

**STATEMENT OF
OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
REVIEW OF THE CURRENT CAPABILITIES OF THE
DEPARTMENT OF VETERANS AFFAIRS TO DELIVER
STATE-OF-THE-ART CARE TO VETERANS WITH AMPUTATIONS
MAY 16, 2012**

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to discuss the results of recent Office of Inspector General (OIG) reports on prosthetic issues dealing with the delivery of care, and contracting and supply issues¹. Based on the Committee's interest in VA's capabilities to deliver state-of-the-art prosthetic limb care, we conducted one review of VA's delivery of prosthetic limb care in its facilities and two audits related to contracting and supply issues. The OIG is represented by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections; Dr. Robert Yang, Physician, Office of Healthcare Inspections, OIG; Mr. Nicholas Dahl, Director of the OIG's Bedford Office of Audits and Evaluations; and Mr. Kent Wrathall, Director of the OIG's Atlanta Office of Audits and Evaluations. The population analysis of veterans with prosthetic limbs was performed under the direction of Limin Clegg, PhD.

BACKGROUND

Prosthetics include limbs, sensory aids, durable medical equipment, and orthotic appliances, parts or accessories required to replace, support, or substitute an anatomical portion of the body. In addition to artificial limbs, VA considers scooters, wheelchairs, telehealth equipment, braces, watches, and implantable devices such as heart valves and stents as prosthetics. From fiscal year (FY) 2007 through FY 2011, the Veterans Health Administration's (VHA) prosthetic costs increased from \$1.0 billion to \$1.8 billion. VA maintains an inventory for most prosthetics items. For some prosthetic items, such as artificial limbs, VA Medical Centers (VAMC) do not maintain inventories and instead order these items as needed for individual patients.

VA uses two automated inventory systems to manage prosthetic inventories. Prosthetic and Sensory Aids Services (PSAS) uses the Prosthetic Inventory Package (PIP) to manage the majority of prosthetic inventories. Supply Processing and Distribution (SPD) Services uses the Generic Inventory Package (GIP) to manage prosthetic supplies stored in Surgery Service and medical supply inventories.

¹ *Healthcare Inspection – Prosthetic Limb Care in VA Facilities*, March 8, 2012; *Veterans Health Administration – Audit of the Management and Acquisition of Prosthetic Limbs*, March 8, 2012; *Veterans Health Administration – Audit of Prosthetics Supply Inventory Management*, March 30, 2012.

Three VA Central Office organizations have responsibilities related to prosthetic inventory management. VHA's PSAS develops policies and procedures for providing prosthetics to veterans. VHA's Procurement and Logistics Office (P&LO) provides VAMCs logistics support and monitors compliance with inventory management policies and procedures. VA's Office of Acquisition, Logistics, and Construction supports VAMCs in acquiring and managing supplies and offers training to VA's acquisition professionals.

HEALTHCARE INSPECTION – PROSTHETIC LIMB CARE IN VA FACILITIES

While the majority of the amputations performed by VA are for older patients with diabetes and poor circulation, we focused on those veterans who had one or more major amputations as a result of injuries sustained during Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND). This group of veterans is a growing and considerably younger group that poses a different set of challenges to VA with regards to prosthetic services.

In order to assess VA's capacity to deliver prosthetic care, we reviewed VA credentialing requirements for prosthetists and orthotists; the demand for health care services; and psychosocial adjustments and activity limitations of OEF/OIF/OND veterans with amputations and their satisfaction with VA prosthetics services. We found that VA prosthetics staff were appropriately certified; that veterans with amputations are a complex population who are significant users of VA health care services including non-prosthetic services; and that veterans adjusted to life with their artificial limbs as well as those in the civilian population.

Demand for Health Care Services

Veterans with a major amputation differ significantly from their peers. To identify how they differ, we examined the records of almost 500,000 veterans who separated from the military from July 1, 2005, to September 30, 2006, for their experience transitioning to VA and using VA health care and compensation benefits through September 30, 2011. We compared frequency of diagnosis for veterans with traumatic major amputations with their non-amputated counterparts in this veteran population. In our analysis, we found that veterans with amputations used significantly more health care services and that this difference held true in every major disease category we examined, not just for prosthetic-related services, traumatic brain injury, or post-traumatic stress disorder (PTSD) issues. This group also had a higher frequency of service-connected disability and higher service-connected disability ratings. Veterans with amputations are more likely to receive medical care at a VA facility than their counterparts.

