Department of Veterans Affairs

Office of Inspector General

REVIEW OF DEPARTMENT OF VETERANS AFFAIRS FISCAL YEAR 2002 SPECIAL DISABILITIES CAPACITY REPORT

Data used for reporting on specialized mental health program staffing, numbers of programs, and expenditures reported in the Fiscal Year 2002 Special Disabilities Capacity Report lacks adequate support.

Report No. 03-01356-10 **October 24, 2003**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

The Office Inspector General (OIG) conducted a review of the Department of Veterans Affairs (VA) Fiscal Year (FY) 2002 Special Disabilities Capacity Report (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 1996.

The review was conducted to comply with the VA 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 it's accuracy. The statute requires that VA measure its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans and provide Congress an annual report on the following programs: (1) mental health, (2) spinal cord injury/disorders, (3) blindness, (4) prosthetics and sensory aids, and (5) traumatic brain injury. The measures of capacity specified in the statute vary by program and include such areas as program costs, staffing, patients treated, number of beds, and recidivism.

Review Results

Results of our review showed that the data reported in the FY 2002 Capacity Report relating to spinal cord injury/disorders; blindness; prosthetics and sensory aids; and traumatic brain injury were adequately supported. However, reported staffing, numbers of programs, and expenditures of specialized mental health programs were not adequately supported.

Our review included 26 tables[1] VA included in the FY 2002 Capacity Report to support the information required by Public Law 107-135 for the following programs:

- Mental Health – Tables A through G (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 13 of the 22 tables addressing specialized mental health program data were unreliable and frequently contradictory. These tables address program staffing, numbers of programs, and expenditures. These findings parallel results of our review of the FY 2001 Capacity Report where we concluded that the accuracy and reliability of five of the specialized

[1] Additional tables are included by VHA in the Capacity Report that are not required by the statute and were therefore excluded from the scope of the review.

mental health program staffing tables were adversely affected by the limitations inherent in VHA's Cost Distribution Report (CDR).

The 13 tables with unreliable data in the FY 2002 Capacity Report are listed below. They include the 5 tables cited in the FY 2001 Capacity Report, 2 tables that rely on the same data sources and reporting mechanisms, and 6 related tables that present contradictory information. *(Details of the review results are presented in Appendix C on pages 8-13.)*

- 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 Psychotic Disorders Programs – Type of Staff by Community Based Outpatient Clinic (CBOC) or Clinic, Facility and VISN (Table F1a) and Number of Programs by CBOC or Clinic, Facility and VISN (Table F2a)
- Outpatient Substance Abuse Programs – Type of Staff by CBOC or Clinic, Facility and VISN (Table F1b) and Number of Programs by CBOC or Clinic, Facility and VISN (Table F2b)
- Outpatient Psychosocial Rehabilitation Programs – Type of Staff by CBOC or Clinic, Facility and VISN (Table F1c) and Number of Programs by CBOC or Clinic, Facility and VISN (Table F2c)
- Outpatient Homeless Mental Health Programs – Type of Staff by CBOC or Clinic, Facility and VISN (Table F1d) and Number of Programs by CBOC or Clinic, Facility and VISN (Table F2d)
- Outpatient Post Traumatic Stress Disorder Programs – Type of Staff by CBOC or Clinic, Facility and VISN (Table F1e) and Number of Programs by CBOC or Clinic, Facility and VISN (Table F2e)
- Outpatient Mental Health Intensive Case Management Programs – Type of Staff by CBOC or Clinic, Facility and VISN (Table F1f) and Number of Programs by CBOC or Clinic, Facility and VISN (Table F2f)

One additional table reporting non-pharmacy mental health expenditures contained erroneous data, but was corrected and re-issued by VHA during the review. We concluded that the remaining 12 tables were adequately supported by data in VHA record systems. *(Details on the national VA databases from which the tables were constructed are presented in Appendix A on pages 5-6.)*

In response to the findings reported in our FY 2001 report, the Under Secretary for Health agreed to improve the reporting mechanism for the specialized mental health tables, but stated that any potential improvements would not be reflected until the FY 2003 Capacity Report, at the earliest. In response to the findings reported in the current FY 2002 report, the Under Secretary for Health advised that a new reporting mechanism would be ready for pilot testing in selected sites by the end of December 2003.

