DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINSTRATION

Excess Purchase of Surgical Supplies and Improper Purchase Card Transactions at the New Orleans VA Medical Center in Louisiana

REVIEW | REPORT #20-00395-224 | SEPTEMBER 14, 2021

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Executive Summary

The VA Office of Inspector General (OIG) evaluated the merits of a hotline complaint received from a source in August 2019 alleging mismanagement of supplies, equipment, and operating rooms while activating the New Orleans VA Medical Center (VAMC) in Louisiana. Activation is the process of identifying, planning, and executing the logistical and operational requirements to bring a facility into fully planned operations. The New Orleans VAMC is the main medical center for the Southeast Louisiana Veterans Health Care System.

Because there were several allegations and an additional issue identified during the review, the OIG grouped them into the following areas:

1. **Unnecessary surgical supplies.** The complainant alleged that the facility purchased hundreds of excess surgical supplies. While reviewing this allegation, the OIG also evaluated whether employees violated VHA Directive 1761, *Supply Chain Inventory Management*; the Federal Acquisition Regulation (FAR), and VA financial policy when purchasing some surgical supplies.[1]
2. **Improper purchase card transactions.** During this review, the team identified potential issues with purchase card transactions not previously alleged. The review team examined whether employees violated the FAR and VA financial policy when they acquired supplies during activation of the catheterization laboratory and interventional radiology departments by using purchase cards when contracts may have been more appropriate, in addition to whether any payments were improper.
3. **Unnecessary equipment and equipment service contracts.** The complainant alleged that the facility purchased unnecessary surgical equipment and wasted funds on service contracts associated with surgical equipment. While evaluating those allegations, the OIG also obtained and reviewed information to determine whether the facility wasted funds on unused leased equipment in two operating rooms that had yet to be activated.
4. **Operating rooms were underused.** The OIG evaluated three allegations that operating rooms were being underused. First, as of August 2019, the New Orleans VAMC was outsourcing more than 50 percent of surgeries at a cost of about $1 million per week. Second, three of eight operating rooms were not open for surgery two years after the surgical department opened and were instead utilized as storage closets. Third, the medical center's surgical department is two to three years behind schedule in becoming fully activated.

[1] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018; FAR 13.003; VA Financial Policy, vol. XVI, chap. 1A, June 2018.

What the Review Found

As detailed in the sections that follow, the OIG substantiated that the medical center purchased about $1.85 million in excess surgical supplies. Employees also violated VA supply chain management policies by not properly accounting for or advertising the excess supplies to other facilities. Employees violated the FAR and VA financial policy when they used purchase cards instead of contracts to obtain supplies. The OIG did not substantiate that the facility purchased unnecessary equipment nor that funds were wasted on purchasing surgical equipment and related service contracts. Finally, the OIG was unable to determine if the operating rooms were underused because the OIG was unable to determine the percentage of surgeries being outsourced. The OIG was unable to evaluate surgeries being outsourced because sufficient data were not available. However, the OIG did substantiate two operating rooms were not being used two years after the surgical department opened and the surgical department activation did experience delays. The OIG found that employees provided evidence supporting the decisions to not yet open all the operating rooms, and that COVID-19 had some impact on delays in surgical department activation.

Facility Purchased Excess Surgical Supplies and Did Not Comply with Supply Chain Management Policies

Facility employees identified excess medical supplies worth about $1.85 million purchased to activate the catheterization laboratory and interventional radiology departments in a review completed in June 2019.[2] The facility stated that they could not account for just over $675,000 of the excess supplies. A former nurse manager for special procedures said the excess purchases occurred because both the supplies needed for activation and those needed for daily operations were ordered before the medical center opened, instead of just the supplies needed for activation. The interventional radiology and radiology chiefs said the New Orleans VAMC staff used other operational medical facilities' supply lists that were not adjusted for the fact that the medical center was only activating services and not fully operational, therefore requiring fewer supplies.

Employees also did not maintain proper accountability of the excess supplies in the inventory system; complete a report of survey until May 24, 2021, to support needed adjustments of supplies that could not be accounted for; or advertise the excess supplies as required.[3] As a result, the excess supplies were not documented or tracked in VA inventory management

[2] Expendable supplies are disposable, commodity items that are typically used one time. Equipment or non-expendable property is property which normally has, but is not limited to, an acquisition cost of $300 or more; has a life expectancy of two years or more; or is of a sensitive nature which requires accountability and control regardless of cost, life expectancy, or maintenance requirements.

[3] A report of survey establishes the circumstances surrounding the possible loss, damage, or destruction of government property and serves as documentation for establishing liability, if any, and adjusting accounts.

systems and adjustments were not adequately supported. Not advertising the excess supplies increased the risk that they could expire before use.

Purchase Card Transactions Violated the FAR and VA Financial Policy

The OIG also determined that medical center employees violated the FAR and VA financial policy by processing about 360 purchase card transactions to obtain about $1.9 million of approximately $4.4 million total in supplies ordered for the activation of the catheterization laboratory and interventional radiology departments; instead, they should have used contracts for these transactions. The violations occurred because the facility's former chief of logistics directed staff to use purchase cards to acquire the supplies. However, under FAR and VA policy, when clinical staff created the list of more than 2,700 items needed for activation, they established a known requirement that should have gone to a contracting officer for procurement instead of being made in split purchases to stay below the $10,000 threshold. The split purchases were unauthorized commitments that must be ratified.[4]

Allegations of Unnecessary Surgical Equipment Purchases and Service Contracts Were Not Substantiated

Regarding the allegation that unnecessary equipment was purchased, the OIG determined that only four of 116 items were unneeded. Employees turned these items in as excess equipment by July 2020. The OIG found medical center staff have the authority to determine medical equipment needs in the absence of any overriding policy or guidance from VA and VHA. Because equipment usage was not documented, the OIG relied on staff interviews to determine whether the equipment items were needed or used.

The OIG also determined funds for an equipment service contract were not being wasted, as alleged, because the equipment included in the contract was needed. The OIG determined usage of surgical equipment was not documented and, therefore, relied on testimonial evidence. Employees indicated the items in question—esophagogastroduodenoscopy scopes, colonoscopy scopes, and portable towers—are used and are needed for services being provided. Therefore, service contracts in place would be appropriate and funds spent on these contracts are not being wasted.

If anticipated surgical volume does not dictate a need for one or more of the facility's eight operating rooms, facility leaders should evaluate whether to return unused leased equipment to

[4] VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004, 5 def. "Ratification" means the act of approval, by an authorized official, of an unauthorized commitment made by a government employee who did not have the authority to make that commitment and the subsequent contractual award or authorization of that commitment by a contracting officer or other official with the required level of authority.

the contractor. Taking these actions could result in yearly savings of about $89,000 per operating room, based on the most recent lease contract between VA and L1 Enterprises, Inc., solicited on December 29, 2020.

Allegation that Operating Rooms Were Underused Was Not Fully Substantiated

The OIG did not fully substantiate the allegation that operating rooms were underused. The allegations concerning underuse of the operating rooms had three components. First, as of August 2019, the New Orleans VAMC was outsourcing more than 50 percent of surgeries at a cost of about $1 million per week. Second, three of eight operating rooms were not open for surgery two years after the surgical department opened and were instead utilized as storage closets. Third, the medical center's surgical department is two to three years behind schedule in becoming fully activated.

The OIG was unable to determine whether 50 percent of surgeries were being unnecessarily outsourced at a cost of about $1 million per week because sufficient reliable data were not available. According to facility and VA central office staff contacted, they do not track or collect sufficient data to evaluate this allegation. Further, the OIG determined there are no VHA policy requirements to do so.

The review team found during its site visits that two (instead of three, as alleged) of the medical center's eight operating rooms were not being used more than two years after the surgical department opened. Employees provided evidence to support their decision for not opening all of them. In addition, the OIG found there is no policy specifying a period that operating rooms must be opened after a surgical department or facility opens. VHA officials and staff at different medical centers were unaware of any established process for determining when additional operating rooms should be open.

The OIG found, based on the latest updated surgical department activation plan provided to the review team, the activation of the surgical department at the New Orleans VAMC would have experienced delays of one year and eleven months if they were able to complete activation by May 31, 2021, as planned. At least one year and three months of these delays were based on operations before the COVID-19 pandemic, and the review team was unable to determine the portion of the delays beyond one year and three months that is specifically related to the unforeseen COVID-19 pandemic.

