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VETERANS HEALTH ADMINISTRATION

Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management

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Executive Summary

According to Veterans Health Administration (VHA) policy, medical facilities are required to establish, operate, and maintain an effective supply chain management program.[1] However, previous VA Office of Inspector General (OIG) audits have found that VHA facilities have struggled with deficient inventory control systems and practices.[2] Without effective supply chain management, VA medical facilities increase the risk of not having supplies available when and where they are needed for patient care.

VHA's Procurement and Logistics Office (P&LO or the "program office") developed quality control reviews as a mechanism to evaluate whether medical facilities are compliant with supply chain policy.[3] According to the branch chief of policy, compliance, and standardization within P&LO (the quality program chief), the reviews are the primary way Veterans Integrated Service Networks (VISNs) ensure facilities in their respective region have the medical supplies required for patient care.[4] VISN chief supply chain officers (supply chiefs) are required to conduct these quality control reviews for each facility annually.[5] VISN directors (network directors) are responsible for their medical facilities' compliance with supply chain management policy.[6] The OIG conducted this audit to determine whether the VISNs conducted effective oversight of supply chain management through quality control reviews. To address the objective, the audit team judgmentally selected six medical facilities from six different VISNs to review their fiscal year (FY) 2023 quality control assessments.[7]

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[1] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020. Supply chain management is the integration and alignment of people, processes, and systems to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities.

[2] See, for example, VA OIG, *Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement,* Report No. 19-07053-51, February 25, 2021; VA OIG, *Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia*, Report No. 19-00260-215, September 26, 2019; VA OIG, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, Report No. 17-05246-98, May 1, 2019; VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

[3] VHA Directive 1761.

[4] The quality control review is administered by a suboffice in P&LO. This report refers to the director of that suboffice as the quality program chief. VHA delivers health care through 18 regional networks called VISNs. Each VISN is led by a director responsible for coordinating and overseeing administrative and clinical activities at medical facilities in the network.

[5] VISNs and VA medical facilities both have chief supply chain officers, which is a lead supply chain management position. This report refers to chief supply chain officers for both levels as simply "supply chiefs."

[6] VHA Directive 1761.

[7] The six facilities were located in Birmingham, Alabama; Chicago, Illinois; Los Angeles, California; Detroit, Michigan; Togus, Maine; and White City, Oregon. For more information on this report's scope and methodology, see appendix A.

What the Audit Found

The OIG found that the VISN supply chiefs completed the required quality control reviews in FY 2023. For these reviews, the VISN supply chief assesses each facility on its responses to over 100 questions that reflect elements of the governing policy requirements.[8] All facilities are evaluated on all questions. To determine compliance, the VISN supply chiefs examine supporting documentation provided by the facilities on a SharePoint site and conduct an in-person site visit.

The quality reviews revealed that overall, the facilities did not comply with supply chain management policy in about 18.5 percent of the areas in the reviews. These deficiencies included activities related to managing inventory, facility staff completing required training, and reporting unaccounted or damaged equipment (referred to as "reports of survey"). P&LO compiles the quality control review results from each VISN supply chief and, according to their information, the medical facilities and VISNs corrected about two-thirds of the identified problems by the end of the fiscal year but had not corrected the remaining issues as required.[9]

For the six facilities the OIG team assessed in this audit, 130 of 205 noncompliant issues (63 percent) remained outstanding, including repeat findings from the previous year's quality control reviews. Three facilities in Birmingham, Chicago, and Greater Los Angeles were responsible for 127 of the 130 unimplemented corrective actions. This was due in part to some VISN supply chiefs not consistently following up on remedial efforts.

VISNs Did Not Always Ensure Medical Facilities Addressed Identified Deficiencies

Although the focus of this audit is on VISNs, medical facilities and program office personnel also have distinct roles in ensuring compliance with supply chain management policy and correcting identified issues. The OIG team found that some VISN supply chiefs struggled to ensure their facilities complied with policy and fixed problems identified through the quality control reviews. As part of their oversight responsibilities, some network directors also did not take sufficient steps to ensure the VISN and facility supply chiefs developed effective corrective actions. Medical facility directors also did not always check that sufficient resources were

[8] The quality control reviews assess each medical facility's inventory management program and ensure compliance with VHA requirements, primarily found throughout VHA Directive 1761. Some of the many requirements assessed in the reviews include whether all expendable inventory items are entered in the VHA-approved inventory system, if an annual inventory of nonexpendable accountable equipment occurred, and if training applicable to employees' positions was assigned and completed yearly.

[9] The OIG team determined that P&LO data were continually being updated. These data were as of October 25, 2023. The FY 2023 quality control review instructions required VISN supply chiefs to ensure deficiencies were corrected by September 30, 2023.

allocated to comply with supply chain management policy as required.[10] According to the quality program chief, P&LO has field support staff who can assist facilities that are struggling with supply chain management if the VISN or facility leaders request help.

The OIG team surveyed all 18 VISN supply chiefs about obstacles to ensuring compliance with supply chain management policy and completing corrective actions. The most common concerns related to vacancies within facilities' supply chain staff, unclear policy or gaps in guidance, and facility supply staff's lack of authority over other services and staff in the facilities.

The team also evaluated VISN oversight at the six facilities selected for site visits. VISN supply chiefs for three of these facilities—those in Detroit, Michigan; Togus, Maine; and White City, Oregon—provided oversight that confirmed the facilities corrected most identified deficiencies. All three facilities notably had a permanent supply chief in place and according to the network directors, collaboration between VISN and facility supply chain management staff was a key contributor to compliance and implementing corrective actions.

The OIG team identified several obstacles faced by facilities that struggled to address noncompliance (those in Los Angeles, California; Chicago, Illinois; and Birmingham, Alabama): significant supply chain staffing vacancies, leadership turnover, complaints of insufficient support from the VISN, and inadequate space.

The Greater Los Angeles, Chicago, and Birmingham facilities all had significant supply chain staffing vacancies (ranging from 29–41 percent) and leadership turnover. In contrast, the three reviewed facilities that had fewer outstanding action plans (Togus, White City, and Detroit) had lower supply chain staff vacancy rates (15–22 percent) than the facilities that struggled with implementing action plans. To address staffing vacancies, the Greater Los Angeles, Chicago, and Birmingham facilities began the process of offering hiring incentives for some of these positions during 2023.

Because the Greater Los Angeles facility faced obstacles with staffing vacancies and turnover, the facility director requested and received a waiver for the quality control review in FY 2022. The FY 2023 quality control review results demonstrate that prior deficiencies persisted and new issues with noncompliance emerged even after the waiver time. According to the VISN supply chief, the facility provided mostly unresponsive action plans. The Greater Los Angeles facility, however, was not alone in being unable to effectively resolve deficiencies. The VISN supply chief, who started in October 2022, said that none of the medical facilities in VISN 22 had completed action plans in FY 2021 and FY 2022.

The Jesse Brown VA Medical Center in Chicago also faced staffing vacancies and turnover in key supply chain management leadership positions, and facility staff stated that they believed the VISN provided inadequate support. The facility director told the OIG team that he made multiple

[10] VHA Directive 1761.

requests to the VISN for staff and subject matter experts to assist in correcting the identified issues, but the assistance was limited, and many deficiencies remained unresolved. According to the VISN supply chief, the facility had consistently been nonresponsive to addressing its action plans to resolve identified deficiencies. The network director said the VISN supported the Chicago facility with additional temporary staff and added that training, mentoring, and departmental oversight were also priorities for the Chicago facility.

In addition to staffing issues, the OIG team found that space constraints hindered the Birmingham facility in VISN 7. The OIG team found that the Birmingham facility did not have enough space to store supplies and stockpiled many expendable supplies in basement hallways because the warehouse or established inventory points were full, risking loss or theft of the supplies.

The VISN supply chiefs communicated the quality control review findings to facility and VISN leaders of these three facilities, but not all corrective actions were completed. The network directors, who have direct authority to enforce policy at these medical facilities, said they were taking some steps to correct the pervasive deficiencies, but the OIG team found these steps had not yet been effective. Collectively, the VISNs, the facilities, and P&LO have not fully resolved issues identified in the quality control reviews.

VISN Supply Chiefs Did Not Report All Noncompliant Practices

In addition, the number of weaknesses may be understated because VISN supply chiefs did not always identify or report noncompliant issues during quality control reviews. This occurred when supply chiefs disagreed with the program office or had different interpretations of the question. When VISN supply chiefs do not accurately report problems, the noncompliant medical facility will not create action plans, and VISN and program officials may be unaware of the need to address the deficiencies.