The Under Secretary for Health agreed with the findings and recommendation to ensure that reporting and data validation mechanisms for specialized mental health programs are strengthened and provided acceptable implementation plans. *(See pages 14-15 for the full text of the Under Secretary's comments.)* We will follow up on planned actions until they are completed.

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

Results and Recommendation

Specialized Mental Health Program Staffing, Numbers Of Programs, And Expenditures Reported In The Fiscal Year 2002 Special Disabilities Capacity Report Lacks Adequate *S*upport

The results of our review showed that the data reported in the FY 2002 Capacity Report addressing spinal cord injury/disorders, blindness, prosthetics and sensory aids, and traumatic brain injury were adequately supported. However, we concluded that 13 of the 22 tables specifically required by the VA Health Care Programs Enhancement Act of 2001 (Public Law 107-135) involving specialized mental health programs were not adequately supported. These 13 tables address program staffing, numbers of programs, and expenditures. During the course of the review, we also identified errors in a data table listing non-pharmacy mental health expenditures for Seriously Mentally Ill (SMI) and Non-SMI veterans. VHA program officials agreed with our findings and corrected and re-issued the table. *(Details of the review results are presented in Appendix C on pages 8-13.)*

The following briefly describes the nature of the inadequate support that we identified for the 13 mental health program tables:

- 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 CBOCs, with a comparison from FY 1996 through FY 2002.*) As we found during the FY 2001 review, Table E is constructed using VHA's CDR to identify staffing charged to cost centers associated with mental health treatment. These cost centers included psychiatry, psychology, social work, mental health nursing, and psychosocial rehabilitation. However, the CDR is not sufficiently discriminating to identify the specific categories of staff required for the Capacity Report. For example, staff allocated to psychiatry cost centers can include clinical staff, administrative staff, and staff from other services. Additionally, each facility independently decides how to allocate staffing in the CDR. As a result, reported staffing is inconsistent among facilities and does not permit discrimination of the staffing categories required by the Capacity Report. VHA program officials also advised us that facility consolidations and reorganizations affect the validity of staffing analysis using the CDR.

  VHA recognizes the limitations of the CDR to construct staffing tables. In the FY 2001 Capacity Report, VA stated 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."

To illustrate, VISN 5 management reported to us that they implemented a service-line management structure in FY 2000 and, as a result, shifted mental health related nursing and social work staff from their traditional cost center assignments into the psychiatry cost center. This reorganization is not reflected in the CDR and, as a result, Table E does not accurately reflect the actual number or type of staff available to provide specialized mental health treatment. VISN 5 management told us that 242.13 FTEE nursing staff were devoted to specialized mental health treatment in FY 2002, where Table E reports only 12.78 FTEE nursing staff.

- Specialized Mental Health Programs – Tables F1a Through Ff2f (*The number and type of mental health staff at each clinic and the number of clinics and types of mental health programs at each facility.*) Tables F1a through F2f (a total of 12 tables) represent a subset of the staffing data included in Table E and, as a result, suffer from the same problems affecting the accuracy of the data. However, we found additional problems for these tables beyond the issues identified for Table E. Specifically, Tables F1a through F1f present the number and type of staff assigned to specialized mental health clinics while tables F2a through F2f present the number of programs at each facility. As a result, the two series of tables should be consistent (i.e., if Table F2a shows that a program exists at a clinic, Table F1a should show at least some staff charged to that program). However, we found numerous examples where programs were shown as existing in Tables F2a through F2f, but no staff were charged to those programs in Tables F1a through F1f. The reverse was also found to exist, i.e. staff were shown as being charged to programs in Tables F1a through F1f, but no programs were shown as existing in Tables F2a through F2f.

Similar reporting problems were identified in our FY 2001 review. We followed up with VA program officials to determine the status of corrective actions. VHA's Chief Patient Care Services Officer reported to us that, following consultation with VHA's Allocation Resource Center (ARC), VHA determined that existing data systems do not have the capability to provide all of the information required by Public Law 107-135. Consequently, VHA's Decision Support System (DSS) Support Office is developing a new quarterly detail report that will reflect FTEE by Budget Object Code, treating specialty, and clinic stop. VHA anticipates this report will satisfy requirements for the Capacity Report.

