



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
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U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
COVID-19 SUPPLEMENTAL FUNDING:
DID IT PROTECT AND IMPROVE VETERAN CARE?
MAY 23, 2023

Chairman Bost, Ranking Member Takano, and Committee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of VA's expenditure of supplemental funds to respond to the COVID-19 pandemic. The OIG expresses our deep gratitude to the VA employees who—often at significant risk and great personal sacrifice—worked tirelessly throughout the pandemic and navigated the intense healthcare demands of not only veterans and their families, but also those of community members whose hospitals were stressed or under-resourced. VA's employees showed their commitment during a time in history when commitment was needed most, and the OIG recognizes and lauds them for that dedication.

I would also like to thank and recognize the OIG staff who seamlessly continued our oversight work throughout these challenging times. COVID-19 required adaptability and perseverance on the part of OIG personnel, who had to find alternatives to on-site inspections and other oversight measures to effectively address VA's response to the pandemic. The additional funding Congress provided the OIG was integral to these efforts. To minimize the time our work typically requires of VA leaders and clinical personnel, OIG teams found other ways to inform their ongoing oversight activities, such as expanded internal capabilities for data collection and monitoring, advanced analytics, and data modeling. These capabilities were used to assess, for example, mortality and patient flow at VA community living centers and medical facilities, and monitor COVID-19 outbreaks, appointment cancellations and rescheduling, and emergency and urgent care activity.

When I testified before this Committee earlier this year, I discussed several recurring themes and deficiencies in VA programs that centered around accountability, which is critical to continuous

improvement.¹ Since April 2020, the OIG has published over 40 pandemic-related reports. These reports identify deficiencies in several areas of accountability, such as strong governance, adequate staffing, and quality assurance. I will initially focus my statement on deficiencies in information technology (IT) systems and business processes, and then discuss criminal prosecutions and healthcare access and delivery. In short, the OIG pandemic-related reports referenced below illustrate how system and process limitations can negatively affect veterans, their families, and their caregivers and can lead to waste or misuse of taxpayer dollars.²

OIG OVERSIGHT OF COVID-19 SUPPLEMENTAL FUNDS

The COVID-19 pandemic was declared a national emergency on March 13, 2020. Within two weeks, Congress provided \$60 million in supplemental funding for VA to respond to the pandemic through the Families First Coronavirus Response Act (FFCRA) and then another \$19.6 billion through the Coronavirus Aid, Relief, and Economic Security (CARES) Act.³ About \$17.2 billion of these funds was appropriated to the Veterans Health Administration (VHA) to support VA's efforts to prevent, prepare for, and respond to the COVID-19 pandemic, including \$14.4 billion allocated to the VHA medical services fund, which is the fund for direct patient care. Later, in March 2021, VA received another \$17.1 billion in supplemental funding from the America Rescue Plan Act of 2021 (ARP).⁴

The OIG found that VA has had significant challenges in assuring accountability and transparency in how it obligates and expends funds due to VA's outdated financial management systems. While this problem existed long before the pandemic, it ultimately led to a lack of assurance that funds allocated specifically for COVID-19-related purposes were being spent as intended.

VA Lacks Adequate Controls on Expending COVID-19 Supplemental Funds

Following the Office of Management and Budget's guidance, the OIG initiated a June 2021 review to report on efforts by VHA to establish financial oversight mechanisms for tracking and reporting supplemental funding.⁵ VA did, in fact, meet the FFCRA and CARES Act requirements to submit monthly reports to OMB and Congress on COVID-19 supplemental fund obligations and expenditures, and it supplemented established policies related to accounting structures for use during declared emergencies. However, the OIG identified concerns that impacted the completeness and accuracy of VA's reporting, which are indications of weaknesses in VA and VHA internal controls for meeting reporting requirements. Additionally, the OIG found that VHA's reliance on several accounting

¹ VA OIG, [Statement of Inspector General Michael J. Missal, Hearing on "Building and Accountable VA: Applying Lessons Learned to Drive Future Success."](#) February 28, 2023.

² See the appendix for a list of OIG reports related to the COVID-19 pandemic.

³ Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, 134 Stat. 178 (March 2020); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, 134 Stat. 281 (March 2020).

