VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Department of Veterans Affairs

Independent Review of VA's FY 2012 Performance Summary Report to the Office of National Drug Control Policy

March 31, 2013
13-00680-142

To Report Suspected Wrongdoing in VA Programs and Operations:

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(Hotline Information: www.va.gov/oig/hotline)

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Department of Veterans Affairs

Memorandum

Date: March 25, 2013

From: Assistant Inspector General for Audits and Evaluations (52)

Subj: Final Report – Independent Review of VA's Fiscal Year 2012 Performance Summary Report to the Office of National Drug Control Policy

To: Principal Deputy Under Secretary for Health (10A)

1. The Office of Inspector General is required to review the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2012 Performance Summary Report to the Director, Office of National Drug Control Policy (ONDCP), pursuant to ONDCP Circular: *Drug Control Accounting* (Circular), dated May 1, 2007, and as authorized by 21 U.S.C. §1703(d)(7).[1] The Performance Summary Report is the responsibility of VA's management and is included in this report as Attachment A (Patient Care) and Attachment B (Research and Development).

2. We reviewed, according to the Circular's criteria and requirements, whether VA has a system to capture performance information accurately and whether that system was properly applied to generate the performance data reported in the Performance Summary Report. We also reviewed whether VA offered a reasonable explanation for failing to meet a performance target and for any recommendations concerning plans and schedules for meeting future targets or for revising or eliminating performance targets; whether the methodology described in the Performance Summary Report and used to establish performance targets for the current year is reasonable given past performance and available resources; and whether VA has established at least one acceptable performance measure for each Drug Control Decision Unit, as defined by the Circular, for which a significant amount of obligations were incurred.

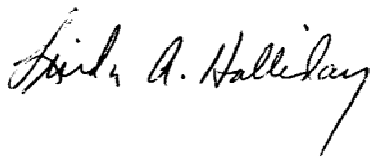
3. We conducted our review in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in Government Auditing Standards, issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination, the objective of which is the expression of an opinion on the matters described in paragraph two. Accordingly, we do not express such an opinion.

[1]To view the Circular, please visit http://www.whitehouse.gov/sites/default/files/ondcp/about-content/2007_drug_control_accounting_final.pdf.

4. Based upon our review and the criteria of the Circular:

   - Nothing came to our attention that caused us to believe VA does not have a system to capture performance information accurately or the system was not properly applied to generate the performance data reported in the Performance Summary Report.
   - VA did not meet its FY 2012 target for the continuity of care performance measure (Patient Care). VA reported, among other factors, outreach has increased access to services for veterans who are in very early stages of recovery. Despite efforts to maintain continuity, these veterans are at increased risk of early dropout and this situation has impacted rates of continuity. In FY 2013, VA will begin implementation of a measure based on patient reported abstinence from drug use during early recovery among patients engaged in a new episode of substance use disorder specialty treatment. A performance target will be established for 2014 based on the analysis of data collected during 2013.
   - Nothing came to our attention that caused us to believe VA did not meet its FY 2012 target for the substance abuse disorder on-going studies performance measure (Research and Development). As a result, VA is not required to offer an explanation for failing to meet a performance target, for recommendations concerning plans and schedules for meeting future targets, or for revising or eliminating performance targets for this measure.
   - Nothing came to our attention that caused us to believe the methodology described in the Performance Summary Report establishing performance targets for the current year is not reasonable given past performance and available resources.
   - Nothing came to our attention that caused us to believe VA did not establish at least one acceptable performance measure for each Drug Control Decision Unit, as defined by the Circular, for which a significant amount of obligations were incurred in the previous fiscal year.

5. We provided you our draft report for review. You concurred with our report without further comments.



LINDA A. HALLIDAY

Attachments

Department of Veterans Affairs

Memorandum

Date: January 4, 2013

From: Principal Deputy Under Secretary for Health (10A)

Subj: Management Representation Letter for the Independent Review of the VA's FY 2012 Performance Summary Report to the Office of National Drug Control Policy (Project Number 2013-00680-R1-0038) (VAIQ 7314357)

To: Assistant Inspector General for Audits and Evaluations (52)

1. We are providing this letter in connection with your attestation review of our Performance Summary Report to the Director, Office of National Drug Control Policy (ONDCP). We confirm, to the best of our knowledge and belief that the following representations made to you during your attestation review are accurate and pertain to the fiscal year (FY) ended September 30, 2012.

