



Department of Veterans Affairs Office of Inspector General

Audit of the Veterans Health Administration's Home Respiratory Care Program

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Table of Contents

	Page
Executive Summary	i
Introduction	1
Purpose.....	1
Background.....	1
Scope and Methodology	2
Results and Conclusions	4
Home Respiratory Care Program Administration Needs Strengthening.....	4
Home Respiratory Care Program Contract Administration Needs Improvement.....	10
Appendixes	
A. Summary of Home Respiratory Care Program Monitoring and Evaluation Deficiencies by Medical Facility	15
B. Sampling Methodology.....	16
C. Monetary Benefits in Accordance with IG Act Amendments.....	18
D. Under Secretary for Health Comments.....	19
E. OIG Contact and Staff Acknowledgments.....	29
F. Report Distribution	30

Executive Summary

Introduction

The Office of Inspector General (OIG) conducted an audit to evaluate the efficiency and effectiveness of the Veterans Health Administration's (VHA) Home Respiratory Care Program (HRCP). Our objectives were to determine whether VHA medical facilities effectively administered the HRCP in accordance with VHA policies and effectively monitored the program's durable medical equipment and services (DME) contracts.

VHA's Prosthetics and Sensory Aids Service (PSAS) provides veterans with DME items such as beds, wheelchairs, walkers, and home oxygen therapy equipment and supplies. These equipment and supply items serve patients' medical needs during an illness or injury and provide sufficient durability to address long-term patient needs. In VHA, the Prosthetics and Clinical Logistics Office (P&CLO) generally oversees PSAS' DME procurement and utilization, but medical facilities administer the HRCP locally to provide eligible VA patients home oxygen and respiratory services. Annually, approximately 194,000 VA patients receive HRCP services to treat respiratory problems associated with chronic obstructive pulmonary disease, spinal cord injuries, and other serious medical conditions valued at about \$157 million.

Local Acquisition and Materiel Management, Medical, Pharmacy, and PSAS staff work with Joint Commission certified or compliant DME vendors to provide home oxygen and respiratory care equipment and services. VHA policy requires Chiefs of Staff (COSs), the Chiefs of PSAS, the Chiefs of Pulmonary, and prescribing physicians at the medical facilities to perform local HRCP oversight functions and to ensure that patients receive quality HRCP care in accordance with VHA policy and Joint Commission standards. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) accredits or certifies nearly 15,000 health care organizations and programs in the United States, including VA facilities. Receipt of Joint Commission accreditation is nationally recognized as a symbol of quality and a reflection of an organization's commitment to meeting Joint Commission performance standards.

Medical facility staff manage the HRCP patients' care and procure the patients' prescribed home oxygen systems, oxygen tank refills, and ancillary items such as disposable masks and hoses from DME vendors. In keeping with Office of Management and Budget (OMB) guidance on internal controls and the reduction of improper payments, VHA HRCP policy and various VA acquisition policies require medical facility staff to maintain supporting documentation for purchases and verify the need for HRCP DME purchases, the receipt of equipment and services, and the accuracy of bills. In fiscal year (FY) 2007, VHA officials expected the HRCP to serve about 219,000 HRCP patients and to expend about \$175 million of PSAS' total budget of \$1.23 billion.

Results

Medical facilities needed to strengthen HRCP oversight and contract administration to ensure the delivery of quality care and services and to reduce unsupported and improper payments. Our audit found that COSs had not established Home Respiratory Care Teams (HRCTs) or completed quarterly program reviews as required by VHA policy. Moreover, the COSs, Chiefs of Pulmonary, Chiefs of PSAS, and prescribing clinicians did not ensure the timely and consistent completion of patient reevaluations, patient home visits, and vendor quality assurance visits. Because patient reevaluations were not completed, a number of facilities issued home oxygen equipment and services to patients with expired prescriptions in violation of the Federal Food, Drug, and Cosmetics Act (21 United States Code (U.S.C.), Section 353). Consequently, VHA had no assurance that HRCP patients received the quality of care and services prescribed by VHA policy and Joint Commission standards or that medical facilities fully complied with Federal prescription laws.

Medical facilities also needed to strengthen HRCP DME contract administration controls. While reviewing HRCP purchases made under contract, we found facility staff did not always ensure patients had prescriptions or other medical record documentation to support DME purchases. Contracting Officer's Technical Representatives (COTRs) certified vendors' DME payments even though they lacked invoices and delivery tickets to verify the delivery of the purchased items. In some cases, patients had passed away or relocated and could not have received the items, and the vendors' billed prices did not match the contract prices. Many of the reviewed HRCP DME purchases lacked supporting documentation required by the VHA Government Purchase Card Program policy although follow-up work conducted during our audit confirmed that the majority of the purchased items had been received.

In total, our review of a statistical sample of 650 HRCP purchase transactions identified 77 (12 percent) transactions with contract administration deficiencies and \$6,152 in unsupported costs and improper payments. Medical facility staff reported that deficiencies in the administration of the HRCP, the program's DME contracts, and documentation of Government purchase card purchases occurred because they either lacked the time and resources to meet VHA requirements or they were not familiar with the requirements. Based on our sample results and a 90 percent confidence level, we project that VHA had about \$3.4 million in unsupported costs and improper payments during our 12-month review period and that an estimated \$16.8 million in unsupported costs and improper payments could occur over the next 5 years if HRCP DME contract administration practices are not strengthened.

Conclusion

VHA does not have adequate assurance that patients are receiving quality HRCP care and services because staff at medical facilities are not complying with VHA policy and adequately monitoring and evaluating HRCP operations, patients, and vendors. In addition, VHA needs to strengthen compliance with current HRCP prescription requirements and generally improve HRCP DME contract administration and Government purchase card practices in order to prevent \$16.8 million in unsupported costs and improper payments.

