US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

DEPARTMENT OF VETERANS AFFAIRS

Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2022

Review | **23-03356-196** | **September 3, 2024**

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September 3, 2024[1]

MEMORANDUM

TO:	Shereef Elnahal, MD, MBA, Under Secretary for Health (10)
FROM:	Larry Reinkemeyer, Assistant Inspector General for Audits and Evaluations (52) VA Office of Inspector General
SUBJECT:	Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2022

Pursuant to 38 U.S.C. § 1706(b)(5), the VA Secretary must submit an annual report to the Committees on Veterans Affairs of the Senate and House of Representatives no later than April 1 of each year. The report must document VA's capacity to provide for the specialized treatment and rehabilitative needs of veterans with disabilities in the following five categories: (1) spinal cord injuries and disorders, (2) traumatic brain injury, (3) blind rehabilitation, (4) prosthetic and sensory aids, and (5) mental health.[2] In turn, each year the VA Office of Inspector General (OIG) is required to review and report to Congress on the accuracy of VA's special disabilities capacity report.[3] This OIG report details the results of VA's special disabilities capacity assessment for fiscal year (FY) 2022.

The review team identified data inaccuracies and omissions that resulted in some material errors in the FY 2022 capacity report. Some of the reporting issues noted in this OIG report persisted from the OIG's previous reviews.[4] With the exception of these items, nothing came to the review team's attention that would lead the OIG to believe that the information in the report was not

[1] This memorandum was sent to the Veterans Health Administration (VHA) on May 31, 2024, for review and comment. VHA did not provide any comments on the report.

[2] 38 U.S.C. § 1706(b)(5). The law uses "spinal cord dysfunction" as the term for spinal cord injuries. However, to reflect VA's current medical terminology, the VA Office of Inspector General (OIG) uses "spinal cord injuries and disorders" throughout this report.

[3] 38 U.S.C. § 1706(b)(5). The VA and OIG reporting requirements have expired and have been reinstated several times since 2004.

[4] VA OIG, *Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2021*, Report No. 22-03217-59, March 7, 2023; VA OIG, *Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2020*, Report No. 21-03260-60, February 9, 2022.

otherwise fairly stated and accurate.[5] In addition, VA is unable to report mental health capacity data comparable to that from 1996 as required by 38 U.S.C. § 1706 for reasons that include changes in how treatment outcomes of veterans with mental illness are defined and tracked.

Background

VA is required to maintain its capacity to provide for the specialized treatment and rehabilitative needs of veterans with disabilities at a level not below that available on October 9, 1996.[6] This requirement was set by Congress to ensure that the decentralization of the Veterans Health Administration (VHA) field management structure in the late 1990s did not adversely affect VA's ability to care for veterans with disabilities.[7] VA is responsible for the information presented in the FY 2022 special disabilities capacity report.

Scope and Methodology

The review team analyzed the FY 2022 capacity report text and appendixes, as well as conducted short-notice site visits to all 25 spinal cord injuries and disorders centers. The team toured these facilities, held interviews with clinical staff, and verified the bed counts reported in the FY 2022 capacity report. The OIG's review was conducted according to attestation standards established by the American Institute of Certified Public Accountants (AICPA) and by the applicable generally accepted government auditing standards.[8] As required by attestation review standards, the team designed inquiries and analytic procedures to provide limited assurance in determining whether the required information in the capacity report was accurate and to identify material errors. Appendix A provides additional details on the review's scope and methodology.

[5] The OIG conducted this work under attestation review standards. According to the American Institute of Certified Public Accountants (AICPA), this type of review is an attestation engagement in which the practitioner obtains limited assurance by obtaining sufficient appropriate review evidence about the measurement or evaluation of the subject matter against criteria to express a conclusion about whether any material modification should be made to the subject matter for it to be in accordance with (or based on) the criteria, or to the assertion for it to be fairly stated. Based on AICPA standards, material misstatements, including omissions, are considered to be material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by intended users based on the subject matter. AICPA, *Statement on Standards for Attestation Engagements*, December 2020, sec. 210; Government Accountability Office (GAO), *Government Auditing Standards,* GAO-18-568G, July 2018 (technical update April 2021).

[6] 38 U.S.C. § 1706(b)(1).

[7] GAO, *VA Health Care: VA's Efforts to Maintain Services for Veterans with Special Disabilities*, GAO/T-HEHS-98-220, July 23, 1998.

[8] AICPA, *Statement on Standards for Attestation Engagements*, sec. 210; GAO, *Government Auditing Standards*.

Results and Conclusion

Except for the effects of the identified inaccuracies and omissions, nothing came to the team's attention that would lead the OIG to believe the information in the FY 2022 capacity report was not otherwise fairly stated and accurate.

As the OIG reported in its reviews of previous capacity reports, VA is unable to meet the requirement to compare its mental health capacity with 1996 levels for reasons that include changes in how treatment outcomes of veterans with mental illness are defined and tracked. The OIG continues to believe that, even if VA could compare capacity to 1996 levels, such reporting would not provide Congress with assurances that VA's capacity is adequate to provide care to these high-risk veterans. VHA reported the wrong spending data for traumatic brain injury when it included obligations rather than expenditures data at the national level but not at the Veterans Integrated Service Network (VISN) or geographic service area level.[9] Because VHA has the capability to report traumatic brain injury spending data as expenditures at the required levels, it should do so for future submissions.

