

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Department of Veterans Affairs

*Independent Review
of VA's Fiscal Year 2010
Performance Summary
Report to the
Office of National
Drug Control Policy*

March 17, 2011
11-00314-123

To Report Suspected Wrongdoing in VA Programs and Operations:
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Department of Veterans Affairs

Memorandum

Date: March 9, 2011

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

Subj: Final Report – Independent Review of VA’s Fiscal Year 2010 Performance Summary Report to the Office of National Drug Control Policy

To: Acting Deputy Chief Patient Care Services, Veterans Health Administration (116)
Chief Research and Development Officer, Veterans Health Administration (12)

1. The Office of Inspector General is required to review the Department of Veterans Affairs’ (VA) Fiscal Year (FY) 2010 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). 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). The Circular is included as Attachment C.
2. We reviewed whether VA has a system to capture performance information accurately and if that system was properly applied to generate the performance data reported in the Performance Summary Report. We 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. We also reviewed 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. Finally, we reviewed 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. Our review was conducted 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 an examination 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 that VA does not have a system to capture performance information accurately and the system was not properly applied to generate the performance data reported in the Performance Summary Report in all material respects;

- Nothing came to our attention that caused us to believe that VA did not meet its FY 2010 target for the continuity of care performance measure (Patient Care) and the substance abuse disorder on-going studies performance measure (Research and Development), in all material respects. 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;
 - Nothing came to our attention that caused us to believe that the methodology described in the Performance Summary Report establishing performance targets for the current year is not reasonable given past performance and available resources, in all material respects; and
 - Nothing came to our attention that caused us to believe that 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, in all material respects.
5. We provided you our draft report for review. You concurred with our report without further comments.
 6. This report is intended solely for the information and use of the U.S. Congress, the ONDCP, and VA management. This report is not intended to be and should not be used by anyone other than these specified parties.

(original signed by:)

BELINDA J. FINN

Attachments

Attachment A

January 4, 2011

Belinda J. Finn
Assistant Inspector General for Auditing (52)
Office of Inspector General
Department of Veterans Affairs

Dear Ms. Finn:

As required by Section 7 of the Office of National Drug Control Policy (ONDCP) Circular, Drug Control Accounting, dated May 1, 2007, enclosed please find the Performance Summary Report for the Veterans Health Administration for your authentication in accordance with the guidelines in Section 8 of the Circular.

We certify that the Veterans Health Administration has established a performance measure for its drug activities; that the methodology to generate this measure is appropriate and accurate; and that the target level for the performance measure is reasonable.

The Veterans Health Administration achieved its target performance goal for fiscal year (FY) 2010.

Sincerely,

(original signed by:)

Antonette Zeiss, PhD
Acting Deputy Chief Patient Care Services
Officer of Mental Health

Enclosure

Attachment A

**Department of
Veterans Affairs**

Memorandum

Date: December 28, 2010

From: Chief Quality and Performance Officer

Subj: Management Representation Letter for the Independent Review of the VA's FY 2010 Performance Summary Report to the Office of National Drug Control Policy (Project Number 2011-00314-R1-0011)

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

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 ended September 30, 2010.

1. We confirm that we are responsible for and have made available to you the following:
 - a. The Performance Summary Report for FY 2010 required by the Circular;
 - b. All supporting records and related information and data relevant to the Continuity of Care performance measure within the FY 2010 Performance Summary Report; and
 - c. Communications, if any, from the ONDCP and other oversight bodies concerning the FY 2010 Performance Summary Report and information therein.
2. We confirm that the FY 2010 Performance Summary Report was prepared in accordance with the requirements and criteria of the Circular.
3. 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.
4. No events have occurred subsequent to September 30, 2010, that would have an effect on the Performance Summary Report and the information therein.

(original signed by:)

Joseph Francis, MD, MPH

Attachment

Attachment A

**Department of Veterans Affairs
Veterans Health Administration
FY 2010 Performance Summary Report**

I. PERFORMANCE INFORMATION**Decision Unit 1: Veterans Health Administration****Measure 1: Continuity of Care**

FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2011 Target
37%	44%	48%	52%	47%	52%	47%

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 staying 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 conditions require ongoing treatment for at least this duration to establish early remission. 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 2010, 52% of VA patients in a specialized SUD program successfully met the measure, exceeding the target of 47%.

