VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of the Timeliness of VISN 7 Power Wheelchair and Scooter Repairs

March 14, 2018
16-04655-70

ACRONYMS

FY	Fiscal Year
HCS	Health Care System
NPPD	National Prosthetic Patient Database
OIG	Office of Inspector General
PSAS	Prosthetic and Sensory Aids Service
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

Executive Summary

Why We Did This Audit

In April 2016, the Chairman of the Senate Committee on Veterans' Affairs expressed concerns to the OIG that delays in the repair of VA-issued power wheelchairs and scooters at the Atlanta VA Health Care System (HCS) placed veterans at physical and financial risk. To evaluate these concerns, the OIG started this audit to assess the timeliness of power wheelchair and scooter repairs at the Atlanta VA HCS and other Veterans Integrated Service Network (VISN) 7 VA medical facilities.

What We Found

The OIG confirmed that VISN 7 Prosthetic Service managers, including Prosthetic Service managers at the Atlanta HCS, did not ensure the timely repair of veterans' VA-issued power wheelchairs and scooters. Since Prosthetic and Sensory Aids Service officials have not established timeliness standards for the completion of repairs, the OIG established a 30-day benchmark for this audit. The benchmark was based on VHA's 30-day timeliness standards in areas like outpatient care, consults, and non-VA Care referrals. The OIG discussed the 30-day benchmark with Prosthetic and Sensory Aid Service officials and VISN 7 Prosthetic Service managers during the course of the audit, and they did not object to the use of this benchmark for this audit.

The OIG's review of a statistical sample of power wheelchair and scooter repairs at eight VA medical facilities in VISN 7 identified a projected 380 veterans, including 39 Atlanta HCS veterans, who experienced delays in the completion of approximately 480 of the VISN's projected 1,200 FY 2016 repairs (40 percent). The OIG projected that these veterans waited an average of 69 days for their repairs, more than a month beyond the OIG's established 30-day timeliness benchmark.

These delays occurred because staff and Prosthetic Service managers at the respective VISN 7 VA medical facilities did not always effectively manage and monitor repair requests. VA medical facility staff, including Prosthetic Service staff, did not always promptly input repair requests in the consult management system so the requests could be properly tracked. Moreover, Prosthetic Service staff did not effectively monitor the completion of the repairs after the purchase orders for the repairs were issued and the consults were closed. These lapses occurred because VISN 7 Prosthetic Service managers had not implemented policies to ensure VA medical facility staff promptly input repair requests after they were received and to ensure Prosthetic Service staff effectively managed and monitored repair requests from inception to completion. Furthermore, Prosthetic Service managers did not ensure vendors completed repairs by the established delivery date. Even without specific VHA policies and standards regarding the timeliness of repairs, VISN 7 should have been more responsive to the needs of some of its more vulnerable veterans. The OIG's review of veterans' medical records could not confirm that

veterans experienced financial hardships due to delayed power wheelchair and scooter repairs, but it did find some veterans experienced physical hardships like confinement to a bed and a missed medical appointment due to the delays.

What We Recommended

The OIG recommended the VISN 7 Director implement controls to ensure VA medical facility staff initiate repair consults as soon as power wheelchair and scooter repair requests are received. Staff must follow consult documentation procedures, monitor and follow up on repairs until they are complete, and monitor vendors to ensure they meet agreed-upon delivery dates for repairs.

Agency Comments

The VISN 7 Director concurred with our report and recommendations, and provided an action plan to address the recommendations. We considered the action plan acceptable.

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INTRODUCTION

Objective

The OIG started this audit to determine whether the Atlanta VA Health Care System (HCS) and other VA medical facilities in Veterans Integrated Service Network (VISN) 7 ensured the timely repair of veterans' power wheelchairs and scooters.

Why We Did This Audit

In April 2016, the Chairman of the Senate Committee on Veterans' Affairs expressed concerns to the OIG that veterans were at physical and financial risk because of delays in the repair of VA-issued power wheelchairs and scooters at the Atlanta HCS.

Management of Wheelchair and Scooter Repairs

When VISN 7 veterans require repairs to power wheelchairs and scooters, they request repairs through VA medical facility staff and are issued a backup manual wheelchair. VA medical facilities rely on Veterans Health Administration's (VHA) consult management system, consult status, and purchase card reports to monitor power wheelchair and scooter repairs. Staff "open" administrative consults in the patients' records to start the repair requests. Purchasing agents receive the consults and change the consults to "pending" when they initiate action, such as request quotes from vendors. Purchasing agents "close" the consults after they issue purchase orders to the vendor with an expected repair completion date, typically 30 days from the issuance of the purchase order. Local Prosthetic Service staff use open and pending consult reports to track the repair process from the start of the consults to the issuance of purchase orders. Local Prosthetic Service managers at some facilities review purchase order transactions at least once a month to identify repairs that vendors have not completed.

Timeliness Standard for Repairs

VISN 7 medical facilities generally follow established VHA prosthetic and sensory aids policies and guidelines to maintain and repair power wheelchairs and scooters.[1] However, these policies and guidelines do not contain a timeliness standard for such repairs. Prosthetic and Sensory Aids Service (PSAS) provided VA medical facilities updated guidance in the May 2017 *PSAS Business Practice Guidelines for PSAS Consult Management*, but the guidance does not address the timeliness of power wheelchair and scooter repairs.

[1] Applicable Prosthetic and Sensory Aids Service policies include: VHA Handbook 1173.1, *Eligibility*; VHA Handbook 1173.06, *Wheelchair and Special Mobility Aids*; and VHA Handbook 1173.2, *Furnishing Prosthetic Appliances and Services*; and *PSAS Business Practice Guidelines for Prosthetics Consult Management*.