Recommendations

1. We recommended that the Under Secretary for Health evaluate why medical facilities have not complied with HRCP administrative policies and procedures and develop an action plan and national monitoring mechanism to improve compliance.
2. We recommended that the Under Secretary for Health provide training to prescribing physicians and other appropriate medical facility staff on HRCP administrative policies and procedures to ensure they understand the program's requirements.
3. We recommended that the Under Secretary for Health establish management controls to ensure compliance with existing HRCP DME prescription and medical documentation requirements.
4. We recommended that the Under Secretary for Health strengthen HRCP DME contract administration procedures to ensure the verification of HRCP DME deliveries and the accuracy of invoices before payment certification and the maintenance of required supporting purchase documentation.
5. We recommended that the Under Secretary for Health provide refresher COTR and Government purchase card training to appropriate PSAS staff.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and recommendations of the report and provided acceptable implementation plans. (See Appendix D, pages 19–28, for the full text of the Under Secretary's comments.) The Under Secretary also agreed with our estimated monetary benefits. The Under Secretary outlined plans to evaluate why medical facilities have not fully complied with HRCP administrative policies and procedures and to strengthen procedures to ensure future compliance. Additionally, refresher training on VHA Handbook 1173.13, Clinical Practice Recommendations (CPR), the Home Oxygen Module user guide, and other VHA guidance or policy pertaining to the HRCP will be given to the appropriate staff. The Under Secretary also

agreed to establish better management controls to ensure compliance with existing HRCP DME prescription and medical documentation requirements, strengthen contract administration procedures to ensure the verification of HRCP DME deliveries and the accuracy of invoices before payment certification, and provide refresher COTR and Government purchase card training to appropriate PSAS staff. We incorporated technical comments provided by the Under Secretary into the report as appropriate. We will follow up on the implementation of the planned improvement actions.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Auditing

Introduction

Purpose

The purpose of the audit was to evaluate the efficiency and effectiveness of VHA's HRCF. The objectives were to determine whether medical facilities effectively administered the HRCF in accordance with VHA HRCF policies and monitored HRCF DME contracts.

Background

VHA's PSAS provides veterans with DME items such as beds, wheelchairs, walkers, and home oxygen therapy equipment and supplies. In VHA, the P&CLO generally oversees PSAS' DME procurement and utilization, but medical facilities administer the HRCF locally to provide eligible VA patients home oxygen and respiratory services. Local Acquisition and Materiel Management, Medical, Pharmacy, and PSAS staff work with DME vendors to provide home oxygen and respiratory care equipment and services. Annually, approximately 194,000 VA patients receive HRCF care to treat respiratory problems associated with chronic obstructive pulmonary disease, amyotrophic lateral sclerosis, lung cancer, spinal cord injuries, and other serious medical conditions.

VHA requires the COS, the Chief of PSAS, the Chief of Pulmonary, and prescribing clinicians at the medical facilities to perform local HRCF oversight functions. The COS must coordinate all of the medical disciplines required to treat HRCF patients and complete quarterly reviews of the HRCF. These reviews ensure that the different medical disciplines work effectively together and the identification of possible HRCF quality assurance initiatives. The Chiefs of PSAS, who administer the HRCF and typically function as the COTRs for the facilities' HRCF DME contracts, manage purchases, certify payments, and monitor HRCF DME contract performance through vendor quality assurance visits and patient home visits. Finally, the Chiefs of Pulmonary and prescribing physicians identify and periodically reevaluate HRCF patients to ensure their DME needs are medically justified, and coordinate with PSAS to ensure patients receive the proper DME for their conditions.

Effective HRCF oversight ensures that patients receive quality HRCF care in accordance with VHA policy and Joint Commission standards. The Joint Commission evaluates and accredits nearly 15,000 health care organizations and programs in the United States, including VA medical facilities. Joint Commission accreditation is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting Joint Commission performance standards.

Medical facility staff coordinate and manage the HRCF patients' care, medical facilities but generally procure the patients' prescribed home oxygen systems, oxygen tank refills, and ancillary items such as disposable masks and hoses from Joint Commission certified

or compliant DME vendors. To comply with OMB Circular A-123 guidance which requires the establishment of internal controls and the reduction of improper payments, VHA HRCF policy and various VA acquisition policies require medical facility staff to maintain supporting documentation for purchases and verify the need for HRCF DME purchases, the receipt of equipment and services, and the accuracy of bills.

In FY 2006, HRCF expenditures totaled about \$157 million or 14.2 percent of PSAS's total expenditures of \$1.1 billion. During this period, VHA spent about \$54.1 million on new oxygen and respiratory care equipment items and \$102.7 million on oxygen and respiratory equipment repairs, consisting primarily of oxygen tank refills. While final FY 2007 program performance information was not available when we concluded our audit, the number of HRCF patients was expected to increase by 13 percent to 219,000, and HRCF spending was expected to increase to about \$175 million of PSAS's projected \$1.23 billion budget.

Scope and Methodology

To address the audit objectives, we assessed compliance with applicable national and local VHA policies on the administration of the HRCF. We also interviewed VHA program officials and local managers at medical facilities to gain an understanding of the HRCF. We evaluated patient health records for compliance with program requirements to ensure that the patient's eligibility, reevaluations, and prescriptions were properly documented by prescribing clinicians. In addition, we reviewed supporting documentation such as purchase orders, vendor invoices, and delivery tickets for HRCF equipment item and service purchases to determine if COTRs effectively monitored HRCF DME contracts.

We contacted and visited medical facilities during our audit from the period, September 2006, through May, 2007. We reviewed available HRCF National Prosthetic Patient Database (NPPD) transaction (the purchase of a HRCF equipment item or service) information for the 12-month period, June 1, 2005, through May 31, 2006, and reviewed program and contract administration practices for the 2-year period, January 1, 2005, through December 31, 2006, which encompasses the reviewed transactions. During our review period, 131 medical facilities initiated over 1.58 million individual HRCF DME purchase transactions valued at \$117.2 million.

We used a two-stage statistical sample where the individual medical facility served as the primary sampling unit and the individual HRCF transaction served as the secondary sampling unit. For a 90 percent confidence level, we randomly selected 13 medical facilities and 50 HRCF DME transactions from each facility, or a total of 650 HRCF NPPD transactions, for review. (See Appendix B, pages 16–17, for a detailed description of our sampling methodology.)

We visited 6 of the randomly selected sites to evaluate compliance with HRCP administrative policies and reviewed 50 HRCP NPPD transactions for each of the 13 sites either on site or remotely from our office to determine if the medical facilities effectively administered HRCP DME contracts. Access to VHA's Computerized Patient Record System (CPRS) also allowed us to assess the timeliness of HRCP patient reevaluations remotely. Table 1 displays the randomly selected sites and the type of review completed.

