



Department of
Veterans Affairs

Office of Inspector General

ALLEGATIONS OF MISMANAGEMENT OF THE EQUIPMENT PROGRAM AT VA MEDICAL CENTER (ATLANTA) DECATUR, GEORGIA

*The Equipment Program was
Mismanaged, ADP Equipment Could
Not Be Located, and New Computers
and Monitors Were in Storage in
Unopened Shipping Cartons*

REPORT NO.: 98-00160-57

DATE: April 5, 2000



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Director (00/508)

**Allegations of Mismanagement of the Equipment Program at
VA Medical Center (Atlanta) Decatur, Georgia**

1. Introduction. The Office of Inspector General (OIG) conducted an evaluation at VA Medical Center (VAMC) Atlanta to determine the validity of allegations that:

- a. Logistics Service mismanaged the Equipment Program.
- b. Past inventories of automated data processing (ADP) equipment identified missing items valued at hundreds of thousands of dollars.
- c. Falsified information was provided to the OIG during the fiscal year (FY) 1997 Consolidated Financial Statement audit.

2. Summary of Results. We substantiated the allegation that the Equipment Program was mismanaged. We found that at the time of our visit, (i) over \$336,000 of new computers and monitors were in storage excess to facility needs, (ii) only 56 percent of the required facility inventories were performed, (iii) the Excess/Turn-in Program was backlogged by 300 documents to process, (iv) Reports of Survey were taking as long as 219 days to process, (v) controls over the Loan-Out Program needed to be strengthened to safeguard VA property, and (vi) unused equipment was sometimes abandoned or placed in hallways or storage rooms and could not be located during a subsequent inventory.

These deficiencies occurred because (i) the Information Technology (IT) Service purchased medical center ADP equipment based on the availability of funds, rather than from a formalized plan, and (ii) the Equipment Program was centralized to Logistics Service without sufficient resources to meet the workload requirements. We recommended that the medical center: (i) develop a formal, written plan to acquire ADP equipment based on need; (ii) ensure that new unused computers and monitors are put to appropriate use or excessed to a VA facility that can properly utilize this equipment; and, (iii) that responsibility for equipment accountability be decentralized to the using services to ensure greater control over facility equipment.

The allegation that hundreds of thousands of dollars worth of ADP equipment could not be located during past inventories was partially substantiated. We found that equipment with a total acquisition cost of \$460,000 could not be located. We

determined that the inventory database was inaccurate, and much of the equipment had been exchanged, excessed, or listed in error. This occurred because equipment had previously been disposed of without preparing the required paperwork to remove the items from the inventory database. Therefore, the inventory database contained items that were no longer located at the facility. Management had recently implemented controls over the receipt, distribution, and movement of ADP equipment, but did not have a formal written policy for staff to follow. We recommended that the draft policy be finalized and enforced.

The allegation that falsified information was provided to the OIG was not substantiated. Based on our review, the complainant agreed that he had misinterpreted the information being requested by the OIG for the FY 1997 Consolidated Financial Statement audit.

3. Details of Evaluation.

Mismanagement of the Equipment Program. Improvements are needed in both IT Service, which manages the medical center's ADP equipment, and Logistics Service, which is responsible for all other medical center equipment.

Information Technology Service -- Our evaluation showed that the facility had accumulated unused computers and monitors designated as "spares" that had an acquisition cost of over \$706,000. Some of the "spares" had been used and returned to IT for reassignment. However, we found more than 100 new computers and almost 400 new monitors in storage in unopened shipping cartons with an acquisition cost of over \$336,000. Some of the equipment had been purchased in 1996. During FY 1998, the facility acquired and installed 107 additional computers and 96 more monitors at a cost of more than \$494,000, even though there were new computers and monitors in storage. At the time of our review, another 38 computers and monitors costing over \$68,000 had been ordered but not yet received.

This occurred, in part, because the facility was purchasing computers and monitors at the same time the Veterans Integrated Services Network (VISN) was also procuring computers and monitors. Since the VISN computers were more technologically advanced and the purchase price included installation, the facility had the VISN computers installed. The computers and monitors purchased by the medical center were placed in a storage room. According to IT management officials, the facility left this equipment in storage and purchased other computers and monitors to provide employees state-of-the-art equipment.

The Chief Information Officer (CIO) told us that he did not intend to ever use the equipment because it was outdated technology. We discussed this equipment with the facility Director during the Exit Conference. He stated that administrative staff could use these computers and that they would be installed. Subsequent to the Exit Conference, the computers and one-half of the monitors were installed. According to the Director, the remainder of the monitors will be used as replacements on an as-needed basis.

