Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

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

Report No. 11-01416-212 **July 7, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

At the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans' Affairs, the Office of Inspector General conducted an inspection of the Prosthetic and Sensory Aids Service at the facility. Specifically, we reviewed the potential loss of veterans' Home Improvement and Structural Alterations (HISA) grant records that contained Personally Identifiable Information[1], which may have caused undue delays in providing these critical modifications to veteran's homes.

We were unable to determine the exact number of HISA records missing. We estimate that as many as 90 records are missing. We found numerous discrepancies in the oversight and administration of the HISA program, which contributed to the lack of management control over this program. During our inspection, we found that some HISA grants were paid without the required documentation and therefore, in those cases the records and associated PII were not missing.

We found that facility managers did not place appropriate emphasis on protecting, investigating, and reporting lost or stolen files that contained PII. The investigations conducted by the facility did not attempt to resolve discrepancies in the number of files lost or the number recovered. More than 3 weeks passed from the discovery of the lost records to notification of appropriate authorities.

Since the discovery of the missing files, personnel and leadership changes in the prosthetics department have been addressed. The facility is implementing changes to improve the delivery of services and bring Prosthetic and Sensory Aids Service into compliance with Veterans Health Administration (VHA) directives. The HISA committee is functioning and other internal controls are being enforced.

We recommended that the Medical Center Director:

- Take additional steps to ensure contact and assistance to those veterans whose HISA consult is unfulfilled.
- Follow VHA directive for reporting, recording, and completing patient complaints.
- Ensure that closures of medical consults 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.

[1] PII is any information about an individual that can reasonably be used to identify that individual and that is maintained by VA.

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.

Introduction

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review of the loss of veterans' prosthetic records at the Durham VA Medical Center (the facility), Durham, NC. The purpose of the inspection was to determine:

- How many records were lost?
- What was the impact of the loss on veterans' care?
- What steps were taken to inform veterans of the lost records?
- What actions were taken to ensure a similar loss would not occur again?

Background

At the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans' Affairs, the OIG Office of Healthcare Inspections conducted an inspection of the Prosthetic and Sensory Aids Service (PSAS) at the facility. Specifically, we reviewed the loss of veterans' Home Improvement and Structural Alterations (HISA) grant records that contained Personally Identifiable Information (PII),[2] which may have caused undue delays in providing critical modifications to veteran's homes.

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

The PSAS provides prosthetic and orthotic services, sensory aids, medical equipment, and support services for veterans. In fiscal year (FY) 2010, the Durham PSAS served 22,000 veterans and managed a budget of approximately $31 million. The HISA program, managed by PSAS, provides funds to veterans to help defray costs associated with structural modifications of homes to accommodate wheelchairs or other special needs. The maximum amount of the grant is currently $6,800 for a service-connected disability and $2,000 for a non-service-connected disability. The veteran is responsible for structural modification costs that exceed the grant amount. Veterans Health Administration (VHA) requires[3] a medical consultation (consult) by a physician for the HISA process to begin. The HISA consult must include the medical justification for the

[2] PII is any information about an individual that can reasonably be used to identify that individual and that is maintained by VA.
[3] VHA Handbook 1173.14, *Home Improvements and Structural Alterations (HISA) Program*, April 18, 2008.

modification, the veteran's name, address, last four digits of Social Security Number (SSN), and phone number. When completed, the veteran's HISA folder contains the medical consult and the following items provided by the veteran:

1. Completed and signed copy of VA Form 10-0103, *Veterans Application for Assistance in Acquiring HISA*
2. If the veteran leases or rents the home, he/she must have a written statement from the owner of the property authorizing the project to be done.
3. The home modification requires three competitive bids from a bonded or licensed contractor, if required by state law, which must include the following:
    a. The contractor's name, address, phone number, and last four digits of SSN or Federal ID number
    b. The veteran's name, address, and phone number
    c. A written statement and the plans of the project to be performed to include a sketch of the work to be completed
    d. An itemized list of materials, including the material and labor costs for each part of the project
4. A signed acknowledgement from the veteran that the veteran understands that the VA assumes no responsibility, warranty, or liability for the home modifications

HISA Program Management Oversight

In June 2010, while performing oversight responsibilities VISN 6 identified problems with the facility's HISA program that involved grant payment irregularities. In July 2010, the VISN reviewer followed up by conducting an on-site review and identified additional concerns. On September 14–17, 2010, VA Central Office (VACO), Office of Patient Care Services conducted a program review of the facility PSAS due to the concerns raised by the VISN and found serious lapses in internal controls, lack of documentation in patient records, and a general disregard of policies and directives. The office where HISA files were maintained was usually cluttered and disorganized. However, the office was cleaned and tidied up prior to the VACO program review.

