VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Department of Veterans Affairs

Independent Review of VA's FY 2013 Performance Summary Report to the Office of National Drug Control Policy

February 11, 2014
14-00257-67

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

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

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Department of Veterans Affairs

Memorandum

Date: February 3, 2014

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

Subj: Final Report: Independent Review of VA's Fiscal Year 2013 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) 2013 Performance Summary Report to the Director, Office of National Drug Control Policy (ONDCP), pursuant to ONDCP Circular: *Accounting of Drug Control Funding and Performance Summary* (Circular), dated January 18, 2013, and as authorized by 21 U.S.C. §1703(d)(7).* The Performance Summary Report is the responsibility of VA's management and is included in this report as Attachment A (Continuity of 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 *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.

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.

*To view the Circular, please visit http://www.whitehouse.gov/sites/default/files/docs/2013_circular-accounting_of_drug_control_funding_and_performance_summary.pdf.

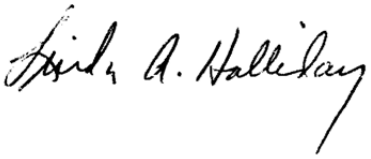
- VA did not meet its FY 2013 target for the Continuity of Care performance measure. VA reported, among other factors, outreach increased access to services for veterans who are in the very early stages of recovery. Despite efforts to maintain continuity of care, these veterans are at increased risk of early dropout. Based on these considerations, VA set a lower Continuity of Care performance target for FY 2014. In FY 2013, VA began implementing a measure of patient reported abstinence from drug use during early recovery among patients engaged in a new episode of substance use disorder specialty treatment. VA reported it will continue to transition to this performance metric in FY 2014.

- Nothing came to our attention that caused us to believe VA did not meet its FY 2013 Research and Development target for the substance abuse disorder on-going studies performance measure. 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 6, 2014

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

Subj: Management Representation Letter for the Independent Review of the VA's FY 2013 Performance Summary Report to the Office of National Drug Control Policy (Project Number 2014-00257-R1-0029) (VAIQ 7427737)

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, 2013.

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

a. The Performance Summary Report for FY 2013 required by the Circular.
b. All supporting records and related information and data relevant to the performance measures within the FY 2013 Performance Summary Report; and
c. Communications, if any, from the ONDCP and other oversight bodies concerning the FY 2013 Performance Summary Report and information therein.

3. We confirm that the FY 2013 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.

Page 2.

Management Representation Letter for the Independent Review of the VA's FY 2013 Performance Summary Report to the Office of National Drug Control Policy (Project Number 2014-00257-R1-0029)

5. No events have occurred subsequent to September 30, 2013, 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 2013 Performance Summary Report

I. PERFORMANCE INFORMATION

Decision Unit 1: Veterans Health Administration

Measure 1: Continuity of Care

FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Target	FY 2013 Actual	FY 2014 Target
52%	52%	47%	42%	47%	38%	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 2013, 38% of VA patients in a new episode of specialized SUD treatment successfully met the criteria for continuity, a decline from 42% in FY11 and below the FY 2013 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. Changes in patient case mix appear to have had a growing impact on performance in FY13. 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 a continuing 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.

Previously recognized limits of the continuity of care performance measure may also have a bearing on FY13 actual results. For instance, VA has been making significant investments in "virtual care" that does not require a face-to-face visit. Despite the increasing emphasis on maintaining contact with Veterans via telephone or secure electronic messaging, coding practices in FY 2013 did not reflect this activity adequately and may have contributed to underestimation of actual continuity of care. Efforts are underway in FY 2014 to assure that telephone encounter workload can be captured appropriately. 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 in SUD specialty programs if integrated services can be provided in other settings.