Assessment of Veterans with a Major Amputation

With the assistance of the Department of Defense (DoD) Inspector General, we acquired the DoD amputee list from TRICARE and Walter Reed National Military Medical Center staff. This list contained 1,288 living service members who served in OEF/OIF/OND with major amputations that occurred during active duty as of August 17, 2011. As of September 30, 2011, 838 (65 percent) of the 1,288 in the DoD

OEF/OIF/OND amputee population were discharged from active military service (veterans) and were our population of interest.

Over 98 percent of this group of amputees were male. The average (mean) age when the service member was injured was 25 years old. Seventy-six percent of them served in the Army, and 20 percent in the Marines. Ninety-three percent of all amputees were enlisted service members. Seventeen percent had served in OEF while 84 percent served in OIF/OND. Seventy-four percent lost one limb, 25 percent lost two limbs, and 1 percent lost three or four limbs. Fifty-eight percent were diagnosed with PTSD after their discharge from military service. Thirty-five percent had a diagnosis of a mood disorder, and 15 percent had a diagnosis of substance abuse.

Daily Living

To assess how well veterans were doing, we conducted in-person visits to a statistically representative sample of the OIF/OEF/OND veterans with at least one lower extremity amputation and as many veterans with upper extremity amputations as we could. The responses of many of the veterans were inspiring as many of them—80 percent of those with upper extremity amputations and 90 percent of those with lower extremity amputation—reported that their lives were full. Many of the amputees also reported that they had adjusted to their prosthetic limb and did not mind people asking them about it.

Most veterans were able to engage in their social relationships and reported that visiting friends and maintaining friendships was not limited at all. However, the majority also noted that they were more dependent on others than they would like to be and that they were limited in the kind of work that they could do. When asked about activity limitations, most veterans reported limitations with vigorous activities such as running, lifting heavy objects, and sports. Working on hobbies was problematic for those with upper extremity amputations while walking for a mile was difficult for those with lower extremity amputations.

Among those veterans who were working, the ranges of limitation for “going to work” were similar between lower limb and upper limb only amputees. Veterans also have adapted to living with pain. For veterans with lower extremity amputations, many veterans expressed limitations based on pain tolerance and complications, such as skin breakdown.

Satisfaction with the prosthetic was assessed by asking veterans to report on the fit, appearance, and reliability of their prosthesis. Over 90 percent of veterans with lower extremity prosthetics reported satisfaction in all three areas as well as being satisfied overall. Veterans with upper extremity amputations reported that their overall satisfaction with their prosthetics was just below 70 percent. Upper extremity prosthetic breakdown was reported by a greater proportion of veterans and occurred more frequently.

While veterans with upper extremity amputations reported limitations with individual activities, most veterans have adapted their overall routine to minimize challenging

activities as most report no or mild difficulty with regular daily activities or normal social activities. These veterans' loss of upper extremity function is similar to the general public with unilateral upper extremity amputations.

Veteran Assessment of VA Prosthetic Care Delivery

We asked veterans open-ended questions about what the VA did well and what they could improve on. While veterans praised their experiences with VA, they also noted areas where the VA should improve on the delivery of prosthetic services. Some of the veterans we interviewed reported experiencing such poor service that they avoid using VA care by using other health insurance, participating in research studies, or discontinuing prosthetic use.

A common complaint by veterans using prosthetic limbs dealt with the facility approval process for obtaining prosthetics through fee-basis and contract care. Many felt that the VA process should be simplified, streamlined, and require fewer visits to get approval for a new prosthetic or major repair. Participants also expressed concerns about the length of time and reliability of paperwork for processing prosthetics requests, particularly between the VA and outside vendors. Several veterans reported that they had to facilitate this paperwork to obtain their prosthetics.

Veterans also reported difficulties with accessing prosthetic services at VAMCs due to drive times, wait times, and unavailability of prosthetic experts. Some veterans noted that their busy schedules made any appointment a major inconvenience and were unsure whether the VA was sensitive to this issue. Others reported that rescheduling a VA appointment could be challenging as schedules could be full and the appropriate clinic might be held infrequently.