The CIO stated that there had been inadequate planning in the past to acquire computers and monitors. ADP equipment had been purchased based upon availability of funds, verbalized requests from using Services, and an attempt to predict future ADP needs, rather than from a formalized plan for procuring computers and monitors on a systematic basis. Since becoming CIO¹, he had collaborated with the current IT manager to formulate an ADP Acquisition Plan, but had not formalized the plan in writing. The facility should have a written plan, as required by VA policy², to ensure that computer equipment is acquired based on need.

Logistics Service -- When the Equipment Program was centralized to Logistics Service, and with the implementation of bar-code technology, Logistics Service took over the responsibility for conducting equipment inventories. This resulted in Logistics Service officials not giving proper attention to their equipment inventories. At the time of the review, the facility had already identified the delinquent condition in the Inventory Program and Reports of Survey and had initiated corrective action. However, the equipment program areas were still severely backlogged.

The backlog occurred because one Supply Technician was given responsibility for the Inventory Program, the Excess/Turn-in Program, and the Report of Survey Program. An analysis of these program areas showed that the processes in place were inefficient and did not allow the workload requirements to be met by the allocated resources. We concluded that the facility needed to decentralize the accountability for management of equipment assets to the using Services. Examples of the backlogs are detailed below.

- Only 74 of 131 (56 percent) inventories were performed during FY 1998. Forty equipment items costing almost \$245,000 could not be located and were written off as lost or stolen. Additionally, 8 inventories could not be reconciled because 28 items with a cost of \$429,181 had not yet been located.
- The Excess/Turn-In Program was backlogged by 300 documents that required processing because Turn-In documents from facility service staff were not accurate or complete. Therefore, Logistics staff were required to spend excessive time researching, correcting, and completing the documents.
- The Report of Survey process was not timely. In some cases, it was taking as long as 219 days to complete the Report of Survey process. The process is supposed to be completed in 10 days.

We also found that controls needed to be strengthened over the Equipment Loan-Out Program. IT Service had over \$435,000 worth of computer equipment loaned out to medical center employees. Loan agreements were not renewed timely, and the required annual physical inventories were not done. As a result, VA equipment was not properly safeguarded.

¹ The current CIO and IT Manager transferred from other VA facilities in February and August 1998, respectively.

² Department of Veterans Affairs Acquisition Regulation – Part 807 – Acquisition Planning

Additionally, because service chiefs were not accountable for equipment assigned to them, unused equipment was sometimes abandoned or placed in hallways or storage rooms, and could not be located during the subsequent inventory. The facility Director agreed that equipment would be better safeguarded by decentralizing the Equipment Program so that the Service assigned the equipment would be responsible for its accountability and inventory.

ADP Equipment Could Not Be Located. A 1996 inventory of ADP equipment showed that ADP equipment items with acquisition costs of almost \$460,000 could not be located. We found that much of the equipment listed as missing had been excessed, exchanged, or listed in error. This occurred because past inventories were performed inconsistently, and ADP equipment was disposed of without preparing the required paperwork to adjust the inventory records. As a result, the inventory database was inaccurate because it contained equipment that was no longer at the facility.

The following examples are equipment items in the inventory database that were listed as missing during the 1996 inventory:

- ADP equipment for the medical center's computer network system costing \$244,427. This equipment was located in "data closets" and could not be removed to read the serial numbers because it would have shut down the entire hospital computer system. These components were inventoried each time one of them was replaced.
- A \$27,478 telephone dialing system. Our review of the contract to upgrade the telephone system showed that the contractor was required to "haul away" the replaced equipment. IT Service officials agreed that the contractor had removed the item during the upgrade, but the required paperwork was never completed.
- A \$9,561 computer that had been returned to the vendor upon receipt in 1992, but was still listed in the inventory database as "In Use." The payment to the vendor had been canceled when the computer was returned.

IT management recently implemented a Work Order System to provide an audit trail of the movement of ADP equipment, and also implemented controls over the receiving and distribution of computer equipment. These actions should improve the accountability for ADP equipment. However, IT Service did not have a formal written policy for these procedures, although a policy was in draft at the time of our evaluation. This policy should be finalized and enforced so that staff are aware of the proper procedures to follow to safeguard and account for VA equipment.

4. Recommendation 1: We recommend that the Director take action to:

- a. Ensure that IT Service develops a formal, written plan to procure ADP equipment based on need.
- b. Ensure that unused computers and monitors are put to appropriate use or excessed.

- c. Decentralize the responsibility for equipment accountability to the using Services.
- d. Finalize and enforce IT Service policy for the receipt, distribution, and movement of ADP equipment.

5. Director Comments and Implementation Plan:

The Director concurred with our recommendations and provided acceptable implementation plans. We consider the implementation plans responsive to the intent of the report recommendations and consider the report issues resolved.

However, in the comments, the Director: (a) did not concur with the dollar value of the new equipment in storage, (b) stated that we should eliminate the dollar impact statement in the report due to the installation and use of the equipment in storage, (c) blamed the delinquent condition of the Equipment Program on a GS-7 Technician, (d) took issue with factual statements in the report, and (e) suggested revised wording for a number of sections in the report.