2. We confirm that we are responsible for and have made available to you the following:

a. The Performance Summary Report for FY 2012 required by the Circular.

b. All supporting records and related information and data relevant to the Continuity of Care performance measure within the FY 2012 Performance Summary Report; and

c. Communications, if any, from the ONDCP and other oversight bodies concerning the FY 2012 Performance Summary Report and information therein.

3. We confirm that the FY 2012 Performance Summary Report was prepared in accordance with the requirements and criteria of the Circular.

4. We understand your review was conducted in accordance with the attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in Government Auditing Standards, issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination and accordingly, you will not express an opinion on the Performance Summary Report and related disclosures.

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Management Representation Letter for the Independent Review of the VA's FY 2012 Performance Summary Report to the Office of National Drug Control Policy (Project Number 2013-00680-R1-0038) (VAIQ 7314357)

5. No events have occurred subsequent to September 30, 2012, that would have an effect on the Performance Summary Report and the information therein.

Robert L. Jesse, M.D., PhD

Attachments

Attachment A

Department of Veterans Affairs
Veterans Health Administration
FY 2012 Performance Summary Report

I. PERFORMANCE INFORMATION

Decision Unit 1: Veterans Health Administration

Measure 1: Continuity of Care

FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2012 Target	FY 2012 Actual
44%	48%	52%	52%	47%	47%	47%	42%

(a) This measure was established to promote better substance use disorder (SUD) treatment outcomes. It applies to patients entering specialty treatment for SUD in inpatient, residential, domiciliary or outpatient programs, but not opioid substitution, to determine if they are engaged in treatment for at least 90 days. Research has shown that good addiction treatment outcomes are contingent on adequate lengths of treatment. Many patients drop out during the initial 90 days of treatment with limited clinical benefit and high rates of relapse. While two contacts per month for at least three months would rarely be sufficient, most patients with chronic addictions require ongoing treatment for at least this duration to stabilize their early recovery. Note: SUD includes patients with an alcohol or drug use disorder diagnosis or both.

Indicator: Percent of patients beginning a new episode of treatment for SUD who maintain continuous treatment involvement for at least 90 days after qualifying date.

Numerator: Veterans beginning a new episode of treatment for SUD who maintain continuous treatment involvement for at least 90 days as demonstrated by at least 2 days with visits every 30 days for a total of 90 days in any of the outpatient specialty SUD clinics.

Denominator: Veterans beginning a new episode of specialty treatment for SUD.

(b) In FY 2012, 42% of VA patients in a new episode of specialized SUD treatment successfully met the criteria for continuity, a decline from the target of 47% that was met in FY11.

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(c) Performance results are updated monthly on a VA intranet site and discussed on monthly national conference calls to provide feedback and encourage attention to barriers to treatment retention. Previously recognized limitations of the measure and changes in patient case mix appear to have had a growing impact on performance in FY12. Given the focus on removing barriers to initial access to treatment and the initiative to end homelessness among Veterans, there have been extensive community outreach efforts and adoption of treatment engagement strategies consistent with harm reduction approaches. This outreach has increased access to services for Veterans who are in very early stages of recovery. Despite efforts to maintain continuity, these Veterans are at increased risk of early dropout and this has had an apparent impact on the decreased rates of continuity. Efforts to improve timely access to care for Veterans with SUD and other mental health conditions have prompted many facilities to establish contracts or otherwise arrange non-VA care that is not tracked in the databases that are the source of the performance measure. In addition, the shift toward implementing measurement-based care using the Brief Addiction Monitor has been accompanied by a greater emphasis on individualized care with a reduced focus on arbitrary duration of continuity of care at some programs. In Q3 FY12, VHA began electronic implementation of clinical symptom monitoring using the Brief Addiction Monitor (BAM) that transmits responses to the national data base with over 5000 administrations in September 2012. VHA specialty care programs are now able to use BAM as part of software that integrates the assessment process with our electronic health record. The BAM is designed to assist SUD specialty care clinicians in monitoring the progress of patients while they are receiving care for a SUD, serving as a basis for giving feedback to them to enhance their motivation for change, and informing clinical decisions, such as the intensity of care required for the patient. Consultation regarding implementation of measurement based care continues to be offered through national resources including the Substance Use Disorder Quality Enhancement Research Initiative and the two Centers of Excellence in Substance Abuse Treatment and Education.

