



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Follow-Up Prosthetic and Sensory Aids Service Records Review Durham VA Medical Center, Durham, North Carolina

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections performed a follow-up review based on a complaint that recommendations from our previous report (*Prosthetic and Sensory Aids Service Records Review*, Report No. 11-01416-212, July 7, 2011) had not been fully implemented. The previous report was initiated at the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans' Affairs.

We recommended that the Medical Center Director:

- Take additional steps to ensure contact and assistance to those veterans whose Home Improvement and Structural Alterations (HISA) consult is unfulfilled.
- Follow the Veterans Healthcare Administration (VHA) directive for reporting, recording, and completing patient complaints.
- Ensure that closures of medical consultations are in compliance with VHA policies.
- Ensure protection of Personally Identifiable Information and reporting of privacy events as required by VHA policies.
- Proactively identify the veterans affected by the loss of their HISA records and provide necessary assistance to them to expedite their HISA services.
- Ensure that the HISA Committee is performing in compliance with VHA policies.
- Delegate the line of authority over Prosthetics Service.

Our previous report dated July 7, 2011, made the first five recommendations listed above. In response, the facility reported that all five of these recommendations had been implemented. In reality, none of these five recommendations had been completely addressed.

The Veterans Integrated Services Network 6 and Medical Center Directors agreed with our findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid-Atlantic Health Care Network (10N6)

SUBJECT: Healthcare Inspection – Follow-Up Prosthetic and Sensory Aids Service Records Review, Durham VA Medical Center, Durham, North Carolina

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted a follow-up review to determine the merit of an allegation that the Durham VA Medical Center had not fully completed action plans related to findings from a previous OIG report (*Prosthetic and Sensory Aids Service Records Review*, Report No. 11-01416-212, July 7, 2011).

Background

The medical center is a 271-bed tertiary care center affiliated with Duke University School of Medicine and provides medical, surgical, and psychiatric services. The medical center is part of Veterans Integrated Service Network (VISN) 6 and serves as a major referral center for North Carolina, southern Virginia, northern South Carolina, and eastern Tennessee.

The Prosthetic and Sensory Aids Service (PSAS) provides prosthetic and orthotic services, sensory aids, medical equipment, and support services for veterans. In fiscal year 2010, the medical center's PSAS served 22,000 veterans and managed a budget of approximately \$31 million. The Home Improvement and Structural Alterations (HISA) Program, provides funds to veterans to help defray costs associated with structural modifications of homes to accommodate wheelchairs or other special needs.

During June-September 2010, Veterans Health Administration (VHA) identified that the medical center's PSAS had serious lapses in internal controls, lack of documentation in patient records, and a general disregard of policies and directives. At the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans' Affairs, the OHI conducted site visits during February and March 2011, and submitted several recommendations in the OIG report dated July 7, 2011. In response to this report, the medical center responded to OHI with brief descriptions of actions taken, most of which were identified as "completed" by May 31, 2011.

In subsequent emails a complainant contacted OHI and alleged that the medical center had not completed the action plans as described in the response to the first report. For purposes of this inspection, we reviewed the following issues:

- Unfulfilled HISA consultation actions
- Patient complaints
- Medical consultation closure
- Personally identifiable information (PII) protection and violation management
- Lost HISA records management
- HISA Committee
- Line of Authority over PSAS

Scope and Methodology

We conducted a second site visit on August 23-26, 2011. We interviewed medical center PSAS employees and managers, as well as clinical and administrative staff. We reviewed local and VHA policies; VHA directives; references for HISA grants; Administrative Investigation Board testimonies and conclusions; and medical center HISA grant files and documentation.

We conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Unfulfilled HISA Consultation Actions

The first report recommended that the medical center take additional steps to ensure contact and assistance to those veterans whose HISA consultations were unfulfilled. The medical center responded with the following:

“Durham VA Medical Center systematically reviewed all HISA applications and HISA-related documents for all veterans whose HISA consult is unfulfilled. Follow-up was done with each Veteran as needed to

determine the status of their application and related files. Some veterans no longer required home structural alterations, so their consult and file were closed. For open cases, prosthetics staff contacted the Veteran and/or the contractor to check current status and provide assistance with any needed authorizations for completion of the work. In cases where there were incomplete or missing files, new document sets were created. All open cases will be closely tracked to completion to ensure needed services are received in a timely manner. *Completed 5/31/2011 - The HISA program will be closely monitored and patient case files will be tracked to ensure all program requirements are met.*"

Finding

Program managers developed a tracking sheet to identify veterans whose HISA consultations had not been completed. Progress had been made in contacting some of the veterans with incomplete HISA files. However, we found that the facility had not contacted all veterans that had received HISA grants to determine whether the home modification had been completed and that they were satisfied with the modification.

We did not find that the facility was meeting all HISA program requirements as reported. The HISA committee met three times in the 5-month period between our site visits. We found that only 4 percent of the HISA grants were reviewed by the HISA committee. A single HISA committee member was approving HISA grants and forwarding only the more complex cases for full committee approval. The HISA committee minutes reflected the review and approval of only one HISA grant.

Conclusion

At the time of our review we determined that the medical center had not completed this action plan as reported. Progress was made, but the remaining veterans whose HISA consultations had not been completed still needed to be contacted to ensure that they received the home modification.

Although improvements were made since our last site visit, we did not find that the importance of the role of the HISA committee was appreciated. The responsibilities of the Director and HISA committee, as stated in the VHA HISA policy¹, are to ensure the medical need and appropriateness of the structural modification. HISA grant applications must be reviewed and approved by this committee. The committee is a key internal control and its responsibilities should not be delegated to any single individual.

¹ VHA Handbook 1173.14, *Home Improvement and Structural Alterations Program*, dated April 18, 2008.

Recommendations

Recommendation 1: We recommend that the Medical Center Director ensure that all veterans that have applied for or received HISA grants are contacted to determine the status of their HISA modification and provided assistance when necessary.

Recommendation 2: We recommend that the Medical Center Director ensure the HISA committee performs in compliance with VHA directives.

Issue 2: Patient Complaints

The first report recommended that the medical center follow the VHA directive² for reporting, recording, and completing patient complaints. The medical center responded with the following:

“Complaints received about Prosthetics and Sensory Aids Service (PSAS) were previously documented in the Patient Advocate Tracking System by the medical center Patient Advocates when the issue was brought to the attention of the facility advocate, but not by PSAS staff if they received the complaint themselves. PSAS has now designated three employees to serve as Patient Advocate Liaisons/Service Level Advocates. These employees have received training in how to enter patient issues into the Patient Advocate Tracking System (PATS), receive and respond to action notifications, and how to enter the resolution for any issues that are initially reported to their service as well as to the facility Patient Advocates. PSAS participates in monthly meetings and related training for the Patient Advocate Liaisons, where all PATS data is reviewed and tracked by the appropriate service level advocate. General facility reports are tracked, trended, and reported at the Customer Service Council. Training has been provided in use of PATS, and systems are in place to monitor and track completeness of PATS entries. *Completed 5/31/2011.*”

Finding

The PATS allows staff to electronically collect, trend, and analyze patient complaints. This information should be included with other quality improvement data and reviewed by the proper medical center committees and forums.² We reviewed prosthetic complaints recorded in the PATS from May 1, 2011, through August 23, 2011, to identify if patients who contacted prosthetics for assistance received it.

Although staff were trained to use the PATS system for complaints, we found that of the 26 prosthetic complaints recorded during the review period, only 13 (50 percent) had documentation that the complaint was addressed and resolved. During our interviews we

² VHA Handbook 1003.4, VHA *Patient Advocacy Program*, September 2, 2005.

were told that PSAS staff received daily complaints. However, we found only one complaint entered by a PSAS employee.

