or more specialized clinic visits within 3 days of their discharge, with a comparison from FY 1996 through FY 2001.
Description of Questionable Data	None
Affected VISNs	N/A
Audit Work Performed	Site visit to NEPEC.
Results	The data were found to be accurate.

Table Div - Substance Abuse Services for Outpatients in Specialized Care

Data Required By Statute	The percentage of unique outpatients seen in a facility or geographic service area during the fiscal year who had one or more specialized clinic visits, with a comparison from FY 1996 through FY 2001.
Description of Questionable Data	None
Affected VISNs	N/A
Audit Work Performed	Site visit to NEPEC.
Results	The data were found to be accurate.

Table Dv - Inpatient Substance Abuse Recidivism

Data Required By Statute	The rate of recidivism of patients at each specialized clinic in each geographic service area.
Description of Questionable Data	A complete absence of patients discharged from VA beds.
Affected VISNs	2, 8, 19
Audit Work Performed	Site visit to VISN 2.
Results	The data were found to be accurate.

Table E – Specialized Mental Health Programs

Data Required By Statute	The number and type of staff that are available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison from FY 1996 through FY 2001.
Description of Questionable Data	The data show large and unusual variances from year to year.
Affected VISNs	All
Audit Work Performed	Site visits to ARC and VISN 2 and interviews with VACO program staff.
Results	The data were found to be misleading and confusing. Additionally; (1) the methodology used to compile the data is based on cost centers rather than personnel type, and as a result, the severe increases and decreases in staffing levels among nursing, psychiatry, etc. are not necessarily a reflection of actual staffing changes but of accounting procedures, and (2) facility consolidations severely affect the validity of any attempt at analysis from year to year.

Tables F – Mental Health – Characteristics of Clinics Providing Care: Type and Number of Staff by Clinics, Facility and VISN.

Table F1a – Outpatient Psychotic Disorders Programs

Data Required By Statute	The number and type of mental health staff at each clinic.
Description of Questionable Data	Overall staffing went up 26%, but VISN 13 went up 111%.
Affected VISN	13
Audit Work Performed	Site visit to ARC and survey of VISN 13.
Results	The data were found to be accurate for VISN 13 (although as with Table E, the use of CDR cost centers does not allow for the clear identification of type of staff).

Appendix C

Table F1b – Outpatient Substance Abuse Programs

Data Required By Statute	The number and type of mental health staff at each clinic.
Description of Questionable Data	Overall staffing went up 14%, but VISN 10 went up 86%.
Affected VISN	10
Audit Work Performed	Site visits to ARC and VISN 10.
Results	The data were found to be accurate for VISN 10 (although as with Table E, the use of CDR cost centers does not allow for the clear identification of type of staff).

Table F1c – Outpatient Psychosocial Rehabilitation Programs

Data Required By Statute	The number and type of mental health staff at each clinic.
Description of Questionable Data	The data appeared out-of-line (i.e., 13 VISNs had facilities reporting they had “0” staff charged to this program, but listed programs in Table F2c).
Affected VISNs	1, 2, 3, 4, 6, 7, 9, 12, 13, 16, 17, 20, 22
Audit Work Performed	Site visits to ARC and VISN 2, and survey of VISN 13.
Results	<p>The data were found to be inaccurate. The Capacity Report shows that in VISN 2, VAMC Bath charged “0” staff to its Outpatient Psychosocial Rehabilitation Program (also known as Compensated Work Therapy or CWT) from FY 1996 through FY 2001. However, the facility also listed a single program in each year from 1996 through 2000 in Table F2c (Outpatient Psychosocial Rehabilitation Programs: Number of Programs by Clinic, Facility, and VISN). We determined that the single program shown in Table F2c is correct per the data definitions section of the Capacity Report. However, the number of staff shown (i.e., “0”) is not correct because the data definitions did not include the cost center where the facility charged its staff.</p> <p>In VISN 13, the same situation was reported for VAMC Minneapolis (i.e., “0” staff were charged to the CWT program in the Capacity Report). Like VISN 2, the CWT staff were charged to CDR cost center that was not counted by the Capacity Report. In total, we noted that 20 facilities in 13 VISNs had similar reporting problems.</p>

Table F1d – Outpatient Homeless Mental Health Programs

Data Required By Statute	The number and type of mental health staff at each clinic.
Description of Questionable Data	The data appeared out-of-line (i.e. 12 VISNs had facilities reporting they had no staff charged to this program but listed programs in Table F2d).
Affected VISNs	3, 4, 5, 7, 9, 12, 13, 15, 16, 20, 21, 22
Audit Work Performed	Site visit to ARC and surveys of VISNs 13 and 18.
Results	<p>The data were found to be inaccurate. The Capacity Report shows that in VISN 13, VAMC Minneapolis charged “0” staff to the Outpatient Homeless Mental Health Program throughout FY 1996 through FY 2001. However, a single clinic was listed for all of these years in Table F2d (Outpatient Homeless Mental Health Programs). We determined that the single program shown in Table F2c is correct per the data definitions section of the Capacity Report. The VISN 13 Director reported to us that there has been a minimum of 2 FTEE assigned to this program throughout the period covered by the Capacity Report, but that these staff were not charged to the cost centers provided for in the data definitions section of the Capacity Report.</p> <p>VISN 18 reported similar problems with the distribution and counting of homeless program staff. In total, we noted that 15 facilities within 12 VISNs had similar reporting problems.</p>