Table 1. List of Onsite and Remote Reviews by Medical Facility

Onsite and Remote Reviews	Remote Reviews
Atlanta VA Medical Center (Atlanta VAMC)	Aleda E. Lutz VA Medical Center (Saginaw VAMC)
James A. Haley Veterans' Hospital (Tampa VAMC)	Birmingham VA Medical Center (Birmingham VAMC)
Southeast Louisiana Veterans Health Care System (Southeast Louisiana HCS)	Boise VA Medical Center (Boise VAMC)
Southern Arizona VA Health Care System (Southern Arizona HCS)	Edith Nourse Rogers Memorial Veterans Hospital (Bedford VAMC)
VA Palo Alto Health Care System (Palo Alto HCS)	Martinsburg VA Medical Center (Martinsburg VAMC)
VA San Diego Healthcare System (San Diego HCS)	Sioux Falls VA Medical Center (Sioux Falls VAMC)
	VA Roseburg Healthcare System (Roseburg HCS)

To evaluate HRCP DME contract administration practices, we verified the accuracy of HRCP DME invoices and payment amounts, the delivery of purchased HRCP equipment items, and the existence of adequate supporting documentation for the purchases in the medical facilities' computerized patient, procurement, and financial management records. To test the reliability of the computerized records, we compared relevant electronic data with source documentation provided by the medical facility. We found the NPPD and other computer-generated data used to verify the HRCP DME purchase transactions to be sufficiently reliable for our audit objectives.

Our assessment of internal controls focused only on those controls related to our audit objectives. We conducted our audit in accordance with generally accepted government auditing standards.

Results and Conclusions

Home Respiratory Care Program Administration Needs Strengthening

Findings

Medical facilities need to improve HRCP administration to promote the delivery of quality HRCP care and services and compliance with VHA policy. Medical facilities did not consistently follow VHA HRCP requirements that ensure the timely and adequate evaluation of the program's operations, patients, and vendors. Medical facility staff generally reported that these lapses in HRCP administration occurred because they were not aware of the program requirements or they lacked the resources to fully comply with the requirements. As a result, VHA does not have adequate assurance that HRCP patients receive the quality of care and services prescribed by VHA policy and Joint Commission standards or that the HRCP consistently complies with Federal prescription laws.

Facilities Need To Improve Program Monitoring. COSs at the medical facilities did not ensure the adequate monitoring and evaluation of the HRCP. VHA policy requires a COS to establish a HRCT that consists of a respiratory care physician and therapist, a PSAS representative, and staff from Pharmacy, Nursing, and Quality Management to monitor the program. The HRCT reviews all HRCP operations including program needs and resources to ensure patients receive quality care and the proper HRCP equipment items and services. VHA policy also requires the COS or a designee to review the program on a quarterly basis and to advise the HRCT of any quality assurance initiatives that need to be implemented. Some facilities said that they had not established HRCTs and performed the required quarterly program reviews because they were not aware of these requirements.

Three (50 percent) of the six facilities we visited had not established HRCTs prior to the start of our audit. (One facility did not establish a HRCT until December 2006 when it was notified of our audit and planned site visit). In addition, 4 (67 percent) of the 6 facilities did not complete 26 (81 percent) of the 32 required quarterly reviews during our 2-year review period in accordance with VHA policy. Table 2 shows whether medical facilities we visited had a HRCT and completed all of the required quarterly program reviews.

Table 2. Establishment of HRCT and Completion of Quarterly HRCP Reviews by Medical Facility

Medical Facility	HRCT Established	Completed All Quarterly Reviews	Missing Quarterly Reviews
Atlanta VAMC	Yes	Yes	0
Palo Alto HCS	No	No	8
San Diego HCS	Yes	No	8
Southeast Louisiana HCS	No	Yes	0
Southern Arizona HCS	Yes	No	2
Tampa VAMC	No	No	8
Total Number of Exceptions	3	4	26

One medical facility missed two of its quarterly reviews because staff did not reschedule two reviews that had been previously canceled. At those medical facilities that did not establish HRCTs and/or complete any of the required quarterly reviews, the COSs stated that they were not aware of these HRCP requirements.

Patient Reevaluations Need To Be Promptly Performed. The COSs and Chiefs of Pulmonary did not ensure that prescribing clinicians promptly completed HRCP patient reevaluations as required by VHA policy. The policy requires each HRCP patient to have an initial reevaluation within 6 months of entering the HRCP and an annual reevaluation to assess the patients' continued need for home oxygen therapy. VHA's Prosthetic Clinical Management Program Practice Recommendations specifically require trained individuals experienced in home oxygen evaluation and treatment to complete these assessments in a clinical setting. Nevertheless, the COSs, Chiefs of Pulmonary, and prescribing physicians did not consider the initial and annual HRCP patient reevaluations to be a high priority.

For the 650 reviewed HRCP patients, 197 (30 percent) had not been reevaluated within 6 months of entering the HRCP, and 160 (25 percent) lacked timely annual reevaluations. Table 3 summarizes our review results for 50 HRCP patients reviewed at each of the reviewed facilities.

Table 3. Initial and Annual Patient Reevaluations by Medical Facility

Medical Facility	Missing Initial Patient Reevaluations	Percentage of Missing Initial Patient Reevaluations	Delayed Annual Reevaluations	Percentage of Delayed Annual Reevaluations
Atlanta VAMC	6	12	50	100
Bedford VAMC	26	52	0	0
Birmingham VAMC	36	72	0	0
Boise VAMC	12	24	15	30
Martinsburg VAMC	16	32	28	56
Palo Alto HCS	50	100	30	60
Roseburg HCS	0	0	2	4
Saginaw VAMC	3	6	0	0
San Diego HCS	0	0	0	0
Sioux Falls VAMC	17	34	7	14
Southeast Louisiana HCS	16	32	5	10
Southern Arizona HCS	5	10	8	16
Tampa VAMC	10	20	15	30
Totals /Percentages	197	30	160	25

Summarized by medical facility, 11 (85 percent) of the 13 reviewed medical facilities had not completed all of the required initial reevaluations, and 9 (69 percent) of 13 had not completed timely annual reevaluations. Three of the nine medical facilities had significant timeliness problems where the period between the patients' reevaluations averaged 23, 27, and 29 months, respectively. In one case, 68 months elapsed between the patient's reevaluations.

