VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Waste of Funds at the VA Medical Center in Madison, Wisconsin

September 30, 2016
15-00650-423

ACRONYMS

OR	Operating Room
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Highlights: Review of Alleged Waste of Funds at the VA Medical Center in Madison, WI

Why We Did This Review

The Office of Inspector General received an allegation regarding the potential waste of funds at the Madison VA Medical Center (VAMC), located in Madison, WI. The complainant alleged that the facility had purchased a laser lead extractor in 2012 for about $1 million and never used it. The complainant also alleged that the facility spent approximately $125,000 on a robot to distribute supplies that could not operate autonomously within the hospital and installed a patient lift for about $2,500, despite staff stating that they did not need it and would not use it.

What We Found

We substantiated the allegation that the Cardiology department did not use the laser lead extractor. We found that the facility did not purchase but leased this device at a cost of about $100,000. Even though the laser lead extractor had been on hand for nearly two and a half years, the Cardiology department was unable to use it because of operating room space utilization and staffing issues. Instead, the Cardiology department sent veterans to non-VA facilities to have the procedures performed. We determined that the VAMC officials involved in the decision to lease the device did not ensure the lease of the laser lead extractor was the most cost-effective approach for extracting pacemaker and defibrillator leads.

We found that the facility purchased two robots for nearly $313,000. We substantiated the allegation that the VAMC could not use the robots effectively because, when planning the acquisition, the logistics department did not consider whether the robots could operate effectively within the facility. As a result, the two robots have not been used in about 2 years. We concluded that the VAMC could have better used the roughly $410,000 it spent to lease the laser lead extractor and purchase the robots.

We did not substantiate the allegation regarding the patient lift. The facility installed the lift in response to an encounter with a double amputee bariatric patient and a Safe Patient Handling Program guidance. We found that the lift provides a benefit to employees and ensures the safety of patients when they need to be moved.

What We Recommended

We recommended the Veterans Integrated Service Network (VISN) 12 Acting Director ensure Madison VAMC management complies with facility policy requiring sufficient justification supporting equipment acquisition requests. We also recommended the VISN 12 Acting Director conduct an analysis to ensure VISN facilities are effectively utilizing any laser lead extractors.

Agency Comments

The VISN 12 Acting Director concurred with our recommendations and provided plans for corrective action. We will monitor planned actions and follow up on their implementation.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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Finding 1 The Madison VA Medical Center Acquired a Laser Lead Extractor It Did Not Use

Allegation

In February 2015, the Office of Inspector General (OIG) received an allegation that the Cardiology department at the William S. Middleton Memorial Veterans Hospital (Madison VAMC), located in Madison, WI, purchased a laser lead extractor in 2012 for about $1 million to remove old pacemaker and defibrillator leads from patients' hearts. The complainant alleged that the Cardiology department never used the laser lead extractor.

Leased Laser Lead Extractor Not Used

We substantiated the allegation that the Cardiology department did not use the laser lead extractor. While the complainant alleged that the Cardiology department purchased the device for about $1 million, we found instead that the facility had leased the device for nearly $100,000 from December 2012 through June 2015. The facility acquired the laser lead extractor in December 2012 after the Food and Drug Administration issued two recall notices related to faulty pacemaker and defibrillator leads. The Cardiology department planned to extract the faulty leads in-house rather than sending veterans to non-VA hospitals. The device was on hand until June 2015, at which time Madison VAMC officials canceled the lease. Despite having the laser lead extractor available for nearly two and a half years, the Cardiology department was unable to use the device due to operating room (OR) space utilization and staffing issues; instead, veterans were sent to non-VA hospitals—at VA expense—to have the procedures performed.

Madison VAMC officials, including the chief of staff, the chief of Cardiology, and other employees involved in the process of obtaining the laser lead extractor were unable to provide documentation to show the lease of the laser lead extractor was a cost-effective decision for the facility. When determining the need for this equipment, the chief of Cardiology did not ensure the facility had the capacity to perform the lead extraction procedures. The decision to lease the laser lead extractor resulted in the facility spending nearly $100,000 on a laser lead extractor that was not used.

Inadequate Acquisition Documentation

In December 2011, the Madison VAMC Director issued Hospital Memorandum No. 001-11-06. The memo states that service chiefs are responsible for identifying and analyzing the equipment needs of their service. The analysis should be consistent with the strategic goals and objectives of the hospital, and reflect the most cost-effective approach to meeting those goals. The memo also states that justification to support a purchase should include a cost-benefit analysis. However, the chief of staff, the chief of Cardiology, and other employees involved in the process of obtaining the laser lead extractor were unable to provide any detailed

documentation, such as a cost-benefit analysis showing that this lease was the most cost-effective approach for performing the lead extraction procedures.