What the OIG Recommended

The OIG recommended the healthcare system director account for the remaining unaccounted-for excess supplies for which there is no documentation and determine if any administrative action should be taken on just over $675,000 in unaccounted-for supplies listed in the report of survey. The director should also ensure FAR violations are identified and reported

to the Financial Services Center, appropriate remedies or penalties are imposed, and requests are made to ratify all unauthorized commitments per policy. The director further needs to ensure employees coordinate with and obtain guidance from National Purchase Card Program staff when they are uncertain if they are properly using government purchase cards. Leased operating room equipment should be returned to the contractor for any operating rooms that will not be used for at least one year.

Management Comments

The Southeast Louisiana Veterans Health Care System director concurred with the findings and recommendations and provided action plans that were responsive to the OIG's recommendations. Appendix C includes the full text of the medical center director's comments. The OIG will monitor the implementation of planned actions and will close the recommendations when facility staff provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

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Contents

Abbreviations

FAR	Federal Acquisition Regulation
GIP	Generic Inventory Package
OIG	Office of Inspector General
VAMC	Veterans Affairs medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) evaluated the merits of an August 2019 hotline complaint alleging mismanagement of supplies, equipment, and operating rooms during the activation of the New Orleans VA Medical Center (VAMC) in Louisiana, which began in fiscal year 2011 and will continue through fiscal year 2023.

Activation is a series of logistical and operational processes that bring a facility to full operation. Those processes include furniture and equipment selection, staff hiring, planning for expansion of health professions trainee positions, staff training, policy and process development, building and systems commissioning, compliance testing, and stakeholder communications. According to VHA's activation process guide, these actions are typically conducted over about 5.5 years, with most occurring from 36 months before a building is accepted and up to 10 months afterward.[5] However, due to the size and complexity of the New Orleans VAMC, a phased activation was required over a longer period. Activation was further delayed due to the COVID-19 pandemic and will take until 2023 for completion.

The New Orleans VAMC consists of eight buildings and is the main medical center for the Southeast Louisiana Veterans Health Care System. The OIG review focused on the activation of the surgical department since the hotline allegations all related to that department.

Because there were several allegations and an additional issue identified during the review, the OIG grouped its information into the following areas:

1. **Unnecessary surgical supplies.** The complainant alleged that the medical center purchased hundreds of excess surgical supplies. While reviewing this allegation, the OIG also evaluated whether employees violated VHA Directive 1761, *Supply Chain Inventory Management;* the Federal Acquisition Regulation (FAR); and VA financial policy when purchasing some surgical supplies.[6]
2. **Improper purchase card transactions.** During this review, the OIG identified potential issues with purchase card transactions not previously alleged by the complainant. The review team examined whether employees violated the FAR and VA financial policy when they acquired supplies during activation of the catheterization laboratory and interventional radiology departments by using purchase cards when contracts may have been more appropriate. The team also investigated whether any payments on the purchase card transactions were improper.

[5] National Activations Office, *Activation Process Guide*, first published in 2013 and last updated in February 2015.

[6] VHA Directive 1761(2), *Supply Chain Inventory Management,* October 24, 2016, amended October 26, 2018; FAR 13.003; VA Financial Policy, vol. XVI, chap. 1A, June 2018.

3. **Unnecessary equipment and service contracts.** The complainant alleged that the medical center purchased unnecessary surgical equipment and wasted funds on service contracts associated with surgical equipment. While evaluating those allegations, the OIG also obtained and reviewed information to determine whether the facility wasted funds on unused leased equipment in two operating rooms that had yet to be activated.
4. **Operating rooms were underused.** The OIG evaluated three allegations that operating rooms were being underused. First, as of August 2019, the New Orleans VAMC was outsourcing more than 50 percent of surgeries at a cost of about $1 million per week. Second, three of eight operating rooms were not open for surgery two years after the surgical department opened and were instead utilized as storage closets. Third, the medical center's surgical department is two to three years behind schedule in becoming fully activated.

New Orleans VA Medical Center

The New Orleans VAMC complex replaced an earlier one left damaged when Hurricane Katrina struck the city in August 2005. The new complex was constructed for about $1.2 billion and was designed to serve more than 70,000 veterans. Activation costs for the VAMC were approximately an additional $834 million. The 1.6 million-square-foot space consists of eight buildings around a 150-foot-long connector on a 30-acre campus covering 12 city blocks in the center of New Orleans. It was designed to meet the full array of VA missions: education, research, national emergency preparedness, and assistance. Groundbreaking was on June 25, 2010. The medical center was officially opened on November 18, 2016. The first outpatients were seen on December 5, 2016; the first inpatients were seen on July 14, 2017; and the first surgery was performed on September 20, 2017. The final building was turned over to VA in June 2018. Figure 1 is an aerial image of the medical center.

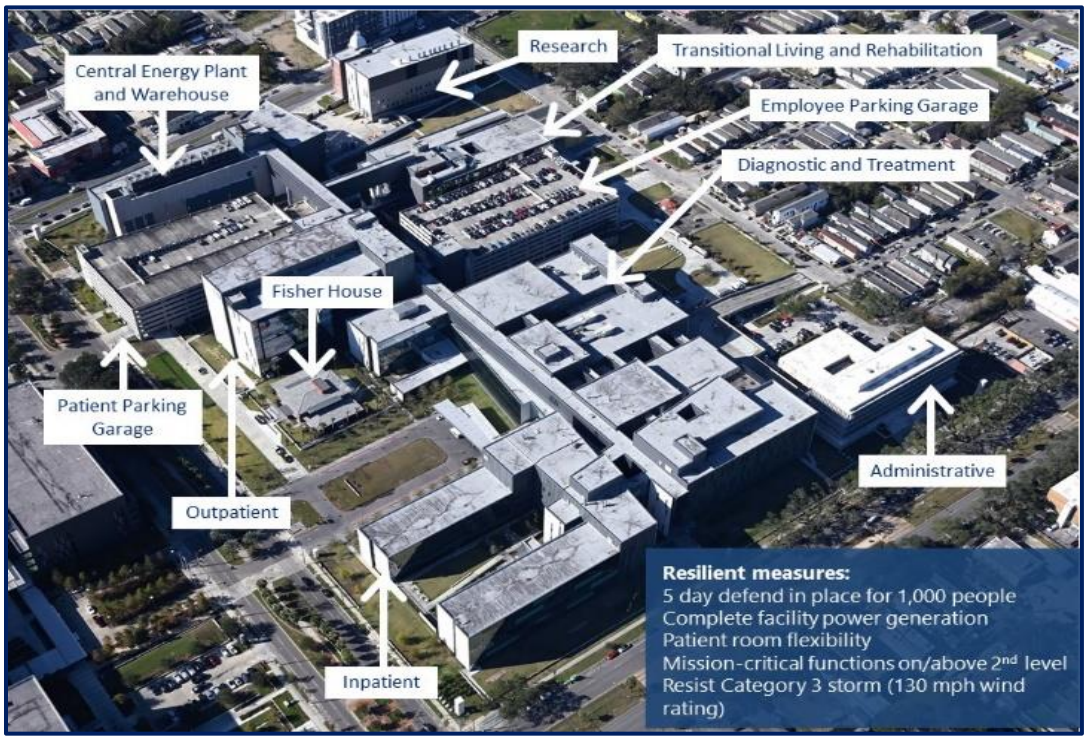

Figure 1. *Aerial photograph of the replacement VA medical center in New Orleans after construction was completed.*
Source: Provided by healthcare system staff on March 26, 2021, and cleared for noncommercial publication.

The following sections describe how responsibilities in the activation process are divided among VHA's National Surgery Office, VHA's National Activations Office, and medical center staff.

National Surgery Office

VHA's National Surgery Office is charged with optimizing surgical care for veterans in accordance with generally accepted standards of medical practice.[7] According to an *International Journal of Healthcare* article published by members of the National Surgery Office on October 28, 2018, a strategic goal of the National Surgery Office is to optimize operating room efficiency to meet veteran demands for services and provide them in a cost-effective manner.[8] Achieving improved operating room efficiency provides great benefits to a medical center. The article estimates up to 40 percent of a hospital's costs and 60 to 70 percent of its revenue can be accountable to the operating room because of the intense staffing, equipment and infrastructure required for proper operating room functioning.

[7] VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019.

[8] Marilyn Lynn, Douglas Bronson, and William Gunnar, "The impact of benchmarking operating room efficiency within the Veterans Health Administration," *International Journal of Healthcare* 5(1), (October 28, 2018): 8–15.