The capacity report also does not capture data on the services veterans receive through community care or the extent to which bed capacity at VA's centers for spinal cord injuries and disorders is used.[10] By including these data, VA would be able to provide more comprehensive insight into the types of care veterans are receiving in these categories and where these veterans are receiving care. Congress would be better informed by modernizing the reporting metrics to assess VA's capacity to provide care for veterans with spinal cord injuries and disorders, traumatic brain injuries, blindness, or mental illness and those needing prosthetic and sensory aids. Finally, some medical facilities' transitions to the new Oracle Cerner electronic health record (EHR) system have affected the completeness of some facility, VISN, and nationally reported data elements. The OIG believes that VA should report special disability data for these facilities separately to allow Congress insight into annual trends across the facilities operating the new system. In FY 2022, five facilities were operating the new EHR system, and VA announced its plan to deploy it at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, in FY 2024. In cases where mandated reporting elements cannot be met by data that are currently captured by facilities operating the new system, VA could take steps to separately report data from this system that most closely align to these requirements to keep

[9] An obligation is a legally binding agreement that will result in payments. Payments made to fulfill an obligation are also referred to as expenditures.

[10] VA provides health care for eligible veterans at its nationwide medical facilities. VA pays for veterans to receive health care from community-based providers when certain conditions are met, such as long appointment wait times or unavailability of specialty care at veterans' local VA facilities. The VA MISSION Act of 2018 consolidated several community care programs into the Veterans Community Care Program in June 2019. John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

Congress more fully informed of its capacity to treat veterans in these five special disability areas.

VA Management Comments and OIG Response

The OIG provided VA with a draft of this report for review and comment. The under secretary for health did not provide comments on the contents of the draft report. See appendix B for VA's management representation letter.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

AICPA	American Institute of Certified Public Accountants
EHR	electronic health record
FTE	full-time equivalent
FY	fiscal year
GAO	Government Accountability Office
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Title 38, section 1706 of the United States Code requires VA to maintain its capacity to provide for the specialized treatment and rehabilitative needs of veterans with disabilities at a level not below that available on October 9, 1996.[11] This requirement was established to ensure that the decentralization of the Veterans Health Administration (VHA) field management structure in the late 1990s would not negatively affect VA's ability to serve veterans with disabilities.[12] As part of this statutory requirement, VA must submit an annual report to Congress documenting its capacity to provide for the specialized treatment and rehabilitative needs of veterans with disabilities in five areas. The VA Office of Inspector General (OIG) is required to submit to Congress certification of the accuracy of VA's capacity report.[13] VA is responsible for the information presented in its fiscal year (FY) 2022 special disabilities capacity report.

What the OIG Did

To fulfill its legislatively mandated responsibility, the OIG reviewed VA's FY 2022 report to Congress to assess whether VA accurately reported its in-house capacity to provide for the specialized treatment and rehabilitative needs of veterans receiving care or support for disabilities in the following five areas: (1) spinal cord injuries and disorders, (2) traumatic brain injury, (3) blind rehabilitation, (4) prosthetic and sensory aids, and (5) mental health.[14] The team conducted the review according to attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the applicable generally accepted government auditing standards.[15] According to the AICPA, an attestation review is substantially narrower in scope than an examination, with the latter expressing an opinion.[16] Therefore, in this review, the OIG does not express an opinion. The purpose of this review is to obtain limited assurance about whether any material modifications should be made to the subject matter for it to be in accordance with the criteria and to express a conclusion, as required by attestation review standards, about whether the practitioner is aware of any material modifications that should be made. Also, as required by attestation review standards, the team's inquiries and analytic

[11] 38 U.S.C. § 1706(b)(1).

[12] Government Accountability Office (GAO), *VA Health Care: VA's Efforts to Maintain Services for Veterans with Special Disabilities*, GAO/T-HEHS-98-220, July 23, 1998.

[13] 38 U.S.C. § 1706(b)(5)(C).

[14] 38 U.S.C. § 1706(b)(5). The law uses "spinal cord dysfunction" as the term for spinal cord injuries. However, to reflect VA's current medical terminology, the OIG uses "spinal cord injuries and disorders" throughout this report.

[15] AICPA, *Statement on Standards for Attestation Engagements*, December 2020, sec. 210; GAO, *Government Auditing Standards*, GAO-18-568G, July 2018 (technical update April 2021).

[16] AICPA, *Statement on Standards for Attestation Engagements*, sec. 210.

procedures were designed to provide limited assurance in determining whether the required information in the capacity report was accurate and to identify material errors.