A summary of the inconsistencies between the F1 series of tables and F2 series noted during the review are shown in the following chart:

Summary of Data Reporting Inconsistencies

F1 Series Tables	F2 Series Tables	Number of Facilities Reporting No Staff Charged But Reporting Active Programs	Number of Facilities Reporting Staff Charged But Reporting No Active Programs
Table F1a -- Outpatient Psychotic Disorders Programs – Type of Staff by CBOC or Clinic, Facility and VISN	Table F2a -- Outpatient Psychotic Disorders Programs -- Number of Programs by CBOC or Clinic, Facility and VISN	18	1
Table F1b -- Outpatient Substance Abuse Programs – Type of Staff by CBOC or Clinic, Facility and VISN	Table F2b -- Outpatient Substance Abuse Programs -- Number of Programs by CBOC or Clinic, Facility and VISN	9	13
Table F1c -- Outpatient Psychosocial Rehabilitation Programs -- Type of Staff by CBOC or Clinic, Facility and VISN	Table F2c -- Outpatient Psychosocial Rehabilitation Programs -- Number of Programs by CBOC or Clinic, Facility and VISN	14	2
Table F1d -- Outpatient Homeless Mental Health Programs -- Type of Staff by CBOC or Clinic, Facility and VISN	Table F2d -- Outpatient Homeless Mental Health Programs -- Number of Programs by CBOC or Clinic, Facility and VISN	19	10
Table F1e -- Outpatient Post Traumatic Stress Disorder Programs -- Type of Staff by CBOC or Clinic, Facility and VISN	Table F2e -- Outpatient Post Traumatic Stress Disorder Programs -- Number of Programs by CBOC or Clinic, Facility and VISN	39	0
Table F1f -- Outpatient Mental Health Intensive Case Management Programs -- Type of Staff by CBOC or Clinic, Facility and VISN	Table F2f -- Outpatient Mental Health Intensive Case Management Programs -- Number of Programs by CBOC or Clinic, Facility and VISN	15	2

Conclusion

We concluded that 13 of 26 tables we reviewed that are included in VA's FY 2002 Capacity Report contain data that are unreliable and frequently contradictory. All 13 tables address staffing and related information for specialized mental health programs and all except one table rely on inconsistent CDR data. In future Capacity Reports, VHA expects to obtain more accurate information using DSS. We also found one table listing non-pharmacy mental health expenditures that contained erroneous data, which was corrected and re-issued by VHA during the review. We found that the remaining 12 tables were adequately supported by data in VHA record systems.

Recommendation

We recommend that the Under Secretary for Health ensure that reporting and data validation mechanisms for specialized mental health programs are strengthened in order to more accurately present the staffing and related data required for the Special Disabilities Capacity Report.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and recommendation.

Implementation Plan

We are confident that reporting capabilities of the DSS, now in the final design phase, will better match data requirements for future capacity reports, including the mental health designations. Prior to full implementation of the DSS enhancements, ARC and DSS Support Office staff have designed an interim CDR-type reporting tool, utilizing existing DSS data that should capture needed information. It is anticipated that this new reporting mechanism will be ready for pilot testing in selected sites by the end of December 2003.

(See Appendix D on pages 14-15 for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

The Under Secretary's implementation plans are acceptable. We will follow up on planned actions until they are completed.

Appendix A

Objectives, Scope, and Methodology

Objectives

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

Our objective was to determine if the data reported in the VA FY 2002 Capacity Report was adequately supported. Specific objectives were to:

- Review and verify that the data presented in the FY 2002 Capacity Report addressed the information required by Public Law 107-135.
- Determine whether the data reported was accurate.
- Determine the nature of corrective actions taken in response to our findings reported in our review of the FY 2001 Capacity Report.