VHA's Program Office Monitoring Was Inadequate to Identify Unimplemented Corrective Actions or Inaccurate Assessments

P&LO tracked the quality control reviews conducted by VISN supply chiefs by performing its own audits of some facilities to assess how well the VISN supply chiefs conducted the facility reviews, but P&LO's tracking tools and audits did not adequately oversee corrective actions. VISN supply chiefs record their reviews using spreadsheets that they upload to a program office SharePoint site. The reviews could contain errors because the reporting spreadsheet can be overwritten. In one case, a facility supply chief manually overwrote noncompliant issues, and as a result, the facility's spreadsheet inaccurately showed a 100-percent compliance rate for FY 2022, when in fact it had noncompliant issues that required corrective actions. P&LO also tracks reviews manually, making the process prone to errors. In October 2023, the quality

program chief said P&LO is developing an automated method to track quality control reviews and corrective actions for FY 2024.

Further, the program office's auditing activities did not assess unimplemented corrective actions. P&LO internal guidance states it will randomly select and audit facilities to ensure VISN supply chief reviews are being used effectively to accurately reflect facility supply chain management programs. Although the audits focused on whether the VISNs correctly assessed the responses to quality control review questions, they did not determine whether action plans were sufficient or even to what extent the plans were implemented. P&LO officials acknowledged that they do not monitor the implementation of action plans.

Additional Action Is Needed to Mitigate Risks Posed by Supply Chain Deficiencies

By not fully addressing deficiencies identified in the quality control reviews, VISNs and medical facilities risk losing supplies or equipment, not having the right supplies when needed, or using expired or damaged products for patient care.

The OIG team determined that five of the six facilities examined did not include all expendable items in the required system and had not inventoried all nonexpendable equipment annually.[11] For expendable items (for example, clinical supplies that have a limited useful life), including all items in the required system is vital to track the receipt and distribution of supplies. The quality control reviews and OIG team's analysis of VHA data also identified noncompliance with policy at five of the six medical facilities.[12] One facility had not inventoried more than $55 million of nonexpendable inventory within the last year. Three of six facilities did not inventory their contingency stock, which puts the facilities at risk of not being prepared for emergencies. Further, two facilities did not physically control and limit access to supplies, which is essential to prevent theft.

As mentioned above, poor supply chain management can also increase the risk of delayed patient care or using expired clinical supplies. During interviews with facility and program office personnel, the OIG team learned of examples of delayed or canceled surgeries because supplies were unavailable. During site visits at three facilities, the team discovered over 150 expired items that facility staff were unaware of, including catheters, syringes, blood collection tubes, and dental implants. VHA facilities will continue to face such risks until problems identified in quality control reviews are fixed and facilities thoroughly comply with policy.

[11] VHA Directive 1761 requires facility staff not only to enter all expendable inventory items in the VHA-approved inventory management system but also inventory nonexpendable accountable equipment annually. Nonexpendable equipment generally has a useful life of two years or more.

[12] VHA Directive 1761.

What the OIG Recommended

The OIG made six recommendations to the under secretary for health. The recommendations address tracking facility supply chain personnel vacancies as part of the quality control reviews. They also call for developing guidelines that define when facility deficiencies require additional interventions and then routinely identify them for network director action. Facility and network directors should work with the program office on a plan to identify resources and milestones to resolve identified supply chain management problems. Additional recommendations are for P&LO to develop a process to provide resources when needed to help networks and facilities address persistent deficiencies, including the facilities identified in this report. The OIG also recommended that the program office continue efforts to automate tracking to accurately capture and monitor all quality control review results, corrective actions, and implementation. It should update its audits of the quality control program to apply risk-based sampling, evaluate action plans and their implementation, and use the results to continuously improve quality control review guidance and requirements.

VA Comments and OIG Response

VHA concurred with all six recommendations and provided corrective action plans to address the issues detailed in the OIG report. To improve the quality review process, VHA actions include updating the quality control review to identify facilities' supply chain staff vacancies and related risks; developing guidelines to better detect risk indicators at facilities; routinely assessing which resources are needed for facilities or VISNs with noncompliance; and developing a process to identify needed actions by the facility, VISN, or program office to provide resources that address supply chain management deficiencies.

VHA plans to advance oversight by working with VA's Office of Information and Technology to develop an automated tool to enhance monitoring of the review results, corrective action plans, and implementation. The program office will also update its own auditing of the program based on facilities' risk indicators. The quality control audit standard operating procedures will be revised to include reviewing action plans and implementation efforts. The comments are provided in full in appendix B.

The OIG will close recommendations when VHA provides sufficient evidence that addresses the intent of the recommendations and the deficiencies identified in this report.

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Contents

Abbreviations

FY	fiscal year
GAO	Government Accountability Office
OIG	Office of Inspector General
P&LO	Procurement and Logistics Office
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Veterans Health Administration (VHA) requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements.[13] Prior VA Office of Inspector General (OIG) audits have reported, however, that VHA facilities have had poor inventory control practices, such as not properly using the inventory system for expendable products and inaccurately recording on-hand stock.[14] Inadequate inventory practices can increase the risk that VA medical facilities will not have the supplies for patient care when and where they are needed, that supplies will be lost or stolen, and that expired products may be mistakenly used.

VHA's Procurement and Logistics Office (P&LO or the "program office") developed quality control reviews to address internal control deficiencies. Quality control reviews are annual evaluations of medical facility operational practices to ensure compliance with regulatory and performance measure requirements.[15] According to the P&LO branch chief in charge of the quality control review program, the reviews are the primary vehicle used by Veterans Integrated Service Networks (VISNs) to ensure that facilities have necessary medical supplies available for patient care.[16] The OIG conducted this audit to determine whether the VISNs conducted effective oversight of supply chain management through quality control reviews.

VISN chief supply chain officers (supply chiefs) conduct these quality control reviews annually to assess each medical facility's inventory management program and ensure compliance with requirements.[17] They do so by assessing each facility on its responses to over 100 questions that reflect the requirements of VHA's supply chain policy. The VISN supply chiefs evaluate the facilities on all questions by examining supporting documentation provided by the facilities on a

[13] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020. Supply chain management is the integration and alignment of people, processes, and systems to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities.

[14] See, for example, VA OIG, *Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement,* Report No. 19-07053-51, February 25, 2021; VA OIG, *Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia*, Report No. 19-00260-215, September 26, 2019; VA OIG, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, Report No. 17-05246-98, May 1, 2019; VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018. Expendable medical supplies are disposable items that are typically used one time. Recording and tracking the number of expendable supplies and their expiration dates is critical to ensuring patients receive necessary medical care in a timely manner.

[15] VHA Directive 1761.

[16] P&LO's branch chief of policy, compliance, and standardization is in charge of the quality control review program. This report refers to this position as the quality program chief. VHA delivers health care through 18 regional networks called VISNs. Each VISN is led by a director responsible for coordinating and overseeing administrative and clinical activities at medical facilities in the network.

[17] VISNs and VA medical facilities both have chief supply chain officers, which is a lead supply chain management position. This report refers to chief supply chain officers as supply chiefs.

SharePoint site and then visiting the facilities. VISN directors (network directors) are responsible for medical facility compliance with supply chain management policy.[18]

Quality Control Review Requirements, Responsibilities, and Coverage

P&LO publishes an annual quality control review checklist and associated instructions for the VISN supply chiefs to follow. The fiscal year (FY) 2023 quality control review instructions (updated in October 2022) required the following steps:

- VISN supply chiefs complete the quality control review for each medical facility within their VISN throughout the fiscal year and submit findings and corrective action plans to P&LO within 20 calendar days of each facility review.
- Medical facilities complete corrective actions within 90 business days from the date of review.
- Network directors, medical facility directors, and both VISN and medical facility supply chiefs sign the quality control review certification, findings, and action plans.
- VISN supply chiefs ensure deficiencies are corrected by the end of the fiscal year.[19]
- The network director or deputy director, the medical facility director or associate director, and VISN supply chief sign a deferment for action plans not completed in FY 2023.[20]
- The VISN supply chief or designee enters the actual date the action plan was completed in a spreadsheet that is uploaded to the program office's SharePoint site.

In addition, the program office conducts its own audits as a way to assess VISN implementation of these quality control reviews. P&LO guidance states that the objective of their audits is to ensure VISNs' quality control reviews are being used effectively to accurately reflect facilities' supply chain management programs.[21] The quality program chief said that P&LO conducts their audits on a random selection of facilities instead of specifically targeting any.[22] Further, quality program officials said they do not review action plans as part of the audits.

The quality control reviews cover both expendable and nonexpendable inventory management. VHA policy defines expendable supplies as items that have a limited useful life and are used to

[18] VHA Directive 1761. This report refers to the VISN director as the network director.

[19] P&LO's FY 2023 planner document recommended all quality control reviews be scheduled before June 30, 2023.

[20] P&LO added this instruction on August 16, 2023. Before this instruction, deficiencies requiring additional completion time needed to be approved by the VISN supply chief and reported to the program office until complete.