(d) Performance Measures are maintained by the VHA Office of Analytics and Business Intelligence. In the case of the SUD measure, workload data generated at the facility is transmitted to the VHA Austin Information Technology Center. The extraction methodology uses the appropriate DSS identifier codes (stop codes) to select the patients who meet the criteria for inclusion in the measure. The patient data is then extracted from the Austin PTF files and is maintained by the Office of Analytics and Business Intelligence. A copy of the FY 2011 Office of Analytics and Business Intelligence, Substance Use Disorder, Continuity of Care Technical Manual Chapter is attached.

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II. MANAGEMENT'S ASSERTIONS

(1) **Performance reporting sy stems appropriate and applied** . Performance Measures are maintained by the VHA Office of Analytics and Business Intelligence. In the case of the SUD measure, workload data generated at the facility is transmitted to the VHA Austin Data Center. The extraction methodology uses the appropriate DSS identifier codes (stop codes) to select the patients who meet the criteria for inclusion in the measure. The patient data is then extracted from the Austin PTF files and is maintained by the Office of Analytics and Business Intelligence. The system was properly applied to generate the performance data.

(2) **Explanations for not meeting perf ormance targets are reasonable.** In FY 2012, the target of 47% was not met with an actual rate of 42%. As noted above, previously recognized limitations of the measure to track non-VA care and changes in patient case mix appear to have had a growing impact on performance in FY12.

(3) **Methodology to establish performance targets is reasonable and applied.** In FY 2013, VA will begin implementation of a measure on patient reported abstinence from drug use during early recovery among patients engaged in a new episode of SUD specialty treatment. A performance target will be set for 2014 based on the analysis of data collected during 2013 when informatics capabilities will permit automatic data extraction and aggregation of performance data at the national level.

(4) **Adequate performance measures exist for all significant drug control activities.** VHA is measuring the processes and outcomes related to treatment of Veterans with SUD.

Performance

This section on FY 2012 performance is based on agency Government Performance and Results Act (GPRA) documents, an OMB assessment, and other agency information. VHA reports performance for two separate drug-related initiatives: (1) health care and (2) research and development. VHA's health care performance measure for ONDCP reporting purposes is "continuity of care" (i.e. the percent of patients who have *engaged* in SUD treatment as demonstrated by being seen for at least three visits in a month and who *persevere* in SUD treatment by being seen for at least two treatment sessions per each of the following three months.

VHA has in place a national system of performance monitoring that uses social, professional, and financial incentives to encourage facilities to provide the highest quality health care. This system has begun to incorporate performance measures related to substance use disorder treatment.

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The dollars expended in VHA research help to acquire new knowledge to improve the prevention, diagnosis, and treatment of disease. These funds also generate new knowledge to improve the effectiveness, efficiency, accessibility, and quality of veterans' health care.

Discussion of Current Program

In FY 2012, VHA provided services in a specialty SUD setting to 127,708 patients with a primary drug use disorder diagnosis. Of these, 36 percent used cocaine, 28 percent used opioids and 26 percent used cannabis. Eighty percent had co-existing psychiatric diagnoses. (These categories are not mutually exclusive.)

VHA provides two types of 24-hour care to patients with particularly severe or acute substance use disorders. These include care in residential rehabilitation treatment programs for substance use disorders and inpatient detoxification in numerous medical and general mental health units.