Conclusion

We did find that training had been documented, but it was not clear the implementation was still in progress. At the time of our review, we determined that the medical center was still not compliant with the VHA directive for reporting, recording, and completing patient complaints.

Recommendation

Recommendation 3: We recommended that the Medical Center Director ensure that patient complaints follow VHA's directive for reporting, recording, and completing the complaint.

Issue 3: Medical Consultation Closure

The first report recommended that the medical center ensure that closures of medical consultations comply with VHA policies. The medical center responded with the following:

“The practice of marking consults as “Complete” without clear documentation of the actual status of the requested item was discontinued as of April 2011. Consults remain in pending status until the request item has been issued or there is specific documentation about the reason for closing the consult. Performance is monitored using the National Prosthetic Patient Database (NPPD) and audits of purchasing agent documentation. Performance standards include expected outcomes for consult completion. Completed 4/7/2011 – new process in place, with supervisory oversight to ensure ongoing compliance.”

Finding

We found that Prosthetics staff had been instructed to leave consults in pending status until the requested item has been issued or there was specific documentation about the reason for closing the consult.

However, a review of 47 completed HISA files found that 46 of the 47 files (98 percent) did not have all of the required elements that VHA Handbook 1173.14 requires. Prosthetics staff reported that they were considered to be complete because payment had already been made, but the files we reviewed did not clearly document all of the required steps of the Handbook.

Furthermore, the medical center had a process in place where HISA consultations were forwarded to an Occupational Therapist (OT) to determine the appropriateness of the HISA project in meeting the veteran's medical needs. When the consult was referred to the OT, the consult was closed. PSAS staff relied on the OT to re-enter the HISA consult once reviewed. The PSAS staff was not tracking these consultations to ensure that they were re-entered into the system for completion. Additionally, we found seven patients awaiting prosthetics services for more than 1 year after the date of the initial HISA consultation.

Conclusion

Program managers did not ensure that HISA consultations documented all required steps of the HISA process before the consultation was closed.

Recommendation

Recommendation 4: We recommend that the Medical Center Director ensure program managers close consultations in compliance with VHA directives.

Issue 4: PII Protection and Violation Management

The first report recommended that the medical center ensure protection of personally identifiable information (PII) and reporting of privacy events as required by VHA policies. The medical center responded with the following:

“It is recognized that the Chief, PSAS and the Privacy Officer were not sufficiently aggressive in conducting a thorough and timely investigation when it was determined that files could not be located. .

The new Privacy Officer and all management officials will ensure protection of Personally Identifiable Information and prompt investigation and reporting of any complaints, potential, or actual privacy violations.
Completed 4/30/2011.”

Finding

We found that the medical center had not notified the 61 additional veterans identified in our report for the possible loss of PII. Securing PII for veterans is the responsibility of all VA employees. As stated in our earlier report, senior managers failed to secure PII data and did not perform their duties in investigating and reporting the loss of PII. Medical center leadership took appropriate action. A VISN Prosthetic Representative is the acting chief for PSAS and the medical center has selected a new service chief.

Conclusion

Medical center managers acknowledged that PII information had been compromised without sufficient management review and not all the veterans had been notified.

Recommendation

Recommendation 5: We recommend that the Medical Center Director ensure that the identified veterans are notified of the possible loss of the PII.

Issue 5: Lost HISA Records Management

The first report recommended that the medical center proactively identify the veterans affected by the loss of their HISA records and provide necessary assistance to them to expedite their HISA services. The medical center responded with the following:

“The medical center has systematically reviewed all HISA applicants including those for whom records were missing or incomplete. Each veteran has been contacted and assisted as needed to expedite their HISA services. New standard operating procedures are in place to ensure careful tracking of all HISA applications and maintenance of files. *Completed 5/31/2011. Review is complete and assistance has been offered.*”

Finding

We found that medical center managers had not completed all HISA record reviews as reported. Medical center managers reported that they had reviewed all HISA records including those for whom records were missing or incomplete. However, not all affected veterans had been contacted or assisted as needed to expedite their HISA services. To improve the process of tracking HISA applications and maintaining record files, new operating procedures were being implemented.