(c) Performance results are updated monthly on a VA intranet site and discussed on semimonthly national conference calls. In addition to establishing standards and providing feedback, pay incentives of leaders at the network, facility, service, and program level are directly linked to these quality metrics. Expansion funding over the past several years has been used to improve the continuum of care in order to promote retention. This includes efforts to arrange accessible transitional housing to facilitate program attendance and establishing telemental health services capability at additional locations. Consultation is offered through national resources including the Substance Use Disorder Quality Enhancement Research Initiative and the Centers of Excellence in Substance Abuse Treatment and Education. Informatics tools are shared within and across VISNs to promote active patient tracking and outreach.

Attachment A

(d) Performance Measures are maintained by the VHA Office of Quality and Performance. 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 Quality and Performance. A copy of the FY 2010 Office of Quality and Performance, 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 Quality and Performance. 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 Quality and Performance. The system was properly applied to generate the performance data.

(2) **Explanations for not meeting performance targets are reasonable.** In FY 2010 the target of 47% was exceeded with an actual rate of 52%.

(3) **Methodology to establish performance targets is reasonable and applied.** The target measures are set by the VHA Office of Quality and Performance in conjunction with the Office of Patient Care Services. The target set for FY 2011 is 47% and the reporting will continue as already established.

(4) **Adequate performance measures exist for all significant drug control activities.** VHA is measuring the identification and treatment of those having a SUD issue.

Performance

This section on FY 2010 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. The table below includes target and achievement levels on performance measures for the most recent year. 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.

Attachment A

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.

VHA Research currently supports a number of projects on drug and alcohol abuse. These include "Alcohol, Aging, and Brain Functions," "Alcohol Antagonists," "Impact of PTSD on Marijuana Use Treatment Outcome," and "Dysregulation of CNS Stress System in Acute Opioid Dependence/Withdrawal."

Performance Measures for Treatment and Research for FY 2010

	Target	Actual
» Percent of clients receiving appropriate continuity of care	47%	52%
Research and Development		
» Number of research studies related to substance use disorder	5	21
» Number of research studies related to alcohol abuse	5	46
» Number of research studies related to both substance use disorder and alcohol abuse	NA	14

Attachment A**Discussion of Current Program**

In FY 2010, VHA provided services in a specialty SUD setting to 108,210 patients with a drug diagnosis. Of these, 46 percent used cocaine, 26 percent used opioids and 36 percent used cannabis. Seventy-five percent had co-existing psychiatric diagnoses. (These categories are not mutually exclusive.)

VA provides two types of 24-hour-a-day care to patients having 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 a sufficient social support system to monitor the patient. Intensive substance use disorder outpatient programs provide at least three hours of service per day and patients attend three or more days per week. Standard outpatient programs typically treat patients one or two hours per session and patients are generally seen once or twice a week.

VHA is steadily expanding the availability of opioid agonist treatment for opioid-dependent Veterans. VA operates methadone maintenance programs at 31 of its 139 facilities. At 23 VA facilities it maintains contractual arrangements for providing these services through community-based licensed opioid agonist treatment programs. Further, 118 VA facilities prescribed buprenorphine to VA patients in FY 2010 reflecting the growing availability of office-based opioid agonist treatment. In sum in FY 2010 121 of 139 VA facilities (87%) provided opiate agonist treatments in-house, through a contracted licensed opioid agonist treatment program or via office-based opioid agonist treatment in FY2010.

VA is also in the process of implementing initiatives to expand access to SUD treatment services. This has focused on hiring new substance use disorder specialists to work in a variety of VA health care settings. Eighty-six percent of the 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 have now been hired or have a set date to begin work. Sixteen additional SUD specialist positions to support Health Care for Homeless Veterans program and 101 to support the VA-HUD initiative to provide housing to homeless Veterans were very recently funded and are in early stages of being filled.

VA is currently conducting a one-year demonstration study at 41 intensive outpatient substance use disorder treatment programs to anticipate and resolve issues that would surround system-wide employment of the Brief Addiction Monitor (BAM). 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 that a patient needs.