RESULTS AND RECOMMENDATIONS

Finding 1 VISN 7 Medical Facilities Did Not Ensure Timely Repairs

The OIG confirmed that VISN 7 medical facilities did not ensure the timely repair of VA-issued power wheelchairs and scooters. PSAS does not have a timeliness standard for the completion of these repairs, so the OIG applied a 30-day standard that VHA uses to measure the timely delivery of other health care services to benchmark the timeliness of the repairs. The OIG's review of a statistical sample of power wheelchair and scooter repairs in VISN 7 disclosed that a projected 380 veterans in VISN 7, including about 39 Atlanta HCS veterans, experienced delays in the completion of approximately 480 repairs in FY 2016.[2] This meant that about 40 percent of all repairs took longer than 30 days. Furthermore, these veterans waited an average of 69 days—39 days beyond a 30-day timeliness benchmark—for their repairs to be completed. These delays occurred because VISN 7 Prosthetic Service managers had not established policies to ensure VA medical facility staff promptly input repair requests when they were received and to ensure Prosthetic Service staff monitored repairs from inception to completion. Prosthetic Service staff did not hold vendors accountable for the timely completion of repairs. Even without VHA policies and standards regarding the timeliness of repairs, VISN 7 should have been more responsive to the needs of some of its more vulnerable veterans. Although the OIG could not confirm from its review of the veterans' medical records that the delayed power wheelchair and scooter repairs financially affected veterans, it confirmed that some veterans experienced physical hardships related to the delays.

No VHA Timeliness Standards

PSAS officials have not established timeliness standards for the completion of power wheelchair and scooter repairs because they consider every repair different and believe setting one standard would be difficult. VISN 7 and medical facilities' prosthetic staff indicated that pending consults should generally be addressed and closed by issuing a purchase order within 30 days. In addition, VHA commonly uses a 30-day standard to gauge the timely delivery of health care services to veterans in a wide range of areas such as outpatient care, consults, and referrals to non-VA care. Because the closure of consults at the issuance of the purchase order for the repairs does not reflect all of the time needed to complete repairs, the OIG applied a 30-day benchmark from the date of the initial repair request to the date of repair completion to assess the timeliness of VISN 7 power wheelchair and

[2] The OIG reviewed 30 power wheelchair and scooter repairs at each VISN 7 VA medical facility, except the Ralph H. Johnson VA Medical Center in South Carolina, where the OIG only identified 20 wheelchair and scooter repair orders after the OIG removed miscoded purchase orders.

scooter repairs. The OIG briefed the national director of PSAS and Prosthetic Service managers at VISN 7 medical facilities on the audit's methodology and did not receive any objections to the use of the 30-day benchmark for the purposes of this audit in the absence of an existing VHA timeliness standard for repairs.

Delayed Power Wheelchair and Scooter Repairs

The OIG's review of VISN 7 wheelchair and scooter repairs disclosed that an estimated 480 of the 1,200 repairs (40 percent) completed in VISN 7 in FY 2016 were not completed within 30 days.[3] Furthermore, the projected 380 veterans who experienced delays in repairs waited an average of 69 days—39 days beyond the 30-day timeliness benchmark.

Table 1. Projected Number of Delayed Repair Orders and Average Days Beyond Benchmark for VISN 7 VA Medical Facilities

VA Medical Facility	Number of Delayed Repair Orders	Average Days Beyond 30-Day Benchmark
Charlie Norwood VAMC	200	52
Carl Vinson VAMC	96	17
Central Alabama VA HCS	59	29
Atlanta VA HCS	45	40
Wm. Jennings Bryan Dorn VAMC	34	47
Birmingham VAMC	30	31
Ralph H. Johnson VAMC	7	34
Tuscaloosa VAMC	7	16
Total	**480**	**39**

Source: VA OIG statistical analysis, performed in consultation with the Office of Audits and Evaluations' statistician

Note: Table 1 lists the projections for the respective VISN 7 VA medical facilities. Differences in projections may be caused by the margins of error in the respective samples of each facility. Only those VA medical facility projections that do not have significant differences in their margins of error should be compared. Appendix C, Tables 9 and 10, shows specifically which VISN 7 VA medical facility projections can be compared based on the OIG's analysis of the margins of error.

[3] This represents the total number of FY 2016 VISN 7 prosthetics purchase orders the OIG identified as wheelchair or scooter repairs in VHA's Corporate Data Warehouse, reduced by an estimate of the number of miscoded purchase orders in the universe. The OIG developed this estimate from the number of miscoded purchase orders identified during the audit.

The following cases demonstrate how inadequate management of veterans' repair requests by Prosthetic Service staff contributed to the delays in the completion of repairs in VISN 7.

Example 1

An in-house wheelchair repair technician created a consult to attach tie downs to a veteran's new power wheelchair. A purchasing agent did not take initial action and request a quote from the vendor until 79 days after the date of request. The vendor completed the work 11 days after the quote was requested. Consequently, the veteran waited a total of 90 days for completion of the repair. According to the purchasing agent, staffing issues caused this repair to be reassigned to multiple staff while the consult was open. However, the OIG could not confirm the purchasing agent's statements due to a lack of supporting documentation. Furthermore, the OIG found no evidence that Prosthetic Service managers had reassigned the consults multiple times or followed up on the consult.