Scope and Methodology

We conducted two site visits on February 15–18 and February 28–March 4, 2011. Prior to our first visit, we reviewed local and VHA policies, VHA directives, references for HISA grants and lost PII reporting requirements; AIB testimonies and conclusions; the report of facility PSAS Program Review conducted by VACO on September 14–17, 2010; and the Privacy Violation Tracking System report files. While onsite, we interviewed facility police, PSAS staff, and administrative staff.

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

Results and Conclusions

Issue 1: Number of HISA Records Missing

Missing Record Chronology

On September 17, 2010, prosthetic employees first noticed the HISA office was less cluttered. On Monday, September 20, when staff was unable to find HISA files in any other location, they reported the missing records to their supervisor. The supervisor contacted facility police later that afternoon. The police did not conduct an investigation or file a report because there was no mention of missing records containing PII.

On September 21, 2010, the supervisor reported to facility management that there might be missing records containing PII. Management directed the supervisor to work with police officers and the facility Privacy Officer to investigate the circumstances surrounding the lost records. On October 8, 2010, the supervisor informed the Privacy Officer of missing records containing PII.

On October 4, 2010, a prosthetics staff worker contacted a second prosthetic staff worker in an effort to find the missing HISA files. The second staff worker reported that there were five–seven records in another office in the facility and arranged for the return of those HISA files to PSAS on October 7, 2010.

On October 12, 2010, the Privacy Officer reported 29 HISA records missing on the Privacy Violation Tracking System. This number of records was provided by the prosthetics supervisor.

On November 3, 2010, the facility Director signed the charge letter to convene an AIB to investigate allegations of improper processing of HISA grants and inappropriate removal of related VA records in PSAS. The AIB concluded that VA records were improperly removed, although they could not determine how many records were removed or whether PII information was compromised.

Findings

We estimate that as many as 90 records are missing, which is 61 more records than the 29 reported by the facility. We conducted a search of the PSAS office spaces, electronic files, and prosthetics file boxes marked for off-site storage to identify all the HISA records present. We performed an analysis of all HISA consults issued with corresponding HISA grant payments made during FY 2010 in an attempt to determine all the records that should be present. We also reviewed the record of patient complaints

that their HISA grants were not received that did not have any corresponding record at the facility.

We determined that 90 HISA records were missing based on the following conditions:

- Record of a HISA grant paid with no supporting documentation – (52 records)
- Record of patient complaints that HISA grant was not paid – (8 records)
- Empty folder in HISA office with patient name and a contents checklist indicating that documentation had been present – (1 record)
- Records reported missing by the facility – (29 records)

We found numerous discrepancies in the oversight and administration of the HISA program, which contributed to the lack of management control over this program. During our investigation, we found that some HISA payments were made without required documentation or appropriate approvals. VHA directives require that the facility Director establish a HISA committee responsible for evaluating, approving, and disapproving HISA requests and contractor bids. The HISA committee is a key internal control to ensure compliance with approval of HISA grant funds. PSAS did not have a functioning HISA committee for more than a year prior to our visits.

The Privacy Officer filed a report in the Privacy Violation Tracking System for 29 missing veteran records and noted the accuracy of this number was questionable. The case was closed with no additional findings. When interviewed by the AIB, the Privacy Officer stated that the number of records reported missing was based on a list provided by the supervisor and was not verified.

We reviewed HISA complaints recorded in the Patient Advocate Tracking system (PATS) to identify veterans whose records were missing and found that veteran complaints in PATS did not identify actions taken to resolve the complaint. We interviewed PSAS staff, who reported that they did not keep a record of complaints that came directly into PSAS or record them in PATS as required.

We reviewed prosthetic consults from FY 2010 and found that most consults were marked competed prior to the work being performed, and therefore, did not comply with VHA directive.[4] We found numerous HISA payments had been made without the required HISA medical consult that was needed to justify the receipt of a HISA grant.

Conclusion

We found that facility managers did not place appropriate emphasis on protecting, investigating, and reporting lost or stolen files that contained PII. The investigations conducted by the Privacy Officer and the AIB did not go far enough to resolve

[4] VHA Directive 2008-156, *VHA Consult Policy*, September 16, 2008.

discrepancies in the number of files lost or the number recovered. More than 3 weeks passed from the discovery of the lost records to notification of appropriate authorities. A more timely and thorough investigation may have revealed the oversight and management problems in the PSAS.

It is difficult to determine the exact number of records that are missing without internal controls and documentation. We found evidence that much of the required HISA documentation was never done and therefore did not exist. The HISA committee would have helped ensure documentation and establish an audit trail of documents present. We estimated that up to 90 records are missing based on our analysis of the records located and the current records that should have been on file.

Recommendation 1: We recommended that the Medical Center Director take additional steps to ensure contact and assistance to those veterans whose HISA consult is unfulfilled.