Scope And Methodology

The review included FY 2002 Capacity Report data required by Section 203 of Public Law 107-135, which, as in prior years, VHA constructed from existing national VA databases. These data were then formatted by VHA into the required 26 data tables. *(Details on each table are presented in Appendix C on pages 8-13.)*

Our review included: (1) comparative analysis of prior year data as a means to identify changes in reporting methodologies and criteria; (2) general analysis of interrelated data tables to identify significant anomalies – e.g., the existence of programs with no related staffing; and, (3) verification of selected data tables to ensure the existence of adequate supporting records. We also followed-up on our prior review of the FY 2001 Capacity Report to determine if corrective actions had been taken to address our findings that five tables contained inaccurate or unreliable information.

We did not review other data tables that VHA included in the Capacity Report because they contain information not required by the statute. We did not address the narrative interpretations of the data since these contained elements of clinical and program judgment. We also did not conduct independent tests to assess the reliability of the underlying national VA databases from which the tables were constructed. These databases include the following:

Appendix A

- VHA's National Patient Treatment File (NPTF).
- VHA's CDR.
- VA's Financial Management System (FMS).
- VHA's national pharmacy cost data.
- VHA's national registry of mental health intensive case management programs.
- VHA's Spinal Cord Injury/Disorder (SCI/D) staffing reports.
- VHA's end of year census reports on substance abuse programs.
- VHA's annual Bed Days Of Care (BDOC) reports for contract residential treatment, and homeless veterans grant and per diem programs.

In our judgment, existing processes used by the Department to measure the accuracy and reliability of these databases were sufficient for our purposes. For example, the NPTF is routinely scrutinized by external clinical peer review groups, the FMS undergoes an annual independent audit process, the SCI/D monthly staffing report is a collaborative effort with an external group (Paralyzed Veterans of America), and BDOC reports for contract care and grant and per diem programs are subject to routine independent audit and oversight. In our experience, the CDR is the least reliable data source used to prepare the Capacity Report because each facility independently decides how to allocate staffing and the CDR does not permit sufficient discrimination of the staffing categories required by the Capacity Report.

We interviewed appropriate program officials and staff at VA Central Office and the following VHA field locations:

- Northeast Program Evaluation Center (NEPEC), West Haven, CT
- Allocation Resource Center (ARC), Braintree, MA
- The Traumatic Brain Injury Lead Program Office and the SCI/D Center at the Hunter Holmes McGuire VA Medical Center, Richmond, VA

We also sent survey questionnaires to the following VISNs addressing specific issues identified during the survey phase of the review:

- VA Capital Health Care Network (VISN 5)
- VA Mid Atlantic Health Care Network (VISN 6)
- VA Mid South Health Care Network (VISN 9)
- VA Heartland Network (VISN 15)
- VA Southwest Health Care Network (VISN 18)
- VA Rocky Mountain Network (VISN 19)

Appendix B

Background

Legislation has required VA to compile the Capacity Report since VHA decentralized its field management structure in 1996. Veterans Services Organizations and other advocates of special disability programs were concerned that the autonomy granted to local managers under VHA's management decentralization would allow local managers to draw off resources from some specialized high-cost rehabilitation programs for the benefit of other clinical programs. 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, current 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." This is the second consecutive year that the OIG has reviewed the Capacity Report.

Appendix C

Results of Data Tables Reviewed

Review of Department of Veterans Affairs Fiscal Year 2002 Special Disabilities Capacity Report

(1). 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.
Survey Results	The FY 2002 table is consistent with the previous years table and there were no irregularities or anomalies noted. The two VISNs noted in last years report (15 & 18) as treating "0" MHICM patients now show active programs with patients being treated. VISN 10's large increase from FY 1996 to FY 2001 was examined last year and adequately explained by the NEPEC. However, VISN 6 is now showing a large increase from FY 2001 in both patients and MHICM teams.
Review Work Performed	We verified that VISNs 15 and 18 started MHICM programs in FY 2002. We confirmed the increase in program activity reported for VISN 6. We also reviewed the National Registry of MHICM programs referenced as the source of the data in the table and confirmed that the Registry supported the table.
Results	The data were found to be supported by existing VHA data systems.

