



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

October 17, 2022

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-22-000101

Dear Mr. Kerner:

I am responding to your December 13, 2021, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that staff at the Tibor Ruben VA Medical Center (Long Beach), Quality, Safety and Value Service in Long Beach, California, may have engaged in conduct that may constitute a violation of law, rule or regulation and a substantial and specific danger to public health or safety.

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, directed the Office of the Medical Inspector to assemble and lead a VA team to investigate the allegations. A site investigation on this matter occurred February 23-25, 2022.

We do not substantiate the whistleblowers' allegations. We make four recommendations to Long Beach. The signed report will be sent to Long Beach with a request for an action plan.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "Denis McDonough".

Denis McDonough

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

**Report to the
Office of Special Counsel
OSC File Number DI-22-000101**

**Tibor Ruben VA Medical Center
Long Beach, California**



Report Date: October 2022

TRIM 2021-C-60

Executive Summary

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations submitted to the Office of Special Counsel (OSC) concerning officials at the Tibor Ruben VA Medical Center (hereafter, Long Beach), Quality, Safety and Value Service (QSV) located in Long Beach, California. The anonymous whistleblower alleged actions by the QSV Chief constitute a violation of law, rule or regulation; a gross waste of funds; and an abuse of authority. We conducted a virtual investigation at Long Beach February 23-25, 2022.

Specific Allegations of the Whistleblower

1. *The QSV Chief acted outside her authority by facilitating the retention of two contract employees after their contract expired, in violation of federal law, acquisition regulations, and agency policy.*
2. *The QSV Chief improperly used agency funds to pay the contract employees' salaries.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **not able to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After a careful review of the evidence, we make the following conclusions and recommendations:

Conclusions for Allegation 1

- We **do not substantiate** that the QSV Chief acted outside her authority by facilitating the retention of two contract employees after their contract expired, in violation of Federal law, acquisition regulations and/or agency policy.
- The QSV Chief at Long Beach, in her role as the facility leader for the Lean Management Program, acted appropriately to ensure that qualified employees work on the Lean Management project.
- One employee formerly employed by Contractor 1 was appropriately hired as a VA employee at Long Beach as a Systems Redesign and Improvement Coordinator Supervisor using the Direct Hiring Authorities.
- One employee transitioned from employment as a contractor with Contractor 1 to employment as a contractor with Contractor 2. The QSV Chief appropriately worked

with Contractor 2 to retain a knowledgeable contractor to work on the Lean Management project.

Recommendations to Long Beach

None.

Conclusions for Allegation 2

- We do not substantiate that the QSV Chief improperly used agency funds to pay contract employees.
- Contract documents established appropriate payment of funds to the contractors. Some contract funds were designated for coaching services performed by contract employees.
- We found no evidence of any payment made directly to a contract employee.

Recommendations to Long Beach

None.

Conclusions for Additional Findings

- There were numerous Contracting Officer Representatives (COR) in succession for both Contractor 1 and Contractor 2 contracts, which resulted in confusion and disorganization in management of the contracts.
- There is no Electronic Contracting Officer Representative (eCOR) file for Contractor 1's or Contractor 2's contract which is a violation of the Deputy Under Secretary for Health for Operations and Management Memorandum, *Mandatory Use of Electronic Contracting Officer Representative (eCOR) File*, issued on November 29, 2019.
- There was no follow-up or discussion of the first quarter fiscal year (FY) 2022 evaluation report prepared by the temporary COR for Contractor 2's contract.
- None of the CORs interviewed attended the COR training held on May 25, 2021.

Recommendations to Long Beach

1. Perform an overview of Contractor 2's contract to ensure that a COR and an alternate COR are appropriately delegated, and that appropriate staff are assigned to manage the contract and monitor the deliverables. Ensure the delegated CORs are appropriately trained, and a plan is established to update and maintain training.
2. Conduct a rapid improvement event for Veteran Health Administration (VHA) employees working on Contractor 2's contract including Fiscal, Finance, Accounting and QSV to clarify roles and responsibilities.

