



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of
the Durham VA Health Care
System in North Carolina



MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

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

FOR MORE
VA OIG REPORTS
CLICK HERE



**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the stewardship and oversight of funds by the Durham VA Health Care System in North Carolina and to identify potential cost efficiencies in carrying out medical center functions.¹ To accomplish this goal, the OIG identified areas that draw on considerable VA financial resources and made recommendations to promote the responsible use of VA's appropriated funds.

This review assessed the following four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight in place:

- I. **Open obligations oversight.** An open obligation is funding for items or services that are not considered closed or complete and have a balance associated with them. The healthcare system finance office should review and reconcile open obligations to ensure that performance dates are correct (i.e., beginning and ending dates are accurate); open balances are accurate and agree with source documents (e.g., contracts and purchase orders, receiving reports, invoices, and payments); and obligations beyond 90 days of the performance end date or without activity in the past 90 days are valid and should remain open. The review team focused on whether the healthcare system performed monthly reviews and reconciliations of sampled obligations to ensure that obligations with no activity for more than 90 days were valid and should remain open. For sampled open obligations with changes to the end date for the period of performance, the team assessed whether evidence from the healthcare system supported the changes.
- II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and obtain goods and services directly from vendors. The review team evaluated whether the healthcare system (1) adhered to strategic sourcing guidelines and considered establishing contracts when making purchases and (2) properly documented sampled transactions.² Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing.

¹ The healthcare system consists of the Durham VA Medical Center and outpatient clinics in Raleigh, Greenville, and Morehead City. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

² VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases," October 22, 2019. This policy defines strategic sourcing as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

- III. **Administrative staffing levels and accuracy of labor costs.** Administrative staff include positions such as medical support assistants, program support assistants, and administrative officers. A healthcare system that has more administrative staff than others of similar size and complexity may not be cost efficient. The review team examined whether the healthcare system managed its administrative staffing levels effectively and tracked the related labor costs accurately.
- IV. **Pharmacy operations and cost avoidance efforts.** To anticipate how much drugs will cost and when inventory needs to be restocked, an efficient healthcare system analyzes available data, such as prime vendor inventory management reports and inventory turnover rates.³ Consistent data review helps ensure that the healthcare system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system managed its pharmacy operations effectively and provided adequate oversight of inventory management.

The OIG selected the healthcare system and areas for review based on an analysis of VA data from the following sources:

- Office of Productivity, Efficiency & Staffing (OPES) efficiency opportunity grid (pharmacy operations and administrative staffing)
- Supply Chain Common Operating Picture (Medical Surgical Prime Vendor Program, although this review did not assess the use of that program)
- Reports from VA's Financial Management System (open obligations)
- US Bank data (purchase cards)

The OIG evaluated financial efficiency practices related to the identified areas for October 1, 2020, through March 31, 2021. The team conducted its review from May 2021 to January 2022, including a virtual site visit during the week of June 21, 2021. For more information about the review's scope and methodology, see appendixes B and C.

The findings and recommendations in this report should help the healthcare system identify opportunities for improving oversight and for ensuring the appropriate use of funds.

What the Review Found

The team identified several opportunities for improvement in the areas reviewed.

- I. **Open obligations oversight.** The healthcare system had 309 inactive obligations totaling \$81.7 million. Of these 309 obligations, 200 obligations totaling over \$74 million had no

³ The inventory turnover rate is the number of times inventory is used during the year. Low inventory turnover rates indicate inefficient use of financial resources.

activity for 181 days or more. The review team performed data analysis and selected 20 inactive obligations from March 2021 totaling \$68 million to determine if the facility's finance office personnel performed required reviews to assess the validity and necessity of the remaining funds associated with each obligation. The team was not able to verify that staff reviewed 17 of the 20 obligations as required by VA policy.⁴

According to finance office personnel, reviewing inactive obligations was not a priority and would be too much work each month, and the healthcare system relied on the Veterans Integrated Service Network (VISN) Centralized Accounting Unit to perform the reviews.⁵ However, the supervisory accountant for the VISN Centralized Accounting Unit was not aware of this requirement in VA policy or any report that would identify obligations with no activity for more than 90 days. The supervisory accountant further stated the initiating service should be responsible for this review. Failure to review inactive obligations leaves the facility vulnerable to the risk that those funds cannot be reobligated and used for other goods or services in that fiscal year to support veterans.

- II. **Purchase card use.** The review team determined that, contrary to VA policy, contracts were not considered when procuring goods and services on a regular basis for 21 of the 40 sampled fiscal year (FY) 2020 transactions (53 percent), totaling approximately \$328,000. Instead of establishing contracts for commonly purchased goods, staff used purchase cards. This occurred because approving officials and cardholders did not work together to adequately review and preapprove requests for goods and services before completing an open market purchase card transaction and determine if alternative contracting options were warranted or available.

Furthermore, 21 of the 40 transactions sampled were missing some required supporting documentation to verify that purchase card transactions were properly approved and payments were accurate. Due to inadequate supporting documentation, the healthcare system had \$308,000 in questioned costs for these transactions.⁶

Moreover, the purchase card coordinator did not always complete quarterly purchase card audits that could identify such issues. Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. According to the purchase card coordinator, the internal audits were paused due to the COVID-19 pandemic. According to an email from the deputy director of contracting, the audits should have resumed in June 2020, but the contracting

⁴ VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," October 2020.

⁵ VHA is organized into 18 regional VISNs, which manage and oversee medical facilities in their specified geographic areas.

⁶ 2 C.F.R. § 200.84. The term *questioned cost* means a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs.

office never received that notification. The purchase card coordinator acknowledged that the audits were not completed for the last two quarters of FY 2020 and the first quarter of FY 2021.

- III. **Administrative staffing levels and accuracy of labor costs.** The healthcare system had 105 more administrative full-time equivalent (FTE) staff than the expected number in FY 2021 through March 2021, according to the OPES administrative staffing model.⁷ The difference between the observed and expected number of administrative FTEs signifies the potential opportunity to improve efficiency and should be used as a starting point for deeper examination. The labor costs for these 105 personnel, based on the average salary for administrative staff in FY 2020, were approximately \$8.8 million and therefore warrant closer scrutiny to ensure the optimization of administrative positions.

The higher administrative staffing level at the healthcare system was caused by several factors. During the COVID-19 pandemic, the healthcare system established the Office of Public Health Epidemiology, which hired staff for approximately 40 temporary administrative positions. In addition, the healthcare system had a microsurgery service line and hosted national programs, so its staff were often tasked to national and local programs. Because the healthcare system provided justifications for the higher administrative staff level and has taken actions to monitor administrative staffing efficiency, the review team did not make any related recommendations.

The review team also examined salary cost data reviews and labor-mapping data reviews for seven pay periods from January 1 to March 31, 2021, and determined that salary cost data and labor-mapping reviews were not conducted as required for seven pay periods from January 1 to March 31, 2021, to ensure labor costs were recorded correctly. The review team found several cost-center errors for administrative employees. Although these errors were minimal, they could have been identified had consistent reviews been conducted. The three cost centers with the highest administrative staffing difference used tools other than the OPES grid to assess the appropriate number of FTEs and implemented strategies to oversee administrative staffing efficiency and management. Labor cost data affect budget formulation, forecasting, and staffing decisions. Without accurate labor cost data, the healthcare system's ability to improve its efficiency is limited.

- IV. **Pharmacy operations and cost avoidance efforts.** The healthcare system could improve pharmacy efficiency by narrowing the gap between the facility's observed drug costs and

⁷ One FTE is equal to one employee working full-time. The number of administrative FTEs is from the OPES administrative staffing model, which includes administrative and clerical personnel, as well as administrative-mapped FTEs. The expected number of administrative FTEs is a predicted value for a facility after accounting for differences in facility, patient, and geographic characteristics.

expected drug costs, bringing the turnover rates closer to the Veterans Health Administration (VHA)-recommended level and meeting requirements for noncontrolled drug line audits.

From FY 2018 through FY 2020, the healthcare system exceeded expected pharmacy costs by an average of \$4.6 million annually, reporting almost \$1 million under expected costs in FY 2018 and increasing to \$10.6 million over expected costs for FY 2020. Pharmacy leaders stated that due to community care, the facility had experienced higher pharmacy costs because non-VA providers tend to prescribe higher-cost drugs in comparison to VA providers.

In addition, the healthcare system's turnover rate for pharmacy inventory could be improved. The inventory turnover rate is the number of times inventory is replaced during the year and is the primary measure to monitor the effectiveness of inventory management. Low pharmacy inventory turnover rates can indicate inefficient use of financial resources for pharmaceuticals purchased and held in stock at the healthcare facility. In FY 2020, the healthcare system reported an inventory turnover rate of 8.01 for the Durham VA Medical Center and 6.52 for the Greenville Health Care Center compared to the VHA average of 10 and VHA's recommended level of 12, as established by the national Pharmacy Benefits Management program office. Furthermore, the healthcare system did not fully use reports from the prime vendor software package, manage drug inventories, or adjust stock levels in accordance with VHA policy. According to pharmacy personnel, instead of using handheld barcode readers and the ABC inventory analysis method as required by VHA policy, the healthcare system was using an "eyeball" approach, estimating the amount needed to fill the shelves.⁸ Additionally, healthcare system pharmacy procurement staff use a wish list provided by staff who worked the previous shifts instead of using calculated reorder points, reorder quantities, and demand forecasting for more accurate inventory management as required by policy.⁹ Failure to use demand forecasting could result in inaccurate reorder points and insufficient inventory levels to meet patient needs.

Finally, the healthcare system did not meet VHA policy requirements for noncontrolled drug line audits. These audits should be performed quarterly for specific drugs identified as potentially at high risk for diversion. In reviewing the healthcare system's quarterly noncontrolled drug line audits for FY 2020, the team found that four of 15 reported variances between the actual and predicted amount of on-hand inventory were calculated

⁸ The ABC classification method states that inventory point items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."