We also found that the documentation used to support the continued lease of the laser lead extractor was inaccurate. For example, the facility contract coordinator gave us a market research document prepared by the nurse manager of Cardiology in December 2013, which stated that the device was in use and meeting their needs—despite the fact that the facility had never used it. We found that, subsequent to the preparation of this document, the VAMC had issued a contract effective May 1, 2014 to continue leasing the laser.

Because no documentation was prepared by the Cardiology department to justify the necessity for the laser lead extractor, we interviewed the chief of staff and the chief of Cardiology; we also reviewed contract documents to determine the rationale supporting the need for the device. We found that the facility acquired the laser lead extractor to address two Food and Drug Administration recall notices related to faulty pacemaker and defibrillator leads. These notices identified two types of leads that may require removal. When the notices were issued, the facility identified 39 veterans who had 1 of the 2 identified types of leads. By acquiring the equipment, the facility planned to perform the procedure in-house rather than send veterans to non-VA hospitals to have the procedure performed.[1]

Madison VAMC Could Not Perform the Procedure

The decision to lease the laser lead extractor was dependent on the Madison VAMC having the capacity to perform the lead extraction procedures in-house. The chief of Cardiology reported that the performance of the extraction procedure, while using the laser lead extractor, required the use of a hybrid OR. A hybrid OR is a specialized OR where staff can address any emergencies or complications that develop during a procedure without having to transfer the patient to another room, thus reducing the risk involved in transferring patients. At the time of the lease, the VAMC was undergoing renovations to relocate and expand the number of facility ORs. This construction included adding a hybrid OR, which did not open until September 2013, 9 months after the Madison VAMC leased the laser. Even after the opening of the hybrid OR, and despite having the laser lead extractor on hand for nearly two and a half years, the Cardiology department was still unable to perform the procedure in-house. According to the chief of staff and the chief of Cardiology, the Cardiology department could not perform the procedure because of OR space utilization and staffing issues.

[1] According to Madison VAMC officials, the Cardiology department monitored all veterans who had one of the identified types of leads and, when necessary, sent veterans to non-VA hospitals to have the laser lead extraction procedure performed.

We were unable to determine if Cardiology department officials were aware of the OR space and staffing issues at the time the facility entered into the lease. We found no evidence showing that Cardiology department officials performed an assessment to ensure that the facility had the capacity to perform the procedure before leasing the equipment. Had Cardiology department officials performed an assessment of the facility's current and anticipated future OR workload, it is likely they would have identified the effect the lead extraction procedures would have on staff and space. This, in turn, would have allowed officials to determine whether performing the procedures was feasible and, at the very least, delayed the decision to lease the equipment until adequate OR space and staff became available.

Additional Laser Lead Extractors Within the VISN

The laser lead extractor in Madison was one of three laser lead extractors in Veterans Integrated Service Network (VISN) 12. The Clement J. Zablocki VAMC, located in Milwaukee, WI, acquired the device in 2005, while the Edward Hines, Jr., VAMC, located in Chicago, IL, acquired a laser lead extractor at the same time as the Madison VAMC. Given that the recall notice affected a limited number of veterans and the OR space and staffing issues, Cardiology department officials could have considered the feasibility that another VA facility could perform some of the extraction procedures, rather than lease their own laser. For example, the Milwaukee facility is about 78 miles from the Madison facility. However, we did not find any indication that this was considered.

Inadequate Acquisition Planning

We determined that facility officials did not adequately ensure the lease of the laser lead extractor was the most cost-effective approach for addressing the need to remove faulty pacemaker and defibrillator leads from patients' hearts. The use of sufficient and accurate information is essential when making a determination of whether the expenditure of funds on any item is cost-effective. Failure to provide sufficient and accurate information puts the facility at risk of expending funds on equipment that may not represent the most cost-effective approach to meeting facility needs. Because Cardiology department officials did not ensure the lease was cost-effective, the facility spent nearly $100,000 on a device it did not use.

Conclusion

We substantiated the allegation that the Cardiology department never used the laser lead extractor. Facility leadership needs to take action to strengthen its controls over the acquisition of equipment and ensure all acquisition requests include sufficient and accurate documentation to support the need to acquire the equipment. If facility leadership does not take action to strengthen its controls, the facility is at continued risk of expending funds on equipment that provides little to no benefit.