Veterans also reported that VA personnel were unfamiliar with their prosthetics or did not have access to or expertise with the latest technologies. This was particularly reported by those with upper extremity prosthetics. One veteran stated his frustration from having to educate VA staff about his prosthetic and the overall needs of veterans with amputations.

Recommendations

Our report contained three recommendations for the Under Secretary for Health:

- Consider the wide-ranging medical needs of traumatic amputees beyond the prosthetic and mental health concerns identified in this report; then adjust, if necessary, the provision and management of health care services accordingly.
- Consider that VHA evaluate the needs of veterans with traumatic upper limb amputations to improve their satisfaction.
- Consider veterans' concerns with the approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations.

The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

AUDIT OF THE MANAGEMENT AND ACQUISITION OF PROSTHETIC LIMBS

In this report, we evaluated VHA's management and acquisition practices used to procure prosthetic limbs, and examined the costs paid for prosthetic limbs.

Overpayments for prosthetic limbs were a systemic issue at all 21 Veterans Integrated Service Networks (VISNs). Overall, we identified opportunities for VHA to: improve controls to avoid overpaying for prosthetic limbs; improve contract negotiations to obtain the best value for prosthetic limbs purchased from contract vendors; and identify and assess the adequacy of in-house prosthetic limb fabrication capabilities to be better positioned to make decisions on the effectiveness of its labs.

Improved Internal Controls Needed

We reported VHA's PSAS needed to strengthen payment controls for prosthetic limbs to minimize the risk of overpayments. We identified overpayments in 23 percent of all the transactions paid in FY 2010. VHA overpaid vendors about \$2.2 million of the \$49.3 million spent on prosthetic limbs in FY 2010. VHA could continue to overpay for prosthetic limbs by about \$8.6 million over the next 4 years if it does not take action to strengthen controls. On average, VHA overpaid about \$2,350 for each of these prosthetic limb payments. Overpayments generally occurred because VHA paid vendor invoices that included charges in excess of prices agreed to in the vendors' contracts with VA. Strengthening controls to ensure invoices submitted by vendors are consistent with contract terms should and can be accomplished without compromising the quality of the prosthetic limbs provided to veterans.

At the four VISNs we visited (VISN 1, 8, 12, 15²), we found that Contracting Officer's Technical Representatives (COTRs) either did not conduct reviews of prosthetic limb invoices or conducted only limited reviews of invoices. Instead, Prosthetic Purchasing Agents were reviewing vendor quotes, creating purchase orders, and reviewing invoices prior to making final payments. This is contrary to the Government Accountability Office's *Standards for Internal Controls in Federal Government* that require key duties and responsibilities be divided to reduce the risk of error or fraud.

Actions Needed to Ensure the Best Value When Procuring Prosthetic Limbs

We found that VISN Contracting Officers were not always negotiating to obtain better discount rates with vendors and some items were purchased without specific pricing guidance from either the Procurement and Logistics Office or PSAS. To illustrate, one VISN we reviewed had a strategy to ensure that they received a discount on prosthetic related contracts of at least 10 percent. Another VISN that was reviewed only obtained an average discount of 8 percent; if they followed the other VISN's lead in seeking a minimum of a 10 percent discount from vendors, they could have saved about \$58,000 in FY 2010. Without negotiating for the best discount rates obtainable, VHA cannot be assured it receives the best value for the funds it spends to procure prosthetic limbs. We noted that while strengthening acquisition practices to ensure contracting officers consistently negotiate better discount rates should result in lower costs, it should in no way compromise the quality of prosthetic limbs procured.

² VISN 1 – New England Healthcare System; VISN 8 – VA Sunshine Healthcare Network; VISN 12 – VA Great Lakes Health Care System; VISN 15 – VA Heartland Network.

We also reported VA paid almost \$800,000 for about 400 prosthetic limb items using “not otherwise classified” (NOC) codes in FY 2010. NOC codes are used by VA to classify items that have not yet been classified or priced by Medicare. While this may not be a significant amount in aggregate, the prices paid for individual items that have not yet been classified can be significant. For example, absent pricing guidance VA was paying about \$13,700 for a type of Helix joint before it was classified. Once the item was classified, the price dropped to about \$4,300. To avoid situations like this, we reported VHA needed to develop guidance to help VISN staff determine reasonable prices for items that Medicare has yet to classify and price.