6. Office of Inspector General Comments:

The Director furnished an initial response to the draft report on July 15, 1999. Since the facility's comments were not consistent with the information and documentation furnished the audit team during the onsite visit, OIG management met with facility officials on July 29, 1999 to discuss these differences. The second response was received on August 20, 1999, and is included in this report as ATTACHMENT I. We have inserted our comments into the facility response where appropriate to clarify the issues, and explain why suggested changes could not be made to the report.

For the Assistant Inspector General for Auditing

(Original signed by:)

JAMES R. HUDSON
Director, Atlanta Audit Operations Division

ATTACHMENTS:

Appendices -

- I** – Comments of the Director
- II** – Monetary Benefits Summary
- III** – Report Distribution

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COMMENTS OF THE DIRECTOR

1. We received and reviewed your second draft incorporating some of the comments from our memo dated July 15, 1999. Although we agree in part with the recommendations listed in paragraph 4, we feel circumstances leading to several key issues at the time of your visit are not acknowledged in this draft. This can only be accomplished by acknowledging that ADP resources in storage were planned for installation and that the individual responsible for your hotline call stopped performing inventories and other duties related to his NX responsibilities and then contacted your office and others to report program delinquencies. These are key issues in our opinion and are important points in presenting and understanding the overall circumstances involved. Additionally, the revised draft does not reflect the outcome and mutual understanding of our follow up meeting with your staff on July 29, 1999. Since copies of the attachments referred to in this memo were provided with our previous response, they are not included, but will be available upon request.

OIG Comment 1a -- ADP resources in storage were planned for installation: During our onsite visit, we discussed the \$336,000 worth of new computers and monitors in storage with the Director, Chief Information Officer (CIO), Information Technology (IT) Service Chief, IT Operations Manager, and the former IT Chief. At no time was information or documentation provided to us that the computers in storage were planned for installation. The CIO stated to us that he did not intend to ever use the equipment because it was outdated technology. The facility subsequently acquired and installed additional new computers and monitors at a cost of more than \$494,000, even though there were \$336,000 worth of computers and monitors in storage. We do not believe that the equipment in storage would have been installed if we had not raised the issue with the Director.

OIG Comment 1b -- The individual responsible for your hotline call stopped performing inventories and other duties related to his NX responsibilities and then contacted your office and others to report program delinquencies: We cannot address this statement due to the complainant's request for anonymity. The complainant alleged that the Equipment Program was mismanaged and we substantiated that allegation. The severe backlogs in the Equipment Program were caused by centralization of the Inventory Program to Logistics, inefficient processes, inadequate supervision, poor record keeping, and unmet training needs. Documented examples of problems we identified are discussed below.

- Unused equipment was many times abandoned or placed in hallways or storage rooms, causing Logistics staff additional time and effort in attempting to locate these items during inventories.
- Incomplete and inaccurate equipment descriptions in the inventory database required Logistics staff to perform extensive research to inventory or excess equipment.
- Inadequate training of facility staff on the use of the electronic Excess/Turn-in package caused inaccurate and incomplete Excess/Turn-In requests. Logistics staff spent excessive time researching, correcting, and completing the documents.
- The inventory database listed \$310,000 more equipment loaned out to Research employees than the manual logs, which were used to account for the loaned-out equipment.
- Poor record keeping, inadequate supervision, and failure to enforce written procedures caused the FY 1998 Supply Processing and Distribution (SPD) inventory to be adjusted by over \$83,000, or 30 percent of the inventory total.

OIG Comment 1c -- The revised draft does not reflect the outcome and mutual understanding of our follow up meeting: All changes to the draft report suggested by facility management were made that were supported by documentation obtained during the onsite visit. It was explained to management during the meeting that there were suggested changes that could not be made because the facility had not provided us any evidence or documentation during our visit that supported those suggested changes.

Summary:

1. Our concurrence in part with the recommendations acknowledges areas where improvements could be made in local operations. However, we believe the recommendation concerning the equipment in storage should be deleted from the report since this equipment was needed and has been installed and is in use or available for replacement of malfunctioning monitors. None of this equipment has been or will be excessed. The resources available in support of the NX-Equipment Program have not been fully acknowledged or accepted in the 2nd draft report. Furthermore, the circumstances leading to the reason for your review and audit have not been fully recognized in the 2nd draft.

OIG Comment 2a -- The recommendation concerning the equipment in storage should be deleted from the report: We found that the facility had accumulated 119 new computers and 393 new monitors costing \$336,313 that were still in storage in unopened shipping cartons. Some of this equipment was purchased in 1996. The facility subsequently acquired and installed computers and monitors costing \$494,000. If resources were so obviously available to install the new equipment, then they were available to install the computers and monitors in storage rather than acquiring additional new equipment. These actions merely reinforce the IT Chief's statement that he did not ever intend to use the equipment in storage. The \$336,313 spent on this equipment could have been better used for direct patient care activities, instead of for computers and monitors that sat in a warehouse long enough to become obsolete and for their warranties to expire.