VHA policy does not provide the National Surgery Office with specific roles and responsibilities for activating a medical center, even though activation of a medical center's surgical department is a major part of the activation process for a facility. However, the National Surgery Office provides subject matter experts for support at activation site visits for medical center surgical programs, as coordinated by the National Activations Office.

National Activations Office

The National Activations Office was approved by the under secretary for health in November 2011 to serve as the focal point for activation advocacy, senior-level advisor to VHA officials, and subject matter expert for field facilities. According to the director of capital asset management, in 2016 the National Activations Office program was moved under the leadership of the Office of Capital Asset Management Engineering and Support director. The capital asset management director said in April 2020 that VA medical centers control all aspects of their activation, and the VHA Activations Program, formerly the National Activations Office, is a support office that focused on budget and funding. The VHA's activation process guide supports this statement by noting facility leaders will appoint activation team members.

Medical Center Staff

The medical center director is ultimately responsible for activating medical center facilities.[9] Medical center directors can appoint employees to manage the activation project or parts of it, such as finance and interior design. As a team, VAMC employees assigned to activation are responsible for developing technical requirements, creating risk mitigation strategies, and deciding key acquisition dates, among other tasks.

[9] GAO, *VHA Should Improve Activation Costs Estimates and Oversight*, GAO-20-169, January 2, 2020.

Results and Recommendations

Finding 1: New Orleans VAMC Staff Purchased Excess Supplies and Did Not Comply with VA Supply Chain Management Policies

The OIG substantiated the allegation that excess medical supplies were purchased during activation of the New Orleans VAMC.[10] Specifically, according to their own internal review conducted at the request of the chief of radiology, the medical center purchased about $1.85 million in excess supplies to activate the catheterization laboratory and interventional radiology department.[11] The medical center director and chief supply chain officer also confirmed in a May 24, 2021, report of survey that just over $675,000 of the excess supplies could not be accounted for.[12] The review team conducted its own review of VHA policies and corresponded with staff within VHA but found no specific policies or guidance from VA or VHA on what supplies are needed to activate a surgical department at a medical center. Therefore, New Orleans VAMC employees used example supply inventory lists from other fully operational medical facilities to determine their own needs. Based on these lists, a former employee said they ordered both the supply quantities needed for activation and those needed for recommended inventory levels after activation. After identifying the excess supplies, they were stored in two consultation rooms until November 2019, when a portion of the supplies were sent to another medical facility.

The OIG also found employees did not follow VA supply chain management policy because they did not maintain proper accountability for the approximately $1.85 million of excess supplies or complete a report of survey for unaccounted-for supplies until May 24, 2021.[13] According to the new chief of logistics, after the excess supplies were identified, they were removed from the Generic Inventory Package (GIP) inventory system by a former employee.[14] The chief of logistics said the supplies were eventually used or disposed of. The facility completed the

[10] Expendable supplies are disposable, commodity items that are typically used one time. Equipment or non-expendable property is property which normally has, but is not limited to, an acquisition cost of $300 or more; has a life expectancy of two years or more; or is of a sensitive nature which requires accountability and control regardless of cost, life expectancy, or maintenance requirements.

[11] Excess supplies are supplies identified by facility staff that were no longer required.

[12] A report of survey establishes the circumstances surrounding the possible loss, damage, or destruction of government property and serves as documentation for establishing liability, if any, and adjusting accounts.

[13] VHA Directive 1761(2), app A. All inactive supplies must be properly stored, accounted for, and disposed of in accordance with VA Handbook 7348; VA Handbook 7348, *Utilization and Disposal of Personal Property*, March 30, 2012, part 2. VA is required to maintain adequate inventory control and accountability of property; VA Handbook 7348, part 4. Unrequired property that cannot be used locally will be reported through the Agency Asset Management System.

[14] The GIP portion of the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) is used to manage the receipt, distribution, and maintenance of supplies used throughout the medical facility.

required report of survey on May 24, 2021, indicating just over $675,000 of the excess supplies were unaccounted for.[15] While the former chief of logistics emailed other medical facilities to say the excess supplies were available, the supplies were not advertised in the Agency Asset Management System as required.[16] This failure to advertise increased the risk that some of the supplies might expire before use. The failure to advertise occurred because the former chief of logistics did not follow VA Handbook 7348, part 4.[17]

Figure 2 shows the timeline of how the New Orleans VAMC handled the excess supplies.

[15] VHA Directive 1761(2), app. F. Report of survey must be initiated for aggregated discrepancies greater than or equal to $5,000 upon discovery during a physical inventory count audit or at any other time an adjustment of greater than or equal to $5,000 is required.

[16] The Agency Asset Management System is a module of the General Services Administration's screening system that allows agencies to report, select, and transfer excess personal property internally. At the end of the internal screening cycles, any property still available is either returned to the agency or is passed to GSAXcess. The OIG reviewed Agency Asset Management System data from May 2019 through February 2020.

[17] VA Handbook 7348, part 4. Unrequired property that cannot be used locally will be reported through the Agency Asset Management System

September 2018–March 2019	New Orleans VAMC purchases approximately $4.4 million of supplies for catheterization lab and interventional radiology department.
June 2019	Internal logistics review identifies approximately $1.85 million of these supplies as excess.
August–October 2019	VAMC officials discuss what to do with excess supplies.
October 2019	**Review team makes its first visit after a hotline complaint. Excess supplies are identified and photographed.**
November 2019	VAMC logistics chief offers excess supplies to other facilities in an email. Supplies stated to have been shipped to Palo Alto VAMC, California.
January 2020	Palo Alto states they received approximately $1.05 million in supplies.
February 2020	**Review team makes its second visit and seeks documentation for the rest of excess supplies.**
March 2020	Former chief of logistics leaves federal service; new chief takes over on 120-day detail and then becomes new chief of logistics.
September 2020	New logistics chief tells OIG all the supplies have been used but cannot document the claim.
September 2020	New logistics chief tells OIG in an email that he would not consider completing a report of survey.
May 2021	Report of Survey indicates approximately $675,000 of excess supplies were unaccounted for.

Figure 2. *Timeline of New Orleans VAMC handling of excess supplies.*
Source: VA OIG analysis from interviews and documents presented.

What the OIG Did

The review team visited the New Orleans VAMC, reviewed documents, and observed and photographed some of the identified excess supplies on-site during its initial visit in October 2019. The team interviewed employees to identify pertinent criteria for determining supply inventory levels, the process used to determine needed supplies and quantities, and reasons why excess supplies were purchased. The team also contacted or interviewed employees at the National Activations Office, National Surgery Office, Veterans Integrated Service Network (VISN) 16, Rocky Mountain Regional VA Medical Center, North Las Vegas VA Medical Center, and Orlando VA Medical Center regarding any applicable criteria and processes used to determine supply needs.

New Orleans VAMC Purchased Excess Supplies During Activation

A new chief of the New Orleans VAMC interventional radiology department started work in March 2019. At the request of the chief of radiology, department employees reviewed the facility's interventional radiology supplies in May 2019 and identified approximately $1.85 million as excess in a June 2019 email. The communication was sent to several facility department chiefs and the deputy director, stating the supplies were no longer required and requested advisement of next steps. The supplies had been purchased between September 2018 and March 2019 for the activation of the interventional radiology department and the catheterization laboratory.

The review team conducted its own review of VHA policies and corresponded with staff within VHA and found neither VA nor VHA had specific policies or guidance to help medical facilities order the optimal amount of supplies for activating their surgical departments. The review team contacted staff at the Office of Procurement and Logistics, the Medical Supplies Program Office, the National Activations Office, the National Surgery Office, Construction Facilities Management, VISN 16, the Southeast Louisiana Veterans Health Care System, and other VA medical centers. None of these officials were aware of any policy or guidance specifying a process for determining the supply needs for activating departments within a medical center. VHA policy states the facility chief logistics officer is responsible for promoting efficient use of supplies by ensuring proper items and levels are in inventory.[18] However, it does not describe how to determine what inventory levels are needed.

The review team contacted the Orlando, Rocky Mountain Regional, and North Las Vegas VA medical centers, all of which opened since 2012. Employees at the North Las Vegas VAMC said supply needs remained about the same when they moved operations to a new facility. An employee at the Orlando VAMC, a new medical facility, said the process was slow-building and methodic. They only ordered necessities modeled after a similar-sized medical center within the same VISN.

