DEPARTMENT OF VETERANS AFFAIRS

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Veterans Health Administration

Resource Summary

	Budget Authority (in Millions)		
	FY 2006 Final	FY 2007 Estimate	FY 2008 Request
Drug Resources by Function			
Research & Development	11.375	11.237	11.303
Treatment	365.323	365.323	380.666
Total Drug Resources by Function	**$376.698**	**$376.560**	**$391.969**
Drug Resources by Decision Unit			
Medical Care			
Domiciliary	44.073	44.073	45.924
Inpatient	155.628	155.628	162.164
Outpatient	165.622	165.622	172.578
Research & Development	11.375	11.237	11.303
Total Drug Resources by Decision Unit	**$376.698**	**$376.560**	**$391.969**
Drug Resources Personnel Summary			
Total FTEs (direct only)	3,500	3,500	3,500
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)	$73.737	$76.918	$86.374
Drug Resources Percentage	0.51%	0.49%	0.45%

Program Summary

Mission

The Veterans Health Administration's (VHA) mission statement is "Honor America's veterans by providing exceptional care that improves their health and well-being." Mental health is an important part of overall health, and care for veterans with mental illnesses and substance use disorders are an important part of overall health care. The goal of VHA's Office of Mental Health Services is to provide effective, safe, efficient, and compassionate care for those with substance use disorders and mental illness, for those who are vulnerable, and for those who are recovering.

Methodology

In accordance with the guidance provided by ONDCP, VA's methodology only incorporates Specialized Treatment costs.

Specialized Treatment Costs

VA's drug budget includes all costs generated by the treatment of patients with drug use disorders treated in specialized substance abuse treatment programs. This budget accounts for drug-related costs for VHA Medical Care and Research. It does not encompass all drug-related costs for the agency. VA incurs costs related to accounting and security of narcotics and other controlled substances and costs of law enforcement related to illegal drug activity; however, these costs are assumed to be

relatively small and would not have a material affect on the aggregate VA costs reported.

Decision Support System

The 2006 actual funding levels are based on the Decision Support System (DSS), which replaced the Cost Distribution Report (CDR). The primary difference between DSS and CDR is a mapping of cost centers by percentage to bed sections or out patient visit groups. DSS maps cost to departments, which are then assigned to one of 56,000 intermediate products using Relative Value Units (RVU). RVUs are defined as the determining factor for the level of resources it takes to produce an intermediate product. Each cost category, for example fixed direct labor or variable labor, has an RVU for each intermediate product. All intermediate products are assigned to an actual patient encounter, either inpatient, outpatient, or residential using the patient care data bases. In DSS, the costs are not averaged; rather they are reported by the total of the encounters and can be drilled down to a specific patient. Also, DSS includes all overhead costs assigned to a facility to include headquarters, national programs, and network costs. DSS does not include the costs of capital expenditures; however, it does account for depreciation costs.

Budget

For FY 2008, VHA requests $391.97 million, which is an increase of $15.4 million from the FY 2007 level. The majority of VHA's funding goes to support inpatient and outpatient drug treatment services. The Department of Veterans Affairs (VA), through its Veterans Health Administration, operates a national network of 250 substance abuse treatment programs located in the Department's medical centers, domiciliaries and outpatient clinics. These programs include 15 medical inpatient programs, 69 residential rehabilitation programs, 49 "intensive" outpatient programs, and 117 standard outpatient programs.

Medical Care

Total FY 2008 Request: $380.7 million
(Includes +$15.3 million in changes)

The Veterans Health Administration, in keeping with modern medical practice, continues to improve service delivery and provide clinically appropriate care by expanding primary care and shifting treatment services to lower cost settings when clinically suitable. Within services for addicted veterans, this has involved a substantial shift over the past 10 years from inpatient to outpatient models of care.

The Medical Care program is comprised of three components: Domiciliary, Inpatient, and Outpatient. These components provide the structure necessary to operate a comprehensive and integrated health care system that supports enrolled veterans; a national academic education and training program to enhance veterans' quality of care; and, administrative support for facilities.

Domiciliary

FY 2008 Request: $45.9 million
(Includes +$1.9 million in changes)

The Domiciliary Residential and Treatment Program provides coordinated, integrated, rehabilitative, and restorative clinical care in a bed-based program with the goal of helping eligible veterans achieve and maintain the highest level of functioning and independence possible. Domiciliary care, as an integral component of VHA's continuum of health care services, is committed to providing the highest quality clinical care in a coordinated, integrated fashion within that continuum. Inpatient treatment for drug addiction has become rare in VA just as it has in other parts of the healthcare system; only 2,000 veterans with a substance abuse problem received such treatment in 2006. The rest of VA's 24-hour care settings are classified as residential rehabilitation. They are based in on-site VA domiciliaries and in on- and off-site residential rehabilitation centers. They are distinguished from inpatient programs as having less medical staff and services and longer lengths of stay (about 50 days).

