VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of
Alleged Mismanagement of
Medical Supplies at the
VA Medical Center
East Orange, New Jersey

June 29, 2015
15-01927-375

ACRONYMS

IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement
MSDS	Medical Supply Distribution Section
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Highlights: Review of Alleged Mismanagement of Medical Supplies at VAMC East Orange, NJ

Why We Did This Audit

In September 2014, the Office of Inspector General received an allegation that Logistics Service at the East Orange VA Medical Center (VAMC)[1] purchased excess medical supplies resulting in mismanagement of government resources. The complainant alleged that the Medical Supply Distribution Section (MSDS) was responsible for the mismanagement. The complainant also alleged that a Logistics Service employee was misusing official time by leaving early every Friday.

What We Found

We substantiated the allegation that MSDS staff at the East Orange VAMC purchased medical supplies that were beyond normal stock levels. Veterans Health Administration (VHA) policy defines normal stock level as the maximum amount of an item that should be maintained in stock.

During an inspection of primary storage areas at the medical center, we identified about 2,900 excess medical supply items valued at approximately $48,100. We reviewed inventory reports to determine whether additional excess medical supplies existed. However, we determined that the inventory reports were inaccurate, and as a result, we could not determine the extent of excess medical supplies at the East Orange VAMC.

These inventory issues occurred because Logistics Service and MSDS management did not effectively monitor and manage the facility's medical supply inventories. Additionally, when they did identify inventory discrepancies, logistics staff did not determine why discrepancies were occurring. Without such action, East Orange VAMC cannot implement effective corrective actions to account for its physical inventories or increase the accuracy of the information in their inventory system. We did not substantiate the time and attendance allegation.

What We Recommended

We recommended the Interim Director of the Veterans Integrated Service Network (VISN) 3 ensure the VA New Jersey Health Care System take steps to improve medical supply inventory controls to minimize purchases of excess medical supplies.

Agency Comments

The Interim Director of VISN 3 concurred with our recommendations and provided plans for corrective action. We consider the actions acceptable and will follow up on their implementation.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

[1] The East Orange VAMC is part of the VA New Jersey Health Care System.

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RESULTS AND RECOMMENDATIONS

Allegation 1 Did Staff at the East Orange VAMC Purchase Excess Medical Supplies?

In September 2014, the Office of Inspector General (OIG) received an allegation that Logistics Service at the East Orange VA Medical Center (VAMC) purchased excess medical supplies resulting in mismanagement of government resources. The complainant alleged that the Medical Supply Distribution Section (MSDS) was responsible for the mismanagement. We substantiated the allegation that MSDS staff purchased medical supplies that were beyond normal stock levels.

What We Did

In February and March 2015, we conducted onsite work at the East Orange VAMC to assess the merits of the allegation. To accomplish our review, we did the following:

- Conducted interviews with Logistics Service and MSDS management, as well as staff responsible for managing medical supply inventory
- Conducted tours and inspected inventory storage areas managed by MSDS
- Inventoried medical supplies and reviewed various inventory reports to determine whether excess medical supplies existed
- Reviewed VHA and local policy related to management of medical supply inventory

Background

Veterans Health Administration (VHA) policy mandates that VA medical facilities use the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system to manage the receipt, distribution, and stock maintenance of all medical supply inventory. VHA policy also requires that VA medical facilities establish stock levels to maintain constant availability of items. The main stock levels are as follows:

- Normal Stock: maximum level of an item to be maintained in stock
- Standard Reorder Point: level at which an item is to be reordered

We defined excess stock as any physical inventory on hand above the normal stock level. Logistics Service management agreed with this definition.

VHA policy requires VA medical facilities to ensure the accuracy of medical supply inventory data and monitor the amount of stock on hand. According to Logistics Service management, supply technicians are responsible for primary storage areas and distribution technicians are responsible for secondary storage areas. VHA policy describes primary inventory as the

main inventory, and secondary inventories are the points of distribution. Secondary inventory locations include storage areas located in the various medical departments throughout the medical facility, such as hemodialysis, imaging, and anesthesia. Logistics Service management reported that supply and distribution technicians are responsible for ensuring the accuracy of physical inventories and adjusting stock levels as appropriate for their assigned storage areas.