⁹ VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

incorrectly by the facility and that the reviews were inadequate. The VHA directive states that a review should be completed if the variance is greater than 5 percent. However, the Pharmacy Benefits Management online tool showed that an in-depth review was only required if the variance was greater than 10 percent. In addition, VHA policy requires the results of these reviews to be reported to healthcare system managers through the quality assurance process on a quarterly basis, and quarterly and annual summaries should be reported to the VISN Pharmacy Executive Committee, along with the results of the reviews and any follow-up actions taken. Interviews with pharmacy staff indicated these requirements were not being followed, and pharmacy leaders and staff were aware of the noncompliance with policy. Failure to fully complete these regular inventory audits can lead to increased risk of drug diversion, inaccurate drug inventory data, and the potential for unnecessary spending in the pharmacy program.

What the OIG Recommended

The OIG made nine recommendations to the healthcare system director and one recommendation to the director of contracting for Network Contracting Office 6, VA Mid-Atlantic Health Care Network. The number of recommendations should not be used, however, as a gauge of the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with effective financial efficiency practices and the strong stewardship of VA resources.

The OIG recommended the healthcare system director (1) ensure that staff are made aware of policy requirements for open obligations and that reviews are conducted as required.

To strengthen oversight of purchase card transactions, the OIG recommended the director of contracting for Network Contracting Office 6, VA Mid-Atlantic Health Care Network (2) ensure quarterly purchase card audits are performed as required. The OIG recommended the healthcare system director (3) establish controls to confirm that approving officials and purchase cardholders review their proposed purchases and make sure contracting is used when it is in the best interest of the government, (4) require purchase cardholders to submit a request for ratification for any unauthorized commitment,¹⁰ (5) develop measures to confirm that completed VA Form 0242 submissions are accurate and updated for all cardholders, and (6) ensure cardholders comply with record retention requirements.

The OIG also recommended the healthcare system director (7) establish controls to make certain that budget or accounting staff review the salary cost data each pay period and promptly address

¹⁰ VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. The directive defines *ratification* as an authorized official converting an unauthorized commitment to a legal contract.

cost center corrections with human resources staff as needed and (8) ensure service chiefs and supervisors review labor mapping for accuracy and completeness.

The OIG made two recommendations regarding pharmacy operations. The healthcare system director should (9) develop and implement a plan to increase inventory turnover closer to the VHA-recommended level and (10) develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy.

VA Comments and OIG Response

The director of the Durham VA Health Care System concurred with all recommendations and provided responsive corrective action plans. The director of contracting for Network Contracting Office 6 concurred in part with the finding and recommendation 2 as stated in the response provided by the director of the Durham VA Health Care System.

The OIG considers all recommendations open. The OIG will monitor the implementation of all planned actions and close the recommendations when the Durham VA Health Care System and Network Contracting Office 6 provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the director of contracting's comments, and appendix F includes the facility director's comments.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Executive Summary	i
Abbreviations	x
Introduction.....	1
Results and Recommendations	4
Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some End Dates Were Not Accurate.....	4
Recommendation 1	8
Finding 2: The Healthcare System Did Not Always Consider Using Contracts or Maintain Supporting Documentation	11
Recommendation 2	14
Recommendations 3–6.....	14
Finding 3: The Healthcare System Provided Justifications for Higher Administrative Staff Levels but Needed to Ensure All Administrative Labor Costs Were Recorded Correctly	17
Recommendations 7–8.....	22
Finding 4: The Healthcare System Could Improve Pharmacy Efficiency, Increase Inventory Turnover Rate, and Strengthen Oversight Controls.....	24
Recommendations 9–10.....	28
Appendix A: Healthcare System Profile.....	30
Appendix B: Scope and Methodology	31

Appendix C: Sampling Methodology33

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments35

Appendix E: VA Management Comments, Director of Contracting, Network Contracting
Office 636

Appendix F: VA Management Comments, Director, Durham VA Health Care System37

OIG Contact and Staff Acknowledgments42

Report Distribution43

Abbreviations

FTE	full-time equivalent
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
OIG	Office of Inspector General
OPES	VHA Office of Productivity, Efficiency & Staffing
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Review teams identify and examine financial activities that are under the healthcare system's control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.¹¹

This review focused on the Durham VA Health Care System in North Carolina. The OIG assessed the following four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 1, 2020, through March 31, 2021:

- I. **Open obligations oversight.** An open obligation is funding for an item or service that is not considered closed or complete and has an associated balance, whether undelivered or unpaid. Open obligations should be reviewed and reconciled by the healthcare system finance office to ensure that time frames are correct (i.e., beginning and ending dates are accurate), open balances are accurate and agree with source documents (e.g., contracts and purchase orders, receiving reports, invoices, and payments), and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.
- II. **Purchase card usage.** The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse. The review also focused on the use of contracts for repetitively ordered goods or services to garner greater savings for VA.
- III. **Administrative staffing levels and accuracy of labor costs.** Having a large number of administrative staff in healthcare facilities is often associated with cost inefficiency.¹² The team identified opportunities to potentially improve administrative staffing efficiency and evaluated whether the healthcare system recorded administrative labor costs correctly.
- IV. **Pharmacy operations and cost avoidance.** The review team assessed whether the healthcare system complied with applicable policies and used cost and performance data

¹¹ The Veterans Health Administration uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The Durham VA Health Care System was rated as a level-1a, high-complexity facility.

¹² "Administrative Staffing Model," VHA Office of Productivity, Efficiency & Staffing, accessed August 10, 2021, <http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx>. (This is an internal VA website not publicly accessible.)

to track progress toward goals developed by the national Pharmacy Benefits Management Office, improve pharmacy program operations, and identify and correct problems.

To assess these areas, the review team performed a virtual site visit at the Durham VA Medical Center during the week of June 21, 2021; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the healthcare system, see appendix A. For more information about the review's scope and methodology, see appendixes B and C.

Durham VA Health Care System

The Durham VA Health Care System serves more than 200,000 veterans in a 27-county area of central and eastern North Carolina. The healthcare system operates the Durham VA Medical Center and three outpatient clinics in Raleigh, Greenville, and Morehead City. In fiscal year (FY) 2021, the Durham VA Medical Center operated 151 hospital beds, with over 3,400 full-time equivalent (FTE) staff and provided services to over 74,000 veterans. The reported FY 2021 medical care budget exceeded \$951 million, a \$55 million increase (6 percent) over the FY 2020 budget of approximately \$896 million and an increase of over \$168 million (22 percent) from the FY 2019 budget of approximately \$783 million.

Facility and Review Area Selection

The review team evaluated VA data to identify healthcare systems with the greatest potential for financial efficiency improvements. The OIG obtained data from the Veterans Health Administration (VHA) Office of Productivity, Efficiency & Staffing (OPES) efficiency opportunity grid, the Supply Chain Common Operating Picture, reports from VA's Financial Management System, and US Bank data. The OIG compiled these data for all VA medical centers. The team used the efficiency opportunity grid to obtain information on pharmacy operations and administrative staffing, VA's Financial Management System reports for open obligations, and US Bank data for purchase cards. Supply Chain Common Operating Picture data were used to gather information about the Medical Surgical Prime Vendor Program, but this review did not assess the use of that program.

VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. It describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team obtained the facility rankings from three statistical models in the grid to assist in selecting facilities for

financial efficiency reviews: the stochastic frontier analysis model, the administrative FTE model, and the pharmacy expenditure model.¹³

¹³ Stochastic frontier analysis is a modeling principle to estimate the optimal or minimum cost (input) after controlling for risks and random factors for each VA medical center given a set of outputs and output characteristics. Based on the minimum cost, an efficiency score is derived for each facility; an efficiency score of 1 is most efficient or idealized, and values greater than 1 are associated with increasing inefficiency.

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a longstanding problem and was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2020 and FY 2019 audited financial statements.¹⁴ Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and ensure that staff follow VA policy regarding required reviews of open obligations.¹⁵ If reviews are not conducted, the facility is vulnerable to the risk that those funds cannot be reobligated and used for other goods or services in that fiscal year to support veterans.

The review team focused on the following areas related to open obligations:

- **Inactive obligations.** The review team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the reviewed inactive obligations were valid and should remain open. Inactive obligations have had no activity for more than 90 days.
- **End-date modifications.** The team identified open obligations with changes to the period of performance end date and reviewed evidence from the healthcare system that supported those changes. The period of performance is the time frame during which the goods or services are to be provided.

Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some End Dates Were Not Accurate

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations beyond 90 days of the period of performance end date or that have been inactive for more than 90 days, to ensure the obligation is still valid and funds are not underutilized.¹⁶ For these obligations, finance office personnel should verify with the initiating service or contracting

¹⁴ VA OIG, Audit of VA's Financial Statements for Fiscal Years 2021 and 2020, Report No. 21-01052-33, November 15, 2021; VA OIG, Audit of VA's Financial Statements for Fiscal Years 2020 and 2019, Report No. 20-01408-19, November 24, 2020; VA OIG, Audit of VA's Financial Statements for Fiscal Years 2019 and 2018, Report No. 19-06453-12, November 19, 2019. A material weakness is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

¹⁵ VA OIG, *Insufficient Oversight of VA's Undelivered Orders*, Report No. 17-04859-196, December 16, 2019. All recommendations in this report have been implemented and closed.

¹⁶ VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," October 2020.

officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should review data from VA’s Financial Management System against supporting documentation monthly to ensure reports, subsidiary records, and systems reflect proper costing, accurate delivery date/end date, and a correctly calculated unliquidated balance.¹⁷

Figure 1 shows the number and dollar amounts of inactive obligations for the healthcare system from October 2020 through March 2021.