[21] Quality Control Review Audit Program, "FY23 Virtual QCR Audit SOP" (standard operating procedure), 2023.

[22] The quality control review is administered by a suboffice in P&LO. This report refers to the director of that suboffice as the quality program chief.

treat patients.[23] According to the policy, expendable supplies are to be inventoried each quarter, semiannually, or once per year depending on their classification. Nonexpendable equipment generally has a useful life of two years or more. Equipment that is sensitive and requires accountability regardless of cost, useful life, or maintenance requirements may also be classified as nonexpendable. Nonexpendable equipment is to be inventoried annually.[24] Other categories of activities covered in the quality control reviews include purchasing, warehouse management, mailroom operations, training facility staff on supply chain management, and reports of survey.[25]

Oversight of Supply Chain Management at VA Medical Facilities

VHA supply chain management policy outlines personnel responsibilities and required internal control activities, such as completing an annual quality control review.[26] This section outlines the core duties of personnel at various levels of VHA.

The executive director of P&LO is responsible for maintaining a VHA supply chain management program by establishing policy and procedures for inventory management, collecting and managing data, performing quality assurance, implementing tools for corrective actions in response to facility noncompliance, and providing staff at all levels with training programs. Although P&LO establishes policy and procedures for the VISN and facility staff, it does not have direct authority over them or their daily activities. VHA policy is silent on any P&LO responsibilities for implementing action plans at medical facilities.

The network director must maintain a VISN-level supply chain management program consistent with policy and must inform VHA leaders when facilities in the VISN's region experience barriers to compliance. To ensure facilities follow VHA supply chain management policy, the VISN supply chief is tasked with assessing each facility using the quality control review. According to the quality program chief within P&LO, VISN supply chiefs are also responsible for ensuring corrective action plans for identified deficiencies are implemented. The VISN supply chief reports to the network director and works directly with medical facilities to effectively implement supply chain management.

The medical facility director ensures sufficient resources are allocated to the supply chain management program to meet VHA operations directive requirements.[27] According to the quality program chief, medical facility supply chiefs are responsible for establishing and implementing

[23] VHA Directive 1761.

[24] VHA Directive 1761.

[25] VA Directive 7002, *Logistics Management Procedures,* January 8, 2020. Reports of survey investigate the circumstances surrounding the loss, damage, or destruction of property and hold responsible officials accountable.

[26] VHA Directive 1761.

[27] VHA Directive 1761.

action plans to address areas of noncompliance revealed by responses to the quality control review questions.

As depicted in figure 1, the network director has direct authority over the VISN supply chief and the medical facility director. The facility director, in turn, has authority over their supply chain staff. However, the VISN supply chiefs who review the facilities do not have direct authority over anyone at the facility. The dotted lines in figure 1 represent the quality control review engagement conducted by a VISN supply chief to assess a facility's supply chain management within the designated region.

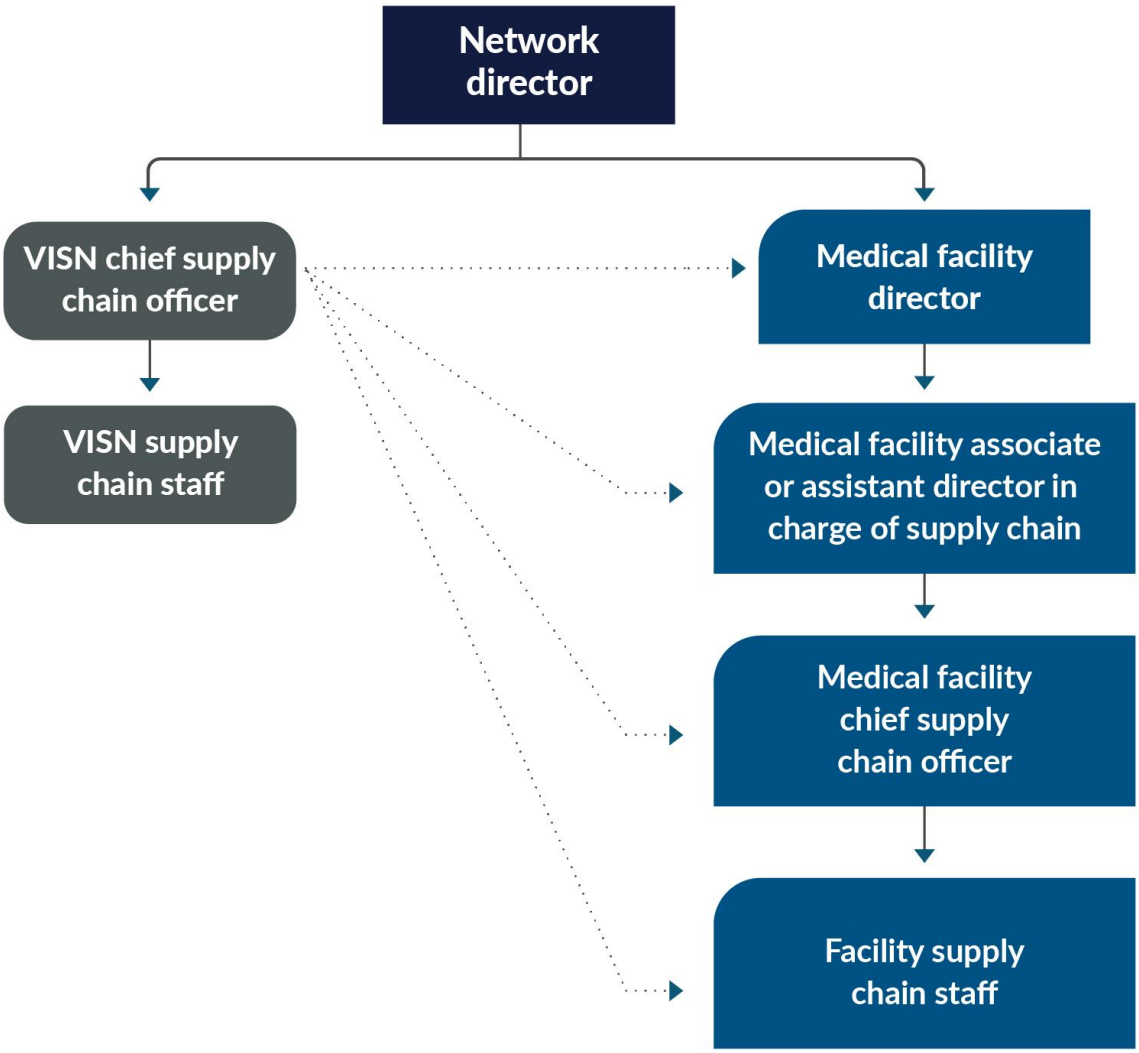

Figure 1. *Lines of authority and interactions among VISN and facility directors and supply chain management staff.*
Source: OIG analysis of organizational charts and VHA policy, as well as interviews with VHA officials.

Results and Recommendations

Finding: Oversight Was Insufficient to Correct All VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management

VHA policy requires VISNs to assess supply chain management programs at all the medical facilities within their network.[28] The VISN supply chiefs completed quality control reviews of supply chain management in FY 2023 and identified noncompliance. Cumulatively, the VISN supply chiefs' assessments found facilities did not comply with policy for about 18.5 percent of the evaluation questions. Noncompliance included activities related to managing inventory; training staff; and completing reports of survey for lost, damaged, or destroyed items.[29] According to data compiled by P&LO, medical facilities and VISNs corrected about two-thirds of the problems identified by VISN supply chiefs but did not correct the remaining one-third by the end of the fiscal year as required.[30] The six facilities the OIG team assessed (detailed in the following section) did not implement corrective actions for 130 of 205 noncompliant issues (63 percent) identified in FY 2023.

These numbers may understate noncompliance, as the OIG determined that VISN supply chiefs did not always identify or report noncompliant issues during quality control reviews. When this happens, the facility will not create needed action plans, and VHA and facility leaders may be unaware of the deficiencies.

The program office, VISNs, and facilities have distinct roles in ensuring compliance with supply chain management policy and correcting deficiencies identified in the quality control reviews. The OIG found that some network directors, however, did not ensure VISN and facility supply chiefs developed effective corrective actions. Facility staffing shortages in supply chain management were also a significant barrier, and medical facility directors did not always obtain the additional storage space or receive the subject matter expertise needed to comply with supply chain policy.[31] Additionally, tracking the quality reviews was a manual process and prone to errors, and the program office's auditing activities were not designed to effectively identify facilities with poor performance. By not implementing corrective actions, the risk increases that medical facilities will lose supplies or equipment, be unprepared for large-scale emergencies, not have the right supplies when needed for patient care, or use expired or damaged products.

[28] VHA Directive 1761.