Most Veterans with substance use disorders are treated in outpatient programs. Outpatient detoxification is available for patients who are medically stable and who have sufficient social support systems to monitor their status. Standard outpatient programs typically treat patients one or two hours per session and patients are generally seen once or twice a week. Intensive substance use disorder outpatient programs provide at least three hours of service per day and patients attend three or more days per week.

VHA is steadily expanding the availability of opioid agonist treatment for opioid-dependent Veterans. In FY 2012, evidence-based medication assisted treatment for opioid dependence, including office-based treatment with buprenorphine, is available at 141 of the 152 VA Medical centers (93%). Including Community-Based Outpatient Clinics separate from the medical centers, over 250 total sites of service provided at least some buprenorphine. VA operates methadone maintenance programs at 28 facilities and 25 VHA facilities maintain contractual arrangements for providing these services through community-based licensed opioid agonist treatment programs.

VHA has also expanded access to other SUD treatment services with continued special purpose funding for 406 additional SUD staff assigned to work in large community based outpatient clinics, mental health residential rehabilitation programs, intensive SUD outpatient programs and PTSD teams. Active monitoring is ongoing for replacing any positions that become vacant. The Homeless Programs are funding 100 SUD specialists to support the Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) program. In addition, there are approximately 80 SUD Specialists working in Health Care for Homeless Veterans (HCHV) programs including 32 newly funded HCHV SUD Specialist positions added in FY 2012. These

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specialists emphasize early identification of SUD as a risk for maintaining permanent housing, promote engagement or re-engagement in SUD specialty care programs and serve as linkages between Homeless and SUD programs.

In Q3 FY12, VHA began electronic implementation of clinical symptom monitoring using the Brief Addiction Monitor (BAM) that transmits responses to the national data base with over 5000 administrations in September 2012. VHA specialty care programs are now able to use BAM as part of software that integrates the assessment process with our electronic health record. The BAM is designed to assist SUD specialty care clinicians in monitoring the progress of patients while they are receiving care for a substance use disorder, serving as a basis for giving feedback to them to enhance their motivation for change, and informing clinical decisions, such as the intensity of care required for the patient.

sa5 Substance Use Disorder – Continuity of Care

Indicator Statement: Percent of patients beginning a new episode of specialty treatment for SUD who maintain continuous treatment involvement for at least 90 days after qualifying date.

Numerator: Number of Veterans beginning specialty treatment for SUD who maintain continuous treatment involvement for at least 90 days as demonstrated by at least 2 days with visits every 30 days for a total of 90 days in any of the outpatient specialty SUD clinics

Denominator: Number of Veterans beginning specialty treatment for SUD

Exclusions:

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- Non Veterans are excluded from this measure. They are identified by either a means test response of "n", "no" (zero) which represents a "non-vet", or by eligibility status indicating non Veteran.
- Patients without an initial enrollment date
- Patients discharged, dead or deceased during the 90-day retention period. To be captured for this measure, data must be in Austin Information Technology Center (AITC) or Beneficiary Identification Record Locator System (BIRLS).
- Smoking cessation visits are excluded. When stop code 707 is paired with any SUD code, the SUD visit is not used.
- All clinic visits, except those listed here are excluded from measure. Clinic visits to outpatient SUD clinic stop 513 SA-IND or 514 SA-Home or 519 SA/PTSD, 523 Opioid Substitution, 545 SA Telephone, or 547 intensive-SA TRT GRP, or 548 intensive-SA TRT IND or 560 SA GRP are included in this measure. See Table A below for discussion on the use of 545 Telephone, 514, SA HOME, 519 SA/PTSD and 523 Opioid Substitution. All other clinic visits, including non SUD clinic visits, are not considered in this measure.
- Veterans seen in multiple facilities will be attributed to the facility where the last retention visit occurred in order to promote coordinated transitions between facilities.
- If the Veteran is not seen in any SUD clinic in VHA during the 1st 30 days of the retention period, he fails the measure. The failure will be attributed to the facility where the 'qualifying' event occurred (i.e. where the 3rd visit occurred that qualified the Veteran as beginning a new episode of care or where the Veteran was discharged from inpatient SUD care).
- If the Veteran **i**s seen for a 1st retention visit in a SUD clinic during the 1st 30-day retention period but is not seen again, the patient fails the measure. The failure will be attributed to the facility where the first retention visit occurred.