Attachment A

FY 2010 Q4

Volume 2

Clinical Measures

Specification Manual

Office of Quality and Performance (10Q)

June 9, 2010



Note: portions of the technical manual are FOIA protected therefore the Technical Manual is not for public distribution.

Attachment A

HSI 9i Substance Use Disorder – Continuity of Care**Mnemonic: sa5**

Description: This measure applies to patients entering specialty treatment for substance use disorders (inpatient, residential, domiciliary or outpatient, but not opioid substitution), to determine if they are staying in treatment for at least 90 days. It involves 100% review of administrative databases using clinic stop codes to determine specialty care of substance use disorders (SUD). Research has shown that good addiction treatment outcomes are contingent on adequate lengths of treatment. There is no predetermined length of addiction treatment that assures success, but duration of treatment is the factor most consistently associated with successful addiction treatment outcome. 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 three months would rarely be sufficient, most patients require ongoing treatment for **at least** this duration to establish early remission.

Various patient, provider and program level interventions have been associated with improved treatment retention. The initial intensity of treatment should be considered primarily as a means to promote treatment retention, e.g., severely dependent patients typically may require multiple treatment contacts per week in order to stabilize early remission. However, for many patients following initial stabilization, it may be appropriate to provide a lower intensity of addiction-focused treatment extending over a longer duration with superior remission rates for those who remain engaged in treatment for 6-12 months. Available evidence supports the effectiveness of telephone follow-up for patients after they have stabilized during the initial weeks of outpatient treatment. Many individuals continue to benefit from treatment (e.g., methadone maintenance) over a period of years.

Consistent with the VHA/DoD Guideline for Treatment of Substance Use Disorder, this performance measure is intended to emphasize the importance of early treatment retention as an essential condition of quality care for addiction. Treatment duration beyond 3 months presents important opportunities to individualize treatment plans consistent with treatment response over time by adjusting the intensity of psychosocial interventions (e.g., frequency of group sessions), pharmacotherapy (e.g., dose amount and monitoring frequency), community recovery support (e.g., promoting Twelve-Step program involvement), and management of co-morbid conditions.

Attachment A

Summary of Quarterly changes

Indicator Statement/Description: 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 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 specialty treatment for SUD

Eligible Population:

Catnum (#)/Cohort: Universe includes all Veterans with an SUD outpatient encounter or inpatient discharge from SUD specialty bed section in VHA.

Age (specify):

Acceptable care setting: Outpatient

Defining characteristics:

Table of relevant ICD-9/DSS codes:

Attachment A

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 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 substance abuse 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 is seen for a 1st retention visit in a substance abuse 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.

Attachment A

- 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.

Methodology:

Data Origin: Workload generated in VistA and sent to AITC. Data submitted after the quarterly report has been collected pertaining to Veteran care already reported will be updated during the following quarterly run.

Extraction: 100% from AITC database by OQP.

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

TABLE A. 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. E.g. 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

Attachment A

TABLE A. Events / Data Source Use During Dormancy, Qualification, and Retention Determination			
	Dormant	Qualifying	Retention
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 ¹	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

¹These are 'encounter forms' generated while a patient is admitted to an inpatient bed section. Prior to 2005, 'outpatient' workload for 'inpatients' was 'blocked' at the facility and not submitted to the Austin Automation Center. In 2005, VHA removed this block and allows encounters for professional workload provided to inpatients to be sent to Austin. See [Directive 2006-026 at http://vaww1.va.gov/vhapublications/publications.cfm?pub=1](http://vaww1.va.gov/vhapublications/publications.cfm?pub=1) Attachment A

Attachment A

TABLE A. Events / Data Source Use During Dormancy, Qualification, and Retention Determination			
	Dormant	Qualifying	Retention
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.

Attachment A**Measurement period:**

Reporting: Time frame issues: Reports include patients who have completed the retention period during the report month or quarter selected. The performance period is consistent with EPRP quarters.