OIG Comment 2b -- The resources available in support of the NX-Equipment Program have not been fully acknowledged or accepted in the 2nd draft report: At the time of our audit, there were three employees assigned to the Equipment Program. The employee assigned the inventory, report of survey, and excess property programs was supported by the clerk who had full responsibility for the loan-out program. The third employee had other duties associated with the equipment program. This information was not only documented during our onsite visit, but facility management stated this in writing in their first set of comments to the draft report dated July 15, 1999.

OIG Comment 2c -- The circumstances leading to the reason for your review and audit have not been fully recognized in the 2nd draft: The draft report clearly states that the review was performed to determine the validity of three allegations. The allegations were made in a complaint letter sent to our Hotline Division.

2. The key issues in our view are:

a. The dollar value of equipment inventory in storage and the acceptance that the equipment is needed and is beneficial to our operations.

OIG Comment 3a -- All of the computers and monitors in storage were still in unopened shipping cartons on pallets in Room C118. IT provided us an electronic copy of the ADP inventory database from which we extracted all equipment listed as located in that room. The database showed that there were 119 computers costing \$197,270 and 393 monitors costing \$139,043 in Room C118, for a total of \$336,313. Some of the equipment had been in storage since October 1996. If these computers and monitors had actually been needed, they would not have still been in storage at the time our onsite visit ended December 2, 1998. It is also doubtful that this equipment, which was considered obsolete, was very beneficial to the facility's operations in February 1999.

b. Elimination of the projected dollar impact statement in the report due to the installation and use of the equipment in storage at the time of your audit.

OIG Comment 3b -- This issue was previously discussed in detail in **OIG Comment 2a**.

c. Acknowledgment that the NX technician contributed to much of the delinquent condition of our Equipment Program through his inaction or by refusal to communicate with his supervision. Additionally, acknowledgment that there are two full-time positions to support the E.I.L. inventory and excess property responsibilities, not one, as the draft report implies.

OIG Comment 3c -- It is the direct responsibility of a manager to resolve such problems as an employee's inaction or refusal to communicate with his supervisor, and it is a supervisor's responsibility to know where their employees are and what they are doing with their time. Although we did not document inaction or refusal to communicate with a supervisor by any Logistics employee, the Logistics Chief raised this issue during our visit. We advised him that successful supervisors hold regularly scheduled meetings with staff to discuss the status of their assigned work, the reason for any backlogs, and a target date for when it will be brought current. The Logistics Chief admitted that the supervisor did not know what the NX technician was doing with his time, but that he would talk to the supervisor about scheduling regular meetings with the employee.

The number of positions assigned to support the inventory, report of survey, and excess property programs was previously discussed in **OIG Comment 2b**.

d. Recognition that the present market value of the items on the IT Report of Survey was significantly less than the acquisition value of the items. While the DVA uses acquisition cost for equipment values, the actual present value is significantly less.

This is an important point considering the proposed distribution of this report and those not familiar with DVA practices.

OIG Comment 3d -- Although IT staff estimated the present market value of the missing items at \$57,435, VA accounting procedures require that the amount to be adjusted off the accounting records is the acquisition cost of the equipment. The amount on the Report of Survey to be “written off” was \$459,861, and that is the amount we reported. Although the inventory was completed in December 1996, the Report of Survey was not prepared until April 1998, which is when the present value was computed. The present value of the missing ADP equipment would have been much greater at the time of the 1996 inventory than it was 2 years later.

However, the larger concern addressed in the report is inadequate equipment accountability. The facility could not account for over 300 ADP items because internal controls were inadequate to safeguard equipment. Past inventories were performed inconsistently, and ADP equipment was disposed of without preparing the required paperwork to adjust the inventory records. ADP equipment acquired in 1995 and 1996 could not be located during the December 1996 inventory, when they were still relatively new. Some examples of recently purchased items that were missing included: (a) two portswitch repeaters costing \$6,700 purchased in September 1996, (b) a computer costing \$8,472 purchased in November 1995, and (c) two color notebook computers costing \$8,480, two laser printers costing \$3,376, and a computer costing \$2,715 purchased in July 1995.