For this review, the team completed the following tasks:

- Interviewed personnel from the program offices responsible for compiling data for the report to identify any potential changes to the development of the report
- Examined the law and identified the data tables in the report that reflected reporting requirements
- Determined the mathematical accuracy of the data by recalculating totals
- Identified material changes from the prior year's report
- Assessed VA's compliance with the reporting requirements

In addition, for the spinal cord injuries and disorders portion of the report, the team compared the reported number of operating beds for each facility to the mandated number of beds in VHA Directive 1176(2).[17] Finally, the team conducted short-notice site visits to all 25 spinal cord injuries and disorders centers. During these site visits, the OIG interviewed clinical staff and verified the authorized and operating beds reported in the FY 2022 capacity report. Appendix A provides additional details about the review's scope and methodology.

VA Reporting Requirements under 38 U.S.C. § 1706

VA is required to report on specific capacity measures for each of the five special disability categories in its annual report to Congress. For example, VA must report on the number of staffed beds and full-time equivalent (FTE) employees at each acute and sustaining or extended care facility for veterans with spinal cord injuries and disorders. This information is supposed to be reported nationally, geographically, or by Veterans Integrated Service Network (VISN) and by medical facility.[18] The five special disability categories and required capacity measures are outlined in table 1.

[17] VHA Directive 1176(2), *Spinal Cord Injuries and Disorders System of Care*, September 30, 2019, amended February 7, 2020. As defined in this directive, authorized beds are the mandated number of beds at each spinal cord injuries and disorders center, which is the sum of operating beds and beds that are temporarily not available. Operating beds are those that are staffed and available for admission of patients.

[18] 38 U.S.C. § 1706. This law requires data to be reported by geographic service area. However, VA divides its system of healthcare facilities in the United States into 18 regional networks, known as VISNs.

Table 1. 38 U.S.C. § 1706 Annual Capacity Measures

Special disability category	Annual capacity measure
1. Spinal cord injuries and disorders	• Number of staffed beds • Number of FTE employees assigned to provide care at specialized centers
2. Traumatic brain injury	• Number of veterans treated • Amounts expended
3. Blind rehabilitation	• Number of staffed beds • Number of FTE employees assigned to provide care at specialized centers
4. Prosthetic and sensory aids	• Amounts expended
5. Mental health a. Intensive community-based care	• Number of discrete intensive care teams available to provide such intensive services to seriously mentally ill veterans • Number of veterans treated
b. Opioid substitution programs	• Number of veterans treated • Amounts expended
c. Dual diagnosis programs (psychiatric and substance use)	• Number of veterans treated • Amounts expended
d. Substance use disorder programs	• Number of beds • Average bed occupancy • Percentage of outpatients who had two or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison to 1996 • Percentage of inpatients with substance use disorder diagnosis treated who had one or more specialized clinic visits within three days of their discharge, with a comparison to 1996 • Percentage of outpatients seen in a facility or geographic service area who had one or more specialized clinic visits, with a comparison to 1996 • Rate of recidivism of patients at each specialized clinic in each geographic service area*
e. General mental health programs	• Number and type of staff available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison to 1996 • Number of such clinics providing mental health care and, for each of these, the number and type of mental health staff and the type of mental health programs • Total amounts expended for mental health

Source: OIG analysis of 38 U.S.C. § 1706.

**According to VA officials, recidivism rates were used to capture veterans' readmission rates to mental health programs when the mandated reporting requirement was enacted. VA no longer uses the term "recidivism" because this term denotes repeat criminal behavior.*

Spinal Cord Injuries and Disorders

Veterans with spinal cord injuries and disorders can access services at 25 centers throughout the country. Nineteen of these centers operate only acute/sustaining beds, five centers operate both acute/sustaining and long-term care beds, and one center operates only long-term care beds. The Spinal Cord Injuries and Disorders National Program Office uses staffing data, which are self-reported by these facilities, in monthly VA and Paralyzed Veterans of America bed and staffing surveys for the capacity report. Staffing counts are given as FTEs. One FTE equals one full-time employee. For example, two 20-hour-per-week staff members are equal to, and would be reported as, one FTE.

Traumatic Brain Injury

For traumatic brain injury, services can be provided through inpatient or outpatient programs, and data on services are captured through administrative databases. Required information for the capacity report focuses on the number of veterans served and the amount of money expended.

Blind Rehabilitation

Blind rehabilitation services can be provided at inpatient or outpatient centers, and services such as adjustment and benefits counseling and training in the use of technology to support independence and integration can be provided by Visual Impairment Service Team coordinators (case managers) and blind rehabilitation outpatient specialists. Required data for the capacity report include bed and associated staffing counts, which are captured through an administrative database at the time of service and reported directly by the facilities. As with spinal cord injury and disorders services, the staffing counts are provided in FTEs.

Prosthetic and Sensory Aids

Prosthetic and sensory aids include devices that support or replace a body part or function, such as artificial limbs and bracing, wheeled mobility and seating systems, sensory-neural aids such as hearing aids and eyeglasses, cognitive prosthetic devices, items for women's health, surgical implants and devices such as hips and pacemakers, home respiratory care devices, and adaptive recreational and sports equipment. Required data for the capacity report are limited to amounts expended, and the data are collected through a program-based data system.

