DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic

REVIEW | REPORT #22-02604-74 | APRIL 11, 2023

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Executive Summary

Ventilators are essential for treating patients with severely impaired lung functions due to injury and other illnesses and are used to support breathing during surgery. The COVID-19 pandemic caused a surge in demand for ventilators and provoked concerns about potential supply shortages because critically ill patients suffering from the disease may require ventilator-assisted breathing for weeks.[1]

The Audie L. Murphy Memorial Veterans' Hospital (the facility) in San Antonio, Texas, provides primary care and specialized services to veterans as part of the South Texas Veterans Health Care System, which employs over 4,500 full-time medical care staff and had a fiscal year (FY) 2021 budget of about $1.2 billion. In FY 2021, the hospital treated about 114,000 unique veteran patients and admitted 844 COVID-19 patients.

Like other VA medical facilities and hospitals across the nation, facility officials were concerned about having enough ventilators to serve veterans during the pandemic. However, during the course of a previous review, the VA Office of Inspector General (OIG) uncovered a potential issue with the number of ventilators procured and stored.[2] The OIG performed this review to determine whether facility officials properly requested, procured, received, and accounted for ventilators in response to the pandemic, consistent with existing VA and facility policies and procedures.

What the Review Found

The review team examined the acquisition and accountability process for ventilators procured for the facility from March 1, 2020, through November 30, 2021. The OIG found officials at the hospital acquired more ventilators than were ultimately needed for veteran care during the pandemic. Facility and Veterans Health Administration (VHA) officials duplicated efforts to purchase ventilators, resulting in the facility obtaining 112 ventilators even though it had historically kept no more than 40 during normal operations. Further, all 56 ventilators from the VHA purchase, worth about $2.5 million, were never used for patient care at the hospital. These ventilators were placed in storage in various states of unwrapping and left unused for more than 19 months during the pandemic. This occurred while other VA facilities across the nation reported ventilator shortages.[3] Further, once facility officials turned in the unused ventilators

[1] "Medical Device Shortages During the COVID-19 Public Health Emergency" (web page), U.S. Food and Drug Administration, accessed September 9, 2022, https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-device-shortages-during-covid-19-public-health-emergency#shortage.

[2] VA OIG, *Inadequate Acceptance of Supplies and Services at Regional Procurement Office West Led to $12.8 Million in Questioned Costs*, Report No. 21-01081-155, July 20, 2022.

[3] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness,* Report No. 20-02221-120, March 26, 2020; VHA, *VHA COVID-19 Response Report*, October 27, 2020.

in 2022, they were quickly redistributed to other VA facilities. Therefore, the decision by facility officials to keep these ventilators in storage instead of turning them in as excess equipment while other facilities reported ventilator shortages may have prevented other hospitals from acquiring needed ventilators.

Facility officials took these actions because they were concerned about (1) the effect of COVID-19 and delays in acquiring ventilators due to congestion in the ventilator supply chain; and (2) because they did not have an effective methodology to determine the number of ventilators the hospital required either before or during the pandemic. Contributing to these unnecessary purchases was VA's lack of an inventory system that can identify excess inventory across the Veterans Health Administration, which oversees all VA hospitals. These factors limited officials' ability to comply with VA Directive 7348, which requires VA to use excess property before purchasing new equipment.[4]

What the OIG Recommended

The OIG recommended the director of the VA South Texas Veterans Health Care System document a methodology for determining the number of ventilators required to fulfill the facility's mission during routine and emergency operations. The OIG also recommended the director determine whether the remaining ventilators are required to support the hospital's mission and to turn in any not needed, as required by VA policy.

VA Comments and OIG Response

The executive director of the VA South Texas Veterans Health Care System concurred with the two recommendations and provided information on its assessment and completed actions.[5] The OIG considers these actions responsive and has closed both recommendations as implemented based on the actions and documentation provided. The full text of the executive director's comments appears in appendix C.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

[4] VA Directive 7348, *Utilization and Disposal of Personal Property*, January 8, 2020.

[5] The network director for Veterans Integrated Service Network 17 also signed the comments transmitted by the executive director of the South Texas Veterans Health Care System.

