Department of Veterans Affairs
Office of Inspector General

AUDIT OF DEPARTMENT OF VETERANS AFFAIRS FISCAL YEAR 2003 SPECIAL DISABILITIES CAPACITY REPORT

VA has begun a process that is expected to improve the quality of data used in the annual Special Disabilities Capacity Report. However, the data reported on specialized mental health programs for this year, as in prior years, remains error prone and lacking in adequate support.

Report No. 04-01972-41 **November 29, 2004**

VA Office of Inspector General
Washington, DC 20420

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Under Secretary for Health (10B5)

SUBJECT: Audit of Department of Veterans Affairs Fiscal Year 2003 Special Disabilities Capacity Report (Report No. 04-01972-41)

1. The Office Inspector General (OIG) conducted an audit of the Department of Veterans Affairs (VA) Fiscal Year (FY) 2003 Special Disabilities Capacity Report (Capacity Report). Congress has required VA to submit the Capacity Report annually, beginning April 1, 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.

2. Our audit 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 as to its accuracy to Congress. 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 (SCI/D), (3) blindness, (4) prosthetics and sensory aids, and (5) traumatic brain injury (TBI). The measures of capacity specified in the statute vary by program and include such areas as numbers of programs, program expenditures, staffing, patients treated, number of beds, and recidivism.

3. Our audit showed that the data reported in the FY 2003 Capacity Report relating to SCI/D, blindness, prosthetics and sensory aids, and TBI were adequately supported. However, the data for specialized mental health programs (including reported staffing, numbers of programs, and expenditures) were not adequately supported. In our FY 2001[1] and 2002[2] audit reports we also found that data for specialized mental health programs

[1] Audit of Department of Veterans Affairs Fiscal Year 2001 Special Disabilities Capacity Report, Report No. 02-01202-164, September 12, 2002.
[2] Review of Department of Veterans Affairs Fiscal Year 2002 Special Disabilities Capacity Report, Report No. 03-01356-10, October 24, 2003.

were not adequately supported. *(Details of the audit are presented in Appendix A on pages 7-11.)* VHA is in the process of taking corrective action and implementing a new reporting process in response to our prior year Capacity Report findings and recommendation. This new reporting process is expected to eliminate the data reporting issues associated with specialized mental health programs. As a result, no new recommendation is included in this report. We will continue to follow up on VHA's implementation of the prior year report recommendation.

(original signed by:)
MICHAEL L. STALEY
Assistant Inspector General
for Auditing

Results of Audit

Introduction

The audit 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 as to its accuracy to Congress. The audit objectives were to:

- Review and verify that the data presented in VA's FY 2003 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 and recommendation made as a result of our review of the FY 2002 Capacity Report.

Scope of Work

The audit included FY 2003 Capacity Report data required by Section 203 of Public Law 107-135, which, as in prior years, VHA constructed from existing national VA databases. The information was formatted by VHA into the required 26 data tables.

Our audit 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 requested and received a formal "management representation" from VHA describing the status of the implementation of our FY 2002 Capacity Report recommendation to strengthen reporting and data validation mechanisms for specialized mental health programs. In May 2004, the Acting Under Secretary for Health (USH), in response to our request, informed us that the FY 2003 Capacity Report would use an interim reporting process with data elements from both the Cost Distribution Report (CDR) and the Decision Support System (DSS). The Acting USH also advised that the FY 2004 Capacity Report remained as the target implementation of the recommendation.

We did not review other data tables[3] 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

[3] These included 5 summary tables, 5 supplemental tables, 2 tables addressing the number of individuals treated and dollars expended for SCI/D and blind rehabilitation, and 1 table addressing a subset of non-pharmacy seriously mentally ill treatment costs.

