US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

VA Can Enhance Reporting of Its Progress to Reduce Drug Overdose Deaths

Management Advisory Memorandum	24-02431-10	December 4, 2024

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The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

December 4, 2024

MANAGEMENT ADVISORY MEMORANDUM

TO: Dr. Shereef Elnahal, Under Secretary for Health, Veterans Health Administration (VHA)

FROM: Larry Reinkemeyer, Assistant Inspector General, Office of Audits and Evaluations, VA Office of Inspector General (OIG)

SUBJECT: VA Can Enhance Reporting of Its Progress to Reduce Drug Overdose Deaths

Many Americans are affected by substance use disorders, with a significant number of diagnosed veterans not receiving specialty treatment, as shown in figure 1. Since 2015, the Office of National Drug Control Policy (ONDCP) has reported sharp increases in overdose deaths. Because of these alarming trends, ONDCP tasked federal agencies with instituting measures to reduce overdose deaths and reporting their progress.

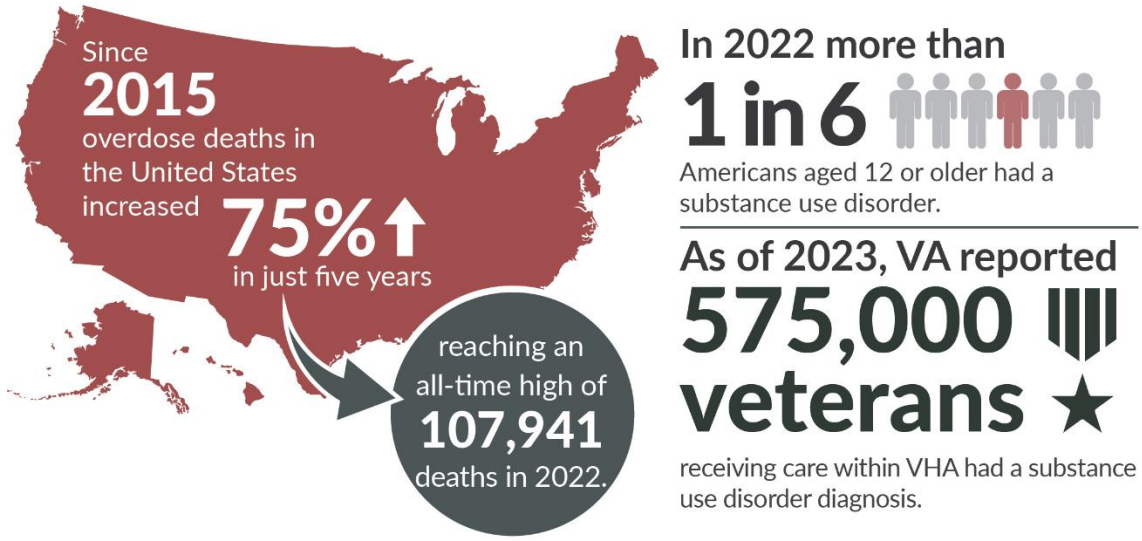

Figure 1. *Substance use disorder diagnoses, treatment, and overdose deaths.*

Source: VA OIG analysis of the ONDCP 2022 performance system report, Centers for Disease Control and Prevention statistics, and VA medical care budget.[1]

[1] ONDCP, National Drug Control Strategy Performance Review System Report (April 2022). The overdose data pertain to the general United States population, not the veteran population. Centers for Disease Control and Prevention (CDC), "Overdose Prevention, Treatment of Substance Use Disorders," fact sheet, April 25, 2024; CDC's National Center for Health Statistics (NCHS), "Drug Overdose Deaths in the United States, 2002–2022," NCHS Data Brief No. 491, March 2024; VA, *FY 2025 Budget Submission*, vol. 2, *Medical Programs* (March 2024), https://www.va.gov/budget/products.asp.

ONDCP is responsible for coordinating and overseeing the implementation of the nation's drug control policy, including the President's National Drug Control Strategy, across the federal government to reduce substance use disorder rates and overdose deaths.[2] ONDCP is also responsible for evaluating the effectiveness of these efforts, the strategy's goals and objectives, and each federal agency's measures.[3]

Accordingly, VA is required to report to ONDCP its annual performance on strategies to mitigate overdose deaths.[4] VHA's Office of Mental Health and Suicide Prevention, including the Program Evaluation and Resource Center, submitted to ONDCP its fiscal year (FY) 2023 targets and actual performance for nine VA treatments and interventions that collectively serve to reduce the risk of drug overdose deaths among veterans. For more information about these nine measures, see appendix A.