2. Our concurrence or non-concurrence with the report recommendations and our implementation plans are as follows:

a. Recommendation 1a. **“Ensure that IT Service develops a formal, written plan to procure ADP equipment based on need.”**

Facility response: We concur in part. We agree that ADP resource acquisitions need to be planned. In lieu of a spending plan, we intend to fund ADP resources based on approved recommendations from our Information Management Committee. An Information Management Committee was established and met for the first time in October 1997. The committee established an information management plan but not a strategic spending plan. The committee was scheduled to meet quarterly. Due to re-organizations of Service Lines and key personnel changes, this committee was inactive until recently. A Medical Center Memorandum 00-42, MANAGEMENT OF INFORMATION PLAN, issued in July 1998, identified the facility's information needs (copy was provided). An Information Management Strategic Plan (IMSP) was presented to the Resource Allocation Committee (copy was provided) by the new CIO. The Information Management Committee was re-activated and held its first meeting in March 1999. The committee's actions are based on the information management initiatives contained in the IMSP. Obligations of funds are made consistent with the approved recommendations of the Committee.

Implementation plan: We consider this item complete.

OIG Comment 4a -- The implementation plan is responsive to the intent of our report recommendation and we consider the report issue resolved.

b. Recommendation 1b. **“Ensure that unused computers and monitors are put to appropriate use or excessed.”**

Facility response: We concur that new computers should be placed in use **but we disagree with the value of new equipment in storage at the time of the review.** Our comments on the value of new equipment in inventory are expressed in detail in our response dated July 15, 1999.

Implementation plan: All of the new CPUs in storage were 166MHZs. All have been installed and in use since February 1999. None of these CPUs were excessed. We consider installation of new equipment a recurring function. **We consider this recommendation item complete.**

OIG Comment 4b -- The value of the equipment in storage at the time of our review is discussed in detail in **OIG Comment 3a.**

The implementation plan is responsive to the intent of our report recommendation and we consider the report issue resolved.

c. Recommendation 1c. **“Decentralize the responsibility for equipment accountability to the using Services.”**

Facility response: We concur.

Implementation plan: Following the OIG audit, our Medical Center Memorandum on Non-Expendable Property Responsibility was re-written to place more responsibility on the using Service officials. Monitors have been put in place to monitor timely processing of equipment inventories (see Attachment C).

OIG Comment 4c -- The implementation plan is responsive to the intent of our report recommendation and we consider the report issue resolved.

d. Recommendation 1d. **“Finalize and enforce IT Service policy for the receipt, distribution and movement of ADP equipment.”**

Facility response: We concur in part.

Implementation plan: The SOP referred to in the draft report was put in place by the Service Line Chief in June 1998. It was in place at the time of the audit. However, he was not requested to produce a copy. A copy of the SOP and the signed cover memorandum is attached (see Attachment D). We have ensured all IT staff are aware of this SOP and are following it to record ADP property movement. We consider action on this recommendation complete with the exception of routine monitoring.

OIG Comment 4d -- On September 16, 1998, we obtained a copy of the policy from the IT Operations Manager while we were onsite. The policy was clearly marked "Draft IT Equipment Procedures." The document was undated and the Operations Manager stated that the policy had not yet been approved. We did not request this policy from the employee who was the Service Line Chief in June 1998, because he no longer worked in IT. The Operations Manager furnished us the information and documentation we requested concerning IT operations. Since the copy of the policy and the signed cover memorandum furnished to us by the facility on July 15, 1999 was undated, we were unable to determine when the policy was implemented. However, the implementation plan is responsive to the intent of our report recommendation and we consider the report issue resolved.

3. Projected dollar impact of the recommendation (\$336,313).

Facility response: **We do not concur with this dollar amount.** Because this equipment is needed and has been installed (except for monitors being held for replacement components as needed), we believe the dollar impact should be deleted from your report.

Explanation: The equipment was in storage only because workload constraints precluded their installation sooner. All of the CPUs and approximately 200 of the monitors in storage at the time of your audit have been installed. The CPUs were installed prior to February 19, 1999 and the monitors are installed as replacement components for failed monitors on an as needed basis. None of this new equipment was excessed. To overcome the high rate of technological obsolescence, management has implemented a plan to replace 25% of our ADP technology each year, resulting in a 4-year replacement schedule.

OIG Comment 5 -- The cost of the equipment in storage is discussed in detail in **OIG Comment 3a**.

Deleting the recommendation concerning the equipment in storage, and whether there were plans to install the equipment, were previously discussed in detail in **OIG Comments 2a and 1a**, respectively.

4. Many of our previous comments that we feel are important were not included in your revised draft. We request you consider the following suggestions, which more appropriately reflect the basis for the findings and should be utilized for revised wording in the Findings portion of the revised draft report.

a. Information Technology Service.