Contents

Abbreviations

DERMS	Deployment of Equipment, Recertification, and Management of Surge Capacity program
FY	fiscal year
OIG	Office of Inspector General
VHA	Veterans Health Administration

Introduction

Ventilators are essential for treating patients with severely impaired lung functions due to injury and other illnesses and are used to support breathing during surgery. The COVID-19 pandemic caused a surge in demand for ventilators because critically ill patients suffering from the disease may require ventilator-assisted breathing for weeks.

The Audie L. Murphy Memorial Veterans' Hospital (the facility) in San Antonio, Texas, like other Veterans Health Administration (VHA) medical facilities, had to overcome critical supply shortages for ventilators to serve veterans while fighting the COVID-19 pandemic. However, during a previous review, the VA Office of Inspector General (OIG) uncovered a potential issue with the number of ventilators they procured and stored.[6] The OIG performed this review to determine whether hospital officials properly requested, procured, received, and accounted for ventilators consistent with existing VA and facility policies and procedures.

Audie L. Murphy Memorial Veterans' Memorial Hospital

Located in San Antonio, Texas, the facility provides primary care and specialized services as part of the South Texas Veterans Health Care System. Table 1 gives a profile of the healthcare system during the COVID-19 pandemic.

Table 1. South Texas Veterans Health Care System Profile for Fiscal Years (FY) 2020 and 2021

Element	FY 2020	FY 2021
Budget	$1.1 billion	$1.2 billion
Number of patients	101,659	114,193
Outpatient visits	1.2 million	1.4 million
Hospital admissions	7,708	7,935
Full-time employee equivalent medical care staff	4,360	4,538

Source: VHA Support Service Center Trip Pack and Operational Statistics report.
Note: The numbers are for the entire South Texas Veterans Health Care System (including multiple health clinics) and not just for the hospital facility. The OIG did not assess VA's data for accuracy or completeness.

[6] VA OIG, *Inadequate Acceptance of Supplies and Services at Regional Procurement Office West Led to $12.8 Million in Questioned Costs*, Report No. 21-01081-155, July 20, 2022.

From FYs 2013 to 2020 (before the COVID-19 pandemic), the hospital maintained an average of 40 ventilators annually. In calendar years 2020 and 2021, during the COVID-19 pandemic, hospital officials reported no more than 36 ventilators were used for providing patient care at the facility at a given time.[7] In 2021, the hospital admitted 844 COVID-19 patients.

[7] Facility officials only documented the number of ventilators in use on the first of each month; the count of 36 ventilators was reported for January 1, 2021.

Results and Recommendations

Finding: Facility Officials Acquired and Held More Ventilators Than Needed, While Other Facilities Reported Shortages

After the COVID-19 pandemic began in March 2020, some VA hospitals reported ventilator shortages.[8] Facility officials were concerned about the effect of COVID-19 and possible delays in acquiring ventilators due to anticipated congestion in the supply chain; therefore, they acquired additional ventilators. However, they did not document how they determined the number of ventilators required to provide patient care. Further, once they received the ventilators, the majority sat unused for almost two years. After they were eventually turned in, the unused ventilators were quickly redistributed to other VA facilities. The team found VA lacks an effective mechanism to monitor excess equipment at facilities, such as these ventilators that were stored in the hospital's basement and other storage rooms. Actions and decisions made by facility officials during the COVID-19 pandemic may have prevented or delayed other VA hospitals from obtaining these critical ventilators sooner.

What the OIG Did

The review team examined the facility's acquisition and accountability process for ventilators procured from March 1, 2020, through November 30, 2021, including the hospital's ventilator inventory listing and other applicable information. During an April 2022 site visit, the team verified the accuracy of the hospital's accountability of ventilators. In addition, the team interviewed facility officials regarding the hospital's acquisition planning procedures and accountability processes. The team also interviewed hospital officials for clarification about the documentation and requested additional documentation when necessary.