Appendix C

Table F1e – Outpatient Post Traumatic Stress Disorder Programs

Data Required By Statute	The number and type of mental health staff at each clinic.
Description of Questionable Data	The data appeared out-of-line. (i.e. all VISNs except 4 had facilities reporting they had "0" staff charged to this program, but listed programs in Table F2e).
Affected VISNs	All except 5, 13, 14, 18
Audit Work Performed	Site visits to ARC, VISN 2, and VISN 10 and survey of VISN 18.
Results	<p>The data were found to be inaccurate. The Capacity Report shows that In VISN 2, VAMCs Albany, Bath and Syracuse charged "0" staff to Outpatient Post Traumatic Stress Disorder (PTSD) programs in Table F1e but nevertheless reported the existence of programs in Table F2e (Outpatient PTSD Programs: Number of Programs by Clinic, Facility and VISN). The number of programs shown in Table F2e is correct and was pulled from the clinic stop codes for specialized PTSD clinics. However, the number of staff is not correct because, per the Data Definition section of the Capacity Report, only staff charged to Outpatient PTSD Clinical Teams were picked up for the Capacity Report and only sites authorized by the NEPEC can use these cost centers. For 2001, VISN 2 had no NEPEC authorized sites.</p> <p>In VISN 10, the Capacity Report showed that VAMCs Columbus and Cincinnati both charged "0" staff to these programs. However, both facilities showed the existence of these programs in Table F2e. Both facilities were asked to provide their correct staffing data for these programs. VAMC Columbus reported that it has 2.5 FTEE and VAMC Cincinnati reported from 3 FTEE in FY 1996 to 10 in FY 2000. These staff were not counted in the Capacity Report due to their being charged to cost centers that were not listed in the data definitions. VISN 18's response to the same question for VAMC Amarillo was "VAMC Amarillo does not have a specialized PTSD Treatment program" and therefore "0" staff were picked up in the Capacity Report. However, PTSD sessions are held at VAMC Amarillo under clinic stop code 516 (PTSD, group) which are run by social workers, psychologists, or registered nurses and were therefore counted in Table F2e. In total, we noted that 37 facilities in all, but 4 VISNs had similar reporting problems.</p>

Table F1f – Outpatient Mental Health Intensive Case Management Programs

Data Required By Statute	The number and type of mental health staff at each clinic.
Description of Questionable Data	The data appeared out-of-line. (i.e., 4 VISNs had facilities reporting they had no staff charged to this program, but listed programs in Table F2f).
Affected VISNs	10, 14, 16, 19
Audit Work Performed	Site visits to the ARC and VISN 10.
Results	<p>The data were found to be inaccurate. In VISN 10, VAMC Columbus and VAMC Cincinnati showed "0" staff charged to these programs in Table F1f while showing the existence of these programs in Table F2f (Outpatient MHICM Programs - Number of Programs by Clinic, Facility, and VISN). Both facilities were asked to provide their correct staffing data for these programs. VAMC Columbus reported to us that the program was staffed with from 3 FTEE in FY 1998 to 3.6 FTEE in FY 2001. VAMC Cincinnati reported to us that their MHICM program was staffed with from 3.75 FTEE in FY 1999 to 4.75 in FY 2001. These staff were not counted in the Capacity Report due to their being charged to cost centers that were not listed in the Capacity Report's data definitions.</p>

Table F2a – Outpatient Psychotic Disorders Programs

Data Required By Statute	The number of clinics and type of mental health programs at each clinic.
Description of Questionable Data	The change in the number of programs appeared unreasonable at VISN 10.
Affected VISNs	10
Audit Work Performed	Site visit to VISN 10.
Results	The data were found to be accurate.

Appendix C

Table F2b – Outpatient Substance Abuse Programs

Data Required By Statute	The number of clinics and type of mental health programs at each clinic.
Description of Questionable Data	The change in the number of substance abuse programs appeared unreasonable at VISN 10.
Affected VISNs	10
Audit Work Performed	Site visit to VISN 10.
Results	The data were found to be accurate.

Table F2c – Outpatient Psychosocial Rehabilitation Programs

Data Required By Statute	The number of clinics and type of mental health programs at each clinic.
Description of Questionable Data	Data appeared out-of-line with related staffing data in Table F1c.
Affected VISNs	1, 2, 3, 4, 6, 7, 9, 12, 13, 16, 17, 20, 22
Audit Work Performed	Site visits to ARC and VISN 2, and survey of VISN 13.
Results	The data for Table F2c were found to be accurate. (The data in Table F1c were found to be inaccurate).