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- If the patient passed the first 30-day retention interval requirement but failed to meet the 2nd 30-day retention interval requirement, the patient fails the measure and the failure is attributed to the facility where the latest retention visit occurred.
- If the patient passed the first and second 30-day retention interval requirement but failed to meet the 3rd 30-day retention interval requirement, the patient fails the measure and the failure is attributed to the facility where the latest retention visit occurred.

Definitions

- **Events in Time:**

Event	Negative SUD Treatment History (Dormancy)	Qualification as New SUD Episode			Continuous Treatment Involvement (Retention Period) 90 Total Days		
Event Description	90 day period of no SUD treatment in the 90 days prior to the 1st outpatient qualifying event date	Inpatient or Outpatient Qualification Date = T			1st 30 days of retention	2nd 30 days of retention	3rd 30 days of retention
Outpatient Qualified Events in Time	(T-90) minus total days from 1st to 3rd outpatient qualifying event	1st Qualif-ying Event Date Not earlier than T-29	2nd Qualif-ying Event Date Not earlier than T-28	3rd Qualif-ying Event Date T	2 SUD visits in period greater than T but not later than T+30	2 SUD visits in period greater than T+30 but not later than T+60	2 SUD visits in period greater than T+60 but not later than T+90
Inpatient Qualified Events in Time	None required for inpatient qualification	1st and only Qualifying event T = Date of any inpatient discharge or transfer from a SUD bed-section			2 SUD visits in period greater than T but not later than T+30	2 SUD visits in period greater than T+30 but not later than T+60	2 SUD visits in period greater than T+60 but not later than T+90

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Veterans beginning new SUD treatment episode: To qualify as a New SUD **Outpatient** Episode, two criteria must be met:

- o A 90-day Negative SUD outpatient or inpatient treatment history (no SUD outpatient visit/encounter, [513, 514, 519, 523, 545, 547, 548, 560], specialty SUD inpatient admission or discharge or inpatient SUD encounters) before the date of the 1st of three qualifying SUD outpatient visits **and**
- o Three visits within 30 days to outpatient SUD clinic stops 513 SA-IND or 547 inter-SA TRT GRP, or 548 intensive-SA TRT IND or 560 SA GRP. Listed stops are included if paired with other stops as primary or secondary except when paired with smoking cessation 707. SUD Telephone visits (Stop Code 545) or 514 SA HOME or 519 SA/PTSD or 523 Opioid. Substitution *will NOT be used to qualify new SUD treatment episodes.*
- o The date of the 3rd SUD visit in 30 days is the "qualifying" date for the outpatient track. The retention period begins the next day.
- o Patients who generate outpatient workload while in an inpatient SUD bed section will not "qualify" for the measure via the outpatient track. Since inpatient workload may not be available until after discharge, the patient may be "picked up" as new and tracked for a period of time. However, upon SUD specialty inpatient discharge or transfer, the outpatient track will be dropped and the patient will be qualified in the inpatient track.

- To qualify as a New SUD **Inpatient** Episode, a single criterion must be met:

- o Discharge or transfer from SUD inpatient bed section (PTF Discharge Specialty 27 SA Res Rehab or 74 SA HI INT, 86 DOM SA with a length of stay at least 4 calendar days).