(1) New computers and monitors in storage. **Although the revised acquisition value of equipment in storage is \$59,325 more than what our records reflect, a greater concern at this point is the inference to plans to not utilize all of the computer equipment in storage. As stated in our previous response, the VISN purchased computers were installed as “priority” only.** The equipment in storage was to be installed (and now has been installed) as soon as resources were available. We would suggest the last two sentences of the last Paragraph on Page 2 to read:

*“Since the VISN computers were more technologically advanced and the purchase price included installation, the facility had the VISN computers installed **as priority**. The computers and monitors purchased by the medical center were placed in a storage room **until resources could be made available for their installation.**”*

OIG Comment 6 -- The acquisition value of the equipment in storage is discussed in detail in **OIG Comment 3a**.

The suggested changes are not consistent with the documentation and information we received during our visit. Since the workpapers do not support the suggested changes, we cannot revise this portion of the report, as suggested.

(2) We would also suggest wording the second sentence in the first Paragraph of the Summary of Results on Page 1 to read:

*“We found that (i) over **\$276,000** of new computers and monitors were in **storage pending installation by the facility**, (ii) only 56 percent of the required facility inventories were performed, (iii) the Excess/Turn-in Program was backlogged by 300 documents to process, (iv) Reports of Survey were taking as long as 219 days to process, (v) controls over the Loan-Out Program needed to be strengthened to safeguard VA property, and (vi) unused equipment was sometimes abandoned or placed in hallways or storage rooms and could not be located during a subsequent inventory.*

OIG Comment 7 -- In the original facility response dated July 15, 1999, management estimated the acquisition cost of the computers and monitors in storage based on the assumption that the computers were all from two purchase orders dated September 12, 1997. Our itemized list of the computers and monitors in the storage room showed that the equipment was procured by six different purchase orders and received during the period October 1996 to August 1998.

In estimating the price of the computers, facility management neglected to include a \$100 charge for upgraded memory and \$72 for a sound card for each computer. They also calculated the acquisition cost based on 200 computers in storage. Their estimated acquisition cost for the computers was \$259,800. There were actually 119 computers costing \$197,270 in storage at the time of our onsite visit.

Their estimated cost of \$16,875 was for 75 monitors purchased September 12 that were upgraded to 17" screens at a cost of \$225 each. This cost was based on an assumption that the other monitors in storage had no cost because it was included with the price of the computers. However, Logistics allocates acquisition costs between computers and monitors to properly adjust the financial records when disposing of the items separately.

Our itemized list of equipment in the storage room showed that 198 of the 393 monitors were from the two September 12 purchase orders. There were also monitors that were procured by five other purchase orders that had acquisition costs that were not included in their estimate. There were actually 393 monitors with acquisition costs of \$139,043 in storage.

Although the facility estimated the total acquisition cost of the computers and monitors in storage at \$276,675, the actual cost of the equipment was \$336,313.

The actual acquisition cost of \$336,313 for the computers and monitors is discussed in detail in **OIG Comment 3a**.

(3) The following wording is suggested for the first and second Paragraphs on Page 3:

"The Chief Information Officer (CIO) discussed the use of the equipment in storage. Because the equipment was essentially outdated technology for the original intended purpose of supporting electronic medical records it could not be used for that application. The equipment was being installed in administrative areas as needed. Subsequent to the exit conference the computers and one-half of the monitors were installed. The remainder of the monitors will be used as replacements as older monitors burn out."

"The Chief Information Officer agreed that in the past there did not appear to be a formal ADP purchasing plan. The computers and monitors in inventory were the result of following national recommendations to procure PC's for the coming Graphical User Interface (GUI) electronic records. Delays in national release of the software made most of these PC's obsolete for that purpose. Secondly, the VISN made a large purchase of PC's for all VISN medical centers which local management was made aware of after delivery of their locally purchased PC's."

Medical Center Memorandum 00-42, MANAGEMENT OF INFORMATION PLAN, issued in July 1998 identified the facility's information needs (which was attached). An Information Management Strategic Plan (IMSP) was presented to the Resource Allocation Committee (was attached) by the new CIO. The Information Management Committee was re-activated and held its first meeting in March 1999. The committee's actions are based on the information management initiatives contained in the IMSP. Obligations of funds are made consistent with the approved recommendations of the committee.

OIG Comment 8 -- The suggested changes are not consistent with the documentation and information we received during the on-site review. Since the workpapers do not support the suggested changes, we cannot revise this portion of the audit report, as suggested.

The equipment in storage was previously discussed in detail in **OIG Comment 1a**.

b. Logistics Service.