3. Establish and use the eCOR file, including performance evaluations for Contractor 2's contract as required.
4. Follow up on the first quarter FY 2022 evaluation report submitted by the temporary COR to determine if there are problematic contractual issues that need to be resolved.

Summary Statement

We developed this report, in consultation with other VHA and VA offices, to address OSC's concerns that Long Beach's QSV Chief's actions constituted a violation of law, rule, or regulation; a gross waste of funds; and/or an abuse of authority. We reviewed the allegations and determined the merits of each. VHA Human Resources examined personnel issues to establish accountability, and the National Center for Ethics in Health Care provided a health care ethics review. We did not substantiate the allegations. We found that the QSV Chief acted within her authority to facilitate the retention of contract employees; there was no evidence of a lapse in time when the contract expired; and agency funds were appropriately paid to the contractor. We found opportunities for improvement in the management of contracts, including the opportunity for training of CORs.

Table of Contents

Executive Summary.....	i
I. Introduction	1
II. Facility Profile.....	1
III. Specific Allegations of the Whistleblower.....	1
IV. Conduct of Investigation.....	1
V. Background, Findings, Conclusions, and Recommendations	3
Allegation 1.....	3
Background	3
Findings.....	5
Conclusions for Allegation 1	7
Recommendations to Long Beach.....	8
Allegation 2.....	8
Findings.....	8
Conclusions for Allegation 2	8
Recommendations to Long Beach.....	9
Additional Findings	9
Conclusions for Additional Findings.....	10
Recommendations to Long Beach.....	10
VI. Summary Statement	10
Attachment A	12

I. Introduction

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations submitted to the Office of Special Counsel (OSC) concerning officials at the Tibor Ruben VA Medical Center (Long Beach), Quality, Safety, and Value Service (QSV) located in Long Beach, California. The anonymous whistleblower alleged actions by the QSV Chief constitute a violation of law, rule or regulation; a gross waste of funds; and an abuse of authority. We conducted a virtual investigation at Long Beach February 23-25, 2022.

II. Facility Profile

Long Beach is one of VA's largest tertiary care facilities and is classified as a Clinical Referral Level 1a Facility, the highest-level complexity category for VA health care facilities. Long Beach is part of the VA Desert Pacific Healthcare Network, Veterans Integrated Service Network (VISN) 22. Additional sites of care include six community based outpatient clinics and a community resource and referral center serving homeless Veterans. In addition to providing primary care and specialty care at the main campus, Long Beach also has an onsite spinal cord injury center, a blind rehabilitation center and a full-service woman's health center. Long Beach currently serves over 68,000 unique Veterans.

III. Specific Allegations of the Whistleblower

- 1. The QSV Chief acted outside her authority by facilitating the retention of two contract employees after their contract expired, in violation of federal law, acquisition regulations, and agency policy.*
- 2. The QSV Chief improperly used agency funds to pay the contract employees' salaries.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of a Senior Medical Investigator and a Clinical Program Manager, both from OMI; a Management Analyst from the Veterans Health Administration (VHA) Office of Finance/Budget Formulation; the VHA Associate Director of Procurement Operations; and an Employee Relations/Labor Relations Consultant.

We conducted entrance and exit briefings with the following VISN 22 and Long Beach leadership:

VISN 22 Leadership

- Network Director
- Geriatrics and Extended Care Lead
- Health Systems Specialist

Long Beach Leadership:

- Medical Center Director (MCD)
- Associate MCD
- Deputy MCD
- Chief of Staff (COS)
- Health Systems Specialist to the MCD

We interviewed the following VISN 22 employees:

- Chief, Office of Strategic Facilities and Master Planning, Greater Los Angeles VA Medical Center (VAMC)
- Deputy Chief Financial Officer
- Division Chief, Network Contracting Office

We interviewed the following Long Beach employees:

- MCD
- Associate MCD
- Chief Financial Officer (CFO)
- CFO Fresno VAMC (Former CFO Long Beach)
- Procurement Branch Chief
- 2 Contracting Specialists
- 3 Contracting Officer Representative (COR)
- Chief, QSV
- Acquisition Utilization Specialist
- Systems Redesign Specialist
- Systems Redesign and Improvement Coordinator Supervisor
- Compliance Officer
- Contract Training Officer Regional Procurement Office (RPO), West
- Administrative Specialist
- Health Systems Specialist
- High Reliability Officer, QSV
- Human Resources (HR) Specialist

V. Background, Findings, Conclusions, and Recommendations

Allegation 1

The Quality, Safety, Value (QSV) Chief acted outside her authority by facilitating the retention of two contract employees after their contract expired, in violation of federal law, acquisition regulations and agency policy.

Background

VA Directive 7401.7, Unauthorized Commitments and Ratification, establishes the policy and requirements for establishing commitments that obligate VA to expend funds for supplies or services. According to this VA Directive, only a Contracting Officer (CO) may enter into and sign a contract on behalf of the Government to obligate funds. VA Directive 7401.7 defines an unauthorized commitment as an agreement that is not binding on the Government because the Government official who made it lacked the authority to enter into a contract on behalf of the Government. This VA Directive states that "employees shall make no unauthorized commitments or promises of any kind purporting to bind the Government".¹

However, there are some situations described in VA Directive 7401.7 where a CO does not obligate the funds, but the obligation does become binding. For example, as stated in the VA Directive, if supplies or services are ordered by an individual without authority to do so, an authorized official may ratify the action. A CO may then sanction the commitment, thereby creating an obligation. Per VA Directive 7401.07, an example of an unauthorized commitment that would require ratification to be binding on the Government is when a COR makes an unauthorized commitment for extra work on an existing contract.² According to the directive, once the unauthorized commitment is ratified, it becomes a legal contract. The ratification must be a proper use of appropriated funds and must be for supplies or services for which VA has authority to contract. Finance officers are responsible for ensuring that invoices to pay for supplies or services were made by or ratified by an appointed CO or by another authorized official.³

On April 18, 2022, approximately 2 months after the investigation, publication of VA Notice 22-09, Recission of Multiple VA Directives and Handbooks Regarding Acquisitions and Procurement Policy, April 18, 2022, rescinded the previously referenced VA Directive 7401.7, Unauthorized Commitments and Ratification.⁴ However, VA Directive 7401.7 was in effect up to and including the time of the investigation. VA Directive 7401.7 was rescinded in anticipation of updates to the VA Acquisition Regulation (VAAR) as a Proposed Rule, published in the Federal Register, to align the VAAR with the Federal Acquisitions Regulation (FAR) and to remove

¹ VA Directive 7401.7, Unauthorized Commitments and Ratification, October 7, 2004.

² Ibid.

³ Ibid.

⁴ VA Notice 22-09, Recission of Multiple VA Directives and Handbooks Regarding Acquisitions and Procurement Policy, April 18, 2022.

duplicative or outdated requirements. According to the Proposed Rule, procedural guidance internal to VA will be incorporated into the VA Acquisition Manual (VAAM).⁵ VHA Procurement and Logistics leadership informed us that although VA Directive 7401.7 was rescinded after the investigation, the procedures and guidance for ratification of unauthorized commitments still apply and can be found in the VHA Procurement Manual.⁶ The VA Office of Acquisitions and Logistics (OAL) provides oversight on behalf of the Secretary VA to ensure VA complies with laws and policies regarding acquisitions and procurement. One of the organizational components of OAL, the Office of Procurement Policy, Systems and Oversight, is responsible for management and oversight of VA's acquisition system and training and support for procurement programs. The VAAR codifies and publishes policies and procedures for VA's acquisition of supplies and services. The VAAR also implements and supplements the FAR.⁷ Section 801.601 of the VAAR includes the same information as VHA Directive 7401.7 and states that an individual may not commit the Government for purchases of supplies, equipment or services unless the individual has received delegated contracting authority as a CO or purchase card holder.⁸