Excess Medical Supplies Identified

We substantiated the allegation that the MSDS staff at the East Orange VAMC purchased excess medical supplies. During an inspection of primary storage areas at the medical center, we identified about 2,900 excess medical supply items valued at approximately $48,100. We found the excess medical supplies in boxes on three pallets. MSDS staff confirmed the medical supplies contained on the three pallets were excess. We inventoried the items and determined the excess included various medical supplies, such as sutures, tape, staplers, and syringes. The following picture shows the boxes containing excess medical supplies that we identified and inventoried.

Picture. Excess Medical Supplies

Source: VA OIG; East Orange, NJ VAMC; 8:07 a.m.; February 12, 2015

Logistics Service management reported that staff documented the excess medical supplies and made them available to other medical facilities within Veterans Integrated Service Network (VISN) 3. Management also reported that they dispose of any items not claimed by other facilities. We requested from Logistics Service management documentation of the excess medical supplies on the three pallets to compare with our inventory list. Of the 2,900 excess medical supplies, MSDS staff did not document about 2,700 of the items, valued at about $44,500. Therefore, we could not determine how long the excess medical supplies had been stored there or verify that MSDS

staff made the excess supplies available to other medical facilities within VISN 3.

Inaccurate Inventory Data

Since we identified excess medical supplies during an inspection of East Orange VAMC storage space, we reviewed IFCAP inventory reports to determine whether there were additional excess supplies. The inventory reports included the normal stock level, average cost, and current amount on hand for each medical supply line item. To assess the accuracy of the report, we selected and inventoried a judgment sample of fifteen medical supply line items. For all fifteen line items, the actual amount of medical supplies was less than the on hand amounts listed in the inventory reports. For example, the report indicated there were 17 high efficiency particulate air filter units. However, we only located nine units during our inspection. The eight air filters unaccounted for cost $218.87 each, or a total value of about $1,751.

VHA policy requires medical facilities to ensure continued accuracy of inventory data and proper management of stock on hand. However, we found the inventory reports were inaccurate. As a result, we could not determine the extent of excess medical supplies or whether the on hand amounts that were less than reported were due to pilferage or poor record keeping.

Annual Wall-to-Wall Inventory Documentation Missing

VHA policy requires the completion of an annual wall-to-wall inventory audit. According to Logistics Service management, they completed a wall-to-wall inventory audit in November 2014. However, Logistics Service management was unable to provide documentation showing that the annual inventory audit was conducted. Conducting and documenting a wall-to-wall inventory audit would allow the medical center to identify and account for inventory discrepancies or missing inventory, correct reporting errors, and better ensure accurate and reliable data is available in IFCAP.

Reasons for Medical Supply Inventory Issues

Logistics Service and MSDS management did not effectively monitor staff to ensure staff managed the facility's medical supply inventory in accordance with VHA and local policy. VHA policy requires the use of barcode scanners to track and maintain medical supply inventory. However, Logistics Service management reported that distribution technicians did not consistently use barcode scanners when tracking and transferring medical supply inventory from one area to another. The facility has three different types of barcode scanners and according to Logistics Service management, this contributed to inconsistent usage of the scanners.

Logistics Service management also reported that distribution technicians did not consistently update IFCAP when transferring medical supplies from one area to another. Local policy required the following:

- Distribution technicians must review their assigned secondary inventory areas and determine what medical supplies are needed.

- Distribution technicians must create inventory lists to indicate the medical supply items that need to be pulled from the primary inventory area for transfer to their assigned secondary inventory areas.
- Supply technicians must review the inventory lists and pull the necessary medical supply items for delivery to the secondary inventory areas.

Instead of supply distribution technicians pulling the supply items from their primary storage areas and delivering to secondary storage areas, Logistics staff reported that distribution technicians pulled the items themselves from primary storage areas. This removed inventory accountability controls at the primary storage areas and affected the accuracy of IFCAP reports.

Lastly, when supply technicians review inventory reports and identify differences between the reported and actual on hand amounts, the technicians manually adjust IFCAP without determining a reason for the discrepancy, such as the possibility of theft. For the period October 2013 through February 2015, negative manual adjustments for about 1,400 line items were made with a total adjustment value of about $463,000. Without determining why inventory discrepancies are occurring, the East Orange VAMC cannot implement effective corrective actions to account for its physical inventories or increase the accuracy of IFCAP.