ONDCP asked the OIG to review the accuracy of VA's FY 2023 reported progress for four of the nine measures related to the goal to reduce overdose deaths.[5] Specifically, ONDCP asked the OIG to assess whether the four following measures accurately reflect the performance of the programs they represent, whether the programs are being executed at a high level, and whether the right programs are in place to achieve the goals of the President's strategy:

- **Measure 1: Patients with nonfatal overdoses with case reviews.** VA reported the percentage of veterans with a nonfatal overdose in the past year who received a case review by an interdisciplinary team of clinicians with expertise in pain, substance use disorders, suicide risk, mental health conditions, and pharmacy.
- **Measure 2: Patients estimated as very high-risk for overdose or suicide and a substance use disorder who received treatment.** VA also reported the percentage of veterans identified as very high-risk for overdose or suicide with a substance use disorder diagnosis who subsequently received treatment for this condition either in a residential or outpatient setting.[6]

[2] Under 21 U.S.C. § 1702(a), ONDCP was established in the Executive Office of the President. Under 21 U.S.C. § 1705(a)(2), the President is responsible for submitting to Congress a National Drug Control Strategy every two years.

[3] 21 U.S.C. § 1702(a)(4).

[4] Under 21 U.S.C. § 1705(g)(2), the head of each agency with a national drug control program shall annually submit to the director of ONDCP an evaluation of the progress by that agency with respect to the National Drug Control Strategy goals.

[5] Under 21 U.S.C. § 1703(d)(7)(B), ONDCP has the authority to request that the respective agency's inspector general assist in performing audits and evaluations of the agency's performance related to those program-level measures.

[6] Residential programs, sometimes referred to as inpatient residential or domiciliary care, provide comprehensive treatment and rehabilitation services to veterans. The programs provide these services in a structured environment.

- **Measure 3: The number of patients receiving contingency management.** Contingency management is a type of evidence-based treatment in which individuals are incentivized through rewards to reinforce positive behavioral changes. Specifically, veterans are offered opportunities to earn rewards by either demonstrating abstinence from substances or attending treatment appointments. VA provided the number of patients who received such treatment.
- **Measure 4: Percentage of patients receiving medication for an opioid use disorder.** VA disclosed the percentage of veterans in an outpatient opioid treatment program or who have pharmacy records demonstrating that they received US Food and Drug Administration–approved pharmacotherapy for this condition.

The OIG agreed to the ONDCP's requests by (1) obtaining the FY 2023 performance data for VA programs, (2) determining whether these measures are suitable for reducing the risk of overdose deaths and accurately reflect the performance of the programs represented, and (3) identifying at a high level what challenges the programs have experienced in implementing the action plans to achieve ONDCP's goal to reduce the number of overdose deaths. This memorandum addresses ONDCP's request and conveys information for the Office of Mental Health and Suicide Prevention to assess whether additional actions are warranted.[7] The OIG is taking no additional steps at this time.

What the OIG Did

The OIG reviewed the Office of Mental Health and Suicide Prevention's reported performance measures 1 through 4 for FY 2023 related to ONDCP's strategic goal 1 to reduce the number of drug overdose deaths. The team attempted to determine whether those four measures were suitable for reducing the risk of drug overdose deaths and to ensure the numbers VA provided were accurate.

To validate that the four measures appropriately captured efforts to reduce the risk of overdose deaths, the team interviewed program officials from the Office of Mental Health and Suicide Prevention, including staff from the Program Evaluation and Resource Center, and senior managers at Veterans Integrated Service Networks (VISNs) and medical facilities with expertise in substance use disorders.[8] Additionally, the team reviewed written material produced by these

[7] This memorandum provides information that has been gleaned from OIG data analyses and provided to the Office of Mental Health and Suicide Prevention leaders to alert them to possible quality control issues leading to inaccurate reporting. The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified by OIG hotline allegations or in the course of its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

[8] VHA divides the United States into 18 VISNs, which are regional systems that work together to meet local healthcare needs and provide greater access to care.

offices that reflect the general rationale for the development of the four measures. These narratives included cited peer-reviewed studies, which the team examined and compared to the justifications provided by Office of Mental Health and Suicide Prevention staff to ensure those measures were reasonably reliable based on independent research.