[29] The number of instances of noncompliance varied among the facilities.

[30] The audit team determined that P&LO data were continually being updated for completeness. The information presented here is as of October 25, 2023.

[31] VHA Directive 1761.

The following determinations support the OIG's finding:

- VISNs did not always ensure medical facilities addressed identified deficiencies.
- VISN supply chiefs did not report all noncompliant practices.
- VHA's program office monitoring was inadequate to identify unimplemented corrective actions or inaccurate assessments.
- Additional action is needed to mitigate risks posed by supply chain deficiencies.

What the OIG Did

The team examined P&LO data from all 140 quality control reviews conducted in FY 2023 and the associated reports of corrective actions. The team also surveyed the 18 VISN supply chiefs, with a 100 percent response rate, to obtain more information related to challenges the facilities in their region face when trying to comply with supply chain management policy. To understand the quality control review process and the program office's oversight, the team also interviewed P&LO staff. To assess the VISNs' oversight, the team judgmentally selected six medical facilities for more detailed examination and site visits. When selecting facilities, the team considered factors such as compliance (both high and low) with the prior year's quality control review; whether the FY 2023 quality control review was completed and the facility had time to implement corrective actions; the facility size; and geographic location. As a result, the team selected the following facilities:

- VA Maine Healthcare System-Togus (the Togus facility) in VISN 1
- Birmingham VA Medical Center (the Birmingham facility) in VISN 7
- John D. Dingell VA Medical Center (the Detroit facility) in VISN 10
- Jesse Brown VA Medical Center (the Chicago facility) in VISN 12
- VA Southern Oregon Rehabilitation Center (the White City facility) in VISN 20
- VA Greater Los Angeles Healthcare System (the Greater Los Angeles facility) in VISN 22

During the site visits, the team interviewed VISN supply chain management staff charged with overseeing the selected facilities, facility supply chain management staff, and facility leaders. The team's work included analyzing facility responses to quality control review questions related to expendable inventory, nonexpendable inventory, staff training, and reports of survey. They observed the application of supply chain management controls and reviewed related documentation. To assess the quality control review process accuracy and follow-through, the OIG team analyzed each VISN supply chief's assessment of responses to selected questions and the follow-up activities for noncompliance with VHA policy. After the site visits, the team

surveyed the six network directors in charge of the selected facilities' VISNs to determine what actions they had taken to ensure the facilities in their region complied with supply chain management policy and corrected deficiencies.[32]

VISNs Did Not Always Ensure Medical Facilities Addressed Identified Deficiencies

During FY 2023, VISN supply chiefs completed quality control reviews for all 140 VA medical facilities and healthcare systems listed on P&LO's quality control review planner. As mentioned above, according to P&LO data collected from the VISNs, supply chiefs identified that about 18.5 percent of the quality control review responses overall revealed noncompliance with VHA policy. As of October 25, 2023, 53 VHA facilities had not implemented corrective actions for almost 900 total identified deficiencies by the end of the fiscal year.[33] The FY 2023 quality control review instructions required VISN supply chiefs to ensure deficiencies were corrected by September 30, 2023.

The OIG team surveyed all 18 VISN supply chiefs about whether their facilities generally complete corrective action plans on time and about challenges they face ensuring facilities comply with supply chain management policy. Ten VISN supply chiefs reported their facilities complete action plans within the required deadlines most of the time, six said their facilities sometimes do, and two said their facilities usually do not. The supply chiefs reported numerous concerns, with the most common responses relating to vacancies within the facilities' supply chain staff; unclear policy or gaps in policy; and the lack of authority that supply staff have over other services that they need cooperation from, such as information technology.[34]

The six facilities that the OIG team reviewed did not implement corrective actions for 130 of 205 problems identified through quality reviews, as shown in table 1.[35] VISN supply chiefs for three of these facilities—Detroit, Togus, and White City—provided oversight that confirmed the corrective actions were taken for most identified deficiencies. The other three facilities (Birmingham, Chicago, and Greater Los Angeles) were responsible for 127 of the 130 unimplemented corrective actions, including 62 of 66 repeat findings (about 94 percent). A

[32] For more information on this report's scope and methodology, see appendix A.

[33] The OIG team determined that the P&LO data were continually being updated for completeness. This information is provided for context to illustrate the significant number of unimplemented corrective actions at VHA medical facilities.

[34] Compliance involves the cooperation of services outside of supply chain management that the facility supply chief does not have direct authority over. These services include information technology, clinicians who are custodial officials, and others. Compliance with supply chain management policy is not always a priority for these services.

[35] The team evaluated the oversight provided by the VISN at the six facilities selected for site visits. This included analyzing each VISN supply chief's assessment of responses to selected questions and their documented or reported follow-up activities for noncompliant facility practices. Additionally, the team reviewed what actions the network directors took to ensure the facilities in their region complied with policy or corrected noncompliance.

repeat finding means the response to a quality control review question on a specific requirement revealed noncompliance for two years in a row.

Table 1. OIG-Reviewed Facilities' Implementation of Corrective Actions for Deficiencies Identified in FY 2023

Facility and VISN	Facility responses indicating noncompliance	Repeat findings	Corrective actions not implemented
Detroit (VISN 10)	23	3	0
White City (VISN 20)	7	1	1
Togus (VISN 1)	5	0	2
Birmingham (VISN 7)	28	12	21
Chicago (VISN 12)	70	35	34
Greater Los Angeles (VISN 22)*	72	15	72
Total	**205**	**66**	**130**

Source: VA OIG analysis of data reported by VISN supply chiefs and P&LO documentation. Data are reported as of September 30, 2023.
** Repeat findings for this facility were determined using FY 2021 results due to an FY 2022 waiver from review.*

Responsibility for fixing deficiencies is shared between the VISN and facilities. Network and medical facility directors are responsible for facility compliance with supply chain management policy.[36] Medical facility directors are responsible for ensuring sufficient resources are allocated to comply with supply chain management policy.[37]

The OIG team identified several obstacles faced by the Greater Los Angeles, Chicago, and Birmingham facilities: significant supply chain staffing vacancies, facility leadership turnover, insufficient support from the VISN, and inadequate space.

All three facilities struggled with staffing vacancies. The Birmingham facility had the highest vacancy rate across supply chain positions (41 percent) in May 2023, followed by the Chicago facility (about 37 percent in July 2023) and the Greater Los Angeles facility (about 29 percent in June 2023). In contrast, the three reviewed facilities that had fewer uncompleted action plans (Togus, White City, and Detroit) had a lower supply chain staff vacancy rate than the facilities that struggled with implementing action plans. For example, the Togus and White City facilities had about a 15 percent vacancy rate, and the Detroit facility had about a 22 percent vacancy rate.

[36] VHA Directive 1761.
[37] VHA Directive 1761.

To address staffing vacancies, during 2023, the Greater Los Angeles, Chicago, and Birmingham facilities began the process of offering hiring incentives for some of these positions.

The Greater Los Angeles facility and the two others that had not implemented action plans also faced challenges with leadership turnover, while Togus, White City, and Detroit facilities had a permanent supply chief in place. The problems with staffing vacancies and turnover were significant enough that in FY 2022, the Greater Los Angeles facility director requested and was granted a waiver for the annual quality control review. This resulted in prior deficiencies and any new issues with noncompliance persisting over that year. The VISN supply chief, new to the position in October 2022, told the OIG team that none of the medical facilities in VISN 22 had completed action plans in FY 2021 and FY 2022.

In response to the FY 2023 quality control review completed in December 2022, the VISN supply chief returned 61 action plans to address 72 areas of noncompliance to the facility because the actions were not responsive to fully addressing the problems identified. As of October 2023, the VISN 22 supply chief told the OIG team that the Greater Los Angeles facility had not completed any of the action plans. He said that he made numerous follow-up attempts regarding any actions from the facility, but the facility staff responded that they did not know when they will complete the action plans due to understaffing. The facility supply chief transferred to another facility during FY 2023. Both the acting network director and VISN supply chief told the OIG team that the facility's supply chain staffing vacancies contributed to its struggles with complying with policy and correcting deficiencies. The acting network director also said that VISN supply chain management staff have been busy assisting other facilities in the VISN "due to performance inadequacies affecting clinical operations."

Later, in November 2023, the acting network director told the OIG team that 15 of the 72 corrective items had been completed, which the team confirmed with the VISN supply chief. The VISN supply chief closed the 15 action plans in mid-October after the OIG team's initial inquiry. The acting network director also reported that they are taking steps to better facilitate the implementation of corrective action throughout their region, including implementing a supply chain deficiency tracker for monitoring implementation of corrective actions and aggregating similarities in deficiencies to detect trends. He also said in November 2023 that a governance committee that reports to the VISN's Healthcare Operations Council began tracking deficiencies, and facility associate directors were now required to validate the implementation of corrective actions.