Facility Officials Acquired and Held Excess Ventilators

The review team found that facility officials acquired and held excess ventilators that were ultimately more than what was required to support the facility's patient population during the COVID-19 pandemic. While the OIG acknowledges there were unknowns on how the pandemic would affect VA's provision of health care, those unknowns do not negate VA officials' responsibility to identify and turn in excess ventilators. VA guidance states that quantities of nonexpendable property, such as ventilators, on-hand at hospitals should only be the amount

[8] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, Report No. 20-02221-120, March 26, 2020.

necessary to perform assigned duties.[9] Each hospital must establish controls to ensure all users continually evaluate the need for assigned equipment. When unrequired property is identified, it will be turned in for reassignment, reuse, or disposal in accordance with excess procedures.[10]

Before the COVID-19 pandemic, the hospital had 40 ventilators. According to hospital officials, the 40 ventilators were nearing the manufacturer-suggested lifecycle replacement date when the President declared a national emergency on March 18, 2020.[11] As a result, on March 25, 2020, facility officials used a local contract to acquire 56 Evita Infinity V500 model ventilators, with accessories, for about $1.8 million.[12] Hospital officials were unable to provide a documented methodology for how they determined that an extra 16 ventilators was an appropriate quantity to meet the anticipated patient care needs of the pandemic.

Five days later, on March 30, 2020, VHA used a national contract to order 500 ventilators for various facilities through the nonexpendable equipment program. Two months later, in May 2020, VHA personnel contacted facility officials to determine whether the facility required any of the 500 ventilators. Facility officials stated that while they had 56 ventilators on order through the local contract, they would accept 56 ventilators from the national contract and would reduce their local order on a one-to-one basis based on the number of ventilators received from the national contract. The 56 ventilators from the national contract were valued at about $1.8 million.[13]

In early June 2020, the local ventilator contractor contacted officials at the facility about the second purchase via VHA's national contract. Ultimately, facility officials decided not to cancel either purchase, citing concerns about potential delays in acquiring the ventilators during the pandemic caused by supply chain congestion and the quality of the national contract ventilators.[14] Officials explained they also felt pressure during this time to ensure they had what

[9] VA Handbook 7002, *Logistics Management Procedures*, January 8, 2020. Nonexpendable equipment is property that has a continuing use, is not consumed in use, is of a durable nature with an expected service life of two or more years, has an acquisition cost of $300 or more, and does not become a fixture or lose its identity as a component of other equipment or physical plants.

[10] VA Handbook 7002.

[11] "Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," 85 Fed. Reg. 15337 (March 18, 2020). Of the 40 ventilators nearing the end of their lifecycles, facility officials had already turned in 22, while 18 remained on-site at the time of the review team's April 2022 site visit. These 18 remaining ventilators were in the process of being replaced and were not the subject of this review.

[12] Accessories included items such as maintenance plans, inspection and setup, installation kits, and software.

[13] According to hospital officials, the ventilators from the VHA national contract did not have the desired upgraded accessories, so hospital officials awarded a local contract to purchase accessories for an additional cost of approximately $689,000.

[14] The concern from facility officials was that the quality of the ventilators from the national contract would not be equivalent to the local contract ventilators. Five accessories were identified as the difference between the ventilators from the national and local contracts. Facility officials determined these accessories were significant enough they upgraded the national contract ventilators.

was required to address the pandemic and did not want to run out of ventilators to take care of veterans. While these actions and decisions were made before the acting director was appointed in June 2022, he and the hospital's incident command team confirmed these concerns contributed to the hospital's decision to acquire all 112 ventilators. The 56 ventilators from the national contract were received in July 2020. The 56 ventilators from the local contract were delivered in three batches, with deliveries occurring in September and October 2020 and January 2021.[15] The ventilator purchases under the two contracts plus the additional accessories provided the facility with 112 ventilators at a total cost of approximately $4.3 million. However, based on the agreement with VHA, facility officials should have canceled all ventilators ordered on the local contract valued at about $1.8 million.

Hospital officials stated that none of the 56 ventilators from the VHA contract were ever used for patient care. These ventilators were put in storage in various states of unwrapping and left unused for at least 19 months during the COVID-19 pandemic. Figure 1 shows some of the ventilators from the VHA contract stored in the hospital basement.

Figure 1. *Excess and unused ventilators in the basement of the hospital.*
Source: VA OIG, April 11, 2022.