TABLE B. Substance Use Disorder Reporting Timelines and Workload Inclusion Information							
EPRP Lagged Quarter	Months included in quarter = Patients completing their retention period in:	OQP Executive Briefing Book Reporting Date	Dormancy Check Range (T- days to first qualification visit date -90)	Index Episode 1st Qualification Visit Date Range for Outpatient Qualification	Index Episode Qualification Date (T) Range	Index Episode Retention Start Date (T+1) Range	Index Episode Retention Completion Date (T+90) Range
1	Oct, Nov	First Friday February 10	03/06/09 - 05/05/09	06/04/09 – 08/30/09	07/03/09- 09/01/09	07/04/09 09/02/09	10/01/09 - 11/30/09
2	Oct, Nov, Dec, Jan, Feb	First Friday May 10	03/06/09 - 08/31/09	06/04/09 – 11/29/09	07/03/09 - 12/01/09	07/04/09– 12/02/09	10/01/09- 02/28/10
3	Oct, Nov, Dec, Jan, Feb, Mar, Apr, May	First Friday August 10	03/06/09 – 12/01/09	06/04/09- 02/28/10	07/03/09- 03/02/10	07/04/09– 03/03/10	10/01/09 - 05/31/10
4	Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun, Jul, Aug	Mid-October 10	03/06/09 - 03/02/10	06/04/09 – 05/31/10	07/03/09- 06/02/10	07/04/09- 06/03/10	10/01/09- 08/31/10

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. See VSSC Web <http://vssc.med.va.gov/PM/SUD.asp>

Definitions (decision rule specific):

- There are 3 events in time analyzed in this measure:
 - Negative SUD Treatment History also called Dormancy
 - New SUD treatment episode through outpatient or inpatient qualification
 - Continuous treatment involvement during the retention period of three 30 day intervals

Attachment A

TABLE C. 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

- 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.

Attachment A

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:** Effective January 1, 2010, SARRTP beds will be assigned the new treating specialty code of #1M. The current SARRTP Treating Specialty Code # 27 will be discontinued at that time. Each SARRTP will be assigned a Domiciliary Suffix as outlined in Treating Specialty Codes Memorandum, MH RRTP Treating Specialty Code and Suffix Guidance and Suffix and Treating Specialty Code Assignments in the Technical Manual Vol. 3: References and Resources.

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.

Attachment A

- 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 B

**Department of
Veterans Affairs**

Memorandum

Date: January 7, 2011

From: Chief Research and Development Officer

Subj: Management Representation Letter for the Independent Review of the VA's FY 2010 Performance Summary Report to the Office of National Drug Control Policy (Project Number 2011-00314-R1-0011)

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

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 ended September 30, 2010.

1. We confirm that we are responsible for and have made available to you the following:
 - a. The Performance Summary Report for FY 2010 required by the Circular;
 - b. All supporting records and related information and data relevant to the FY 2010 Performance Summary Report; and
 - c. Communications, if any, from the ONDCP and other oversight bodies concerning the FY 2010 Performance Summary Report and information therein.
2. We confirm that the FY 2010 Performance Summary Report was prepared in accordance with the requirements and criteria of the Circular.
3. 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.
4. No events have occurred subsequent to September 30, 2010, that would have an effect on the Performance Summary Report and the information therein.

(original signed by:)

Joel Kupersmith, MD

Attachment

Attachment B

**Office of Research and Development,
Department of Veterans Affairs
Fiscal Year 2010 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.

Comparison of the most recent fiscal year to its target: The targets for FY 2010 were exceeded. See Table 1.

Target for the current fiscal year: Although the actual values (number of studies) exceeded the target for FY 2010, we have not increased the target for FY 2011. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2011 Target
Number of ongoing research studies related to substance abuse disorder	17	20	5	21	5
Number of ongoing research studies related to alcohol abuse	38	45	5	46	5
Number of ongoing research studies related to both substance abuse disorder and alcohol abuse	14	10		14	

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.

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

Attachment B

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, but none of the projects that were funded in FY 2010 were submitted using that mechanism. For FY 2010 these proposals were tracked via spreadsheets and uploaded into RAFT manually (HSR&D and RR&D) or electronically (BLR&D and CSR&D).

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.

For FY 2010, no RR&D projects related to drug or alcohol abuse were identified.

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).

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.