Because of the significant lapses in the annual reevaluation of HRCF patients, these 9 medical facilities also violated Federal prescription laws when they issued home oxygen to 160 patients with expired prescriptions. The Federal Food, Drug, and Cosmetics Act (21 U.S.C Section 353) requires drugs intended for use under professional supervision of a practitioner be dispensed by written prescription from a practitioner licensed by law to administer the drug. Moreover, P&CLO officials noted that the absence of a valid prescription would have been inconsistent with Joint Commission home care standards that require care, treatment, and services to be provided under a physician's or other licensed independent practitioner's order.

During our site visits, medical facility staff agreed that home oxygen prescriptions must be renewed annually and that oxygen should not be dispensed without a valid medical prescription. However, they did not make HRCF patient reevaluations a high priority because of perceived high workloads, limited staffing, and resistance from the prescribing physicians. Prescribing physicians generally felt that they adequately

addressed the patients' HRCF needs during the patients' routine medical visits and that separate HRCF reevaluations were unnecessary. Medical facility staff acknowledged that they did not realize that so many HRCF patients were not receiving timely annual HRCF reevaluations.

Patient Home and Vendor Quality Assurance Visits Need To Be Completed. PSAS managers did not always complete annually required random visits to HRCF patients' homes and vendors' facilities. VHA policy requires the Chief of PSAS to schedule a minimum of 15 home visits annually so that multidisciplinary teams consisting of clinicians and PSAS staff can assess HRCF patients' use and storage of the HRCF DME and quality of vendor-provided services. In addition, VHA policy requires PSAS to perform quarterly quality assurance visits to HRCF DME vendors' facilities in order to monitor their operations and compliance with Joint Commission standards. Nonetheless, PSAS staff did not ensure the completion of these visits because of what they viewed as higher priority patient care needs at the medical facilities and a lack of resources.

VHA policy requires clinicians and PSAS staff to visit HRCF patients' homes to ensure the proper operation of home oxygen DME and education of the patient on the use of the equipment. During these home visits, staff check back-up oxygen systems, reserve oxygen cylinders, oxygen canister storage, the flow rate of the equipment, the placement of warning signs, and the availability of the vendors' emergency numbers. Similarly, PSAS managers must ensure that vendors store oxygen properly, properly maintain equipment and vehicles, comply with safety regulations, and have properly trained and certified employees during quarterly vendor quality assurance visits.

Despite the importance of these visits in ensuring the quality of HRCF patient care, we found that 4 (67 percent) of the 6 medical facilities had not completed 71 (39 percent) of the 180 required patient home visits during our 2-year review period. In addition, 3 (50 percent) of the 6 medical facilities had not performed 13 (27 percent) of the 48 required quarterly vendor quality assurance visits. Table 4 displays the results of our review by medical facility.

Table 4. Patient Home and Vendor Quality Assurance Visits by Medical Facility

Medical Facility	Missing Patient Home Visits	Percentage Missing Patient Home Visits	Missing Vendor Visits	Percentage of Missing Vendor Visits
Atlanta VAMC	3	10	2	25
Palo Alto HCS	24	80	0	0
San Diego HCS	17	57	0	0
Southeast Louisiana HCS	0	0	3	38
Southern Arizona HCS	0	0	0	0
Tampa VAMC	27	90	8	100
Totals/Percentages	71	39	13	27

We determined that the safety of 806 HRCP patients at 1 medical facility had been compromised because the medical facility had not completed several HRCP patient home visits and vendor quality assurance visits. (This medical facility also had not established an HRCT nor completed any of the required quarterly program reviews during our review period.) As a result, the medical facility did not learn of its HRCP vendor's serious performance problems and related patient safety deficiencies until the vendor notified the facility that it had received a preliminary denial of accreditation from the Joint Commission. Consequently, the medical facility's HRCP patients and its unqualified Joint Commission accreditation were at risk until it mitigated vendor-related patient safety issues and contracted with a different vendor.

In general, PSAS managers claimed that respiratory therapists or other qualified personnel were often unavailable to conduct required patient and vendor visits because they were needed by patients at the medical facility. One PSAS manager stated that staff sent out to the field to perform a home visit spent half a day benefiting only one patient. Nevertheless, they agreed that all patient and vendor visits needed to be completed and that they needed to do a better job of prioritizing and planning HRCP patient and vendor visits to ensure compliance with VHA policy.

Conclusion

VHA does not have adequate assurance that patients are receiving quality HRCP care and services because medical facilities are not complying with VHA policy and adequately monitoring and evaluating HRCP operations, patients, and vendors. VHA needs to evaluate and address the reasons why medical facilities have not complied with HRCP administrative monitoring and evaluation requirements. Moreover, medical facility management and staff need to comply with these requirements to promote the safety and well-being of HRCP patients and ensure compliance with applicable Joint Commission standards and Federal prescription laws. (For more information see Appendix A, page

15, for a summary of HRCP program monitoring and evaluation deficiencies for the six visited facilities.)

Recommendations

1. We recommended that the Under Secretary for Health evaluate why medical facilities have not complied with HRCP administrative policies and procedures and develop an action plan and national monitoring mechanism to improve compliance.

The Under Secretary for Health agreed with the recommendation and stated that the VHA P&CLO will survey the Chief Medical Officers (CMOs) to determine compliance with VHA HRCP policy. Additionally, the P&CLO, will implement national performance monitors to ensure all medical facilities establish HRCTs to: (1) review and adopt standards contained in the CPR for the Home Use of Supplemental Oxygen, (2) review the medical records of all new home oxygen patients for appropriate and complete medical documentation and compliance with CPR prescription criteria, (3) monitor and maintain CPR compliant home oxygen prescription renewal dates, and (4) conduct prescribed quarterly audits to ensure appropriate equipment delivery and the accurate billing of purchased supplies and services. We find the improvement plan acceptable, and we will follow up on the planned actions until they are completed.

2. We recommended that the Under Secretary for Health provide training to prescribing physicians and other appropriate medical facility staff on HRCP administrative policies and procedures to ensure they understand the program's requirements.

The Under Secretary for Health agreed with the recommendation and stated that P&CLO officials will collaborate, as needed, with the VA Employee Education System to provide all Veterans Integrated Service Network (VISN) Prosthetic Representatives with refresher training on VHA Handbook 1173.13, the CPR, the Home Oxygen Module user guide, and any other VHA guidance or policy pertaining to the HRCP. P&CLO officials will also discuss each of these documents with the CMOs to further familiarize them with the administrative policies and procedures, and this will be shared with all COSs to ensure adherence. We find the improvement plan acceptable, and we will follow up on the planned actions until they are completed.

