US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas

Review | **24-00166-35** | **March 18, 2025**

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

According to Veterans Health Administration (VHA) policy, VA medical facility managers must establish, operate, and maintain an effective, cost efficient, transparent, and responsive supply chain management program.[1] This includes logistics, inventory, and distribution. Inventory management aims to minimize costs and ensure sufficient stock to meet demand. VHA facilities must implement policies and continually improve their supply chain performance to support high-quality health care.

In 2023, the VA Office of Inspector General (OIG) received several allegations that raised concerns about the management of supplies and equipment and workplace culture at the Michael E. DeBakey VA Medical Center in Houston, Texas. Over 131,000 veterans receive care at the facility, which is part of Veterans Integrated Service Network (VISN) 16. In November 2023, the facility had about $203 million in nonexpendable equipment inventory and about $5.5 million in expendable supplies.[2] The VISN supply chief conducts annual quality control reviews and provides staff training at the eight VA medical facilities under the VISN's purview. A facility chief supply chain officer (supply chief) and two deputy supply chain officers oversee the medical facility's supply chain management program. Specifically, the facility supply chief is in charge of ensuring the supply chain management program meets VHA policy requirements, which include using a VHA-approved inventory management system, establishing a local supply chain program, and completing a year-end certification of inventory values and equipment inventory.

The OIG initiated this review to evaluate whether the Houston facility supply chain management staff established and maintained inventory controls in accordance with VA policy.[3]

What the Review Found

The OIG identified deficiencies in managing supplies, equipment, and implant inventory at the Houston facility. Supply chain management staff did not ensure accurate recording and accountability of expendable supplies, nonexpendable equipment, and implants in the inventory management systems, as mandated by VHA policy. These deficiencies stemmed from inadequate oversight and failure to follow inventory procedures, risking the loss of supplies or the use of expired products for patient care.

[1] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[2] Nonexpendable equipment is designed for continuous use, has a service life of two years or more, and generally costs $300 or more. Expendable supplies are disposable items that are typically used once, such as gloves, syringes, and catheters.

[3] For more information on the review's scope and methodology, see appendix A.

Houston Facility Personnel Did Not Effectively Manage or Inventory Expendable Supplies and Nonexpendable Equipment

VA policy requires the facility supply chief to monitor staff's use of the Generic Inventory Package (GIP) system for inventory management and mandates that personnel enter expendable supplies into GIP for tracking and distribution.[4] The review team identified discrepancies between the inventory system and the physical inventory.

The review team physically observed and counted a judgmental sample of 60 types of expendable medical or surgical supply items across the medical facility. The team found inaccurate inventories in 49 of the 60 items (82 percent), with levels above or below what was reported in GIP. Not maintaining inventory levels can lead to supplies becoming obsolete or expiring or shortages that can affect patient care and operational effectiveness. Additionally, supply chain staff generally did not use GIP to set emergency stock levels for expendable supplies as required. The OIG team found that 50 of the 60 sampled supplies (83 percent) had an emergency stock level set to zero, which could lead to supply shortages and misrepresent the facility's compliance with policy. Inventory managers also did not update barcode labels or A, B, and C designation labels.[5] The review team also discovered 15 types of supplies that had 1,568 expired items in the medical facility warehouse, valued at around $109,000.

For nonexpendable equipment, staff and responsible custodial officials did not accurately update equipment location and status in the Maximo inventory system. Of 90 judgmentally sampled nonexpendable equipment items, the team determined 85 items (94 percent) were in different locations than recorded. Additionally, 23 of 90 items (26 percent) lacked required barcode labels needed to conduct annual inventory scans.

Separately, during the first site visit, the team looked for 133 specific Omnicell cabinets and found only 43 of these cabinets (32 percent) in the location recorded in Maximo. Omnicell cabinets are automated dispensing cabinets that serve as controlled secondary inventory points and range in cost from about $2,500 to over $41,000 each.

Many of the service line custodial officers did not accept equipment assigned to their respective equipment inventory list (EIL).[6] In March 2024, about 73 percent of operational, accountable

[4] VHA Directive 1761.

[5] VHA Directive 1761. VHA uses the ABC classification method for inventory management. Inventory items with the highest annual usage spending (the top 80 percent) are classified as "A" and must be counted each quarter. Supplies with the next highest annual usage (the next 10 percent) are considered "B" items and are counted in the first and third quarters, and items representing the remaining 10 percent (lowest usage) are in the "C" category and are inventoried in the second quarter.

[6] VA Handbook 7002, *Logistics Management Procedures*, January 8, 2020, requires all sensitive and accountable nonexpendable equipment to be assigned to an EIL and a designated custodial officer for inventory accountability.

nonexpendable equipment with a value of about $86.4 million had not been accepted in Maximo by the designated custodial officers.[7]

In addition, the team found that some of the facility's supply storage rooms and the warehouse lacked sufficient physical security controls to protect supplies, equipment, and veterans' personal information from loss or theft.

Expendable and Nonexpendable Inventory Management Policies and Procedures Were Not Enforced

The OIG team determined inventory management deficiencies stemmed from inadequate oversight and failure to enforce inventory procedures. Both the fiscal year (FY) 2022 and FY 2023 quality control reviews conducted by VISN 16 found limited deficiencies in expendable inventory at the Houston facility. These reviews failed to identify deficiencies that the OIG team found, including inventory discrepancies, missing important stock level data, expired supplies, as well as deficiencies with nonexpendable equipment barcoding, location, and EIL acceptance.

According to supply chain personnel, the previous Houston supply chief ignored supply chain management policy, discouraged staff from asking questions, opposed the use of performance measurement reports, and did not communicate or share information with employees. This lack of communication resulted in a failure to transfer accountability when the supply chief abruptly retired. Supply chain supervisors stated that the former chief dismissed efforts to correct inventory mismanagement and that changing the department's culture has been difficult. The deputy supply chief of expendable supplies worked to ensure accurate stock levels and coordinated inventory management training in June 2024.

VISN 16's involvement in the facility's inventory management was limited to annual quality control reviews, which are based on self-reported data and documentation uploaded by facility staff. The VISN provided minimal engagement and advice when facility staff requested it. In the FY 2023 quality control review, the Houston facility was noncompliant because accountable officer designees failed to complete required logistics and accountable officer training. However, overall, both the FY 2022 and FY 2023 quality control reviews showed limited deficiencies in inventory management and did not catch the deficiencies identified by the OIG team.

Mismanagement of Implant Inventory Led to a Significant Number of Expired Items

The OIG determined a significant number of implants expired because staff did not effectively track and manage their inventory throughout the implant life cycle. The Houston facility lacked an authoritative source of overall implant inventory as departments use different tracking

[7] This analysis included only equipment recorded as operational that should be available to support patient care.

methods: GIP, TrackCore, and WaveMark. Furthermore, the facility lacked mechanisms to identify consignment inventory and ensure vendors had local agreements to set stock levels to meet demand and hold vendors accountable for monitoring their inventory for excess and expiration dates. Staff roles and responsibilities were unclear because facility leaders failed to formally designate an implant coordinator, and the facility's local policy does not align with the VHA directive regarding managing implants.[8] Supervisors also did not properly oversee implant management and did not correct issues after staff documented multiple reports of survey—a process to investigate the circumstances surrounding the loss, damage, or destruction of property and hold responsible officials accountable—and patient safety reports related to implants.[9] As a result of the mismanagement of implant inventory, the facility incurred at least $1.2 million in financial losses related to expired implants in 2023.[10] By not addressing these process deficiencies, the facility risks patient safety and further financial losses.

What the OIG Recommended

The OIG made 10 recommendations to the Houston medical facility director: six recommendations to improve inventory management oversight and compliance with inventory procedures and four recommendations to improve implant management.

The recommendations for improved oversight include ensuring that supervisors conduct periodic inventory reviews and root cause analysis of identified discrepancies. Routine monitoring should be established for verifying barcode label use and reporting deficiencies. The OIG further recommended the facility address unaccepted equipment and establish requirements for custodial officers to routinely accept equipment in the system of record. The accountable officer should ensure service line staff who conduct physical inventories are designated in writing and receive annual training. The accountable officer and supply chain staff should verify and update the information in Maximo and ensure all nonexpendable equipment is received through the warehouse, recorded in Maximo, delivered on time to the requesting service, and accepted by the custodial officer. Finally, facility staff should address all physical security issues and provide recurring training on security controls and procedures.

To improve implant management, the OIG recommended that the Houston medical facility director ensure all biological and nonbiological implants are recorded in VHA's approved inventory management system and reconciled with systems managing implant expiration dates.

[8] VHA Directive 1081.02, *Management of Biological and Non-Biological Implants*, October 29, 2020, requires supply chain management service to coordinate with the VA medical facility implant coordinator to manage the VA medical facility's non-consignment implant inventories.

[9] VA Directive 7002, *Logistics Management Policy*, January 8, 2020. The report of survey program is the required method used to obtain an explanation of the circumstances surrounding the loss, damage, or destruction of government property.

[10] For more information about the monetary benefits, see appendix B.

The facility director should ensure that controls are developed to create local agreements for existing and future consignment implants, officially designate a facility implant coordinator and establish monitoring mechanisms for compliance with their role, update the local implant management policy to clarify roles and responsibilities, and train staff in these roles related to implant management responsibilities.

VA Management Comments and OIG Response

The medical facility director concurred with and provided action plans for all 10 recommendations. The full text of the VA management comments is presented in appendixes C and D.[11]

The planned actions are responsive to all recommendations and address the issues identified in both findings. The VISN 16 network and Houston medical facility director did not request closure of any recommendations, and all remain open at the time of this report's publication. The OIG will close recommendations when VA provides sufficient evidence addressing the intent of the recommendations and the issues identified.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

[11] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—January 24, 2025.

Contents

Abbreviations

EIL	equipment inventory list
FY	fiscal year
GAO	Government Accountability Office
GIP	Generic Inventory Package
OIG	Office of Inspector General
PSAS	Prosthetic and Sensory Aids Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Veterans Health Administration (VHA) policy mandates that facility managers establish, operate, and maintain a supply chain management program that is effective, cost efficient, transparent, and responsive to customer requirements.[12] Supply chain management involves overseeing the entire process of acquiring supplies and equipment and delivering these items to customers, ensuring efficient coordination at every stage from procurement to distribution. Inventory management is the process of overseeing and controlling the flow of inventory, with the goal to minimize costs associated with holding inventory while ensuring that enough stock is available to meet demand. VHA facilities are required to implement and follow all policies and procedures as well as continually identify ways to improve supply chain management performance in support of high-quality veteran care.[13]

The VA Office of Inspector General (OIG) identified a trend of reported allegations related to supply chain management at the Michael E. DeBakey VA Medical Center in Houston, Texas. Allegations in 2023 raised concerns with the management of supplies and equipment, such as unused surgical instruments and obsolete equipment, expired implants, and the purchase of excess automated dispensing cabinets. The OIG initiated a review to evaluate whether the Houston facility's supply chain management staff established and maintained inventory controls in accordance with VA policy. The review team assessed the facility's inventory management of expendable supplies, nonexpendable equipment, and implants.

Facility Supply Chain Management

The Houston facility, part of Veterans Integrated Service Network (VISN) 16, offers services to veterans, with spending on supplies and equipment detailed in figure 1.

Figure 1. *Houston medical facility size and spending.*
Source: VA OIG Financial Analysis Tool.

[12] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.
[13] VHA Directive 1761.

In November 2023, the facility had about $203 million of operating nonexpendable equipment in inventory and about $5.5 million in expendable supplies.[14] The medical facility's supply chain management program is overseen by a chief supply chain officer (supply chief), a deputy supply chain officer (deputy supply chief) who manages the expendable supplies, and a deputy supply chief responsible for nonexpendable equipment. The VISN 16 supply chief is required to conduct an annual quality control review and provides training to staff at the eight VA medical facilities in the VISN.[15]

The medical facility's supply chief is responsible for ensuring that the supply chain management program meets operational needs and requirements outlined in VHA policy.[16] These responsibilities include ensuring supply staff use a VHA-approved inventory management system to maintain automated inventories; establishing a local supply chain program that meets VHA policy and requirements, including inventory accounting; and reporting and completing a year-end certification of inventory values and equipment inventory. Figure 2 depicts the Houston facility's supply chain management organizational structure.

[14] Values are based on Maximo data on November 20, 2023, and Generic Inventory Package (GIP) stock status data for medical-surgical expendable supplies for November 2023.

[15] Quality control reviews are annual evaluations of medical facility operational practices to ensure compliance with regulatory and performance measure requirements.

[16] VHA Directive 1761.

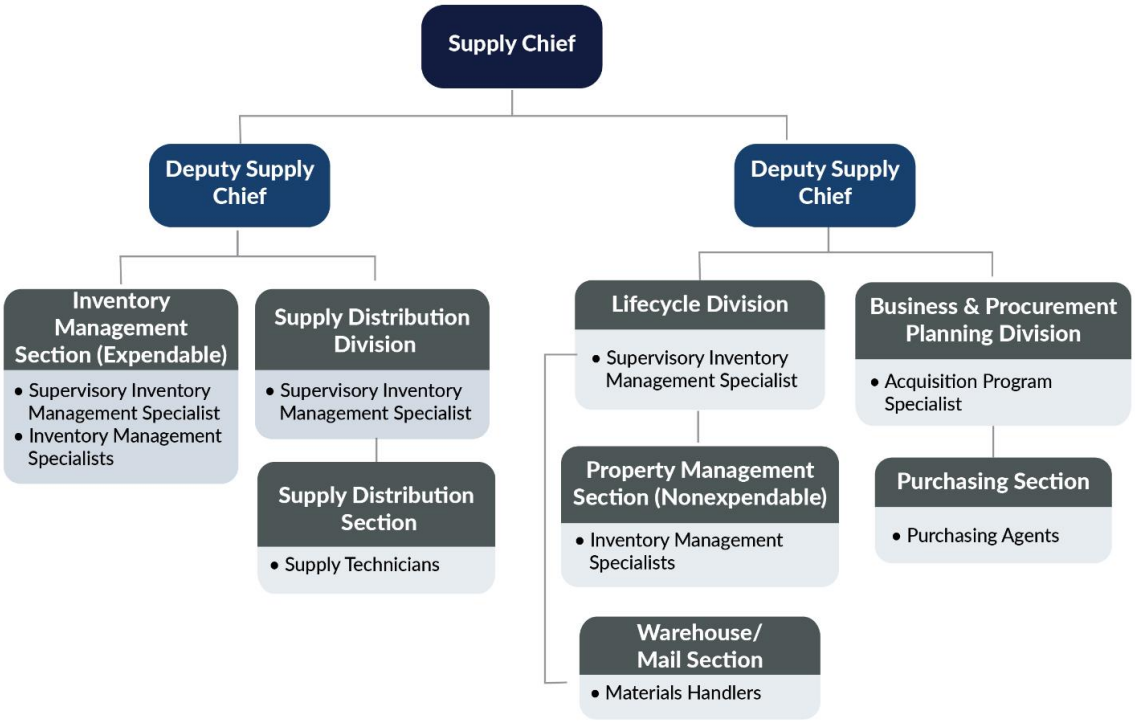

Figure 2. *Supply chain management organizational chart.*
Source: Derived from the facility supply chain management organizational chart signed August 1, 2023.