In FY13, VHA continued implementation of clinical symptom monitoring using the Brief Addiction Monitor (BAM) that transmits responses to the national data base with an average of approximately 2400 administrations per month to patients beginning new episodes of SUD specialty care. VHA specialty care programs are now able to use BAM as part of software that integrates the assessment process with our electronic health record, however VA does not yet have the capability to incorporate patient generated data directly into the electronic health record (e.g., using waiting room computer tablets or remote web-based data entry) and this limits clinical feasibility for efficient collection and entry of these patient reported outcomes during treatment. Higher rates across programs of initial assessment and re-assessment during treatment may provide more representative estimates of self-reported recovery during early abstinence than the preliminary estimates based on the selected samples collected from programs that have begun implementation to date. During the last three quarters of FY 2013, nearly 4,000 Veterans with drug use disorder diagnoses were assessed at intake and reassessed as part of continuing care 30-90 days later.

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Approximately 86% reported no drug use in the prior 30 days at reassessment. As implementation continues during FY 2014, VA will monitor assessment rates and self-reported abstinence to inform performance targets for FY 2015 that do not provide disincentives for retaining in care Veterans with conditions that may take longer to respond to treatment interventions. 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.

II. MANAGEMENT'S ASSERTIONS

(1) **Performance reporting systems 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 performance targets are reasonable.** In FY 2013, the target of 47% was not met with an actual rate of 38%. 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 FY13.

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(3) **Methodology to establish performance targets is reasonable and applied.** In consultation with the program office in Patient Care Services and the Office of Analytics and Business Intelligence, targets are set to promote performance improvement while considering changes in the healthcare delivery system and the impact on case mix in SUD specialty care. As VA mental health services evolve toward team-based integrated care that provides more comprehensive services for a panel of patients, early stabilization may still involve SUD specialty care, but with more rapid transition for continuing care with the general mental health team when appropriate; however, this care would not be tracked by the methods of the current performance measure. Based on careful consideration of all these factors, VA has identified for FY 2014, a target of 42% continuity within SUD specialty care.

In FY 2013, VA began 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 and will continue the transition to that performance metric in FY 2014.

(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 2013 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 2013, VHA provided services to 129,361 patients with a primary drug use disorder diagnosis. Of these, 34 percent used cocaine, 30 percent used opioids and 27 percent used cannabis. Eighty percent had co-existing psychiatric diagnoses. (These categories are not mutually exclusive.)

According to the 2012 *Drug and Alcohol Program Survey* (DAPS), at the start of FY 2013, 56 percent of VA facilities were able to offer 24-hour Substance Use Disorder (SUD) care on-site, 41 percent of facilities offered intensive outpatient services as their highest intensity of SUD care, and 82 facilities (59 percent) reported offering stand-alone intensive outpatient treatment that was not a component of a 24-hour care program. In FY12, 97 percent of facilities offered either 24-hour care or intensive outpatient programming on site. All VA facilities currently provide SUD services within a specialty setting, as well as in general mental health settings.

VA provides two types of 24-hour-a-day care to patients having particularly severe substance use disorders. VA offers 24-hour care in residential rehabilitation treatment programs for substance use disorders. Additionally, 24-hour care is provided for detoxification in numerous inpatient medical and general mental health units throughout the VA system. Outpatient detoxification is available for patients who are medically stable and who have sufficient social support systems to monitor their status. Most Veterans with substance use disorders are treated in outpatient programs. Intensive substance use disorder outpatient programs provide at least three hours of service per day to each patient, and patients attend them three or more days per week. Standard outpatient programs typically treat patients for an hour or two per treatment day and patients attend one or two days a week.

VA continues to expand the availability of opioid agonist treatment for Veterans with opioid use disorders. In FY 2013, evidence-based medication assisted treatment for opioid dependence, including buprenorphine, was available at 155 locations that served at least 10 patients and an additional 125 CBOCs or other locations that had at least some active buprenorphine treatment. 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 SUD staff assigned to work in large community based

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outpatient clinics, mental health residential rehabilitation programs, intensive SUD outpatient programs and posttraumatic stress disorder (PTSD) teams. Active monitoring is ongoing for replacing any positions that become vacant.