Serving as a link between the CO and the contractor, the COR is essential in the administration and management of contracts. The COR plays a critical role in ensuring that contractors meet the commitment of their contracts. The CORs "are the eyes and the ears of the CO, ensuring that the work the CO has authorized gets properly done."⁹

Contracts are managed using the Electronic Contract Management System (eCMS). The eCMS has a vendor portal application that allows contractors to access VA procurement actions, provide responses, receive contract awards and submit invoices. The eCOR File System is also essential in the management of contracts. The eCOR File is a centralized digital repository that allows the CO, the COR and Contract Specialists to collaborate and share post-award contract administration documents and communications. On November 29, 2019, the Deputy Under Secretary for Health for Operations and Management issued a Memorandum, *Mandatory Use of Electronic Contracting Officer Representative (eCOR) File*, to all VISN Directors mandating the use of the eCOR File System by all CORs.¹⁰ The purpose of the mandate was to ensure transition from the previously used manual paper file system to a modern updated electronic file for all contracts.

⁵ Federal Register VA Acquisition Regulation: Department of Veterans Affairs Acquisition Regulation System and Research and Development. A proposed Rule by the Veterans Affairs Department on February 23, 2022.

⁶ [Ratification of Unauthorized Commitments SOP \(sharepoint.com\)](#) VHA Procurement Manual, part 801.602-3.

⁷ VA Office of Acquisition and Logistics (OAL) [Part 801 - Department of Veterans Affairs Acquisition Regulation System - Office of Acquisition and Logistics \(OAL\) \(va.gov\)](#)

⁸ Code of Federal Regulations, Title 48, Department of Veterans Affairs Acquisition Regulation System, Part 801.601(c). (48 C.F.R. § 801.601(c))

⁹ [Federal Acquisition Certification for Contracting Officer's Representatives Training - Veterans Affairs Acquisition Academy \(VAAA\)](#)

¹⁰ VA Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, Mandatory Use of Electronic Contracting Officer Representative (eCOR) File, November 29, 2019.

Findings

A High Reliability Organization (HRO) is an organization with a goal of achieving “zero harm” in an environment where accidents are expected to occur due to complexity or risk factors. To help achieve the goal of becoming an HRO, in September 2017, Long Beach established a contract with the Contractor 1 to provide Lean Management services that included consulting, training, coaching and support for process improvement and Systems Redesign. The establishment of Lean Management service is mandated by VHA Directive 1026.01, VHA Systems Redesign and Improvement Program, dated December 12, 2019, which established policy for the deployment of a VHA-wide integrated program of Systems Redesign and improvement.¹¹ According to the VHA Directive, the MCD is responsible for ensuring the facility is striving to become an HRO through the use of Lean process improvements, with the goal of achieving “zero harm” and a robust culture of improvement and patient safety.¹²

At Long Beach, Systems Redesign is a function of the QSV program. We reviewed the organizational chart for Long Beach and found that the Chief, QSV is responsible for Systems Redesign. The Chief, QSV reports to the MDC. We reviewed the current Systems Redesign Program and found there are a total of 12 full time equivalent employees (FTEE): 2 Systems Redesign and Improvement Coordinator Supervisors, 8 Systems Redesign Coordinators, 1 Data Management Analyst and 1 Administrative Specialist. Of these 12 FTEEs, there are 2 vacant positions (one Systems Redesign and Improvement Supervisor and one Systems Redesign Coordinator position).

We reviewed the Lean Management contract established to support the journey to becoming an HRO and found that the contract was originally awarded to Contractor 1. The contract stated that the period of performance was September 20, 2017 through September 19, 2018. There were four option periods to continue the contract with Contractor 1. The duration of each option period was 1 year. We found documentation that the facility elected to exercise option periods one, two and three, which continued the contract through September 19, 2021.