In February 2022, facility officials received a request from the Deployment of Equipment, Recertification, and Management of Surge Capacity (DERMS) program to identify excess

[15] From the local contract, the facility received 15 ventilators in September 2020, 13 ventilators in October 2020, and 28 ventilators in January 2021.

equipment for redistribution to other facilities.[16] Facility officials turned in 39 of the 56 ventilators from the VHA national contract (about 70 percent), while the remaining 17 (about 30 percent) stayed in basement storage. In April 2022, the 17 remaining ventilators were still unused in basement storage.[17] For the 39 ventilators turned into DERMS, 30 were redistributed within two weeks to facilities in Minnesota and Maine. As of August 23, 2022, the remaining nine ventilators were sold on the General Services Administration's website.

Most Ventilators Were Unused and Stored in Areas Not Readily Accessible for Patient Care

The review team performed a site visit during the week of April 11, 2022. The team conducted an accountability inventory of the 112 ventilators purchased for the facility on the two contracts. At the time of the team's site visit, only 73 were still listed in the inventory system as being at the facility. Figure 2 shows the status of all the ventilators based on the team's inventory and record analysis during the site visit. Table 2 provides further explanations of each status type.

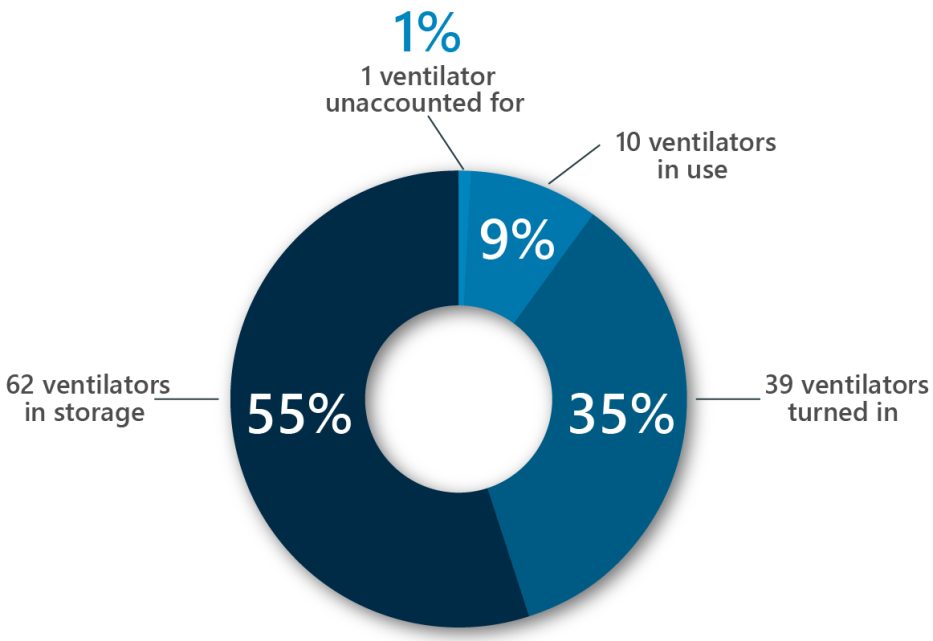

Figure 2. *Status of 112 Evita Infinity V500 ventilators as of the week of April 11, 2022.*
Source. VA OIG analysis of inventory records and April 2022 physical inventory.

[16] This program is for the recertification, repair, redeployment, and decompression of high-quality, safe, and functional equipment that is currently stored as excess inventory across VHA.

[17] Of the 17 ventilators stored in the basement, five were designated as "out of service" (awaiting repair) and not ready to provide patient care.

Table 2. Ventilator Status Descriptions

Status	OIG Definition
In use	Ventilators were on a floor used for providing care to patients or in rooms ready to receive patients.
Turned in	Ventilators were sent to DERMS for reutilization.
Storage	Ventilators were located in (1) buildings around the hospital campus not providing care to patients, (2) storage closets on floors not used for providing care to patients, and (3) the hospital basement.
Unaccounted for	Records could not demonstrate the location of the ventilator and the review team was unable to locate it.

Source: VA OIG analysis of inventory records and April 2022 physical inventory.