Conclusion

Progress had been made in contacting and assisting veterans requiring HISA grants; however, not all affected veterans were contacted as reported.

Recommendation

Recommendation 6: We recommend that the Medical Center Director ensure program managers systematically contact and assist all veterans requiring HISA grants.

Issue 6: Line of Authority over PSAS

In the course of our inspection, we found that many of the issues raised in our report were the result of a lack of oversight and leadership in PSAS. The VHA HISA policy³ allows for oversight by the Medical Center Director or the VISN Prosthetics Representative. Adequate monitoring of PSAS performance requires a level of expertise and access to compliance data that is not suited to the expertise available at the medical center.

Recommendation

Recommendation 7: We recommend that the VISN Director and Medical Center Director consider assigning the line of authority over the PSAS Chief to the VISN Prosthetics Representative.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

³ VHA Handbook 1173.14, *Home Improvement and Structural Alterations Program*, dated April 18, 2008.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 23, 2011

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Healthcare Inspection – Follow-Up Prosthetic and Sensory Aids Service Records Review, Durham VA Medical Center, Durham, North Carolina**

To: Director, Healthcare Financial Analysis Division (54D)

Thru: Director, Management Review (10A4A4)

The attached subject report is forwarded for your review and further action. I have reviewed the responses and concur with the facility's recommendations.

Please contact Ralph Gigliotti, Director, Durham VA Medical Center, at (919) 286-6903, if you have any further questions.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Director, VA Mid-Atlantic Health Care Network (10N6)

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 23, 2011

From: Director, Durham VA Medical Center (558/00)

Subject: **Healthcare Inspection – Follow-Up Prosthetic and Sensory Aids Service Records Review, Durham VA Medical Center, Durham, North Carolina**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

This memo serves to acknowledge receipt and review of the draft Healthcare Inspection Report for the Follow-up Prosthetics and Sensory Aids Service Records Review, Durham VA Medical Center, Durham, North Carolina.

Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Sara Haigh, Assistant Director, at (919) 286-6904.

(original signed by:)

RALPH T. GIGLIOTTI, FACHE

Director, Durham VA Medical Center (558/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the Medical Center Director ensure that all veterans that have applied for or received HISA grants are contacted to determine the status of their HISA modification and provided assistance when necessary.

Concur **Target Completion Date:** February 24, 2012

Medical Center's Response:

In a previous report, the Office of Inspector General (OIG) recommended that the Medical Center take additional steps to ensure contact and assistance to Veterans whose Home Improvement and Structural Alterations (HISA) consult was unfilled. At the time of the May 31, 2011 response, Prosthetics staff had called or reviewed documentation for all open consults from 2010 and created a spreadsheet summarizing the work. Documents were reviewed, patients and vendors were called, and HISA checklists were added for files that did not have them. Additional steps were taken to ensure contact and assistance to this group of Veterans.

Following the May response, we continued to work to improve the HISA program. A change in leadership in the Prosthetics Service resulted in comprehensive reviews of departmental processes. We realized that while follow-up had occurred, not all of the cases had been brought to closure and the documentation of the follow-up done by our staff was not complete.

Additional contacts have now been made with patients who received HISA grants during 2010 to confirm any modification had been completed and the patient was satisfied with the modification. While no major issues were identified during this follow-up process, some patients indicated that the \$2,000 HISA benefit allowance for non-service connected (NSC) veterans was not enough to cover the full range of desired modifications.

We have now added additional controls to strengthen this process going forward. For all active and new cases, Prosthetic staff members are following up on all claims by calling Veterans to ensure that they have received the HISA application and to discuss any concerns the Veterans may have with the overall process of obtaining the benefit. Each patient contact is documented via a comment added to the Veteran's HISA consult in the Computerized Patient Record System (CPRS).