(1) The revised draft report still reflects that the backlog in the NX Program was a result of one Supply Technician given the responsibility for the Inventory Program, the Excess/Turn-in Program, and the Report of Survey Program. We would suggest the following wording of the section Logistics Service – beginning on Page 3:

*“When the equipment program was centralized to Logistics Service, and with the implementation of bar-code technology, Logistics Service took over responsibility for the conduct of EIL inventories. This resulted in Logistics Service attempting to do too much and using Service officials not giving management of their equipment inventories proper attention. At the time of the review, the facility had already identified the delinquent condition in the CMR/EIL inventories and Report of Surveys. **Corrective action was initiated and was progressing in accordance with facility labor relations practices.** However, during our review we determined that the facility also needed to decentralize the accountability for management of equipment assets to the using Services. Examples of the backlogs are detailed below.”*

OIG Comment 9 -- Although Logistics officials identified the delinquent condition of the Inventory and Report of Survey programs in April 1998, the programs were still severely backlogged when we completed our site visit in December 1998. Facility management stated that the delinquent inventories could have been completed by other employees or supervisors, but were determined to be a reasonable responsibility of the NX Technician. They also stated that they were unaware that the backlog of Excess property documents was severely delinquent until we brought it to their attention. We believe management could have taken more aggressive action to bring these programs current in a timely fashion.

We do not know whether the corrective actions were progressing in accordance with facility labor relations practices. We were provided no information or documentation during our visit concerning this issue. We did not review this issue as it was beyond the scope of our audit.

The second paragraph under Logistics Service should be deleted (see note below) and the first bullet should read:

- *“Only 74 of 131 (56 percent) inventories were performed during FY 1998. Forty equipment items **with an acquisition cost of almost \$245,000 could not be located and were written off under standard Report of Survey procedures as unaccountable losses.**”*

OIG Comment 10 -- The second paragraph in the report under Logistics Service explains, in part, what caused the Equipment Program to become so severely backlogged and, therefore, cannot be deleted from the report.

Note: If it is determined not to remove the second paragraph, it should acknowledge that the NX Technician is directly supported by the NX clerk position who provides clerical and program support to the NX Technician. The true backlog occurred due to the NX Technician’s failure to perform inventories or request support/assistance from the supervisor.

OIG Comment 11 -- The clerical and program support received by the NX Technician was previously discussed in detail in **OIG Comment 2b**.

The reason for the severe backlogs in the Equipment Program was previously discussed in detail in **OIG Comment 1b**.

We do not feel that the last sentence in this bullet should be included since without your data to review, we assume the 8 EILs with 28 items of equipment to be located were inventories in progress. Once the EIL Responsible Official finalizes the EIL inventory, a Report of Survey would be initiated for any item not located. A review and investigation by an appropriate survey officer or board and the Medical Center Police and Security staff would be conducted, as required by DVA regulations.

OIG Comment 12 -- The issue being discussed in the report is equipment accountability. Since the Equipment Program was centralized to Logistics, service chiefs would abandon unused equipment or place it in hallways or storage rooms. As a result, the items could not be located during the subsequent inventory without a prolonged search, and sometimes could not be located at all. These 8 inventories had not been finalized because Logistics staff were still attempting to locate the 28 missing items. Forty items with acquisition costs of \$245,000 had already been written off as lost or stolen, and another 28 items with acquisition costs of \$429,181 were potential write-offs because the equipment could not be located. Adjusting almost \$675,000 off the accounting records during one fiscal year because the equipment could not be located is excessive and demonstrates the lack of accountability for equipment.

The third bullet under this section should not include the last sentence, which indicates that the Report of Survey process should be completed in 10 days. There is no manual reference that states this time frame.

OIG Comment 13 -- The 1997–1998 Performance Plan (PD #037920) for the NX Technician contains a critical element that requires that Reports of Surveys be recorded and processed within 10 days after receipt from the using services.

c. IT/Logistics Service

(1) Loan Agreement Issues. We agree that loan agreements were not renewed timely in many cases. **However, it was dealt with immediately and proper controls and follow up procedures are now in place. Individuals with Government ADP property are required to electronically acknowledge same by EE number annually or action is initiated to return the property to the Medical Center.** We would suggest the following wording for the first Paragraph on Page 4:

*“We also found that controls needed to be strengthened over the Equipment Loan-Out Program **to ensure equipment was properly safeguarded.** IT Service had over \$435,000 worth of equipment loaned out to medical center employees. Loan agreements were not renewed timely and required annual inventories were not done.”*

OIG Comment 14 -- Our review of the Loan-Out Program showed that controls were not adequate to ensure equipment accountability and safeguard VA equipment. We found that 27 of 50 (54 percent) of the loans we reviewed had expired and had not been renewed, nor had the equipment been returned. The required physical inventories were not done annually to ensure accountability for the loaned out equipment. As a result, the 1996 inventory identified 3 laptop computers that had been loaned out that were “missing.” They had not been recovered when we completed our visit on December 3, 1998.

We also found a \$310,000 discrepancy between the equipment inventory database and the manual logs for ADP equipment loaned to Research employees. The equipment inventory database showed that Research equipment costing \$435,000 was loaned out, but the manual logs showed only \$124,217. Since loaned-out equipment was controlled from the manual log, there was inadequate accountability for this equipment.

Based on the facility’s comments above, appropriate action has not been taken to comply with VA’s policy requiring annual physical inventories of all equipment loaned out to employees.