(2). 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.
Survey Results	The FY 2002 table has somewhat different historical data than the FY 2001 table (in terms of national totals). When added, the individual VISN totals sum to the totals shown in the prior (FY 2001) table - not the current (FY 2002) table even though the VISN level numbers are the same. Also, the FY 2001 dollars for VISN's 3 & 4 have been lowered in the current (FY 2002) table. Again, as with last year, there is a complete lack of this program in several VISNs (2, 9, 18 &19) and a large variation in the dollars spent per patient.
Review Work Performed	1. We determined that the reason for the disparate numbers between the FY 2001 report and the FY 2002 report was that in the FY 2001 report the VISN totals were simply added to arrive at a national total. However there was some concern within VHA that this may be perceived as a double counting for those patients who were treated in more than one VISN. As a result, the calculation of the national totals was changed to include only unique Social Security Numbers (SSNs). 2. We confirmed directly with the affected VISNs that the reported lack of a VA opioid substitution program was accurate, however, these VISNs provided information explaining the measures they have taken to ensure that veterans in need of this service have access to care. One of these VISNs cited an August 2001 requirement by the Assistant Deputy Under Secretary for Health that all VISNs submit a formal “Plan for Enhancing Deployment of Opiate Substitution Services” and their compliance with that requirement. Formal policies governing the existence of opioid substitution programs exist in the form of clinical practice guidelines, however, VISNs are not required to maintain “in-house” programs. 3. We also determined that the 6-visit/year criteria used to identify the individuals and related costs represented in the table is not a formal VHA approved criteria for counting the number of program participants but does represent a general consensus within VHA that it is an appropriate criteria for Capacity Report purposes since the 6 visit/year criteria is also used to define patients treated for serious mental illness.
Results	The data were found to be supported by existing VHA data systems.

Appendix C

(3). 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.
Survey Results	The table was re-issued last year as a result of our review. At that time, the FY 1997 data were found to be incorrect. However, the FY 2002 table is not consistent with the corrected table that was included in the final FY 2001 Capacity Report. The total number of individuals at the national level for prior years is consistently lower in the FY 2002 report while the VISN level totals are consistently, if only slightly, higher. Also, the program costs in the FY 2002 report are consistently higher. Finally, the spread in program costs per patient is extreme - from $7,400/yr in VISN 18 to over $23,000/yr in VISN 3.
Review Work Performed	We visited the ARC and determined that the differences between the FY 2001 and FY 2002 versions of the table are valid. 1. The FY 2001 report presents higher national totals due to the simple addition of each VISNs totals without eliminating patients that were treated by more than one VISN. For FY 2002 only unique SSNs were counted for the national totals, which eliminated a perceived duplicate counting. 2. Each VISN's total patients treated are slightly higher in the FY 2002 report (for the current as well as prior years) due to the inclusion of clinic stop 590 (Domiciliary for Homeless Veterans) for FY 2002, as well as for prior years in order to provide valid comparative data. 3. Total program costs are slightly higher for each prior year in the FY 2002 report due to the inclusion of phone costs for homeless veterans. 4. ARC staff provided data showing that the large variations in cost per patient among the VISNs is related to the extent to which these patients are treated in an inpatient setting.
Results	The data were found to be supported by existing VHA data systems.

Substance Abuse Disorders Programs

(4). 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.
Survey Results	The data in the FY 2002 table are consistent with the FY 2001 table. Last year we verified the large increases and decreases in four VISNs. This year, the data remain consistent with those increases and decreases.
Review Work Performed	We reviewed subsidiary records at the NEPEC and determined that the data presented in the table were adequately supported.
Results	The data were found to be supported by existing VHA data systems.

(5). 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 that had 2 or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison from FY 1996 through the current FY.
Survey Results	The data were analyzed and found to be reasonable and consistent with those published in the FY 2001 Capacity Report.
Review Work Performed	A site visit to VISN 2 was conducted in conjunction with the FY 2001 Capacity Report. The FY 2002 data were analyzed and determined to be consistent with the results of that visit.
Results	The data were found to be supported by existing VHA data systems.

Appendix C

(6). 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 that had one or more specialized clinic visits within 3 days of their discharge, with a comparison from FY 1996 through the current FY.
Survey Results	The data were analyzed and found to be reasonable and consistent with those published in the FY 2001 Capacity Report.
Review Work Performed	Comparative analysis of FY 2002 data with prior years data.
Results	The data were found to be supported by existing VHA data systems.