FY 2008 Changes (+$1.9 million)
Funding will maintain service levels.

Inpatient

FY 2008 Request: $162.2 million
(Includes +$6.5 million in changes)

All inpatient programs provide acute, in-hospital care and a subset of programs also provide detoxification and stabilization services. These programs typically treat patients for 14-28 days and then provide outpatient aftercare. Inpatient programs are usually reserved for severely impaired patients (e.g., those with co-occurring substance abuse and serious mental illness).

Inpatient includes costs associated with the following: care, treatment and support of inpatients in a locally designated sub-acute substance abuse psychiatry bed; diagnosis and treatment of patients admitted to a drug, alcohol, or combined alcohol and drug treatment unit; a Psychiatric Residential Rehabilitation Treatment Program focusing on the treatment and rehabilitation of substance abuse patients; and, staff and contract costs associated with the Alcohol and Drug Contract Residential Treatment Program.

FY 2008 Changes (+$6.5 million)
Funding will maintain services levels.

Outpatient
FY 2008 Request: $172.6 million
(Includes +$6.96 million in changes)

Most drug-dependent veterans are treated in outpatient programs. Intensive outpatient programs provide more than three hours of service per day to each patient, and patients attend them three or more days per week. Standard outpatient programs typically treat patients for an hour or two per treatment day, and patients attend one or two days a week. Outpatient treatment sessions include costs associated with outpatient substance abuse programs and diagnostic and/or therapeutic care related to substance abuse disorder provided by a Post Traumatic-Stress Disorder Team.

FY 2008 Changes (+$6.96 million)
Funding will maintain service levels.

Research and Development
FY 2008 Request: $11.3 million
(Includes +$0.07 in changes)

VHA research helps to acquire new knowledge to improve the prevention, diagnosis and treatment of disease, and generate new knowledge to improve the effectiveness, efficiency, accessibility, and quality of veterans' health care.

FY 2008 Changes (+$0.07 million)
The Budget proposes a minor adjustment.

Performance

Introduction

This section on the FY 2006 performance of the VHA program is based on agency GPRA documents and the PART review, discussed earlier in the Executive Summary. The table includes conclusions from the PART assessment, as well as performance measures, targets and achievements for the latest year for which data are available.

The VA medical care program was rated through the 2003 PART assessment. 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 of health care. This system has begun to incorporate performance measures related to substance abuse disorder treatment. A measure related to treatment for substance use disorders is expected to be added in 2007 or 2008.

In addition, a performance improvement effort is underway through the Centers of Excellence in Substance Abuse Treatment and Education and the Quality Enhancement Research Initiative (QUERI) to assist programs experiencing difficulty in achieving their performance goals. This is based on recently completed VA research studies that identify a range of evidence-based practices that can be used to improve performance.

Veterans Health Administration		
PART Review		
Year of Last Review: 2003	Reviewed as part of VA Medical Care Program	
Selected Measures of Performance	FY 2006 Target	FY 2006 Achieved
» Percent of clients receiving appropriate continuity of care.	39%	37%

Discussion

In FY 2006, VHA provided services to 93,010 patients with a drug diagnosis, of whom 45 percent used cocaine, 20 percent used opioids, and 70 percent had coexisting psychiatric diagnoses. These categories are not mutually exclusive.

VHA is steadily expanding the availability of methadone maintenance clinics and buprenorphine agonist treatment for opioid-dependent veterans. A specific initiative to initiate buprenorphine treatment has been funded for FY 2007 that will distribute funding to stations with high prevalence of opiate dependence among patients.

The implementation of self-report measures of drug and drug/alcohol abstinence as an outcome measure for evaluating the performance of VHA's treatment programs is strongly being considered. To develop this measure, VHA will evaluate the distribution of changes in abstinence rates across individuals and programs, the stability of potential targets, and the relationship of potential targets with other measures of quality. This will be accomplished through ongoing data acquisition and analysis from the pilot program through early FY 2008. Subsequent steps will include further studies comparing outcomes assessed using the methods of the pilot study with a modified approach in which both baseline and follow-up data are obtained by the clinical team. The goal will be to develop a pilot outcome-based quality indicator to be evaluated by December 2007.