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- **Note:** During 2010, SARRTP beds were assigned the new treating specialty code of #1M. The previous SARRTP Treating Specialty Code # 27 was discontinued during that conversion.
- The SUD bed section discharge or transfer date is the "qualifying" date for the inpatient track. The retention period begins the next day.
- Continuous Treatment Involvement (Retention period): Continuous treatment involvement for at least 90 days is defined as visits on at least 2 days during every 30 day retention interval for a total of 90 days (three discrete 30 day intervals) in any of the outpatient specialty SUD clinics. The continuous SUD treatment retention period begins the day after the qualifying date and ends the 90th day from the beginning of the continuous treatment involvement retention period.
- Telephone care: Substance use disorder clinical care by telephone which meets the same standard as face-to-face visits (e.g. staff qualifications, time spent with the Veteran, etc.) will be accepted for continuity of care for visits during the 2nd and 3rd 30-day retention intervals. Stop code 545 (Telephone/Substance Abuse) will be used for the measure. Telephone visits will not be used to "qualify" new Veterans into the measure.
- Admission during the retention period: If a Veteran has already qualified for the measure (from the inpatient or the outpatient tracks) and, during the retention period has an admission to or a discharge from one of the SUD inpatient bed sections listed above:
  - LOS < 4 calendar days will have no effect on the measure.
  - LOS of at least 4 calendar days, the Veteran will be dropped from the previous qualifying track. Upon discharge or transfer from the SUD bed section, he will re-qualify for the measure.

Attachment A

Notes:

1. This table answers the question: Will these sources be used to contribute information for specified period/event?

TABLE: Events/Data Source Use During Dormancy, Qualification, and Retention Determination

	Dormant	Qualifying	Retention
SUD Clinic stops: 513, 514, 519, 523, 545, 547, 548 and 560	SUD clinic stops 513, 514, 519, 523, 545, 547, 548 and 560 are used to evaluate the dormant period. If the patient has any of these SUD clinic stops, they will be considered "NOT dormant" and do not newly qualify for the measure for at least 90 more days.	Only SUD clinic stops 513, 547, 548 and 560 will be used to qualify a Veteran. For example, if a Veteran has 3 visits in 30 days, he qualifies in the measure.	SUD clinic stops 513, 514, 519, 523, 545 [note exception during first 30 day retention period], 547, 548 and 560 will be used to determine retention compliance.
SA/Home 514	Yes. SA/Home clinic stop 514 will be used to evaluate the dormant period. For example, Pt is receiving SUD 'maintenance' care in a Grant & Per Diem program (514) so will 'show-up' in a search for 'dormant time' and 'count' as SUD visits, therefore the patient will not be 'dormant' if 514 visits are present.	No. 514 will NOT be used to evaluate for qualifying events. E.g. Pt has a true dormant period (no SUD workload in 90 days) then 3 visits in 30 days with a 514 code. This workload will NOT be used to determine a 'qualifying' event. The patient will not be considered newly 'qualified' based on 514 workload.	Yes. 514 clinic stops will be used to determine retention compliance in all retention periods
SA/PTSD 519	Yes. SA/PTSD clinic stop 519 will be used to	No. 519 will NOT be used to evaluate for	Yes. 519 clinic stops will be used

	evaluate the dormant period. For example, Pt is receiving SUD 'maintenance' care in a PTSD Outpatient clinic (519) so will 'show-up' in a search for 'dormant time' and 'count' as SUD visits, therefore the patient will not be 'dormant' if 519 visits are present.	qualifying events. E.g. Pt has a true dormant period (no SUD workload in 90 days) then 3 visits in 30 days with a 519 code. This workload will NOT be used to determine a 'qualifying' event. The patient will not be considered newly 'qualified' based on 519 workload.	to determine retention compliance in all 3 retention periods
Opioid Substitution 523	Yes. Opioid Substitution clinic stop 523 will be used to evaluate the dormant period. For example, Pt is receiving SUD 'maintenance' care in a Opioid Substitution program (523) so will 'show-up' in a search for 'dormant time' and 'count' as SUD visits, therefore the patient will not be 'dormant' if 523 visits are present.	No. 523 will NOT be used to evaluate for qualifying events. E.g. Pt has a true dormant period (no SUD workload in 90 days) then 3 visits in 30 days with a 523 code. This workload will NOT be used to determine a 'qualifying' event. The patient will not be considered newly 'qualified' based on 523 workload.	Yes. 523 clinic stops will be used to determine retention compliance in all 3 retention periods
Telephone stop 545	Yes. Telephone clinic stop 545 will be used to evaluate the dormant period. For example, Pt is receiving SUD 'maintenance' telephone care (545) so will 'show-up' in a search for 'dormant time' and 'count' as SUD visits, therefore the patient will not be 'dormant' if 545 visits are present.	No. 545 will NOT be used to evaluate for qualifying events. E.g. Pt has a true dormant period (no SUD workload in 90 days) then 3 telephone visits in 30 days. This workload will NOT be used to determine a 'qualifying' event. The patient will not be considered newly 'qualified' based on 545	Yes. 545 clinic stops will be used to determine retention compliance in the 2nd & 3rd period only