Contractor 1’s contract supports the Long Beach strategic plan, which is responsive to VHA Directive 1026.01 and requires an “extensive system-wide approach to shift the culture in performance improvement and daily management.” We reviewed Contractor 1’s contract and found specific objectives and deliverables to support the shift in culture and performance improvement using Lean Management techniques. The QSV Department at Long Beach manages the Lean Management Program developed by Contractor 1. We found that Contractor 1 utilized a subcontractor, Subcontractor 1, who staffed Long Beach with three contract employees to develop the program and provide consulting, training, coaching and support for performance improvement.

In calendar year 2021, toward the end of the third option period with Contractor 1, Long Beach decided not to execute the fourth option period. The facility determined that a new contract was needed to align with its goals and objectives more appropriately as it

¹¹ VHA Directive 1026.01, VHA Systems Redesign and Improvement Program, December 12, 2019.

¹² Ibid.

moved toward becoming an HRO. Documentation indicated that a new contract with Contractor 2 was planned as a 5-year contract with a period of performance from September 1, 2021 through August 31, 2026, otherwise known as an Indefinite Delivery Indefinite Quantity contract. This contract allowed Long Beach to place delivery orders and task orders for defined services without the restrictions inherent in a firm fixed-price contract.

The contract was signed by Contractor 2 on July 29, 2021, and by the CO on August 3, 2021, with an effective award date of September 1, 2021. The contract with Contractor 2 was signed while the contract with Contractor 1 was still in effect. Option period three for Contractor 1 continued their contract through September 19, 2021. The first task order for Contractor 2 was scheduled from September 1, 2021, through August 31, 2022. The overlap of the Contractor 2's contract with the Contractor 1's contract allowed the facility to transition without any lapse in services. According to the facility CO and the VISN 22 contracting leadership, this overlap is an acceptable practice to maintain continuity of services.

We reviewed the documents required to be completed for the transition from the Contractor 1's contract to Contractor 2's contract; these documents included closing statements of completed work and payment of all invoices for Contractor 1. The review of payments and invoices included de-obligation of excess funds when the Contractor 1's contract was completed. There was no evidence of funds from the original Contractor 1's contract being used for any other purpose. We reviewed the contracts for Contractor 1 and Contractor 2 and found that in accordance with VA Directive 7401.7, the CO appropriately signed both contracts to obligate funds.¹³ There was no evidence of any unauthorized commitment related to either contract.

The documents reflecting the transition from Contractor 1 to Contractor 2 included letters sent on August 3, 2021, to contractors who submitted a bid but were not selected for the new contract. We reviewed a proposed work statement for Contractor 2's contract and a PowerPoint presentation for the post-award kick-off meeting conducted with Long Beach employees on August 18, 2021. The kick-off meeting included a discussion regarding review of resumes and selection of new contract employees to work on the Lean Management project. We questioned the timing of the kick-off meeting for Contractor 2's contract prior to the formal end of Contractor 1's contract on September 19, 2021. In response, contracting leadership at Long Beach informed us that a brief overlap is often recommended for large contracts during a transition period to ensure that the contractor is ready to perform and to maintain continuity of the project.

The transition includes selection of Contractor 2's employees. The selection process requires Contractor 2 to submit resumes to Long Beach for review and approval of contractual employees. We found documentation that on August 20, 2021, 2 days after the kick-off meeting, Long Beach contacted Contractor 2 to request they consider the resume and hiring of a contractual employee who worked for Contractor 1 and worked

¹³ VA Directive 7401.7, Unauthorized Commitments and Ratification, October 7, 2004.

at Long Beach on the Lean Management project. We questioned this action. In response, contracting leadership informed us that retaining knowledgeable contractual employees during the transition from one contractor to another are common and are of value to VHA. We found that this contractual employee, who was previously employed by Contractor 1, was hired by Contractor 2 to continue work at Long Beach on the Lean Management project.