Improved Prosthetic Limb Fabrication and Acquisition Practices Needed

We did not identify information that showed either how many limbs specific VHA labs could fabricate or how many limbs they should be fabricating. PSAS management did not know the current production capabilities of their labs and could not ensure labs were operating efficiently. VHA guidance states that PSAS should periodically conduct an evaluation to ensure prosthetic labs are operating as effectively and economically as possible. We found that PSAS suspended their review of labs in January 2011 after reviewing only 9 of 21 VISNs. Because reviews of all VISNs were not conducted, PSAS was unaware of its in-house fabrication capabilities and management does not know if labs are operating as effectively and efficiently as possible.

We also reported VISN prosthetic officials did not always identify the appropriate number of contractors needed to provide prosthetic limbs to veterans. VHA guidance recommends three to five vendors receive contract awards depending on the geographic area and workload volume. However, three of four VISN prosthetic managers interviewed were under the assumption they were to award contracts to all vendors who responded to their solicitation, provided those vendors met VA’s criteria to qualify as a contract vendor. The VHA guidance conflicted with prosthetic limb contract guidance that states maximum flexibility be given to individual medical centers to determine the number of contracts required to meet their needs.

Due to the inconsistencies in guidance, differing procurement practices existed among the four VISNs visited. Three of the four VISNs did not identify an appropriate number of contract vendors and VISN contracting officers made awards to nearly all vendors that submitted proposals, many of which were located in the same general areas. As a result, overlaps and gaps in service existed and VISN contracting staff may have been performing unnecessary contract work. Additionally, VHA could not be assured the decision to make contract awards was effectively aligned with workload volume or with what individual medical centers required to meet their needs in serving patients.

Use of VA’s Electronic Contract Management System (eCMS) Needs to Improve

Use of eCMS is mandatory for all procurement actions valued at \$25,000 or more. We found that contracting officers did not consistently use eCMS to document contract awards to prosthetic limb vendors. Nearly all of the eCMS contract files for awards made to vendors at the four VISNs visited were missing key acquisition documentation.

Missing documentation included evidence of required oversight reviews and determinations of responsibility of the prospective contractors through a check of the Excluded Parties List System. Further, contract invoices were not included in eCMS. As a result, we could not readily verify whether a COTR had reviewed vendor invoices prior to certification to ensure they accurately reflected that goods received were in accordance with contract requirements, including prices charged.

Recommendations

We made eight recommendations to the Under Secretary of Health. They include strengthening controls over the process for reviewing vendor quotes, purchase orders, and verification of invoices and costs charged by prosthetic limb vendors. In conjunction with this, we recommended VHA take collection action to recover the \$2.2 million overpaid to vendors. We also made recommendations to ensure contracting officers conduct price negotiations to obtain the best value for prosthetic limb items. In addition, pricing standards need to be established and an assessment of the capabilities of VHA's prosthetic labs needs to be conducted. The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

AUDIT OF VHA'S PROSTHETICS INVENTORY MANAGEMENT

This report provides a comprehensive perspective of the suitability of VHA's prosthetic supply management policies. In assessing VAMC prosthetic inventory management, VHA agreed that inventories maintained above the 30-day level would be considered excessive unless there was evidence VAMCs needed a higher inventory level to meet replenishment and safety requirements. VHA also agreed prosthetic inventory levels of 7 days or less would create a risk of supply shortages.

We found VHA needs to strengthen VAMC management of prosthetic supply inventories to avoid disruption to patients, to avoid spending funds on excess supplies, and to minimize risks related to supply shortages. Further, because of weak inventory management practices, losses associated with diversion could go undetected. VHA needs to improve the completeness of its inventory information and standardize annual physical inventory requirements.

Inventory Systems Are Not Integrated

VAMC inventory managers need real-time information from VA's Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) and its Computerized Patient Record System (CPRS) to keep PIP quantities accurate and manage prosthetic inventories effectively. However, VHA's PIP does not integrate with IFCAP and CPRS. As a result, when warehouse staff record received supplies in IFCAP and when clinical staff record used supplies in CPRS, PIP is not automatically updated. Consequently, staff must manually record all supplies received and used in PIP. This work is labor-intensive and reduces the time staff have to actively manage supply inventories, and introduces errors into these systems.