		workload.	
Inpatient SUD Dischg w/ LOS ≥ 4 calendar days	Yes. Discharge data will be evaluated and considered as active SUD workload when evaluating the dormant period. Therefore, if a patient has an admission or discharge during the dormant period, it will not be considered 'dormant'.	Yes. Discharge data from an inpt SUD bed section will be used as a qualifying event. Such a discharge will 'disconnect/drop' a Veteran from any previous qualifying track AND will re-qualify a patient with a new qualifying date.	Yes. If a patient was ADMITTED to a SUD Bed Section during the retention period, those data will be used to 'disconnect' him from the previous qualifying track. He will be re-qualified upon discharge or transfer from the SUD Bed sec.
Inpatient w/ SUD Encounters	No. SUD encounters provided on inpatients will NOT be used to evaluate for a dormant period. Therefore if a patient has received SUD consult while an inpatient (on any bed section), it will not be considered when evaluating for a dormant period. If the patient had ONLY inpatient encounters for 90 days, he will be considered as having a 'dormant' period.	No. SUD encounters provided on inpatients will NOT be used to evaluate for qualifying events	Yes. SUD encounters provided on inpatients will be used to evaluate retention compliance

	Census on SUD bed section w/ LOS ≥ 4 calendar days	No. SUD census data will not be used to evaluate a dormant period (when the patient is discharged, the measure will pick-up the discharge information)	No. SUD census data will not be used to evaluate for a qualifying event (when the patient is discharged, the measure will pick-up the discharge information)	Yes (partially). SUD census data will be used to evaluate whether to 'disconnect' a vet from previous qualifying track. But it will not be used to meet retention visit requirements. The patient will be re-qualified upon discharge from the SUD Bed Section.

Attachment B

Office of Research and Development,

Department of Veterans Affairs

Fiscal Year 2012 Performance Summary Report

To the Office of National Drug Control Policy

1. Performance Information

Performance Measure: Each fiscal year the Office of Research and Development (ORD) will have at least 10 ongoing studies directly related to substance abuse disorder: 5 ongoing studies related to alcohol abuse and 5 ongoing studies related to other substance abuse.

How the measure is used in the program: Most ORD-funded studies are investigator-initiated. Many clinicians who treat patients also perform research, so their research is targeted at diseases and disorders that they treat. Investigators will be encouraged to undertake research in this important area.

Performance results for the previous fiscal years: In fiscal year (FY) 2008, ORD funded 17 studies related to substance abuse disorder, 38 related to alcohol abuse, and 14 that were related to both substance abuse disorder and alcohol abuse. In FY 2009, ORD funded 20 studies related to substance abuse disorder, 45 related to alcohol abuse, and 10 related to both. In FY 2010, ORD funded 21 studies related to substance abuse disorder, 46 related to alcohol abuse, and 14 related to both. In FY 2011, ORD funded 37 studies related to substance abuse disorder, 51 related to alcohol abuse, and 8 related to both.

Comparison of the most recent fiscal year to its target: The targets for FY 2012 were exceeded. See Table 1.

Target for the current fiscal year: Although the actual values (number of studies) exceeded the target for FY 2012, we have not increased the target for FY 2013. This is because there is wide variation in the amount of funding per project. The more expensive studies are usually multisite clinical trials. Leaving the target at its present level would allow flexibility in the types of studies that are funded.