On March 13, 2020, the President issued a proclamation that the coronavirus (COVID-19) outbreak constitutes a national emergency beginning March 1, 2020. As a result, the Office of Personnel Management (OPM) approved the VA request for six separate COVID-19 Direct Hire Authorities (DHA). DHAs are intended to assist VA in meeting staffing needs resulting from the national emergency. On March 24, 2021, the Office of the Chief Human Capital Officer (OCHCO) published a Bulletin extending the DHA for occupations approved by the OPM. The extension was in effect through December 31, 2021. DHAs grant VA the authority to expedite filling critical occupations with qualified applicants by eliminating competitive rating and ranking. One of the occupations approved for direct hire was a Health Systems Specialist.¹⁴

The organizational chart for Long Beach was updated to include two positions for Health Systems Specialists to function in the role as Systems Redesign Improvement Coordinator Supervisors in QSV. This update occurred during the time when the third option period for Contractor 1 was ending, and a new contractor was being selected. VHA Directive 1026.01, mandates that each facility employ a Systems Redesign and Improvement Coordinator to perform duties related to the execution of principles incorporating the Lean methodology.¹⁵ We found that the position was posted on USAJOBS as Health Systems Specialist on July 2, 2021, and applications were accepted through USA Staffing. The position was filled using the DHA extension announced on OCHCO Bulletin dated March 24, 2021. An employee who previously worked for Contractor 1 applied and was selected by Long Beach to fill the Systems Redesign Improvement Coordinator Supervisor position. We reviewed HR documentation and found that the process to hire this employee was appropriate. We found that the employee completed work with Contractor 1 prior to the beginning of their VHA start date of September 7, 2021.

Conclusions for Allegation 1

- **We do not substantiate** that the QSV Chief acted outside her authority by facilitating the retention of two contract employees after their contract expired, in violation of Federal law, acquisition regulations, and/or agency policy.
- The QSV Chief at Long Beach, in her role as the facility leader for the Lean Management Program, acted appropriately to ensure that qualified employees work on the Lean Management project.

¹⁴ U.S. Department of Veterans Affairs, Office of the Chief Human Capital Officer (OCHCO) Bulletin, March 24, 2021.

¹⁵ VHA Directive 1026.01, VHA Systems Redesign and Improvement Program, December 12, 2019.

- One employee formerly employed by Contractor 1 was appropriately hired as a VA employee at Long Beach as a Systems Redesign and Improvement Coordinator Supervisor using the DHA.
- One employee transitioned from employment as a contractor with Contractor 1 to employment as a contractor with Contractor 2. The QSV Chief appropriately worked with Contractor 2 to retain a knowledgeable contractor to work on the Lean Management project.

Recommendations to Long Beach

None

Allegation 2

QSV Chief improperly used agency funds to pay the contract employees' salaries.

Findings

We reviewed the invoices and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system documents for payment of Contractor 1's and Contractor 2's contracts. Invoices for services were appropriately paid from Long Beach to the contractor. We found no evidence of agency funds being paid specifically to any contract employees.

We reviewed an amendment to the Contractor 1's contract for the third quarter of the third option year dated April 4, 2021, that referenced increasing funding for the contract to pay for additional coaching services. The amendment requested additional funds for Gemba Coaches services for an increased level of effort. The vendor on this amendment is Contractor 1. The purpose of the amendment is clearly identified as payment for services provided by employees working for Contractor 1. The amendment states that the delivery of services must be on or before the end date of Contractor 1's contract which was September 19, 2021. The amendment for payment of funds to a contractor for the purpose of paying the salary of contract employees was approved.

Conclusions for Allegation 2

- We do not substantiate that the QSV Chief improperly used agency funds to pay contract employees.
- Contract documents established appropriate payment of funds to the contractors. Some contract funds were designated for coaching services performed by contract employees.
- We found no evidence of any payment made directly to a contract employee.