Accountable Officer

The facility supply chief also serves as the accountable officer, delegated by the facility director. The accountable officer has overall responsibility for all expendable supplies and nonexpendable equipment from acquisition to final disposition.[17] The accountable officer's primary role is to ensure all inventories are accurate and maintained in accordance with VA policy—including the oversight of the receipt and inspection of all incoming shipments—and to ensure that property is appropriately used, maintained, and conserved.[18] When an accountable officer's position changes, all property accounts must be verified for completeness and accuracy before transfer of accountability to a successor.

In September 2023, the facility's previous supply chief left VA. The Houston facility hired a new supply chief in January 2024. In the interim, the deputy supply chief over expendable supplies was the accountable officer.

[17] The accountable officer shall be the individual at each facility responsible for the Logistics Service's personal property management functions and can further delegate responsibility in writing to carry out the day-to-day requirements.

[18] VA Handbook 7002, *Logistics Management Procedures*, January 8, 2020; VHA Procurement and Logistics Office, "Accountable Officer Overview" (fact sheet).

Expendable Clinical Supplies Inventory Management in VA Healthcare Facilities

Expendable clinical supplies are disposable items that are critical in everyday medical practices and are typically used once, such as gloves, syringes, and catheters.[19] These supplies are essential for the proper operation of healthcare facilities and the delivery of treatment and care to patients.

Roles and Responsibilities of Facility Staff Who Manage Expendable Supplies

The supervisory inventory management specialist for expendables focuses on supplies, inventory management, control and distribution, recalls, and supervision. Inventory management specialists are responsible for determining which supplies are required and using the auto-generate order function in the Generic Inventory Package (GIP) system to create orders to replenish inventory and deliver the supplies at the primary inventory point, as discussed below. Supply technicians distribute supplies to primary and secondary inventory points, and warehouse staff are responsible for receiving supplies at the loading dock and delivering them to the appropriate location.

GIP's Role in Expendable Supply Management

VHA uses the GIP software application to manage expendable supplies. GIP is part of a larger system known as the Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement system, which contains data on supplies, equipment, vendors, procurement history, and control point activity. GIP enhances inventory control and accountability by enabling users to manage the receipt, distribution, and maintenance of expendable supplies.

GIP tracks two types of inventory points: primary and secondary. The primary inventory point is a storeroom that houses all expendable supplies for an inventory account. Staff use the inventory account to determine what has been used and then order replacements for the used supplies.[20]

A secondary inventory point is a distribution point for services within a facility that is typically replenished using supplies from the primary inventory point. In some cases, the primary inventory point will be the distribution point to the end user, commonly referred to as a stand-alone primary inventory point. The supplies purchased for a stand-alone primary inventory point are specialized, such as dental or prosthetic supplies.[21] Figure 3 depicts the flow of supplies from receipt to the end user.

[19] VHA Directive 1761.
[20] VHA Directive 1761.
[21] VHA Directive 1761.

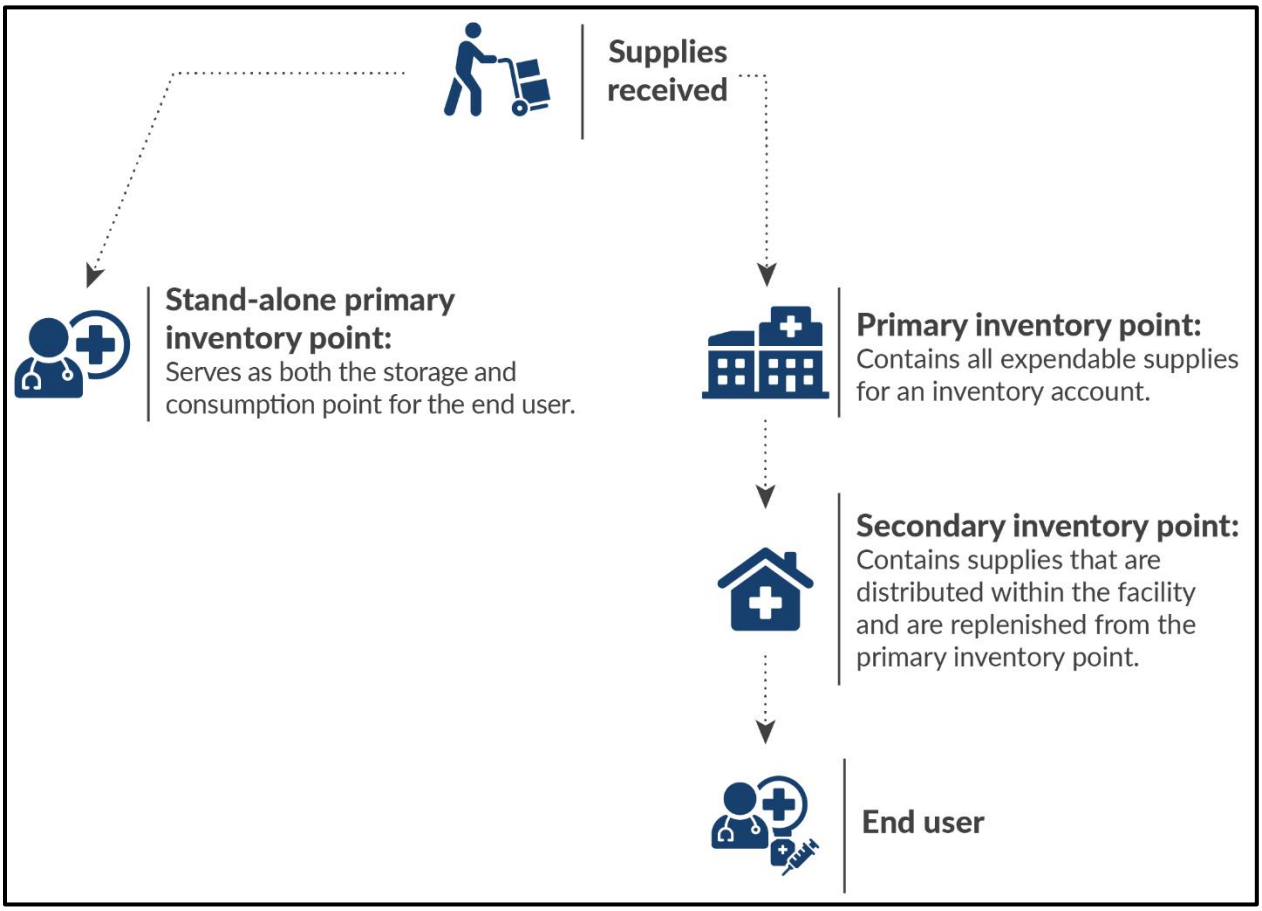

Figure 3. *Flow of supplies through inventory points.*

Source: VA OIG analysis of VHA Directive 1761 and GIP User Training Guide.

GIP generates a distribution order, also known as a "picking ticket," which is used to pull supplies from the primary inventory point to replenish the secondary inventory point. To ensure inventory accuracy, staff must post distribution orders to GIP after supplies have been picked up from the primary inventory point and delivered to the secondary inventory point. GIP uses data from barcodes to track all expendable inventory. This enables a facility to track and manage costs while monitoring usage by service line staff. VHA requires barcode labels on all expendable supplies.[22] Furthermore, all supplies on storeroom shelves must have barcode labels to help replenish and track inventory.

Physical Inventory Requirements

VHA uses the ABC classification method for inventory management.[23] This method is based on annual inventory usage, in dollars, of all items at a specific inventory point. To establish ABC

[22] VHA Directive 1761.

[23] VHA Directive 1761.

categories, items are ranked from highest dollar amount of usage to lowest. Items with the highest 80 percent of annual usage dollars are classified as "A" and must be counted each quarter. The next highest 10 percent are classified as "B" and are counted in the first and third quarters, and items representing the remaining 10 percent are in the "C" category and are inventoried in the second quarter. According to VHA policy, physical counts are not required for stand-alone inventory points as long as inventory is taken monthly with a scanner or other electronic means. Inventory at secondary points should be scanned and reconciled every month.[24]

Nonexpendable Equipment Inventory Management

VA policy states all equipment requires basic accountability in the automated equipment inventory system to provide data for inventory and financial management and reporting.[25] According to VA procedures, equipment is classified as nonexpendable if it is durable, for continuous use, has a service life of two or more years, and costs $300 or more. Examples of nonexpendable equipment include medical beds, warming and cooling tables, electronic cabinets, surgical tables, and medical care carts. Nonexpendable equipment is classified as accountable when it has an acquisition cost of $5,000 or more or is considered sensitive (for example, laptops).[26] VA policy requires all nonexpendable equipment to be accounted for in an approved automated equipment inventory system, such as Maximo. The policy also requires custodial officers to inventory accountable nonexpendable equipment annually.[27]

Roles and Responsibilities of Staff Managing Nonexpendable Equipment

The nonexpendable inventory management staff comprise a supervisor and inventory management specialists. The nonexpendable supervisory inventory management specialist plans and directs property management, equipment management, warehouse receiving, and distribution activities, as well as ensures staff are trained.[28] The nonexpendable inventory management specialists receive and create new equipment records in Maximo, generate equipment inventory list (EIL) reports, and update equipment location and last inventory date. While inventory due dates can change, the interval between inventories must not exceed 12 months after the previous

[24] VHA Directive 1761.

[25] VA Directive 7002, *Logistics Management Policy*, January 8, 2020.

[26] VA Handbook 7002.

[27] VA Directive 7002.

[28] VHA Procurement & Logistics Office, "NX Supervisory Inventory Management Specialist (GS-11) Position Description Overview" (fact sheet).

inventory completion date.[29] Specialists also retrieve, process, and record equipment turn-ins and disposition and manage and coordinate reports of survey and work orders.[30]

Maximo

The Houston nonexpendable inventory management staff use Maximo. VHA defines Maximo as an asset life cycle and workflow process management system. The system is used to manage both asset operations and business processes and stores key data, including location, condition, and maintenance records.[31] Maximo allows key performance indicators, such as the mandatory field completion rate and equipment inventory compliance report, to be tracked in VHA's nonexpendable inventory reports.[32]

Custodial Officer

To account for all equipment, facilities maintain an EIL for each service line.[33] VHA policy requires all nonexpendable equipment to be assigned to an EIL and a designated custodial officer for inventory accountability.[34] The custodial officer is generally a service chief, component head, or equivalent employee designated by the facility director to assume responsibility for nonexpendable equipment assigned to their area. When a nonexpendable item is delivered to a facility and processed in the Maximo system, the system sends an email to the designated custodial officer to notify them that a new item has been added to the EIL. The Maximo system user guide calls on the custodial officer to log into Maximo to validate the equipment information and electronically accept the item. This is considered their electronic signature. When the custodial officer electronically signs the EIL in Maximo to certify that all property is accounted for, they accept responsibility for that property until relieved from their responsibility. Figure 4 highlights the steps required to record, deliver, and manage nonexpendable equipment received at a VA medical facility.

[29] VA Handbook 7002.

[30] The nonexpendable inventory management specialist is also referred to as a nonexpendable technician or nonexpendable supply technician. A report of survey is a process used to obtain an explanation for lost, damaged, or destroyed property. A work order is a document that details maintenance tasks and outlines a process for completing those tasks.

[31] VHA Procurement & Logistics Office, "Your Role in Receiving New Equipment Using Maximo" (fact sheet).

[32] VHA Procurement & Logistics Office, "Your Role in Receiving New Equipment Using Maximo" (fact sheet). The mandatory field completion report provides the rate of completion of required fields for new items entered into Maximo. The equipment inventory compliance report provides the accountability status for equipment not inventoried in the past 13 months.

[33] Service line refers to clinical and nonclinical departments in a hospital environment.

[34] VHA Directive 1761.

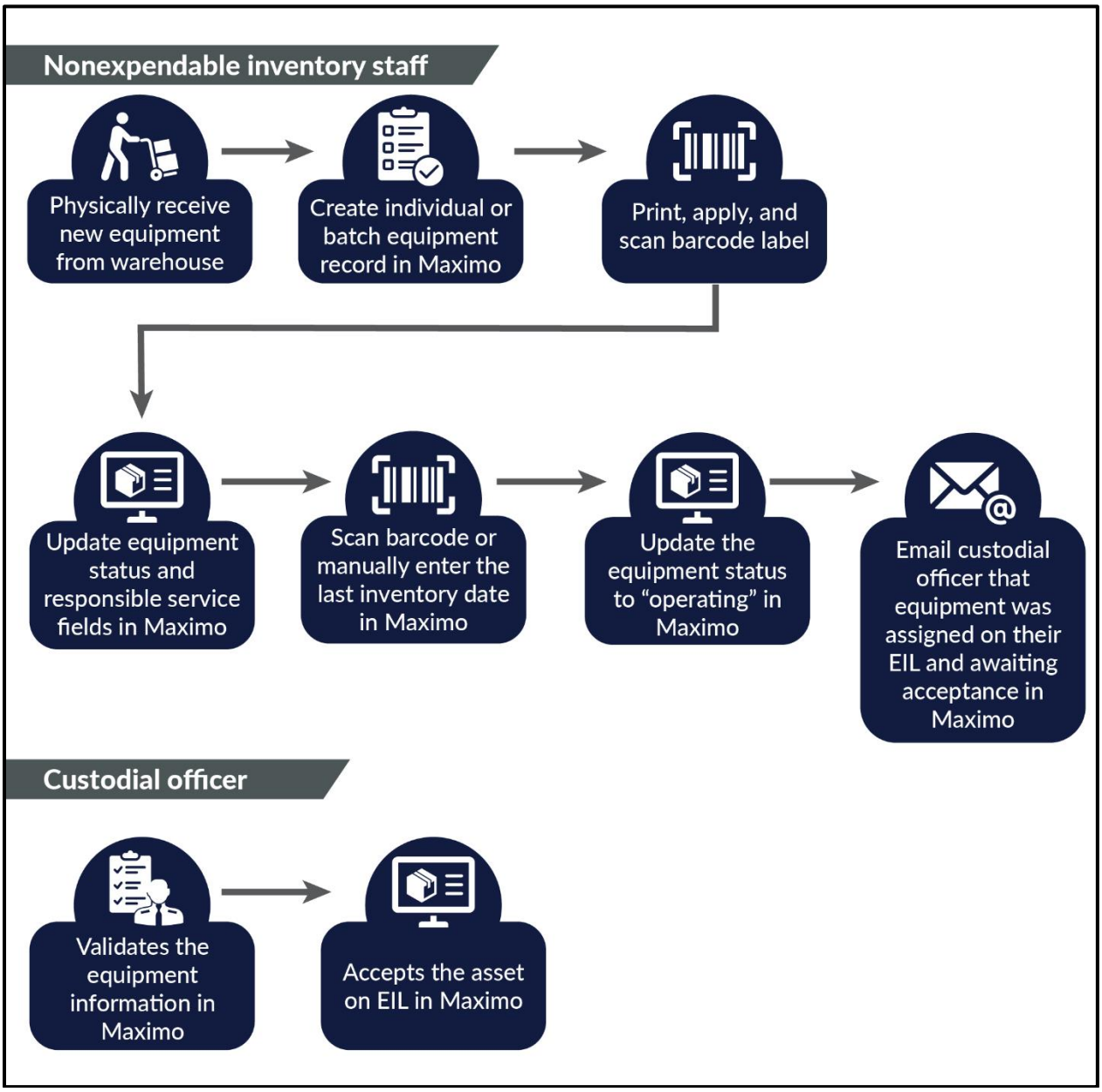

Figure 4. *Equipment receipt process for nonexpendable inventory.*

Source: VA OIG analysis of VHA Maximo training custodial official user guide.