Procedures used to ensure that the performance data is accurate, complete, and unbiased. The data is obtained from the Office of Research and Development's (ORD's) database that lists all of its funded projects. A report is produced that lists all funds sent to the VA medical centers for projects on drug and alcohol dependence for the four ORD services for a given fiscal year. The number of projects in the list is counted.

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Table 1

Measure	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Target	FY 2012 Actual	FY 2013 Target
Number of ongoing research studies related to substance abuse disorder	17	20	21	37	5	32	5
Number of ongoing research studies related to alcohol abuse	38	45	46	51	5	56	5
Number of ongoing research studies related to both substance abuse disorder and alcohol abuse	14	10	14	8	n/a*	10	n/a

*****Targets have not been established.

2. Management Assertions

Performance reporting system is appropriate and applied.

The VA Office of Research and Development (ORD) consists of four main divisions:

Biomedical Laboratory: Supports preclinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans.

Clinical Science: Administers investigations, including human subject research, to determine feasibility or effectiveness of new treatments (e.g., drugs, therapy, or devices) in small clinical trials or multi-center cooperative studies, aimed at learning more about the causes of disease and developing more effective clinical care.

The Cooperative Studies Program (CSP) is a major division within Clinical Science R&D that specializes in designing, conducting, and managing national and international multi-site clinical trials and epidemiological research.

Health Services: Supports studies to identify and promote effective and efficient strategies to improve the organization, cost-effectiveness, and delivery of quality healthcare to Veterans.

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Rehabilitation: Develops novel approaches to restore Veterans with traumatic amputation, central nervous system injuries, loss of sight and/or hearing, or other physical and cognitive impairments to full and productive lives.

In order for funds to be allocated to a project, they must be entered into the Research Analysis Forecasting Tool (RAFT) database.

Starting in FY 2009, all Merit Review proposals (our major funding mechanism) were submitted electronically via the eRA Commons system, and projects that were approved for funding were identified. Funding data for these projects were transferred electronically to RAFT. A few Career Development proposals are included in the list of projects. The capability to submit Career Development proposals electronically via eRA Commons was in place near the end of FY 2010.

Preparation of the list of projects:

The BLR&D/CSR&D administrative officer extracted all funded projects for the fiscal year from RAFT and exported the data into an Excel spreadsheet. The alcohol and drug abuse projects were identified by reviewing the title. Any questionable projects were verified as relevant or not relevant upon review of the abstract. In some cases, the title listed was the type of investigator award. For those, the title was obtained from the abstract. Project start and end dates were included in the spreadsheet. If there were multiple researchers or a researcher with multiple funds for the same project (e.g., salary award plus Merit Review award), then the earliest start date and latest end date were used. Although great care is taken to provide an inclusive list of projects, our database management system does not have robust reporting capabilities, so some projects may have been omitted.

Explanations for not meeting performance targets are reasonable.

Not applicable. The targets were met.

Methodology to establish performance targets is reasonable and applied.

VA Research and Development focuses on research on the special healthcare needs of Veterans and strives to balance the discovery of new knowledge and the application of these discoveries to Veterans' healthcare. VA Research and Development's mission is to "discover knowledge and create innovations that advance the health and care of Veterans and the Nation." ORD supports preclinical, clinical, health services, and rehabilitation research. This research ranges from studies relevant to our aging Veterans (e.g., cancer, heart disease, Alzheimer's disease) to those relevant to younger Veterans returning from the current conflicts (e.g., PTSD, spinal cord injury). The targets were set at that level to allow flexibility in the projects funded in terms of both subject (e.g., cancer, addiction, heart disease) and type (e.g., preclinical, clinical trials).

Attachment B

Adequate performance measures exist for all significant drug control activities.

Since many of the projects do not involve direct interaction with patients, the measure looks at the number of projects rather than specific activities.

Appendix A Office of Inspector General Contact and Staff Acknowledgments

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