P&LO personnel told the OIG team that staffing is both a facility and VISN responsibility. The OIG's first recommendation is for VISN supply chiefs and P&LO to incorporate facilities' supply chain personnel vacancies as part of the quality control reviews and take appropriate action.

In addition to facility understaffing and leadership turnover, the Chicago facility also struggled with what they believed was inadequate support from the VISN. The VISN supply chief said that

the facility had consistently been nonresponsive about addressing its action plans, and the network director reported that the VISN supported the Chicago facility with additional temporary staff. The facility director, in contrast, reported he made multiple requests to the VISN for staff and subject matter experts to assist in correcting the identified issues, but the assistance was limited, and many deficiencies remained unresolved.

The network director said the VISN supply chief was adding positions to assist with overseeing and training facility staff on deficient practices identified by the quality control review findings. The network director also stated he added a metric to the facility director's performance plan for implementing corrective actions. However, the facility director did not think that the VISN's assistance was sufficient to help his facility resolve the long-standing supply chain issues.

According to the network director, the VISN 12 supply chief has biweekly meetings with all of the medical facilities he oversees to resolve quality control deficiencies. For the Chicago facility specifically, meetings were held weekly, and the network director attributed those meetings with helping the facility implement more than 30 corrective actions. However, the facility director said that the meetings only reiterated the long list of remaining issues but did not help resolve them. More than 30 other corrective actions remained unimplemented and deferred until FY 2024.

In contrast, the network directors for the Togus, White City, and Detroit facilities emphasized collaboration between VISN and facility supply chain management staff as a key reason the facilities were compliant with policy and implemented corrective actions. Of note, the Detroit facility had 23 areas of noncompliance and executed all the related action plans to remediate the problems by the end of the fiscal year. According to the VISN supply chief, the facility was proactive in fixing issues for nine noncompliant practices while the quality control review team was still on-site or shortly after. The VISN supply chief said he and his deputy had been in their roles for several years and that they visit the facilities in their region two to five times per year. Although the Detroit facility had a higher vacancy rate than Togus and White City, the facility supply chief has been in the role for nearly 10 years. The supply chiefs confirmed that experience and continuity were integral to managing the facility's supply chain, including implementing corrective actions.

In addition to staffing challenges, the OIG team found that the Birmingham facility did not have enough space to store supplies, a concern also emphasized by the network director and VISN supply chief. During the site visit, the OIG team noted that the facility stored many expendable supplies in unsecured hallways in the basement (accessible to the public) rather than in the warehouse or at established inventory points, making the supplies difficult to locate when needed and susceptible to damage or theft (figure 2).

Figure 2. *Expendable supplies stored in unsecured rooms and hallways not designated for inventory in the basement at the Birmingham medical facility.*
Source: VA OIG June 13, 2023.

The network director overseeing the Birmingham facility said that the facility has supplemented staffing with contractors; developed incremental goals; and requested additional mentoring, consulting, and assistance from the VISN supply chief, including three on-site visits within a 12-month period. The network director emphasized that the VISN as a whole supports all facilities with resources and consultations. Additionally, he said that the VISN added external report closure, including quality review action plans, as a measure to assess their senior executives in their performance evaluations. The network director also noted the VISN recently revised the governance structure with a newly established supply chain subcommittee intended to increase oversight of the quality control reviews and associated action plans.

Although the network directors said they were taking some steps to correct the pervasive deficiencies at the Greater Los Angeles, Chicago, and Birmingham facilities, these steps had yet to prove effective. Network directors have direct authority to enforce policy at the medical facilities. Their oversight responsibilities include ensuring their facilities meet supply chain management performance standards and comply with policy. Network directors are also to inform their facility leaders about barriers to their facilities' compliance.

However, P&LO lacks direct authority over VISN and facility staff to enforce compliance measures. Still, according to the quality program chief, P&LO does have field support staff who can assist facilities that request help with supply chain management policy compliance—though past assistance, including at the Chicago facility in FY 2023, has only fixed problems temporarily.

Collectively, P&LO, the VISNs, and the facilities have not effectively resolved deficiencies identified in the quality control reviews, contrary to federal internal control guidance that organizations should delegate authority, evaluate performance, design control activities, and fix deficiencies.[38]

To address supply chain management problems at facilities that consistently struggle with policy compliance and implementing corrective actions, recommendation 2 is for VHA to develop guidelines that define when facility supply chain management problems require additional interventions and then routinely identify them for network director action. Recommendation 3 calls for facility and network directors to work with P&LO on a plan to identify resources and milestones to resolve identified supply chain management problems. Recommendation 4 is for P&LO to develop a process to provide resources (such as temporarily assigning subject matter experts or a team) to help VISNs and facilities resolve persistent supply chain management deficiencies, including those identified in this audit.

VISN Supply Chiefs Did Not Report All Noncompliant Practices

As noted earlier, when VISN supply chiefs do not identify or report all noncompliant practices, the facilities fail to take remedial steps, and VISN and program office officials are unaware of specific deficiencies and their scope. For example, two VISN supply chiefs inaccurately concluded that the required inventory system was being used to manage all expendable items and documented their facilities as compliant. However, the OIG audit revealed that these facilities were in fact noncompliant because staff did not include implants in the required system.[39] One VISN supply chief disagreed with the OIG's assessment that implants should be in the required system to be compliant because she believed the system the facility was using was better. The VHA program office staff opposed the VISN supply chief's assessment because the system that the facility used did not interface with the health record as required. The other VISN supply chief was unaware that five biological and 54 nonbiological dental implants were not in the required system until the OIG audit. He stated he was waiting on VHA approval to use the existing system to track implants. All other covered implants were in the required system.

Five of six facilities did not provide their quarterly supply chain management training completion status to the VISN supply chief, as required.[40] In four of these cases, the VISN supply chiefs inaccurately marked the question as not applicable when they should have been

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

[39] VHA Directive 1761 requires all expendable inventory items (including biological and nonbiological implants) to be entered in the VHA-approved inventory management system. Before FY 2023, the quality control review used a separate question to evaluate whether implants were inventoried in the appropriate system. For the FY 2023 quality control review, P&LO consolidated this question with another expendable inventory question.

[40] VHA Directive 1761 states that training aligned with each employee's position description must be assigned and completed yearly.

noncompliant because the facility supply chief did not provide the quarterly training status to the VISN. Generally, the VISN supply chiefs said they had not provided their facilities with a format to report the training, so they did not want to mark their facilities as noncompliant because they did not provide clear instructions.

The OIG team also found that one VISN supply chief incorrectly marked the responses to six questions as reflecting compliant facility activity. The VISN supply chief explained that some facilities were noncompliant on an issue that covered more than one quality control review question, and he felt it would not help the medical facility improve if he deemed them noncompliant on too many questions for a single issue. For example, the facility was storing supplies in hallways because their warehouse was full. The VISN supply chief found the facility noncompliant with the requirement to store all supplies in a secured location. However, the facility also failed to comply with VHA policy that mandates the use of barcodes to identify all expendable items. To the extent possible, the barcode labels are to be affixed at the location the item is stored.[41] Without barcodes, supply chain management staff cannot inventory these items with scanners, risking loss and inaccurate inventories, making it difficult to maintain an adequate quantity of supplies to meet patient care needs. The VISN supply chief did not find the facility noncompliant with this barcode requirement because he felt the root cause of the issue was the supplies stored in the hallway, which was already addressed in another quality control review question.

The program office provides VISN supply chiefs with examples of ways to assess compliance, such as which data to review or records to obtain to determine if the facility is compliant with a certain requirement. However, there are no specific standards or parameters for each supply chief to follow—contributing to incorrect assessments of facility responses to questions as compliant. Although VISN supply chiefs did not explicitly state they were confused by the program office's instructions, the lack of clear guidance was evident in the varying interpretations of facility responses and inconsistent determinations of compliance. The chief of the quality program said that VISN supply chiefs can use other methods to validate compliance instead of referring to the examples provided. In sum, the OIG team found that the lack of compliance standards or parameters resulted in inconsistent assessments among the VISN supply chiefs in their quality control reviews for the same or similar facility activity.

VHA's Program Office Monitoring Was Inadequate to Identify Unimplemented Corrective Actions or Inaccurate Assessments

Although P&LO tracked whether VISNs conducted quality control reviews, it did not have an effective system to monitor whether VISN supply chiefs accurately determined facility

[41] VHA Directive 1761.

compliance with policy or the implementation of corrective action plans.[42] Federal internal control guidance states that organizations should exercise oversight responsibility, identify and analyze risk, design activities for the information system, and monitor internal controls.[43] P&LO required VISN supply chiefs to document the date when action plans were closed, but the program office did not verify that the action plans were implemented and whether the problems were resolved. VISN supply chiefs recorded their review results manually using spreadsheets that they uploaded to the program office's SharePoint site—a process prone to inaccuracies. P&LO also conducted audits of some VISN supply chief quality control reviews but did not evaluate action plans.