According to interviews and a timeline provided by the deputy director, the review team determined facility staff used example supply lists from other facilities and input from clinical staff to develop the list of supplies needed for the activation of the catherization laboratory and interventional radiology department.

The OIG determined that multiple factors led to the ordering of the excess supplies. A former VA nurse manager for special procedures told the review team that this occurred because supplies needed for activation and those needed for daily operations were ordered before the medical center opened, instead of just the supplies needed for activation. The chiefs of interventional radiology and radiology said the New Orleans VAMC used supply lists from other

[18] VHA Directive 1761(2).

medical facilities but that the lists had not been adjusted for the fact that the medical center was only activating services and required fewer supplies.

Employees Did Not Properly Account for Excess Supplies

When the interventional radiology employees' review identified approximately $1.85 million in excess supplies in June 2019, the medical supply division section chief asked the facility's deputy director and other officials what to do. However, it appears nothing was done until after an OIG site visit in October 2019.

VA Handbook 7384 states that unrequired property that cannot be used locally will be reported through the Agency Asset Management System.[19] The OIG did not find where the $1.85 million in excess supplies was reported in the system, which would advertise them to other medical centers for possible use. The facility's new chief of logistics said he had never determined why the former chief did not ensure the excess supplies were not properly accounted for in the Agency Asset Management System.

The medical center's new chief of logistics, who started work in March 2020, said the excess supplies were removed from the GIP system and reportedly placed in what was supposed to be a secured, limited-access room during the tenure of his predecessor, who left VA after a second OIG visit in February 2020. The new chief said he was unable to inventory and account for the excess supplies because additional supply items had been placed in the same room before he took over.

The new chief of logistics said some of the excess supplies were transferred to the Palo Alto Health Care System in California in January 2020, but the transfer was not completed using the Agency Asset Management System. The OIG contacted the chief supply chain officer in Palo Alto, who confirmed receipt of supplies valued at about $1.05 million from the New Orleans VAMC. Because the excess supplies were removed from the GIP system, over $675,000 in supplies were reported as unaccounted for after the OIG began the review, while the final outcome of the other approximately $125,000 in supplies is unclear. The new chief of logistics said he believed local employees used them, but he could not document that claim. VA policy requires inactive supplies to be properly inventoried, stored, and accounted for.[20] According to VHA Directive 1761, a report of survey must be initiated for aggregated discrepancies greater than or equal to $5,000 upon discovery during a physical inventory count audit or at any other time an adjustment of greater than or equal to $5,000 is required.[21] As of May 24, 2021, a report

[19] VA Handbook 7348, part 4.

[20] VHA Directive 1761(2), app. A. All inactive supplies must be properly stored, accounted for, and disposed of in accordance with VA Handbook 7348. VA Handbook 7348, part 2. VA is required to maintain adequate inventory control and accountability of property.

[21] VHA Directive 1761(2), app. F.

of survey had been completed and signed by the facility director. The report of survey indicated over $675,000 of the excess supplies were unaccounted for. According to the chief of logistics, the report of survey only included line items greater than $5,000, which is why the survey did not address the approximate $800,000.

By failing to use the Agency Asset Management System and delaying the report of survey, policy was not followed. This resulted in a lack of ability to account for the excess supplies and the VA's ability to ensure assets are promptly transferred to another service at the facility, to other VA installations, or other federal agencies.

Finding 1 Conclusion

New Orleans VAMC staff purchased approximately $1.85 million in excess supplies and did not ensure they properly accounted for the supplies as required. This increased the risk that VA funds were wasted if the supplies were not used before expiring. The Palo Alto Health Care System received about $1.05 million in supplies from New Orleans VAMC, but the final outcome of the other approximately $800,000 worth of supplies is unclear.

Recommendations 1–2

1. The OIG recommended the Southeast Louisiana Veterans Health Care System director account for the disposition of just over $125,000 in unaccounted-for supplies in accordance with VA policies.
2. The OIG recommended the Southeast Louisiana Veterans Health Care System director determine if any administrative action should be taken on just over $675,000 in unaccounted-for supplies listed in the report of survey.

Management Comments

The Southeast Louisiana Veterans Health Care System director concurred with recommendations 1 and 2. To address recommendation 1, an additional report of survey has been initiated for the unaccounted-for supplies. To address recommendation 2, regular audits will be conducted to review for the potential of split orders, and purchase cardholders along with the purchase card coordinator and fiscal officer will receive semiannual training to begin in September 2021.

OIG Response

The director's corrective action plans were responsive to the OIG's recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when New Orleans staff provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and issues identified. Appendix C includes the full text of the director's comments.

Finding 2: Purchase Card Transactions Violated the FAR and VA Financial Policy

The OIG found that New Orleans VAMC employees violated the FAR and VA financial policy when they used about 360 purchase card transactions to buy about $1.9 million in supplies instead of obtaining the supplies through contracts. The former chief of logistics directed staff to use purchase cards to obtain the supply items but told the review team she was not aware of the total or that it created a policy violation. However, after reviewing purchase card information and consulting with legal staff, the OIG determined that each of the 360 transactions resulted in split purchases and unauthorized commitments.[22] Employees did not use an appropriate contracting vehicle for the procurement of the supplies, which precludes VA from ensuring the best price for the supply purchases.

What the OIG Did

The review team visited the New Orleans VAMC, interviewed staff, and reviewed documents related to supply purchases. The team also interviewed the VHA National Purchase Card Program manager and cardholders about applicable criteria and purchase card use.

Use of Purchase Cards Was Improper

The OIG found that New Orleans facility employees improperly made about 360 purchase card transactions to buy about $1.9 million worth of supplies. When clinical staff created a list of more than 2,700 items needed for the activation of the catheterization laboratory and interventional radiology departments, the list established a known requirement that should have gone to a contracting officer for procurement.[23] The FAR states that a micro purchase is the acquisition of supplies or services using simplified acquisition procedures, the aggregate of which does not exceed the micro-purchase threshold. At the time of the activation purchases, logistics employees' micro-purchase threshold for purchase cards was $10,000. If the list of required items did not exceed the threshold of $10,000, the use of purchase cards would have been acceptable. Therefore, logistics employees should have known that they could not use purchase cards for the large amount of supplies.

About $2.5 million of the approximately $4.4 million worth of supplies on the list were obtained through contracts; however, the former chief of logistics directed that employees use purchase cards to buy the remaining approximately $1.9 million, and they complied. The former chief of

[22] VA Financial Policy, vol. XVI, chap. 1A, "Definitions," June 2018. "Split purchase" is defined as intentionally modifying a known requirement into two or more purchases or payments to circumvent the micro-purchase threshold for a single purchase. "Unauthorized commitment" is defined as a purchase made by a government representative who lacks the authority to bind the government or who exceeds their delegated authority, or purchases made that are not in accordance with FAR and VA Acquisition Regulation.

[23] FAR 2.101; FAR 7.104.

logistics said this was a top priority and directed employees to do so, even authorizing overtime for the purpose.

The former chief of logistics, who left VA in March 2020, told the review team she directed staff to use purchase cards to obtain the supply items but added she was unaware of the volume being purchased and that it created a policy violation. However, once the total cost of the supply list exceeded the micro-purchase threshold, only a warranted contracting officer should have completed the procurement.[24] The OIG spoke with the National Purchase Card Program manager, who agreed that only a contracting officer with a valid warrant should have completed the orders for the supply items.

The section chief of the facility's medical supply division, who reported to the former chief of logistics, was responsible under VA policy as the approving official for ensuring purchase cards are only used for authorized purchases.[25] However, the OIG confirmed she had not received all required purchase card training before being appointed to her position and did not complete the required training until May 2020. Policy requires that the chief of logistics ensures supply chain management staff have completed all mandatory education and training.[26]

The section chief said she relied on the former chief of logistics to make the final decisions on purchase card activities and had discussed concerns about the purchases, which were raised by the medical supply division staff, with her. The section chief said the former logistics chief told her using the purchase cards to obtain the supply items did not violate policy because the supplies were needed for activation and because each order was under the micro-purchase threshold. For example, on November 9, 2018, nine separate supply purchases were made using purchase cards from the same vendor for just under the micro-purchase limit. The section chief did not discuss the matter with any other staff and followed the former logistics chief's direction to approve the purchases. The section chief said she did not realize using purchase cards to acquire the supply items was a violation of policy until after discussing the issue with the OIG and after taking the VA online purchase card training.