To validate how VA gathered the data pulled for the four measures, the team observed program staff's data-gathering techniques. The OIG also obtained access to Program Evaluation and Resource Center data files from VHA's Corporate Data Warehouse servers and reran the steps to pull the data. OIG staff compared the numbers and were able to obtain similar figures to those the Office of Mental Health and Suicide Prevention reported to ONDCP.

The team was unable to completely verify the accuracy of the performance measures data that were submitted to ONDCP because the Program Evaluation and Resource Center did not maintain a repository of the data submitted. The OIG was able to replicate the numbers within 1 percent, and Program Evaluation and Resource Center officials explained that the difference is due to the nightly updating of veterans' records. However, these scope limitations prevented the team from providing categorical assurance to ONDCP that the results reported by the Office of Mental Health and Suicide Prevention were complete and accurate.

VHA Demonstrated Progress Toward Reducing Drug Overdose Deaths Among Veterans

The Office of Mental Health and Suicide Prevention provided the OIG with reasonable assurance that it demonstrated to ONDCP its progress toward reducing drug overdose deaths. In addition to the four measures reviewed by the OIG in this memorandum, VA reports five other measures to ONDCP that collectively serve to meet the overall goal of reducing drug overdose deaths. These measures included interventions such as distributing naloxone kits to veterans with substance use disorders to prevent overdose deaths.[9] The team interviewed VHA VISN and medical centers' mental health staff who provide or coordinate care for veterans to achieve programmatic goals. The consensus among these staff is VHA, as a whole, has a robust set of measures aimed at reducing the risk of drug overdose deaths among veterans. Figure 2 shows ONDCP's assessment of VHA's targets and actual performance for the four measures that ONDCP asked the OIG to review for suitability and accuracy.

[9] For more information on the other five measures, see appendix A.

Measure	Measures of performance	FY 2023 target	FY 2023 actual	Status
1	Patients with nonfatal overdoses with case reviews	60%	79.1%	Met
2	Patients estimated as very high-risk for overdose or suicide and a substance use disorder who received treatment	44%	51.2%	Met
3	The number of patients receiving contingency management	600	1,044	Met
4	Percentage of patients receiving medication for an opioid use disorder	47.5%	48.1%	Met

Figure 2. *ONDCP determined VHA met the FY 2023 targets for the four measures ONDCP asked the VA OIG to review.*

Source: ONDCP letter to the VA OIG dated February 27, 2024, summarizing its FY 2023 assessment for the four measures.

The OIG reviewed the four requested measures and found measures 3 and 4 were fairly represented, but VHA reported incomplete populations to ONDCP for measure 1 by not adequately identifying and reporting veterans with overdoses who received community care and for measure 2 by not including veterans who received residential treatment. The director of the Performance Evaluation and Resource Center could not confirm whether the target for measure 1 would still have been met if the data had included those veteran groups. Despite the incomplete data for measure 2, program officials from the Office of Mental Health and Suicide Prevention were confident they would still have met the targets and likely exceeded them if the additional populations had been included.

VHA's Reporting Was Generally Accurate but Additional Controls Are Needed to Ensure All Key Veteran Populations Are Included

VHA's reporting of the effectiveness of its measures reflects its continued efforts to reduce overdose deaths among veterans, but controls should be strengthened to ensure the accuracy of the data reported to ONDCP. For the two measures that VHA did not report key portions of its veteran populations (measures 1 and 2), there was a lack of data-quality controls to verify the data before reporting. If VHA does not ensure the veterans' data used for the reported measures are complete, it risks misrepresenting substance use disorder rates among veterans and setting inadequate targets for improvement. VHA officials and the OIG team also discussed challenges with VA's progress toward meeting ONDCP's goal for increasing the number of patients who receive contingency management (measure 3) and how VA is improving its performance for that

measure. The director of the Program Evaluation and Resource Center expressed to the OIG team that progress with providing veterans medications for the treatment of opioid use disorder was increasing slowly but incrementally over time (measure 4) and this is in line with their expectations. VISN and medical facility staff responsible for administering substance use disorder treatments did not report to the OIG team any specific concerns or updates to processes related to the medications for the treatment of opioid use disorder.

Officials from the Office of Mental Health and Suicide Prevention and staff from selected VISNs and medical facilities agreed that the four measures the OIG reviewed reflected good strategies to reduce the risk of drug overdose deaths but represent only some of the treatments VHA provides to mitigate overdose risks among veterans.