Example 2

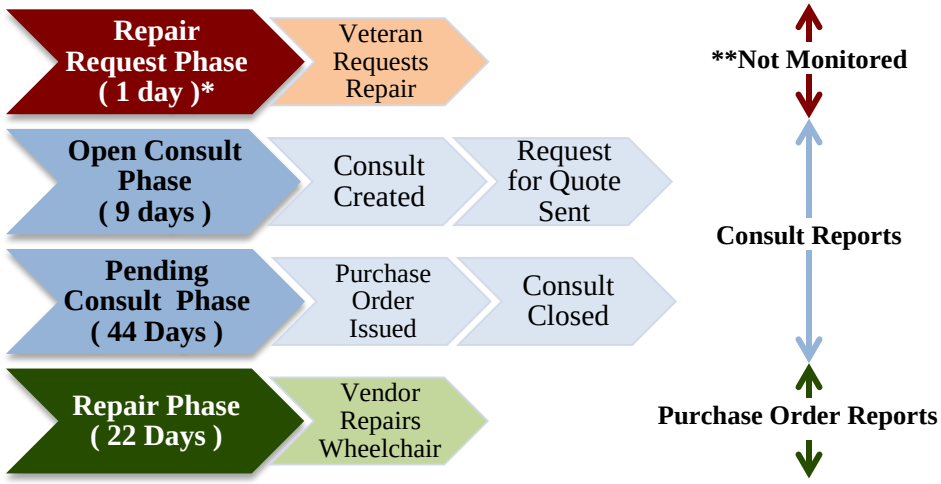
A clinician submitted a repair consult for a new battery for a veteran's power wheelchair. The purchasing agent did not take initial action and request a quote from the vendor until 69 days after the veteran's repair request. The vendor replaced the battery nine days after the quote request. In total, this veteran waited 78 days for the battery replacement. According to the purchasing agent, the consult requesting the repair was reassigned to multiple staff during this period due to staffing issues. It appears Prosthetic Service managers did not adequately monitor the staff and follow up on this consult, even though the veteran contacted the medical facility on three separate occasions about the status of the repair.

Factors Contributing to Delayed Repairs

Prosthetic Service managers at the Atlanta HCS and other VISN 7 VA medical facilities did not effectively monitor power wheelchair and scooter repairs consults from the date of request to their completion.

Figure 1 shows the four phases of the repair process, the average length of each phase for the projected 480 delayed orders, and the related management controls used to monitor the repair process.

Figure 1. Repair Phases, Average Length of Phases for Delayed Repairs, and Related Management Controls



Source: VA OIG analysis of VHA's processes related to repair consults as of April 2017

**The length of Repair Request Phase is probably understated because PSAS does not monitor this phase, and the OIG could not establish the dates veterans requested 157 of the 230 reviewed repairs (68 percent).*

***PSAS does not monitor the repair request phase because it is assumed the repair consults will be created almost immediately after the veteran requests the repair.*

Under VHA Directive 1232(1), *Consult Processes and Procedures*, VA medical facility and Prosthetic Service staff who initiate repair consults are responsible for reviewing the status of ordered consults to ensure patients receive timely care, and Prosthetic Service staff are responsible for promptly reviewing and responding to the consults. However, the OIG found that:

- In the Repair Request Phase, VISN 7 VA medical facility staff, including Prosthetic Service staff, did not always enter veterans' repair requests in the consult management system at the time they received or became aware of the requests. Subsequently, Prosthetic Service managers could not effectively monitor the timeliness of repairs.

- In the Pending Consult Phase, the purchasing agents complied with the general *PSAS Business Practice Guidelines for Prosthetics Consult Management* and closed pending consults for the repairs at the time they issued purchased orders. The closure of the consults meant Prosthetic

Service managers and staff could no longer monitor the repairs through the consult management system, even though they were not completed.[4]

- Throughout the repair process, VISN 7 Prosthetic Service managers did not ensure purchasing agents properly annotated actions taken on consults, promptly issued purchase orders, and monitored vendors to ensure the completion of repairs by the delivery date.

Consults Not Promptly Entered

The OIG found that Prosthetic Service staff received the veterans' repair requests for eight of the projected 480 delayed repairs but they did not enter the requests in the consult management system (2 percent) at the time the requests were received. Instead, the Prosthetic Service staff entered the consults into the consult management system on average 120 days after the veterans requested the repairs and/or the consults should have been created. In these cases, the Prosthetic Service staff began addressing the repairs once they became aware of the requests, but they did not ensure the consults were entered in the consult management system until it was necessary to process the payments for the completed repairs. Consequently, delays in inputting repair consults made it appear that Prosthetic Service staff had addressed these repairs on the same day the consults were created or the day the veterans requested the repairs.

Delays in inputting consults skew consult management data and provide VA medical facility and Prosthetic Service managers an inaccurate picture of the responsiveness of Prosthetic Service staff and the timeliness of the Repair Request Phase.

Example 3

A Prosthetic Service staff member entered a consult for a repair request 54 days after the repair request was received. As a result, it appeared that the purchasing agent had promptly opened the consult and issued the purchase order all on the same day. However, the purchasing agent knew about the veteran's needed repair and had sent a request for a quote to the vendor nearly two months earlier for the evaluation of the veteran's power wheelchair. Consequently, the OIG estimated the consult should have been input in the consult management system at least 54 days earlier than it was. The OIG could not determine why a consult was not entered at the time the purchasing agent became aware of the need for the repair because the purchasing agent was no longer employed at the medical facility at the time of the audit. Both the chief of Prosthetic Service and the supervisory purchasing agent stated that they would not have been able to monitor this repair until the consult was created.

[4] *PSAS Business Practice Guidelines for Prosthetics Consult Management*.

When consults are not established in the consult management system on the dates veterans request the repairs, VA medical facility and Prosthetic Service managers cannot effectively monitor staff to ensure they are promptly addressing veterans' requests by procuring needed repairs and services.