P&LO's Manual Tracking of the VISNs' Quality Control Reviews Hindered Its Monitoring Capabilities

P&LO manually tracked the implementation of corrective actions for the FY 2023 quality control reviews by aggregating numerous spreadsheets from VISN supply chiefs. However, VISN supply chiefs did not always update their spreadsheets or ensure they were correct, making the aggregated spreadsheet incomplete and inaccurate. For the six facilities selected for site visits, the OIG team examined P&LO's data as of October 25, 2023, to assess the accuracy of information related to the VISN supply chiefs' documented quality review findings and any related implemented corrective actions. P&LO's data had incorrect or missing information for three of the six sites. The team also reviewed all the VISN information in P&LO's aggregated data and identified errors in the information for 10 of the VISNs.

The VISN supply chiefs submit their annual quality control review results to the program office on a SharePoint site. The files could contain errors because the spreadsheets used to document each facilities' results can be overwritten. For example, a medical facility supply chief manually overwrote what the VISN supply chief documented for areas of noncompliance after he implemented corrective actions for the identified areas of noncompliance from the FY 2022 quality control review. The facility supply chief should not have changed the VISN's initial assessment to reflect any subsequent compliance measures. As a result, the facility's spreadsheet inaccurately showed 100 percent compliance for FY 2022. In October 2023, the quality program chief said they have updated their training procedures to inform staff not to edit their review documents after submission. Additionally, he said P&LO is implementing an automated method to track quality control reviews and corrective actions for FY 2024, and he planned on discussing with the developer a way to safeguard the files from further edits.

[42] The GAO defines monitoring as "activities management establishes and operates to assess the quality of performance over time and promptly resolve the findings of audits and other reviews." GAO, *Standards for Internal Control in the Federal Government*.

[43] GAO, *Standards for Internal Control in the Federal Government.*

To acknowledge that plan and ensure implementation, recommendation 5 is for P&LO to continue efforts to automate tracking that will accurately capture and monitor all quality control review results, corrective action plans, and implementation of those plans.

P&LO's Oversight of the Quality Control Program Missed Some Medical Facilities with Many Noncompliant Areas

P&LO's quality control program is governed by internal guidance that states it will audit the reviews of a number of facilities conducted by VISN supply chiefs.[44] The guidance states that medical facilities are selected at random and, according to the program director, P&LO does not target any specific facility. The guidance says these audits are intended to make certain that VISN reviews are being used effectively to accurately reflect the state of facilities' supply chain management programs. The quality program chief added that the audits are done to ensure consistent determinations of facility compliance, based on the supporting documentation. In FY 2022, P&LO audited 19 facilities. The facilities were randomly selected, and P&LO did not audit any facilities from six VISNs in FY 2022, some of which included facilities with many identified deficiencies. For example, VISN supply chiefs identified more noncompliant issues (about 300) in VISN 22 than any other VISN, putting those medical facilities at higher risk for supply chain problems, but P&LO's audits did not include any VISN 22 facilities in FY 2022.

Further, P&LO program officials stated they do not review action plans as part of the audits. In May 2023, the quality program chief said that P&LO does not oversee action plans and instead relies on the VISNs to report on the status of corrective actions. Specifically, P&LO required VISN supply chiefs to report on their quality control review spreadsheets the date when they determined the action plans to be closed.

Improved audit coverage, including assessments of action plans, would allow the quality control reviews to provide more meaningful information and improve oversight of supply chain management. Recommendation 6 is for P&LO to update its audits of the VISN quality control program to apply risk-based sampling, evaluate action plan sufficiency and implementation, and use audit results to continuously improve quality control review guidance and requirements.

Additional Action Is Needed to Mitigate Risks Posed by Supply Chain Deficiencies

By not implementing action plans to address deficiencies identified in the quality control reviews, medical facilities are at risk of losing supplies or equipment, having items damaged or stolen that are not physically secured, not having the right supplies when needed, or using expired or damaged products for patient care.

[44] Quality Control Review Audit Program, "FY23 Virtual QCR Audit SOP."

Inventory Needs to Be Accounted For

Inventory that has not been accounted for is at risk of theft or becoming lost. The OIG team determined, through on-site observations, testing, and data review, that five of six facilities did not include all expendable items in the required system and had not inventoried all nonexpendable equipment.[45] Including expendable items in the required system and completing inventories as required is vital to tracking the receipt and distribution of supplies. Depending on the expendable clinical supplies classification, they are to be inventoried each quarter, semiannually, or once per year.[46]

Nonexpendable equipment inventories are required annually, and the OIG team identified noncompliance with that mandate at five of the six medical facilities as well.[47] The team's analysis of VHA data as of August 2023 still reflected noncompliance at the same five facilities (table 2). Notably, the Greater Los Angeles facility had not inventoried more than $55 million of nonexpendable inventory within the last year, as required (and more than half of the equipment (2,941 items worth about $30 million) had not been inventoried in more than two years).[48]

Table 2. Unaccounted Nonexpendable Equipment

Facility	Number of equipment items not inventoried in the previous 13 months	Dollar amount
Greater Los Angeles	7,441	$55,929,603
Birmingham	559	$2,463,273
Chicago	774	$1,307,173
Togus	337	$874,483

[45] The OIG team did not find expendable items or nonexpendable equipment were managed outside the required system at the White City facility.

[46] 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 the first and third quarter, and items representing the remaining 10 percent (lowest usage) are in the "C" category and are inventoried in the second quarter.

[47] VA Handbook 7002, *Logistics Management Policy,* January 8, 2020.

[48] VHA's tracking report lists nonexpendable equipment that has not been inventoried for 13 months. The VHA requirement is to inventory nonexpendable items every 12 months.

Facility	Number of equipment items not inventoried in the previous 13 months	Dollar amount
Detroit	32	$72,972
White City	0	$0

Source: OIG analysis of Equipment Inventory Accountability Report as of August 2023.

The Greater Los Angeles and Chicago facilities started reports of survey for missing inventory but did not complete them as required. Reports of survey are important to investigate the circumstances surrounding the loss, damage, or destruction of property and to hold responsible officials accountable.[49] Staff at the Greater Los Angeles facility initiated 11 reports of survey in FY 2023, but the medical facility supply chief at that time said he was unaware of them. These reports of survey remained incomplete at the time of the OIG team's site visit in May 2023. The medical facility director at the Chicago facility would not sign 16 reports of survey completed by his staff during FY 2023. In July 2023, the director said he was waiting for a wall-to-wall inventory to be completed by a contractor before signing the reports of survey because he believed the reports of survey were "excessive." Leaders from the Greater Los Angeles facility said they were also contracting for additional inventories.

Further, three of the six facilities visited did not inventory their contingency stock, making it difficult to determine whether the facilities have sufficient supplies available if needed. Two of these facilities did not review their contingency inventory with the emergency management committee as required.[50] The third facility had an emergency management committee meeting in which individual clinics discussed the contingency supply items within their clinics, but supply staff did not communicate the status of the storage of contingency stock in the warehouse. Without knowing the levels of contingency inventory, key facility leaders were unaware of the sufficiency of their actual inventory of medical supplies and personal protective equipment on hand in the event of an emergency.

Inventory Needs to Be Physically Secured

Two facilities did not control or limit access to supplies. Physical security is essential to protecting VHA assets. The Birmingham facility did not lock three supply rooms, contrary to

[49] VA Handbook 7002.

[50] VHA Directive 1761. Pandemic medical supplies must be labeled as contingency inventory in the required system and inventoried annually. Further, the emergency management committee must review the contingency inventory each year. The primary contingency inventory should only maintain medical supplies for pandemics, disasters, or other emergencies.

requirements that access be restricted to authorized personnel.[51] The OIG team discovered one door leading to a primary supply location in the basement had a broken lock, and two other doors (one to the laboratory and the other to a supply cabinet) were open. Further, supplies were stored on pallets in the basement hallway where staff and visitors have unrestricted access. The Chicago facility had an off-site warehouse but did not restrict physical access to inventory—other federal agencies using the warehouse had access, and none of the supplies were caged or locked, including high-dollar information technology equipment.

Supplies Must Be Available When Needed

Poor supply chain management, including the failure to properly order, inventory, and track medical supplies, can also increase the risk of delayed or canceled patient care. During interviews with clinicians and leaders at facilities and program office personnel, the OIG team learned of delayed surgeries because needed supplies were unavailable. For example, the Greater Los Angeles facility delayed a patient's vascular surgery at the pre-operation stage because staff discovered a supply item (a specific catheter) did not arrive in time. This surgery was completed two weeks later. In another instance, a patient came to the facility for a scheduled surgery, and then staff determined they did not have the needed specimen retrieval bags. The patient agreed to be referred to a care provider in the community as a result. Although the incidents were due to poor supply chain management, the OIG team could not ascertain whether external manufacturer shortages could have contributed to their unavailability. In addition, according to documentation provided by P&LO, another facility (outside of the six the OIG team visited) had canceled four surgeries in April 2023 because needed supplies were not available in the laboratory and operating room.