In accordance with FAR 13.003 and VA financial policy, contracts should have been used to acquire all the required supplies on the list. Use of purchase cards was a violation of both the FAR and VA financial policy because the total procurement cost for split purchases far exceeded the $10,000 threshold for purchase card use.[27]

According to VA financial policy, purchases of goods and services that exceed the $10,000 micro-purchase threshold can only be made by warranted contracting personnel, unless

[24] VA Financial Policy, vol. XVI, chap. 1B, "Overview," October 2019.

[25] VA Financial Policy, vol. XVI, chap. 1A, "Roles and Responsibilities," June 2018.

[26] VHA Directive 1761(2), "Responsibilities."

[27] FAR 2.101. "Micro purchase" means an acquisition of supplies or services using simplified acquisition procedures, the aggregate amount of which does not exceed the micro-purchase threshold.

specifically allowed by legislation.[28] The FAR and VA financial policy also state that purchase cardholders must not break down requirements into several purchases, called split purchases, that are less than the $10,000 threshold merely to permit use of simpler acquisition procedures. Cardholders who split purchases or commit an unauthorized purchase may be subject to disciplinary action.[29] According to the VAMC deputy director, because the former chief logistics officer is no longer at VA and because of the amount of time that has passed since the purchases were made, no disciplinary action had been taken. In addition, the deputy director stated the staff has been instructed that split orders are prohibited, and they have not identified any subsequent instances of split purchases.

According to VA Directive 7401.7, the split purchases were unauthorized commitments that must be ratified.[30] Only appointed contracting officers, including purchase cardholders, or other authorized officials, within their level of authority, may commit VA to pay for supplies or services.[31] Any purchase cardholder or contracting officer who makes a commitment, including a split order, that exceeds his or her delegated or appointed level of authority must submit a request for ratification.[32] These split purchases are also considered improper payments because the payments should not have been made under statutory requirements.[33]

Finding 2 Conclusion

The OIG found that New Orleans VAMC employees violated the FAR and VA financial policy by not using contracts for activation purchases. This resulted in about 360 split purchases, which are also unauthorized commitments and improper payments that require ratification. Facility staff did not use an appropriate contracting vehicle for the procurement of the supplies, which precludes VA from ensuring the best price for the supply purchases.

Recommendations 3–5

The OIG recommended the Southeast Louisiana Veterans Health Care System director take the following actions:

[28] FAR 13.003 and VA Financial Policy, vol. XVI, chap. 1, "010204 Purchase Account Thresholds," January 2017.

[29] VA Financial Policy, vol. XVI, chap 1, "010209 Unauthorized Use," January 2017.

[30] VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004, 5 def. "Ratification" means the act of approval, by an authorized official, of unauthorized commitment made by a government employee who did not have the authority to make that commitment and the subsequent contractual award or authorization of that commitment by a contracting officer or other official with the required level of authority.

[31] VA Directive 7401.7.

[32] VA Directive 7401.7.

[33] The Office of Management and Budget Circular A-123 defines "improper payments" as any payments that should not have been made or that were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.

3. Ensure Federal Acquisition Regulation violations that resulted when purchase cards were used to acquire the approximately $1.9 million of supplies are reported to the Financial Services Center, and appropriate remedies, discipline, or penalties are taken in accordance with VA Financial Policy, Volume XVI.
4. Request the Veterans Health Administration's head of contract activity ratify the approximately $1.9 million of identified split purchases.
5. Ensure appropriate medical center employees coordinate with and obtain guidance from National Purchase Card Program staff when they are uncertain if they are properly using government purchase cards.

Management Comments

The Southeast Louisiana Veterans Health Care System director concurred with recommendations 3, 4, and 5. To address recommendation 3, the facility chief logistics officer will ensure violations are reported to the Financial Services Center and take appropriate remedies, discipline, or penalties in accordance with VA Financial Policy, vol. XVI. To address recommendation 4, the facility will develop a ratification package to be submitted to the VISN and network contracting office for review and ratification. To address recommendation 5, the facility plans to conduct semiannual training for all purchase cardholders at the facility. The training will include point of contacts for advice and guidance.

OIG Response

The director submitted corrective action plans responsive to the OIG's recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when New Orleans staff provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and issues identified. Appendix C includes the full text of the director's comments.

Finding 3: Allegations that Unnecessary Equipment Was Purchased and Funds for Service Contracts Were Wasted Were Not Substantiated, but Funds Could Be Saved by Turning in Leased Equipment

The OIG did not substantiate the allegation that the New Orleans VAMC surgical department purchased unnecessary equipment. Employees indicated that only four of the 116 equipment items identified in the complaint were excess or not needed. Further, the OIG determined funds were not wasted on service contracts for surgical equipment because the equipment was needed. However, the OIG concluded that approximately $89,000 could possibly be saved annually by returning leased equipment in the unused operating room.

What the OIG Did

The review team visited the New Orleans VAMC, interviewed surgeons regarding equipment usage and unnecessary equipment, reviewed applicable facility equipment purchase orders, and requested justification for equipment purchases. The OIG also researched relevant criteria and coordinated with employees and other VHA facilities regarding the processes used for determining equipment needs.

The review team held several discussions with the complainant to identify exactly which equipment items the complainant felt were unnecessary. The team also reviewed the applicable service contract. In addition, the team interviewed surgeons and the on-site service contractor responsible for equipment maintenance to determine if the equipment was needed and being used. Finally, the team toured the facility to visually inspect the equipment mentioned in the allegation.

Employees were interviewed regarding operating room activation and whether there were any plans to activate the unused operation rooms. In addition, the team reviewed various surgical department activation plans and the contracts for leased equipment in the seven multipurpose operating rooms.

New Orleans VAMC Did Not Waste $2.3 Million in Surgical Equipment

The OIG did not substantiate the complaint that New Orleans VAMC officials purchased unnecessary equipment. The OIG identified 116 equipment items that correlated with the complaint, worth about $2.3 million, purchased before September 2017 as part of the facility's activation. The items included point-of-care ultrasound machines, cell savers (blood recovery systems used in an operating room), hemostasis analyzers, heart-lung bypass machines, and fiber-optic and battery powered surgeon's head lamps. While most of the items are used in the surgical department, some are used throughout the medical center.

In February 2020, subject matter experts and the chief of anesthesiology identified four of seven hemostasis analyzers, purchased at a total cost of about $97,000 in 2016, as excess or unrequired equipment items. These four excess analyzers were recorded in the Maximo equipment inventory system as turned in by July 2020. The OIG found medical center staff have the authority to determine medical equipment needs in the absence of any overriding policy or guidance from VA and VHA. The review team coordinated with VHA and medical center officials to identify whether there was any policy or guidance that described how to determine equipment needs and quantities.[34] None of the officials contacted were aware of any relevant policy or directive. According to the Procurement and Logistics One Book on Supply Chain Management, VAMC clinical service chiefs are ultimately responsible for assessing the medical equipment needs of their facility and ensuring those needs are met because they are the most senior representatives of the clinical community at the facility level.[35]

Since VHA does not record equipment usage, the OIG relied upon interviews to determine whether the remaining 112 pieces were used. The 11 surgeons interviewed said they either used the remaining equipment identified in the hotline complaint or said they were needed in the operating rooms. The surgeons were not aware of any additional excess or unneeded surgical equipment.

Service Contract Funds Were Not Wasted on Unused Equipment

The hotline complainant indicated two esophagogastroduodenoscopy scopes (a scope used in a procedure that allows a doctor to examine the patient's esophagus, stomach, and duodenum); two colonoscopy scopes; and two portable towers were unused or not necessary and that funds for a service and warranty contract covering the equipment were being wasted. However, the chief of surgery and several surgical staff members said the items in question were used and needed for services being provided. The equipment maintenance contractor said the equipment does not incorporate the ability to track or provide use data.

The medical center's chief of surgery stated the scopes and towers were all in use and necessary for procedures in the operating rooms. Also, the chief stated the scopes are required for emergencies and the operating room needs to have access to and control of its own scopes. Three other surgeons also indicated they have used one or both scopes. Further, the three surgeons indicated they have used the portable towers. The three surgeons said they were not aware of any of the equipment that was not being used or unnecessary.

[34] Medical center officials included those from the Orlando VAMC, Rocky Mountain Regional VAMC, and North Las Vegas VAMC.

[35] VHA Procurement and Logistics Office One Book, December 18, 2019, a guide to effective Supply Chain Management.