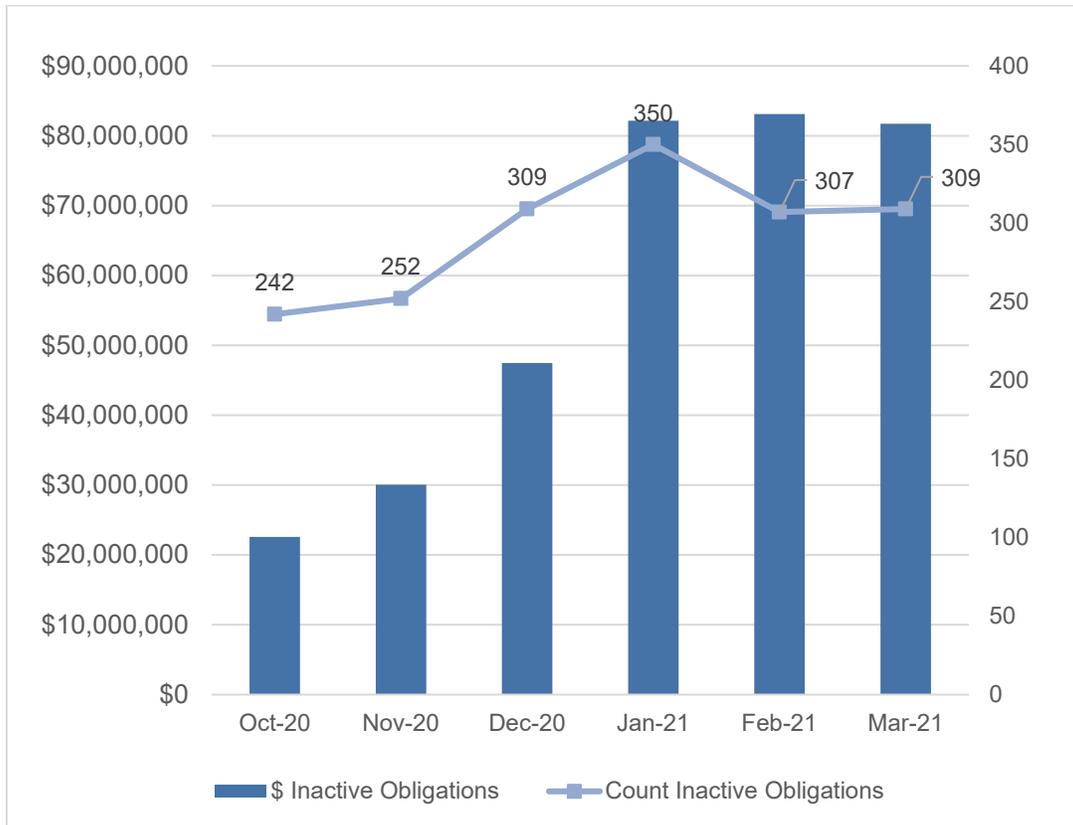


Figure 1. VA OIG analysis of inactive obligations for the Durham VA Health Care System, October 2020 through March 2021.

Source: VA Financial Management System F850 Report.

As of March 2021, the healthcare system had 309 inactive obligations totaling over \$81.7 million. Figure 2 shows the age and dollar amounts of the 309 obligations. As shown, 200 obligations totaling over \$74 million had no activity for 181 days or more.

¹⁷ 2 C.F.R. § 200.97. The term *unliquidated balance* means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

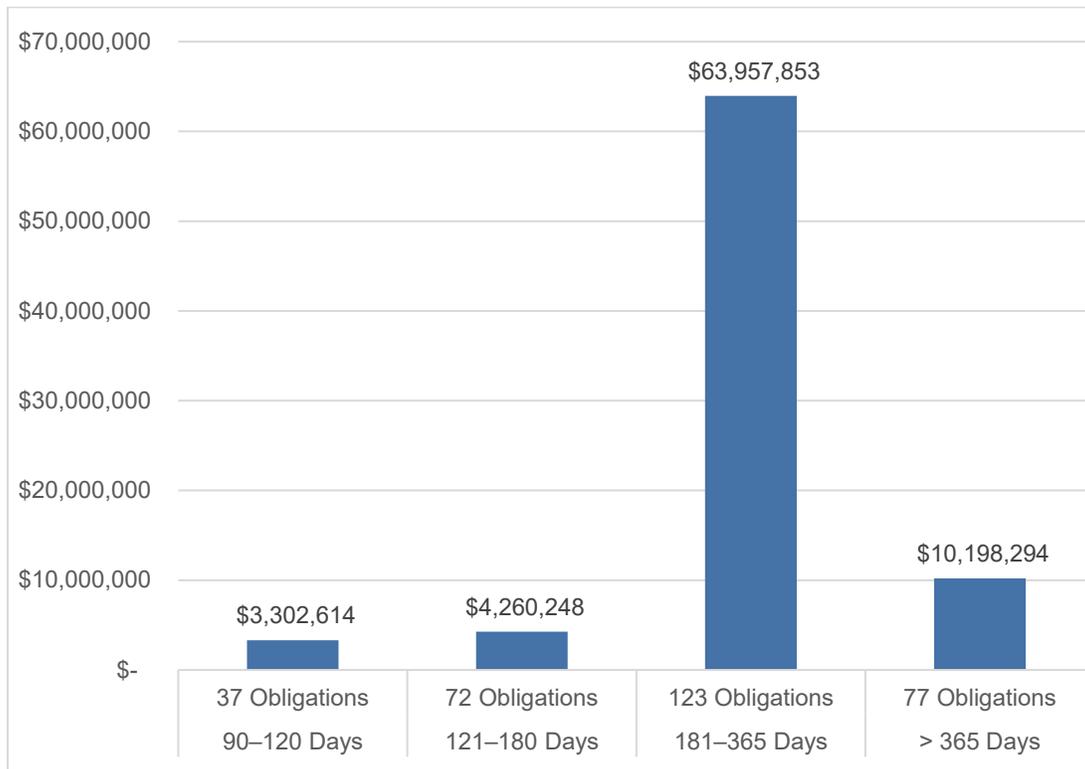


Figure 2. VA OIG analysis of inactive obligations for March 2021.

Source: VA Financial Management System F850 Report.

Inactive Obligations

The review team selected 20 inactive obligations from March 2021 totaling over \$68.4 million. The team reviewed supporting documentation to assess whether healthcare system staff identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.¹⁸ Ten obligations were still within the performance period, while the remaining 10 were more than 90 days past the performance period end date. See appendix B for additional details on scope and methodology and appendix C for details on the review’s sampling. The team was not able to verify that a review was completed on 17 of the 20 obligations.

The healthcare system uses a SharePoint tool to identify open obligations for review. The Veterans Integrated Service Network (VISN) 6 Centralized Accounting Unit created this tool in FY 2020 to help identify open obligations 60 days or more past the performance end date, which is more rigorous than VA policy, to identify open obligations 90 days past the performance end

¹⁸ VA Financial Policy, “Obligations Policy.”

date.¹⁹ The identifying report is loaded in the SharePoint tool for facility services to record the status of obligations, as well as any contracting actions taken or needed for end-date extensions. Healthcare system staff were trained on how to use the tool in January 2021. The tool, along with monthly executive leader response reports, should aid in identifying and documenting required monthly reviews of aged obligations.

Although the SharePoint tool showed the healthcare system that some of the obligations were past the performance period end date, these obligations were not always reviewed to determine whether they needed to remain open. According to finance office personnel, the sampled obligations past the end date were not always reviewed because the initiating services did not respond in a timely manner to requests for monthly reviews and adjustments of open obligations due to competing priorities. The initiating service is the individual or program office that initiated the request for the obligation and must be consulted before an open obligation can be closed.

Furthermore, the finance office did not always identify or review the remaining obligations that were within the performance period but were inactive for 90 days. VA policy states that open obligations should be reviewed by the finance office, in coordination with the initiating service, to ensure that obligations beyond 90 days of the period of performance end date or inactive in the past 90 days are valid and should remain open.²⁰ According to finance office personnel, reviews were not done because reviewing inactivity was not a priority and would be too much work each month, and the healthcare system relied on the VISN Centralized Accounting Unit to perform the reviews. However, the VISN Centralized Accounting Unit supervisory accountant was not aware of this policy requirement or any report that would identify inactive obligations beyond 90 days. The supervisory accountant further stated the initiating service should be responsible for this review.

End-Date Modifications

The review team selected and evaluated 15 open obligations, totaling approximately \$658,000, to determine if the end dates were accurate and reconciled between the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system (IFCAP), and VA's Financial Management System. IFCAP handles the processing of certified invoices and receiving documents to the VA Financial Management System. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.²¹ The

¹⁹ VHA is organized into 18 regional VISNs, which manage and oversee medical facilities in their specified geographic areas.

²⁰ VA Financial Policy, "Obligations Policy."

²¹ A control point is a financial element used to permit the tracking of monies from an appropriation or fund to a specified service, activity, or purpose.

end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other.

The team determined that VA's Financial Management System reflected accurate end dates for all 15 obligations; however, end dates were not reconciled and accurately recorded in IFCAP for seven of the 15 obligations totaling over \$12,000. The dates were not reconciled because end dates for obligations using VA Form 1358 cannot be modified in IFCAP due to system limitations; however, it appears the end-date modifications for the seven exceptions were due to exigencies created by the COVID-19 pandemic.²² Therefore, the review team was unable to conclude based on the evidence whether these issues would have existed without the pandemic. However, end dates are not reconciled monthly, as required by policy, nor identified for review of accuracy until 60 days or more past the obligations' performance end date. If the end date has passed and the obligation is no longer valid, those funds could be deobligated and used elsewhere.

Finding 1 Conclusion

Although the VISN Centralized Accounting Unit has provided support and is a resource for the healthcare system, it is the healthcare system's responsibility to identify and review inactive obligations and performance period end dates. Healthcare system personnel were noncompliant with VA policies and reported they were unaware of requirements for routine follow-up of open obligations. The review team found that open obligations with no activity for more than 90 days were not reviewed for validity and accurate end dates. Failure to properly manage open obligations increases the risk of not spending appropriations within the associated fiscal year and leaves funds attached to orders that could be closed and used for other purposes to benefit veterans.

Recommendation 1

The OIG made the following recommendation to the director of the Durham VA Health Care System:

1. Ensure finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."

²² VA Financial Policy, vol. 2, chap. 6, "1358 Obligations," app. A, "VA Form 1358 Approved Uses," October 2020. VA offices may use VA Form 1358 (1358) as an obligation control document only for certain limited uses.

VA Management Comments

The director of the Durham VA Health Care System concurred with recommendation 1. The responses to all report recommendations are provided in full in appendixes E and F.

To address recommendation 1, the director reported that the Centralized Accounting Unit staff are aware of the VA policy and are making changes to ensure open obligations with no activity for more than 90 days are reviewed. The assistant chief of fiscal service, in conjunction with station accounting and the Centralized Accounting Unit, will conduct monthly audits and disseminate the report to services included in the newly created report. In addition, finance office personnel will verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed.