Conclusion

We substantiated the allegation that the East Orange VAMC purchased excess medical supplies because we identified about 2,900 excess medical supply items valued at approximately $48,100 during an inspection of primary storage areas at the facility. Because of inaccurate inventory reports, we could not determine the extent of excess medical supplies at the medical center or what inventory could potentially be missing. The facility must improve inventory controls to ensure the timely identification of inventory discrepancies, correction of reporting errors, and the accuracy of IFCAP data.

Recommendations

1. We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System purchases and maintains medical supplies at normal stock levels.

2. We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System conducts a 100 percent wall-to-wall inventory of all Medical Supply Distribution Section inventory storage areas and document results.

3. We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System uses the results of the wall-to-wall inventory to assess the accuracy of the

Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system, and makes adjustments as deemed appropriate.

4. We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System obtains and mandates the use of one model of barcode scanner to track and maintain medical supply inventory.

5. We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System implements measures to determine reasons discrepancies are occurring in inventories and takes appropriate corrective action before technicians manually adjust the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system.

Management Comments and OIG Response

The Interim Director of VISN 3 concurred with our recommendations and provided plans for corrective action. We considered the actions acceptable. We will monitor implementation of these actions and will close the recommendations when we receive sufficient evidence demonstrating VISN 3 has addressed the identified issues. Appendix B contains the full text of the Interim Director's comments.

Allegation 2 Did a Logistics Service Employee at the East Orange VAMC Misuse Official Time?

In September 2014, the OIG received an allegation of a possible time and attendance issue within Logistics Service at the East Orange VAMC. The complainant alleged that a Logistics Service employee was misusing official time by leaving early every Friday. We did not substantiate this allegation.

What We Did

To assess the merits of the allegation, we reviewed the Logistics Service employee's time and attendance records. We also discussed the employee's work schedule and time and attendance records with the employee's approving official.

Criteria

VA policy allows employees to work alternate schedules with supervisory approval. Specifically, employees may request different starting and stopping times. The employee's supervisor must approve such tours, and changes to such tours.

What We Found

We did not substantiate the allegation that a Logistics Service employee was misusing official time by leaving early every Friday. Based on an interview and a review of the employee's time and attendance records, we determined that the Logistics Service employee had an alternate schedule and did leave work at 11:00 a.m. each Friday. However, the employee's time and attendance records showed that the employee worked 40 hours per week with an early departure on Fridays. Specifically, the employee's weekly schedule included 9 hours on Monday through Thursday and 4 hours on Friday.

The employee's supervisor approved the alternate schedule when the Logistics Service employee was hired. As a result, we did not substantiate the allegation that the Logistics Service employee was misusing official time by leaving early every Friday.

Government Standards

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

Appendix A Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Value of excess medical supplies we identified during an inspection of primary storage areas at the East Orange VAMC	$48,100	$0
	Total	**$48,100**	**$0**

Appendix B Interim VISN 3 Director Comments

Department of Veterans Affairs

Memorandum

Date: May 18, 2015

From: Interim Network Director, Veterans Integrated Service Network 3 (10N3)

Subj: Draft OIG Report – Veterans Health Administration: Review of Alleged Mismanagement of Medical Supplies at the VA Medical Center East Orange, New Jersey Project Number 2015-01927-R1-0099

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

1. The VA New York/New Jersey VISN Integrated Service Network (VISN3) has reviewed and concurs with the draft report regarding the allegation that the VA New Jersey Health Care System Logistics Service mismanaged medical supplies.

2. Should you have questions concerning the information submitted, please do not hesitate to contact Pam Wright, RN MSN, VISN 3 QMO at telephone number 718-741-4135.

(original signed by:)

Joan McInerney, MD, MBA, MA, FACEP

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION
Action Plan

Draft OIG Report – Veterans Health Administration: Review of Alleged Mismanagement of Medical Supplies at the VA New Jersey Health Care System, East Orange, New Jersey.
Date of Draft Report: April 27, 2015