To delegate physical inventory responsibilities, the custodial officer must give the individual performing these duties a delegation letter and send a copy to the Logistics Service.[35] Custodial officers who delegate inventory responsibilities are still responsible for certifying the accuracy of the inventory upon completion.

[35] VHA Procurement & Logistics Office, "Custodial Officer" (fact sheet).

Custodial officers or their delegates must conduct an annual inventory of all accountable nonexpendable equipment assigned to their EILs. To conduct a physical inventory, the custodial officer or delegate must find and physically scan each equipment barcode label or confirm the equipment recorded on their EIL is available and on hand. Once all items have been inventoried and accounted for, the custodial officer is required to certify the inventory with an electronic signature in Maximo.

Report of Survey

VA policy requires facilities to immediately submit reports of survey to explain the circumstances surrounding the loss, damage, or destruction of government property. Any employee who discovers a loss or damage to government property must immediately orally report the incident to their supervisor, who will notify the VA police (if necessary) and the Logistics Service.[36] According to VA procedures, the facility accountable officer is required to keep a report of survey register during the fiscal year. The overall report of survey process will not last more than 60 days, unless there is a risk of financial liability or an ongoing investigation. A board of survey of three impartial and qualified members is required to review and determine responsibility when the value of the loss or damage exceeds $5,000 or when assigning pecuniary liability to an individual.[37]

Implant Inventory Management

VHA policy defines surgical implants as biological or nonbiological material that is placed in a patient's body. A biological implantable device is tissue from a human or animal or is artificially manufactured and is implanted into or grafted onto the body to replace damaged tissue. Examples of biological implants include bone, skin, or ligaments. A nonbiological device, such as a cardiac pacemaker or an artificial joint, is implanted in the body to replace, support, or substitute for deformed or weakened parts of the body.[38]

Managing surgical implants at the facility level requires a multidisciplinary approach and coordination among several parties responsible for tracking an item from procurement to implantation. VHA facilities use both VA-owned and consigned implants for patient care.[39] VHA policy requires initial stock of implants and associated expendable surgical implants to be purchased with general purpose funds.[40] After a surgical implant is used, a Prosthetic and Sensory Aids Service agent purchases a replacement implant. Consigned implants are governed

[36] VA Directive 7002.

[37] VA Handbook 7002.

[38] VHA Directive 1081.02, *Management of Biological and Non-Biological Implants*, October 29, 2020.

[39] Consignment implants are contractor-owned supplies held at a medical facility for clinical use on an as-needed basis. Consigned implants are paid for when VA notifies the vendor that an implant has been used.

[40] VHA Directive 1761.

by facility agreements derived from VA national contracts and are provided by a vendor reimbursed by VA only when the implant is used.

The medical facility supply chief is responsible for ensuring that all VA-owned implants and implant-related expendable inventories are maintained in the VHA-approved system with appropriate stock levels set and that inventory managers or supply technicians check for expiration dates, damage, and cleanliness of storage areas on a weekly basis.[41]

The medical facility implant coordinator's responsibilities include ensuring policies governing implants are followed and coordinating all aspects of implant management by working with staff from contracting, supply chain management, prosthetics, the sterile processing service, as well as all clinical areas using implants. Close partnership among these employees is critical. The implant coordinator also oversees a team of four implant program analysts whose main responsibility is to ensure that implants are properly documented. In addition, according to the implant coordinator, two logistics employees designated as implant inventory managers provide procurement and inventory support to clinical areas using implants.

VA-owned implants that are expired or unable to be returned to storage should be discarded and documented accordingly in the inventory system or returned to the vendor if permitted.[42] Vendors are responsible for replenishing used, expired, or near-expired consigned inventory during service visits to the facility.

TrackCore and WaveMark

The Houston facility uses multiple tracking systems to manage implants—GIP, TrackCore, and WaveMark. VHA policy requires supply chain organizations to establish and manage facility implant inventories in an approved system.[43] GIP was the only VHA-approved inventory management system during the scope of this review.

Commercially available tracking software programs, such as TrackCore and WaveMark, provide facilities the ability to clinically track chain of custody for implants. TrackCore, a web-based application used to monitor biologic and nonbiologic implants, captures the complete chain of custody by tracking the receipt, movement, condition, and status of implants.[44] The Houston facility uses TrackCore to manage biological implants from arrival to the facility through final use, return, or disposal. However, TrackCore does not interact with GIP and does not include

[41] VHA Directive 1081.02.

[42] VHA Directive 1081.02.

[43] VHA Directive 1081.02. The VISN chief logistics officer is responsible for ensuring VA medical facility staff establish and manage facility implant inventories in the VHA-approved inventory management system (which was GIP at the time of this review).

[44] TrackCore Site Management User Guide.

item master file numbers.[45] Two clinical areas in the Houston facility use WaveMark, a third-party software system that links product usage to a patient's record with reporting capabilities for expiration dates and recalls, to track clinical products.

[45] VHA Directive 1761. The item master file stores item information, including description, mandatory source, vendor, unit price, and product manufacturer information.

Results and Recommendations

Finding 1: Houston Facility Personnel Did Not Effectively Manage Inventory for Expendable Supplies and Nonexpendable Equipment

The Houston VA medical facility personnel responsible for supply chain management did not ensure adequate accountability of expendable supplies and nonexpendable equipment. The review team found overstocked and understocked inventory, missing important stock level data, and expired expendable supplies.

The team also discovered inaccurate accounting of nonexpendable equipment, missing barcodes, and custodial officials not accepting assigned equipment in Maximo. These deficiencies stemmed from inadequate oversight and failure to follow inventory procedures, putting the facility at risk of losing equipment or using expired products for patient care.

This finding is based on the following determinations:

- Facility staff did not adequately manage expendable inventory.
- Facility staff did not accurately record or account for nonexpendable equipment.
- Oversight of expendable and nonexpendable inventory was insufficient.
- Inventory management policies and procedures were not followed or enforced.
- Inventory was not physically secured.
- Inaccurate inventories increased the risk of losing equipment and of using expired products for patient care.

What the OIG Did

The review team conducted unannounced site visits to the Houston VA medical center in November 2023 and January 2024. While on site, the team physically inventoried 60 judgmentally sampled types of expendable supplies in the primary inventory point and a judgmental sample of 90 nonexpendable equipment items observed throughout the facility's floor and warehouse locations. The team selected various types of expendable supply items to sample and stratified the selection based on physical inventory frequency—20 from each ABC classification category. The team reviewed VA and VHA policy, procedures, and supply chain program documentation and compared the team's inventory of sampled supplies and equipment to the facility's automated inventory management systems at the time of the visits.

The team interviewed medical facility leaders and VISN managers to determine what steps were taken to oversee and monitor the facility's supply chain management and interviewed logistics

and clinical staff charged with the physical inventory, security, and accountability of the facility's expendable supplies and nonexpendable equipment.[46]

Facility Staff Did Not Adequately Manage Expendable Inventory

The review team identified discrepancies between the inventory system and physical inventory, missing emergency stock level data, and expired supplies.

Inventory Records Did Not Align with On-Hand Supplies for Sampled Items

VA policy requires the facility supply chief to monitor staff's use of GIP for inventory management and mandates that personnel enter expendable supplies into GIP for tracking and distribution purposes.[47] However, the OIG team found that facility staff did not adequately track expendable inventory.

The review team counted the inventory of a sample of 60 various expendable medical-surgical supply items from the medical facility's primary inventory point. The team found discrepancies in 49 of the 60 items (82 percent), both over and under what was reported in GIP. Inventory levels above or below required levels can cause supplies to become obsolete or expire and can cause shortages or excesses that may affect patient care and operational effectiveness.

For 33 of these 49 items (67 percent), the Houston facility had fewer actual on-hand quantities than what the system reported; the discrepancies ranged from one to 4,549 fewer units. Figure 5 compares the actual on-hand quantity and the system quantity for the five sampled supply items with the greatest underreporting discrepancies and the five with the greatest overreporting discrepancies.

[46] For more information about the review's scope and methodology, see appendix A.

[47] VHA Directive 1761.

Sample	Physically on hand	System quantity on hand	Difference	Percent difference	Average unit cost	Value difference
Decontamination gown	1	1,182	-1,181	-100%	$6.49	-$7,662
Portable male urinal	43	4,592	-4,549	-99%	$0.48	-$2,179
High pressure flow control	8	241	-233	-97%	$3.19	-$744
Catheter	9	184	-175	-95%	$3.43	-$601
Warming blanket	12	172	-160	-93%	$7.37	-$1,179
Needle safety	155	93	62	67%	$5.03	$312
ChloraPrep antimicrobial solution	2,928	1,060	1,868	176%	$0.75	$1,397
Olcott torque device	115	34	81	238%	$20.90	$1,693
Silicone gel adhesive dressing	99	20	79	395%	$66.70	$5,269
Sterilization record envelope	1,000	15	985	6,567%	$22.85	$22,511
Aggregate of all 60 sampled items	6,296	10,520	-4,224	-40%		

Figure 5. *Inventory discrepancies of 10 sampled items.*

Source: VA OIG analysis of physical inventory of judgmentally selected sample of 60 medical-surgical expendable supplies and GIP inventory system data.

Note: The 10 supplies listed are made up of the five sampled supply items with the largest underreporting discrepancies and the five with the greatest overreporting discrepancies.

According to VA policy, the minimum acceptable inventory accuracy rate of the aggregate of all stock is 95 percent.[48] From October 2023 through January 2024, the facility reported their inventories complied with the 95 percent threshold. However, from February through June 2024, the accuracy rates for the facility's reported inventories ranged from only 11 percent to 51 percent. The inventory reports noted that the low accuracy rates were due to a lack of sufficient inventory management staff, inaccurate system data, and inaccurate unit conversions. The supervisory inventory management specialist attributed the earlier higher accuracy rates to ongoing manual inventory adjustments by the logistics management specialist. For example, in 2023, the specialist made a $6,187 adjustment in October, a $2,379 adjustment in November, a $6,270 adjustment in December, and a $13,040 adjustment in January 2024. To rectify discrepancies discovered during an inventory, staff must prepare a positive or negative adjustment transaction via an expendable adjustment voucher, either manually or in GIP, as mandated by VA policy.[49] However, according to the deputy supply chief, the logistics management specialists were given shared responsibilities with the inventory managers to adjust inventory data by the former supply chief. The deputy supply chief clarified that only inventory managers should have the sole responsibility to make inventory adjustments. As a result, the deputy supply chief instructed inventory managers to manage their inventories and asked logistics management specialists to scale back their involvement during inventories, effective February 2024.

Supplies Were Not Maintained Within the Required Stock Levels

The review team's analysis of the physical inventory data in GIP further revealed that 39 of the 60 sampled items (65 percent) had quantities higher than VHA's required normal stock levels or below the reorder point.[50] The normal stock level, also known as the periodic automatic replacement level, is established for new items based on the lead time, the storage space available, and the amount estimated to be used in 30 or 45 days, depending on the procurement source type. For existing goods in GIP, the level is determined using data gathered from GIP reports, lead time, and available storage space.

Of the 39 supplies with quantities on hand that were not within the required levels, 21 (54 percent) exceeded the normal stock level—up to 1,428 units over, with a total value of about $44,197. The remaining 18 supplies (46 percent) had quantities on hand ranging from two to 2,357 units below the reorder point.

Maintaining supplies above normal stock levels leads to overstocking and increases the risk of supply damage, expiration, contamination, or wasted supplies. Conversely, failing to keep

[48] VA Directive 7002.

[49] VA Handbook 7002.

[50] VHA Directive 1761. The normal stock level represents the largest quantity of an item to be maintained in the inventory point, and the reorder point level represents the level at which the item is to be reordered.

supplies above their reorder points increases the risk of supply shortages, not having the right items when needed for patient care, increased spending on expedited delivery, and a loss of trust in supply chain staff.

The Inventory System Was Missing Emergency Stock Level Data for Expendable Supplies

Supply chain staff generally did not use GIP to set emergency stock levels for expendable supplies as required to ensure adequate inventory management during emergencies. The emergency stock level is the minimum quantity of an item that should be maintained in inventory and must be set for all primary inventory point items.[51] The emergency stock report, which is recommended to be run weekly, alerts staff when inventory levels reach the emergency stock threshold—signaling a potential need for immediate purchase. The OIG team discovered that 50 of the 60 sampled supplies had an emergency stock level set to zero in GIP. This means that facility staff did not set the level, which could lead to supply shortages and misrepresent the facility's compliance with this policy.

Inventory managers stated they did not update the emergency stock level fields in GIP when they became inventory managers and took over supply administration either due to time constraints or a lack of attention to this specific field.

According to the GIP training guide, if no emergency stock level is set, no data will be generated in the emergency stock report. Therefore, having a zero in the emergency stock level field is equivalent to not setting an emergency stock level for the supply. Setting the emergency stock level correctly is important for reporting and monitoring supply levels.

It is critical that inventory managers accurately set emergency stock levels and use oversight reporting functions to ensure timely restocking of supplies. Failure to do so may result in disruptions of inventory availability. The deputy supply chief of expendable supplies confirmed the review team's findings related to the facility's noncompliance with the emergency stock level policy and stated that staff inventory managers had been directed to rectify this issue.

Expired Supplies Were Stocked in the Warehouse with Current Supplies

The review team discovered 15 different types of supplies that had 1,568 expired items in the medical facility warehouse. These amounted to an inventory value of around $109,000. The expired supplies, still in their boxes, were in the medical-surgical supply section of the warehouse alongside new supplies.