OIG Response

The healthcare system director's action plan is responsive to the recommendation. The OIG will monitor implementation of the planned actions and will close the recommendation when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified.

II. Purchase Card Use

The VA Government Purchase Card Program was established to reduce the administrative costs related to acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and obtain goods and services directly from vendors. From October 1, 2020, through March 31, 2021, the Durham VA Health Care System spent approximately \$30 million through purchase cards, representing approximately 41,000 transactions. The amount and volume of spending through the VA Government Purchase Card Program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas:

- **Purchase card transactions.** The review team examined whether the healthcare system ensured that employees considered the most appropriate purchasing mechanism (e.g., obtaining contracts when procuring goods and services on a regular basis), which VA refers to as “strategic sourcing.” Using contracts in place of open market or individual purchases lowers the potential risk for split purchases or duplicate payments on purchase cards.²³ VA is also able to leverage its purchasing power through using competitively priced contracts.
- **Purchase card oversight.** The review team assessed whether the facility’s purchase card coordinator provided oversight of the purchase card program by conducting quarterly internal audits. The internal audit is an example of a systematic control that reduces the risk of error, fraud, waste, and abuse within the purchase card program.²⁴
- **Supporting documentation.** Documentation is required for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, and vendor invoices. Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

²³ VA Financial Policy, vol. 16, chap. 1B, “Government Purchase Card for Micro-Purchases,” October 22, 2019. Purchases that exceed the cardholder’s single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

²⁴ VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

Finding 2: The Healthcare System Did Not Always Consider Using Contracts or Maintain Supporting Documentation

The review team evaluated a judgmental sample of 40 purchase card transactions totaling over \$531,000 from October 1, 2020, through March 31, 2021, to determine whether the healthcare system's purchase card program considered using contracts and properly documented transactions.²⁵ See appendix B for more information on the review's scope and methodology and appendix C for details on the review's sampling. The team determined that contracts could have been considered for 21 of the 40 sampled transactions (53 percent), totaling just over \$328,000, due to multiple orders of similar products or services. In addition, 21 transactions sampled were missing some of the required supporting documentation needed to verify accuracy and approval of the purchase card transactions. The team also identified 18 transactions as potential split purchases that resulted in approximately \$128,000 of potentially unauthorized commitments.

These issues occurred, in part, because approving officials, purchase card coordinators, and cardholders did not work together to adequately review and preapprove requests for goods and services before completing an open market purchase card transaction. VA policy requires a review to ensure that cardholders properly communicate with the contracting office when a contract is warranted for the purchase of goods or services on a regular basis.²⁶ Additionally, a purchase card program coordinator did not conduct quarterly internal audits for the last two quarters of FY 2020 and the first quarter of FY 2021. Quarterly audits of the purchase card program, as well as more effective reviews by approving officials, could have detected and mitigated the lack of strategic sourcing and documentation issues identified, which resulted in approximately \$308,000 of questioned costs.²⁷

Purchase Card Transactions and Oversight

Pursuant to VA financial policy, VA should consider establishing contracts, which generally provide greater savings to VA than using purchase cards for open market acquisitions without a negotiated price.²⁸ Approving officials, the agency/organization program coordinator, and cardholders must review purchases to determine when it is in the best interest of the government to obtain contracts and ensure purchasers are obtaining the most competitive prices. Generally, VA should use contracts if the purchase is for an ongoing repetitive order of goods or services. Contracts must also be used when the total value of the requirement exceeds the micropurchase

²⁵ A judgmental sample is a nonstatistical sample that is selected based on auditors' opinion, experience, and knowledge.

²⁶ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

²⁷ 2 C.F.R. § 200.84. The term *questioned cost* means a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs.

²⁸ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

threshold or the cardholder's authorized single purchase limit.²⁹ Cardholders must not modify a requirement or order into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures. The requirement for the goods or services should be communicated to the contracting office for procurement.³⁰

The review team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single-purchase limit. The team selected 18 transactions totaling approximately \$128,000 to determine if cardholders split purchases. The team interviewed cardholders and approving officials to discuss the transactions. Based on its analysis of the 18 transactions and the interviews, the team was able to confirm that one transaction was a split purchase and an unauthorized commitment, as shown in the example below.³¹

Example 1

A facilities service assistant requested repair of three like-model sterilization machines totaling \$12,003. The cardholder placed the service orders with the vendor using two purchase orders, totaling \$9,000 and \$3,003. The single requirement, as evidenced in the request memorandum provided as supporting documentation for this transaction, was known to the cardholder at the time when the two purchases were made. Since the total need and cost were known at the time of purchase to exceed the cardholder's micropurchase threshold of \$10,000, these transactions constitute a split purchase.

The proper way to purchase commonly needed or high-cost goods above the purchase card limit is to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded—or established, if none exists—to purchase the products in time for scheduled use. Any VA purchase cardholder who makes an unauthorized commitment, including a split purchase, exceeding his or her level of authority has made an improper payment and must submit a request for ratification to the chief of the contracting office that provides contracting support to the organization involved.³²

²⁹ VA executive director memo, "Emergency Acquisition Flexibilities – Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19)", March 15, 2020, increased the micro-purchase threshold to \$20,000 for goods and services purchased in the United States due to COVID-19 and has not been rescinded. The previous micro-purchase threshold was \$10,000.

³⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

³¹ Unauthorized commitments occur when a purchase is made by a government representative who lacks the authority to bind the government or who exceeds his or her delegated authority, or purchases are made that are not in accordance with the Federal Acquisition Regulation and VA Acquisition Regulation.

³² VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. The directive defines *ratification* as the process by which an authorized official converts an unauthorized commitment to a legal contract.

Generally, the improper reliance on purchase cards and any related unauthorized commitments appeared to persist because approving officials did not adequately review those purchases to determine if alternative contracting options were warranted or available.

Moreover, the purchase card coordinator did not complete quarterly purchase card audits that could identify such issues. Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. Upon completion of the quarterly audit, VHA procedures require the purchase card coordinator to send a formal memorandum of audit results to the medical center director, with copies to the approving official or supervisor, no later than the end of the calendar month after the close of the quarter.³³ According to the purchase card coordinator, these internal audits were paused during the COVID-19 pandemic. An email from the deputy director of contracting in April 2021 stated the audits should have resumed in June 2020, but that notification was never received by the contracting office. The purchase card coordinator acknowledged that the audits were not completed for the last two quarters of FY 2020 and the first quarter of FY 2021. The purchase card coordinator completed the internal audit and memorandum for the second quarter of FY 2021 as required.

Additionally, the team found that eight of 17 cardholders responsible for the 40 transactions had a VA Form 0242 listing an inaccurate approving official or alternate approving official, as well as instances of inaccurate spending limits. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations relative to the purchase card program. A revised form is required when the approving officer changes, cardholders legally change their names, or the single-purchase limit is increased above the originally requested amount.³⁴

Supporting Documentation

VA financial policy requires cardholders to upload and store supporting documents for purchase card transactions electronically to a VA-approved document-imaging system.³⁵ When healthcare system staff buy goods and services using a purchase card, they must maintain supporting documentation—such as approved purchase requests, vendor invoices, purchase orders, and receiving reports—for six years. This documentation verifies that purchase card transactions were properly approved and payments were accurate.

³³ VHA Government Purchase Card Program, “Internal Audits—Purchase Cards and Convenience Checks,” Standard Operating Procedure, June 20, 2019.

³⁴ VA Financial Policy, vol. 16, chap. 1A, “Administrative Actions for Government Purchase Cards,” June 14, 2018.

³⁵ VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

The review team identified that 21 of the 40 transactions sampled were missing some required supporting documentation, which resulted in \$308,000 in questioned costs. This occurred because the healthcare system was not using the Charge Card Portal or another VA-approved document-imaging system for electronically storing purchase card documentation. In addition, the healthcare system had not implemented any other consistent process for storing all supporting documentation for purchase card transactions. Ultimately, approving officials did not ensure cardholders retained sufficient documentation to support purchase card transactions.

Finding 2 Conclusion

The healthcare system did not use contracts for certain commonly used goods. In addition, some of the sampled purchase card transactions were missing proper documentation. These issues, which resulted in at least \$308,000 of questioned costs, could have been detected by quarterly audits of the purchase card program and more effective reviews by approving officials. The healthcare system missed an opportunity to evaluate the purchase card program and its compliance with regulations and policies, as well as to improve the effectiveness of internal controls.

Recommendation 2

The OIG made the following recommendation to the director of contracting for Network Contracting Office 6, VA Mid-Atlantic Health Care Network:

2. Ensure quarterly purchase card audits are performed as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."

Recommendations 3–6

The OIG made the following recommendations to the director of the Durham VA Health Care System:

3. Establish controls to confirm approving officials and purchase cardholders review their purchases and make sure contracting is used when it is in the best interest of the government.
4. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.
5. Develop measures to confirm that completed VA Form 0242 submissions are accurate and updated for all cardholders.
6. Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. 16, "Charge Card Programs."

VA Management Comments

The director of the Durham VA Health Care System concurred with recommendations 2–6. The director of contracting for Network Contracting Office 6 concurred with the response from the Durham VA Health Care System, and per the response from the Durham VA Health Care System, the director of contracting for Network Contracting Office 6 concurred in part with recommendation 2.

To address recommendation 2, the Durham VA Health Care System response stated that the Network Contracting Office 6 director concurs “in part” and that although purchase card audit completion was temporarily suspended due to the COVID-19 pandemic, purchase card coordinators continued with quarterly account reviews in accordance with existing VHA policy. Further, Network Contracting Office 6 was not notified when the temporary audit suspension was lifted. This resulted in the quarterly audit finding memorandum to the medical center director “not being issued for completeness.” To ensure this process is fully compliant, the response stated that the VISN purchase card manager will track each memorandum until fully signed, upload each memorandum into the Network Contracting Office 6 SharePoint site, and report to the Network Contracting Office 6 director and deputy once completed.