(7). 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 the current FY.
Survey Results	All percentages for prior years have been reduced in the FY 2002 table - yet there is no explanation as to any change in criteria.
Review Work Performed	We determined that for the FY 2001 table (including the presentation of prior years) the total population (numerator) included all patients who received care in a substance abuse clinic regardless of their diagnosis. VHA determined that for the FY 2002 table (including the presentation of prior years) it would be more appropriate to use only those who received care in a substance abuse clinic who also carried a diagnosis of alcohol/drug abuse/dependency. The result lowered the percentages for all VISNs.
Results	The data were found to be a supported by existing VHA data systems.

(8). 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.
Survey Results	The data were analyzed and found to be reasonable and consistent with those published in the FY 2001 Capacity Report.
Review Work Performed	A site visit to VISN 2 was conducted in conjunction with the FY 2001 Capacity Report. The FY 2002 data were analyzed and determined to be consistent with the results of that visit.
Results	The data were found to be supported by existing VHA data systems.

(9). 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 CBOCs, with a comparison from FY 1996 through the current FY.
Results of Survey	The data showed large and unusual variances from year to year.
Review Work Performed	We determined the status of the corrective actions identified in the Under Secretary for Health's response to last years review findings.
Results	The table does not reflect the actual number or type of staff available to provide specialized mental health treatment. VHA has determined that existing data systems do not have the capability to provide the information required by the statute. VHA expects to utilize the Decision Support System (DSS) for the FY 2003 Capacity Report at the earliest.

Appendix C

(10 through 21). Table F – Mental Health – Characteristics of Clinics Providing Care: Type and Number of Staff by Clinics, Facility and VISN.

(10 and 11). Tables F1a & F2a Outpatient Psychotic Disorders
(12 and 13). Tables F1b & F2b Outpatient Substance Abuse
(14 and 15). Tables F1c & F2c Outpatient Psychosocial Rehabilitation
(16 and 17). Tables F1d & F2d Outpatient Homeless Mental Health Rehabilitation
(18 and 19). Tables F1e & F2e Outpatient Traumatic Stress Disorder
(20 and 21). Tables F1f & F2f Outpatient Mental Health Intensive Case Management

Data Required By Statute	Number and type of mental health staff and number of clinics and type of mental health programs.
Results of Survey	The data show large and unusual variances from year to year and are inconsistent with data reported in related tables.
Review Work Performed	We determined the status of the corrective actions identified in the Under Secretary for Health's response to last years review findings.
Results	The tables do not accurately reflect the number or type of staff available to provide specialized mental health treatment. VHA has determined that existing data systems do not have the capability to provide the information required by the statute. VHA expects DSS will be used for the FY 2003 Capacity Report at the earliest. We also found numerous examples where programs were shown as existing in Tables F2a through F2f, but no staff were charged to those programs in Tables F1a through F1f. The reverse was also frequently found to exist, i.e. staff were shown as being charged to programs in Tables F1a through F1f, but no programs were shown as existing in Tables F2a through F2f.

(22). 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.
Results of Survey	1. Prior year expenditures shown in Table G1 are not completely consistent with last year's version; however the differences were not significant (a few thousand dollars for each facility in FY 2000 and FY 2001). 2. Table G2 contains non-pharmacy seriously mentally ill (SMI) treatment costs - which should be a subset of the total non-pharmacy SMI and non-SMI treatment costs shown in Table G1 However, in one instance (VISN 23 in FY 2001) total SMI and non-SMI spending shown in Table G1 is less than the SMI expenditures shown in Table G2. 3. Also, in Table G2, VISN 9 shows a peculiar drop in the percentage of dollars spent on non-SMI patients in FY 2001 (0.5 percent) from over 10 percent in FY 2000 and FY 2002.
Review Work Performed	1. Although the data in Table G2 is not required by statute and was therefore outside the scope of the review, its relationship to Table G1 required us to exam the cause behind the inconsistencies between Table G1 and Table G2. 2. We determined that the inconsistencies in prior year expenditures shown in Table G1 for FY 2002 and FY 2001 were due to ongoing liquidations and other adjustments to obligation balances for prior year appropriations. This is the result of charges incurred against obligations established in prior years. As a result, final expenditure totals for prior years will continue to change slightly for several years following the close of each fiscal year. 3. The ARC addressed our concerns about the data anomalies that we pointed out. They identified the cause as a programming error. The error was corrected and VHA re-issued Table G1 with the amended data.
Results	Although we initially found that the data were erroneous, VHA corrected and re-issued the table during the review.