[51] VHA Directive 1761.

According to the warehouse supervisor, their storage practice is first-in, first-out. He further stated warehouse staff do not check for expiration dates because that is the responsibility of inventory managers.[52] The supplies stored in the warehouse are used to stock the primary inventory point or are sometimes distributed directly to end users. The expired supplies, which included gastric tubes used for endoscopies and ventilator circuit tubing that connects a ventilator to a patient, were expired by 10 to 260 days at the time the review team found them (as shown in figure 6 on the next page).

According to the supervisory inventory management specialist, this is an ongoing issue, and supplies expire because inventory managers order too many supplies rather than use what they have on hand. The supervisor went on to explain that they advised inventory managers on how to properly organize stock so that supplies with the earliest expiration dates are moved to the primary inventory location for distribution to secondary distribution points. The supervisor added that employees would cooperate with the guidance for a while but then would return to old habits of storing the supplies on shelves in the order they arrive from the vendor, regardless of the expiration date. The supervisor claimed to have also discovered expired supplies in the warehouse two weeks before the OIG's visit and did not realize that inventory managers never removed the expired supplies from the shelves until the OIG team found them. The review team also alerted the deputy supply chief for expendable supplies to the expired supplies, and they completed the required turn-in form.[53] Failure to identify expired medical supplies risks these supplies entering clinical areas where patients are treated or supplies being unavailable when needed.

[52] VHA Directive 1761. Stock must be cycled according to the first-in, first-out principle, which is a technique for making sure older supplies are used before fresh ones. However, stock rotation for products with expiration dates must follow the first-expired, first-out method.

[53] VA Handbook 7002 states that personal property that is no longer required by a service provider or that has become unserviceable due to normal use is considered "unrequired." Property that is no longer required should be turned in to the Logistics Service along with VA Form 2237.

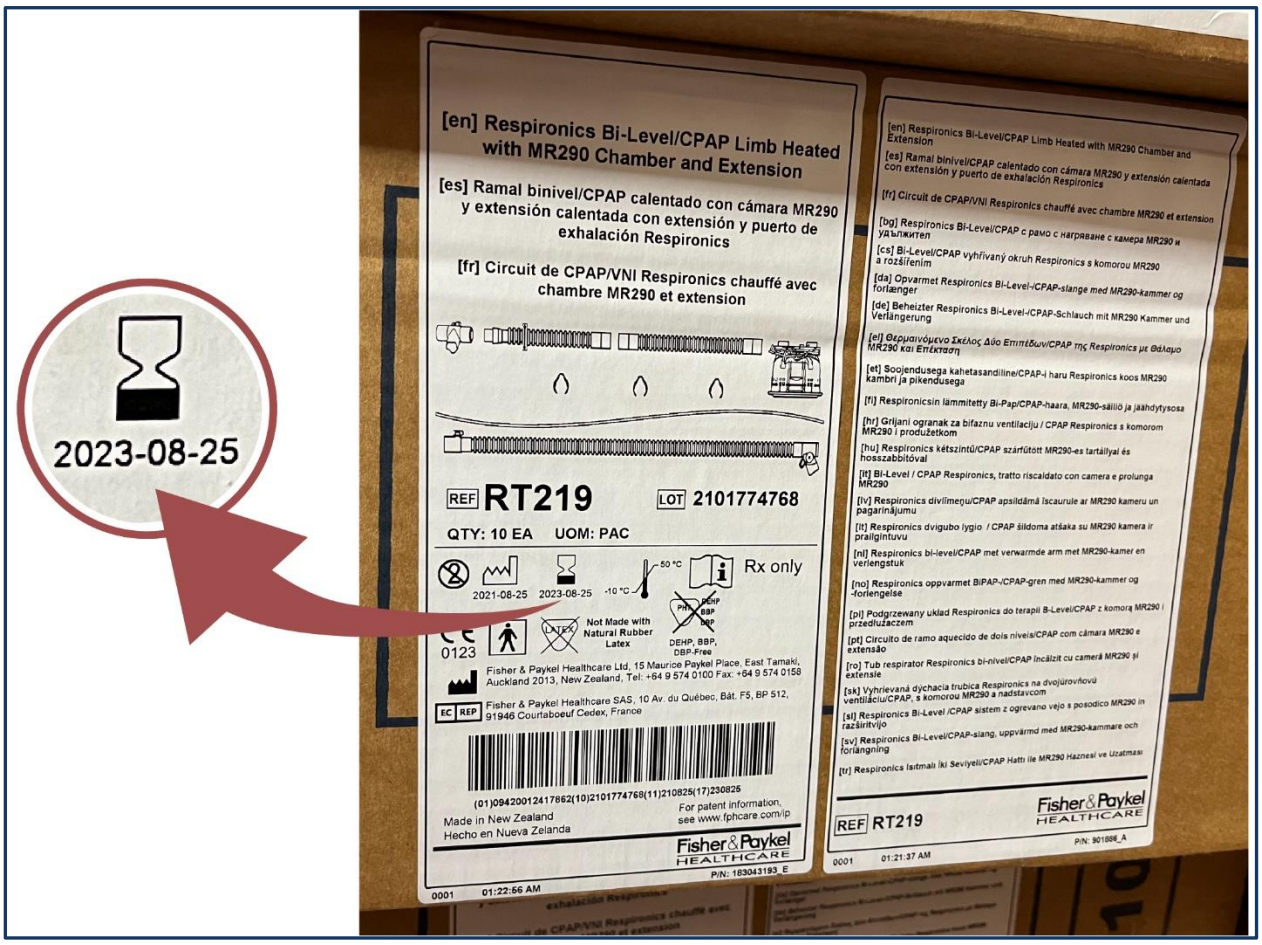

Figure 6. *Expired ventilator circuit tubing. This item had been expired for 95 days (expired August 25, 2023) when the review team found it on a shelf in the Houston VA medical facility's warehouse.*

Source: VA OIG, November 28, 2023.

Note: The hourglass symbol denotes the medical device's use-by date.

Unopened Supplies Were Found in Dumpsters

Additionally, the team discovered new and unopened expendable supplies worth $1,124 in the facility's dumpsters. The supervisory inventory management specialist suggested that this was most likely caused by supply technicians disposing of items from a crash cart rather than returning them to the service lines.[54] The supervisory inventory management specialist clarified that once supplies leave the primary inventory point for distribution, they cannot be returned and supply technicians must work with the service to ensure their retention. If the clinics do not want to keep the supplies, the supply technician must complete a turn-in form to ensure proper disposal.

[54] A crash cart is a cart stocked with emergency medical equipment, supplies, and drugs typically used by medical personnel attempting to resuscitate a patient in cardiac arrest.

Facility Staff Did Not Accurately Record or Account for Nonexpendable Equipment

Facility staff did not ensure all nonexpendable equipment was properly recorded and accounted for in Maximo as required.[55] Deficiencies included inaccurate locations and statuses, missing barcodes, and custodial officials not accepting assigned equipment in Maximo.

The Inventory System Reflected Inaccurate Locations and Statuses, and Some Items Were Missing Barcodes

The review team found that staff and responsible custodial officials did not ensure equipment location and status were accurately updated in Maximo. To assess the accuracy of nonexpendable inventory, the review team identified a sample of 90 nonexpendable equipment items physically present throughout the facility's rooms and warehouse. The team captured pertinent identifiers and the locations of the equipment and then compared this information to the inventory data recorded in Maximo.

The team determined 85 of the 90 sampled items (94 percent) were found in a different location than recorded in Maximo. The team located 18 of these 85 items (21 percent) in a warehouse cage, unused. However, the Maximo system showed nine of these items were assigned to an EIL and were operating in a medical care service area. The other nine items in the warehouse were not assigned to an EIL.

When equipment is not located where the Maximo system indicates, it can delay operations if the needed equipment cannot be found. Misplaced equipment also risks wasted funds and excess equipment purchases if the existing equipment is replaced and then later found in the facility. Further, it can result in difficulties tracking equipment needed for patient care or performing required maintenance or updates.

The review team also found that 23 of 90 items (26 percent) did not have the required barcode labels needed to conduct annual inventory scans. Barcode labels are used to identify and track equipment and include the item description, facility station number, and equipment entry and serial numbers. As an example, 11 unused items stored in a warehouse cage that were recorded at other locations did not have the required barcode labels. Without accurate location information and barcode labels, facility staff cannot properly identify and account for assigned equipment or ensure the accuracy of inventory results.

[55] VA Handbook 7002. This policy requires Logistics Service staff to populate data fields in the automated equipment inventory system at the initial receipt of new nonexpendable equipment, and, to the maximum extent possible, inventories will be conducted using barcode technology. Data fields in the equipment inventory system include serial number, EIL number, use status, using service, location, and last inventory date. Attached barcode labels should include the asset description, equipment entry number, serial number, and station number. Inventory data collected on the barcode scanner will be uploaded to the automated equipment inventory system.

Maximo Showed Inaccurate Omnicell Locations

The review team determined the facility had 232 Omnicell cabinets, a type of nonexpendable equipment, recorded in Maximo. Omnicell cabinets are automated dispensing cabinets that serve as controlled secondary inventory points and range in cost from about $2,500 to over $41,000 each. Omnicell cabinets restrict physical access to the supplies or medication stored in them.[56] The inventory levels in the Omnicell cabinets are monitored by integrated computers, which update the facility's inventory records. Omnicell cabinets are restocked by pharmacy and supply chain management staff as items are used. As shown in figure 7, the team observed two different types of Omnicell cabinets at the Houston facility: enclosed shelving units for medical supplies (left) and dispensers for pharmaceuticals (right).

Figure 7. *Omnicell cabinets observed at the Houston VA medical facility.*
Source: VA OIG, January 24, 2024.

The team used Maximo records to first identify the locations of the Omnicell cabinets and then observed them floor by floor. During the first site visit, the team looked for 133 specific Omnicell cabinets and found that only 43 (32 percent) were in the correct location as recorded in Maximo.

However, the team did not find the other 90 Omnicell cabinets (valued at $1,057,823) in the locations recorded in Maximo. The team continued to search in the facility and eventually found 29 of them in a different location than recorded in Maximo. For example, the team located two

[56] Omnicell Implementation Guide, 67-3004 Revision J.

cabinets in the equipment and storage room on the fifth floor of the Houston facility, whereas Maximo recorded their location in the warehouse basement.

Because of inaccurate data in Maximo, the team could not locate the remaining 61 Omnicell cabinets (valued at $717,059) after searching the additional areas and coordinating with staff responsible for nonexpendable equipment.[57] After the site visit, facility staff eventually located 54 of the remaining 61 Omnicell cabinets. As of May 15, 2024, 48 were in different locations than listed in Maximo, and six had been decommissioned and were no longer in use. Most of these Omnicell cabinets (40) were recorded by nonexpendable equipment staff as in the facility warehouse, but they were found throughout the hospital. When equipment is moved, nonexpendable equipment staff need to update the location in Maximo.

Because Omnicell cabinets can be used to store medication and to restrict access to other types of supplies, not knowing where they are or what they contain poses risks for loss and drug diversion at the Houston facility, in addition to the significant value of the cabinets themselves.

Custodial Officers Did Not Accept Assigned Equipment

VHA policy requires all sensitive and accountable nonexpendable equipment to be assigned to an EIL and a designated custodial officer.[58] The custodial officer is typically a service chief, component head, or equivalent employee designated to assume responsibility for nonexpendable equipment assigned to that area. When a custodial officer signs the EIL, they certify that all property placed into official use is listed on the EIL and is present and accounted for. They also acknowledge responsibility for that property until relieved.[59]

However, many of the service-line custodial officers did not actually accept all the equipment assigned to their respective EILs in the Maximo system. In March 2024, 47,268 of 64,777 operational, accountable nonexpendable equipment (73 percent) with a value of about $86.4 million had not been accepted in Maximo by the designated custodial officers.[60] If the custodial officers do not accept equipment in Maximo, it is unclear whether the equipment they received matches what is recorded in Maximo. Further, accountability is lost when equipment is missing during subsequent inventories.

The acceptance status is readily available to nonexpendable equipment staff and custodial officers in Maximo, where they can identify unaccepted equipment. The nonexpendable

[57] Seven of the 61 Omnicell cabinets were not reviewed because they were inaccessible and in secured facility locations.

[58] VA Handbook 7002.

[59] VA Directive 7002.

[60] The overall total number of accountable nonexpendable equipment that was not accepted by the facility's custodial officers was greater. This analysis focused only on equipment recorded as operational that should be available to support patient care.

equipment supervisor said his staff record, barcode, and add new equipment to the EIL when it is received at the facility. They then deliver the equipment to the service lines and have the staff sign the receiving report as acknowledgment of physical receipt of the equipment. When logistics staff add items to the EIL, the custodial officer is notified via email. However, the supervisor does not verify whether the custodial officers accept the equipment on the EIL via electronic signature in Maximo, as required.[61]

Oversight of Expendable and Nonexpendable Inventory Was Insufficient

Two supply chain personnel told the review team that the facility's previous supply chief (who also served as the accountable officer) disregarded supply chain management policy, and supply chain personnel did not question him for fear of reprisal. Two supervisory inventory management specialists report to the supply chief and are responsible for inventory management, control, and distribution. The supervisory inventory management specialist for expendable supplies stated that the former supply chief opposed the use of performance measurement reports or GIP tools to monitor supplies and did not like to be questioned when issues were identified. He gave an example, stating that the former supply chief failed to respond to multiple inquiries about poor inventory management practices. As a result, he said he lacked confidence that issues could be addressed locally.

The supervisory inventory management specialist further claimed that the former supply chief opposed change and eventually stripped him of all supervisory responsibilities, effectively cutting off communication with inventory managers. He stated that resuming supervisory responsibilities over inventory managers has been very challenging.

The facility's high rate of items with more than 90 days of stock (called long-supply items) suggests a lack of proper oversight and monitoring, as the facility supply chief is responsible for ensuring these levels remain within the allowable percentage. VHA policy allows facilities to designate up to 10 percent of their inventory as long-supply items to accommodate fluctuations in product demand.[62] The supply chief must verify that these items meet the permitted percentage or take corrective action. On April 30, 2024, the total value of medical-surgical supplies on hand at the Houston facility was around $5.5 million, with long-supply items accounting for roughly $3 million (about 54 percent).[63] The supervisory inventory management specialist attributed this to the former supply chief's lack of oversight and inventory managers'

[61] VHA Procurement and Logistics Office, "Your Role in Receiving New Equipment Using Maximo." After the custodial official validates the information on the equipment, they indicate their acceptance of the equipment on their EIL in Maximo. This is considered their electronic signature.

[62] VHA Directive 1761.