(2) ADP Equipment Could Not Be Located. As previously suggested, we feel that to accurately reflect the overall situation it is necessary to include the current market value of the ADP items that were unaccounted for. We suggest the following wording for Paragraph 3 on Page 4:

*“A 1996 inventory of ADP equipment showed that ADP equipment items with acquisition costs of almost \$460,000 could not be located. **Due to the age and condition of these items the current market value was estimated at \$57,435.** We found that much of the equipment listed as missing had been excessed, exchanged, or listed in error. This occurred because past inventories were performed inconsistently, and ADP equipment was disposed of without preparing the required paperwork to adjust the inventory records. As a result, the inventory database was inaccurate because it contained equipment that was no longer at the facility.”*

OIG Comment 15 -- This issue was previously discussed in detail in **OIG Comment 3d**.

- *“ADP equipment for the medical center’s computer network system costing \$244,427. This equipment was located in “data closets” and could not be removed to read the serial numbers because it would have shut down the entire hospital computer system. The components were inventoried each time one was replaced. **These items were listed on the Report of Survey not because they were missing, but because they were not physically inventoried and to establish an audit record to check when data closets were replaced. Replacement items were obviously in place. Logistics***

Service should have been provided with the replacement information at the time of installation so that inventory records could have been posted. ”

OIG Comment 16 -- The Report of Survey process is not intended to serve as an audit record to check when equipment items are replaced, but is used to report property that is lost, damaged, or destroyed. The inventory process serves as the audit record for equipment items. Since replacement items were obviously in place, the data closet items were missing, and were appropriately listed on the Report of Survey. This is another example of inadequate accountability for equipment due to disposing of equipment without preparing the required paperwork to adjust the inventory records.

Logistics Service should have been provided with the replacement information at the time of installation so that inventory records could have been posted. Since this did not occur, the equipment inventory database was inaccurate and overstated by \$244,427 for the data closet items.

- *“A \$27,478 telephone dialing system. Our review of the contract to upgrade the telephone system showed that the contractor was required to “haul away” the replaced equipment. IT Service officials agreed that the contractor had removed the item during the upgrade, but the required paperwork was never completed. **Therefore, the Report of Survey process was the appropriate vehicle to remove it from the records at that time.**”*

OIG Comment 17 -- This is another example of the required paperwork not being completed to timely remove the item from the equipment inventory database. As a result, unnecessary resources and time were expended trying to locate this item after it was determined to be “missing” during the 1996 inventory. We are not taking issue with the vehicle used to remove the item from the accounting records and see no reason to add this statement to the report.

- *“A \$9,561 computer that had been returned to the vendor upon receipt in 1992, but was still listed in the inventory database as “In Use.” The payment to the vendor had been canceled when the computer was returned. **This was identified during the joint IT/Logistics inventory. An adjustment was processed in June 1997 to remove the item from the equipment records. During the OIG review, the audit team was able to determine through fiscal records that the facility did not process payment for the computer. The adjustment to remove the item was considered to be an appropriate action. This item was included on the ADP Report of Survey by the NX Technician and should have been removed when the adjustment was made.**”*

OIG Comment 18 -- This computer was reported as “missing” during the 1996 inventory because it was still listed in the equipment inventory database as “in use.” The computer had been returned to the vendor on December 4, 1992 and adjusted off the financial records on June 25, 1997, almost 5 years later. We determined that the vendor did not bill the facility for the computer because it had been returned. Therefore, the computer was adjusted off the financial records even though payment was never made. Because the computer could not be located during the 1996 inventory it was listed on the Report of Survey to again be adjusted off the accounting records. On August 24, 1998, we brought this to the attention of the Logistics Chief so that the cost of the computer could be removed from the Report of Survey before it was finalized. However, as of December 7, 1998, the item was still included on the list of missing equipment. If past inventories had been performed consistently, this computer would not have remained in the equipment inventory database for six years after it was returned to the vendor.

5. The above suggestions are provided for your consideration for the final report. We have been working towards correcting program weaknesses that have been identified, some of which were underway at the time of your review. The suggestions for the revised wording, once incorporated into the final report, will more accurately reflect the circumstances in place at the time of the audit.

/s/

R. A. Perreault, CHE
Attachments

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MONETARY BENEFITS SUMMARY
(IN ACCORDANCE WITH OIG ACT AMENDMENTS)

REPORT TITLE: Allegations of Mismanagement of the Equipment Program
 at VA Medical Center (Atlanta) Decatur, Georgia

PROJECT NUMBER: 8R3-217

Recommendation <u>Number</u>	Category/Explanation <u>of Benefits</u>	Better Use <u>Of Funds</u>	Questioned <u>Costs</u>
1	Funds spent for unused computers and monitors could have been better used for direct patient care activities.	\$336,313	

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