The following sections detail the deficiencies in reporting with the two measures that lacked controls:

- **Measure 1:** Patients with nonfatal overdoses with case reviews.
- **Measure 2:** Patients estimated as very high-risk for overdose or suicide and a substance use disorder who received treatment.

VHA Did Not Include Interdisciplinary Case Review Rates for Veterans Receiving Community Care for Measure 1

VHA's measure 1 includes the percentage of veterans with a nonfatal overdose in the past year who received a case review by an interdisciplinary team with expertise in pain, substance use disorders, suicide risk, mental health conditions, and pharmacy. VHA disclosed to ONDCP in its FY 2023 reporting that VHA's electronic medical record and national pharmacy records do not fully capture veterans enrolled in VHA health care who receive treatment in the community.[10] According to the program office, when veterans receive treatment through community care for nonfatal overdoses, this care is not consistently documented in VHA medical records. [11] For example, if a community care record is scanned into the VHA medical record, the ONDCP data pull will not catch it unless clinical staff take the time to enter a specific templated note into a veteran's medical record. Additionally, those templated notes did not have a way for clinicians to specify whether a veteran had an overdose. The director of the Program Evaluation and Resource Center informed the OIG team that this gap in processes led to a documentation issue and resulted in systematic underreporting. The director of the Program Evaluation and Resource Center also stated that

[10] ONDCP, National Drug Control Assessment, May 2024.

[11] Assistant under secretary for health, Office of Integrated Veteran Care (16), "For Action: Community Care Suicide Behavior and Overdose Report (SBOR) Training," memorandum to network directors and business implementation managers, May 2024; Community Care SBOR Training, June 2024.

> In FY23, there was not a standard protocol for community care providers to report non-fatal overdoses to VHA for documentation in the VHA medical record. Without this process, community care providers may have treated an unknown number of non-fatal overdoses without the awareness of VHA health care providers.

The templated note was updated so that overdoses could be documented more clearly, and the Integrated Veteran Care office is training field staff so that veterans with overdoses treated in the community are consistently reported in VHA's medical records moving forward.[12] Additionally, the director of Program Evaluation and Resource Center stated that a new process of reviewing billing codes would also help identify more overdoses in community care.

Because community care was underreported in this measure, VHA may be overreporting its performance. If VHA had included all veterans who received community care for overdoses in measure 1, it could lower the reported percentage of veterans who received interdisciplinary reviews. In other words, in FY 2023, it is possible that more veterans treated for nonfatal overdose appear to have received interdisciplinary reviews than actually did. The templated notes in veterans' medical records are also an essential step for initiating those reviews. The director of Program Evaluation and Resource Center Director stated she could not be sure whether VHA still would have met the President's National Drug Control Strategy goal for this measure if veterans receiving community care for overdoses had been adequately included in VHA's reporting (the FY 2023 target was 60 percent; VHA reported 79.1 percent). The OIG could not confirm how the performance would change the numbers because the Program Evaluation and Resource Center was unable to provide the information. The director of Program Evaluation and Resource Center explained that this information was not available because they could not identify the number of nonfatal overdoses that were treated in community care and not reported to VHA.

Program officials from the Office of Mental Health and Suicide Prevention, including the Program Evaluation and Resource Center, have considered reporting these populations separately but believe that because veterans can receive care for overdoses in both the community and at VA, it would be complicated and may lead to inaccuracies. Therefore, the Office of Mental Health and Suicide Prevention is considering using the same performance measure description for next year's assessment, including veterans receiving community care for overdoses in the reporting for this measure, and providing a brief explanation for the change in the metric's performance. Program Evaluation and Resource Center officials have stated that the community care training and new processes for reporting veterans treated with nonfatal

[12] The OIG requested that the Program Evaluation and Resource Center quantify the amount of underreporting that occurred for measures 1 and 2, but the director stated that they could not estimate this information.

overdoses would help ensure this information is included in future reporting. However, VHA senior leaders have not yet made a final decision on how this measure will be reported.

VHA Did Not Include Veterans Receiving Residential Care for Measure 2

As stated earlier, VHA's measure 2 includes the percentage of veterans who are identified as very high-risk for overdose or suicide, who have a substance use disorder diagnosis, and who subsequently received substance use disorder treatment either in a residential or outpatient setting. Because Office of Mental Health and Suicide Prevention officials confirmed that the numbers reported to ONDCP may have excluded veterans who received some types of treatment in residential programs, VHA may be underreporting its actual performance for this metric. Office of Mental Health and Suicide Prevention officials believe their targeted rates probably could have been higher for FY 2023 (the FY 2023 target was 44 percent; VHA reported 51.2 percent).