Home Respiratory Care Program Contract Administration Needs Improvement

Findings

Medical facilities need to strengthen HRCF DME contract administration controls to ensure the purchase of only needed equipment and services and to prevent unsupported or improper payments. Improper payments include payments made to ineligible recipients or for ineligible services, duplicate payments, payments for services not received, payments made in the incorrect amount, and payments where it cannot be determined if they are proper due to insufficient documentation (OMB Circular A-123, Appendix C). To establish internal controls and reduce improper payments as required by OMB, VHA HRCF policy and various VA acquisition policies require medical facility staff to maintain supporting documentation for purchases and verify the need for purchases, the receipt of equipment and services, and the accuracy of bills. However, medical facility staff did not consistently meet these requirements because they reported they either lacked adequate time and/or resources or they were unaware of the requirements. Based on the results of our sample review, we projected that these contract administration lapses resulted in the certification of about \$3,353,554 in unsupported HRCF DME costs during our 12-month review period. Moreover, HRCF unsupported costs could equal \$16.8 million over the next 5 years if HRCF contract administration procedures are not strengthened.

Purchased HRCF DME Items Lacked Required Medical Documentation. PSAS staff ordered and COTRs approved payments for HRCF DME without verifying that the purchases were necessary and authorized thereby increasing the possibility of improper payments. VHA Handbook 1173.13 only allows the purchase of respiratory equipment for patients when it has been prescribed by a clinician in accordance with VHA policy and procedures. Nevertheless, 15 (2 percent) of 650 transactions totaling \$1,510 lacked prescriptions and documentation in the patient's medical record showing why these items were needed and issued to patients. These 15 transactions for Continuous Positive Airway Pressure (CPAP) items such as masks and chinstraps for airway pressure devices occurred at 3 (23 percent) of the 13 medical facilities.

The Chiefs of PSAS at the three medical facilities did not consider these purchases to be a problem because they did not believe that the issuance and purchase of every HRCF item and service needed to be documented and supported by a prescription. In addition, the Chiefs of PSAS stated that it was difficult to ensure that each individual CPAP item was properly documented and prescribed due to the large number of CPAP patients, volume of monthly CPAP items, and shortage of PSAS staff. However, we noted that the other 10 reviewed medical facilities did not have the same problem even though some had a larger number of CPAP patients. Besides increasing the risk of improper payments, the absence of required medical documentation and prescriptions posed a problem

because medical facilities had no assurance that the patients needed the purchased items and that the items had been issued in accordance with VHA policy.

PSAS Staff Did Not Verify HRCP Equipment Invoices and Deliveries. COTRs certified HRCP DME payments without verifying the accuracy of the invoices and the delivery of the equipment items to HRCP patients, which increased the risk of improper payments. In accordance with VA's COTR Handbook, HRCP COTRs must monitor vendor performance and verify that ordered DME have been delivered to patients and billed at the correct price before they certify payments. Nevertheless, 7 (54 percent) of the 13 medical facilities had unsupported costs or improper payments because of inadequate or inconsistent contract monitoring practices. The medical facilities' COTRs claimed that these problems occurred due to lapses in communications with the prescribing physicians, the volume of HRCP purchases, and their lack of familiarity with COTR requirements, even though the COTR designations, including duties and responsibilities, were communicated in writing from the contracting officers.

In total, we found the COTRs had not verified deliveries or the accuracy of prices for 62 (10 percent) of the 650 HRCP transactions totaling \$4,643:

- The COTRs and the HRCP DME vendors for three medical facilities could not provide documentation such as invoices or delivery tickets for 52 HRCP transactions totaling \$4,066 to show that the ordered HRCP DME had been delivered.
- COTRs at three medical facilities certified the payment of three HRCP transactions totaling \$279 although the DME could not have been delivered to three patients who had died or had relocated.
- COTRs at four medical facilities certified vendor invoices for payment that contained seven HRCP transactions totaling \$298 where the item prices did not match those listed in the HRCP contract.

We also identified other examples of unsupported costs or improper payments outside of our sample. At one medical facility, 68 patients had notified their prescribing clinicians that they had relocated and were no longer receiving HRCP DME. However, the Chief of PSAS still certified 1,088 HRCP DME transactions for \$61,987 in vendor payments related to these patients. Five medical facilities also had 79 HRCP transactions totaling \$6,364 where the COTRs certified payments for 8 patients who had died or relocated. In one case, the payments for a patient who had died 27 months earlier totaled \$3,007.

COTRs at the medical facilities stated that prescribing clinicians who documented status changes such as relocation or death in the medical records did not communicate the changes to PSAS. In addition, they acknowledged that they had not consistently verified the accuracy of invoices and deliveries of HRCP equipment items and services because

of the large volume of DME items purchased each month. Finally, some COTRs claimed they were unaware of contract monitoring requirements even though training records showed that they had attended VA-mandated COTR training.

PSAS Purchase Card Holders Did Not Maintain Required Supporting Documentation. PSAS purchase card holders at 9 (69 percent) of the 13 medical facilities did not follow VHA Government purchase card policy and maintain required supporting documentation for HRCP DME purchases. Of the sampled 650 HRCP DME transactions, 567 (87 percent) transactions totaling \$38,698 involved the use of a Government Purchase Card. Of the 567 transactions, 405 (71 percent) transactions totaling \$29,698 (77 percent) lacked documentation verifying the patients' receipt of the delivered HRCP DME. In order to provide an audit trail, VHA Government purchase card policy requires cardholders to request and maintain appropriate receipt records such as packing slips and sales slips for purchased items a minimum of 6 years and 3 months after their receipt. However, PSAS purchase card holders either reported that they had obtained, but not retained, the receipt documentation or that they had never obtained the documentation because they were unfamiliar with Government purchase card requirements.

The Chiefs of PSAS at three (33 percent) of the nine medical facilities stated that the delivery tickets were not retained after they certified the purchase card payments, and purchase card holders who we interviewed reported that they were not familiar with the verification of delivery and receipt retention requirements of VHA's purchase card policy even though they had attended the mandatory training. Follow-up conducted during the audit provided reasonable assurance that patients had received the HRCP DME item purchases made on the Government purchase card. However, we could not confirm the receipt and delivery of HRCP DME items for 19 transactions totaling \$2,012, and these are included in the unsupported costs discussed above. The significant magnitude of the documentation deficiencies identified during our audit demonstrates the vulnerabilities in the use of the Government purchase card to purchase HRCP DME.