Consults Closed Before Repairs Were Completed

Prosthetic Service staff at all of the reviewed VISN 7 VA medical facilities closed consults for wheelchair and scooter repairs after they issued the purchase orders, rather than at the completion of repairs. Under the *PSAS Business Practice Guidelines for Prosthetics Consult Management* in place at the time of the audit, this was the standard operating procedure for repair consults.[5] Subsequently, reports from the consult management system allowed VA medical facility and Prosthetic Service managers to track only the timeliness of a portion of the repair process—the period from the request through to the purchasing agent's issuance of a purchase order. This limitation in the tracking process became a major problem for repairs that required the issuance of separate purchase orders for parts and labor.[6]

Example 4

A veteran needed to have the casters on his power wheelchair replaced. The Prosthetic Service staff opened the consult, maintained it as pending until he issued a purchase order to purchase the casters, and then closed the consult. The purchasing agent had the parts delivered to the veteran's home but did not issue another purchase order to have the casters installed. Subsequently, Prosthetic Service staff lost track of the repair and did not issue another purchase order to have the casters installed until 163 days after the agent shipped the parts to the veteran. Consequently, the veteran waited a total of 210 days to have the repair completed. When questioned about the reason for this delay, the supervisory purchasing agent stated that it was the veteran's responsibility to contact Prosthetic Service after he received the parts.[7] Per VHA Handbook 1730.01, *Use and Management of Purchase Cards*, it is the government purchase cardholder's responsibility to ensure orders are delivered.

PSAS's standard operating procedure required the chief of Prosthetic Service and a responsible employee to perform weekly reviews of pending consults.[8] However, it also allowed them to close the consults when the purchase orders for the repairs were issued. Thus, the standard operating procedure did not require Prosthetic Service managers to use the consult management system

[5] *PSAS Business Practice Guidelines for Prosthetics Consult Management*.
[6] PSAS issued new business practice guidelines for consult management in May 2017, which required consults to remain in their original status if the consults required additional purchase orders. However, this still did not address the underlying issue of closing consults before repairs were completed.
[7] The OIG could not obtain additional information regarding the delay in the installation of the casters due to the lack of documentation in the consult.
[8] *PSAS Business Practice Guidelines for Prosthetics Consult Management*.

to monitor repairs through completion even though this would have improved visibility over the repairs. The OIG estimated that Prosthetic Service staff closed the repair consults on average about 44 days after initial action was taken for the projected 480 delayed VISN 7 repairs, even though the repairs actually took an average 69 days to complete.

Actions on Consults Improperly Documented

VISN 7 Prosthetic Service managers did not provide purchasing agents adequate oversight as they administered the power wheelchair and scooter repair process. PSAS guidelines direct staff to document each time they review a pending consult, the action taken, the person contacted, and the date.[9] In addition, VHA policy requires purchasing staff to document in consults the steps needed to promptly resolve the consults and to ensure the consult notes are properly linked to the consult requests.[10] Despite these requirements, the purchasing agents did not consistently annotate communications with veterans and vendors in consults, and some consults contained purchase order information for unrelated repair requests. During OIG interviews the purchasing agents provided various reasons why they did not properly document communications in the consults, including that they did not consider it a part of their routine process or they were working on other consults at the time of the communication. These types of documentation issues prevented Prosthetic Service managers and staff from effectively monitoring and tracking the repairs while they were in process. Because of these issues, the Prosthetic Service staff could not explain what caused the repair delays.

Consult Reports Ineffectively Monitored

Some Prosthetic Service managers did not effectively monitor purchasing agents after they received consults for repairs. For example, a supervisory purchasing agent at a VISN 7 medical facility stated the facility did not start monitoring pending consult reports regularly until she came on board in mid-August 2016. For the review period of the audit, the OIG estimated that the purchasing agents at this facility took an average of about 61 days to issue purchase orders after the consults were created for 30 delayed repairs. At another facility, the then acting chief of Prosthetic Service stated that open consults were monitored on a daily basis but pending consults were monitored only about once a month.

Consult Reports Improperly Monitored

The OIG found that VISN 7 Prosthetic Service managers and purchasing agents did not adequately monitor the timeliness of vendor performance. The "Date Required" field for the reviewed purchase orders typically indicated the vendors were to complete the repairs within 30 days. However, the OIG found Prosthetic Service staff at five of the eight reviewed VISN 7 VA medical facilities did not consistently use purchase card reports or other controls to monitor the completion of repairs. Instead, some Prosthetic

[9] *PSAS Business Practice Guidelines for Prosthetics Consult Management*.
[10] Veterans Health Administration Directive 1232(1), *Consult Processes and Procedures*.

Service staff stated that they relied on the vendors' submission of the invoices to monitor the completion of the repairs. Although the Prosthetic Service managers stated they monitored the purchase card reports and conducted follow-ups with their purchasing agents or vendors, the OIG could not confirm vendors were contacted based on the available consult documentation. Subsequently, the OIG found the vendors took more than 30 days to complete the repairs after they received the purchase orders for 93 of the projected 480 delayed repairs.

Active Monitoring Improves Timeliness

The Tuscaloosa VAMC had one of the lowest rates of delayed repairs compared to the other VISN 7 facilities because it had stronger monitoring and follow-up controls for repairs. The Tuscaloosa VAMC Prosthetic Service staff stated that they monitored open purchase card transactions at least once a week and contacted the vendor to determine if there were any foreseeable delays in the completion of repairs. In addition, the Tuscaloosa VAMC Chief of Prosthetic Service stated that staff at the VAMC monitored purchase order reports to assist them in managing their workload.