It was apparent to the OIG team that the program office discovered the issues regarding the completeness of the data reported to ONDCP for measure 2 only after the OIG requested a reporting process narrative. The director of the Program Evaluation and Resource Center told the OIG team that this underreporting was due to errors that can be attributed to quality control issues, and Office of Mental Health and Suicide Prevention officials stated this population would be included in future reporting. The director noted that there is some overlap in the data since many veterans who receive residential treatment also receive outpatient treatment during the same quarter; therefore, the numbers for this metric are expected to increase by only a small percentage.

VHA Lacks a Quality Control Process for Verifying Data, Which Affected Reporting for Measures 1 and 2

The Office of Mental Health and Suicide Prevention does not have adequate data-quality controls to verify the accuracy of its data before reporting it to ONDCP. According to program office staff, the discrepancy in the data reported may have occurred because the measures were developed quickly and could have been vetted more carefully if staff had more time. Documenting the reporting process and developing a quality assurance review process could help the Office of Mental Health and Suicide Prevention identify incomplete data reporting in the future. Furthermore, the Program Evaluation and Resource Center does not have a system to archive the datasets used to generate the numbers reported to ONDCP. Archiving the data would allow verification or further analysis.

As stated earlier, when the OIG's data analytics team attempted to reproduce the steps that the Program Evaluation and Resource Center had provided for pulling the data, they could not obtain the same numbers. However, the OIG data analytics team reproduced the numbers the Office of

Mental Health and Suicide Prevention reported with a less than 1 percent variance. The director of the Program Evaluation and Resource Center explained that this variance occurred because patient data are recalculated nightly and clinicians update medical records daily. Although the OIG team determined this difference was immaterial, without archived datasets, VHA cannot maintain an adequate audit trail. VA policy requires data repositories to be maintained in compliance with federal records management policy, including proper retention and archiving. Records need to be appropriately maintained when they are received by a federal agency for preservation because of the value of those data.[13] This audit trail would provide a more reliable record to answer any questions ONDCP may have or to examine VHA's performance for these metrics.

The Office of Mental Health and Suicide Prevention Has Challenges with Laboratory Testing for Contingency Management

The Office of Mental Health and Suicide Prevention noted that the most significant challenge with meeting the ONDCP performance measures was implementing the contingency management incentive program (measure 3). In this program, veterans undergo regular substance use testing and receive rewards, such as funds for use at VA medical facility retail stores, cafeterias, or coffee shops, for abstaining from substance use. However, medical facilities require that these tests be evaluated by medical center–approved laboratories, which increases the time it takes to reinforce a veteran's abstinence from substance use with rewards. Immediate rewards would make contingency management more effective.

Almost universally, field staff relayed their concerns with barriers related to the laboratory protocols designed to protect the legitimacy of contingency management testing results. VISN and medical facility staff responsible for administering substance use disorder treatment stated that the point-of-care drug testing needed for the timeliness of the reward program is critical and is not always available. The deputy national mental health director of the Office of Mental Health and Suicide Prevention–Substance Use Disorder stated that self-testing is the key condition that would increase the effectiveness of the contingency management effort. Rewards for veterans with negative test results work best when delivered immediately.

On June 26, 2024, VHA released a memorandum that supports contingency management programs by providing an option for patient self-testing.[14] As a result, the Office of Mental Health and Suicide Prevention will be rolling out a testing alternative that will provide veterans

[13] VA Handbook 6300.1, *Records Management Procedures*, March 24, 2010.

[14] Assistant under secretary for health for clinical services/chief medical officer, "For Action: Implementation of a Patient Self-Testing Option in Support of the Provision of Contingency Management," memorandum to VISN directors, June 26, 2024.

the ability to self-test while in a VA clinic or at home via telehealth calls with their clinicians, which should enable greater participation and success in this measure.[15]

Requested Action

The OIG requests that VA inform ONDCP and the OIG what actions will be taken to update the accuracy of its future reporting for measures 1 and 2. VHA should also coordinate with ONDCP to determine whether datasets used for reporting should be archived to some extent for tracking, testing, and verification, as well as for compliance with VA policy on records management.