Recommendations to Long Beach

None

Additional Findings

During the investigation, we saw evidence of a general lack of understanding and confusion regarding the delegation of CORs. We made multiple requests for delegation memorandums to clarify the sequence of CORs for Contractor 1's contract and delegation of CORs for Contractor 2's contract. The Chief QSV informed us that there were five different CORs from 2018 until Contractor 1's contract ended in September 2021. When Contractor 2's contract started in September 2021, a temporary COR was assigned. On February 15, 2022, approximately 1 week prior to this investigation, a permanent COR was assigned to Contractor 2's contract.

As previously discussed, an expected job function of the COR is to provide a link between the CO and the contractor and to ensure that the work the CO has authorized is accomplished. We found that on January 21, 2022, the temporary COR for Contractor 2's contract sent a quarterly performance evaluation report to the Chief QSV and the CO. The report included information about expenses for Gemba coaching for first quarter fiscal year (FY) 2022 and findings from an informal survey developed by the COR to evaluate Contractor 2's performance of the contract deliverables. The former temporary COR informed us that he was not contacted by the CO or the Chief QSV to review the quarterly evaluation report. The CO informed us that the report was informally discussed with the Chief QSV. The Chief QSV and the CO determined that the report was not accurate, and it was possibly too soon to evaluate performance on a new contract. The recently appointed permanent COR assigned to the contract acknowledged that there are plans to follow up on the quarterly evaluation report.

During the investigation, efforts to obtain contract documents was labor intensive, slow and confusing. We were able to obtain documents from numerous staff; however, there was no central location for the contract documents in the eCMS. In addition, there was no eCOR file for Contractor 1's or Contractor 2's contract. Use of an eCOR file is mandated by the Deputy Under Secretary for Health for Operations and Management Memorandum, Mandatory Use of Electronic Contracting Officer Representative (eCOR) File, issued on November 29, 2019.¹⁶ The facility CO acknowledged that although the use of the eCOR is a requirement, the eCOR file is not being used as mandated to monitor contractual performance for Contractor 1's or Contractor 2's contract. The Network CO for VISN 22 is aware that there are some contracts without eCOR files and informed us that this issue is being addressed.

The Regional Director for Procurement, RPO West held a town hall meeting on May 25, 2021, to provide updates and training for CORs while Contractor 1's contract was still in effect. The town hall training agenda included, but was not limited to, review of COR duties and responsibilities, communication with contractors and unauthorized

¹⁶ VA Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, Mandatory Use of Electronic Contracting Officer Representative (eCOR) File, November 29, 2019.

commitments. Three hundred seventy one CORs from VISN 22 attended the training. No one we interviewed at Long Beach who was delegated to work on Contractor 1's or Contractor 2's contract claimed awareness of the training. We reviewed the town hall training attendance records and found that no one assigned to Contractor 1's or Contractor 2's contract attended.

Conclusions for Additional Findings

- There were numerous CORs in succession for the Contractor 1 and Contractor 2 contracts, which resulted in confusion and disorganization in management of the contracts.
- There is no eCOR file for Contractor 1's or Contractor 2's contract which is a violation of the Deputy Under Secretary for Health for Operations and Management Memorandum, Mandatory Use of Electronic Contracting Officer Representative (eCOR) File, issued on November 29, 2019.
- There was no follow-up or discussion of the first quarter FY 2022 evaluation report prepared by the temporary COR for Contractor 2's contract.
- None of the CORs interviewed attended the COR training held on May 25, 2021.

Recommendations to Long Beach

1. Perform an overview of Contractor 2's contract to ensure that a COR and an alternate COR are appropriately delegated, and that appropriate staff are assigned to manage the contract and monitor the deliverables. Ensure the delegated CORs are appropriately trained, and a plan is established to update and maintain training.
2. Conduct a rapid improvement event for VHA employees working on Contractor 2's contract including Fiscal, Finance, Accounting and QSV to clarify roles and responsibilities.
3. Establish and use eCOR file, including performance evaluations for Contractor 2's contract as required.
4. Follow up on the first quarter FY 2022 evaluation report submitted by the temporary COR to determine if there are problematic contractual issues that need to be resolved.