Mental Health

Programs for mental health are divided into five subcategories: (1) intensive community-based care, (2) opioid substitution, (3) dual diagnosis (psychiatric and substance use), (4) substance use

disorder, and (5) general mental health. These programs can be provided at VA medical facilities, at outpatient clinics, or through inpatient programs. Required information for the capacity report includes data on the number of programs, counts of veterans served, amounts expended, number of inpatient beds, and number and type of clinics and programs with the number of associated staff. Some of these data are collected through an administrative database at the time of service. For substance use disorder programs and general mental health programs, VA is required to report comparisons to 1996 capacity levels. See table 1 above for the required mental health capacity measures.

Results

The FY 2022 Report Was Generally Fairly Stated and Accurate

Except for the issues discussed in the following sections and detailed in table 2, nothing came to the review team's attention that would lead the OIG to believe that the information required by 38 U.S.C. § 1706 and presented in the FY 2022 capacity report was not otherwise fairly stated and accurate. This conclusion is based on attestation standards used for this review.

Inaccuracies and Omissions Resulted in Material Errors for Some Capacity Measures

The FY 2022 capacity report had inaccuracies and omissions that resulted in material errors for some of the capacity measures.[19] Specifically, some required data from three of the five special disability areas were either inaccurate, incomplete, or omitted from the report. VA's compliance with the mandated reporting requirements is summarized in table 2.

Table 2. Capacity Measures in the FY 2022 Special Disabilities Capacity Report

Capacity measure	Did VA report data on this capacity measure in FY 2022?
For spinal cord injuries and disorders centers—Spinal Cord Injuries and Disorders System of Care	
Number of staffed beds	Yes
Number of FTEs assigned to provide care at such centers	Yes
Reported data totaled nationally and detailed at the medical facility and VISN levels	Yes
For traumatic brain injury—Polytrauma/Traumatic Brain Injury System of Care	
Number of veterans treated	Partial, only for veterans treated as outpatients
Amounts expended	No, obligations data provided instead
Reported data totaled nationally and detailed at the medical facility and VISN levels	Partial, only for veterans treated as outpatients
For blind rehabilitation specialized centers—Blind Rehabilitation Services	
Number of staffed beds	Yes
Number of FTEs assigned to provide care at such centers	Yes

[19] The team used a 10 percent threshold for any data variances when determining the materiality of errors. This methodology was consistent with how errors were identified in prior OIG reviews of VA's capacity reports.

Capacity measure	Did VA report data on this capacity measure in FY 2022?
Reported data totaled nationally and detailed at the medical facility and VISN levels	Yes
For prosthetic and sensory aids—Prosthetic and Sensory Aids Service	
Amounts expended	Yes
Reported data totaled nationally and detailed at the medical facility and VISN levels	Yes
For mental health	
Mental health intensive community-based care—Northeast Program Evaluation Center	
Number of discrete intensive care teams available to provide such intensive services to veterans with serious mental illness	Yes
Number of veterans treated	Yes
Reported data totaled nationally and detailed at the medical facility and VISN levels	Partial, did not include total VISN-level data for number of unique veterans treated
Opioid substitution programs—Northeast Program Evaluation Center	
Number of veterans treated	Yes
Amounts expended	Yes
Reported data totaled nationally and detailed at the medical facility and VISN levels	Yes
Patients with dual diagnosis (psychiatric and substance use)—Northeast Program Evaluation Center	
Number of veterans treated	Yes
Amounts expended	Yes
Reported data totaled nationally and detailed at the medical facility and VISN levels	Yes
Substance use disorder programs—Northeast Program Evaluation Center	
Number of beds employed	Yes
Average occupancy of such beds	Yes
Percentage of unique outpatients who had two or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison to 1996	Partial, did not include a comparison to 1996
Percentage of unique inpatients with substance use disorder diagnoses treated who had one or more specialized clinic visits within three days of their index discharge, with a comparison to 1996	Partial, did not include a comparison to 1996
Percentage of unique outpatients seen in a facility or geographic service area who had one or more specialized clinic visits, with a comparison to 1996	Partial, did not include a comparison to 1996

Capacity measure	Did VA report data on this capacity measure in FY 2022?
Rate of recidivism of patients at each specialized clinic in each geographic service area	No, recidivism rate data no longer used for mental health programs
Reported data totaled nationally and detailed at the medical facility and VISN levels	Partial, national totals were not presented for all areas
Mental health programs—Northeast Program Evaluation Center	
Number and type of staff available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison to 1996	Partial, did not include a comparison to 1996
Number of such clinics providing mental health care and, for each of these, the number and type of mental health staff and the type of mental health programs	Partial, did not include data for all facilities operating residential and ambulatory programs
Total amounts expended	Yes
Reported data totaled nationally and detailed at the medical facility and VISN levels	Partial, did not include data for all facilities operating residential and ambulatory programs

Source: OIG analysis of VA's FY 2022 special disabilities capacity report.