Table F2d – Outpatient Homeless Mental Health Programs

Data Required By Statute	The number of clinics and type of mental health programs at each clinic.
Description of Questionable Data	Data appeared out-of-line with related staffing data in Table F1d.
Affected VISNs	3, 4, 5, 7, 9, 12, 13, 15, 16, 20, 21, 22
Audit Work Performed	Site visit to ARC and surveys of VISNs 13 and 18.
Results	The data for Table F2d were found to be accurate. (The data in Table F1d were found to be inaccurate).

Table F2e – Outpatient Post Traumatic Stress Disorder Programs

Data Required By Statute	The number of clinics and type of mental health programs at each clinic.
Description of Questionable Data	Data appeared out-of-line with related staffing data in Table F1e.
Affected VISNs	All except 5, 13, 14, 18
Audit Work Performed	Site visits to ARC, VISN 2, and VISN 10, and survey of VISN 18.
Results	The data for Table F2e were found to be accurate. (The data in Table F1e were found to be inaccurate).

Table F2f – Outpatient Mental Health Intensive Case Management Programs

Data Required By Statute	The number of clinics and type of mental health programs at each clinic.
Description of Questionable Data	Data appeared out-of-line with related staffing data in Table F1e.
Affected VISNs	10, 14, 16, 19
Audit Work Performed	Site visits to the ARC and VISN 10.
Results	The data for Table F2f were found to be accurate. (The data in Table F1f were found to be inaccurate).

Table G1 – Total Seriously Mentally Ill and Non-Seriously Mentally Ill Non-Pharmacy Treatment Expenditures

Data Required By Statute	The total amount expended for mental health during the year.
Description of Questionable Data	VISN 15 showed in excess of 140% increase in mental health spending from FY 2000 to FY 2001.
Affected VISNs	15
Audit Work Performed	Site visit to the ARC.
Results	The table was found to contain erroneous data. A programming error resulted in the double counting of costs for VISN 15. VHA agreed to correct and re-issue the table.

Appendix C

Table H1 – Spinal Cord Injury/Disorders Staffed Beds and FTEE Assigned

Data Required By Statute	The number of staffed beds and the number of FTEE assigned to provide care at Spinal Cord Injury/Disorders Centers.
Description of Questionable Data	None
Affected VISNs	N/A
Audit Work Performed	Review of supporting records at VACO program offices.
Results	The data were found to be accurate.

Table I1 – Blindness - FTEE and Operating Beds

Data Required By Statute	The number of staffed beds and the number of FTEE assigned to provide care at Blind Rehabilitation Centers.
Description of Questionable Data	Staffing data appeared out-of-line for 2 facilities in VISN 8.
Affected VISNs	8
Audit Work Performed	Site visit to the ARC.
Results	The table was found to contain erroneous data. A programming error resulted in combining the staffing data for VAMC San Juan and VAMC West Palm Beach. VHA agreed to correct and re-issue the table.

Table J – Prosthetics and Sensory Aids Expenditures

Data Required By Statute	The annual amount expended for prosthetics and sensory aids.
Description of Questionable Data	None
Affected VISNs	N/A
Audit Work Performed	Review of supporting records at VACO program offices.
Results	The data were found to be accurate.

Table K – Traumatic Brain Injury Patients Treated and Total Expenditures

Data Required By Statute	The number of patients treated annually and the amounts expended.
Description of Questionable Data	None
Affected VISNs	N/A
Audit Work Performed	Review of supporting records at VACO program offices.
Results	The data were found to be accurate.

Under Secretary for Health Comments

August 27, 2002

Under Secretary for Health (10/11)

Advisory Letter, Fiscal Year 2001 Special Disabilities Capacity Report (Project Number 2002-1202-D2-0080)

Director, Central Office Audit Operations Division (52CO)

1. The Advisory Letter, Fiscal Year 2001 Special Disabilities Capacity Report (Project Number 2002-1202-D2-0080), dated August 6, 2002, has been reviewed by staff in the Veterans Health Administration (VHA). Thank you for your thorough review and comments.
2. The three data tables identified as having incorrect data due to programming errors have been corrected. The five data tables, new in FY 2001, identified in your review as containing unreliable and inaccurate data have been reviewed in the Office of Patient Care Services and the Allocation Resource Center (ARC). The data in these tables are not reliable at this time because of reporting problems in the current reporting system, the Cost Distribution Report (CDR).
3. Over the course of the next year, I will task the ARC and Patient Care Services to determine actions needed for improving data feeds into the reporting mechanism for those five tables. However, it should be recognized that any potential improvements would not be reflected in the data until FY 2003, at the earliest. VHA will improve education at the VHA facility level to improve information input to fully comply with Section 203 of Public Law 107-135. We do plan to meet with representatives of the House and Senate committees to discuss the requirements of Section 203 of Public Law 107-135, and the possibility of changes and improvements in those requirements.
4. I appreciate your comments on the report and I look forward to working with you and your staff in the future.

/s/

Robert H. Roswell, M.D.

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