Appendix C

(23). 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 (SCI/D) centers.
Results of Survey	The data were analyzed and found to be reasonable and consistent with those published in the FY 2001 Capacity Report. (Note: for Table H2 – Individuals and Dollars – many of the reported dollars appear out-of-line with equivalent VISN's. However, the table is not required by statute and was therefore outside the scope of the review).
Review Work Performed	We visited the SCI/D center at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia to review and confirm bed and staff level reporting procedures. We also determined that large variations among VISNs in cost/individual shown in Table H2 are the result of facilities without any inpatient SCI/D bed section costs reporting only those costs for outpatient clinic stops. As a result, cost data for these VISNs are not comparable with cost data for VISNs that have inpatient SCI/D centers, SCI/D clinics, and SCI/D support clinics.
Results	The data were found to be supported by existing VHA data systems.

(24). 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.
Results of Survey	Data appear reasonable and consistent with last year. (Note: for Table I2 – Individuals and Dollars – many of the reported dollars appear out-of-line with equivalent VISN's. However, the table is not required by the statute and was therefore outside scope of the review).
Review Work Performed	We visited the ARC and determined there was adequate support for the data included in Table I1. We also determined that, similar to the adjunct data table for SCI/D, large variations among VISNs in cost/individual shown in Table I2 are the result of facilities without blind centers reporting costs only for outpatient clinic stops. As a result, cost data for these VISNs are not comparable with cost data for VISNs that have blind centers.
Results	The data were found to be accurate.

(25). Table J – Prosthetics and Sensory Aids Expenditures

Data Required By Statute	The annual amount expended for prosthetics and sensory aids.
Results of Survey	The data were analyzed and found to be reasonable and consistent with those published in the FY 2001 Capacity Report.
Review Work Performed	Review of supporting records at VACO was conducted in conjunction with the FY 2001 Capacity Report. The FY 2002 data were analyzed and determined to be consistent with the results of that work.
Results	The data were found to be supported by existing VHA data systems.

(26). Table K – Traumatic Brain Injury Patients Treated and Total Expenditures

Data Required By Statute	The number of patients treated annually and the amounts expended.
Results of Survey	The criteria for selecting patients (and therefore related costs) have been changed from last years report. Several diagnostic related groups have been added as well as outpatient clinic stops. Total costs and spending per patient also vary widely among VISNs.
Review Work Performed	We visited the Traumatic Brain Injury (TBI) national program office located on the grounds of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia and reviewed supporting records for the data contained in Table K. We determined the following:

Appendix C

	The TBI working group made several changes to Table K that more than doubled the number of patients reported and increased the funding by 50 percent. These changes included: 1. Increasing the number of facilities whose TBI workload may be counted as specialty care. 2. Adding two International Classification of Diseases codes. 3. Adding six clinic stops if the patient was an inpatient in a Commission on Accreditation of Rehabilitation Facilities accredited program. 4. Adding costs from relevant DSS accounts for each episode. We also determined that several issues remain to be resolved among clinicians and program experts regarding who to include within TBI specialty care services. As a result, future versions of Table K will likely incorporate these changes. An example of an unresolved issue is that the ARC currently uses the Veterans Equitable Resource Allocation TBI registry to count patients. Inclusion in this registry requires that a patient have an inpatient admission at some point. At first look, this seems reasonable, however, TBI clinical and program experts point out that this excludes patients who are treated by VA as an outpatient only, including a significant number of military personnel who are discharged after receiving TBI inpatient care at military health care facilities and who use VA only for outpatient TBI care and rehabilitation.
Results	The data were found to be supported by existing VHA data systems. We determined that the changes in patient counting criteria account for the differences in Table K data in the FY 2001 and 2002 Capacity Reports. However, we also determined that the methods for counting TBI patients will continue to change in future Capacity Reports as the question of who to include is resolved among clinicians and program experts.