Data Omissions Caused Material Errors in Some Mental Health Data

When assessing the mathematical accuracy of the 14 mental health capacity tables selected for review, the team determined that in three of those tables, the data for some residential and ambulatory programs were incorrect. Through interviews with various VHA personnel responsible for the report, the review team determined that the data provided by the mental health program office had been erroneously changed during the formatting and concurrence process that occurred before the capacity report was submitted to Congress. As a result, VA's capacity to treat veterans with mental health across some of its programs was inaccurately reported to Congress. The errors included both overstatements and understatements of VA's true capacity. The following are a few examples, but not all, of the material errors identified by the review team:

- VA underreported the number of VISNs that operate mental health residential programs. According to the report, nine VISNs did not operate any residential programs; however, the team determined in its review of data obtained from the Northeast Program Evaluation Center that 121 residential mental health programs operated across these VISNs.
- VA reported that VISN 20 operated 128 ambulatory mental health programs in FY 2022, but the OIG determined that the VISN operated 162 programs in FY 2022.

- VA reported that VISN 16 operated Compensated Work Therapy programs at 42 facilities; however, Northeast Program Evaluation Center data indicated that these facilities did not operate any such programs in FY 2022.

Representatives from VHA's Office of Government Accountability Office (GAO)/OIG Audit Liaison reported to the review team that the erroneous data changes were applied to the report by a VA contractor responsible for adjusting formatting to bring the report into alignment with VHA's style guide. These errors were not identified because VHA does not have a process in place to validate the integrity of report content after it was modified by the contractor.

Inaccuracies Caused Material Errors in Some Spinal Cord Injuries and Disorders Data

The OIG previously reported on inaccuracies with VA's reporting of bed data in its reviews of VA's capacity reports for FYs 2017, 2018, 2019, and 2020.[20] During the FY 2020 review, VHA agreed that data from VHA Directive 1176(2), the primary data source to document the bed values reported in VA's capacity reports, sometimes are not consistent with bed change request letters.[21] For example, discrepancies can occur when a facility has not yet entered a bed change request letter to update VA's National Bed Control System or if the national program office has not otherwise been notified of a local change in bed capacity. Furthermore, not all facility bed change requests are guaranteed to be granted by the approving officials. Proposed bed changes must be submitted to, and approved by, the executive director of the Spinal Cord Injuries and Disorders National Program Office, the deputy under secretary for health for operations and management, and then the under secretary for health.

In response to OIG reviews of VA's capacity reports, the Spinal Cord Injuries and Disorders National Program Office reviews bed change requests from the 25 centers for veterans with spinal cord injuries and disorders and uses these data to update its annual bed count report. According to VHA Directive 1176(2), facilities operating these centers must staff and operate the bed counts specifically detailed in the directive. As of February 2024, program officials reported they had not received any additional bed change requests since January 2023. In May 2024, a program official reported that the national program office had convened a workgroup to revise and update VHA Directive 1176(2) and stated that the work group will develop an execution

[20] VA OIG, *Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2020*, Report No. 21-03260-60, February 9, 2022; VA OIG, *Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2019*, Report No. 21-00612-189, September 13, 2021; VA OIG, *Independent Review of VA's Special Disabilities Capacity Reports for Fiscal Years 2017 and 2018*, Report No. 19-06382-111, April 16, 2020.

[21] Spinal cord injuries and disorders facilities electronically submit bed change request letters into the web-based VA National Bed Control System.

plan as well as associated timelines for revisions and updates to the directive in the third quarter of FY 2024.

The team compared the number of operating beds for each facility in the capacity report for FY 2022 to the mandated number of operating beds in VHA Directive 1176(2) and identified discrepancies—some of which were explained by table notes included in the report's spinal cord injuries and disorders appendix and others that were not. Inadequate staffing was the most frequent reason facilities reported not being able to operate the mandated number of beds in accordance with the directive.

The review team also visited all 25 spinal cord injuries and disorders centers and identified additional instances where the reported data did not reflect facilities' operating bed capacity. The team identified 10 facilities that were operating with fewer beds than reported and six facilities that were operating with more beds than reported; most of these differences were material. For example, according to the acting chief nurse for spinal cord injuries and disorders and the nurse manager at the Lt. Col. Luke Weathers Jr. VA Medical Center in Memphis, Tennessee, the facility is staffed to operate 20 beds (as opposed to the reported 28 beds). In August 2020, the facility medical center director initiated a request to permanently reduce the number of its operating beds to 20, citing reduced historical demand and corresponding workload. In August 2021, the Spinal Cord Injuries and Disorders National Program Office nonconcurred with the permanent reduction but approved the facility to temporarily operate at 20 beds. According to documentation in VHA's National Bed Control System, the program office allowed the temporary reduction in the center's operating beds but cited facility construction and the relocation of veterans from the Community Living Center to the spinal cord injuries and disorders center as the reason—as opposed to reduced historical demand and corresponding workload. The program office further stated that the facility should consider allowing veterans to be placed in private rooms when possible, using two-bed and four-bed rooms, in addition to one-bed rooms, within both the east and west units of the spinal cord injuries and disorders center. The reduction in operating bed capacity should not exceed a 24-month duration, according to VHA's National Bed Control System. However, as of December 2023, the facility's chief of clinical operations reported they are in the process of obtaining approval from the Spinal Cord Injuries and Disorders National Program Office to continue operating at the reduced 20-bed capacity.