Based on our sample results and a 90 percent confidence level, we project that VHA had about \$3.4 million in unsupported costs and improper payments during our 12-month review period and that there will be an estimated \$16.8 million in unsupported costs and improper payments over the next 5 years if HRCP DME contract administration practices are not strengthened. (See Appendix B on pages 16–17 for details of our sampling methodology and a summary of HRCP DME deficiencies and unsupported costs by medical facility.)

Conclusion

VHA needs to strengthen compliance with current HRCP prescription requirements and generally improve HRCP DME contract administration and Government purchase card practices. Our review of a sample of 650 HRCP DME transactions totaling \$50,300

identified problems at 8 (62 percent) of the 13 reviewed medical facilities. Furthermore, 77 (12 percent) of the 650 transactions totaling \$6,152 lacked required medical and prescription documentation for purchases or had other HRCP DME contract administration deficiencies. Improvements in HRCP contract administration and Government Purchase Card practices could prevent about \$16.8 million in unsupported costs and improper payments over the next 5 years.

Recommendations

3. We recommended that the Under Secretary for Health establish management controls to ensure compliance with existing HRCP DME prescription and medical documentation requirements.

The Under Secretary for Health agreed with the recommendation and stated that the P&CLO will ensure that each medical facility's HRCT reviews the medical records of all new home oxygen patients for appropriate and complete medical and prescription documentation and monitors and maintains appropriate home oxygen prescription renewal dates in accordance with the CPR. Furthermore, the Chief P&CLO will work with the Office of Information Technology to revise CPRS consult forms to ensure CPR required information such as the patients' smoking and risk assessments, required equipment and supplies, and due date for renewal and/or reassessment is filled in before an HRCP consult can be released. We find the improvement plan acceptable, and we will follow up on the planned actions until they are completed.

4. We recommended that the Under Secretary for Health strengthen HRCP DME contract administration procedures to ensure the verification of HRCP DME deliveries and the accuracy of invoices before payment certification and the maintenance of required supporting purchase documentation.

The Under Secretary for Health agreed with the recommendation and stated that the P&CLO will ensure that each medical facility's HRCT conducts a quarterly audit to verify appropriate equipment delivery and accuracy of billings for purchased supplies and services. Monthly and quarterly HRCT meeting minutes, which include the audit results, will then be submitted to the respective VISN CMOs through their VISN Prosthetic Representatives, and the VISNs will report each medical facility's results on the Deputy Under Secretary for Health for Operations and Management (DUSHOM) website. In addition, the P&CLO and the DUSHOM also plan to conduct quarterly audits of HRCP DME invoices to ensure accuracy. We find the improvement plan acceptable, and we will follow up on the planned actions until they are completed.

5. We recommended that the Under Secretary for Health provide refresher COTR and Government purchase card training to appropriate PSAS staff.

The Under Secretary for Health agreed with the recommendation and stated that the P&CLO and the DUSHOM will direct all medical facility Chief Logistics Officers and VISN Prosthetic Representatives to conduct and coordinate refresher training for appropriate PSAS staff on Government purchase card requirements and other duties and responsibilities as a COTR. We find the improvement plan acceptable, and we will follow up on the planned actions until they are completed.

Summary of Home Respiratory Care Program Monitoring and Evaluation Deficiencies by Medical Facility

Medical Facility	HRCT	Quarterly Program Reviews	Initial Patient Evaluation	Annual Patient Evaluation	Patient Home Visits	Vendor Visits
Atlanta VAMC			✓	✓	✓	✓
Palo Alto HCS	✓	✓	✓	✓	✓	
San Diego HCS		✓			✓	
Southeast Louisiana HCS	✓		✓	✓		✓
Southern Arizona HCS		✓	✓	✓		
Tampa VAMC	✓	✓	✓	✓	✓	✓

Sampling Methodology

Sampling Methodology

To determine whether VHA accurately paid for HRCP equipment items and services and that the items were medically necessary, we used VHA's NPPD to identify the population and sample. VHA provided the OIG with a copy of the database for the review period.

Population

The population consisted of 1,582,840 HRCP DME purchase transactions made by 131 medical facilities during the period June 1, 2005, through May 31, 2006. The purchases totaled \$117,241,167.

Sampling Design

We used a two-stage variable random sample. The 131 medical facilities served as the primary sampling unit, and the 1,582,840 HRCP DME purchase transactions reported in the NPPD served as the secondary sampling unit.

At a 90 percent confidence level, the Army Audit Agency's Statistical Sampling System software yielded a two-stage sample requiring the review of 50 HRCP DME purchase transactions at 13 medical facilities. We used EZ Quant Statistical Analysis software to randomly select 13 medical facilities and 50 HRCP DME transactions for review at each facility.¹ In all, we reviewed 650 transactions (13 medical facilities x 50 transactions) and considered a transaction to be in error if:

- The medical facility lacked required prescriptions or other medical documentation to support the purchase of the DME.
- The medical facility and vendors lacked effective contract administration controls and supporting documentation, such as delivery tickets and invoices, to provide reasonable assurance that patients had received purchased HRCP DME.
- The patient had died or relocated and could not have received the purchased DME.
- The HRCP transaction prices did not match any of the prices in the DME contract.

¹The Army Audit Agency Statistical Sampling System is statistical sampling software used within the Federal Government to generate two-stage variable samples. EZ Quant Statistical Analysis Software was developed by the Defense Contract Audit Agency and is used to generate sample sizes and random numbers.

Estimation Methodology

At 8 of the 13 reviewed medical facilities, we found 77 transaction errors totaling \$6,152. The following table summarizes the errors and costs by medical facility.