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:

- National Patient Treatment File (NPTF).
- CDR.
- Financial Management System (FMS).
- National pharmacy cost data.
- National registry of mental health intensive case management programs.
- SCI/D staffing reports.
- End-of-year census reports on substance abuse programs.
- 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 VA to measure the accuracy and reliability of these databases were sufficient for our purposes. For example, NPTF is routinely scrutinized by external clinical peer review groups, 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. The CDR also does not permit sufficient discrimination of the staffing categories required by the Capacity Report.

We interviewed appropriate program officials and staff and reviewed appropriate records at VA Central Office (VACO) and the Allocation Resource Center (ARC) in Braintree, MA. The audit was made in accordance with generally accepted government auditing standards for staff qualifications, independence, and due professional care; field work standards for planning, supervision, and evidence; and reporting standards for performance audits.

Results

The data reported on specialized mental health programs for this year, as in prior years, remains error prone and lacking in adequate support. Our FY 2002 audit report found that 13 of the 22 data tables addressing specialized mental health programs were unreliable and frequently contradictory. These tables addressed program staffing, numbers of programs, and expenditures. Our findings also paralleled the review results for the FY 2001 Capacity Report. Both of the FY 2001 and FY 2002 Capacity Reports were based in large part on questionable data generated by VHA's CDR.

In response to our findings, VHA agreed with the FY 2002 OIG audit report recommendation to improve the reporting mechanism for the specialized mental health tables. VHA outlined a change that would be made in the reporting systems from which the mental health tables are derived. This new reporting process is expected to be implemented in time for preparation of the FY 2004 Capacity Report.

VHA plans to replace the CDR as the primary source of mental health capacity data with DSS. DSS is a "derived database," in that information is taken from existing VA systems [e.g., Veterans Information Systems and Technology Architecture, FMS, NPTF, etc.] and used for management analysis.

We reviewed 26 tables that VA included in the FY 2003 Capacity Report to support the information required by Public Law 107-135. *(Details of the audit are presented in Appendix A on pages 7-11.)* These tables cover the following programs:

- Mental Health – (22 tables)
- SCI/D – (1 table)
- Blindness – (1 table)
- Prosthetics and Sensory Aids – (1 table)
- TBI – (1 table)

For VHA's FY 2003 Capacity Report, data for the 22 mental health tables were generated by an interim reporting process using a "…CDR-type reporting tool utilizing existing DSS data." We found that 12 tables were accurately supported by data in VHA's systems and 13 tables continue to display some of the same unreliable and contradictory data found in prior Capacity Reports. We initially identified one additional table presenting data on Mental Health Intensive Case Management (MHICM) "Individuals and Teams" as being inappropriately based on a calendar year. During the course of the audit, VHA corrected and re-issued the table to properly reflect a fiscal year basis.

The following briefly describes the nature of the data reporting issues we identified for 13 of the specialized mental health program tables:

- Table E (1 table) *(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 (CBOCs), with a comparison from FY 1996 through FY 2003.)* During our reviews of FYs 2001 and 2002 Capacity Reports, we found that Table E was constructed using VHA's CDR to identify staffing charged to cost centers associated with mental health programs. These cost centers included psychiatry, psychology, social work, mental health nursing, and psychosocial rehabilitation.

However, we concluded that the CDR did not specifically identify the categories of staff required for the Capacity Report. For example, staff allocated to psychiatry cost centers frequently included clinical staff, administrative staff, and staff from other services. Additionally, we found that each facility independently decided how to allocate staffing in the CDR. As a result, reported staffing was inconsistent among facilities and did not permit discrimination of the staffing categories required by the Capacity Report. VHA program officials also advised us that facility consolidations and reorganizations affected the validity of staffing analysis using the CDR.

For FY 2003, VHA's interim reporting process using DSS data now allows VHA to identify the type of staff by position or budget object code. This eliminates the unintended inclusion and exclusion of staff that, because of the inconsistent use of CDR cost centers, were erroneously counted (or not counted).