Hospital officials defined ventilators as "in use" if they were inspected and ready to be used regardless of whether they were actively in use to provide care to a patient. However, the OIG found this definition did not fully reflect the actual status of the ventilators—for example, a ventilator could be stored in a closet or a basement, not being used for patient care, and be considered "in use." Further, the team identified one ventilator listed as being "in use" that could not be located.[18] Therefore, the team only categorized ventilators as "in use" if they were being used by a patient or were on a medical ward (such as at a nurses' station) and ready to be used. Although the inventory documentation showed 68 of the facility's 73 ventilators were considered "in use" by the hospital as of April 11, 2022, the team only identified 10 that met the OIG's definition.

Facility officials stored some ventilators (that they categorized as "in use") at the Frank M. Tejeda Outpatient Clinic, which was not providing any COVID-19 patient care and was closed in December 2022. The clinic is located about two miles away from the facility. Figure 3 depicts some of the unused ventilators stored in a room filled with miscellaneous office equipment at the clinic.

[18] The review team advised the director of logistics that one ventilator was unaccounted for during the site visit.

Figure 3. *Excess and unused ventilators marked as "in use" in a room filled with miscellaneous equipment at the Frank M. Tejeda VA Outpatient Clinic.*

Source: VA OIG, April 11, 2022.

Facility Officials Did Not Document How They Determined the Number of Ventilators They Needed for Care

Facility officials were unable to provide the methodology by which they determined the number of ventilators the hospital needed either before or during the COVID-19 pandemic. As previously discussed, the facility historically maintained an average of 40 ventilators dating back to FY 2013. Based on facility officials' 2020 and 2021 reporting, during the COVID-19 pandemic, the most ventilators used for providing care at one time was 36.[19] Figure 4 shows the number of ventilators used in calendar years 2020 and 2021.

[19] The ventilator usage information was reported by hospital officials and was not validated by the review team.

Figure 4. *Ventilators used for patient care in calendar years 2020 and 2021.*
Source: Facility officials.

During the COVID-19 pandemic, VHA developed a response plan that included strategies to address positive cases and assumptions to help calculate the number of ventilators a facility might require. The plan also established that the facility director was responsible for the equipment needs of the facility, which would have included ventilators. According to the plan, about 20 percent of the infected population would require hospitalization; of this, about 2.3 percent would require ventilator support.[20] Facility officials reported that they were not aware of the response plan and did not use it to help determine the number of ventilators the facility required.

However, in anticipation of the increased number of patients, facility officials developed a surge plan that addressed additional beds, alternative treatment locations, and strategies for treating patients at each surge level.[21] However, the plan did not include equipment necessary to support

[20] VHA, *VHA COVID-19 Response Plan*, March 23, 2020.

[21] The hospital had seven surge levels, categorized by color, that identified the hospital's capabilities to treat COVID-19 patients.

a potential surge in COVID-19 patients, nor did it provide specific guidance or a methodology to determine the number of ventilators required.

The review team requested documentation detailing the facility's process for determining the number of ventilators that would likely be needed during the pandemic, but officials could not provide any, nor could they describe a reasonable methodology. Facility officials explained the number of ventilators needed during the pandemic was "patient-driven." According to facility officials they consulted national averages, had discussions with their subject matter experts, and had an incident command team that addressed equipment needs of the facility, but the situation was constantly changing. While neither the VHA response plan nor the hospital's surge plan could have provided a specific number of ventilators the hospital would require, they gave alternative information, such as the number of beds and assumptions that could be used for ventilator forecasting. Facility officials could have used this information to help make an informed decision on the number of ventilators needed but did not.

VA Lacks an Effective Mechanism to Monitor Excess Equipment at Medical Facilities

VHA manages about $10 billion each year in medical supplies and equipment inventory.[22] As discussed previously, VA guidance says hospitals will maintain nonexpendable equipment only in the amount necessary to perform assigned duties.[23]

Facility officials stated that they use the Automated Engineering Management System/Medical Equipment Reporting System to manage its nonexpendable equipment, including ventilators. However, the system does not identify excess equipment. In addition, the system relies on manual inputs, which increases the risk of data entry errors. According to facility officials, there is no oversight of the inventory system inputs; therefore, errors may not be identified until users conduct a physical inventory. These limitations prevent officials from complying with VA Directive 7348, which required VA to use excess property before purchasing new equipment.[24] VA continues to work on modernization of its systems and implementation of a new supply chain solution. Therefore, the OIG did not make a recommendation on this issue.