Recommendation 1: We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System purchases and maintains medical supplies at normal stock levels.	
VHA Comments Concur.	Action Plan: VANJHCS Logistics Service and MSDS Management will review the VHA policy requirements, VANJHCS local policy (MCM # EC-77); and IFCAP System to manage the receipt, distribution, and stock maintenance of all medical supply inventory with their distribution technicians (GS 2005-06) and supply technicians (GS 2005-07). This review will include the requirement for VANJHCS to have established stock levels to maintain constant availability of items. The main stock levels will be set as follows per VHA policy: • Normal Stock - maximum level of an item to be maintained in stock • Standard Reorder Point – level at which an item is to be reordered. The Chief of Logistics Service and MSDS Management will monitor staff to ensure staff manage and maintain the medical supply inventory in accordance with VHA and VANJHCS policy stock levels. To ensure accountability controls at the primary storage areas and accuracy of the IFCAP, the Chief of Logistics Service and MSDS Management will cover the following items in their review with the distribution technicians and supply technicians: • Distribution technicians must review their assigned secondary inventory areas and determined what medical supplies are needed; • Distribution technicians must create inventory lists to indicate the medical supply items that need to be pulled from the primary inventory area for transfer to their assigned secondary inventory areas; and • Supply technicians must review the inventory lists and pull the necessary medical supply items from the primary inventory area for delivery to the secondary inventory areas. VANJHCS Logistics Service will initiate a 100% wall-to-wall inventory of all MSDS inventory storage areas and document the results annually. This will ensure that the Logistics Service has a current accurate medical supply inventory and to maintain the normal stock level. This inventory will be completed by the end of July 2015. Target Completion Date: December 2015
Supporting Documentation:	
Status:	_X_ In process __ Completed, Request closure

Recommendation 2:	We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System conducts a 100 percent wall-to-wall inventory of all Medical Supply Distribution Section inventory storage areas and document results.
VHA Comments Concur.	Action Plan: VANJHCS Logistics Service will initiate a 100% wall-to-wall inventory of all MSDS inventory storage areas and document the results. This will ensure that the Logistics Service has a current accurate medical supply inventory and to maintain the normal stock level. A Postmaster email notification will be sent out to alert the clinical services of the date for the wall-to-wall inventory to ensure this does not disrupt the provision of patient care. VANJHCS' MSDS will close operations for the time required to perform the 100% wall-to-wall inventory and to complete the documentation of the inventory results. In order to ensure there is no disruption in the delivery of patient care during this time, Logistics will provide the all areas affected with a three day supply and a contact should any emergency arise. The review of primary inventory included in the 100% wall-to-wall inventory are: MED OPERATING RM, MED ANESTHESIA, MED CARDIAC CATH, MED CENTRAL SUPPLY, MED CIR 1, MED CIR 2, MED CLC, MED GI-EO, MED GI-LY, IMG RADIOLOGY, LAB EO LABORATORY, LAB LY LABORATORY, DEN EO DENTAL, DEN LY DENTAL Chief of Logistics Service will set up a timetable to ensure a 100% wall-to-wall inventory is completed annually as required; and if accuracy is below 90% in any individual inventory source area, that individual inventory area will have a wall-to-wall inventory repeated in 6 months. Target Completion Date: July 2015.
Supporting Documentation:	
Status:	X In process __ Completed, Request closure

Recommendation 3:	We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System uses the results of the wall-to-wall inventory to assess the accuracy of the Integrated Funds Distribution, Control Point Activity, Accounting & Procurement System, and makes adjustments as deemed appropriate.
VHA Comments Concur.	Action Plan: VANJHCS Logistics Service will initiate a 100% wall-to-wall inventory of all MSDS inventory storage areas and document the results. This will ensure that the Logistics Service has a current accurate medical supply inventory and to maintain the normal stock level. VANJHCS' MSDS will close operations for the time required to perform the 100% wall-to-wall inventory and complete the documentation of the inventory results. This inventory will be completed by the end of July 2015. Chief of Logistics Service and MSDS Management will utilize the results of this 100% wall-to-wall inventory to assess the accuracy of their IFCAP, and make the appropriate adjustments to ensure normal stock levels are achieved and can be maintained. VANJHCS Logistics Service and MSDS Management will review the VHA policy requirements, VANJHCS local policy, and inventory process with their distribution technicians and supply technicians. To ensure accountability controls at the primary storage areas and accuracy of the IFCAP, they will cover the following items: • Distribution technicians must review their assigned secondary inventory areas and determined what medical supplies are needed • Distribution technicians must create inventory lists to indicate the medical supply items that need to be pulled from the primary inventory area for transfer to their assigned secondary inventory areas. • Supply technicians must review the inventory lists and pull the necessary medical supply items from the primary inventory source for delivery to the secondary inventory areas. MSDS Management will conduct random spot checks on a sample of inventoried units to validate the accuracy of the inventory reports. The spots will be initiated after the completion of the wall-to-wall in July 2015. The results of these spot checks will be reported to the Associate Director. Target Completion Date: December 2015
Supporting Documentation:	
Status:	_X_ In process __ Completed, Request closure