For recommendation 3, the healthcare system director reported that among its actions, service chiefs and local leaders will increase acquisition and utilization specialist application, oversight, and FTEs to assist in identifying recurring card purchases that qualify for strategic sourcing opportunities. To address recommendation 4, the director reported purchase cardholders and approving officials must complete unauthorized commitment training every two years, and purchase card coordinators will continue to confirm all healthcare system personnel have completed all unauthorized commitment training in accordance with policies. Approving officials will use the purchase card preapproval and monthly reconciliation process to identify possible split or unauthorized purchases, and the Network Contracting Office 6 purchase card team will continue conducting monthly spot checks and take action as appropriate. For recommendation 5, the director reported a 100 percent quarterly review of employees’ VA Form 0242 will continue to be conducted and that healthcare personnel will notify purchase card program coordinators of changes. To address recommendation 6, the director reported that approving officials and cardholders must read purchase record retention guidance within VA financial policy and then attest their understanding by signing an acknowledgment and understanding document. During monthly cycle reconciliations, approving officials will ensure that all pertinent purchasing documents are available, and service chiefs and local leaders will ensure records are retained in accordance with National Archives and Records Administration and Federal Acquisition Regulation requirements.

OIG Response

The action plans the director of contracting and the director of the healthcare system provided are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations upon receiving sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Administrative Staffing Levels and Accuracy of Labor Costs

Large administrative overhead in healthcare facilities is often identified with cost inefficiency.³⁶ Medical centers can help ensure funds are appropriately spent by identifying potential indicators of inefficiencies, such as employing more administrative staff than VHA facilities that are similar in size and complexity. Differences in numbers of personnel serve as a starting point for deeper examination but in themselves do not indicate that the facility had an unnecessary number of administrative staff. Administrative personnel, such as medical support assistants, program support assistants, and administrative officers, help clinicians with administrative duties and facilitate the healthcare system's operations. Accordingly, staffing efficiency numbers should be a starting point for leaders to develop improvement strategies that consider effects on veterans' access to quality care. Oversight and controls on labor costs help ensure that accurate data are used for efficiency analysis and improvement.

The review team assessed the following administrative staffing areas:

- **Administrative staffing efficiency** involves comparing the facility's administrative staffing levels with those at comparable facilities.
- **Healthcare system resource management** includes how facilities oversee administrative staffing and address identified problems.
- **Salary cost and labor-mapping reviews** determine whether staff hours and salary were assigned the correct codes in VA's Financial Management System and Managerial Cost Accounting System based on the duties performed. This helps ensure that correct information is available for budget decisions and forecasting and allows facilities to compare data from one period to another.

Finding 3: The Healthcare System Provided Justifications for Higher Administrative Staff Levels but Needed to Ensure All Administrative Labor Costs Were Recorded Correctly

The healthcare system had 105 more administrative FTEs than the expected number in FY 2021 through March 2021, according to the OPES administrative staffing model.³⁷ The difference between the observed and expected number of administrative FTEs represents a potential opportunity to improve efficiency and should be used as a starting point for deeper

³⁶ "Administrative Staffing Model," VHA Office of Productivity, Efficiency & Staffing, accessed August 10, 2021, <http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx>. (The website is not accessible by the public.)

³⁷ One FTE is equivalent to one employee working full-time. The number of administrative FTEs is from the OPES administrative staffing model, which includes administrative and clerical personnel, as well as administrative-mapped FTEs. The expected number of administrative FTEs is a predicted value for a facility after accounting for differences in facility, patient, and geographic characteristics.

examination.³⁸ In this instance, the higher administrative staffing level at the healthcare system was caused by several factors. During the COVID-19 pandemic, the healthcare system established the Office of Public Health Epidemiology, which hired approximately 40 temporary staff to fill administrative positions. In addition, the healthcare system has a microsurgery service line and hosts national programs, so its staff are often tasked with supporting both national and local programs.

Among the cost centers in the healthcare system, the Medical Service, Health Administration Service, and Surgical Service had the largest administrative staffing differences when compared to the medical center group average.³⁹ These three cost centers used tools other than the OPES grid to assess the appropriate number of FTEs and implemented strategies to oversee administrative staffing efficiency and management. Because the healthcare system has taken steps to strengthen staffing efficiency and management, the OIG did not make any related recommendations.

Administrative Staffing Efficiency

Using the OPES administrative staffing model, the review team compared the healthcare system's observed administrative staffing to the expected staffing, as well as individual service lines' administrative FTE levels to those of similar VA facilities.⁴⁰ According to the administrative staffing model, the difference between the facility's actual administrative FTE level and expected administrative FTE level stayed about the same from FY 2019 to March 2021. The healthcare system had 110 FTEs over the expected administrative FTE level in FY 2019 and 105 FTEs over the expected administrative FTE level in FY 2021. Figure 3 shows the differences between the observed and expected levels.

³⁸ Additional scrutiny is warranted given the high cost of salaries—in this case, about \$8.8 million for the 105 administrative FTEs, which is based on the average salary for administrative staff in FY 2020.

³⁹ Cost centers are codes that help VA correctly identify and record costs. The medical center group average is the average of a group of VA hospitals that are similar in size and complexity as determined by OPES. The Durham VA Health Care System was a 1a-high complexity facility in FY 2021.

⁴⁰ The staffing model compares a facility's observed number of administrative FTEs to an expected number and compares the number of administrative FTEs in a cost center to the average of the same cost center in similar facilities.

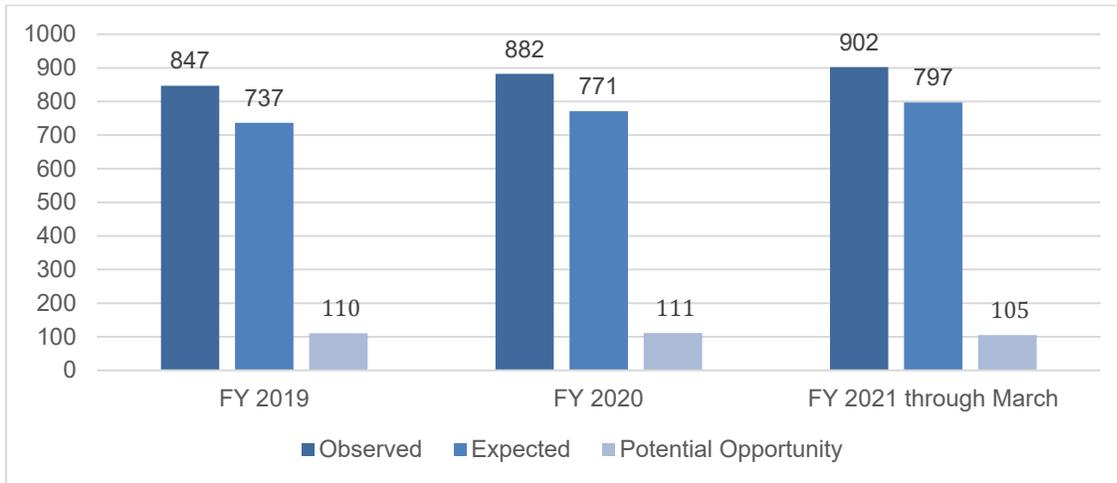


Figure 3. The healthcare system’s observed versus expected administrative FTEs between FY 2019 and FY 2021 through March.

Source: OPES efficiency opportunity grid administrative staffing model.

In FY 2021, three cost centers had the largest administrative staffing differences when compared to the average for similar VA medical facilities.⁴¹ Table 1 shows the differences for the cost centers.

Table 1. Healthcare System Cost Centers with Biggest Differences Compared to Similar VA Medical Facilities

Cost center	Durham VA Health Care System	Medical center group average	Difference
Medical Service	91	34	57
Health Administration Service	87	67	20
Surgical Service	34	17	17

Source: OPES efficiency opportunity grid administrative staffing model.

Through meetings with leaders and service-line staff, the review team determined that multiple factors affected the staff level of these three service lines in FY 2021:

- Medical Service.** This cost center included staff for the Office of Public Health Epidemiology, which the healthcare system established as a first-response team during the COVID-19 pandemic. VHA does not have a standardized cost center for this office; therefore, the healthcare system decided to include it under Medical Service. The Office

⁴¹ This is the average for the medical center complexity level group, a group of VA hospitals that are similar in size and complexity as determined by OPES.

of Public Health Epidemiology has approximately 40 temporary administrative positions, including administrative officers, medical support assistants, and screeners.

- **Health Administration Service.** Twenty-six administrative staff assigned to this cost center worked for and mapped their entire labor hours to a different cost center (Revenue Cycle Activity, cost center 8457) from January to March 2021. Although the labor mappings correctly reflected the workload, these employees should not have been counted as staff for Health Administration Service.
- **Surgical Service.** This cost center included employees who worked in the microsurgery service line because VHA does not have a separate cost center for this service line. According to the healthcare system leaders, this is the only microsurgery service line in VISN 6. The microsurgery service has 15 administrative employees, which helps account for the Surgical Service having more administrative staff than the average for similar VA medical facilities.

Healthcare System Resource Management

The healthcare system has a resource management committee with a mission to ensure efficient, effective, and appropriate allocation and use of facility resources. According to the associate director, the resource management committee meets regularly to review staffing reports and vote on position requests. The finance office uses a report from the VHA Allocation Resource Center to monitor administrative staff efficiency.⁴² This report calculates ratios between direct administrative costs and direct medical costs for facilities and displays VISN and national averages. In addition, the healthcare system has a group practice manager team that routinely audits medical support assistants for scheduling accuracy and reviews providers' labor-mapping data to ensure mapping to administrative areas is appropriate.⁴³

Because the healthcare system provided justifications for the higher administrative staff level and has taken actions to monitor administrative staffing efficiency, the OIG did not make any related recommendations.

⁴² The VHA Allocation Resource Center's website displays multiple resource management reports, including unit cost reports. The Direct Administrative Costs per Direct Medical Costs Report is used to evaluate administrative staffing efficiency.

⁴³ In 2015, VHA created the group practice manager position to provide oversight and administrative management of ambulatory care services in VA medical centers and related community-based outpatient clinics to improve access to care.

Salary Cost and Labor-Mapping Reviews

VA financial policy requires two types of reviews of labor cost data:

1. **Salary cost reviews.** These reviews determine whether employees' hours and salaries are assigned to the correct cost center using an accurate budget object code.⁴⁴

- A **cost center** helps VA correctly identify and record costs. Cost centers identify the office and function as part of the accounting record for financial transactions. The accuracy of labor costs in VA's Financial Management System, the core accounting system, depends on human resources staff selecting the correct cost center.
- **Budget object codes** reflect the nature of financial transactions. In accordance with VA financial policy, administrative employees should be assigned to budget object code 1001 or 1002. The policy also requires that finance personnel record financial obligations and expenditures in accordance with appropriate budget object codes.⁴⁵

Budget or accounting staff at each facility are required to review the salary cost data each pay period and promptly address cost center corrections with human resources as needed.⁴⁶ This review ensures cost data are recorded accurately in VA's Financial Management System.