HRCF Transaction Errors and Related Unsupported Costs by Medical Facility

Medical Facility	Lacked Medical Support	Lacked Invoice or Delivery Support	Patient Deceased or Relocated	Prices Did Not Match	Unsupported Costs
Bedford VAMC	3			3	\$149.31
Birmingham VAMC		14			462.50
Boise VAMC	2				118.32
Martinsburg VAMC			1	1	250.00
Roseburg HCS			1	1	118.49
Saginaw VAMC		1			8.55
San Diego HCS	10		1	2	1,450.14
Southeast Louisiana HCS		37			3,594.50
Total = 77	15	52	3	7	\$6,151.81

The total value of the 650 sampled transactions was \$50,300. Of the 650 HRCF DME transactions, we found 77 (12 percent) had \$6,152 in unsupported costs and improper payments. With the assistance of an Army Audit Agency statistician, we projected at a 90 percent confidence level that VHA had 117,866 HRCF transactions totaling \$3,353,554 in unsupported costs and improper payments during our 12-month review period. The confidence interval was +/- 2.8 percent with lower and upper confidence limits of \$3,258,045 and \$3,449,063 respectively. Over the 5-year life of HRCF DME contracts, we estimate that unsupported costs and improper payments could total as much as \$16,767,770 (\$3,353,554 x 5) unless contract and Government purchase card administration practices are strengthened.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendations</u>	<u>Explanation of Benefit</u>	<u>Annual Questioned Costs</u>	<u>5-Year Projection</u>
3,4	HRCP transactions not supported by valid prescription, contract price, or adequate documentation.	\$3,353,554	\$16,767,770
	Total	\$3,353,554	\$16,767,770

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 12, 2007

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, *Audit of the Veterans Health Administration's Home Respiratory Care Program*, Project no. 2006-00801-R7-0001 (WebCIMS388590)**

To: Assistant Inspector General for Auditing (52)

1. I have carefully reviewed your draft report, and I concur with the recommendations. Ensuring that patients receive quality home respiratory care and services is an important issue, and the report cites valuable opportunities for improvement that need to be addressed. I believe that VHA Handbook 1173.13, *Home Respiratory Care Program*, and the VHA CPR-Home Use of Supplemental Oxygen contain the necessary elements for implementing and maintaining a uniform and consistent national HRCP. However, as your report points out, adherence to national guidance is inconsistent throughout the organization. As such, I agree that VHA needs to strengthen HRCP oversight and administration. For example, the Office of Prosthetics and Clinical Logistics is developing additional quality assurance monitors and issuing clarification to the CPR about how and where reassessments are done. It is expected that all three documents will be republished early in 2008.

2. The establishment of a HRCT in every VHA medical facility is a crucial element of strengthening the oversight and administration of a successful Home Respiratory Care Program. For that reason, I will ensure that each facility that has not yet established a HRCT according to VHA Handbook 1173.13, do so as soon as possible.

3. Additionally, in order to further facilitate program oversight and administration, VHA will implement national performance monitors with vigorous reporting requirements. These performance monitors will help facilities adopt the standards as written in the CPR-Home Use of Supplemental Oxygen, review the medical records of all new home oxygen patients for appropriate and complete medical documentation and prescription criteria, monitor and maintain appropriate home oxygen prescription renewal dates, and ensure appropriate equipment delivery and accurate billing of purchased supplies and services through quarterly audits of home oxygen patient invoices. I will direct all facilities to target implementation of these monitors by March 31, 2008.

4. Lastly, although I initially disagreed with your estimate of monetary benefit due to concerns with segments of your finding that certain HRCP DME items lacked required medical documentation, I appreciate your willingness to mutually discuss and resolve the issue, and I now concur with the revised estimate of monetary benefit.

5. Attached is VHA's complete plan of corrective action, which provides a summary of specific initiatives that I believe appropriately address identified issues in the report. Thank you for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 565-7638.

(original signed by:)

Michael J. Kussman, MD, MS, MACP

Attachments

Under Secretary for Health Comments to Office of Inspector General's Report

The following Under Secretary for Health comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the Under Secretary for Health evaluate why medical facilities have not complied with HRCP administrative policies and procedures and develop an action plan and national monitoring mechanism to improve compliance.

Concur

Target Completion Date: 03-31-08

Establishment of a HRCT and completion of program reviews are crucial in administering and ensuring a successful HRCP. For that reason, the VHA P&CLO will survey the CMOs, through the DUSHOM, to determine whether they have an established HRCT within each facility and whether they complete quarterly program reviews, patient reevaluations, patient home visits, and vendor quality assurance visits as required by VHA Handbook 1173.13. The CMO at any facility that is not in compliance with any of the aforementioned requirements will be required to submit an explanation and an action plan to become compliant by a specific target completion date.

Additionally, P&CLO, in conjunction with the DUSHOM Office, will implement national performance monitors (see attachment) to ensure that facilities establish a HRCT according to VHA Handbook 1173.13. P&CLO and DUSHOM Office presented the national monitoring plan, which will require each facility to report its compliance, during the CMO Conference Call on October 1, 2007. Specifically, each facility's HRCT will be required to: 1) review and adopt the standards as written in the Clinical Practice Recommendations (CPR)-Home Use of Supplemental Oxygen, signed by the Under Secretary for Health on July 6, 2005; 2) review the medical records of all new home oxygen patients for appropriate and complete medical documentation and prescription criteria in accordance with the CPR; 3) monitor and maintain appropriate home oxygen prescription renewal dates in accordance to the CPR; and 4) conduct a quarterly audit of at least 15 unique home oxygen patient invoices or 5 percent of the total number of home oxygen patients' invoices, whichever is higher, to ensure appropriate equipment delivery and accurate billing of purchased supplies and services. Target compliance will require 100 percent of the facilities to have implemented all monitors by March 31, 2008.

Recommendation 2. We recommend that the Under Secretary for Health provide training to prescribing physicians and other appropriate medical facility staff on HRCP administrative policies and procedures to ensure they understand the program's requirements.

Concur

Target Completion Date: 03-31-08

The VHA P&CLO, with collaboration from the VA Employee Education System (if necessary), will provide all VISN Prosthetic Representatives with refresher training on VHA Handbook 1173.13, the CPR, Home Oxygen Module User Guide, and any other VHA guidance or policy pertaining to the HRCP. VHA P&CLO officials will also discuss each of these documents with the CMOs during the CMO Conference calls in order to further familiarize them with the administrative policies and procedures. The CMOs will share these documents and information with all Chiefs of Staff to ensure adherence.

Recommendation 3. We recommend that the Under Secretary for Health establish management controls to ensure compliance with existing HRCP DME prescription and medical documentation requirements.