Recommendation 2: We recommended that the Medical Center Director ensure that patient complaints follow VHA directive for reporting, recording, and completing the complaint.

Recommendation 3: We recommended that the Medical Center Director ensure that closures of medical consults are in compliance with VHA policies.

Issue 2: Affected Veterans Notified of Lost Records

Findings

The VA has the responsibility to protect PII at all times. A privacy violation event occurs when PII is compromised or lost. VA Directive[5] states that when notified of any complaint, potential or actual privacy violation, the Privacy Officer will file a report within 1 hour of discovery of the event in the PVTS. The Privacy Officer must resolve each incident as soon as possible.

On November 17, 2010, 2 months after the first discovery of missing records and more than 1 month after notification of the Privacy Officer, the facility notified the 29 identified veterans that prosthetic records were missing that included their PII. The letter recommended that the veteran request a credit report and gave instructions on how to enroll in credit monitoring. During our review, we identified 61 additional veterans who were not identified by the facility with missing HISA records. The facility is notifying the additional 61 identified veterans.

[5] VHA Handbook 6502.1, *Privacy Event Tracking,* February 18, 2011.

Conclusion

We determined that the delayed Privacy Officer's investigation was due to attempts to get information on all veterans involved in the lost records from involved PSAS employees. However, the facility should have been more aggressive in investigating, reporting, and notifying veterans of a potential compromise of PII information.

Recommendation 4: We recommended that the Medical Center Director ensure protection of PII and reporting of privacy events as required by VHA policies.

Issue 3: Effect of the Record Loss on Veterans

Findings

Veterans' care is hampered when patient records are not properly secured and maintained to ensure privacy and confidentiality. The loss of prosthetics records not only compromised veterans' privacy, but also delayed the approval and payment of HISA services. We found the PSAS department was not proactive in determining the extent of the loss of records and only attempted to investigate the issue when complaints were made. PSAS staff told us that they knew there were more missing records than the 29 reported, but steps were not taken to identify the additional missing records.

Conclusion

Facility managers failed to mitigate the loss of patient records and the delays imposed on veterans waiting for HISA services.

Recommendation 5: We recommended that the Medical Center be more proactive in identifying the veterans affected by the loss of their HISA records and provide necessary assistance to them to expedite their HISA services.

Issue 4: Review Changes to Prevent Re-Occurrences

Findings

Since the discovery of the missing files, personnel and leadership changes in the prosthetics department have been addressed. The facility is implementing changes to improve the delivery of services and bring PSAS into compliance with VHA directives. The HISA committee is functioning and other internal controls are being enforced.

Conclusion

Management has recognized the improvement needed in the PSAS and appropriate changes have been made to improve the delivery of services. Both the facility and VACO are monitoring PSAS changes.

Comments

The VISN and Medical Center Directors concurred with our findings and recommendations (see Appendixes A and B, pages 8–12 for the full text of their comments). The implementation plans are acceptable, and we will follow up on the actions in six months.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 9, 2011

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

Subject: **Healthcare Inspection – Prosthetics and Sensory Aids Service Records Review, Durham VA Medical Center; Durham, North Carolina**

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

Thru: Director, VHA Management Review Service (10A4A4)

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

2. 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)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 9, 2011

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

Subject: **Healthcare Inspection –Prosthetics 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 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)

Facility 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 recommended that the Medical Center Director take additional steps to ensure contact and assistance to those veterans whose HISA consult is unfulfilled.

Concur **Completion Date:** May 31, 2011

Facility's Response:

The 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 was 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.

Status: The HISA program will be closely monitored and patient case files will be tracked to ensure all program requirements are met.

Recommendation 2. We recommended that the Medical Center Director ensure that patient complaints follow VHA directive for reporting, recording, and completing the complaint.

Concur **Completion Date: May 31, 2011**

Facility's Response:

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.

Status: Training has been provided in use of PATS, and systems are in place to monitor and track completeness of PATS entries.

Recommendation 3. We recommended that the Medical Center Director ensure that closures of medical consults are in compliance with VHA policies.

Concur **Target Completion Date:** April 7, 2011

Facility's Response:

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.

Status: Complete–new process in place, with supervisory oversight to ensure ongoing compliance.

Recommendation 4. We recommended that the Medical Center Director ensure protection of PII and reporting of privacy events as required by VHA policies.

Concur **Completion Date:** April 2011

Facility's Response:

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.

Status: Complete.

Recommendation 5. We recommended that the Medical Center be more proactive in identifying the veterans affected by the loss of their HISA records and provide necessary assistance to them to expedite their HISA services.

Concur **Target Completion Date:** May 31, 2011

Facility's Response:

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.

Status: Review is complete and assistance has been offered.

Appendix C

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, Team Leader Nathan Fong, CPA Cathleen King, RN Thomas Seluzicki, CPA

Appendix D

Report Distribution

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