Consistent with principles of recovery, VA is setting the standard for a new and emerging health care profession, known as "Peer Specialists." As of November 5, 2013, VHA had hired 815 Peer Specialists and Peer Apprentices, exceeding the hiring goal set in President Obama's August 31, 2012, Executive Order aimed at improving access to mental health services for Veterans, service members and military families. Through the development of position descriptions that clearly outline the job duties of both Peer Specialists and Peer Support Assistants, certification of training requirements for both positions and consistently-defined, job-specific competencies, Peer Specialists and Peer Support Assistants are poised to provide a unique set of services to Veterans seeking care for mental health and substance use disorders.

VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management. Among other efforts, VA has completed initial implementation of a national initiative that provides facilities with training on use of real-time data on opioid prescribing practices at the patient and provider level. Consistent with the Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain that VA developed in collaboration with the Department of Defense, educational presentations for providers have addressed evidence on relative benefits and challenges of chronic opioid therapy, examples of strong models for changing practice behavior and lessons learned from sites regarding implementation strategies of the stepped care model of pain management.

The Homeless Programs Office continues to fund SUD specialists to support the Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) program. In addition, there are SUD Specialists working in Health Care for Homeless Veterans (HCHV). These 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. As another effort to reduce homelessness and risk of homelessness, VHA has expanded outreach services to justice involved Veterans with funding for 172 full time Veterans Justice Outreach Specialists distributed across facilities based on need.

During FY13, VHA continued implementation of clinical symptom monitoring using the Brief Addiction Monitor (BAM) that transmits responses to the national data base with over 7,500 Veterans assessed at the beginning of a new episode of SUD specialty care during the 4th quarter of FY2013. The BAM is designed to assist SUD specialty care clinicians in initial treatment planning and 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

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the intensity of care required for the patient. In addition to items addressing risk and protective factors for recovery, the BAM assesses self-reported substance use in the prior 30 days including an item asking about days of any use of illicit or non-prescribed drugs as well as items on use of specific substances.

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:

- 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

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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.
- 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.

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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 Qualifying Event Date Not earlier than T-29	2nd Qualifying Event Date Not earlier than T-28	3rd Qualifying 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:

- 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**
- 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.*
- 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.
- 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:

- 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).

- **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

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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:

o LOS < 4 calendar days will have no effect on the measure.

o 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.

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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 3 retention periods
SA/PTSD 519	Yes. SA/PTSD clinic stop 519 will be used to 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.	No. 519 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 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.	Yes. 519 clinic stops will be used 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 workload.	Yes. 545 clinic stops will be used to determine retention compliance in the 2nd & 3rd period only
Inpatient SUD Dischg w/ LOS $\geq$ 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 $\geq$ 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.

2. **Repository**: Monthly, facility, VISN, VHA and SSN specific data are available for trouble shooting and understanding local patterns retrospectively after the completion of a retention period; however this is not sufficiently close to 'real time' data to provide prospective tracking during the retention period.

Attachment B

Office of Research and Development
Department of Veterans Affairs
Fiscal Year 2013 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. In FY 2012, ORD funded 32 studies related to substance abuse disorder, 56 related to alcohol abuse, and 10 related to both.

Comparison of the most recent fiscal year to its target: The targets for FY 2013 were exceeded. See Table 1.

Target for the current fiscal year: Although the actual values (number of studies) exceeded the target for FY 2013, we have not increased the target for FY 2014. 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.

Attachment B

Table 1

Measure	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Target	FY 2013 Actual	FY 2014 Target
Number of ongoing research studies related to substance abuse disorder	20	21	37	32	5	30	5
Number of ongoing research studies related to alcohol abuse	45	46	51	56	5	59	5
Number of ongoing research studies related to both substance abuse disorder and alcohol abuse	10	14	8	10	N/A*	17	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 FY2009, 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, traumatic brain injury, 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).

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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

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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