VA Management Comments

The under secretary for health accepted OIG's feedback on how to enhance reporting of its performance measures and responded that VA is proud to be a leader in several metrics, including the provision of medication for opioid use disorder and contingency management. Additionally, the under secretary stated that in FY 2023, VA identified and conducted case reviews with over three-quarters of veterans with a nonfatal overdose (79.1 percent). The full text of the under secretary for health's response is included in appendix B.

OIG Response

The OIG acknowledges VHA's efforts to prevent deaths from fatal overdoses among veterans. However, unclear reporting of metrics creates challenges for progress and may impact the services veterans receive. The OIG requests VHA inform the OIG of what additional actions, if any, it takes to update the accuracy of its future reporting for measures 1 and 2 as well as the results of VHA's coordination with ONDCP.

[15] Self-testing options include US Food and Drug Administration–approved, over-the-counter/home-use products exempt from laboratory regulatory oversight. Self-testing results would be relied on only for the contingency management incentive program.

Appendix A: Fiscal Year 2023 VA Measures Reported to the Office of National Drug Control Policy (ONDCP)

Measure	Measures of performance	FY 2023 target	FY 2023 actual	Status
1	The percentage of patients with a nonfatal overdose in the past year who received a case review by an interdisciplinary team with expertise in pain, substance use disorder, suicide risk, mental health conditions, and pharmacy	60%	79.1%	Met
2	Patients estimated as very high-risk for overdose or suicide and a substance use disorder who received treatment	44%	51.2%*	Met
3	The number of patients receiving contingency management	600	1,044	Met
4	The percentage of patients with opioid use disorder receiving Food and Drug Administration approved pharmacotherapy	47.5%	48.1%	Met
5	The percentage of patients with opioid use disorder who have had a prescription filled for naloxone in the last 12 months	75%	67.3%	Not Met
6	The percentage of patients with substance use disorder who have had a prescription filled for naloxone in the last 12 months	35%	45.7%	Met
7	The percentage of patients on long-term opioid therapy with a urine drug screen at a VHA facility	85%	88.1%	Met
8	The number of programs by the end of the fiscal year that have a Syringe Service Program	20	29	Met
9	Number of substance use disorder specific purpose–funded positions (aligned with the President's budget) on board this year divided by the number of approved specific purpose–funded positions in FY 2022 and FY 2023	70%	64.45%	Not Met

Figure A.1. *OIG analysis of the ONDCP National Drug Control Assessment, May 2024. VA's Office of Mental Health and Suicide Prevention reported on nine performance measures for fiscal year (FY) 2023 that collectively aim to reduce the risk of overdose deaths among veterans.*

**This information is a point-in-time snapshot at the end of FY 2023. VA may revise this measure and expects this will alter scores; targets may need to be adjusted accordingly going forward.*

Appendix B: VA Management Comments

Department of Veterans Affairs Memorandum

Date: November 1, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Management Advisory Memorandum (MAM), VA Can Enhance Reporting of Its Progress to Reduce Drug Overdose Deaths (VIEWS 12354741)

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

1. Thank you for the opportunity to review and comment on OIG's MAM regarding how Department of Veterans Affairs (VA) Can Enhance Reporting of Its Progress to Reduce Drug Overdose Deaths. I appreciate the feedback on how VA can enhance reporting of its performance. VA is proud to be a national leader in several metrics, i.e., provision of medication for opioid use disorder (MOUD) and provision of Contingency Management (CM).
2. I want to highlight that the percentage of Veterans with opioid use disorder (OUD) who received MOUD continued to grow in fiscal year (FY) 2023 and exceeded the percentage of patients with OUD in the community (22.3 percent) who received MOUD. Additionally, as a part of the VA's effort to prevent fatal overdoses, the VA uses a data-based case review process to identify and offer treatment to Veterans at risk of fatal overdose. Through the end of FY 2023, VA identified and conducted case reviews with over three quarters (79.1 percent) of Veterans with a non-fatal overdose. When conducted for high-risk patients on opioid analgesics, case reviews were associated with a significant reduction in mortality risk. These case reviews also serve the interest of facilitating access to needed SUD treatment among Veterans at high-risk of overdose or suicide. Lastly, from FY 2022 to FY 2023, VA saw the number of Veterans it treated with CM increase by nearly 150 percent.
3. I appreciate the collegial and timely correspondence provided to the Veterans Health Administration throughout the review.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal M.D., MBA

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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