Recommendations

1. We recommended the Veterans Integrated Service Network 12 Acting Director ensure management at the William S. Middleton Veterans Hospital complies with the facility policy requiring all equipment requests contain sufficient and accurate information to justify the acquisition request.

2. We recommended the Veterans Integrated Service Network 12 Acting Director ensure all laser lead extractors within the Veterans Integrated Service Network are being utilized to the extent possible.

Management Comments and OIG Response

The VISN 12 Acting Director concurred with our recommendations and provided plans for corrective action. We consider the planned actions to be acceptable. We will monitor implementation of planned actions and will close the two recommendations when we receive sufficient evidence demonstrating progress in addressing the issues identified. Appendix C provides the full text of the VISN Acting Director's comments.

Finding 2 The Madison VA Medical Center Purchased Robots That Could Not Operate Effectively Within the Hospital

In February 2015, the OIG received an allegation that the distribution department at the Madison VAMC spent about $125,000 on a robot[2] to distribute supplies to various departments throughout the VAMC. The complainant alleged that the robot could not operate autonomously and required an employee to follow it around because it would become stuck in doorways and block passages.

Purchased Robots Could Not Operate Effectively at the VAMC

We substantiated the allegation that the robot could not operate effectively at the VAMC. While the complainant alleged that the facility purchased one robot for about $125,000, we found that the facility had purchased two robots for a total cost of about $313,000. The facility acquired the robots in September 2012 to assist with the distribution of supplies throughout the facility. The use of these robots would give employees who normally distributed supplies the ability to focus on other priorities. Facility officials reported that the robots initially worked at the facility. However, problems began once the hallways included staff and patient traffic. For example, at the time of our site visit, the chief of logistics said that the robots would get stuck next to each other in the hallways and, in doing so, would block staff and patients from passing by. In an effort to mitigate the problems encountered with the robots, the facility employed different tactics to better utilize the robots. For example, the logistics department sent employees out with the robots and tried to use them at times when hallway traffic was minimal. Despite these efforts, the chief of logistics, at the time of our site visit, said that he determined their use was not effective and took them out of service in July 2014.

We found that the facility transferred the robots to the Clement J. Zablocki VAMC, located in Milwaukee, WI, in May 2015. Despite receiving the robots, the Clement J. Zablocki VAMC did not place them in service. Instead, the Clement J. Zablocki VAMC transferred them to the Edward Hines, Jr., VAMC, located in Chicago, IL, in October 2015. We discovered that the Edward Hines, Jr. VAMC excessed the robots in March 2016 and placed them up for auction. The facility sold the robots to the winning bidder−the manufacturer of the robots−in May 2016 for $1,937.

Inadequate Acquisition Planning

We found that when planning for the acquisition of the robots, the logistics department did not adequately plan for their use. Madison VAMC officials could not provide documentation showing that the logistics department had performed an assessment of whether the robots could operate effectively within the facility before they acquired them. Because of inadequate

[2] The robot consists of two parts, the tug and a cart. When combined, these parts are about 2 feet wide and 4 feet tall and can haul up to 500 pounds of supplies.

acquisition planning, we determined that the facility spent about $313,000 on two robots that could not operate effectively within the facility.

Federal Acquisition Regulation Part 7 requires agencies to perform acquisition planning. To assist in the planning of an acquisition, the facility implemented Hospital Memo No. 001-11-06, which states each acquisition request should contain sufficient justification and information to support the purchase. Because we found no documentation to support the acquisition of the two robots, we determined the logistics department did not adequately plan for the acquisition of the two robots.

Lack of Assessment To Determine Operational Effectiveness

We reviewed documents related to the acquisition of the robots and found nothing to indicate the logistics department considered whether the robots could operate effectively within the facility. Federal Acquisition Regulation Part 7 requires agencies to take into consideration any known capability or performance constraints that could affect the acquisition. Hospital Memo No. 001-11-06 suggests an assessment of the impact on patient care and other facility missions be included to support the purchase. Given that the robots were new to the facility, logistics officials should have performed an assessment to determine if the robots could operate as intended within the Madison VAMC.

The robots are programmed to avoid obstacles by adjusting their route when they detect an object up to 18 inches away. If the robots are unable to adjust their route, they will stop until the object is cleared. In light of this information, along with the design and layout of the facility (e.g., hallway widths, hallway foot traffic, and lack of a dedicated freight elevator), it would have been critical to assess whether the robots could operate within the facility. While the acquisition plan for the purchase of the robots stated that the robots worked at another facility within the VISN, this did not relieve the chief of logistics, at the time of purchase, of his responsibility to assess the feasibility of the robots' ability to operate effectively within his/her facility. Absent sufficient and reliable information, we found that this individual did not perform an adequate assessment of the robots' ability to operate within the design and layout of the Madison VAMC.