The new Chief of Prosthetics met with the Chief of Physical Medicine and Rehabilitation Service and has scheduled weekly meetings between their Services to ensure strict compliance with the VHA Directive 1173.14 when processing all HISA applications. Other actions taken include:

- The Chief of Prosthetics will review each HISA application and folder to ensure compliance with the VHA Directive 1173.14.
- A systematic process will be used to annotate each action taken into the consult and to record documents and quotes received. This process will ensure direct interaction and guidance to the patient throughout the process. The Chief will work closely with his staff on the continued processing of HISA benefit claims.
- The Chief of Prosthetics will coordinate HISA Committee meetings by attending HISA Committee meetings, ensuring complete applications are available to committee members, timely recording of appropriate minutes and communicating results to patients.
- The Medical Center Memorandum for the HISA program is being revised to describe this new process. Finalization is expected no later than (NLT) December 31, 2011.

Status: The implementation of the complete action plan is still in progress. The following actions have been completed: (1) Contact with Veterans receiving HISA payments in 2010. (2) Establishment of new processes used by Prosthetics staff to actively manage all open cases. (3) Establishment of a new review process by the Chief of Prosthetics.

Completion of the publication of the revised Medical Center Memorandum is expected NLT December 31, 2011.

The Medical Center will also conduct a 100% review of HISA consults to ensure the new process is effective by (1) looking at all pending consults on a weekly basis to check on the status and follow up with the patient as necessary; (2) reviewing HISA Committee minutes for each meeting to ensure the decision for each case referred to the Committee was

documented both in the minutes and on the HISA consult itself; (3) marking the CPRS HISA consult as “Complete” once the HISA Committee has made its decision and the final purchase order has been created or the Veteran declines the benefit; (4) ensuring the overall HISA file is closed only after confirmation that a statement of satisfaction with the completed work has been received in writing from the Veteran; a follow-up phone call from Prosthetic staff to the Veteran has confirmed satisfaction; and the invoice and after photographs from the vendor are in the file.

Recommendation 2. We recommend that the Medical Center Director ensure the HISA Committee performs in compliance with VHA directives.

Concur **Target Completion Date:** February 24, 2012

Medical Center’s Response:

As of May 31, 2011, the HISA Committee had met to improve its processes, added a more specific clinical review of the proposed modifications, and added this review to the CPRS consult. Since that time, the HISA Committee has implemented these new processes and is more completely documenting its work in the committee minutes. The new Chief of Prosthetics will now attend each HISA Committee meeting and record appropriate minutes of all Committee deliberations. The Chief will review each HISA application and folder before the Committee meets to ensure compliance with VHA Directive 1173.14.

The Medical Center will conduct 100% review of HISA consults to ensure the new process is effective by (1) looking at all pending consults on a weekly basis to check on the status and follow up with the patient as necessary; (2) reviewing HISA Committee minutes for each meeting to ensure the decision for each case referred to the Committee was documented both in the minutes and on the HISA consult itself; (3) marking the CPRS HISA consult as “Complete” once the HISA Committee has made its decision and the final purchase order has been created or the Veteran declines the benefit; (4) ensuring the overall HISA file is closed only after confirmation that a statement of satisfaction with the completed work has been received in writing from the Veteran; a follow-up phone call from Prosthetic staff to the Veteran has confirmed satisfaction; and the invoice and after photographs from the vendor are in the file.

Status: Implementation of this recommendation is still in progress.

Recommendation 3. We recommended that the Medical Center Director ensure that patient complaints follow VHA's directive for reporting, recording, and completing the complaint.

Concur **Target Completion Date:** February 24, 2012

Medical Center's Response: As of May 31, 2011, staff members in Prosthetics had been designated as Patient Advocate Liaisons for Prosthetics and had the necessary keys to create and close Issue Reports. Those employees received training in how to enter patient issues into the Patient Advocate Tracking System (PATS), receive and respond to action notifications, and enter the resolution for any issues that are initially reported to their service as well as to the facility Patient Advocates.