VI. Summary Statement

We developed this report, in consultation with other VHA and VA offices, to address OSC's concerns that Long Beach's QSV Chief's actions constituted a violation of law, rule, or regulation; a gross waste of funds; and/or an abuse of authority. We reviewed the allegations and determined the merits of each. VHA HR examined personnel issues to establish accountability, and the National Center for Ethics in Health Care provided a health care ethics review. We did not substantiate the allegations. We found that the

QSV Chief acted within her authority to facilitate the retention of contract employees; there was no evidence of a lapse in time when the contract expired; and agency funds were appropriately paid to the contractor. We found opportunities for improvement in the management of contracts, including the opportunity for training of CORs.

Attachment A

VA Directive 7401.7, Unauthorized Commitments and Ratification, October 7, 2004.

VA Notice 22-09, Recission of Multiple VA Directives and Handbooks Regarding Acquisitions and Procurement Policy, April 18, 2022.

Federal Register VA Acquisition Regulation: Department of Veterans Affairs Acquisition Regulation System and Research and Development. A proposed Rule by the Veterans Affairs Department on February 23, 2022.

Ratification of Unauthorized Commitments SOP (sharepoint.com) VHA Procurement Manual (VHA PM) part 801.602-3.

VA Office of Acquisition and Logistics (OAL) Part 801 - Department of Veterans Affairs Acquisition Regulation System - Office of Acquisition and Logistics (OAL) (va.gov)

Code of Federal Regulations, Title 48, Department of Veterans Affairs Acquisition Regulation System, Part 801.601(c). (48 C.F.R. § 801.601(c))

Federal Acquisition Certification for Contracting Officer's Representatives Training - Veterans Affairs Acquisition Academy (VAAA)

VA Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, Mandatory Use of Electronic Contracting Officer Representative (eCOR) File, November 29, 2019.

VHA Directive 1026.01, VHA Systems Redesign and Improvement Program, December 12, 2019.

U.S. Department of Veterans Affairs, Office of the Chief Human Capital Officer (OCHCO) Bulletin, March 24, 2021.

Key to Investigative Team Members

- [REDACTED], M.D., MPH, Chief Senior Medical Investigator, Acting Associate Deputy Undersecretary for Health, Oversight, Risk and Ethics
- [REDACTED], RN, MSN, Clinical Program Manager
- [REDACTED], MHSA, Management Analyst, VHA Office of Finance/Budget Formulation
- [REDACTED], Associate Director Procurement Operations
- [REDACTED], Employee Relations/Labor Relations Consultant, HR Center of Expertise, Workforce Management and Consulting

Key to Interviewees

We interviewed the following VISN 22 employees:

- [REDACTED], Chief Office of Strategic Facilities and Master Planning, Greater Los Angeles VAMC
- [REDACTED], Deputy Chief Financial Officer VISN 22
- [REDACTED], Division Chief, Network Contracting Office, VISN 22

We interviewed the following Long Beach employees:

- [REDACTED], MCD
- [REDACTED], Associate MCD
- [REDACTED], Chief Financial Officer (CFO)
- [REDACTED], CFO Fresno VAMC, Former CFO Long Beach
- [REDACTED], Procurement Branch Chief
- [REDACTED], Contracting Specialist
- [REDACTED], Contracting Specialist
- [REDACTED], Contracting Officer Representative
- [REDACTED], Contracting Officer Representative
- [REDACTED], Contracting Officer Representative
- [REDACTED], Chief, Quality Safety and Value
- [REDACTED], Acquisition Utilization Specialist
- [REDACTED], Systems Redesign Specialist
- [REDACTED], Systems Redesign and Improvement Coordinator Supervisor
- [REDACTED], Compliance Officer
- [REDACTED], Contract Training Officer Regional Procurement Office, West
- [REDACTED], Administrative Specialist
- [REDACTED], Health Systems Specialist
- [REDACTED], High Reliability Officer, QSV
- [REDACTED], Human Resources Specialist