Failure To Adequately Plan for Acquisition

We determined that the chief of logistics at the time of purchase did not adequately plan for the use of the robots. The submission of sufficient and reliable information is essential when making a determination of whether the expenditure of funds on any item is in the best interest of the facility. Failure to provide sufficient and reliable information puts the facility at risk of expending funds on equipment that provides little to no benefit. Because of inadequate planning, the facility spent about $313,000 on two robots that could not operate effectively within the facility. Despite efforts made by the facility to transfer the robots to another facility, the robots were unused for approximately 2 years, and were auctioned off in May 2016 for $1,937.

Conclusion

We substantiated the allegation that the robots could not effectively operate within the Madison VAMC. Facility leadership needs to take action to strengthen its controls over the acquisition of equipment to ensure all acquisition requests include sufficient and reliable documentation to support the acquisition of the equipment. If facility leadership does not strengthen its controls, the facility is at continued risk of expending funds on equipment that provides little to no benefit.

Recommendation 1 of this report addresses the acquisition planning deficiencies identified and related to the purchase of the robots.

Management Comments and OIG Response

The VISN 12 Acting Director responded the physical structure of the Madison VA Hospital did not prohibit the appropriate use of the robots, as stated in the report. However, during our site visit the Acting Director of the VAMC, the Chief of Logistics, and the Chief of Engineering all made statements to the effect that the physical structure of the facility did have an impact on the use of the robots. As a result, we reported the robots could not be utilized effectively within the facility. This was evidenced by the fact that the facility took the robots out of service after making a significant investment in purchasing them. Our focus in reporting on the purchase of the robots was the facility's lack of planning for this acquisition and not whether the physical structure of the facility prohibited the robots use. We could find no evidence that facility personnel conducted an assessment of whether the robots could operate effectively within the facility before they acquired them.

The VISN 12 Acting Director concurred with the recommendation and provided acceptable plans for corrective action. We will monitor implementation of planned actions and will close the recommendation when we receive sufficient evidence demonstrating progress in addressing the issues identified. Appendix C provides the full text of the VISN Acting Director's comments.

Finding 3 The Madison VA Medical Center Purchased and Installed a Lift Required for Safe Patient Handling

In February 2015, the OIG received an allegation that the Madison VAMC purchased and installed a patient lift in a Cardiac Echocardiogram room at a cost of about $2,500. The complainant alleged that the Madison VAMC purchased and installed the patient lift despite echo cardiographers stating they did not need and would not use the equipment.

Patient Lifts Installed and In Use

We did not substantiate the allegation. While we confirmed the installation of a ceiling lift in Cardiac Echocardiogram Room 3, we did not consider it a waste of funds. We found that the Safe Patient Handling department had the ceiling lift installed in response to an incident with a patient, in addition to safe patient handling guidance received from the Veterans Health Administration[3] (VHA) and the facility.[4] The lift is for the benefit of not only the employees, but also ensures the safety of patients when there is a need to move a patient. Based on this finding, we do not question the $5,693 spent to acquire and install the ceiling lift in Cardiac Echocardiogram Room 3.

Safe Patient Handling Is Priority for VHA

We found that the Safe Patient coordinator had recommended the installation of a ceiling lift after an encounter with a bariatric double amputee patient. The Safe Patient coordinator reported that staff needed to move a patient, but the portable lift in place at the time was not capable of moving the patient safely. He said that while the staff were able to move the patient, he had recommended the installation of the ceiling lift, as this is the easiest and safest way to move patients.

In 2010, VHA issued a directive that provided policy for the implementation of a Safe Patient Handling program within facilities and background information as to why this type of program was necessary and cost beneficial. The directive also suggested that ceiling lifts, like the patient lift installed in the Cardiac Echocardiogram room, were more effective in patient handling and safer for the patient and caregiver than portable devices. In 2012, the facility issued a memo requiring the use of mechanical lift equipment and other patient-handling aids to the furthest extent possible for the lifting, transporting, transferring, and repositioning of patients, with the only exception being a recognized emergency.

During our site visit in September 2015, an echo cardiographer told us that the Echo staff had received training on how to use the lift and could use it if needed. In March 2016, Echo staff confirmed that they had recently used the

[3] VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*
[4] Hospital Memorandum No. 001S-12-05, *Safe Patient Handling Policy and Patient Care Ergonomics*

lift when they encountered a patient who required the use of the ceiling lift in order to perform a procedure.