PATS data for August, September, and October show documentation of 49 complaints related to Prosthetics, none of which were directly entered by Prosthetics employees although the resolution text clearly shows that Prosthetics staff worked with each patient to resolve the issue. Additional emphasis is needed on completing the required data entry for complaints that go straight to Prosthetics.

To begin this process, Prosthetics has now developed a new procedure to route all non-routine calls to specific staff members. These employees will document these inquiries or complaints directly into the PATS program. Upon confirmation that the issue is resolved, it will then be closed in the PATS program.

Selections have been made for four existing vacant positions in Prosthetics. The additional staff members will help ensure timely resolution of complaints. The Chief of Prosthetics will be attending the PATS training sessions with his key staff on a monthly basis. During the weekly Prosthetic Staff meetings the Chief will reiterate with the staff the importance of VHA Handbook 1003.4, VHA Patient Advocacy Program and its requirement for all staff to report any complaint to the appropriate person. This expectation will be entered into each staff member's performance plan and recorded and reported in the appraisal process.

Status: Implementation of this recommendation is still in progress.

Recommendation 4. We recommend that the Medical Center Director ensure program managers close consultations in compliance with VHA directives.

Concur**Target Completion Date:** February 24, 2012

Medical Center's Response: The appropriate closing and pending of prosthetic consults is defined in the National Prosthetic and Sensory Aids Service Business Practice Guidelines for Prosthetic Consult Management, dated April 2010. For HISA consults, these guidelines state that the HISA consult is to be marked as "pending" with entry of the date of the future appointment scheduled for the HISA Committee. After the HISA Committee meeting has determined the necessary modifications and equipment, the consult is to be closed.

The facility's practice of marking consults as "Complete" without clear documentation of the actual status of the requested item was discontinued as of April 2011. The facility has now implemented procedures consistent with the national guidelines.

As an additional management control, Durham will keep the HISA consults in a "pending" status in the Prosthetic Suspense file for tracking until the final purchase order is created or until the Veteran declines the benefit. HISA consults in "pending" status will be reviewed weekly by PSAS to monitor progress. Patients will be contacted as needed to assist them with each step.

The Chief, Physical Medicine and Rehabilitation Service, and the new Chief, Prosthetics Service, have discussed the correct process to manage consults. The HISA consult is no longer being forwarded to the Occupational Therapist. Instead, the Chief of Physical Medicine & Rehabilitation Service and the Chief of Occupational Therapy are view alerted on all HISA consults and each patient case will be reviewed by the HISA Committee. Findings will be documented on the HISA consult and in the HISA Committee minutes.

Status: Implementation of this recommendation is still in progress. The Medical Center will conduct 100% review of HISA consults to ensure the new process is effective by (1) looking at all pending consults on a weekly basis to check on the status and follow up with the patient as necessary; (2) reviewing HISA Committee minutes for each meeting to ensure the decision for each case referred to the Committee was documented both in the minutes and on the HISA consult itself; (3) marking the CPRS HISA consult as "Complete" once the HISA Committee has made its decision and the final purchase order has been created or the Veteran declines the benefit; (4) ensuring the overall HISA file is closed only after confirmation

that a statement of satisfaction with the completed work has been received in writing from the Veteran; a follow-up phone call from Prosthetic staff to the Veteran has confirmed satisfaction; and the invoice and after photographs from the contractor are in the file.

Recommendation 5. We recommend that the Medical Center Director ensure that the identified veterans are notified of the possible loss of the PII.

Concur **Completion Date:** September 15, 2011

Medical Center's Response: Two groups of patients received letters from the Director about missing files.

- The first group of 29 patients had their files removed from Prosthetics at some point in late September 2010 and then later returned by a VA employee from another department. These patients received notifications in November 2010.
- A second group of patients had a HISA consult in CPRS between October 2009 and October 2010 but no original, signed application has been found in the facility files. Sixty-four (64) patients received a letter informing them of this situation in September 2011.

Neither mailing generated any significant volume of inquiries from the patients who received them. Two patients contacted the Privacy Officer to ask questions about the process for using Equifax.