According to the FY 2022 report, the Minneapolis VA Medical Center in Minneapolis, Minnesota, was operating 16 beds. However, the review team on-site observed 26 operating beds. The facility's chief of spinal cord injuries and disorders and the nurse manager explained that the operating data reported in the FY 2022 report were outdated and inaccurate. The facility's operating capacity had decreased in FYs 2020 and 2021 because this inpatient center space was temporarily merged with the polytrauma, traumatic brain injury, and stroke center space. However, the spinal cord injuries and disorders acute and sustaining center returned to its

full operating capacity of 26 beds in FY 2022. Facility personnel provided the team with documentation accordingly. Table 3 summarizes the results of the team's on-site reviews for each facility and includes an adjustment for an approved bed change request submitted by the Rocky Mountain Regional VA Medical Center in Denver, Colorado, after FY 2022 and through the OIG site visit. It should be noted that the facilities operating in West Roxbury and Brockton, Massachusetts, belong to the Boston Spinal Cord Injuries and Disorders Center.

Table 3. Locations with Differences between Reported and Operating Bed Counts Observed during OIG Site Visits

Facility name and location	Beds reported in the FY 2022 Capacity Report	Beds staffed, available, and observed	+/- Beds
West Roxbury VA Medical Center, Massachusetts	25	24	-1
James J. Peters VA Medical Center, Bronx, New York	33	48	+15
East Orange VA Medical Center, New Jersey	18	15	-3
Syracuse VA Medical Center, New York	8	12	+4
San Juan VA Medical Center, Puerto Rico	17	18	+1
Lt. Col. Luke Weathers, Jr. VA Medical Center, Memphis, Tennessee	28	20	-8
Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio	32	30	-2
Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin	14	12	-2
Dallas VA Medical Center, Texas	26	22	-4
Rocky Mountain Regional VA Medical Center, Denver, Colorado	26 (+4)*	21	-9
Seattle VA Medical Center, Washington	32	19	-13
Palo Alto VA Medical Center, California	32	33	+1

Facility name and location	Beds reported in the FY 2022 Capacity Report	Beds staffed, available, and observed	+/- Beds
Raymond G. Murphy VA Medical Center, Albuquerque, New Mexico	26	16	-10
Tibor Rubin VA Medical Center, Long Beach, California	60	77	+17
Minneapolis VA Medical Center, Minnesota	16	26	+10
Brockton VA Medical Center, Massachusetts	28	25	-3
Total	**421 (+4)**	**418**	**-7**

Source: The FY 2022 Special Disabilities Capacity Report, appendix G–Beds and Spinal Cord Injury and Disorder bed counts performed during site visits during the week of November 13, 2023. The site visit bed count observations in this table are reported by facility for consistency in how beds were reported in the capacity report appendix.

**The Rocky Mountain Regional VA Medical Center in Denver, Colorado, received approval for a bed change request that increased their operating beds from 26 to 30 in March 2023 (after FY 2022 and before the OIG site visit). When analyzing the data, the review team increased this facility's operating beds by four.*

Some Special Disability Data Were Not Reported

The report continues to be incomplete because of VA's inability to report mental health capacity data that would allow comparisons with its 1996 capacity, as required by the law.[22] As noted in prior OIG reviews, VA reported that this inability stems from how mental health conditions are diagnosed and treated, how services are provided, and how data are collected, which are all now performed differently than in 1996. For example, VA is required to report on the recidivism rate for patients at each specialized mental health clinic; however, VA officials reported that VA no longer collects data on recidivism for mental health programs because it is not an appropriate outcome measure for this population. The OIG notes that VA did, however, meet other portions of the reporting requirements, including the percentage of unique inpatients with substance use disorder diagnoses treated who received outpatient services, the number of beds employed, and the average occupancy of those beds.

[22] 38 U.S.C. § 1706(b)(2)(D–E).

Furthermore, the traumatic brain injury spending information in the capacity report contained obligations, not expenditures data as required by law.[23] Also, obligations data provided in the report were only at the national level, not at the VISN or geographic service area level as required. The OIG reported this issue in prior reviews. The review team confirmed that the program office did not specifically request traumatic brain injury expenditures data from VHA's Allocation Resource Center to inform the report. According to the Allocation Resource Center program analyst, they provided the program office with traumatic brain injury obligations not because expenditure data were unavailable but because the program office did not specify what kind of spending data were required by the mandate. Because VHA has the capability to report traumatic brain injury expenditure data at the national and VISN or geographic service area, it should do so in future submissions. A traumatic brain injury program office official reported they will take steps to make sure future report submissions will be informed by national- and VISN-level traumatic brain injury expenditure data. VHA also did not report on all veterans with traumatic brain injuries treated annually. The review team determined that the number of veterans treated as inpatients for traumatic brain injuries was erroneously omitted by the program office.