Effects of Delayed Repairs

The OIG discovered that some veterans found it necessary to follow up with medical facility Prosthetic Service staff multiple times to ensure the completion of their repairs. The OIG's review of veterans' VA health records found that delays in the repair of veterans' power wheelchairs or scooters could significantly affect veterans' independence and quality of life. For example, the OIG identified at least one veteran who was confined to his bed due to safety concerns and waited 108 days for his wheelchair to be repaired. Another veteran missed his medical appointment while waiting 32 days for his wheelchair repair. The veterans' VA health records did not provide information about the financial effect the delayed repairs had on veterans so the OIG could not confirm these delays created financial hardships for veterans.

Conclusion

VA medical facilities in VISN 7, including the Atlanta HCS, need to focus on monitoring and measuring the timeliness of power wheelchair and scooter repairs from the veterans' initial request through completion. Information in VHA's consult management system, by itself, does not provide VA medical facility and Prosthetic Service management sufficient information to effectively monitor and ensure the timeliness of power wheelchair and scooter repairs. Likewise, weak VA medical facility and Prosthetic Service oversight of the four phases of the repair process have made veterans in VISN 7 susceptible to delays averaging anywhere from 16 to 52 days beyond a 30-day timeliness benchmark, depending on the VISN 7 VA medical facility managing the repair. VISN 7 needs to reduce veterans' wait times for the completion of their power wheelchair and scooter repairs and to minimize unnecessary hardships caused by delayed repairs.

Recommendations

1. The OIG recommended the Veterans Integrated Service Network 7 Director require VA medical facility staff to input power wheelchair and scooter repair requests as soon as they are received and implement management controls to ensure repairs with closed consults are monitored to completion.

2. The OIG recommended the Veterans Integrated Service Network 7 Director ensure Prosthetic Service staff follow documentation procedures by making annotations in the consults as required by Veterans Health Administration Directive 1232(1), *Consult Processes and Procedures*, and the *Prosthetic and Sensory Aids Service Business Practice Guidelines for Prosthetics Consult Management* for power wheelchair and scooter repair.

3. The OIG recommended the Veterans Integrated Service Network 7 Director implement controls to ensure Prosthetic Service staff monitor and follow up on repairs from initial request through completion to ensure the repairs are timely.

4. The OIG recommended the Veterans Integrated Service Network 7 Director ensure Prosthetic Service managers and staff monitor vendors to ensure they meet agreed-upon delivery dates for repairs.

Management Comments

The VISN 7 Director concurred with our recommendations and provided an action plan to address these recommendations. The VISN 7 Prosthetic Representative will ensure medical facility staff comply with the newly initiated "REPAIR" Template consult that allows staff to create easily identifiable administrative repair consults. PSAS supervisors will run the Delay Order Report on pending and open consults to ensure timely service. The Prosthetic Service representative will also ensure medical facility staff verify information on the VA Form 2319 (Record of Prosthetic Services), contact veterans within five business days, and send a request for quote within three business days. For repairs at the facility, veterans will be notified on estimated duration of repair. If repair is not done at the medical facility, veterans will be provided with contractors' information. Furthermore, medical facility staff must annotate invoice receipt dates and veteran contact on VA Form 2319 and confirm repair status and satisfaction by documented veteran contact and/or signed repair satisfaction letter. In addition, PSAS managers will complete quarterly audits to monitor and improve documentation of repairs and monitor the quality of repairs and develop corrective action plans.

OIG Response

The VISN 7 Director's action plan to address the OIG's recommendations is acceptable. Appendix D contains the full text of the VISN 7 Director's comments.

Appendix A Background

Program Office and Eligibility for Prosthetics

VA's PSAS, which is part of VA's Rehabilitation and Prosthetic Service, provided services for 3.3 million veterans in FY 2016. The term "prosthetic" covers artificial limbs and devices that support or replace a body or function, including wheelchairs and scooters. PSAS provides prosthetic items from prescriptions through procurement, delivery, training, replacement, and any necessary repair.

Eligibility for prosthetic items is open, generally, to all veterans enrolled in the VA health care system. Veterans in the following groups are eligible even though they may not be enrolled:

- Veterans needing prosthetics, medical equipment, and supplies for a service-connected disability
- Veterans with a service-connected disability rating of at least 50 percent

VISN 7: VA Southeast Network

Eight VISN 7 VA medical facilities in the states of Alabama, Georgia, and South Carolina provide power wheelchair and scooter repair services to veterans. At the time of the OIG's review, the VISN 7 Prosthetic Service representative, who reports to PSAS, managed all VA medical facility Prosthetic Services within the VISN. However, as of May 28, 2017, management of Prosthetic Services at the VISN 7 VA medical facilities shifted from the VISN 7 prosthetic representative to the individual medical facility directors.

Government Purchase Card Use

There are no contracts for wheelchair and scooter repairs in VISN 7 because purchases for repair services, including parts and labor, fall under the micro-purchase threshold, outlined in federal acquisition regulation.[11] Purchases under the micro-purchase threshold, including services, can be made using a government purchase card. In addition, per the VISN 7 Prosthetic Service representative, contracts would not work well for wheelchair and scooter repairs because it is important to have local vendors who are accessible to veterans in different geographical locations. Therefore, medical facilities use local vendors for wheelchair and scooter repairs and purchase the repairs using a government purchase card.

[11] Title 48, Code of Federal Regulations, § 13.3, Simplified Acquisition Methods.

Appendix B Scope and Methodology

Scope

The OIG conducted audit work from October 2016 through September 2017. The OIG obtained a universe of power wheelchair and scooter repair orders from the National Prosthetic Patient Database (NPPD) that was paid to vendors from October 1, 2015, through September 30, 2016. The OIG reviewed a random sample of 230 repair orders from the eight VA medical facilities in VISN 7 to evaluate the monitoring of the repairs and the time frames for the completion of the repairs. Table 2 lists the eight VISN 7 VA medical facilities the OIG reviewed.