This new method also allows the data to be derived from existing data systems that are subject to more rigorous data validation (e.g., NPTF and FMS). In many instances the data is more accurate. For example, in the FY 2003 Capacity Report, Table E now shows that VISN 5 had 223.33 Full-time Equivalent Employees (FTE) nursing staff devoted to specialized mental health treatment, which represents a more accurate number than the CDR derived data provided in prior years.

However, VHA's change in methodology created a compatibility issue with prior year data. This is significant because the purpose of the Capacity Report is to be able to monitor changes in staffing since FY 1996; the year the law was enacted. VHA addressed this by adding a separate set of "extrapolated" FY 1996 data to use as a comparison with FY 2003 Capacity Report data. This methodology appears reasonable; however, in our opinion, it is not verifiable.

- Table F (12 tables) *(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 represent a subset of the staffing data included in Table E and, as a result, have the same accuracy problems as the CDR derived data. In previous years, we also 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. 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 are charged to that program).

  However, we again found examples where programs were shown to exist, but no staff was charged to those programs. The reverse was also found to exist, with staff shown as being charged to programs, but no existing programs were shown.

A summary of the data reporting inconsistencies found between the F1 and F2 series of tables included in the FY 2003 Capacity Report are shown in the following chart:

Summary of FY 2003 Data Reporting Inconsistencies

F1 Series Tables	F2 Series Tables	Number of Facilities Reporting No Staff, 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	20	2
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	13	9
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	24	7
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	16	11
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	20	9
Table F1f - Outpatient MHICM Programs - Type of Staff by CBOC or Clinic, Facility, and VISN	Table F2f - Outpatient MHICM Programs - Number of Programs by CBOC or Clinic, Facility, and VISN	10	7

Staff at VHA's ARC advised that these types of data reporting issues should be corrected when the new reporting process is completed for future Capacity Reports (as opposed to the interim CDR/DSS hybrid process used for this year's report).

Conclusion

The data for specialized mental health programs (including reported staffing, numbers of programs, and expenditures) are not adequately supported in the FY 2003 Capacity Report. Specifically, we concluded that 13 tables addressing staffing and related information for specialized mental health programs contain data that are unreliable and contradictory. In response to our FY 2002 Capacity Report findings and recommendation, VHA is in the process of taking corrective action and implementing a

new reporting process. It is expected that the data reporting issues associated with specialized mental health programs will be eliminated in the FY 2004 Capacity Report. As a result, no new recommendation is included in this report. We will continue to follow up on VHA's implementation of the prior year report recommendation.

Appendix A

Results of Data Tables Reviewed

Audit of Department of Veterans Affairs Fiscal Year 2003 Special Disabilities Capacity Report

(1) Table A – MHICM - Individuals and Teams

Data Required By Statute	The number of discrete 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 Veterans Integrated Service Network (VISN) since FY 1996.
Survey Results	The FY 2003 table is consistent with the previous year's table and there were no irregularities or anomalies noted.
Work Performed	We found that the reporting methodology has not changed from the previous year. Since the data were confirmed last year through our review of the National Registry of MHICM programs referenced as the source of the data in the table, we concluded that additional verification work was not necessary.
Conclusion	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 2003 table is consistent with the previous year's tables in all respects. There were no irregularities or anomalies noted in the FY 2003 data. Last year, we resolved an apparent reporting issue and found through direct contact with selected VISNs that the data were accurate.
Work Performed	We found that the reporting methodology has not changed from the previous year. Since the data were confirmed last year through review of supporting data at selected VISNs, we concluded that additional verification work was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(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 in FY 2001 as a result of our review. At that time, the FY 1997 data were found to be incorrect. Last year, we noted that the FY 2002 table was not consistent with the corrected table that was included in the final FY 2001 Capacity Report. However, we visited the ARC and found that the differences between the FYs 2001 and 2002 versions of the table were valid as follows: 1. The FY 2001 report presented higher national totals due to the addition of each VISN's totals without eliminating patients that were treated by more than one VISN. For FYs 2002 and 2003, only unique social security numbers were counted for the national totals, which eliminated a perceived duplicate counting. 2. Each VISN's total patients treated were slightly higher in the FY 2002 report (for the current as well as prior years). This was 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 were slightly higher for each prior year in the FY 2002 report due to the inclusion of telephone costs for homeless veterans. 4. ARC staff provided data showing that the large variation in cost per patient among the VISNs is related to the extent to which these patients are treated in an inpatient setting.