Transition to Oracle Cerner Electronic Health Record System May Result in Data Omissions and Inaccuracies

VA acknowledged in the report that because of the transition to the new Oracle Cerner electronic health record (EHR) system, some workload data for the five sites that are using the new system could be missing or wrong. Medical facilities located in VISN 20—Spokane and Walla Walla, Washington, and Roseburg and White City, Oregon—adopted the new EHR system in FYs 2021 and 2022. The facility in Columbus, Ohio, in VISN 10 adopted the new system in FY 2022. The report stated that caution should be used when interpreting measurement scores for any of the five facilities that are using the new Oracle Cerner system, as well as measurement scores for VISNs 10 and 20 and national-level measurements for FY 2022. Furthermore, the report noted that for a few measurements, data that include information from healthcare systems using the new EHR system were not available:

- Eight of the 14 mental health tables reviewed included notes stating that EHR data for VISNs 10 and 20 were included but could affect the accuracy of some data.
- One of the 14 mental health tables reviewed did not include data for VISNs 10 and 20 because these measurements were not available for facilities operating the new EHR system.

[23] 38 U.S.C. §§ 1706(b)(3) and 1706(b)(3)(C). An obligation is a legally binding agreement that will result in payments. Payments made to fulfill an obligation are also referred to as expenditures.

The OIG believes that in cases where mandated reporting elements cannot be met by data that are currently captured by facilities operating the new system, VA could take steps to separately report data from this system that most closely align to these requirements. Doing so would allow VA to keep Congress fully informed of its capacity to treat veterans in these five special disability areas.

Conclusion

Except for the effects of the inaccuracies and omissions discussed in this report, nothing came to the team's attention that would lead the OIG to believe the information in the FY 2022 capacity report was not otherwise fairly stated and accurate.

As the OIG reported in its review of the FY 2021 capacity report, VA is required to compare its mental health capacity to 1996 levels. The statute does not require this comparison for the other four special disability categories. VA is unable to meet the requirement to compare its mental health capacity with 1996 levels because of changes in medical diagnoses, treatments, treatment settings, infrastructure, information technology, data systems, and terminology.

VHA reported the wrong spending data for traumatic brain injury when it included obligations rather than expenditures data at the national level but not at the VISN or geographic service area level. Because VHA has the capability to report traumatic brain injury spending data as expenditures at the required levels, it should do so for future submissions. Currently, VA is not required to include information on community care received by veterans with these disabilities.[24] The OIG believes that Congress would be better informed by requiring VA to report community care data and by modernizing the reporting metrics—such as with utilization data—to further assess VA's ability to provide care for veterans with spinal cord injuries and disorders, traumatic brain injuries, blindness, or mental illness and those who need prosthetics and sensory aids.

Finally, as additional medical facilities transition to the Oracle Cerner EHR system, the completeness of some facility, VISN, and nationally reported data elements will be affected. The OIG believes that VA should report special disability data for these facilities separately to give Congress insight into annual trends across these five facilities and any future facilities that adopt the new system. For example, VA announced its plan to continue to deploy this system at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, in FY 2024. In cases where mandated reporting elements cannot be met by data that are currently captured by facilities operating the new EHR system, VA could take steps to separately report data from this

[24] VA provides health care for eligible veterans at its nationwide medical facilities. VA pays for veterans to receive health care from community-based providers when certain conditions are met, such as long appointment wait times or unavailability of specialty care at veterans' local VA facilities. The VA MISSION Act of 2018 consolidated several community care programs into the Veterans Community Care Program in June 2019. John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

system that most closely align to these requirements to keep Congress fully informed of its capacity to treat veterans in these five special disability areas.

VA Comments and OIG Response

The OIG provided VA with a draft of this report for review and comment. The under secretary for health did not provide comments on the contents of the draft report. See appendix B for VA's management representation letter.

Appendix A: Scope and Methodology

Scope

The review team conducted its work from September 2023 to May 2024. The team assessed whether VA's fiscal year 2022 special disabilities capacity report accurately reflected VA's in-house capacity to provide for the specialized treatment and rehabilitative needs of specified categories of disabled veterans, as required by 38 U.S.C. § 1706.

Internal Controls

Internal controls related to communication were significant to this attestation review. To assess these controls, the team interviewed officials from the following VA offices: Spinal Cord Injuries and Disorders National Program Office, Polytrauma/Traumatic Brain Injury System of Care, Blind Rehabilitation Services, Prosthetic and Sensory Aids Service, and the Northeast Program Evaluation Center.

Fraud Assessment

The team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in the context of the review objective, could occur during this attestation review. Specifically, the team coordinated this review with the VA Office of Inspector General's (OIG) Office of Investigations and considered potential fraud indicators when reviewing data tables, such as looking at large fluctuations or outliers. The OIG did not identify any instances of fraud or potential fraud regarding the capacity report.