Table 2. VISN 7 VA Medical Facilities and Their Location

Number	VA Medical Facility	Location
1	Atlanta VA HCS	Decatur, GA
2	Birmingham VAMC	Birmingham, AL
3	Carl Vinson VAMC	Dublin, GA
4	Central Alabama VA HCS (East and West)	Tuskegee, AL and Montgomery, AL
5	Charlie Norwood VAMC	Augusta, GA
6	Ralph H. Johnson VAMC	Charleston, SC
7	Tuscaloosa VAMC	Tuscaloosa, AL
8	Wm. Jennings Bryan Dorn VAMC	Columbia, SC

Source: VA OIG analysis of power wheelchair and scooter repair orders as of April 2017

Methodology

The OIG reviewed applicable laws, regulations, policies, procedures, and guidelines related to VA-issued power wheelchair and scooter repairs. The OIG interviewed staff from VHA PSAS and VISN 7 Prosthetic Service managers at the VISN. The OIG conducted a research site visit to the Atlanta VA HCS to review processes and to gain an understanding of how staff receive, track, and process wheelchair and scooter repair orders.

The OIG also performed site visits to two VA medical facilities and desk reviews of the remaining six VA medical facilities in VISN 7.[12] During these reviews, the OIG interviewed management and staff to evaluate monitoring and processing of power wheelchair and scooter repair orders. Lastly, the OIG tested randomly selected samples from all eight VA medical facilities within VISN 7. During this testing, the OIG collected key dates and

[12] The OIG selected the two VA medical facilities to visit based on the number of veterans with wheelchair and scooter repairs, number of repair orders, and repair expenditures.

information from VHA systems and documentary and testimonial evidence to arrive at its conclusions.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during the audit. The audit team exercised due diligence in staying alert to any potential fraud. Based on a review of fraud indicators, the OIG identified one instance of potential fraud during the audit and referred this information to the OIG Office of Investigations.

Data Reliability

The OIG used computer-processed data obtained from the Corporate Data Warehouse that were collected locally at VA medical facilities via the NPPD menu as part of the Veterans Health Information Systems and Technology Architecture (VistA) interface. To ensure the data were reliable to achieve the audit objective, the OIG tested the data universe for errors like missing key fields or calculation errors. The OIG did not identify any instances where these errors occurred and, thus, concluded the data were reasonable and complete.

In addition, the OIG performed early reviews of 30 sampled purchase orders for power wheelchair and scooter repairs. During these reviews, the OIG confirmed required data fields were the same as in the systems where these data values had originated or resided. This was determined by tracing them to the NPPD menus in VistA and the veterans' medical record via VA's Compensation and Pension Record Interchange and VistA Web. Furthermore, as needed to meet the audit's objective, the OIG completed a detailed review of key data fields for each sampled purchase order to determine if medical facilities adequately oversaw the repairs and promptly completed them. Consequently, the OIG's review of the 230 sampled orders required the tracing of data values to the systems where the values originated or resided. The OIG did not find any instance when the sample data values and the systems values differed and concluded the data were appropriate and sufficiently reliable.

Government Standards

Our assessment of internal controls focused on those controls related to the audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require us to plan and perform the audit to obtain sufficient, appropriate evidence and to provide a reasonable basis for our findings and conclusions based on the audit's objective. We believe that the obtained evidence provides a reasonable basis for our findings and conclusions based on the audit's objective.

Appendix C Statistical Sampling Methodology

To determine if VHA effectively monitored and provided timely prosthetic repair services in VISN 7, the OIG reviewed a random sample of power wheelchair and scooter repair orders.

Population

The OIG obtained NPPD purchase orders paid to vendors during the period from October 1, 2015, to September 30, 2016. From this data set, the OIG reviewed the codes used to set up the purchase orders and the consult descriptions to identify purchase orders for power wheelchair and scooter repairs. The OIG applied this method to develop the universe of power wheelchair and scooter repairs and identified approximately 1,200 purchase orders valued at about $559,000 for the eight VA medical facilities in VISN 7. The OIG statistician adjusted this universe and the related projections after the reviews determined that VA medical facility staff had miscoded some of the identified power wheelchair and scooter repairs. Where possible, the OIG replaced the miscoded purchase orders with other orders to be able to review 30 repairs at each VA medical facility. However, at one VA medical facility, the OIG could only identify 20 power wheelchair and scooter repairs for review.

Sampling Design

The OIG used a random sample approach to select the sample. The OIG stratified the universe by VA medical facility and placed each purchase order in random order, with each purchase order having an equal chance of selection regardless of its size. To be able to project results at the medical facility level, and based on the characteristics of the universe, the OIG computed a sample size of 30 samples for seven of the VA medical facilities and 20 samples for one VA medical facility. This sample design allowed the OIG to make statistical projections of the results at each of the eight VA medical facilities. The OIG reviewed 230 samples.

Table 3 shows the universe stratified at the VA medical facilities and the OIG's sample selection.

Table 3. Universe and Sample of Power Wheelchair/Scooter Repair Orders in VISN 7 During FY 2016

VA Medical Facilities	Repair Orders Universe	Universe of Payments	Sampled Orders From Universe	Sampled Payment Amounts From Universe
Atlanta VA HCS	90	$79,000	30	$26,300
Other Seven Facilities in VISN 7	1,100	$480,000	200	$98,400
Total	**1,190**	**$559,000**	**230**	**$124,700**

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Weights

The OIG calculated estimates in this report using weighted sample data. The OIG computed sampling weights by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The random sample approach is based on 6.5 precision, a 90 percent confidence level, and an expected error rate of no more than 10 percent of the total number of orders. The OIG estimated that at the Atlanta VA HCS 39 veterans experienced delays in the completion of 45 repairs in FY 2016.