Returning Unneeded Leased Operating Room Equipment Could Save Approximately $89,000 a Year

The OIG concluded that returning leased equipment from the unused operating room would save approximately $89,000 annually. This is based on the most recent lease contract between the VA and L1 Enterprises Inc., solicited on December 29, 2020. The New Orleans VAMC has eight operating rooms—seven of these rooms are multipurpose, and one is utilized exclusively by the ophthalmology department. Each of the seven multipurpose operating rooms has leased equipment.

In February 2020, employees told the OIG that there was no need to open two of the seven multipurpose operating rooms based on the criteria they used to determine when an additional operating room needed to be activated. The chief of surgery in September 2020 added two operating rooms that were still closed, and limitations imposed by the COVID-19 response continued to affect operating room utilization. In November 2020, employees indicated the facility activated one of the previously unused operating rooms so one could be designated specifically for COVID-19-positive patient emergencies.

The OIG reviewed the leased-equipment contract for the seven multipurpose operating rooms. The information in the contract solicited on December 29, 2020, indicated it had a performance period of January 1, 2021, through December 31, 2021, with four additional option years. Thus, this contract could be in effect through December 31, 2025, if the New Orleans VAMC renews the contract for all the option years. From the contract, the OIG was unable to break out leased equipment items by each operating room. However, the yearly cost for the leased equipment contract for all seven multipurpose operating rooms is about $621,000, or about $89,000 for each one.

Finding 3 Conclusion

The OIG did not make any recommendations on the allegations that unnecessary equipment was purchased and that funds were wasted on service contracts because the allegations could not be substantiated. The OIG concluded that leased equipment for unused operating rooms should be returned to the vendor if there are no plans to open an operating room or if anticipated surgical volume does not dictate a need to have all seven multipurpose operating rooms open for the following year. Taking these actions could result in yearly savings of about $89,000 per operating room each year based on the contract solicited on December 29, 2020.

Recommendation 6

6. The OIG recommended the Southeast Louisiana Veterans Health Care System director ensure leased operating room equipment is returned to the contractor as soon as possible if there are no plans to use that operating room for at least one year.

Management Comments

The Southeast Louisiana Veterans Health Care System director concurred with recommendation 6. To address the recommendation, the facility will continue to evaluate the usage of leased equipment and adjust to meet demands in the next option year of the contract in December 2021.

OIG Response

The director submitted an acceptable corrective action plan to address the recommendation. The OIG will monitor implementation of the planned action and will close the recommendation when New Orleans staff provide sufficient evidence demonstrating progress in addressing the intent of the recommendation and issue identified. Appendix C includes the full text of the director's comments.

Finding 4: The Allegation that Operating Rooms Were Underused Was Not Substantiated

The OIG did not fully substantiate the allegation that operating rooms were underused. The allegations concerning underuse of the operating rooms had three components. First, as of August 2019, the New Orleans VAMC was outsourcing more than 50 percent of surgeries at a cost of about $1 million per week. Second, three of eight operating rooms were not open for surgery two years after the surgical department opened and were instead utilized as storage closets. Third, the medical center's surgical department is two to three years behind schedule in becoming fully activated.

The OIG could not determine whether more than 50 percent of surgeries were being unnecessarily outsourced at a cost of about $1 million per week because sufficient reliable data were not available. According to facility and VA central office staff contacted, they do not track or collect data sufficient to evaluate this allegation. Further, the OIG determined there are no VHA policy requirements to do so.

The review team found during its site visits that two (instead of three, as alleged) of the medical center's eight operating rooms were not being used more than two years after the surgical department opened. Employees provided evidence to support their decision for not opening all of the operating rooms, as the department was still being fully activated. In addition, the OIG found no policy specifying a deadline for operating rooms to open after a surgical department or facility opens. This lack of policy was confirmed by VHA officials and staff at other medical centers, who were unaware of any established process for determining when additional operating rooms should be open.

The OIG found based on the latest updated surgical department activation plan, as of March 2021 the activation of the surgical department at the New Orleans VAMC would have experienced delays of one year and eleven months if they were able to complete activation by May 31, 2021, as planned. At least one year and three months of these delays were based on operations before the COVID-19 pandemic. As such, the review team was unable to determine the portion of the delays beyond one year and three months that was specifically related to the unforeseen COVID-19 pandemic. New Orleans VAMC surgical department staff explained that various surgical services were delayed for one or more of several different reasons that included staff recruitment, equipment procurement, contract execution, and not having staff dedicated to the activation of the surgery department.

What the OIG Did

The review team interviewed staff at the New Orleans VAMC about what information was used to determine when additional operating rooms should be opened and whether there was any applicable VHA policy. The team also discussed those issues with employees at the National

Surgery Office, National Activations Office, VISN 16, and four other VA medical centers.[36] The OIG also reviewed the data New Orleans VAMC staff used to determine when additional operating rooms should be opened.

The team reviewed data regarding fiscal year 2019 surgeries performed in-house, surgical consults outsourced, and various surgical department activation plans. The team also interviewed New Orleans VAMC employees to discuss activation of the surgery department, outsourced surgeries during fiscal year 2019, how and why outsourced surgical consults occur, and whether surgeries occurred as a result of the consults. The team also discussed outsourced surgeries and ways to obtain reliable data with staff from several VHA facilities—information that could be used to evaluate the allegation.

Monitoring of Outsourced Surgeries Was Insufficient to Determine Whether Any Were Unnecessary

During fieldwork, the review team could not find sufficiently reliable data to evaluate whether 50 percent of surgeries at the New Orleans VAMC were being outsourced, and therefore the OIG could not substantiate the allegation. The data available could not be used to determine the number of actual surgeries outsourced, the cost for the outsourced surgeries, or the exact reasons for the outsourced surgery consultations. Staff advised they were not aware of how to obtain all the information the review team needed to evaluate the allegation.

Staff at the National Surgery Office, National Activations Office, VISN 16, Southeast Louisiana, and the four other VA medical centers track outsourced surgical data using their own local procedures or do not track outsourced surgical data at all. Further, staff at all five VA medical centers contacted by the review team added they were not aware of any national process or policy to monitor and track outsourced surgeries or of any requirement to track outsourced surgical data.

The OIG did not make any recommendations for this allegation because there was insufficient data available to determine if operating rooms were underused.

[36] The four medical centers were the Michael E. Debakey VAMC in Houston, Texas; Rocky Mountain Regional VAMC; North Las Vegas VAMC; and Orlando VAMC.

New Orleans VAMC Staff Provided Evidence to Support Their Decision for Not Opening All Operating Rooms

New Orleans VAMC employees reviewed the National Surgery Office's operating room utilization rate to determine if additional operating rooms needed to be opened.[37] The chief of surgery stated when National Surgery Office data show the medical center has or is about to have a cumulative utilization rate of 60 percent for all active operating rooms, staff open an additional operating room.[38] The chief of surgery and the VISN 16 surgical lead, who was the former New Orleans VAMC chief of surgery, implemented this approach because VAMCs in VISN 16 try not to open additional operating rooms until the facility can sustain the 60 percent rate for all active operating rooms.

Neither VA nor VHA has any criteria or guidance specifying when an operating room must be activated after a medical facility has opened. Further, employees at the National Surgery Office, National Activations Office, VISN 16, facility, and four other VA medical centers were not aware of any criteria or guidance that specified when operating rooms should be opened after a medical center or surgical department opens. Given the lack of criteria or guidance, VHA staff at the National Activations Office and several VA medical centers all agreed the medical facility director is responsible for determining when to activate operating rooms and surgical services. Staff at the other medical centers used various data and processes to determine when to open operating rooms and agreed these decisions are left to the individual facilities and their leaders.

In February 2020, New Orleans VAMC staff said initial plans to open the seventh and eighth operating rooms by September 2020 had been postponed because current surgical volume did not dictate a need to open additional operating rooms and they were not certain when these two operating rooms would be activated. In September 2020, the chief of surgery added that two operating rooms were still closed, and operating room utilization continued to be impacted by limitations imposed by the COVID-19 response. In November 2020, the chief of surgery said the medical center activated the seventh operating room, allowing one other operating room to be designated specifically for COVID-19-positive patients.

The chief of surgery said the first two operating rooms were opened in September 2017. Each subsequent operating room was opened using the 60 percent benchmark. When the 60 percent utilization rate was sustained for all active operating rooms, or enough surgical tracks were

[37] According to the National Surgery Office Quarterly Report Interpretation Document, revised September 4, 2019, operating room utilization rates are calculated as the total time all operating rooms are being used for a given week divided by the available operating room hours. Determination of available operating room hours are left to the individual VAMCs. As of February 2020, calculation of the facility's operating room utilization rate is the total time all operating rooms are used for a week divided by 195, which equals the utilization rate.