	The FY 2003 table is consistent with the previous year's table in all respects. There were no irregularities or anomalies noted in the FY 2003 data. Last year, we resolved several apparent reporting issues and found through contact with the ARC that the data were accurate.
Work Performed	We found that the reporting methodology has not changed from the previous year. Since the data were confirmed last year through review of supporting data, we concluded that additional verification work was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(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 2003 table are consistent with the FYs 2001 and 2002 tables. For FY 2001, we verified the large increases and decreases in four VISNs. For FYs 2002 and 2003, the data remained consistent with those increases and decreases.
Work Performed	For the FY 2002 Capacity Report, we reviewed subsidiary records at the Northeast Program Evaluation Center in West Haven, CT. We found that the data presented in the table were adequately supported. We found that the reporting methodology has not changed for FY 2003. Since the data were confirmed last year through review of supporting data, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	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 two 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.
Work Performed	A site visit to VISN 2 was conducted in conjunction with the FY 2001 Capacity Report. The FYs 2002 and 2003 data were analyzed and found to be consistent with the results of that visit. We found that the reporting methodology has not changed for FY 2003. Since the data were confirmed last year through review of supporting data, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(6) Table Diii - Substance Abuse Services for Inpatients

Data Required By Statute	The percentage of unique patients with substance abuse 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 FYs 2001 and 2002 Capacity Reports.
Work Performed	We found that the reporting methodology has not changed for FY 2003. Since the FY 2002 table was found to be supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	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 fiscal year.
Survey Results	Last year, we noted that all percentages for prior years had been reduced in the FY 2002 table. At that time, we determined that for the FY 2001 table (including its presentation of prior years) the total population (numerator) included all

Appendix A

	outpatients who received care in a substance abuse clinic regardless of their diagnosis. VHA determined that for the FY 2002 table (including its presentation of prior years), it was more appropriate to use only those who received care in a substance abuse clinic and who also carried a diagnosis of alcohol/drug abuse. The result lowered the percentages for all VISNs.
Work Performed	We found that the reporting methodology has not changed for FY 2003. Since the FY 2002 table was found to be supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	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	A site visit to VISN 2 was conducted in conjunction with the FY 2001 Capacity Report and found that the data were adequately supported. The FY 2003 data were analyzed and found to be reasonable and consistent with those published in the FYs 2001 and 2002 Capacity Reports.
Work Performed	We found that the reporting methodology has not changed for FY 2003. Since the FY 2002 table was found to be supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	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 fiscal year.
Survey Results	As in prior years, the data showed large and unusual variances from year to year. FY 2003 data were significantly changed from earlier years. A significant change in the methodology is apparent. However, the accuracy of the data is still questionable given the continuing variances in the data reported. A management representation letter received from the Acting USH outlined the status of VHA's actions to address last year's recommendation concerning Table E.
Work Performed	We determined the status of the corrective actions identified in VHA's response to last year's recommendation.
Conclusion	As in previous Capacity Reports, 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 being used do not have the capability to provide the information required by the statute. For the FY 2004 Capacity Report, VHA expects to utilize DSS to provide the information required by the statute.

(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 MHICM

Data Required By Statute	Number and type of mental health staff and number of clinics and type of mental health programs.
Survey Results	As in prior years, the data show large and unusual variances from year to year and are inconsistent with data reported in related tables.
Work Performed	We reviewed the status of corrective actions identified in VHA's response to last years review findings.