Tables 4, 5, and 6 show the estimated number of delayed repairs, average days, and affected veterans at the eight VA medical facilities in VISN 7. In Tables 4, 5, and 6, the Total (Combined Projections) do not add up to the sums of each column because the numbers have been rounded. For Tables 4, 5, 6, 7, and 8, the OIG statistician used a 90 percent confidence interval for these projections.

The OIG found that the delayed repair order projections for the Atlanta VA HCS, Carl Vinson VAMC, Birmingham VAMC, and Wm. Jennings Bryan Dorn VAMC should not be compared to the Tuscaloosa VAMC's projection because the differences could be caused by the margin of error.

Table 4. Projections of Delayed Repair Orders in VISN 7 During FY 2016

VA Medical Facility	Point Estimate	Margin of Error	Lower Limit	Upper Limit
Atlanta VA HCS	45	15	30	60
Birmingham VAMC	30	10	20	40
Carl Vinson VAMC	96	27	69	120
Central Alabama VA HCS	59	28	31	87
Charlie Norwood VAMC	200	72	130	270
Ralph H. Johnson VAMC	7	4	3	11
Tuscaloosa VAMC	7	9	2	16
Wm. Jennings Bryan Dorn VAMC	34	11	23	46
Total (Combined Projections)	**480**	**85**	**390**	**560**
Percentages (Combined Projections)	**41%**	**7%**	**34%**	**48%**

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table 5. Projections of Average Days for Delayed Mobile Wheelchair and Scooter Repair Orders in VISN 7

VA Medical Facility	Point Estimate	Margin of Error	Lower Limit	Upper Limit	Beyond 30 Days Benchmark
Atlanta VA HCS	70	18	51	88	40
Birmingham VAMC	61	2.3	2	4.3	16
Carl Vinson VAMC	47	9	38	57	17
Central Alabama VA HCS	59	12	47	71	29
Charlie Norwood VAMC	82	38	44	120	31
Ralph H. Johnson VAMC	64	22	42	86	34
Tuscaloosa VAMC	46	2.3	44	48	47
Wm. Jennings Bryan Dorn VAMC	77	26	51	100	52
Total (Combined Projections)	**69**	**16**	**53**	**84**	**39**

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table 6. Projections of Veterans Affected by Delayed Repair Orders in VISN 7 During FY 2016

VA Medical Facility	Point Estimate	Margin of Error	Lower Limit	Upper Limit
Atlanta VA HCS	39	13	27	52
Birmingham VAMC	26	9	17	35
Carl Vinson VAMC	75	21	54	96
Central Alabama VA HCS	44	22	22	66
Charlie Norwood VAMC	150	54	97	210
Ralph H. Johnson VAMC	7	4	3	11
Tuscaloosa VAMC	6	7	2	12
Wm. Jennings Bryan Dorn VAMC	32	10	21	42
Total (Combined Projections)	**380**	**66**	**310**	**450**
Percentages (Combined Projections)	**42**	**7**	**35**	**49**

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table 7 shows the average length of time of each repair phase for the projected delayed repairs.

Table 7. Projected Average Phase Length for FY 2016 Delayed Wheelchair Repairs in VISN 7 (in Days)

Repair Phases	Point Estimate	Margin of Error	Lower Limit	Upper Limit
Phase 1: Repair Request Phase	1	1	0	1
Phase 2: Open Consult Phase	9	2	6	11
Phase 3: Pending Consult Phase	44	14	29	58
Phase 4: Repair Phase	22	8	14	31

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table 8 shows the projected number of delayed repairs where the consults were not promptly entered, the average projected delay in the input of the consults, and the projected number of delayed repairs where vendors took over 30 days to perform the repairs. All the projections presented in these tables are based on a 90 percent confidence interval.

Table 8. Other Projections Related to FY 2016 Delayed VISN 7 Repairs Orders

Other Projections Used	Point Estimate	Margin of Error	Lower Limit	Upper Limit
Consults Not Promptly Input – Count	8	6	2	14
Consults Not Promptly Input – Percentage (of Total Errors Identified)	1.6%	1.3%	0.3%	3%
Consults Not Promptly Input – Average Days	120	96	28	220
Delayed Repairs Where Vendors Took Over 30 Days to Complete the Repairs – Count	93	52	41	150
Delayed Repairs Where Vendors Took Over 30 Days to Complete the Repairs – Percentage (of Total Errors Identified)	8%	4%	4%	12%

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table 9 shows the OIG's analysis of the statistically significant differences when it applied Tukey's Studentized Range test to the projected number of delayed repair orders.

Table 9. Statistically Significant Differences Test for Number of Delayed Repair Orders

VA Medical Facilities	Atlanta VA HCS	Tuscaloosa VAMC	Carl Vinson VAMC	Central Alabama VA HCS	Birmingham VAMC	Ralph H. Johnson VAMC	Wm. Jennings Bryan Dorn VAMC	Charlie Norwood VAMC
Atlanta VA HCS								
Tuscaloosa VAMC	**Significant Difference**							
Carl Vinson VAMC	Not Significant	**Significant Difference**						
Central Alabama VA HCS	Not Significant	Not Significant	Not Significant					
Birmingham VAMC	Not Significant	**Significant Difference**	Not Significant	Not Significant				
Ralph H. Johnson VAMC	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant			
Wm. Jennings Bryan Dorn VAMC	Not Significant	**Significant Difference**	Not Significant	Not Significant	Not Significant	Not Significant		
Charlie Norwood VAMC	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant	

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table 10 shows the average number of days beyond the 30-day benchmark for the eight VISN 7 VA medical facilities. Table 10 also shows the results of Tukey's Studentized Range test for the average number of days beyond the 30-day benchmark projections. The OIG found that the projections for the Wm. Jennings Bryan Dorn VAMC and Charlie Norwood VAMC should not be compared with the Tuscaloosa VAMC's projection because the differences might be caused by the margin of error.