[38] The operating room utilization rate is given a score of 1 to 4 by the National Surgery Office. An operating room utilization rate of 40 percent or less receives a 1, between 40 percent and 60 percent receives a 2, between 60 percent and 80 percent receives a 3, and greater than 80 percent receives a 4. A score of 4 is considered optimal.

implemented, a new operating room was opened.[39] A third operating room was opened on January 9, 2018, the fourth on July 9, 2018, the fifth on February 11, 2019, and the sixth on September 4, 2019. On November 13, 2020, the seventh operating room was opened, allowing one other operating room to be designated specifically for COVID-19-positive patients.

The OIG did not make any recommendations for this allegation because facility managers provided data for this review indicating there was no need to open additional operating rooms.

New Orleans Surgical Department Activation Experienced Delays

New Orleans VAMC staff explained that there were delays in the activation of the surgical department. The first surgical department activation plan was created by New Orleans VAMC staff in August 2018 and had the surgical department fully activated by June 2019. This plan was then continually updated as the New Orleans VAMC surgical department activated surgical tracks. The updated surgical department activation plan provided by New Orleans VAMC staff, dated January 15, 2020, was the last updated plan received by the review team before the Health and Human Services Secretary declared a public health emergency in response to COVID-19. This plan had the surgery department fully activated by September 2020. Based on the comparison of the original August 2018 plan and the updated January 2020 plan, the surgical department at New Orleans VAMC had already experienced a delay of one year and three months as of January 2020. The latest updated surgical department activation plan from March 2021 has the surgical department fully activated by May 31, 2021, and if the New Orleans VAMC was able to complete activation by that date, they would have experienced total delays of one year and eleven months. However, the review team was unable to determine the portion of the additional eight months of delay that is specifically related to the COVID-19 pandemic.

The surgery administrative officer stated the August 2018 surgical department activation plan was a best guess based on nine months to recruit and on what equipment and supplies the New Orleans VAMC already had on-hand. However, the review team found that the New Orleans VAMC director and chief of surgery had never activated a surgery department before, and there is no standard VA guidance on activating a surgery department. The chief of surgery stated once she began activating the surgical department based on her August 2018 plan, she realized fully activating the surgical department by June 2019 would not be possible. Various surgical services were delayed for one or more of several different reasons. These include staff recruitment delays, equipment procurement delays, and not having staff dedicated to the activation of the surgery department. The chief of surgery further explained, activation of some surgical specialties had their own unique sets of challenges potentially creating delays. For example, recruiting cardiac surgeons in New Orleans is very difficult. The chief of surgery and the medical center director

[39] According to the chief of surgery, examples of surgical tracks include robotic general surgery, plastic surgery, and complex vascular surgery.

also stated, all staff aiding in activations had to balance the work related to activation with their normal duties as New Orleans VAMC medical professionals. The surgery administrative officer also explained, there were instances where getting contracts for the activation of the surgical department took approximately two years to complete, which caused delays.

The OIG did not make any recommendations for this allegation because there is no standard VA guidance on activating a surgery department.

Finding 4 Conclusion

The OIG concluded that the allegation could not be fully substantiated. First, the OIG found there was insufficient data to determine whether 50 percent of surgeries were being outsourced as alleged and could not find any requirement to track that information. Also, the OIG substantiated two (instead of three, as alleged) of the medical center's eight operating rooms were not being used more than two years after the surgical department opened. However, VAMC employees provided evidence to justify their decision not to open two operating rooms, and the review team could not find a policy specifying when they should be opened. Last, the OIG found the activation of the surgical department at the New Orleans VAMC did experience delays; however, there is no standard VA guidance on activating a surgery department. As a result, the OIG made no recommendation.

Management Comments

The Southeast Louisiana Veterans Health Care System director concurred with the OIG's conclusion concerning the VAMC's decision to not open additional operating rooms.

Appendix A: Scope and Methodology

Scope

The OIG conducted its review from October 2019 through July 2021, and assessed the management of facility operating rooms, medical equipment, and surgical supplies.

Methodology

The OIG reviewed applicable laws, regulations, policies, procedures, and documentation related to the management of operating rooms, equipment, and supplies. The review team visited the New Orleans VAMC in October 2019 and February 2020 and observed equipment and supplies in the surgical department and other areas. The team interviewed current and former facility managers, medical staff, and procurement and logistics officials. The team also interviewed VA, VHA, VISN, National Activations Office, and National Surgery Office officials and medical center staff from other VAMCs. The team obtained activation, procurement, and surgical caseload documentation from facility and VHA staff; and from the electronic Contract Management System.[40]

Internal Controls

The OIG assessed the internal controls of the facility significant to the review objectives. This included review of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring. In addition, the OIG assessed the principles of internal controls as associated with the review objective. The OIG identified the following two components and three principles as significant to the review objective. The OIG identified internal control weaknesses during this review and proposed recommendations to address these control deficiencies.

- Component 1: Control Environment
    - Principle 2: Exercises Oversight Responsibility
    - Principle 5: Enforces Accountability
- Component 3: Control Activities
    - Principle 12: Deploys Through Policies and Procedures

[40] The electronic contract management system was used to obtain equipment contract documents.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators by

- reviewing contracts, purchase orders, invoices, and
- consulting with OIG Office of Investigations to identify potential areas and types of fraud that could occur within the review objectives.

The OIG did not identify any instances of fraud or potential fraud during this review.

Data Reliability

Computer-processed data was used and determined to be reliable for the purpose of this review. Information was obtained from the Corporate Data Warehouse by OIG data services and compared against vendor invoices received from facility staff. The OIG believes the documents obtained are sufficiently reliable to support its objectives, conclusions, and recommendations.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix B: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–2	Just over $675,000 listed in report of survey as unaccounted for.	$675,291	$0.00
1	Additional amount of unaccounted for supplies, not included in the report of survey.	$125,000	$0.00
3–5	New Orleans VAMC cardholders used purchase cards inappropriately, splitting about 360 transactions, which violated FAR and VA policy.	$0.00	$1.9 million
6	Approximately $89,000 per year for each operating room.[41] The cost savings of returning leased equipment in the unused operating room would result in VA cost savings of about $89,000 per year based on the Contract between VA and L1 Enterprises, Inc.	$445,000[42]	$0.00
	Total	**$1,245,291**	**$1,900,000**

[41] The per year cost estimate is determined based on the yearly cost of the leased equipment in the unused operating room from the most recent contract between VA and L1 Enterprises, Inc. This contract had a solicitation issue date of December 29, 2020. This lease agreement included a base year (January 1, 2021, through December 31, 2021), plus four option years (January 1, 2022, thru December 31, 2025). The total monthly cost of this contract is $51,783 for an estimated yearly cost of about $621,000 to lease equipment for seven multipurpose operating rooms, making a yearly cost of about $89,000 per operating room.

[42] Based on a February 2020 operating room utilization rate of 53 percent, it is possible that the New Orleans VAMC will not need the additional operating room at all during future years. Therefore, the cost savings for the leased equipment for the unused operating room may be in perpetuity. The *Office of Audits and Evaluations Policy Handbook*, updated July 1, 2019, says estimates of monetary benefits to future time periods will be limited to no more than five years unless the life of the contract exceeds five years. The review team calculates the potential cost savings as approximately $445,000 or $89,000 per year for five years based on the L1 Enterprises, Inc. lease contract with a solicitation issue date of December 29, 2020.

Appendix C: Management Comments, Director for Southeast Louisiana Veterans Health Care System

Department of Veterans Affairs Memorandum

Date: August 10, 2021

From: Medical Center Director (629/00)

Subj: Review of Facility Operating Rooms, Equipment and Supplies Mismanagement Allegations, Southeast Louisiana Veterans Health Care System (SLVHCS), New Orleans, LA (project number 2020-00395-R9-0001)

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

1. Facility Purchased Excess Surgical Supplies and Did Not Comply with Supply Chain Management Policies [Unnecessary surgical supplies] Substantiated.

- $675,000.00 excess supplies.
- Employees did not maintain proper accountability of the excess supplies in the inventory system.
- Did not complete a Report of Survey until May 24, 2021.
- Did not advertise (in the Agency Asset Management System, as required) excess supplies increasing risk could expire before use. Former Chief of Logistics did not follow Department of Veterans Affairs (VA) Handbook 7348, part 4.