[22] VA, *Enterprise Supply Chain Modernization (ESCM) Implementation Plan: Defense Medical Logistic Standard Support/LogiCole Initial Operating Capability to Full Deployment*, January 10, 2019. This plan states that the $10 billion for VHA's supply chain consists of $5 billion for consumable supplies (expendable supplies that are disposable items typically used one time) and $5 billion in equipment costs (nonexpendable supplies that cost $300 or more or have a life expectancy of two years or more). VHA is America's largest integrated healthcare system, offering care at more than 1,255 medical facilities for more than nine million veterans enrolled each year. (See www.va.gov/health/aboutvha.asp.)

[23] VA Handbook 7002.

[24] VA Directive 7348, *Utilization and Disposal of Personal Property*, January 8, 2020.

Facility Officials Missed Opportunities to Redistribute Unneeded Ventilators to Other VA Medical Facilities

Facility officials kept the 56 national contract ventilators and upgraded accessories, worth about $2.5 million, in various states of unwrapping and left them unused for 19 months throughout the COVID-19 pandemic, when ventilators were listed by the Food and Drug Administration as being in short supply.[25] This occurred while other VA facilities across the nation reported ventilator shortages and surges in demand.[26] Since facility officials acquired but never used the ventilators for patient care, the OIG determined the $2.5 million in funds could have been put to better use.

As previously discussed, facility officials reported that at most 36 ventilators were in use at any one time to provide care in FY 2020 and FY 2021, raising questions about their decision to acquire and maintain more than 112 ventilators. The OIG determined the officials' actions did not comply with the VA guidance that requires excess property to be identified and turned in. While the OIG acknowledges concerns about surges during the pandemic, they do not negate the responsibility officials have to identify and turn in excess ventilators.

Because the facility kept significantly more ventilators than needed to provide care, other hospitals with a demonstrated need may have been denied the opportunity to promptly acquire or receive them. Most of the 39 ventilators turned into DERMS were redistributed to other facilities across VA within two weeks.

Conclusion

Facility officials did not accurately determine the number of ventilators needed and held more than required to support their local veteran population during the COVID-19 pandemic supply shortage. Though hospital officials felt pressure to ensure they had enough ventilators to provide care for their own patients, they did not have a documented methodology to determine a reasonable quantity to perform that mission either before or during the pandemic. Until facility officials determine, document, and implement a methodology for the number of ventilators necessary to perform their mission, other hospitals may be denied these ventilators to treat patients experiencing impaired lung functions.

[25] "Medical Device Shortages During the COVID-19 Public Health Emergency" (web page), U.S. Food and Drug Administration, accessed September 9, 2022, https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-device-shortages-during-covid-19-public-health-emergency#shortage.

[26] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness,* Report No. 20-02221-120, March 26, 2020; VHA, *VHA COVID-19 Response Report*, October 27, 2020.

Recommendations 1–2

The OIG made the following recommendations to the director of the VA South Texas Veterans Health Care System:

1. Document a methodology for determining the number of ventilators required by the Audie L. Murphy Memorial Veterans' Hospital to fulfill its mission and provide care during routine and emergency operations.
2. Determine whether the remaining ventilators are required to support the hospital's mission. If excess ventilators are identified, perform procedures to turn them in for reassignment, reutilization, or disposal in accordance with VA Handbook 7002.

VA Management Comments

The executive director of the VA South Texas Veterans Health Care System concurred with both recommendations.[27] To address recommendation 1, the executive director provided documentation of a review the facility conducted (with input from a pulmonary specialist) detailing the number of ventilators required during routine operations, intermediate increased demand, and high increased demand. To address recommendation 2, the executive director determined that the number of ventilators at the facility (currently 73, "to account for back-up ventilators and downtime for preventative maintenance and/or repairs") was appropriate to support the hospital's mission. These actions were completed in February 2023.

OIG Response

The actions taken and documented by the VA South Texas Veterans Health Care System appear to be fully responsive. Both recommendations are considered by the OIG to be closed as implemented.

[27] The network director for Veterans Integrated Service Network 17 also signed the comments transmitted by the executive director of the South Texas Veterans Health Care System.