2. **Labor-mapping reviews.** To ensure that VA cost information is accurate, employees must have their hours and salary correctly assigned, or mapped, to the functional cost centers, known as account level budgeter cost centers, where they perform their duties. VA policy requires service chiefs and organizational leaders to review labor mapping periodically for accuracy and completeness.⁴⁷

The review team examined salary cost data reviews and labor-mapping data reviews for seven pay periods from January 1 to March 31, 2021. Salary cost data and labor-mapping reviews were not conducted as required to ensure labor costs were recorded correctly. Cost center errors lead to an inaccurate number of FTEs reported for service lines in VA's Financial Management System. The review team found several cost-center errors for administrative employees. Although these errors were minimal, they could have been identified earlier if reviews had been conducted routinely.

⁴⁴ VA Financial Policy, vol. 13, chap. 2, "Budget Object Class Codes," October 20, 2020; VA Financial Policy, vol. 13, chap. 3, "Managerial Cost Accounting," December 10, 2019. Budget object codes correspond to financial obligations according to the nature of the services or items purchased by the federal government.

⁴⁵ VA Financial Policy, "Budget Object Class Codes."

⁴⁶ VA Financial Policy, "Managerial Cost Accounting."

⁴⁷ VA Financial Policy, "Managerial Cost Accounting."

Similarly, the healthcare system did not always review labor mappings, and the review team found some labor-mapping errors. To facilitate productivity analyses and other important analyses, VA policy requires healthcare system staff to review individual physician and dentist labor mapping to ensure that it is accurate and current within three working days after the close of the calendar month. Physicians in the healthcare system mapped time to different cost centers in administrative, research, teaching, and clinical areas; however, because their labor mappings were not always reviewed, the healthcare system did not have assurance that these were accurate. Inaccurate labor mapping to administrative areas reduces providers' bookable time for patient care and inflates productivity analysis results. For providers' productivity analyses, only the clinical portion of the hours worked is considered; hours associated with administration, research, and education are excluded. Routine reviews of labor mapping help ensure that cost information and productivity analysis results are correct and allow facilities to compare one period to another.

Finding 3 Conclusion

The healthcare system had higher administrative staffing than the medical center group average of similarly sized facilities, some of which can be attributed to additional services and national programs provided at the healthcare system. Differences in numbers of personnel should be a starting point for deeper examination but in themselves do not determine whether the healthcare system had too many administrative staff. The labor costs for these personnel differences are millions of dollars and therefore warrant closer scrutiny to ensure the optimization of administrative positions and salary dollars.

Healthcare system leaders have taken actions to monitor administrative staffing efficiency, such as the resource management committee reviewing and approving all position requests and the service lines tracking workload. The healthcare system's cost center assignment and labor mapping were generally adequate. However, some errors could have been identified had reviews been conducted more consistently. Because labor cost data affect budget formulation, forecasting, and staffing decisions, without accurate labor cost data, the healthcare system's ability to improve its efficiency is limited.

Recommendations 7–8

The OIG made the following recommendations to the director of the Durham VA Health Care System:

7. Establish controls to make certain that budget or accounting staff review the salary cost data each pay period and promptly address cost center corrections with human resources staff as needed.
8. Ensure service chiefs and supervisors review labor mapping for accuracy and completeness.

VA Management Comments

The director of the Durham VA Health Care System concurred with recommendations 7 and 8. To address recommendation 7, the director reported that fiscal service established controls through salary cost data audits performed each pay period by budget staff. Budget staff will communicate any necessary corrections to human resources promptly. For recommendation 8, the director reported the cost accounting site manager will conduct audits of the supervisors' and service chiefs' labor mapping to ensure accuracy and completeness, and training sessions for supervisors and service chiefs will be conducted in the third and fourth quarters of FY 2022 to strengthen the knowledge base and deepen understanding of core mapping principles.

OIG Response

The healthcare system director's action plan is responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

IV. Pharmacy Operations and Cost Avoidance Efforts

In FY 2020, prescription drug spending at the Durham VA Health Care System was approximately \$97.2 million, which represented almost 11 percent of the healthcare system's \$896 million budget. Because pharmacy accounts for a substantial percentage of any medical center's budget, it is important for medical center leaders to analyze spending and identify opportunities to use pharmacy dollars more efficiently. The review team used the pharmacy cost model in the OPES efficiency grid to identify opportunities for improvement at the healthcare system.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** allow VHA facilities to track cost performance and identify potential opportunities for improvement.
- **Inventory turnover rate**, or the number of times inventory is replaced during the year, is the primary measure to monitor the effectiveness of inventory management per VHA policy.⁴⁸ Low inventory turnover rates can indicate inefficient use of financial resources.
- **Noncontrolled drug line audits** should be performed quarterly for specific drugs identified at high risk for diversion and are required by VHA policy.⁴⁹

Finding 4: The Healthcare System Could Improve Pharmacy Efficiency, Increase Inventory Turnover Rate, and Strengthen Oversight Controls

The healthcare system could improve pharmacy efficiency and reduce the difference between observed and expected drug costs, increase its inventory turnover rate closer to the VHA-recommended level, and meet noncontrolled drug line audit requirements. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs, and can decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system had approximately \$97.2 million in drug costs in FY 2020. According to the model, this amount was approximately \$10.6 million higher than the expected costs of about \$86.6 million. Based on these numbers, the facility's

⁴⁸ VHA Directive 1761(2), *Supply Chain Inventory Management*, app. H, December 30, 2020. Inventory turnover is based on total dollar value purchased for the year divided by dollar value of items on the shelf.

⁴⁹ VHA Directive 1108.08 (1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

observed-to-expected ratio was 1.12, which ranked it 118 out of 139 VHA facilities for pharmacy drug cost efficiency.

For FY 2018 through FY 2020, the healthcare system exceeded expected costs by an average of \$4.6 million annually, reporting almost \$1 million under expected costs for FY 2018 and increasing to \$10.6 million over expected costs for FY 2020. Pharmacy leaders stated that due to community care, the facility had experienced higher pharmacy costs because non-VA providers tend to prescribe higher-cost drugs in comparison to VA providers. Figure 4 shows the observed-to-expected drug costs for the healthcare system.

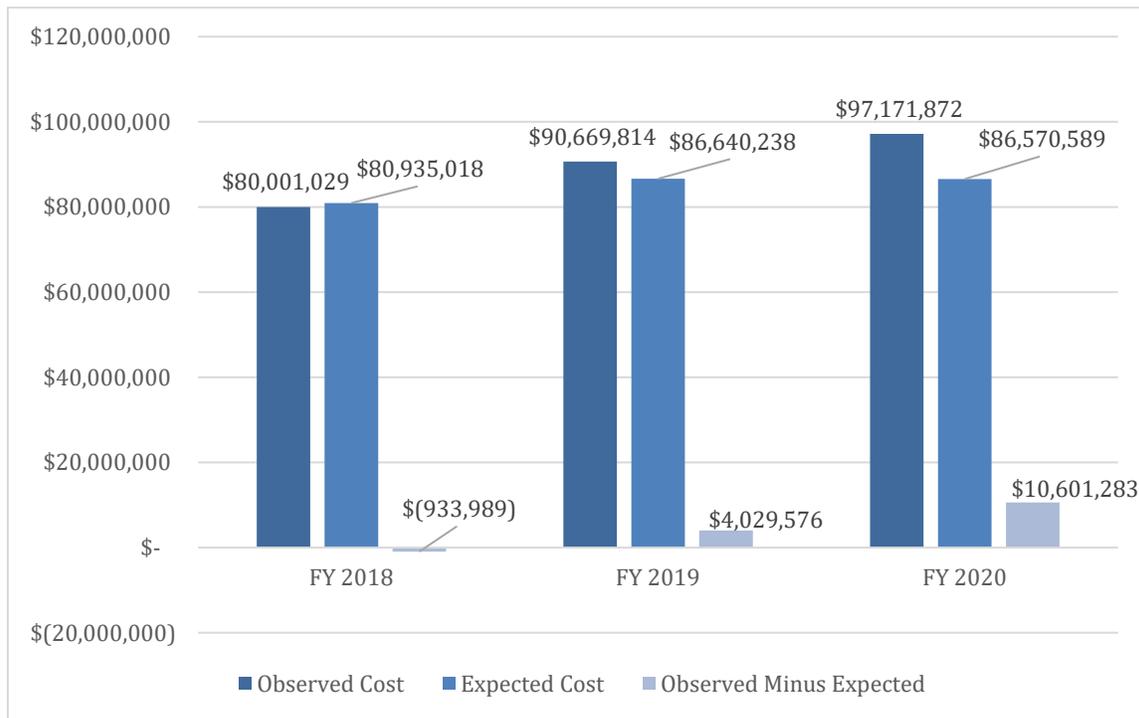


Figure 4. Observed versus expected drug cost, FYs 2018–2020.

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous FY data (i.e., the FY 2021 data model was based on FY 2020 data).

In response to this issue, the healthcare system has taken a unique approach to community care prescription management. The Care in the Community pharmacy unit was established in September 2019, with a team of two pharmacists and three technicians; this unit acts as a gatekeeper for outside prescriptions coming into the healthcare system. According to OIG analysis, in FY 2021 the community care–prescribed cost per prescription was \$101 compared to \$47 for in-house prescriptions. The Care in the Community pharmacy unit works closely with community providers to suggest alternative medications that often meet VA formulary criteria

and are a lower-cost alternative than what was originally prescribed.⁵⁰ A study completed in FY 2021 by the healthcare system and provided to the OIG team identified Care in the Community pharmacy efforts resulted in \$515,871 in direct cost savings during a six-month period. This was a net savings after calculating the cost of the staff that comprise the Care in the Community team.

Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.⁵¹ Increasing the inventory turnover rate decreases inventory carrying cost, which is the cost associated with holding inventory in storage. VHA policy also mandates the use of an inventory management system to manage all VA medical facility pharmacy inventories.⁵²

In FY 2020, the healthcare system reported an inventory turnover rate of 8.01 for the Durham VA Medical Center and 6.52 for its Greenville Health Care Center, compared to the VHA average of 10 and VHA's recommended level of 12 as established by the national Pharmacy Benefits Management program office. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast needed amounts of drugs to meet patient care needs. In addition to manually filling orders, pharmacy managers stated that the healthcare system uses automated dispensing equipment filled with high-cost and fast-moving drugs. These automated systems have forecasting tools that, according to facility pharmacy managers, are used to improve inventory turnover and drug inventory management. However, the review team determined that the healthcare system did not fully utilize inventory reports from the prime vendor, manage drug inventories, or adjust stock levels in accordance with VHA policy. According to pharmacy personnel, instead of using handheld barcode readers and the ABC inventory analysis method as required by VHA policy, pharmacy staff used an "eyeball" approach to estimate the amount needed to fill the shelves.⁵³ Additionally, the facility pharmacy procurement staff used a wish list provided by the staff who worked the previous shifts instead of using calculated reorder points and reorder quantities with demand forecasting for more accurate inventory management as required by policy.⁵⁴ Demand forecasting applies weighting factors to

⁵⁰ The VA formulary is a listing of products (e.g., drugs and drug-related supplies) that must be available for prescription at all medical facilities.

⁵¹ VHA Directive 1761(2), app. H.

⁵² VHA Directive 1761(2), app. H.

⁵³ The ABC classification method states that inventory point items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."

⁵⁴ VHA Directive 1108.08(1).

past purchases and must be used in calculating both the reorder points and reorder quantities for more accurate inventory management.

Noncontrolled Drug Line Audits

VHA policy states that regular facility-based inventory audits should be performed for specific drugs identified as at high risk for diversion. A manual count of each drug item selected must be completed and compared to reports and other tools chosen by local pharmacy managers. The variance between the observed and predicted amount on hand for the reporting period must be calculated. Variances greater than 5 percent require the healthcare system to perform an in-depth review and analysis.⁵⁵

The OIG team reviewed the facility quarterly noncontrolled drug line audits for FY 2021 and determined that they did not meet the requirements of VHA policy. The team identified the following issues:

- **Inaccurate calculations.** When the team calculated and reviewed quarterly variances greater than 5 percent, it found that the facility inaccurately calculated four of the 15 reported variances.
- **Inadequate reviews.** The healthcare system's calculated percentage variance and the variance explanations did not demonstrate evidence that the reviews were in depth and reflected the appropriate analysis required by VHA policy.
- **Missed reviews.** The VHA directive states that the healthcare system must complete an in-depth review if the variance between the actual and predicted amount of inventory on hand is greater than 5 percent. Durham pharmacy personnel stated that they used an online tool provided by the Pharmacy Benefits Management program office to complete this quarterly audit. However, the Pharmacy Benefits Management online tool showed that an in-depth review was only required if the variance is greater than 10 percent. Therefore, the healthcare system did not conduct an in-depth review due to contradictory VHA and Pharmacy Benefits Management guidance and was found noncompliant with VHA policy. Pharmacy Benefits Management personnel confirmed that the online tool does not align with VHA policy.
- **Unreported reviews.** VHA policy requires the results of these audits to be reported to facility management through the quality assurance process on a quarterly basis, and quarterly and annual summaries should be reported to the VISN Pharmacy Executive Committee indicating the results of the reviews and any follow-up actions taken. An

⁵⁵ VHA Directive 1108.08(1).

interview with pharmacy staff indicated these requirements were not being followed and pharmacy leaders and staff were not aware of this noncompliance with VA policy.

Failure to fully complete these regular inventory audits can increase the risk of drug diversion, inaccurate drug inventory data, and unnecessary spending in the pharmacy program.

Finding 4 Conclusion

The healthcare system has taken a proactive approach to improving pharmacy efficiency by establishing a Care in the Community pharmacy unit. This unit works closely with community providers to suggest alternative medications that often meet VA formulary criteria and are a lower-cost alternative than what was originally prescribed. Although the gap between observed and expected drug costs has not been reduced yet, this is a positive step. The healthcare system could further improve efficiency by increasing inventory turnover, as well as improving inventory management and demand forecasting. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked. Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 9–10

The OIG made the following recommendations to the director of the Durham VA Health Care System:

9. Develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.
10. Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy.

VA Management Comments

The director of the Durham VA Health Care System concurred with recommendations 9 and 10. To address recommendation 9, the director reported that pharmacy service will expand use of the required ScriptPro Inventory Management System to assist with establishing calculated reorder points and quantities for purchased outpatient stock. The Durham VA Health Care System conducted its inventory in January 2022 and is awaiting results. The director requested that the healthcare system report on progress following the inventory scheduled in January 2023 to demonstrate effects of proposed improvements for inventory turnover rates. For recommendation 10, the director reported that all noncontrolled audits were completed per VHA policy; recent audits identified less than a 5 percent variance and thus required no additional internal follow-up reporting. The Pharmacy Benefits Management online tool that inaccurately communicated a need for follow up action for variances greater than 10 percent has also since been corrected to reflect 5 percent or greater variance and now aligns with VHA policy.

OIG Response

The healthcare system director's action plan is responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Healthcare System Profile

Table 1 provides general background information for this level-1a, high-complexity facility reporting to VISN 6.⁵⁶

Table A.1. Facility Data for Durham VA Health Care System as of September 30, 2021

Item	FY 2019	FY 2020	FY 2021
Total medical care budget	\$782,823,537	\$896,345,182	\$951,369,718
Number of patients	68,330	68,179	74,171
Outpatient visits	780,682	741,450	869,704
Total medical care FTEs	3,329	3,397	3,455
Number of operating beds:	151	151	151
Hospital			
Community living center	100	100	100
Average daily census:	121	104	116
Hospital			
Community living center	59	40	28

Source: VHA Support Service Center, Trip Pack and Operational Statistics report.

Note: The OIG did not assess VA's data for accuracy or completeness.

⁵⁶ The facility complexity model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

Appendix B: Scope and Methodology

Scope

The OIG conducted its review of the Durham VA Health Care System from May 2021 to January 2022, including a virtual site visit during the week of June 21, 2021. The review team evaluated financial efficiency practices for FY 2020 related to open obligations and purchase card transactions. The team also analyzed financial efficiency practices related to the healthcare system's administrative FTE labor costs and pharmacy costs using the FY 2021 OPES data model; however, the FY 2021 data model was based on FY 2020 data.

To conduct the review, the team

- interviewed facility leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, and addressing inefficiencies in administrative FTE and pharmacy costs;
- judgmentally sampled 20 inactive obligations to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy and 15 obligations to review end-date modifications; and
- judgmentally sampled 40 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Data Reliability

The review team used computer-processed data obtained from US Bank files through the corporate data warehouse, a central repository for such bank information updated monthly and the OPES efficiency opportunity grid. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The review team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase order numbers, payment dates, payee names, payment amounts, vendor identification numbers, and check numbers as provided in the data received in the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives.

In addition, computer-processed data included reports from VA's Financial Management System to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the facility's open obligations.

Government Standards

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

Appendix C: Sampling Methodology

Open Obligations

The review team evaluated a judgmental sample of open obligation transactions from October 2020 through March 2021 to determine if (1) the Durham VA Health Care System performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open and (2) the facility had evidence to support end-date modifications to the period of performance.

Population

During March 2021, the facility had 978 open obligations, totaling approximately \$169 million. Of those open obligations, 309 obligations, totaling approximately \$82 million, had no activity for more than 90 days. From October 2020 through March 2021 there were 69 obligations with 74 end-date modifications totaling over \$63 million.

Sampling Design

The review team selected two judgmental samples:

- **Inactive obligations.** The team selected 20 obligations with no activity for more than 90 days from the March 2021 Financial Management System F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, while the remaining 10 were more than 90 days past the performance period end date.
- **End-date modifications.** The team selected 15 obligations with modified end dates to the period of performance for all open obligations from Financial Management System F850 reports for October 2020 through March 2021.

The samples included 35 total open obligations: 20 with no activity for more than 90 days, totaling approximately \$68 million, and 15 with end-date modifications, totaling approximately \$658,000.

To review the sampled obligations, the team requested supporting documentation for each of the 35 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Projections and Margins of Error

The review team did not use projections and margins of error because statistical sampling was not used.

Purchase Cards

The review team evaluated a judgmental sample of FY 2021 purchase card transactions to determine if (1) the Durham VA Health Care System's reviewed purchase card payments were adequately monitored, approved, and supported by documentation and (2) the reviewed transactions complied with processes to prevent split purchases and transactions exceeding the cardholder's authorized single purchase limit and to ensure goods or services were procured using strategic-sourcing procedures.

Population

During the first two quarters of FY 2021 (October 1, 2020–March 31, 2021), purchase cardholders at the facility made about 41,000 purchase card transactions totaling approximately \$30 million. There were 139 bundles of transactions that could be potential split transactions, including 3,259 individual transactions. The other potential high-risk transactions were selected from the remaining 38,000 transactions.

Sampling Design

The review team selected two judgmental samples:

- **Potential split purchases.** The team identified 30 transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single purchase limit.
- **Other potential high-risk purchase areas.** The team identified 10 transactions that involved an area of potential risk, such as merchants not commonly associated with a medical facility, purchases that included sales tax, or timing of purchases.

The sample included 40 total individual transactions, 30 potential split-purchase transactions totaling approximately \$289,000, and 10 high-risk transactions totaling approximately \$242,000 in spending.

To review the sampled transactions, the team requested supporting documentation for each of the 40 sampled transactions, VA Form 0242s, and documentation to support the completion of quarterly purchase card audits.

Projections and Margins of Error

The review team did not use projections and margins of error because it did not use a statistical sample.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs ⁵⁷
5	Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. 16, "Charge Card Programs."		\$308,000
	Total		\$308,000

⁵⁷ 2 C.F.R. § 200.84. As stated earlier, the term *questioned cost* includes a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation.