Data Reliability

This attestation review was designed to provide a moderate level of assurance as to whether the subject matter is presented accurately and fairly, to present a conclusion, and to accumulate sufficient evidence to restrict attestation risk to a moderate level, as required by American Institute of Certified Public Accountants (AICPA) review attestation standards. The team's review was generally limited to inquiries and analytical procedures to assess the accuracy of the data VA reported in its capacity report. The team compared data from the report text to the data tables to identify inconsistencies, analyzed data tables to identify mathematical errors, performed a year-over-year analysis of the data to identify any increases or decreases equal to or more than 10 percent or anomalies, and followed up with program office officials as needed. In addition, the team replicated a sample of key data tables to determine whether the results would be like those provided by VA when the same parameters were applied.

For the spinal cord injury disorder data that could not be replicated, the team conducted site visits to all the centers to count the number of beds and compare the physical counts to what VA reported. VA operates a total of 25 spinal cord injuries and disorders centers nationally. Nineteen of these centers operate only acute/sustaining beds, five centers operate both acute/sustaining and long-term care beds, and one center operates only long-term care beds. The team determined that the data in VA's capacity report were sufficiently reliable and appropriate for the purpose of reviewing the accuracy of VA's reported data. Finally, as in prior reviews of VA's special disabilities capacity reports, the OIG interviewed representatives from the program offices responsible for compiling the capacity report to determine if they were aware of any limitations with the sources that could affect the accuracy of the data in the capacity report. For this review, the team confirmed with the program offices that there were no significant changes affecting capacity data since the last capacity report. The team did not test the reliability of the information systems used to compile the data in the capacity report because such testing was beyond the scope of this attestation review.

Government Standards

The OIG conducted this review in accordance with attestation standards established by the AICPA and by the applicable generally accepted government auditing standards. An attestation review is substantially less in scope than an examination. The objective of an examination is the expression of an opinion on the assertions in the submission. The OIG does not express such an opinion.

Appendix B: VA Management Representation Letter

Department of Veterans Affairs Memorandum

Date: June 27, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Independent Review of VA's Fiscal Year (FY) 2022 Special Disabilities Capacity Report (Project Number: 2023-03356-AE-0134)

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

1. We are providing this memorandum in connection with the Office of the Inspector General's (OIG) independent attestation review of the Department of Veterans Affairs (VA)'s fiscal year (FY) 2022 Special Disabilities Capacity Report. This review was to assess VA's reporting of its capacity for FY 2022 to provide for the specialized treatment and rehabilitation of specified categories of disabled Veterans.

2. VA is responsible for the fair presentation of all statements in the FY 2022 Special Disabilities Capacity Report in conformity with 38 U.S.C. § 1706. This statute requires VA to maintain its in-house capacity to provide for the specialized treatment and rehabilitative need of disabled Veterans with mental illness, spinal cord injuries and disorders, traumatic brain injury, blindness, or prosthetics and sensory aides. VA believes the statements, and other information in the subject report, are fairly presented in conformity with the law, unless otherwise disclosed in the report.

3. VA is responsible for the data definitions used in the FY 2022 Special Disabilities Capacity Report, and VA believes those definitions are appropriate and consistent with the requirements of 38 U.S.C. § 1706, unless otherwise disclosed in the report.

4. VA made available to the OIG the following:

a. The FY 2022 Special Disabilities Capacity Report required by 38 U.S.C. § 1706;

b. All supporting records, related information, and program and financial data relevant to the special disability programs included in the FY 2022 Special Disabilities Capacity Report;

c. Communications, if any, from oversight bodies concerning the FY 2022 Special Disabilities Capacity Report; and,

d. Access to VA officials responsible for overseeing the programs that provided services to Veterans with mental illness, spinal cord injuries and disorders, traumatic brain injury, amputation, blindness, and prosthetic and sensory aids.

5. VA confirms the FY 2022 Special Disabilities Capacity Report was prepared in accordance with 38 U.S.C. § 1706. VA has no knowledge of instances in which VA did not report required information under 38 U.S.C. §1706 in the FY 2022 Special Disabilities Capacity Report, except for those instances disclosed in the report.

6. VA is not aware of any events that have occurred subsequent to September 30, 2022, that would influence the FY 2022 Special Disabilities Capacity Report and the information therein. There have been no material changes in the FY 2022 Special Disabilities Capacity Report since the report was submitted to the Congress on April 13, 2023.

7. VA believes the effects of any uncorrected misstatements in the FY 2022 Special Disabilities Capacity Report are immaterial, both individually and in aggregate, to the report taken as a whole.

8. VA is responsible for the design and implementation of program processes and internal controls to prevent and detect fraud. VA has no knowledge of deficiencies in internal controls or of fraud, or suspected fraud, that could have a material effect on the FY 2022 Special Disabilities Capacity Report.

9. VA understands the OIG 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, OIG does not express an opinion on the FY 2022 Special Disabilities Capacity Report.

10. Certain representations in this memorandum are described as being limited to matters that are material. VA considers items to be material, regardless of size, if they involve an omission or misstatement of information that that could influence a reasonable person's views given surrounding circumstances.

11. I confirm, to the best of our knowledge and belief, the representations made to OIG during this attestation review are accurate and pertain to FY 2022, which ended September 30, 2022.

(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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