[63] VHA's long-supply report captures the long-supply percentage rate and total value of supplies but not their quantity.

tendency to overorder—adding that maintaining high levels of long-supply items will result in excess supplies, waste, and increased costs. Subsequently, the supervisory inventory management specialist stated that they instructed inventory managers to evaluate the days of stock on hand and to turn in excess supplies as needed. He added that reducing the days of stock on hand will also result in better storage space allocation. He also told the review team in April 2024 that the former supply chief left the program in such disarray that fixing these problems was taking a great deal of time, staff, and work.

The deputy supply chief responsible for nonexpendable property management stated that the former chief also was reluctant to communicate or share information with staff. This lack of communication was underscored when the supply chief retired in September 2023, and the required accountable officer transfer of authority did not occur because neither of the deputy chiefs were aware the former supply chief was leaving VA. Consequently, both deputy chiefs said that a transfer of accountability was never executed as required, and formal accountability of the facility's equipment was not transferred to the deputy, the newly designated accountable officer.[64]

Both the expendable and nonexpendable inventory supervisors stated that efforts to correct inventory mismanagement failed because the former supply chief dismissed feedback and recommendations. A new supply chief was hired in January 2024, but the expendable inventory supervisor stated that changing a culture lacking direction and accountability has been difficult and will take time. Although managers attributed deficiencies to the former supply chief, staff had an obligation and responsibility to ensure the accuracy and accountability of VA's equipment according to VA policy. Facility supply chain management staff are now taking appropriate steps to address inventory management weaknesses. The deputy supply chief set goals of ensuring accurate stock levels and coordinated inventory management training for supply chain employees that took place in June 2024. In August 2024, the new supply chief established action plans for inventory reviews and root cause analyses. He requires reports twice a month on training and equipment acceptance by custodial officers, weekly reports on physical security, and updates on barcode use and maintenance for supplies and equipment.

VISN 16 involvement in the oversight of the facility's inventory management was limited to the annual quality control reviews, and the VISN provided minimal engagement and advisement unless the facility staff requested assistance. The quality control review is a VISN-led review of operational practices to ensure compliance with supply chain management policies and metrics. The quality control review assesses various categories, including supplies and equipment, and must be completed at least once per year by the VISN supply chief. In fiscal year (FY) 2023, the

[64] When an accountable officer changes, formal accountability—as distinguished from liability—will be immediately transferred to the successor who is designated via memorandum, which is routed through the director and included in the human resources clearance sheet for VA facilities. If the outgoing official is prevented from executing this action, the justification will appear on the memorandum in lieu of the signature.

VISN 16 quality control review found the Houston facility noncompliant because accountable officer designees lacked the required annual training. Both the FY 2022 and FY 2023 quality control reviews found limited deficiencies in expendable and nonexpendable inventory management. These reviews did not identify deficiencies that the OIG team found, including inventory discrepancies, missing important stock level data, and expired supplies as well as a lack of nonexpendable equipment barcoding, inaccurate location and status, and lack of EIL acceptance. The quality control reviews leverage self-reported data and documentation uploaded by facility staff before the VISN staff's site visit, and facility supply chain staff told the OIG team that VISN 16 staff did not validate the information the facility reported.[65]

To improve oversight, the OIG's first recommendation is for supervisors to conduct additional monitoring activities. These include periodic reviews of expendable and nonexpendable inventory and root cause analyses of identified discrepancies to strengthen controls over VA supplies.

Inventory Management Policies and Procedures Were Not Followed or Enforced

The OIG determined inventory management deficiencies stemmed from inadequate oversight and failure to follow inventory procedures. Many inventory policies and procedures were not followed or enforced at the facility, including inventory verifications, using updated barcode labels, and effectively using the system to ensure supplies can be reordered when needed.

Inventory Managers Did Not Update Barcode Labels or ABC Designation Labels

The deputy supply chief responsible for expendable supplies did not ensure that barcode labels affixed to supply storage locations contained accurate GIP inventory data, contributing to inaccurate inventory levels. VHA policy requires updating the barcode labels for expendable supplies whenever normal stock levels change or units of issue change.[66] The review team found that 23 of 60 sampled supply items had outdated labels due to stock level changes caused by either normal or reorder point fluctuations, as shown in figure 8.

[65] The OIG separately assessed VISNs' oversight of supply chain management through VHA's quality control review program. See VA OIG, *Improved Oversight Is Needed to Correct VISN Identified Deficiencies in Medical Facilities' Supply Chain Management*, Report No. 23-02123-202, September 12, 2024.

[66] VHA Directive 1761.

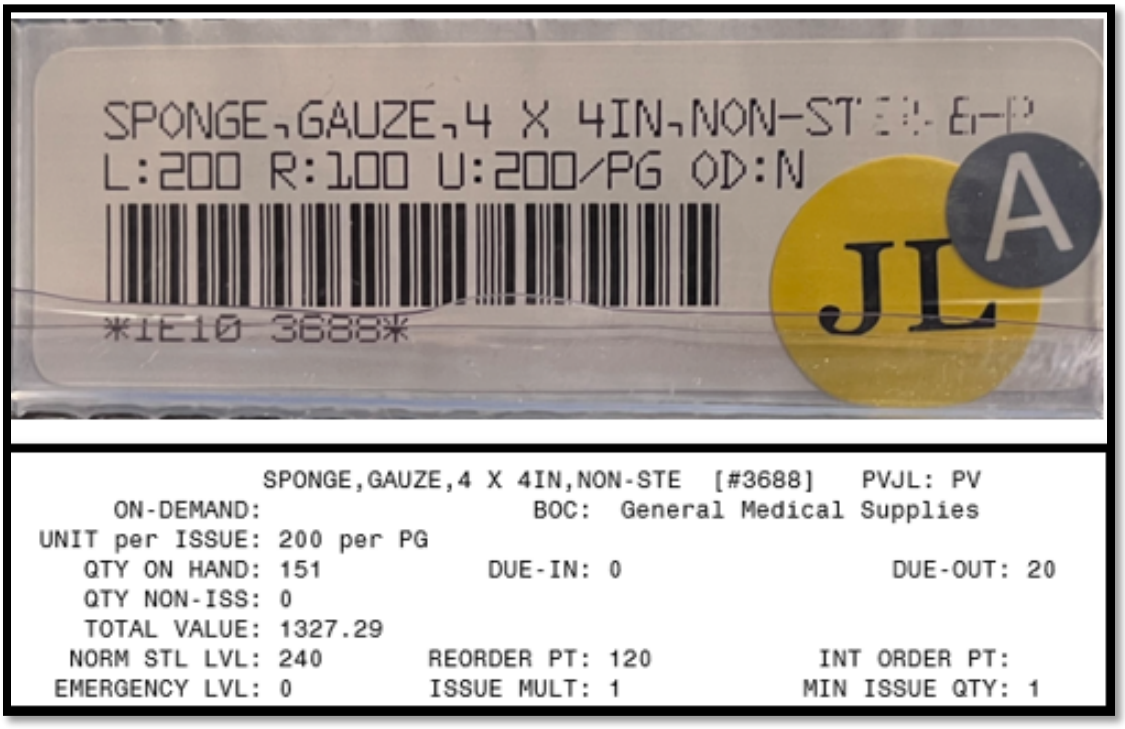

Figure 8. *Barcode label for sponge gauze with an outdated normal stock level of 200 and a reorder point of 100 (top); screenshot of GIP system showing the most up-to-date normal stock level of 240 and a reorder point of 120 for the sponge gauze (bottom).*

Source: VA OIG, November 28, 2023 (top); GIP screenshot taken on November 29, 2023 (bottom).

In addition to outdated barcode labels, the A, B, or C designation labels did not accurately match the FY 2024 ABC classification report.[67] A supply item's classification may change from year to year, and supply chain personnel must review all primary inventory points at the beginning of each year for potential reclassification.[68] The review team compared the A, B, or C designation affixed to the barcode labels of the 60 sampled supply items to the classification report and found that 12 of the sampled items did not match the report. When the correct classification is not displayed, logistics staff cannot ensure inventory is properly rotated.

In October 2023, the logistics management specialist emailed inventory managers a memorandum containing barcode and A, B, and C designation display instructions, as well as the classification report for FY 2024. The supervisory inventory management specialist said the instructions were also verbally communicated to all inventory managers. However, inventory

[67] VHA Directive 1761. VHA uses the ABC classification method for inventory management. Inventory items with the highest annual usage spending (the top 80 percent) are classified as "A" and must be counted each quarter. Supplies with the next highest annual usage (the next 10 percent) are considered "B" items and are counted in the first and third quarters, and items representing the remaining 10 percent (lowest usage) are in the "C" category and are inventoried in the second quarter.

[68] VHA Directive 1761.

managers cited time constraints and occasional printer malfunctions as challenges in updating barcode labels. Inventory managers also admitted that they sometimes overlooked these classification designations and did not have time to reclassify items. The supervisory inventory management specialist claimed that inventory managers' unwillingness to comply with the policy stemmed from the previous supply chief's refusal to hold anyone accountable for not following policy.

To ensure the accuracy of expendable inventory data, recommendation 2 is for the accountable officer to routinely verify the required use of barcode labels to track and identify supplies and equipment and report deficiencies for barcode replacement.

Custodial Officers Did Not Electronically Accept Equipment

Custodial officers can delegate the inventory and management of equipment to service-line staff but are still responsible for accepting equipment to the EIL and certifying the annual inventories. The review team found that custodial officers did not ensure equipment added to the EIL was electronically accepted after the items were physically delivered to their service lines. Additionally, custodial officers told the OIG team that besides signing and certifying the annual inventories, all other activities were delegated to service-line staff.

According to the nonexpendable equipment supervisor, when new equipment is added to a service-line EIL, an email is sent to the custodial official asking them to accept the equipment. Custodial staff the team interviewed acknowledged receiving the new equipment email, but none of them were aware they had to electronically accept the new equipment in Maximo. For example, one custodial officer told the OIG team that only 10 items were pending acceptance; however, when reviewing the Maximo dashboard with the team, the officer identified 1,378 items pending acceptance.[69] Additionally, a custodial officer's designee said all equipment on the EIL was accepted, but the review team identified 433 items in operational status that had not been accepted. Upon review, the team determined the designee's Maximo dashboard did not include the menu for accepting new equipment added to the service line's EIL. Subsequently, the dashboard was corrected to give access to the custodial designee.

The nonexpendable supervisor said that if the custodial officer completed and signed the annual inventories, he did not see a problem with them not accepting the items on the EIL in Maximo. Custodial officers are still responsible for the equipment despite not accepting the equipment in the system. To ensure all nonexpendable inventory is accounted for, recommendation 3 calls on the medical facility director to address all unaccepted equipment and establish a requirement for custodial officers to routinely accept equipment in Maximo.

[69] The 1,378 unaccepted items may also include building service equipment and expendable equipment items that are also recorded on a service line's EIL.

VA policy states that, to the maximum extent possible, equipment inventories will be conducted using barcode technology or electronic tracking that is compatible with Maximo.[70] However, service-line staff did not consistently conduct physical inventory via barcode scanning or report missing barcode labels to nonexpendable staff for replacement. According to the nonexpendable supervisor, barcoding is the primary method for conducting inventories. The nonexpendable staff notify the service-line staff via email about upcoming inventories and provide them with barcode scanner and inventory training. The supervisor acknowledged that nonexpendable staff provide training to all service-line staff appointed to conduct the department's inventories, but this training is not mandatory.

The nonexpendable supervisor expressed a lack of confidence in the accuracy of the inventories conducted by service-line staff. However, nonexpendable equipment staff are not required to verify the accuracy of inventories completed by service-line staff, as this requirement was removed from VHA policy in 2020. Two custodial staff that were delegated such responsibility confirmed they were not trained on barcode scanning but would use scanners if available to conduct inventories. They use both scanners and manual methods for inventories at the medical facility and manual methods at off-site locations.[71] According to the supervisor, sometimes service-line staff return barcode scanners with incomplete inventories, and nonexpendable staff must repeat the service-line notification process and submit a report of survey if they are unable to locate the unaccounted-for equipment.

To ensure custodial officers and service-line staff follow nonexpendable inventory procedures, recommendation 4 calls for the facility to implement a mechanism in which the accountable officer routinely monitors and ensures service-line staff who conduct physical inventory are designated in writing by the custodial officers and receive the appropriate nonexpendable inventory training.

Staff Did Not Update Inventory System Records for Nonexpendable Equipment Locations

Staff responsible for nonexpendable equipment are required to create a record and barcode label for new equipment, tag the equipment, and assign it to a service-line EIL. When the equipment is delivered to the service line, nonexpendable inventory staff should update the location in Maximo.[72] Nonexpendable inventory staff told the OIG team they record the equipment's future location when it arrives in the warehouse. The nonexpendable inventory supervisor acknowledged that some new equipment remains in the warehouse longer than expected pending

[70] VHA Directive 1761. Electronic tracking methods include radio frequency identification, which bounces signals between a tag and a reader to determine the equipment location, and real-time location systems, which can include the use of tags and badges that track equipment location in real time.

[71] Manual inventory is conducted by matching barcode data to the hard-copy EIL.

[72] VHA Directive 1761.

installation, ongoing construction, or available space at the service location. However, nonexpendable inventory staff did not update Maximo to reflect the correct equipment locations for 44 items recorded as being in the warehouse that were located elsewhere in the facility.

To ensure accurate inventory records, recommendation 5 is for the accountable officer and supply chain staff to verify location information in Maximo is accurate and to ensure all nonexpendable equipment is received through the warehouse, recorded in Maximo, delivered on time to the requesting service, and accepted by the custodial officer.

Inventory Was Not Physically Secured

VA policy states that effective physical security requires planning to protect resources and property and prevent loss or theft of vulnerable supplies and equipment.[73] The facility's standard operating procedures also call on facility staff to always exercise good judgment in the use and storage of VA property to mitigate loss, damage, or theft. During the site visits, the review team found the facility supply storage rooms and warehouse lacked adequate physical security controls to protect supplies, equipment, and veterans' personal information from loss or theft.

In November 2023, the review team identified three inoperable locks on doors from the supply breakdown room that led to the medical-surgical supplies primary inventory room.[74] The supervisory inventory management specialist for expendable supplies said the locks had been inoperable for a while, and a work order was submitted in August 2023 to request repairs. The OIG team found the locks were still not fixed as of the site visit in January 2024. The facility's failure to repair the broken locks in a timely manner exposes the primary inventory point to unauthorized access and risks the security of medical supplies purchased for patient care.[75] Figure 9 shows unsecured doors from the hallway entry into the breakdown room and into the primary inventory storage room that stores the facility's medical-surgical supplies.

[73] VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

[74] A breakdown area is a temporary supply room where bulk medical supplies are separated before being moved into the primary inventory storage location.