Supplies Should Not Be Expired

During the FY 2023 quality control review, the VISN supply chief overseeing the Chicago facility identified expired implants and other items throughout the facility. Facility staff subsequently reported they had made efforts to remove all expired items and correct the issues that prevented them from identifying the expired items. However, expired items were again identified during the OIG team's site visit. On site visits to Chicago and two other facilities, the OIG team discovered more than 150 expired items, including catheters, syringes, blood collection tubes, and dental implants. A thoracic catheter in the Chicago facility's cardiac catheter operating room had been expired since June 2019 (figure 3). Staff did not know about these expired items in their operating rooms and common supply areas until the OIG team

[51] VHA Directive 1761.

discovered them. Medical facility supply chain management staff are expected to check shelves, bins, and items on a weekly basis to ensure storage areas are clean and items are not expired.[52]

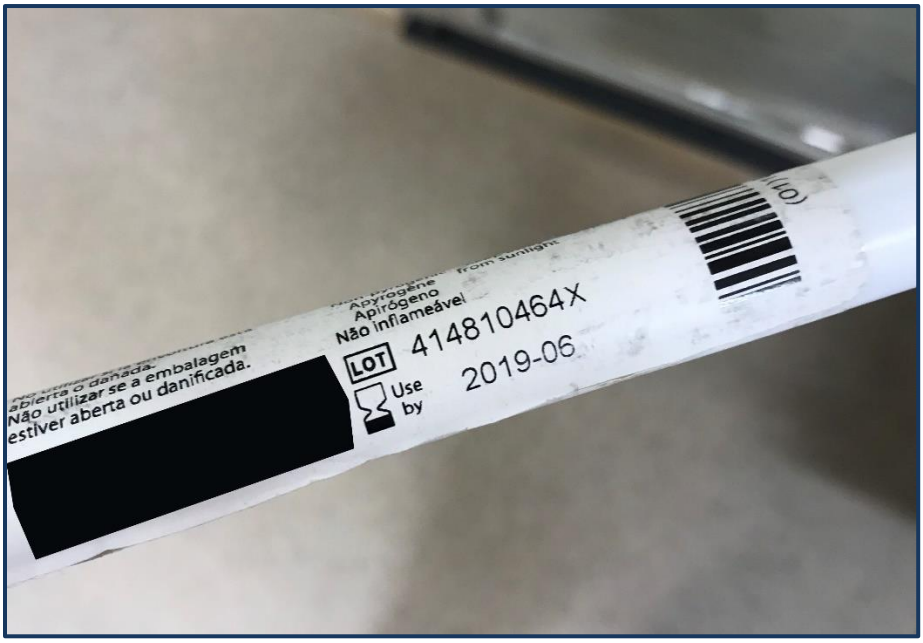

Figure 3. *Thoracic catheter that expired in June 2019 found in the Chicago facility's cardiac catheter operating room.*
Source: VA OIG July 11, 2023.

Facilities are also required to inspect the biological and nonbiological implant inventories each week but were not conducting them at three of the six facilities the OIG team visited.[53] Failing to conduct these inspections increases the risk of expired or damaged items being used for patient care or not being located when they are needed.

Conclusion

VISN supply chiefs conducted quality control reviews of 140 medical facility supply chain management programs in FY 2023, finding that facilities did not comply with policy for about 18.5 percent of the evaluation questions and required corrective actions. Among the most concerning deficiencies were failing to complete and document all inventory in the approved supply management system to ensure adequate quantities of items were available; not securing supplies from loss, theft, and damage; and neglecting to barcode supplies for tracking where they could be located when needed. The OIG found that VISNs and facilities did not always fix the problems that were identified, largely due to facilities' lack of staff, stability in leadership positions, resources, or expertise. The large number of persistent or pervasive supply chain

[52] VHA Directive 1761.
[53] VHA Directive 1761.

problems identified may be understated as well because the VISN supply chiefs did not consistently identify noncompliant practices during the initial quality reviews. The program office, VISNs, and facilities all have roles in ensuring compliance with supply chain management policy and correcting deficiencies. Regarding monitoring, P&LO tracked completed quality control reviews and conducted some audits, but its tracking tools and audits were inadequate for providing effective oversight of corrective actions. Some network directors did not make certain that effective corrective action plans were developed and implemented, and did not muster the resources to provide effective assistance to struggling facilities. Facility directors did not always attain the needed staff or subject matter expertise needed to comply with VHA policy and reported varying degrees of success with obtaining VISN help. VHA facilities will continue to risk loss or damage to supplies and equipment paid for by taxpayer dollars and impede efforts to provide prompt high-quality patient care until the problems and noncompliance concerns identified by quality control reviews are fixed.

Recommendations 1–6

The OIG made the following recommendations to the under secretary for health:

1. Track facilities' supply chain personnel vacancies as part of the quality control reviews and take appropriate action.
2. Develop guidelines that define when facility supply chain management problems require additional interventions and then routinely identify them for network director action.
3. Ensure facility and network directors work with the Procurement and Logistics Office on a plan to identify resources and milestones to resolve identified supply chain management problems for identified facilities.
4. Direct the program office to develop a process to provide resources when needed to help networks and facilities resolve persistent supply chain management deficiencies, including those identified in this report.
5. Continue Procurement and Logistics Office efforts to automate tracking that will accurately capture and monitor all quality control review results, corrective action plans, and implementation of those plans.
6. Update the Procurement and Logistics Office audits of the quality control program to apply risk-based sampling, evaluate action plan sufficiency and implementation, and use the results to continuously improve quality control review guidance and requirements.

VA Management Comments

VHA concurred with all six recommendations and submitted corrective action plans to address the issues identified in the report, with a target completion date of June 2025. For recommendation 1, VHA reported that among its responses the program office will add a review

question to the annual quality control checklist for FY 2025 to identify facilities' supply chain vacancies and related risks to enable the appropriate office to take action. To address recommendation 2, the program office will develop and publish guidelines regarding risk indicators to identify facility or VISN risks related to noncompliance with supply chain requirements. The VHA response noted that the program office will also request that the quality control review compliance goal be included on the Senior Executive Service performance plans for network and facility directors.

Regarding recommendation 3, VHA stated it will establish a plan to evaluate the results of the risk indicators to routinely identify the resources that facilities need. VHA reported that to implement recommendation 4, it will develop a process to identify necessary actions by the facility, VISN, and program office to provide those resources in response to its published risk indicators.

For recommendation 5, VHA proposes to work with VA's Office of Information and Technology to continue to develop an automated tool to enhance monitoring of quality control review results, corrective action plans, and implementation. Finally, VHA responded that to carry out recommendation 6, the program office will update its own auditing of the program based on facilities' risk indicators and incorporate a review of action plans and their implementation. The VHA comments are included in full in appendix B.

OIG Response

VHA's planned actions are responsive to the recommendations and address the report findings. The OIG will continue to evaluate VA's actions and supporting documentation to ensure program improvement and will close the recommendations as sufficiently implemented when VA provides adequate evidence of having addressed the intent of the recommendations and the identified issues detailed in the report.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team conducted its work from May 2023 through June 2024. The scope of the audit included evaluating the quality control reviews conducted by the Veterans Integrated Service Networks (VISN) during fiscal year (FY) 2023. The team further assessed six judgmentally selected medical facilities from different VISNs with varying levels of compliance.

Methodology

The team identified and assessed applicable laws, regulations, VA policies, operating procedures, and guidelines related to the Veterans Health Administration (VHA) supply chain management and quality control reviews. The team examined Procurement and Logistics Office (P&LO) data from all 140 quality control reviews conducted in FY 2023 and the associated reports of corrective actions. To conduct a more detailed evaluation of facility compliance with the quality control reviews, including the implementation of corrective actions, the team selected and visited six medical facilities (table A.1). When selecting facilities for review, the team considered factors such as compliance (both high and low) with the prior year's quality control review; whether the FY 2023 quality control review was completed and the facility had time to implement corrective actions; facility size; and geographic location. The team also selected a facility from VISN 20 that had implemented the new electronic health record.[54]

Table A.1. Medical Facilities' Quality Control Reviews Evaluated by the OIG Team

Facility and VISN	Enrolled veterans as of September 30, 2023 (approximate)	Reason selected based on evaluation of FY 2022 quality control review
The VA Greater Los Angeles Healthcare System (Greater Los Angeles facility; VISN 22)	120,000	Facility granted a waiver
The Birmingham VA Medical Center (Birmingham facility; VISN 7)	89,000	High noncompliance rate
The Jesse Brown VA Medical Center (Chicago facility; VISN 12)	54,000	High noncompliance rate
The VA Maine Healthcare System-Togus (Togus facility; VISN 1)	50,000	High compliance rate

[54] The team included one VISN 20 facility to determine if its implementation of the new electronic health record affected its ability to comply with VHA supply chain requirements. According to the VISN 20 supply chief, it was not a material factor in the facility's ability to comply with the requirements.