Table 10. Statistically Significant Differences Test for Average Delay Beyond 30-Day Benchmark

VA Medical Facilities	Atlanta VA HCS	Tuscaloosa VAMC	Carl Vinson VAMC	Central Alabama VA HCS	Birmingham VAMC	Ralph H. Johnson VAMC	Wm. Jennings Bryan Dorn VAMC	Charlie Norwood VAMC
Atlanta VA HCS								
Tuscaloosa VAMC	Not Significant							
Carl Vinson VAMC	Not Significant	Not Significant						
Central Alabama VA HCS	Not Significant	Not Significant	Not Significant					
Birmingham VAMC	Not Significant	Not Significant	Not Significant	Not Significant				
Ralph H. Johnson VAMC	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant			
Wm. Jennings Bryan Dorn VAMC	Not Significant	**Significant Difference**	Not Significant	Not Significant	Not Significant	Not Significant		
Charlie Norwood VAMC	Not Significant	**Significant Difference**	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant	

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Appendix D Management Comments

Department of Veterans Affairs Memorandum

Date: December 29, 2017

From: Acting Network Director, VA Southeast Network (10N7)

Subj: Draft Transmittal – Audit of Prosthetic Mobile Wheelchairs and Scooters in VISN 7, Project Number 2016-04655-R6-0209

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

1. I have had the opportunity to review the Draft Report Transmittal – Audit of Prosthetic Mobile Wheelchairs and Scooters in VISN 7. I concur with the four recommendations of the Draft Report Transmittal – Audit of Prosthetic Mobile Wheelchairs and Scooters in VISN.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care for our Veterans.

3. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer at (678) 924-5700.

(Original signed by)

Ajay K. Dhawan, MD
Acting Network Director

Attachment

For accessibility, the format of the original documents in this appendix has been modified to fit in this document to comply with Section 508 of the Americans with Disabilities Act.

Attachment

Veterans Health Administration
VA Office of Inspector General
Office of Audits and Evaluations
Audit of the Timeliness of VISN 7 Power Wheelchair and Scooter Repairs

Recommendations:

1. The OIG recommends the Veterans Integrated Service Network 7 Director require VA medical facility staff to input power wheelchair and scooter repair requests as soon as they are received and implement management controls to ensure repairs with closed consults are monitored to completion.

Response: Concur

Narrative: The VISN 7 Prosthetic Representative will ensure VAMC compliance with the newly initiated "REPAIR" Template consult. This template allows clinical staff or Prosthetic Supervisory Staff to create an easily identifiable administrate repair consult. Prosthetic Sensory Aids Service (PSAS) supervisors will run the Delay Order Report (DOR) on pending and open consults to ensure timely service.

Target date: February 28, 2018

2. The OIG recommends the Veterans Integrated Service Network 7 Director ensure prosthetic service staff follows documentation procedures by making annotations in the consults as required by Veterans Health Administration Directive 1232(1) Consult Processes and Procedures and the Business Practice Guidelines for Prosthetics Consult Management for power wheelchair and scooter repairs.

Response: Concur

Narrative: The VISN 7 Prosthetic Representative will ensure that VAMC staff verify information on the 2319 form and contact the Veteran within five (5) business days. If the wheelchair can be repaired at the facility, the Veteran will be notified on estimated duration of repair. At VAMCs with no wheelchair labs, PSAS staff will issue a request for quote (1090 form) and provide a response within three (3) business days. VAMC PSAS staff will notify Veterans of the contractor's information when the Purchase Order is issued.

Target date: March 31, 2018

3. The OIG recommends the Veterans Integrated Service Network 7 Director implement controls to ensure prosthetics service staff monitor and follow up on repairs from initial request through completion to ensure the repairs are timely completed.

Response: Concur

Narrative: The VISN 7 Prosthetic Representative will ensure that VAMC staffs annotate invoice receipt dates on the 2319 form. PSAS staff will confirm repair status by documented Veteran contact and/or a signed repair satisfaction letter. The VAMC PSAS manager will follow Standard Operating Procedures to complete quarterly audits of no less than five (5) transactions per purchasing agent to monitor and improve documentation of Prosthetic equipment repairs.

Target date: March 31, 2018

4. The OIG recommends the Veterans Integrated Service Network 7 Director ensure prosthetics service managers and staffs monitor vendors to ensure they meet agreed-upon delivery dates for repairs.

Response: Concur

Narrative: The VISN 7 Prosthetic Representative will ensure that VAMC staff document Veteran contact and verify satisfaction with repairs. VAMC staff will send letters to obtain Veterans' satisfaction of vendors and repairs. Returned letters will be annotated on Veteran's 2319 and scanned to the Advanced Prosthetic Acquisition Tool (APAT) library as part of the purchase packet. The VAMC PSAS manager will complete quarterly audits of no less than five (5) transactions per purchasing agent to monitor quality of repairs and develop corrective action plans. VAMC PSAS managers will submit audit results and action plans to the VISN 7 Prosthetic Representative quarterly.

Target date: March 31, 2018

Appendix E OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Janet Mah, Director Rhiannon Barron Herlin Guerra-Sagastume Sunny Lei Andrea Lui Michael Reyes Andrea Sandoval Leslie Yuri

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