[75] VHA Directive 1761 states that access to clean and sterile storerooms is restricted to authorized personnel.

Figure 9. *The lock on the door of the medical-surgical supplies breakdown room (left) was broken, permitting unauthorized access to the primary inventory point through the breakdown room (right).*

Source: VA OIG, November 28, 2023.

The team observed several times that the warehouse door was left open when no deliveries were happening.[76] The nonexpendable inventory supervisor explained that the warehouse was unsecured because one of the bay doors was broken and remained open, allowing anyone to walk in. Later, the deputy supply chief for nonexpendable equipment told the review team that the broken bay door was fixed and only authorized staff could enter using their identification cards.[77]

In addition to unsecured doors, the review team identified unsecured nonexpendable equipment throughout facility and basement hallways. The nonexpendable inventory supervisor said several service lines store new equipment in the warehouse, resulting in space challenges in the warehouse. The supervisor stated that due to space constraints, he has asked service-line staff to hold onto unneeded equipment at their location. Without an effective plan to address the perceived lack of warehouse space, the security of equipment scattered around the hospital is vulnerable. Figure 10 shows examples of nonexpendable medical equipment stored in a facility hallway.

[76] VA Handbook 0730/4 requires valid access cards to gain warehouse access.

[77] The Houston nonexpendable inventory supervisor subsequently provided video and photographs confirming the warehouse bay door was fixed.

Figure 10. *Assorted nonexpendable equipment observed in the hallway on the fifth floor of the Houston VA medical facility, including beds and cooling units.*

Source: VA OIG, November 28, 2023.

VA policy also mandates proper control of personally identifiable information, which is any information about an individual that is maintained by VA and can be linked to that individual.[78] The review team observed unlocked bins outside the warehouse door that contained documents with veterans' personal and health information. The team also observed labels with veterans' personal information affixed to prosthetic shoe boxes in the equipment turn-in section of the warehouse. To protect patient information, the bins should have been secured and returned to a collection point within the facility, and labels on the shoe boxes should have been removed and processed appropriately to ensure patient information was properly disposed of. Overall, these findings highlight a need for improved measures to safeguard goods and sensitive information.

Recommendation 6 is for the medical facility director to address the physical security issues identified and provide initial and recurring training on proper physical security controls and procedures to individuals with authorized access to the primary inventory point and warehouse.

[78] VA Directive 6502, *VA Enterprise Privacy Program*, May 5, 2008.

Inaccurate Inventories Increased the Risk of Losing Equipment and of Using Expired Products for Patient Care

Overstocking expendable supplies can result in inventory obsolescence or expiration. As discussed earlier, the facility had about $3 million in long-supply items, which further increases the risk of supply damage, expiration, contamination, or waste. Conversely, failing to keep supplies above their reorder points or not establishing emergency stock levels could lead to supply shortages, not having the right items when needed for patient care, increased spending on expedited delivery, and a loss of trust in supply chain staff.

Improper accounting of nonexpendable inventory increases the risk of loss or theft of the facility's equipment. The OIG team found Houston facility staff inaccurately recorded equipment locations and did not accept over $1.9 million worth of nonexpendable accountable equipment on an EIL. These issues highlight the financial and operational risks associated with inadequate inventory management practices. Improved oversight and adherence to inventory procedures are needed to mitigate loss and ensure efficient use of VA's resources.

Finding 1 Conclusion

Houston facility supply chain personnel did not establish and maintain proper accountability for expendable supplies and nonexpendable equipment under their care. This was demonstrated by the significant over- and underreporting of supply quantities in the inventory management system, unestablished emergency stock levels, and expired supplies. Regarding nonexpendable equipment, responsible staff did not accept equipment added to their service-line EILs, physical locations of equipment were not correctly recorded in Maximo, equipment operating status was inaccurate, and equipment was missing barcode labels required for physical inventories. The facility was also vulnerable to unauthorized access to the supply rooms and the warehouse. Taken together, the facility risks losing equipment, using expired products, and inaccurately accounting for equipment required for patient care.

Recommendations 1–6

The OIG recommended that the Houston medical facility director take the following actions:

1. Ensure supervisors conduct monitoring activities, including periodic reviews of expendable and nonexpendable inventory and root cause analyses of identified discrepancies to strengthen controls over VA supplies.
2. Establish routine monitoring for the accountable officer to verify the required use of barcode labels to track and identify supplies and equipment and report deficiencies for barcode replacement.
3. Address all unaccepted equipment and establish a requirement for custodial officers to routinely accept equipment in Maximo.

4. Implement a mechanism for the accountable officer to routinely monitor and ensure service-line staff who conduct physical inventory are designated in writing by the custodial officers and receive the appropriate nonexpendable inventory training annually.
5. Require the accountable officer and supply chain staff to verify and update the information in the Maximo system and create procedures to ensure all nonexpendable equipment is received through the warehouse, recorded in Maximo, delivered in a timely manner to the requesting service, and accepted by the custodial officer.
6. Address the physical security issues identified and provide recurring training on proper physical security controls and procedures to individuals with authorized access to the primary inventory point and warehouse.

VA Management Comments

The medical facility director concurred with recommendations 1 through 6 and submitted action plans for each recommendation. The VISN 16 network director agreed with the facility's response and stated the network would work with the facility to ensure the recommendations are appropriately addressed. Appendixes C and D provide the full text of their comments, which are summarized here.[79]

For recommendation 1, the facility director stated he will ensure the supply chief conducts expendable and nonexpendable inventory reviews and completes root cause analyses timely and according to VHA Directive 1761. The review results, discrepancies, and action plans will be reported to the facility's associate director and network logistics officer monthly.

In response to recommendation 2, the facility director said the supply chief will establish routine monitoring and verification of supply and equipment barcode label accuracy through the Environment of Care evaluations and that identified discrepancies and corrective actions will be reported monthly.

Regarding recommendation 3, the facility director responded that the supply chief will collaborate with the biomedical engineering chief to address unaccepted equipment and establish requirements for custodial officers to routinely accept equipment in Maximo. The director stated that an explanation of roles and responsibilities will be deployed to ensure expectations are clear, and staff will review the Equipment Inventory List Business Intelligence and Reporting Tools monthly for compliance and submit the review findings to the VISN logistics officer and medical facility leaders.

In response to recommendation 4, the facility director stated he will ensure the supply chief designates, in writing, service-line staff to conduct physical inventories and makes certain those

[79] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—January 24, 2025.

staff receive the appropriate nonexpendable inventory training annually. Additionally, he said a mechanism for routine monitoring was established and the findings will be reported to the facility's associate director and network logistics officer monthly.

For recommendation 5, the facility director reported the supply chief will collaborate with supply chain staff to verify that nonexpendable equipment information is entered into the Maximo system, and the chief is to develop a standard process requiring all nonexpendable equipment received in the warehouse to be recorded in the system, delivered to service lines timely, and accepted in Maximo by the custodial officers. Additionally, he directed the supply chief to ensure staff compliance with the process and that corrective action progress be reported to the facility's associate director and network logistics officer monthly.

Lastly, for recommendation 6, the facility director said that key card access limits entry into the warehouse, the facilities management service chief currently conducts camera surveillance, and the facility police service routinely conduct physical safety checks of the warehouse. The facility director stated he will ensure the supply chief addresses the physical security issues identified in this report. He noted that recurring physical security training was established in January 2025 for individuals currently authorized access to the primary inventory points and warehouse, and newly hired staff will receive the training during orientation, with the requirement for all eligible staff to receive the training annually. Additionally, he directed that compliance and progress toward the remediation of the physical security issues be reported to the facility's associate director monthly.

OIG Response

The facility's planned actions are responsive to recommendations 1 through 6 and address the issues identified in the report. All recommendations remain open at this time. The OIG will continue to evaluate VA's actions and close all recommendations when VA provides complete documentation and sufficient evidence addressing the intent of the recommendations and the issues identified.

Finding 2: Mismanagement of Implant Inventory Led to a Significant Number of Expired Items

VHA policy requires the facility implant coordinator and supply chief to manage the medical facility's VA-owned implant inventory.[80] The implant coordinator must also report any issues with consigned inventory, such as expired implants or inadequate inventory levels, to the contracting officer's representative.[81] The OIG team found that the Houston implant coordinator and inventory management teams did not effectively manage implant inventory, which led to at least 225 expired implants during 2023, valued at about $1.2 million. In addition, the OIG team found another 164 expired consigned implants in the cardiac catheter laboratory storage room.[82]

Implants expired at the facility because the responsible staff did not effectively track and inventory the items throughout their life cycle. The facility did not have mechanisms to identify consignment inventory and ensure that vendors had local agreements in place to establish stock levels to fulfill demand (periodic automatic replacement levels) and hold vendors accountable for monitoring their inventory for excess and expiration dates. Roles and responsibilities were unclear among staff because facility leaders failed to formally designate an implant coordinator to manage implants through interdepartmental collaboration, as required by VHA policy and procedures. Finally, supervisors did not properly oversee implant management and did not correct issues after staff documented multiple reports of survey and patient safety reports related to implants.[83] By not implementing controls to address process deficiencies, the facility risks patient safety and further financial losses.

This finding is based on the following determinations:

- Facility staff did not prevent implants from expiring.

[80] VHA Directive 1761. Shelves, bins, and items must be checked on weekly basis for cleanliness, item expiration, and damage, and any necessary corrective actions should be taken. Further, VHA Directive 1081.02 requires the facility supply chief to coordinate with the facility's implant coordinator to manage the non-consigned implant inventories. The facility implant program's supervisory program analyst was not formally assigned as the implant coordinator, but his responsibilities were centered around managing implants. Therefore, this report refers to the supervisory program analyst as the implant coordinator.

[81] A consignment agreement is a delivery method in which the vendor provides an item and receives reimbursement only when the item is used. Facility contracting officer's representatives are the liaisons between the medical facility and the vendor and are responsible for keeping the contracting officer apprised of events that occur in facilities concerning the vendor. Federal Acquisition Regulation 1.602-2(d) (2023).

[82] The review team validated that 136 of 164 products were on the national consignment contract administered by the VISN. Facility staff stated they were unsure whether the remaining 28 items were on the consignment agreement. According to the contract, the vendor representative must remove and replace expiring inventory and the facility is not liable for products that are allowed to expire. For more information about the monetary benefits, see appendix B.

[83] VA Directive 7002. The report of survey program is the required method used to obtain an explanation of the circumstances surrounding the loss, damage, or destruction of government property.

- Staff did not establish adequate controls to manage implants.
- Ineffective implant inventory management resulted in financial loss and patient safety risks.

What the OIG Did

To assess the accuracy of implant data in the systems of record, the team reviewed a judgmental sample of 59 implants from various clinical storage locations. The team also interviewed supply chain, implant program, clinical, and contracting personnel to gather information about implant management processes. Additionally, the team reviewed consignment contract documentation and guidance from the national program office to ensure adherence to established policies. The review also included analyzing reports of survey and disposal records for expired implants to evaluate the handling and documentation of expired implants.

Facility Staff Did Not Use or Return Implants Before Expiration

VHA policy requires the facility implant coordinator to collaborate with various departments and reconcile implants from both VA-owned inventory and vendor consignment stock and ensure proper tracking.[84] Additionally, the facility supply chief must complete physical inventories of all VA-owned implants and ensure managers or supply technicians conduct weekly reviews of inventory and expiration dates.

At the time of the review team's first site visit in November 2023, the deputy supply chief of expendable supplies stated she collected expired implants from various facility locations starting in June 2023. The review team's analysis of expired implants revealed that facility staff had collected and stored at least 225 expired VA-owned implants valued at $1.2 million. The expiration dates ranged from January 2021 to November 2023. Figure 11 depicts some of the expired implants collected and stored in the supply chief's office.

[84] VHA Directive 1081.02.

Figure 11. *Expired implants in the supply chief's office.*
Source: VA OIG, November 28, 2023.

The following example illustrates the financial loss of an expired implant.

Example 1

Among the implants in the warehouse cage, there were nine transcatheter valves, with a value ranging from $30,000 to $32,500. All these items expired in 2021. The inventory management specialist explained to the team that clinicians order multiple sizes for one procedure but sometimes fail to return the unused products for reimbursement.

In addition to what facility staff found, the OIG team identified another 164 expired implants in the cardiac catheter laboratory storage room. The inventory management specialist stated those implants were on consignment, meaning that the facility did not pay for them because they were not used. The review team confirmed most of the implants were on the VISN 16 consignment contract and because they had expired before use no payments were made. However, in November 2023, the implant coordinator reported having two consignment agreements and

neither belonged to the vendor of the expired implants. Local consignment agreements are necessary to set stock levels at the facility. Without them the facility contracting officer's representative will not ensure vendors check for expiration dates and monitor inventory levels as required by the national contracts.[85] According to the Prosthetic and Sensory Aids Services program office, national contracts were executed at the VISN level. One VISN contract noted that the vendor was responsible for removing and replacing expiring inventory and the medical facility is not liable for products that expire.

VHA implant policy requires the supply chain officer to collaborate with the clinical service, the implant coordinator, and the contracting office to generate local consignment agreements. Local consignment agreements are important not only to establish adequate periodic automatic replacement levels to avoid overstocking but also to ensure vendors review and replace inventory near expiration.[86] Expired implants have been an issue at the Houston facility for several years. Facility records analyzed by the review team showed that from November 2018 to August 2022, logistics staff used the turn-in process to dispose of 450 implants worth at least $851,376.[87] According to one inventory manager, the former supply chief had directed them to dispose of expired implants by completing a 2237 form signed by the corresponding clinical service line and logistics staff. After the deputy supply chief for expendable supplies was hired in July 2022, she instructed supply chain staff to document the expired implants using a report of survey because the financial loss of the expired implants exceeded $5,000.[88] In August 2024, the chief supply chain officer provided an update to the OIG team on the steps the facility has taken to improve its implant management and procurement process, including engaging with the VHA Procurement and Logistics Office to revise the process and reevaluate roles to effectively manage implants.

Staff Did Not Establish Adequate Controls to Manage Implants

The Houston facility lacked controls to manage and track implants, leading to the significant number of expired products and patient safety risks. First, the facility lacked an authoritative source of implant inventory due to multiple tracking methods. Second, the facility's implant coordinator failed to establish local consignment agreements despite a new, standardized local consignment process. Third, the implant coordinator and inventory managers were not aware of their roles and responsibilities, and the facility's local policy did not always align with the VHA

[85] VHA Directive 1081.02. The contracting officer's representative is responsible for ensuring that only items specified in the consignment agreement are included in the consignment inventory, as well as notifying the contracting officer if any additional items must be added to the agreement before being included in the inventory.

[86] VHA Directive 1081.02.