Inefficiencies from Using Two Inventory Systems

VHA policies require VAMCs to use PIP to manage prosthetic supplies and GIP to manage surgical device implants (SDIs). VAMCs use of two inventory systems caused staff confusion about the responsibility for managing SDI inventories and created inefficiencies in managing SDIs stored in Surgery Service closets, crash carts, and operating rooms. As a result, VAMCs did not use either PIP or GIP to manage about 7,000 (28 percent) of 25,000 SDIs. The estimated inventory value for these items was almost \$8 million. By replacing PIP and GIP with one automated system, VHA can help VAMCs manage these inventories and avoid excess prosthetic inventories and shortages.

Inadequate Staff Training

Inadequate training was a major cause of VAMCs accumulating excess inventory and experiencing supply shortages. VHA's *Inventory Management Handbook* requires staff to receive training from qualified instructors on basic inventory management principles, practices, and techniques and how to use PIP and GIP effectively. However, staff at the six VAMCs³ we visited had not received training from qualified instructors. Because staff did not receive adequate training, they did not consistently apply basic inventory management practices and techniques.

VHA requires VAMCs to conduct annual wall-to-wall inventories of quantities on hand with inventory accuracy rates of at least 90 percent. However, none of the six VAMCs we audited had the required documentation of physical inventories. VAMCs' failure to consistently conduct and document physical inventories was also a contributing cause of reporting inaccurate quantities on hand. When VAMCs do not keep quantities on hand current, the automated inventory systems cannot accurately track item demand, which VAMCs must know in order to establish reasonable stock levels.

Insufficient Oversight

Insufficient VHA Central Office and VISN oversight contributed to VAMCs maintaining excess inventory and supply shortages. VHA's *Inventory Management Handbook* states that GIP will be the source of reported inventory data and lists seven performance metrics VAMCs must report every month. However, because the Handbook does not specifically require VAMCs to extract performance metric data from PIP, VAMCs did not report the required performance metrics for prosthetic inventories.

In addition, VHA's Handbook does not sufficiently define the role of VISN prosthetic representatives' (VPRs) inventory oversight responsibilities. The VPRs, who had jurisdiction over the audited VAMCs, stated they conducted VAMC site visits. However, the frequency of the site visits varied from quarterly to annually and during the site visits VPRs did not consistently perform a complete assessment of prosthetic supply inventory management.

³ VA Medical Centers in Decatur, Georgia; Indianapolis, Indiana; Northampton, Massachusetts; Nashville and Murfreesboro, Tennessee; Salem, Virginia; Clarksburg, West Virginia.

VHA Handbook Inadequacies

Although VHA's *Inventory Management Handbook* provided a reasonable foundation for VAMC management of prosthetic supplies, the Handbook needed more guidance to ensure VAMCs do not accumulate excess supplies or experience supply shortages. We identified several Handbook inadequacies VHA must improve to help ensure VAMCs maintain reasonable inventory levels. For example, the Handbook did not have clear guidance on establishing normal, reorder, and emergency stock levels or timeliness standards for recording supplies received and used in PIP and GIP. A comprehensive and clear Handbook is an essential VHA control to ensure proper stewardship and accountability of VAMC prosthetic inventories.

Recommendations

Our report included recommendations for VISN and VAMC directors to eliminate excess prosthetic inventories and avoid prosthetic shortages, develop a plan to implement a modern inventory system, and strengthen management of prosthetic supply inventories. In addition, we recommended VHA officials collaborate with the Executive Director, Office of Acquisition, Logistics, and Construction, to develop a training and certification program for prosthetic supply inventory managers. The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

CONCLUSION

Veterans with amputations are a complex group of patients with specialized needs both medically and administratively. There are opportunities to improve the prosthetic and medical care that VA delivers to these individuals. While overall veterans with amputations have had positive experience with VA, there is room for improvement in the delivery of prosthetic services.

Administratively, until VHA strengthens management and acquisition practices to procure and fabricate prosthetic limbs, VA will not have assurances that its practices are as effective and economical as possible. Furthermore, VHA must increase its inventory system capabilities, provide staff training, implement sufficient oversight, and establish adequate policies and procedures. By taking these actions, VHA will reduce the risk of spending taxpayer dollars on excess prosthetic supply inventories and disrupting patient care caused by supply shortages.

Madam Chairwoman, thank you for the opportunity to discuss our work. We would be pleased to answer any questions that you or other members of the Subcommittee may have.