Facility and VISN	Enrolled veterans as of September 30, 2023 (approximate)	Reason selected based on evaluation of FY 2022 quality control review
The John D. Dingell VA Medical Center (Detroit facility; VISN 10)	55,000	High compliance rate
The VA Southern Oregon Rehabilitation Center (White City facility; VISN 20)	20,000	High compliance rate and implemented the new electronic health record

Source: VA OIG analysis of VHA Support Service Center data and FY 2022 quality control reviews.
Note: The number of enrolled veterans at each facility is rounded.

The team judgmentally selected 29 quality control review questions focused on expendable inventory, nonexpendable inventory, training, and reports of survey, among other categories of supply chain management to assess during site visits. The team analyzed the findings and action plans detailed in the completed quality control reviews. As part of that analysis, the team observed supply chain controls and inspected documentation. The team also interviewed directors, associate or assistant directors in charge of supply chains, as well as staff engaged in supply chain management, quality management, and clinical work at the selected facilities. To assess VISN oversight, the team interviewed VISN supply chain management staff and surveyed the six network directors in charge of the selected facilities.

The team conducted an electronic survey of all 18 VISN supply chiefs to obtain information related to their experience with the quality control review program. Access to the survey was limited by using a list of preprogrammed email addresses for the intended recipients. The team received and analyzed the 18 completed surveys from the VISN supply chiefs (a 100 percent response rate). The survey results are self-reported data.

The team interviewed staff from P&LO to understand and assess how the program office administers and oversees the program. The team evaluated P&LO's tracking of deficiencies and corrective actions and that office's audits of facility quality control reviews. The team also interviewed staff from VA's Office of Acquisition and Logistics regarding applicable VA policy.

Internal Controls

The team assessed the internal controls of VHA's supply chain management quality control review program significant to the audit objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[55] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified five components and 15 principles

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

as significant to the objective.[56] Of those, the team identified internal control weaknesses in four components and nine principles and made recommendations to address those weaknesses:

- Component 1: Control Environment
    - Principle 2–Exercises oversight responsibility
    - Principle 3–Establishes structure, authority, and responsibility
    - Principle 4–Demonstrate commitment to competence
    - Principle 5–Enforces accountability
- Component 2: Risk Assessment
    - Principle 7–Identifies and analyzes risk
- Component 3: Control Activities
    - Principle 10–Designs control activities
    - Principle 11–Designs control activities for information systems
- Component 5: Monitoring
    - Principle 16–Performs monitoring activities
    - Principle 17–Elevates issues and remediate deficiencies

Data Reliability

The team obtained data from various sources during the audit and assessed the reliability of the data used to support findings, conclusions, or recommendations related to the audit objective. The data included completed quality control reviews from six VISN supply chiefs. During site visits, the team interviewed VISN and facility supply chain management staff, including the chiefs; observed supply chain management controls; and inspected documentation to assess whether the quality control review tool accurately captured VISN supply chiefs' assessments of facility compliance with supply chain management policy. After performing these steps, the OIG team determined that the quality control reviews from six VISN supply chiefs were sufficiently reliable for the purposes of this audit. The team also conducted a survey of VISN supply chiefs. VA provided the team with a list of email addresses for all 18 VISN supply chiefs to distribute the survey. The team tested the completeness and accuracy of the list by sending survey notification emails to potential survey participants. The notification informed the individuals that they had been identified as supply chiefs and that they should notify the audit team if that was not correct. The survey included a qualifying question as well to ensure that the survey

[56] Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

respondent was a supply chief. The team determined that the staff listings were reliable and used them to successfully disseminate surveys to targeted participants.

After obtaining P&LO's deficiency and action plan implementation tracking spreadsheet, the OIG team interviewed program office officials and evaluated the spreadsheet. The team also tied the entries from the spreadsheet back to the six sites selected for visits. Based on its evaluation, the team determined that the program office spreadsheet was being continually updated and that its reliability could not be verified. The OIG team reported this issue to the program office during the audit and made a recommendation for corrective action. Although the tracking spreadsheet could be unreliable, the team used the information on identified deficiencies from the VISN supply chiefs and how many corrective action plans remained unimplemented as context for this report, acknowledging that was the information VA was relying on during the audit.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objective. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objective.

Appendix B: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 9, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management (VIEWS 11873404)

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Veterans Integrated Service Network oversight of supply chain management. The Veterans Health Administration (VHA) concurs with recommendations 1-6 and provides action plans in the attachment.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal, M.D., MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management
(OIG Project Number 2023-02123-AE-0077)

Recommendation 1. The Under Secretary for Health tracks facilities' supply chain personnel vacancies as part of the quality control reviews and take appropriate action.

VHA Comments: Concur

VHA Directive 1761, *Supply Chain Management Operations*, published December 30, 2020, establishes the Veterans Integrated Service Network (VISN) Chief Logistics Officer is responsible for "assessing programs at VISN medical facilities through a quality control review (QCR) once per fiscal year (FY) utilizing the QCR checklist and instructions." The FY 2025 QCR checklist will include a new question to identify facilities' supply chain personnel vacancies and related risk. This will enable the appropriate office to take action. The Supply Chain Committee (SCC) will provide the appropriate justification for Hybrid Title 38 supply chain management positions to VA Workforce Management and Consulting (WMC) Office. The SCC will provide WMC with the appropriate documentation to implement standardized VISN position descriptions addressing minimal staffing levels across the VISN offices.

Status: In progress Target Completion Date: June 2025

Recommendation 2. The Under Secretary for Health develops guidelines that define when facility supply chain management problems require additional interventions and then routinely identify them for network director action.

VHA Comments: Concur

VHA Procurement and Logistics Office (P&LO) will develop guidelines and publish them as a Notice to supplement VHA Directive 1761. The Notice will contain risk indicators to identify facility and/or VISN risks related to non-compliance with SCC requirements. VHA P&LO will submit a request to the VHA Senior Executive Service (SES) Performance Oversight Committee to include the overall QCR compliance goal on the VHA SES Performance Plans for Network Directors and Medical Center Directors.

Status: In progress Target Completion Date: June 2025

Recommendation 3. The Under Secretary for Health ensures facility and network directors work with the Procurement and Logistics Office on a plan to identify resources and milestones to resolve identified supply chain management problems for identified facilities.

VHA Comments: Concur

The Supply Chain Committee, in conjunction with the VISN, will establish a plan to evaluate the results of the risk indicators to routinely identify what resources are required for identified facilities.

Status: In progress Target Completion Date: June 2025

Recommendation 4. The Under Secretary for Health directs the program office to develop a process to provide resources when needed to help networks and facilities resolve persistent supply chain management deficiencies, including those identified in this report.

VHA Comments: Concur

The SCC will develop a process to identify necessary actions at the VA Medical Center, VISN, and program office necessary to provide resources when needed based on the analysis of the risk indicator report. These will be published as a Notice to supplement VHA Directive 1761. The Notice will contain risk indicators to identify facility and/or VISN risks related to non-compliance with SCC requirements and will include a process to identify the necessary actions required in response to risk indicator results.

Status: In progress Target Completion Date: June 2025

Recommendation 5. The Under Secretary for Health continues Procurement and Logistics Office efforts to automate tracking that will accurately capture and monitor all quality control review results, corrective action plans, and implementation of those plans.

VHA Comments: Concur

The QCR Automation Workgroup project, in conjunction with VISNs and VA Office of Information Technology (OIT) Innovation team, will continue to develop an automated QCR tool. The program office will lead discussions, requirements, additional enhancements to monitor QCR results, corrective action plans, and implementation of those plans.

Status: In progress Target Completion Date: June 2025

Recommendation 6. The Under Secretary for Health updates the Procurement and Logistics Office audits of the quality control program to apply risk-based sampling, evaluate action plan sufficiency and implementation, and use the results to continuously improve quality control review guidance and requirements.

VHA Comments: Concur

VHA P&LO will update the QCR audit sampling based on facilities' previous year's risk indicators, such as high number of findings, lack of reporting action plans, and lack of closure of action plans. The QCR Audit SOP will be updated to include reviewing action plans and implementation of those action plans.

Status: In progress Target Completion Date: June 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.

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