Attachment C

ONDCP Circular: Drug Control Accounting
May 1, 2007

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Annual Accounting and Authentication of Drug Control Funds and Related Performance

1. **Purpose.** This circular provides the policies and procedures to be used by National Drug Control Program agencies in conducting a detailed accounting and authentication of all funds expended on National Drug Control Program activities and the performance measures, targets, and results associated with those activities.
2. **Rescission.** This circular rescinds and replaces the ONDCP Circular, *Annual Accounting of Drug Control Funds*, dated April 18, 2003.
3. **Authority.**
 - a. 21 U.S.C. § 1704(d) provides: “The Director [ONDCP] shall –

(A) require the National Drug Control Program agencies to submit to the Director not later than February 1 of each year a detailed accounting of all funds expended by the agencies for National Drug Control Program activities during the previous fiscal year, and require such accounting to be authenticated by the Inspector General of each agency prior to submission to the Director; and

(B) submit to Congress not later than April 1 of each year the information submitted to the Director under subparagraph (A).”
 - b. 21 U.S.C. § 1703(d)(7) authorizes the Director of National Drug Control Policy to “... monitor implementation of the National Drug Control Program, including – (A) conducting program and performance audits and evaluations; and (B) requesting assistance of the Inspector General of the relevant agency in such audits and evaluations ...”
4. **Definitions.** As used in this circular, key terms related to the National Drug Control Program and budget are defined in Section 4 of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007. These terms include: *National Drug Control Program*, *National Drug Control Program agency*, *Bureau*, *Drug Methodology*, *Drug Control Functions*, and *Budget Decision Units*. Further, Reprogrammings and Fund Control Notices referenced in Section 6 of this circular are defined in Section 6 and Section 8 of the ONDCP Circular, *Budget Execution*, dated May 1, 2007.
5. **Coverage.** The provisions of this circular apply to all National Drug Control Program agencies.
6. **Detailed Accounting Submission.** The Chief Financial Officer (CFO) of each agency, or other accountable senior level senior executive, shall prepare a Detailed Accounting Submission to the Director, ONDCP. For agencies with no bureaus, this submission shall be a single report, as defined by this section. For agencies with bureaus, the Detailed Accounting Submission shall consist

Attachment C

of reports, as defined by this section, from the agency's bureaus. The CFO of each bureau, or accountable senior level executive, shall prepare reports. Each report must include (a) a table highlighting prior year drug control obligations data, and (b) a narrative section making assertions regarding the prior year obligations data. Report elements are further detailed below:

- a. **Table of Prior Year Drug Control Obligations** – For the most recently completed fiscal year, each report shall include a table of obligations of drug control budgetary resources appropriated and available during the year being reported.² Such table shall present obligations by Drug Control Function and Budget Decision Unit, as these categories are displayed for the agency or bureau in the *National Drug Control Strategy Budget Summary*. Further, this table shall be accompanied by the following disclosures:
 - (1) **Drug Methodology** – The drug methodology shall be specified in a separate exhibit. For obligations calculated pursuant to a drug methodology, this presentation shall include sufficient detail to explain fully the derivation of all obligations data presented in the table.
 - (a) **Obligations by Drug Control Function** – All bureaus employ a drug methodology to report obligations by Drug Control Function.
 - (b) **Obligations by Budget Decision Unit** – For certain multi-mission bureaus – Customs and Border Protection (CBP), Coast Guard, Immigration and Customs Enforcement (ICE), Indian Health Service (IHS), Bureau of Indian Affairs (BIA), and the Veterans Health Administration (VHA) – obligations reported by Budget Decision Unit shall be calculated pursuant to an approved drug methodology. For all other bureaus, drug control obligations reported by Budget Decision Unit shall represent 100 percent of the actual obligations of the bureau for those Budget Decision Units, as they are defined for the National Drug Control Budget. (See Attachment B of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007.)
 - (2) **Methodology Modifications** – Consistent with ONDCP's prior approval, if the drug methodology has been modified from the previous year, then the changes, their purpose, and the quantitative differences in the amount(s) reported using the new method versus the amount(s) that would have been reported under the old method shall be disclosed.³
 - (3) **Material Weaknesses or Other Findings** – Any material weakness or other findings by independent sources, or other known weaknesses, including those identified in the

² Consistent with reporting requirements of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007, resources received from the following accounts are excluded from obligation estimates: (1) ONDCP – High Intensity Drug Trafficking Areas (HIDTA) and (2) DOJ – Organized Crime Drug Enforcement Task Force Program. Obligations against these resources shall be excluded from table required by this section but shall be reported on a consolidated basis by these bureaus. Generally, to prevent double-counting agencies should not report obligations against budget resources received as a reimbursement. An agency that is the source of the budget authority for such reimbursements shall be the reporting entity under this circular.