Appendix E: VA Management Comments, Director of Contracting, Network Contracting Office 6

Department of Veterans Affairs Memorandum

Date: February 18, 2022

From: VISN 6 Contracting Office

Subj: Draft Report, Financial Efficiency Review of the Durham (NC) VA Health Care System (2021-02458-AE-0111)

To: Director, Office of Inspector General for Audits and Evaluations (52)
Assistant Inspector General for Audits and Evaluations

1.I have reviewed and concur with the findings and response for Recommendation 2, from the Office of the Inspector General (OIG) Draft Report Financial Efficiency Review of the Durham VA Health Care System in North Carolina.

(Original signed by)

Leah Trossen,

Deputy Director of Contracting

For

Irma Ferro,

Director of Contracting Regional Procurement Office (RPO) East,

Network Contracting Office (NCO) 6)

Appendix F: VA Management Comments, Director, Durham VA Health Care System

Department of Veterans Affairs Memorandum

Date: March 2, 2022

From: Executive Director, Durham VA Health Care System (558/00)

Subj: Draft Report, Financial Efficiency Review of the Durham (NC) VA Health Care System (2021-02458-AE-0111)

To: Director, Office of Inspector General for Audits and Evaluations (52)
Assistant Inspector General for Audits and Evaluations

1. I have reviewed and concur with the recommendations and findings from the Office of the Inspector General (OIG) Draft Report Financial Efficiency Review of the Durham VA Health Care System in North Carolina.

2. Attached is the Durham VA Health Care System's comments for each recommendation. I have reviewed the recommendations and concur with the responses and actions provided by our team here at the Durham VA Health Care System to ensure we continue to deliver excellent care to our Veterans.

(Original signed by)

Marri M. Fryar

Interim Executive Director

Durham VA Health Care System

Attachments (1)

Attachment

Recommendation 1

Ensure finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: The director of the Durham VA Health Care System concurred with recommendation 1. The responses to all report recommendations are provided in full in appendixes E and F.⁵⁸ Durham and Centralized Accounting Unit (CAU) staff are aware of the VA policy and making changes to ensure open obligations with no activity for more than 90 days are reviewed. The Assistant Chief of Fiscal Service, in conjunction with station accounting and CAU, will conduct monthly audits and disseminate the report to services who appear on the newly created report. The station accountant will take a larger role in reviewing aged and inactive orders. For these obligations, finance office personnel will verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed.

Recommendation 2-VISN 6

Ensure quarterly purchase card audits are performed as required by the Veterans Health Administration’s standard operating procedure, “Internal Audits—Purchase Cards and Convenience Checks.”

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: The Network Contracting Office (NCO) 6 Director concurs in part with OIG’s finding and recommendation 2. Although audit completion was temporarily suspended due to initial COVID-19 outbreak in FY21, the Director of Contracting reported Purchase Card Coordinator(s) continued with quarterly account reviews in accordance with existing VHA policy. Further, NCO was not notified of the temporary audit suspension being lifted which resulted in the Quarterly Audit Finding Memorandum to the Medical Center Director not being issued for completeness. To ensure this process is fully compliant the VISN Purchase Card Manager shall track each memorandum until fully signed by each Medical Center Director then load each memorandum into the NCO 6 SharePoint and report to the NCO 6 Director/Deputy once completed.

Recommendation 3

Establish controls to confirm approving officials and purchase cardholders review their purchases and make sure contracting is used when it is in the best interest of the government.

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: Service Chiefs and local leadership will increase Acquisition & Utilization Specialist (AUS) application, oversight, and full-time equivalence (FTE) to assist in identifying recurring

⁵⁸ The OIG does not edit the responses provided by VA. The appendixes in the response are referring to the appendixes in the OIG report.

purchase card program purchases that qualify for strategic sourcing opportunities. Approving official and cardholder standardized learning requirements will be implemented to increase awareness of reoccurring provision. That will include analysis of strategic sourcing within the context of a best-practice investment model. To aid in this process, the AUS shall work alongside approving officials, cardholders, and NCO6 stakeholders. AUS' will make every effort to partner with the Purchase Card Manager and NCO 6 Purchase Card Coordinators. A paramount action item for the AUS group is a review of the top 1000 vendor list provided by the Office of Acquisition, Logistics and Construction (OALC). From there, and in tandem with supply chain leadership, local contracts will be established.

Recommendation 4

Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: Purchase Cardholders and Approving Officials must complete Unauthorized Commitment (UAC) TMS training every two years. NCO 6 purchase card coordinators will continue to confirm all Healthcare System personnel have completed all UAC training in accordance with set policies. To mitigate risk, approving officials will utilize the purchase card pre-approval and monthly reconciliation process to identify possible split purchases and other unauthorized card use. Additionally, the NCO 6 purchase card team will continue their monthly spot checks. Spot checking transactions aid in identifying unauthorized commitments through methodical and unbiased random sampling procedures. Those requiring further investigation will be analyzed in detail. All actions requiring ratifications shall be submitted to the MCD or designee for review and processing

Recommendation 5

Develop measures to confirm that completed VA Form 0242 submissions are accurate and updated for all cardholders.

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: The NCO 6 GPC team will continue to conduct 100% quarterly reviews per VA Form 0242 submissions. Additionally, healthcare personnel will notify NCO 6 purchase card program coordinators of mission changes, dollar limit threshold changes, card holder updates and replacements, and approving official (AO) and alternate approving official's (AAO) names. The Charge Card Portal (CCP) which is maintained by Purchase Cards Operations will be used as depository for all VA Form 0242s.

Recommendation 6

Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. 16, "Charge Card Programs."

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: Health Care System approving officials and cardholders must read purchase record retention guidance within both VA Financial Policy, vol. XVI, chapter 1A, *Administrative Actions for Government Purchase Cards* June 14, 2018 and Financial Policy, vol XVI, chapter 1B

Government Purchase Card for Micro-Purchases, July 14, 2021 then attest their understanding by signing an acknowledgment and understanding document for referenced policies. A copy must be maintained by NCO 6 purchase card coordinators. Approving officials will ensure all pertinent purchasing documents are available during their monthly cycle reconciliations. Service Chiefs and local leadership will ensure the purchase record is retained for six (6) years in accordance with National Archives and Records Administration (NARA) 410, General Schedule 6 and Federal Acquisitions Regulation (FAR) subpart 4.805.

Recommendation 7

Establish controls to make certain that budget or accounting staff review the salary cost data each pay period and promptly address cost center corrections with human resources staff as needed.

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: Fiscal Service established controls through salary cost data audits being performed each pay period by budget staff. Budget staff communicate any necessary corrections to HRMS promptly. Budget staff utilize Employee Cost audit worksheet and Salary Costing audit worksheet within PAID data Access database.

Recommendation 8

Ensure service chiefs and supervisors review labor mapping for accuracy and completeness.

Healthcare system concurred.

Target date of completion: December 01, 2022

Healthcare system response: Managerial Cost Accounting Site Manager position has been approved to oversee the MCA section at Durham VAHCS. The site manager will conduct audits of the supervisors' and service chiefs' labor mapping to ensure accuracy and completeness. Mapping training sessions for supervisor and service chiefs will be conducted by MCA/DSS staff in FY22Q3 and Q4 to strengthen the knowledge base and deepen understanding of core mapping principles.

Recommendation 9

Develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.

Healthcare system concurred.

Target date of completion: January 31, 2023

Healthcare system response: In FY 2020, the healthcare system reported an inventory turn rate of 8.01 for the Durham VAMC and 6.52 for its Greenville Healthcare Center compared to the VHA average of 10 and VHA's recommended level of 12, as established by the national Pharmacy Benefits Management program office. In January 2022, Durham VA Healthcare System conducted its inventory and still awaits results. For that reason, it is requested that the healthcare system report on progress made following inventory scheduled in January of 2023 to demonstrate impacts of proposed improvements on inventory turn rates.

Recommendation 10

Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy.

Healthcare system concurred.

Target date of completion: January 31, 2023

Healthcare system response: The Facility's Associate Medical Center Director reported On June 21, 2021, Durham VA Healthcare System was found to be noncompliant specific to reporting variances greater than 5 percent given that the Pharmacy Benefits Management online tool created to complete these audits inaccurately communicated a need for follow up action for variances greater than 10 percent, instead of 5 percent as published in VHA policy. The online tool has been corrected and Durham has been compliant since that time with completing audits. Of note, recently conducted audits identified less than a 5% variance thus requiring no additional follow up reporting. Quarterly audits will be completed over the next fiscal year to demonstrate a pattern of compliance moving forward.

The Associate Director of the Durham VA Healthcare System concurred with recommendations 9 and 10. To address recommendation 9, the associate director reported that pharmacy service will expand utilization of the required ScriptPro Inventory Management System (SIMS) to assist with establishment of calculated reorder points and quantities for purchased outpatient stock. They will further work to deploy a central pharmacy management software system to streamline the handling of purchased inpatient stock with establishment of calculated reorder points and quantities procured. Use of McKesson Mobile Managers will be required when physically scanning shelves to identify inventory that must be reordered, and they will strictly comply with the ABC inventory analysis methodology as required by VHA Directive 1761, while mitigating potential for damage, outdating, contaminations, and obsolescence. On 1/21/2022, the healthcare system conducted its annual inventory, but preliminary data to include projected inventory turn rate is not available for inclusion in this report. For that reason, it is requested that the healthcare system report on progress made following inventory scheduled in January of 2023 to demonstrate impacts of proposed improvements on inventory turn rates. For recommendation 10, the associate director reported that all noncontrolled audits were completed, as per VHA policy, and recent audits identified less than a 5 percent variance thus requiring no additional internal follow up reporting. The Pharmacy Benefits Management online tool that inaccurately communicated a need for follow up action for variances greater than 10 percent has also since been corrected to reflect 5 percent or greater aligning now with VHA policy.

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
----------------	---

Review Team	Anthony Leigh, Director Tesia Basso Melissa Garcia Steven King Lance Kramer Melanie Tsai
--------------------	---

Other Contributors	Dyanne Griffith Jill Russell Rasmi Simhan
---------------------------	---

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 6: VA Mid-Atlantic Health Care Network
Director, Durham VA Health Care System

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Richard Burr, Thom Tillis
U.S. House of Representatives: David E. Price

OIG reports are available at www.va.gov/oig.