Recommendation 4:	We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System obtains and mandates the use of one model of barcode scanner to track and maintain medical supply inventory.
VHA Comments Concur.	Action Plan: Nationally a new system called the "Point Of Use" (POU) System is scheduled to start it's roll out in a month with full implementation in VANJHCS Logistics Service GIP within 4 -5 months. This is a national package that would unify all the barcode scanners with the inventory system for the medical / clinical inventory at VANJHCS. In the interim while awaiting the implementation of this new system, and to improve compliance with maintaining an accurate medical supply inventory; VANJHCS Logistic Service will unify the model of barcode scanners by Campus by doing the following: • Lyons Campus – all technicians will utilize the Tracker2410 barcode scanners • EO Campus – all technicians will utilize the CK30 barcode scanners IT and Logistic will schedule an inservice for technicians at their respective campuses on their barcode scanner. This inservice will provide each technician with an individual written direction sheet for barcode scanner they utilize; it will review the functions of both the Tracker2410 and the CK30 barcode scanners. Logistic Service will incorporate these direction sheets into their Service Level SOP and utilize this to ensure and demonstrate technician competency in the use of their barcode scanners. Logistics Service will appoint their Supervisor Inventory Management Specialist as a "train the trainer" to ensure local expertise is available when refresher education is provided at the service level. For the interim measure, all technicians will have completed this inservice and begun utilizing the appropriate scanners for their campus by July 30th. A sign-in sheet with the technician attendee signature will demonstrate participation in and completion of the training. Target Completion Date of interim measure is July 2015. National "POU" System will unify the organization with one model of barcode scanner to track and maintain medical supply inventory. Target Completion Date: March 2016.
Supporting Documentation:	
Status:	_X_ In process __ Completed, Request closure

Recommendation 5:	We recommended the Interim Director of Veterans Integrated Service Network 3 ensure the VA New Jersey Health Care System implements measures to determine reasons discrepancies are occurring in inventories and takes appropriate corrective action before technicians manually adjust the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system.
VHA Comments Concur.	Action Plan: As noted in the OIG report findings, the recommendations above and concurred by VANJHCS Logistics Service and MSDS Management, there were many factors that contributed to the discrepancies in the inventories. The lack of standardized processes and lack of local re-enforcement of the correct procedures were key factors in causing the discrepancies in the inventories. VANJHCS Logistic Service will implement the following corrective actions: • The Chief of Logistics Service and MSDS Management will inservice their distribution technicians (GS 2005-06) and supply technicians (GS 2005-07) to ensure that frontline staff including supply and distribution perform their job responsibilities correctly. o The distribution technicians review their assigned secondary inventory areas at the unit and clinic level and determined what medical supplies are needed there. The distribution technicians will not access the primary inventory source as they had previously done. The distribution technicians will give the inventory list to the supply technician. o The supply technicians review these inventory lists and only the supply technicians will pull the necessary medical supply items from their primary inventory source for delivery by the distribution technicians to the secondary inventory areas (unit & clinic level). This will ensure the inventory accountability controls and the accuracy of the IFCAP reports. o Supply technicians will not manually adjust IFCAP if differences occur between the reported and actual amounts on hand, without determining a reason for the discrepancy and the reporting this discrepancy and their findings to the Chief of Logistics for approval • Following the inservice education noted above, staff will be instructed that they must be properly utilized to track & maintain the medical supply inventory. • Chief of Logistics Service and MSDS Management will conduct random spot checks on a sample of inventoried units to validate the accuracy of the inventory reports when compared to items on hand. The results of these spot checks will be reported to the Associate Director. • Any technician who fails to follow the above instructions will receive appropriate corrective action. Target Completion Date: December 2015
Supporting Documentation:	
Status:	_X_ In process __ Completed, Request closure

Appendix C Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nick Dahl, Director Stephen Bracci David Orfalea Ann Wolf

Appendix D Report Distribution

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