Concur

Target Completion Date: 03-31-08

Specifically for usage of home oxygen, the VHA P&CLO, in conjunction with the DUSHOM, will implement national performance monitors (see attachment) to help ensure compliance with existing HRCP DME prescription and medical documentation requirements. P&CLO and DUSHOM presented the national monitoring plan, which required each facility to report its compliance during the CMO Conference Call on October 1, 2007. As part of this monitoring plan, each facility's HRCT is required to: 1) review the medical records of all new Home Oxygen patients for appropriate and complete medical documentation and prescription criteria in accordance with the CPR-Home Use of Supplemental Oxygen; and 2) monitor and maintain appropriate home oxygen prescription renewal dates in accordance to the CPR. Target compliance will require 100 percent of the facilities to have implemented all monitors by March 31, 2008.

Furthermore, the Chief P&CLO will work with the Office of Information Technology to revise the current Computerized Patient Record System consult to ensure certain fields on the consult are mandated prior to release in accordance with the CPR, e.g., smoker; high or low risk patient; required equipment and supplies; and due date for renewal and/or re-assessment.

Recommendation 4. We recommend that the Under Secretary for Health strengthen HRCP DME contract administration procedures to ensure the verification of HRCP DME deliveries and the accuracy of invoices before payment certification and the maintenance of required supporting purchase documentation.

Concur

Target Completion Date: 03-31-08

The VHA P&CLO, in conjunction with the DUSHOM, will implement national performance monitors (see attachment) to help ensure the verification of HRCP DME deliveries and the accuracy of invoices before payment certification and the maintenance of required supporting purchase documentation. P&CLO and DUSHOM presented the national monitoring plan, which required each facility to report its compliance during the CMO Conference Call on October 1, 2007. As part of this monitoring plan, each facility's HRCT is required to conduct a quarterly audit of at least 15 unique home oxygen patient invoices or 5 percent of the total number of home oxygen patients' invoices, whichever is higher, to ensure appropriate equipment delivery and accurate billing of purchased supplies and services. Target compliance will require 100 percent of the facilities to have implemented all monitors by March 31, 2008.

VHA P&CLO and DUSHOM will conduct quarterly audits of HRCP DME invoices to ensure accuracy. The HRCT will report the percentage of correct/consistent invoices to all audited invoices in their monthly and quarterly meeting minutes. Each facility will forward its monthly/quarterly HRCT meeting minutes to the respective VISN CMO through the VISN Prosthetic Representative on a continuing basis. In turn, VISNs will report each facility's compliance on the DUSHOM web site. CMOs and VISN Prosthetic Representatives will continue to monitor all other quality assurance measures, as identified in the CPR-Home Use of Supplemental Oxygen, in the facility's HRCT meeting minutes.

Recommendation 5. We recommend that the Under Secretary for Health provide refresher COTR and Government purchase card training to appropriate PSAS staff.

Concur

Target Completion Date: 03-31-08

The VHA P&CLO and DUSHOM will direct all facility Chief Logistics Officers (CLO) and VISN Prosthetic Representatives (VPR) via memo to conduct and coordinate refresher training for appropriate PSAS staff on purchase card requirements and other duties and responsibilities as a COTR. This direction will also be reiterated at future VPR/CLO meetings. VISNs will report compliance to P&CLO and DUSHOM by March 31, 2008.

Under Secretary for Health Comments

ATTACHMENT

TARGETS:

- Contract Compliance each quarter on *all national contracts* with the exception of power wheelchairs is 95 percent; yellow is 85 percent to 94.99 percent (not fully compliant, but making progress towards compliance); below 85 percent is red (needs significant improvement).
- For *all power wheelchair contracts* the goal is set at 90 percent; anything between 70 - 89.99 percent is yellow; and below 70 percent is red.

DATA SOURCE: P&CLO will provide quarterly reports from the NPPD to show percent of contract compliance by product for each facility and VISN.

CONTACT: Robert Baum, Program Analyst @ (202) 254-0440 or Robert.Baum@va.gov

2. Prosthetics Home Respiratory Therapy Program :

RATIONALE: An audit of VHA's HRCP was conducted by the Inspector General's Office to determine whether medical facilities are complying with VHA's HRCP policy and administering the program effectively. The audit was also conducted to determine whether medical facilities are effectively administering the HRCP durable medical equipment contracts and paying the correct amounts for purchased equipment and services.

ACTION: VISN Prosthetic Representatives will self-report the status of the following to the Prosthetics and Clinical Logistics Program Office:

- a. Each facility will establish a HRCT according to VHA Handbook 1173.13. Each team is to review and adopt the standards as written in the CPR-Home Use of Supplemental Oxygen, signed by the USH on 7/6/05; <http://vaww.teamshare.va.gov/PCLO/ProstheticsPCM/Home%20Oxygen/Forms/AllItems.htm>.

b. The HRCT at each facility will review the medical records of all new Home Oxygen patients for appropriate and complete medical documentation and prescription criteria in accordance with the CPR.

c. The HRCT at each facility will monitor and maintain appropriate home oxygen prescription renewal dates in accordance to the CPR. The prosthetics software module will be updated accordingly.

d. The HRCT at each facility will audit at least 15 unique home oxygen patient invoices or 5 percent of the total number of home oxygen patients' invoices, whichever is higher, per quarter, to ensure appropriate equipment delivery and accuracy of vendor billing of purchased supplies or services.

REPORTING:

a. At the end of the first quarter FY08, facilities will validate the status to their respective VISN Office who will forward to the Prosthetics and Clinical Logistics Office (10FP), VA Central Office (VACO).

b. The HRCT will report the percentage of new patients with appropriate/complete documentation to all new patients, in their meeting minutes.

c. The HRCT will report the percentage of patients with current and appropriate renewal dates, in the prosthetic software package, to all prescriptions, in their meeting minutes.

d. The HRCT will report the percentage of correct/consistent invoices to all audited invoices, in their meeting minutes.

VISN reports compliance for b, c, and d of each facility on the DUSHOM web site.

Each facility will forward the monthly/quarterly HRCT meeting minutes to their respective VISN Chief Medical Officer through the VISN Prosthetic Representative on a continuing basis.

TARGET: By the end of the first quarter FY08, 100 percent of facilities will have implemented all above monitors. Success rate for B, C, and D, will be measured at 95 percent

CONTACT: Robert Baum, Program Analyst @ (202) 254-0445 or Robert.Baum@va.gov

OIG Contact and Staff Acknowledgments

OIG Contact	Janet Mah (310) 268-4335
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Acknowledgments	Gregory Gladhill John Carnahan Theodore Smith Daniel Rico Kelly To
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