[87] Expendable or nonexpendable property that is no longer needed or is unserviceable through normal use is considered unrequired. Unrequired property is returned to the Logistics Service using VA Form 2237 in accordance with local turn-in procedures.

[88] VA Directive 7002.

directive. Finally, despite having issues with expired implants, the facility was found compliant with implant inventories during VISN oversight reviews in FYs 2022 and 2023.

Staff Used Three Different Systems to Track Implants

The Houston facility did not have an authoritative source of overall implant inventory because departments use different tracking methods—GIP, TrackCore, and WaveMark.[89] According to the implant coordinator, the facility acquired TrackCore in 2019 and it was being used to track biological implants. This system includes various reporting functions, including chain of custody and expiration dates. However, VHA had not approved TrackCore as an inventory system of record because it does not interface with patient records like GIP does.

In October 2021, the facility implant program was realigned under the chief of staff. Based on Maximo data, clinics have used TrackCore for implants since 2019. However, according to the implant coordinator, TrackCore was relaunched in June 2023 to comply with Joint Commission requirements for tracking biological implants.[90] At the time, the implant coordinator and clinics decided not to track nonbiological implants with TrackCore due to issues with the data and because the software was not hosted on the national server and did not have full functionality.[91]

The Houston facility used WaveMark to track nonbiological implants in two clinics. According to the inventory manager assigned to the catheter laboratory, Logistics Service staff started adding items to WaveMark in 2023 and were not required to enter implants in GIP.

Although VHA policy requires staff to use GIP to manage all implant inventory, GIP cannot track expiration dates of implants or other expendable supplies. The OIG team reviewed 59 implants in the service lines and found that 28 were not recorded in GIP's implant records.

The OIG's seventh recommendation addresses the need for the supply chief and implant coordinator to ensure all biological and nonbiological implants are recorded in VHA's approved inventory management system and routinely reconciled with other systems used to manage implant expiration dates.

[89] As of May 2024, GIP is VHA's approved inventory management system.

[90] The Joint Commission is a private company that specializes in accrediting and certifying healthcare professionals in patient safety and quality standards. The Joint Commission standards require hospitals to use standardized procedures for managing tissues and to trace all tissues bi-directionally: from the donor or tissue supplier to the recipient or other final disposition including discard, and from the recipient back to the donor or tissue supplier. A biological implant is human or animal tissue implanted into or grafted onto the body. A nonbiological implant is an artificial device used to replace, support, or substitute for deformed or weakened parts of the body.

[91] The implant coordinator and supply chief acknowledged the need to track nonbiological implants in TrackCore. The supply chief's latest update in August 2024 included a preliminary action plan to ensure both biological and nonbiological implants are being tracked in a VHA-approved system.

Facility Staff and Vendors Did Not Follow Consignment Agreement Procedures

VHA policy requires the implant coordinator to compare implants used with VA inventory records and consigned stock lists to reconcile the records and account for all implants.[92] However, as mentioned earlier, Houston staff did not identify existing national agreements and establish corresponding local consignment agreements for implants. Consequently, facility staff said vendors brought in consigned and trunk stock implant inventory without notifying the implant team.[93] This resulted in more implants that were not tracked and monitored for expiration dates and item master file numbers.

In October 2023, VHA's Prosthetic and Sensory Aids Service communicated a new standardized local consignment process that required medical facilities to establish local agreements under newly awarded national contracts by following guidelines and templates. The updated guidance also suggested medical facilities with existing agreements collaborate with vendors to create new ones with the new contract numbers and pricing. Before this change, the VISN network contracting officer created all consignment contracts. According to the VISN 16 acquisition and utilization specialist, a step-by-step process for establishing local agreements was in place.

Interviews with clinical and supply chain staff revealed that the vendors interacted directly with clinical providers to coordinate consignment inventories and not through the implant coordinator or contracting officer's representative as required.[94] A nurse manager stated that vendors brought implants as trunk stock into the clinic. The inventory manager for the same clinic said vendor representatives brought the products in based on conversations with a physician. In addition to issues tracking consigned implants, a nurse manager from a different clinic said they did not have consignment agreements and that he maintained trunk stock implants in an office because they were expensive and difficult to track. However, as of December 2023, the OIG team identified one example of an inventory manager who signed a local consignment agreement with a vendor without the knowledge or approval of the implant coordinator and clinical staff, as required by VHA policy.

Recommendation 8 calls for the medical facility director to reconcile and appropriately manage VA-owned and consigned implants by developing controls to ensure implant program staff identify and create local agreements for existing and future consignment implants in accordance with national guidance.

[92] VHA Directive 1081.02.

[93] Trunk stock are items with different sizes or that are used for specific clinical procedures brought in by vendors and are not recorded in the facility's inventory.

[94] VHA Directive 1081.02 requires the implant coordinator to assist clinical service staff in developing all requirements and documents needed for consignment agreements.

Facility Leaders Did Not Effectively Assign Roles and Responsibilities for Managing Implants

The review team found that the implant coordinator and inventory managers did not follow or understand their roles and responsibilities. VHA policy requires the VA medical facility director to designate an implant coordinator to ensure facility staff follow the policies governing implant management.[95]

Effective October 2021, the Houston implant team was realigned under the chief of staff. At the time, the implant coordinator manager position was vacant. The vacancy was filled in October 2022 with a supervisory program analyst. However, the review team learned that facility leaders referred to—but did not officially designate—the supervisory program analyst as the facility's implant coordinator.

According to the supervisory program analyst, facility leaders defined his role as the supervisor for the implant team. However, he stated his understanding of the role as outlined in his position description was to provide oversight of the consult process and work with clinical service lines to develop consignment agreements but it did not include responsibilities for all aspects of implant management. This also led to confusion among clinical staff regarding the roles and responsibilities related to implant management. In one clinic, a nurse referred to themself as the implant coordinator, and in other clinics, staff were unsure who the facility implant coordinator was.

Another key responsibility in implant management is for the inventory manager or supply technician to review implant inventory on a weekly basis. Various clinics reported inventory or supply staff were not completing this step, which prompted clinical staff to establish processes to perform recurring reviews of expiring inventory.[96]

The review team also found that the facility's local policy did not always align with the VHA directive regarding managing implants. The national policy requires the facility's supply chief and the implant coordinator to work together to manage all VA-owned implants, and the responsibilities are specified for each role. In contrast, Houston's local policy combines the responsibilities of the implant coordinator and inventory manager, not clearly identifying the person responsible for each critical task—which contributed to the supervisory program analyst not fully understanding his role.

The OIG's ninth recommendation is for the medical facility director to clearly define the roles and responsibilities for managing implants at the facility by officially designating the facility implant coordinator and establishing a monitoring mechanism to ensure compliance with implant coordinator roles and responsibilities. Furthermore, recommendation 10 is to update the local

[95] VHA Directive 1081.02.

[96] VHA Directives 1761 and 1081.02.

implant management policy to clarify roles and responsibilities and to train staff in these roles related to implant management.

VISN Oversight Did Not Detect or Address Implant Program Deficiencies

During the annual quality control reviews, VISNs examine the inventory compliance of both biological and nonbiological implants. The quality control review includes checking if biological and nonbiological VA-owned implant inventories are reviewed weekly by supply chain management staff to ensure items are not damaged or past their expiration dates and product and storage areas are clean. During FYs 2022 and 2023, the VISN 16 material manager found that the Houston facility complied in this area. The VISN material manager told the OIG team they had no knowledge of expired implants at the facility. Facility staff told the team they reported implant inventory issues to facility leaders multiple times. Clinical and supply staff also submitted patient safety reports and reports of survey related to implant expirations and availability.

During the OIG team's site visit in January 2024, the VISN supply chief reported being unaware of the expired implants until the OIG notified the facility. On May 2, 2024, the facility's executive leaders said steps are being taken to improve implant management including partnering with the VISN and the VHA Procurement and Logistics Office to redesign the implant program.

Ineffective Inventory Management Resulted in Financial Loss and Patient Safety Risks

According to two reports of survey, the Houston facility had at least $1.2 million in losses during 2023 due to expired implants. Although these reports were submitted to facility leaders to document financial loss resulting from the expired implants, there was no evidence of actions taken to improve the management of implant inventory at the time of the OIG team's site visits.

In March 2024, the reports of survey were approved by the facility director.[97] Because the losses exceeded the $5,000 threshold, a board of survey of three impartial members was established to review and determine responsibility. According to their report, the board of survey found several individuals pecuniarily liable for the financial loss and determined that the responsible parties did not follow or have a clear understanding of applicable policies. The board made specific recommendations, including calling for a multidisciplinary implant committee, training plans for

[97] The reports of survey approved by the director were a combination of the two reports of survey reviewed by the OIG team and included additional implants identified after the team's original review.

inventory managers, standard operating procedures, and clarification of roles and responsibilities.[98]

In December 2023, facility staff separately identified about six biological tendon implants in a freezer that was being defrosted in the operating room. According to staff, the inventory manager had placed these implants in the freezer, and the implants had thawed. The implants, together valued at $10,800, were on the unauthorized local consignment agreement signed by the inventory manager in December 2023. According to the report of survey filed by the deputy supply chief of expendable supplies: Because the implants were damaged while in the facility and could not be returned, the facility was responsible for the loss. A separate board of survey determined that an unauthorized commitment was made because the inventory manager lacked the authority to sign the consignment agreement.[99]

Ineffective implant inventory management risks not only financial losses but also patient safety, such as unavailability of implants when needed and the inability to track implanted devices. For example, an internal patient safety report documented that two separate implantable devices were brought to a procedure but they had expired two months before the procedure date. The implants were referred to the implant coordinator. Staff obtained the needed implantable device from another clinic, and the procedure was completed on the same day.

In December 2023, another patient safety report documented an insufficient supply of contraceptive implants to accommodate upcoming scheduled procedures. The report showed that the inventory manager refused clinical staff's requests for additional supplies; this was further validated with the inventory manager. On the patient safety report, the deputy supply chief for expendable supplies response explained that the contraceptive implants had not been ordered by the Logistics Service since 2019. Instead, implants were replenished by the prosthetics department through clinical consults. To follow policy guidelines to procure implants, an emergency clinical product review and approval was granted for the Logistics Service to place an order for the needed implants.

Finding 2 Conclusion

Poor inventory practices and a lack of controls to manage the implant program led to waste and risks to patient safety at the Houston facility. As a result of the mismanagement of implant inventory, the facility incurred at least $1.2 million in financial losses related to expired implants in 2023, in addition to losses in previous years as documented in their inventory disposal records.

[98] As of May 2024, the supply chief stated that the acting associate director concurred with the survey board's decisions and was moving forward with all the recommendations, except collecting funds from the individuals found pecuniary liable.

[99] An unauthorized commitment is an agreement that is not binding solely because the government representative who made it lacked authority to enter into that agreement on behalf of the government. Ratification is the act of approving an unauthorized commitment by an official who has the authority to do so.

Until the Houston facility establishes adequate controls to effectively manage its implant program, the facility will continue to face challenges in consistently and continuously tracking all implants. In May 2024, facility leaders said steps are being taken to improve the facility's implant management and procurement process, including engaging with the VHA Procurement and Logistics Office to redesign the facility's implant program and reevaluating roles to effectively manage implants.

Recommendations 7–10

The OIG recommended that the Houston medical facility director take the following actions:

7. Ensure all biological and nonbiological implants are recorded in the approved inventory management system and are routinely reconciled with other systems used to manage implant expiration dates.
8. Develop controls to ensure implant program staff identify and create local agreements for existing consignment implants and establish agreements for future consignment implants in accordance with national guidance.
9. Officially designate a facility implant coordinator and establish a monitoring mechanism to ensure compliance with implant coordinator roles and responsibilities.
10. Update the local implant management policy to clarify roles and responsibilities and to train staff in these roles about their implant management responsibilities.

VA Management Comments

The medical facility director concurred with recommendations 7 through 10 and submitted action plans for each recommendation. The VISN 16 network director agreed with the facility's response and stated the network would work with the facility to ensure the recommendations are appropriately addressed. Appendixes C and D provide the full text of their comments, which are summarized here.[100]

For recommendation 7, the facility director stated he will collaborate with the associate director and chief of staff and ensure the facility implant coordinator, supply chief, and Prosthetic and Sensory Aids Service work with the clinical areas that use implants to confirm and validate that all biological and nonbiological implants are recorded in the approved inventory management system and are routinely reviewed to manage expired implants. He stated that a monthly review for compliance will be reported to the facility's associate director and chief of staff through the clinical executive board.

[100] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—January 24, 2025.

For recommendation 8, the director stated he will ensure the associate director, chief of staff, and facility implant coordinator collaborate with the Prosthetic and Sensory Aids Service, supply chain management, and all clinical areas to create local agreements for existing consignment implants. He added that a plan will be developed to ensure all consult implant requests are reviewed by the facility implant coordinator. He further stated that progress on corrective actions will be reviewed monthly and reported to the clinical executive board.

For recommendation 9, the facility director reported that he officially designated the Supervisory Program Analyst-Implant Program as the facility's implant coordinator, and he directed the implant coordinator to collaborate with the Prosthetic and Sensory Aids Service, supply chain management staff and all clinical areas to establish a monitoring mechanism to validate compliance with implant coordinator roles and responsibilities.

Finally, for recommendation 10, the facility director stated he will ensure the associate director and chief of staff update the local implant management policy to clarify roles and responsibilities and train staff regarding implant management responsibilities. He also noted that the facility implant coordinator is to collaborate with Prosthetic and Sensory Aids Service, the surgical implant coordinator, and supply chain management on the development of the local policy. He added that initial training will be deployed and monitored, and an annual report on training compliance will be provided to the clinical executive board committee.

OIG Response

The medical facility's planned actions are responsive to recommendations 7 through 10 and address the issues identified in the report. All recommendations remain open at this time. The OIG will continue to evaluate VA's actions and close all recommendations when VA provides complete documentation and sufficient evidence addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The review team conducted its work from November 2023 to December 2024. The review focused on expendable medical-surgical supplies, nonexpendable equipment, and implants managed at the Michael DeBakey VA Medical Center in Houston, Texas, during the first and second quarters of fiscal year (FY) 2024. The review team also conducted unannounced site visits in November 2023 and January 2024.

Methodology

The review team interviewed Veterans Integrated Service Network (VISN) 16 and facility leaders to assess oversight of the facility's supply chain management program and interviewed clinical and supply staff responsible for the management, accountability, and physical security of supplies and equipment. The team identified and reviewed applicable laws, regulations, and policies related to Veterans Health Administration (VHA) supply chain management, including consignment contracts and guidance documents. The team also reviewed specific facility patient event reports from the Joint Patient Safety Reporting Systems, FY 2022 and 2023 quality control reviews, and other relevant documentation. The team also physically observed the facility's storage areas, which held expendable supplies, nonexpendable equipment, and implants.