CONCLUSION: (Line 338) By failing to use the Agency Asset Management System and delaying the Report of Survey, policy was not followed. This resulted in lack of ability to account for the excess supplies, and the VA's ability to ensure assets are promptly transferred to another service at the facility, or to other VA installations, or other federal agencies.

OIG Recommendations (1-2):

1. OIG recommended the SLVHCS Director ensure they account for the disposition of $125,000 in unaccounted-for supplies in accordance with VA policy.
2. OIG recommended the SLVHCS Director determine if any administrative action should be taken on just over $675,000 in unaccounted-for supplies listed in Report of Survey.

Management Comments:

Recommendation #1: OIG recommended the SLVHCS Director ensure they account for the disposition of $125,000 in unaccounted-for supplies in accordance with VA policy.

Concur

Target Date for Completion 9/10/2021 **Status:** Open

The $125,000 in unaccounted-for supplies is being assessed and accounted for in accordance with VA policy. The original Report of Survey (ROS) submitted covered only the items over $5,000 per policy, the Chief, Logistics Officer (CLO) has initiated an additional ROS for the remaining $160,373 losses. This ROS will be completed by 9/10/2021.

Recommendation # 2: OIG recommended the SLVHCS Director determine if any administrative action should be taken on just over $675,000 in unaccounted-for supplies listed in Report of Survey.

Concur

Target Date for Completion 9/17/2021 **Status:** Open

The following administrative actions have occurred: 1) Changes in Leadership to include the resignation of the Chief Logistics Officer (February 2020), and departure of the Medical/Surgical Distribution Section Chief (May 2021). 2) Changes in Policy or Practice include regular audits of purchase card orders to review for the potential of split orders, and closer collaboration between Item Managers and customers to ensure better communication. 3) Education and Training; Internal to Logistics Intense training of purchase card holders on current federal requirements by the Chief Logistics Officer with concentration on split orders, and Semi-annual training of all purchase card holders on current processes in conjunction with Purchase Card Coordinator and Fiscal Officer to commence September 2021.

2. Purchase Card Transactions Violated the FAR and VA Financial Policy [Improper purchase card transactions]:

- Employees violated the FAR and VA financial policy by processing 350 purchase card transactions to obtain $1.9 m (of $4.4m) in supplies. Threshold for use of purchase cards at the time was $10,000. Logistics employees should have known that they could not use purchase cards for the large amount of supplies. Should have used contracts for these transactions. Employees did not use an appropriate contracting vehicle for the procurement of the supplies, which precludes VA from ensuring the best price for the supply purchases.
- Former Chief of Logistics directed staff to use purchase cards to acquire the supplies and they complied. Former Chief said this was a top priority and directed employees to do so, even authorizing overtime for the purpose.
- Employees created a list of 2700 items needed for activation which established a “known” requirement that should have gone to contracting for procurement instead of split purchases to stay below the $10,000.00 threshold. The split purchases were unauthorized commitments the must be ratified.

CONCLUSION: (Line 437) The OIG found that New Orleans VA Medical Center (VAMC) employees violated the FAR and VA financial policy by not using contracts for activation purchases. This resulted in about 350 split purchases, which are also unauthorized commitments and improper payments that require ratification. Facility staff did not use an appropriate contracting vehicle for the procurement of the supplies, which precludes VA from ensuring the best price for the supply purchases.

OIG Recommendations (3-5):

3. Ensure Federal Acquisition Regulation violations that resulted when purchase cards were used to acquire the $1.9 million of supplies are reported to the Financial Services Center, and appropriate remedies, discipline, or penalties are taken in accordance with VA Financial Policy, Volume XVI.
4. Request the Veterans Health Administration’s head of contract activity ratify the $1.9 million of identified split purchases
5. Ensure appropriate medical center employees coordinate with and obtain guidance from National Purchase Card Program staff when they are uncertain if they are properly using government purchase cards.

Management Comments:

Recommendation # 3: Ensure Federal Acquisition Regulation violations that resulted when purchase cards were used to acquire the $1.9 million of supplies are reported to the Financial Services Center, and appropriate remedies, discipline, or penalties are taken in accordance with VA Financial Policy, Volume XVI

Concur

Target Date for Completion 10/22/2021 **Status:** Open

The facility CLO will ensure any Federal Acquisition Regulation violations that resulted are reported to the Financial Services Center and appropriate remedies, discipline, or penalties are taken in accordance with VA Financial Policy, Volume XVI. The current CLO is reviewing stated charges for evidence where financial processes may not have been followed. Episodes of non-compliance with process that are identified will be elevated appropriately through the ratification processes established by NCO for review. The CLO will evaluate each order placed to identify which ones were considered split orders. This is a lengthy process that will require a dedicated review through October.

Recommendation # 4: Request the Veterans Health Administration's head of contract activity ratify the $1.9 million of identified split purchases

Concur

Target Date for Completion 10/22/2021 **Status:** Open

The facility CLO, through the Director's Office, is in process of reviewing the identified purchases in question and developing a ratification package to be submitted to the Veterans Integrated Services Network (VISN) and Network Contracting Office (NCO) for review for ratification.

Recommendation # 5: Ensure appropriate medical center employees coordinate with and obtain guidance from National Purchase Card Program staff when they are uncertain if they are properly using government purchase cards.

Concur

Target Date for Completion 9/17/2021 **Status:** Open

To ensure appropriate medical center employees coordinate with and obtain guidance from National Purchase Card Program staff when they are uncertain if they are properly using government purchase cards, beginning in August 2021 and repeated semi-annually, training will be provided to all purchase card holders within the facility. This will include points of contact for advice and guidance in the event questions arise concerning split orders. Additionally, the NOLA CLO will work with the Purchase Card Coordinator to conduct periodic audits.

3. Allegations of Unnecessary Surgical Equipment Purchases and Service Contracts Were Not Substantiated [Unnecessary equipment and service contracts]:

Facility leaders should evaluate whether to return unused leased equipment to the contractor. Taking these actions could result in yearly savings of about $89,000.00 per OR (based on recent leaser contract with L1 Enterprises).

CONCLUSION: (Line 547) The OIG did not make any recommendations on the allegations that unnecessary equipment was purchased, and funds were wasted on service contracts because the allegations could not be substantiated. The OIG concluded that leased equipment for unused operating rooms should be returned to the vendor if there are no plans to open an operating room or if anticipated

surgical volume does not dictate a need to have all seven multipurpose operating rooms open for the following year. Taking these actions could result in yearly savings of about $89,000 per OR each year based on contract solicited on December 29, 2020.

OIG Recommendations (6):

The OIG recommended the SLVHCS Director ensure leased Operating Room (OR) equipment is returned to the contractor as soon as possible if there are no plans to use that OR for at least 1 year.

Management Comments:

Recommendation # 6: The OIG recommended the SLVHCS Director ensure leased OR equipment is returned to the contractor as soon as possible if there are no plans to use that OR for at least 1 year.

Concur

Target Date for Completion: 12/31/2021 **Status:** Open

The surgery service is currently evaluating the usage of leased equipment. The option year ends in December 2021. At that time, the contract will be right sized to meet the demands as is common practice.

The Allegation that Operating Rooms Were Underused Was **Not Substantiated**. This allegation has 3 components [Operating rooms were underused]:

- As of 8/2019 SLVHCS outsourcing more than 50% of surgeries – *OIG unable to determine.*
- 3 of 8 OR suites not open for surgery 2 years after surgical department opened and utilized as storage closets. *OIG determined that 2, instead of alleged 3 OR's were not being used. No VA policy to follow on OR openings and time frame.*
- Surgical Department is 2-3 years behind schedule in becoming fully activated. *OIG unable to determine portion of delays beyond 1yr and 3mos due to COVID.*

CONCLUSION: The OIG concluded that the allegation could not be fully substantiated. First the OIG found there was insufficient data to determine whether 50% of surgeries were being outsourced as alleged and could not find any requirement to track that information. Also, the OIG substantiated two (instead of three, as alleged), of the medical center's eight OR's were not being used more than two years after the surgical department opened. However, VAMC employees provided evidence to justify their decision not to open two operating rooms, and the review team could not find a policy specifying when they should be opened. Last, the OIG found the activation of the surgical department at the New Orleans VAMC did experience delays; however, there is no standard VA guidance on activating a surgery department. As a result, the OIG made no recommendations.

Management Comments: Concur

(Original signed by)

Fernando O. Rivera, FACHE

SLVHCS Medical Center Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended

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