Conclusion

We did not substantiate the allegation. We found there to be a valid purpose for the installation of the ceiling lift. Therefore, we did not consider the $5,693 spent to acquire and install the lift to be a waste of funds and thus offer no recommendations.

Appendix A Scope and Methodology

Scope

We conducted our review from September 2015 through August 2016. Our review focused on the acquisition and use of a laser lead extractor, two robots, and a patient lift installed in Cardiac Echocardiogram Room 3.

Methodology

We conducted a site visit in September 2015 at the William S. Middleton Memorial Veterans Hospital, located in Madison, WI, and conducted interviews with facility management and staff involved with the acquisitions. We also interviewed a representative from the VA's Great Lakes Acquisition Center. We reviewed applicable acquisition regulations, local equipment acquisition policies, as well as national and local policies for safe patient handling. We obtained and reviewed documentation used to support the justification to acquire the items mentioned in the allegation.

Data Reliability

We used computer-processed data obtained from facility officials to determine the cost of the laser lead extractor, the robots, and the patient lift. To assess the reliability of the data obtained, we compared the data provided to purchase orders and invoices received by the Madison VAMC to ensure the cost information was accurate. We concluded the data we obtained were sufficiently reliable for the purposes of this review.

Government Standards

We 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 Potential Monetary Benefits

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Costs associated with unused laser lead extractor	$98,809	$0
1	Costs associated with robots that were unable to operate effectively within the hospital	$310,962[5]	$0
	Total	**$409,771**	**$0**

[5] To calculate this amount, we started with the total cost of the robots ($312,899) and subtracted the amount received when they were sold at auction ($1,937).

Appendix C Management Comments

Department of Veterans Affairs

Memorandum

Date: August 26, 2016

From: Acting Director, VA Great Lakes Health Care System (10N12)

Subj: Draft Report, *Review of Alleged Waste of Funds at the Madison VA Medical Center* (Project Number 2015-00650-R1-0280)

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

1. Thank you for the opportunity to review the OIG draft report, Alleged Waste of Funds at the Madison VA Medical Center. I have reviewed the document and concur with the response as submitted.
2. The attachment contains the VISN 12 action plan for addressing the recommendations.
3. The physical structure of the Madison VA Hospital did not prohibit the appropriate use of these robots, as stated in the report. Madison did conduct a fifteen month trial period to implement a new technology to possibly increase operational efficiency; however this trial did not demonstrate the desired outcome. In this case, when it became apparent it was not going to be as successful as originally planned, the appropriate mechanism was utilized to excess the equipment.
4. If you have any questions, please contact Joe Zimmerman, VISN 12 Strategic Planner at 708-492-3923

(original signed by:)

RENEE OSHINSKI
Acting, Network Director

Attachment

Attachment

Recommendations

1. We recommended the Veterans Integrated Service Network 12 Director ensure management at the William S. Middleton Veterans Hospital complies with the facility policy requiring all equipment requests contain sufficient and accurate information to justify the acquisition request.

Concur/Non Concur

Target date for completion: December 31, 2016

Response: The Director of the William S. Middleton Memorial Veterans Hospital will ensure the local Equipment Committee minutes are submitted to the VISN 12 Capital Asset Manager (CAM) after each meeting, to include the justification section for approved equipment acquisitions. The VISN 12 CAM will coordinate a VISN evaluation of Equipment Committee minutes to assure purchase decisions are based on acquisition criteria and projected utilization in accordance with facility policy during 1st qtr FY 17. This evaluation will be shared with the Network Director.

2. We recommended the Veterans Integrated Service Network 12 Director ensure all laser lead extractors within the Veterans Integrated Service Network are being utilized to the extent possible.

Concur/Non Concur

Target date for completion: Completed August 23, 2016

Response: VISN 12 conducted a review of all laser lead extractor acquisitions. The Zablocki VAMC acquired a laser lead in 2005 and has consistently been using the equipment. Hines VAH began a lease for a laser lead extractor in 2013 and has been consistently utilizing the equipment since then. Both Hines and Zablocki had the acquisition proposals go through their respective equipment committees that evaluated space, staffing and projected workload.

For accessibility, the format of the original documents in this appendix has been modified to fit in this document.

OIG Note: The attachment to this attached memo was not included with documents received from the OALC.

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nick Dahl, Director Michael Cannata Ronald Comtois Zachery Jensen

Appendix E Report Distribution

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