Appendix D

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: October 21, 2003

From: Under Secretary for Health (10/10B5)

Subj: OIG Draft Report: **Review of DVA Fiscal Year 2002 Special Disabilities Capacity Report** (EDMS 242946)

To: Assistant Inspector General for Auditing (52)

1. VHA program officials have reviewed your assessment of our FY 2002 special disabilities capacity report to the House and Senate Veterans' Affairs Committees, and we concur in your findings and recommendation. We share your concerns about the ongoing unreliability of data relating to specialized mental health programs, and are committed to identifying corrective actions that will significantly minimize such discrepancies in next year's report. As the attached action plan details, involved VHA program offices are working cooperatively to provide necessary oversight throughout the data validation process.

2. As you are aware, the capacity report has depended upon data generated by the Cost Distribution Report (CDR), a system with recognized flaws. We are confident that reporting capabilities of the Decision Support System (DSS), now in the final design phase, will better match data requirements for future capacity reports, including the mental health designations. Prior to full implementation of the DSS enhancements, Allocation Resource Center (ARC) and DSS Support Office staff have designed an interim CDR-type reporting tool, utilizing existing DSS data, that should capture needed information. It is anticipated that this new reporting mechanism will be ready for pilot testing in selected sites by the end of December 2003.

3. The ARC, in coordination with the Office of Patient Care Services, will soon convene a special work group, composed of appropriate representatives from those offices, as well as from the DSS Support Office and the Office of the Deputy Under Secretary for Health/Operations and Management, to assess the validity of the generated data throughout the collection and pilot testing phases and to recommend corrections as necessary. Selected field staff will also participate. The work group will also seek the input and expertise of your project auditor during the course of their deliberations. This coordination should facilitate your efforts during the FY 2003 capacity report assessment.

4. Thank you for the opportunity to respond to this draft report. If additional assistance is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5) in my office, at 273-8360.

/s/
Robert H. Roswell, M.D.

Attachment

Appendix D

Under Secretary for Health Comments

Action Plan for Draft OIG Report, Review of DVA Fiscal Year 2002 Special Disabilities Capacity Report, September 8, 2003

Recommendation: The Under Secretary for Health ensures that reporting and data validation mechanisms for specialized mental health programs are strengthened in order to more accurately present the staffing and related data required for the *Special Disabilities Capacity Report*. VHA concurs

Recommendation Metrics

Percentage of achievement of accomplishing an action within specified timeframes. The actions listed below will require unique estimated milestone/completion dates, which have not yet been fully determined by the responsible program offices. Appropriate metrics to validate action progress will be developed and reported to the OIG at the time of status update requests.

GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL		PRIOR FY
To strengthen reporting and data validation mechanisms for specialized mental health programs to more accurately present the staffing and related data required for the *Special Disabilities Capacity Report*.	Enhancements being made to the Decision Support System (DSS) should eventually match needed data requirements for the *Capacity Report*. In the interim, the DSS Support Office and the Allocation Resource Center (ARC) designed a reporting system, based on DSS data, that should capture required information for the FY 2003 reporting period.	Data accuracy compliance expectations TBD in conjunction with pilot testing.	June 2004	TBD	The interim CDR-type reporting system, based on DSS data is developed; however, it has not been pilot tested for validation. Pilot testing of the interim data reporting system is anticipated by November 30, 2003.		OIG assessments of the FY 2001 and FY 2002 special disabilities capacity reports.
	The ARC, in coordination with the Office of Patient Care Services, will convene a work group composed of representatives from involved program offices, the field and the OIG audit manager, to assist in development of effective data collection tools and to oversee pilot testing of the system to assure reporting accuracy. Completion dates for pilot testing and system wide application of the system are still to be determined.	TBD	June 2005		Final enhancements to DSS, which should ultimately provide data required for the *Capacity Report* are nearing completion and will be pilot tested.		

Appendix E

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