Status: Complete.

Recommendation 6. We recommend that the Medical Center Director ensure program managers systematically contact and assist all veterans requiring HISA grants.

Concur **Completion Date:** February 24, 2012

Medical Center's Response: For cases from 2010, CPRS records and HISA files were reviewed and cross-referenced with all available data sources (HISA grants paid in 2010; folders in file cabinet in Prosthetics; HISA consult requests in CPRS; the OIG list of records they could not find during their review) to identify a consolidated list of 157 cases that were not clearly fully complete based on available documents. The response to Recommendation 1 describes how patients were individually contacted to ensure satisfaction with work performed and to offer assistance if needed.

All patients whose records were missing or incomplete have been reviewed and patients notified as to the status of their claim.

The process described in the response to Recommendation 1 will ensure a systematic process of patient contact and documentation to ensure each HISA case is carefully tracked and the patient receives any needed assistance throughout the process.

Status: The implementation of the complete action plan is still in progress. The following actions have been completed: (1) Contact with Veterans receiving HISA payments in 2010; (2) Establishment of new processes used by Prosthetics staff to actively manage all open cases; (3) Establishment of a new review process by the Chief of Prosthetics.

Completion of the publication of the revised Medical Center Memorandum is expected before December 31, 2011.

The Medical Center will also conduct a 100% review of HISA consults to ensure the new process is effective by (1) looking at all pending consults on a weekly basis to check on the status and follow up with the patient as necessary; (2) reviewing HISA Committee minutes for each meeting to ensure the decision for each case referred to the Committee was documented both in the minutes and on the HISA consult itself; (3) marking the CPRS HISA consult as "Complete" once the HISA Committee has made its decision and the final purchase order has been created or the Veteran declines the benefit; and (4) ensuring the overall HISA file is closed only after confirmation that a statement of satisfaction with the completed work has been received in writing from the Veteran; a follow-up phone call from Prosthetic staff to the Veteran has confirmed satisfaction; and the invoice and after photographs from the vendor are in the file.

Recommendation 7. We recommend that the VISN Director and Medical Center Director consider assigning that line of authority over the PSAS Chief to the VISN Prosthetics Representative.

Concur **Target Completion Date:** February 24, 2012

Medical Center's Response: The VISN Director and Medical Center Director carefully considered this recommendation. It was determined that the current line of authority will be maintained at this time, with the Associate or Assistant Director at each facility having line authority for PSAS employees at the local facility. This allows for direct oversight of

daily operations by facility administrators who are in the same location and have the ability for frequent and direct contact to address any administrative issues that might arise. The VISN 6 Prosthetics Representative provides technical oversight and guidance in a matrix model, and uses performance data, site visits, educational calls and meetings, and electronic messages to evaluate performance and compliance with directives, handbooks, and PSAS business rules. The VISN 6 Associate and Assistant Directors are included on key email communications and will be provided with periodic educational sessions on Prosthetics topics.

In addition, the VISN and Medical Center Director will consult with the VISN Prosthetics Representative as well as leadership in the Office of the Deputy Under Secretary for Health (DUSH) for Policy and Services, Prosthetics and Sensory Aids Service (PSAS), and the Office of the Deputy Under Secretary for Operations and Management (DUSHOM) to discuss how to ensure that prosthetics operations at the Durham VA Medical Center can best meet the needs of Veterans who need prosthetics services.

Also, the DUSHOM and PSAS officials in collaboration with the VISN 6 leadership and the VISN Prosthetics Representative will specify a monthly reporting process for the facility to report progress on implementation of the action plan to address concerns and improve prosthetics operations at the Durham VAMC. This reporting is expected to continue until VHA Central Office leadership verifies that changes are in place and well established.

Status: Implementation of this recommendation is still in progress.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Anthony Murray Leigh, CPA, Project Leader Cathleen King, MHA, CRRN, Team Leader Nelson Miranda, LISW Dr. Robert Yang, MD, Medical Consultant

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