During the two site visits to the Houston facility, the team selected a judgmental sample of expendable supplies to test the accuracy of the inventory data in GIP and of nonexpendable equipment to test the accuracy of the equipment inventory data in Maximo. During the January 2024 site visit, the review team also tested a judgmental sample of implants.

Expendable Supplies Physical Inventory

The team reviewed 60 total items from the primary inventory. The team selected various types of expendable supply items to sample and stratified the selection based on physical inventory frequency—20 from each ABC classification category. Teams of two auditors performed physical counts for each sample, and if there were any discrepancies between the two auditors, the physical counts were repeated until all counts were reconciled. The team recorded the physical counts of the sampled items in a data collection instrument and compared them to the quantities recorded in the inventory management system. The team also examined GIP's medical-surgical supply inventory data to determine the normal stock level, reorder point, emergency stock level, on-hand quantity, and total value. When the review team discovered discrepancies between the physical inventories and GIP's inventory data, they shared these discrepancies with the deputy supply chief for expendables for review and concurrence.

Nonexpendable Equipment Physical Inventory

VHA policy requires medical facility staff to use an automated inventory management system to track and distribute nonexpendable equipment.[101] Facilities use the system to provide data for inventory management, financial management, and reporting needs. The review team assessed 90 pieces of equipment from the facility's main floors and basement. The team documented the locations of the sampled equipment, as well as the equipment barcode label information and any other identifying information. To ensure the accuracy of the nonexpendable inventory data, the team compared the equipment location, entry, and serial number on barcode labels or other attached documents to data in Maximo and worked with nonexpendable managers to reconcile deficiencies.

To further test the accuracy of the Maximo equipment inventory data, the team identified a population of 232 Omnicells worth approximately $2.7 million, that, according to the data, were located throughout the facility. The team searched for a sample of 133 Omnicells during the November 2023 site visit. The team collected information from relevant Maximo data fields, such as the equipment barcode serial number, the manufacturer serial number, the physical location, and the operational status. The team recorded this information in a data collection instrument and compared it to the Omnicells data tested. The team photographed each Omnicell and worked with facility staff to locate any that were not physically present at the listed locations in Maximo.

Implant Inventory

During the January 2024 site visit, the team selected 62 sample items from six clinics to assess the accuracy of GIP and TrackCore inventory data. Upon further analysis and confirmation from the facility implant coordinator, three samples were not classified as implants and were removed from the sample list, leaving 59 sample items for assessment. The team photographed the samples—recording the implant's name, expiration date, and lot or serial number in a data collection instrument. The team also analyzed the inventory data to determine each sample's service location, serial number, lot number, manufacturer, product name, expiration date, item master file number, and TrackCore identification (if applicable). The team interviewed supply chain, implant program, clinical, and contracting personnel to gather information about implant management processes. The team discussed issues identified during the review with OIG investigators and referred a potential issue for further review.

Internal Controls

The review team determined that internal controls were significant to the review objective. This included an assessment of the five internal control components: control environment, risk

[101] VHA Directive 1761.

assessment, control activities, information and communication, and monitoring.[102] In addition, the team reviewed the principles of internal controls associated with the objective. The team identified internal control weaknesses in the following five components and seven principles and made recommendations to address those weaknesses:

- Component 1: Control Environment
    - Principle 1: Demonstrate commitment to integrity and ethical standards.
    - Principle 5: Enforce accountability.
- Component 2: Risk Assessment
    - Principle 6: Define clear objectives.
    - Principle 7: Identify risk and tolerance.
- Component 3: Control Activities
    - Principle 12: Implement control activities.
- Component 4: Information and Communication
    - Principle 14: Communicate internally.
- Component 5: Monitoring
    - Principle 16: Perform monitoring activities.

Data Reliability

The team relied on computer-processed data from GIP, Maximo, the Omnicell application, and TrackCore to support the findings, conclusions, and recommendations of this review. The team checked for the completeness and accuracy of the data from the four systems. For example, VHA policy requires medical facility staff use GIP to track and distribute all supplies for expendable supplies.[103] To test for data reliability, the review team traced a sample of medical-surgical supplies from their physical location to GIP (using information such as item master file number, normal stock level, reorder point, and unit of issue).

To test for data reliability, the team captured physical observations on sampled equipment—such as location, description, equipment entry number, and equipment serial number—and traced it back to the Maximo records. The Omnicell application is used to operate the Omnicell cabinets at the facility. To test for data reliability, the team verified that the information listed to the physical equipment matched the information in the system (for example, equipment barcode

[102] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[103] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

serial number, manufacturer serial number, physical location, and operational status). TrackCore is a web-based application that is specialized for tracking implants. To test for data reliability, the team sampled a set of implants and validated six key fields to TrackCore. The review team's assessment determined the electronic data the team relied on were complete, accurate, and relevant for supporting the review objective and results.

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

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs[104]
7–10	The value of purchased implants that were allowed to expire before use.	$1.2 million	$0
	Total	**$1.2 million**	**$0**

[104] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the review.

Appendix C: VA Management Comments—VISN Director

Date: January 24, 2025

From: Director, South Central VA Health Care Network (10N16)

Subj: VA OIG Draft Report –OIG Review of Supply Chain Management at the Michael E. DeBakey VA Medical Center, Houston, TX

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

Chief, Integrity, and Compliance Officer (10OIC)

1. I have reviewed the draft report and concur with the response provided by the facility for the Review of Supply Chain Management at the Michael E. DeBakey VA Medical Center, Houston, TX.

2. I want to thank the Office of Inspector General for a thorough review of this case, and we will work closely with the facility on actions to ensure the recommendations are appropriately addressed. If you have additional questions, please contact VISN 16 Quality Management Officer (QMO).

(Original Signed)

Skye McDougall, PhD

Network Director

South Central VA Health Care Network (VISN 16)

Appendix D: VA Management Comments—Facility Director

Date: January 24, 2025

From: Director, Michael E. DeBakey VA Medical Center (580)

Subj: Office of Inspector General (OIG) Report, Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E DeBakey VA Medical Center in Houston, Texas

To: Director, VA Heart of Texas Health Care Network (10N17)

1. Thank you for the opportunity to review and respond to the draft report, Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VAMC in Houston, Texas. I concur with the recommendations contained in the report. The attached document contains a thorough description of the robust corrective actions that have been developed and implemented.

2. Michael E. DeBakey VA Medical Center endeavors to ensure that we are prudent stewards of our resources and have employed more stringent measures for oversight and management of the supply, equipment, and implant inventory.

3. If you have additional questions, please contact the Director Quality and Patient Safety.

(Original Signed)

Francisco Vazquez

Medical Center Director, Michael E. DeBakey VA Medical Center

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Report, Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas

(2024-00166-AE-0006)

Recommendation 1. Ensure supervisors conduct monitoring activities, including periodic reviews of expendable and nonexpendable inventory and root cause analyses of identified discrepancies to strengthen controls over VA supplies.

VHA Comments: Concur

The VA Medical Center Director will ensure the Supply Chain Management Chief conducts reviews of the expendable and nonexpendable inventory and that root cause analyses of identified discrepancies are completed timely in accordance with VHA Directive 1761 Appendix B (requirement for inventory management). A monitoring plan has been developed to review expendable and nonexpendable inventory monthly for compliance in order to strengthen controls over VA supplies in accordance with VA Directive 7002 EIL/Equipment management through a review of Maximo data. The progress of these reviews, to include identified discrepancies and corrective action plans, are reported monthly to the Associate Director (AD) and Veteran Integrated Service Network (VISN) Chief Logistics Officer (CLO).

Status: In-Progress Target Completion Date: February 2025

Recommendation 2. Establish routine monitoring for the accountable officer to verify the required use of barcode labels to track and identify supplies and equipment and report deficiencies for barcode replacement.

VHA Comments: Concur

The VA Medical Center Director will ensure the Supply Chain Management Chief establishes a process for routine monitoring to verify the required use of barcode labels to track and identify supplies and equipment, and report deficiencies for barcode replacement. Routine monitoring and verification of barcode label accuracy will be conducted using the Environment of Care (EOC) rounding process of which SCM is a part. Reviews of identified discrepancies and corrective actions will be reported monthly to the EOC committee and at the Continued Survey Readiness Forum.

Status: In-Progress Target Completion Date: February 2025

Recommendation 3. Address all unaccepted equipment and establish a requirement for custodial officers to routinely accept equipment in Maximo.

VHA Comments: Concur

The VA Medical Center Director will ensure the Supply Chain Management Chief in collaboration with the Chief of Biomedical Engineering addresses all unaccepted equipment and establishes a requirement for custodial officers to routinely accept equipment via Maximo. A delineation of roles and responsibilities will be outlined to ensure expectations are clear. Assigned staff will pull and review the Equipment Inventory List Business Intelligence and Reporting Tools (BIRT) report monthly to review compliance. Findings will be reported to the VISN Chief Logistic Officer (CLO) and VAMC leadership.

Status: In-Progress Target Completion Date: January 2025

Recommendation 4. **Implement a mechanism for the accountable officer to routinely monitor and ensure service-line staff who conduct physical inventory are designated in writing by the custodial officers and receive the appropriate nonexpendable inventory training annually.**

VHA Comments: Concur

The VA Medical Center Director will ensure the Supply Chain Management Chief designates, in writing, the service-line staff who are responsible for conducting physical inventory. The Supply Chain Management Chief will work with the designated service line staff to ensure they receive the appropriate nonexpendable inventory training annually. A mechanism for routine monitoring has been established and will be reported to the Associate Director (AD) and VISN CLO monthly.

Status: In-Progress Target Completion Date: January 2025

Recommendation 5. **Require the accountable officer and supply chain staff to verify and update the information in the Maximo system and create procedures to ensure all nonexpendable equipment is received through the warehouse, recorded in Maximo, delivered in a timely manner to the requesting service, and accepted by the custodial officer.**

VHA Comments: Concur

The VA Medical Center Director will ensure the Supply Chain Management Chief works with the supply chain staff to verify that up-to-date information is entered into the Maximo system and establishes a Standard Operating Process (SOP) whereby all nonexpendable equipment is received through the warehouse, recorded in Maximo, delivered timely, and accepted by the custodial officer via Maximo. Compliance with the SOP and progress on corrective actions will be reported monthly to the AD and VISN CLO.

Status: In-Progress Target Completion Date: February 2025

Recommendation 6. **Address the physical security issues identified and provide recurring training on proper physical security controls and procedures to individuals with authorized access to the primary inventory point and warehouse.**

VHA Comments: Concur

The VA Medical Center Director will ensure that the Supply Chain Management Chief addresses the physical security issues identified in this report. Key card access limits entry into the warehouse and camera surveillance is monitored by Facilities Management Service. Police Service routinely makes rounds to ensure the physical safety of the campus including the warehouse. A training plan for the provision of recurring training to individuals with authorized primary inventory points and warehouse access will begin in January 2025, and training will be continued during initial orientation for new hires and annually for all pertinent staff. Training compliance and progress toward the remediation of the physical security issues will be reported to the VAMC AD monthly.

Status: In-Progress Target Completion Date: March 2025

Recommendation 7. **Ensure all biological and nonbiological implants are recorded in the approved inventory management system and are routinely reconciled with other systems used to manage implant expiration dates.**

VHA Comments: Concur

The VA Medical Center Director will work with the AD and the Chief of Staff (COS) to ensure that the Facility Implant Coordinator, in collaboration with the Supply Chain Management Chief, and Prosthetic and Sensory Aids Services will work with all clinical areas that utilize implants to confirm and validate all biological and nonbiological implants in the approved inventory management system and are routinely reconciled to manage expired implants. A monthly review and compliance will be reported to the AD and COS through the Clinical Executive Board.

Status: In-Progress Target Completion Date: August 2025

Recommendation 8. Develop controls to ensure implant program staff identify and create local agreements for existing consignment implants and establish agreements for future consignment implants in accordance with national guidance.

VHA Comments: Concur

The VA Medical Center Director will ensure the AD and COS, in collaboration with the Facility Implant Coordinator, will work with Prosthetic and Sensory Aids Services, Supply Chain Management, and all clinical areas to create local agreements for existing consignment implants. A plan to have all consult implant requests vetted through the Facility implant coordinator to establish local consignment agreements for all implant devices. This process and subsequent future consignment implant agreements will be reviewed by PSAS, Facility Implant Coordinator, and SCM to confirm alignment with national guidance. Progress on corrective actions will be reviewed monthly and reported to the Clinical Executive Board. Currently, the facility has established 13 of the 17 required agreements. The remaining 4 are in progress.

Status: In-Progress Target Completion Date: August 2025

Recommendation 9. Officially designate a facility implant coordinator and establish a monitoring mechanism to ensure compliance with implant coordinator roles and responsibilities.

VHA Comments: Concur

The VA Medical Center Director has officially designated the Supervisory Program Analyst-Implant Program to serve as the Facility Implant Coordinator. The Medical Center Director will ensure that the Facility Implant Coordinator will work with Prosthetic and Sensory Aids Services, Supply Chain Management, and all clinical areas to establish a monitoring mechanism to validate compliance with implant coordinator roles and responsibilities as denoted on the SOP Management of Biological and Non-Biological Implant Devices (112-004). Compliance will be monitored through annual performance appraisal outcomes.

Status: In-Progress Target Completion Date: August 2025

Recommendation 10. Update the local implant management policy to clarify roles and responsibilities and to train staff in these roles about their implant management responsibilities.

VHA Comments: Concur

The VA Medical Center Director will ensure the AD and COS update the local implant management policy to reflect clarification of roles and responsibilities and train staff regarding implant management responsibilities. A MEDVAMC Standard Operating Procedure (SOP) - Management of Biological and Non-Biological Implant Devices (112-004) was recently finalized. The Facility Implant Coordinator worked with Prosthetic and Sensory Aids Services, Surgical Implant Coordinator, and Supply Chain Management on the development of the MEDVAC SOP 112. Initial training will be deployed and then monitored

annually thereafter. The annual report on training compliance will be reported to the Clinical Executive Board Committee (CEB).

Status: In-Progress Target Completion Date: December 2025

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Daniel Morris, Director Clark Beecken Glenn Dawkins Veronica Manges Andrea Sandoval Grisbell Soto
Other Contributors	Roy LaFollette Victor Rhee Jill Russell Jill Talbot Rashiya Washington Oana Yablonski

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 16: South Central VA Health Care Network
Director, Michael E. DeBakey VA Medical Center

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: John Cornyn, Ted Cruz
US House of Representatives: Dan Crenshaw, Lizzie Fletcher, Sylvia Garcia, Al Green, Wesley Hunt, Morgan Luttrell

Pursuant to Pub. L. 117-263, section 5274, non-governmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference. The comments can be found on the report summary page.

OIG reports are available at www.vaoig.gov.