Conclusion	As in previous Capacity Reports, 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 being used do not have the capability to provide the information required by the statute. For the FY 2004 Capacity Report, VHA expects to use DSS to provide the information required by the statute. We continue to see 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, as staff were shown as being charged to programs in Tables F1a through F1f, but no existing programs were shown 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 fiscal year.
Survey Results	Our review of the FYs 2001 and 2002 tables identified data anomalies that were corrected by VHA. Our review of the FY 2003 table found it to be consistent with the corrected data reflected in the prior reports. No additional anomalies or irregularities were noted.
Work Performed	We found that the reporting methodology has not changed for FY 2003. Since we found that the tables in the prior reports were supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(23) Table H1 - SCI/D Staffed Beds and FTE Assigned

Data Required By Statute	The number of staffed beds and the number of FTE assigned to provide care at SCI/D centers.
Survey Results	The FY 2003 data were analyzed and found to be reasonable and consistent with those published in the FY 2002 Capacity Report.
Work Performed	During our review of the FY 2002 Capacity Report, we visited the SCI/D center at the Hunter Holmes McGuire VA Medical Center in Richmond, VA to review and confirm SCI/D beds and staff level reporting procedures. We found that the reporting methodology has not changed for FY 2003. Since the FY 2002 table was found to be supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(24) Table I1 - Blindness - FTE and Operating Beds

Data Required By Statute	The number of staffed beds and the number of FTE assigned to provide care at Blind Rehabilitation Centers.
Survey Results	The FY 2003 data were analyzed and found to be reasonable and consistent with those published in the FY 2002 Capacity Report.
Work Performed	During our review of the FY 2002 Capacity Report, we visited the ARC and found there was adequate support for the data included in Table I1. Since the FY 2002 table was found to be supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(25) Table J - Prosthetics and Sensory Aids Expenditures

Data Required By Statute	The annual amount expended for prosthetics and sensory aids.
Survey Results	The FY 2003 data were analyzed and found to be reasonable and consistent with those published in the FY 2002 Capacity Report.
Work Performed	Review of supporting records at VACO was conducted in conjunction with the FY 2002 Capacity Report. The FY 2003 data were analyzed and found to be

	consistent with the results of that work. Since the FY 2002 table was found to be supported by existing VHA data systems, we concluded that additional verification work for FY 2003 was not necessary.
Conclusion	The data were found to be supported by existing VHA data systems.

(26) Table K – TBI Patients Treated and Total Expenditures

Data Required By Statute	The number of patients treated annually and the amounts expended.
Survey Results	The criteria for selecting TBI patients (and therefore related costs) have changed each year that the Capacity Report has been published. Data for FY 2003 show a continuing effort to define which patients are properly reportable as TBI associated workload.
Work Performed	During our review of the FY 2002 Capacity Report, we visited the TBI national program office located at the Hunter Holmes McGuire VA Medical Center in Richmond, VA. We also reviewed supporting records for the data contained in Table K. We found that 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. During our FY 2002 review, we also determined that several issues remained to be resolved among clinicians and program experts regarding who to include within TBI specialty care services. As a result, we noted that future versions of Table K would incorporate these changes. Our review of the FY 2003 TBI data confirmed that the definitions of who to include as a TBI patient continue to change. As a result, TBI data in the FY 2003 Capacity Report are not comparable to TBI data reported in the FYs 2002 and 2001 Capacity Reports. However, the revised FY 2003 definitions are applied to prior years in the FY 2003 table in order to provide a basis for historical comparisons.
Conclusion	In our review of the FY 2002 Capacity Report, we concluded that the data were supported by existing VHA data systems. Changes in data definitions (TBI patient counting criteria) account for the differences in Table K data in the FYs 2001, 2002, and 2003 Capacity Reports. The methods for counting TBI patients will likely continue to change in future Capacity Reports as the question of who to include is resolved among clinicians and program experts.

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Stephen Gaskell, Director, Central Office Operations Division (202-565-4098)
Acknowledgments	Gregory Gibson, Project Manager Melvin Reid Steven Cucina

Appendix C

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Appendix C

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