Appendix A: Scope and Methodology

Scope

The review team conducted its work from May 2022 through January 2023, and evaluated whether the hospital properly requested, procured, received, and accounted for ventilators, consistent with existing VA and facility policies and procedures.[28] The team assessed ventilator purchases at the Audie L. Murphy Memorial Veterans' Hospital during the period of March 1, 2020, through November 30, 2021. There were two contracts for ventilators for the facility:

- Contract number 36C25720P0585
- Contract number 36C77620C0013

Methodology

The team identified and reviewed the Federal Acquisition Regulation and VA directives and handbooks related to requesting, procuring, receiving, and accounting for nonexpendable equipment.

The review team conducted a site visit to the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Texas, from April 11 through April 14, 2022. During the site visit, the team performed on-site observations to include a 100 percent physical inventory of ventilators, interviewed employees of the hospital, and reviewed documentation related to the hospital's ventilator inventory. The team requested clarification about documentation or requested additional records or information, as necessary.

Internal Controls

The review team assessed VHA's internal controls significant to the objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring. In addition, the team assessed the principles of those internal control components. The team identified internal control deficiencies with two components and two principles:

- Component: Control Activities

[28] The scope of this review was meant to address concerns raised by observations in the course of a previous OIG review.

  - Principle 12: Management periodically reviews policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks.

- Component: Information and Communication
  - Principle 14: Management communicates quality information down and across reporting lines to enable personnel to perform key roles in achieving objectives, addressing risks, and supporting the internal control system.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, and contracts, 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 the VA OIG fraud indicators and assessment checklist to identify fraud indicators that were applicable to this project.

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

Data Reliability

The review team obtained inventory listings from the Audie L. Murphy Memorial Veterans' Hospital showing equipment obtained from March 1, 2020, through November 30, 2021. In particular, the team verified the ventilator purchase and receipt documentation in the contract file reconciled with the inventory information at the hospital. The team also verified the accuracy of the inventory listing by performing a 100 percent physical inventory of the ventilators. The team determined the data were reliable to support its findings, 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	By establishing a methodology for determining the number of ventilators required at the Audie L. Murphy Memorial Veterans' Memorial Hospital, officials could avoid acquiring excess ventilators.	$2.5 million	
	Total	**$2.5 million**	

Appendix C: VA Management Comments

Department of Veterans Affairs Memorandum

Date: February 27, 2023

From: Executive Director, VA South Texas Veterans Health Care System

Subj: Draft Report, Review of Ventilators at Audie L. Murphy Veterans Hospital, (project number 2022-02604-AE-0109)

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

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Health Care inspection conducted at the VA South Texas Veterans Health Care System from April 11-14, 2022.

2. Please find the response to each recommendations below.

Recommendation 1: Document a methodology for determining the number of ventilators required by the Audie L. Murphy Veterans Memorial Hospital to fulfill its mission and provide care during routine and emergency operations.

Concur with recommendations.

Director Comments: Audie L. Murphy Veterans Memorial Hospital has 234 licensed beds. The facility performed a review of licensed beds with ventilators capacity during routine operations, intermediate increased demand and high increased demand (See Attachment A).[29] A total of 90 licensed beds were identified as available for ventilator-supported care depending on demand. With input from the Chief - Pulmonary and Critical Care Medicine and Respiratory Therapy Supervisor, the facility will retain 73 ventilators to account for back-up ventilators and downtime for preventative maintenance and/or repairs.

Target date for completion: Completed – February 22, 2023.

Recommendation 2: Determine whether the remaining ventilators are required to support the hospital's mission. If excess ventilators are identified, perform procedures to turn them in for reassignment, reutilization, or disposal in accordance with VA Handbook 7002.

Concur with recommendations.

Director Comments: No excess ventilators have been identified. The facility currently has 73 ventilators on site which have been deemed necessary to support the hospital's mission.

Target date for completion: Completed – February 22, 2023.

(Original signed by)

Julianne Flynn, MD

Executive Director

Wendell Jones, MD, MBA

Network 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.

[29] Attachment A is not included in the report. Please contact the VA OIG Release of Information Office to request a copy if needed. For more information go to https://www.va.gov/oig/foia/default.asp/.

OIG Contact and Staff Acknowledgments

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