³ For changes that did not receive prior approval, the agency or bureau shall submit such changes to ONDCP for approval under separate cover.

Attachment C

Agency's Annual Statement of Assurance, which may affect the presentation of prior year drug-related obligations data, shall be highlighted. This may be accomplished by either providing a brief written summary, or by referencing and attaching relevant portions of existing assurance reports. For each material weakness or other finding, corrective actions currently underway or contemplated shall be identified.

- (4) **Reprogrammings or Transfers** – All prior year reprogrammings or transfers that affected drug-related budgetary resources shall be identified; for each such reprogramming or transfer, the effect on drug-related obligations reported in the table required by this section also shall be identified.
 - (5) **Other Disclosures** – Agencies may make such other disclosures as they feel are necessary to clarify any issues regarding the data reported under this circular.
- b. **Assertions** – At a minimum, each report shall include a narrative section where the following assertions are made regarding the obligation data presented in the table required by Section 6a:
- (1) **Obligations by Budget Decision Unit** – With the exception of the multi-mission bureaus noted in Section 6a(1)(b), reports under this section shall include an assertion that obligations reported by budget decision unit are the actual obligations from the bureau's accounting system of record for these Budget Decision Units.
 - (2) **Drug Methodology** – An assertion shall be made regarding the reasonableness and accuracy of the drug methodology used to calculate obligations of prior year budgetary resources by function for all bureaus and by budget decision unit for the CBP, Coast Guard, ICE, IHS, BIA, and VHA. The criteria associated with this assertion are as follows:
 - (a) **Data** – If workload or other statistical information supports the drug methodology, then the source of these data and the current connection to drug control obligations should be well documented. If these data are periodically collected, then the data used in the drug methodology must be clearly identified and will be the most recently available.
 - (b) **Other Estimation Methods** – If professional judgment or other estimation methods are used as part of the drug methodology, then the association between these assumptions and the drug control obligations being estimated must be thoroughly explained and documented. These assumptions should be subjected to periodic review, in order to confirm their continued validity.
 - (c) **Financial Systems** – Financial systems supporting the drug methodology should yield data that fairly present, in all material respects, aggregate obligations from which drug-related obligation estimates are derived.
 - (3) **Application of Drug Methodology** – Each report shall include an assertion that the drug methodology disclosed in this section was the actual methodology used to generate the table required by Section 6a. Calculations must be sufficiently well

Attachment C

documented to independently reproduce these data. Calculations should also provide a means to ensure consistency of data between reporting years.

- (4) **Reprogrammings or Transfers** – Further, each report shall include an assertion that the data presented are associated with obligations against a financial plan that, if revised during the fiscal year, properly reflects those changes, including ONDCP's approval of reprogrammings or transfers affecting drug-related resources in excess of \$1 million.
- (5) **Fund Control Notices** – Each report shall also include an assertion that the data presented are associated with obligations against a financial plan that fully complied with all Fund Control Notices issued by the Director under 21 U.S.C. § 1703(f) and Section 8 of the ONDCP Circular, *Budget Execution*.

7. **Performance Summary Report.** The CFO, or other accountable senior level senior executive, of each agency for which a Detailed Accounting Submission is required, shall provide a Performance Summary Report to the Director of National Drug Control Policy. Each report must include performance-related information for National Drug Control Program activities, and the official is required to make certain assertions regarding that information. The required elements of the report are detailed below.

a. **Performance Reporting**– The agency's Performance Summary Report must include each of the following components:

- (1) **Performance Measures** – The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: reflect the purpose of the program; contribute to the National Drug Control Strategy; and are used in the management of the program. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those activities.
- (2) **Prior Years Performance Targets and Results** – For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recent fiscal year with the projected (target) levels of performance established in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.
- (3) **Current Year Performance Targets** – Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.

Attachment C

- (4) **Quality of Performance Data** – The agency must state the procedures used to ensure the performance data described in this report are accurate, complete, and unbiased in presentation and substance.
- b. **Assertions** – Each report shall include a letter in which an accountable agency official makes the following assertions are made regarding the information presented in Section 7a:
- (1) **Performance reporting system is appropriate and applied** – The agency has a system to capture performance information accurately and that system was properly applied to generate the performance data.
- (2) **Explanations for not meeting performance targets are reasonable** – An assertion shall be made regarding the reasonableness of any explanation offered 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.
- (3) **Methodology to establish performance targets is reasonable and applied** – An assertion that the methodology described above to establish performance targets for the current year is reasonable given past performance and available resources.
- (4) **Adequate performance measures exist for all significant drug control activities** - Each Report shall include an assertion that the agency has established at least one acceptable performance measure for each Drug Control Decision Unit identified in reports required by section 6a(1)(A) for which a significant amount of obligations (\$1,000,000 or 50 percent of the agency drug budget, whichever is less) were incurred in the previous fiscal year. Each performance measure must consider the intended purpose of the National Drug Control Program activity. The criteria associated with these assertions are as follows:
- (a) **Data** – If workload, participant, or other quantitative information supports these assertions, the sources of these data should be well documented. If these data are periodically collected, the data used in the report must be clearly identified and will be the most recently available.
- (b) **Other Estimation Methods** – If professional judgment or other estimation methods are used to make these assertions, the objectivity and strength of these estimation methods must be thoroughly explained and documented. These estimation methods should be subjected to periodic review to confirm their continued validity.
- (c) **Reporting Systems** – Reporting systems supporting the assertions should be current, reliable, and an integral part of the agency's budget and management processes.
8. **Inspector General Authentication.** Each report defined in Sections 6 and 7 shall be provided to the agency's Inspector General (IG) for the purpose of expressing a conclusion about the

Attachment C

reliability of each assertion made in the report. ONDCP anticipates that this engagement will be an attestation review, consistent with the *Statements for Standards of Attestation Engagements*, promulgated by the American Institute of Certified Public Accountants.

9. **Unreasonable Burden.** Unless a detailed report, as specified in Section 6, is specifically requested by ONDCP, an agency or bureau included in the National Drug Control Budget with prior year drug-related obligations of less than \$50 million may submit through its CFO, or its accountable senior level executive, an alternative report to ONDCP, consisting of only the table highlighted in Section 6a., omitting all other disclosures. Such a report will be accompanied by statements from the CFO, or accountable senior level executive, and the agency IG attesting that full compliance with this Circular would constitute an unreasonable reporting burden. In those instances, obligations reported under this section will be considered as constituting the statutorily required detailed accounting, unless ONDCP notifies the agency that greater detail is required.

10. **Point of Contact and Due Dates.** Each agency CFO, or accountable senior level executive, shall transmit a Detailed Accounting Submission, consisting of the report(s) defined in Sections 6 and 7, along with the IG's authentication(s) defined in Section 8, to the attention of the Associate Director for Performance and Budget, Office of National Drug Control Policy, Washington, DC 20503. Detailed Accounting Submissions, with the accompanying IG authentication(s), are due to ONDCP by February 1 of each year. Agency management must submit reports to their Office of Inspector General (OIG) in sufficient time to allow for review and IG authentication under Section 8 of this Circular. ONDCP recommends a 31 December due date for agencies to provide their respective OIG with the required reports and information.

Attachment D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of General Counsel
Chief Patient Care Services Officer, Veterans Health Administration
Chief Quality and Performance Officer, Veteran Health Administration
Chief Research and Development Officer, Veterans Health Administration
Chief Financial Officer, Veterans Health Administration
Deputy Chief, Patient Care Services Officer for Mental Health, Veterans Health Administration
Director, Management Review Service, Veterans Health Administration
Director of Performance Management, Veterans Health Administration

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
Office of National Drug Control Policy