⁴ American Rescue Plan Act of 2021, Pub. L. No. 117-2, tit. VIII, 135 Stat. 4, 112-17 (March 2021).

⁵ VA OIG, [Review of VHA's Financial Oversight of COVID-19 Supplemental Funds](#), June 10, 2021.

subsystems for payroll and purchase card transactions meant that VHA staff had to perform a significant amount of manual work to identify and perform adjustments so that the COVID-19 obligations and expenditures were captured in VA's reporting. The complexity of VHA's reporting process indicates that controls around VA's data reporting and validation efforts can be improved. Accordingly, the OIG recommended VHA and VA's Office of Management develop procedures to review and validate data to ensure that information in reports accurately represents the underlying source transactions.

To provide for greater oversight of VA's spending of these supplemental funds, the VA Transparency & Trust Act of 2021 (Transparency Act), which was enacted in November 2021, requires the OIG to report semiannually on VA's actual obligation and expenditure of the supplemental funds compared to its plans.⁶ To date, the OIG has published three reports, and the inaugural report concluded that VA only partially complied with the Transparency Act. In the inaugural report, the OIG found it unclear whether all of the planned uses of ARP Act funds were captured in the plan VA submitted to Congress, as the plan did not include a projected cost to support maintaining IT projects originally started with CARES Act funds.⁷ The OIG made two recommendations to the assistant secretary for management/chief financial officer and both are closed.

In the second Transparency Act report, the OIG found VA generally complied with the Transparency Act because VA provided justification for its spend plan programs and activities and generally aligned actual spending to the plan.⁸ However, VA was using expenditure transfers, a manual adjustment process to transfer funds from one account to another, for nearly half of its ARP Act obligations and expenditures. The OIG found that VA's manual expenditure transfer process resulted in at least 53 potential reporting errors. VA corrected these errors by manually adjusting funding balances to avoid misstating VA's reported obligations and expenditures to Congress.

VA was again found to have generally complied with the Transparency Act in the OIG's third and most recent review, but VA did not provide sufficient supporting documentation requested by the review team to assess line-level details needed to make a full assessment.⁹ Additionally, VA's Office of Management acknowledged that "manual processes for expenditure transfers can lead to potential reporting errors and data reliability issues" and that replacing its "antiquated legacy financial management system by implementing a modern solution" will reduce these potential errors.

This issue of using manual expenditure transfers due to system limitations contributed to the lack of transparency and accountability into VHA purchases that used CARES Act funds. Earlier this month,

⁶ VA Transparency & Trust Act of 2021, Pub. L. No. 117-63, § 2(c), 135 Stat. 1484, 1485 (November 2021).

⁷ VA OIG, [VA's Compliance with the VA Transparency & Trust Act of 2021](#), March 22, 2022.

⁸ VA OIG, [VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2022](#), September 22, 2022.

⁹ VA OIG, [VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023](#), March 21, 2023.

the OIG published a proactive audit on the effectiveness of VA's controls over VHA's use of supplemental funds, which found issues involving both methods used by VHA medical facility staff to process COVID-19-related transactions: (1) manual expenditure transfers and (2) the direct obligation of funds from the CARES Act medical services funds.¹⁰ First, manual expenditure transfers require staff to make several manual entries using journal vouchers to document the transfers in VA's financial management software system, so that an audit trail is maintained. However, medical facility staff were not always properly preparing the journal vouchers, supporting the vouchers with documentation showing amounts or reasons for transfers, or having the vouchers signed by an authorizing official. This failure limits transparency and accountability. This happened, in part, because VHA's Office of Finance was not following established VA financial policies. In other words, the systems' limitations and lack of guidance meant that VHA medical facility staff were left to determine what documentation would be sufficient to ensure the vouchers were supported without the benefit of proper internal controls.

Second, medical facility staff did not comply with key controls when they made pandemic-related purchases directly from CARES Act supplemental funds. In an estimated more than 10,000 transactions, medical facility staff did not always

- have documented purchase authority;
- segregate duties so the same employee was not approving the purchase or acting as the purchase card holder and requestor;
- certify and pay invoices properly; and/or
- track the receipt of goods to ensure the quantities ordered were received.

These issues occurred because VHA did not develop guidance that included protocols for accounting processes and procedures that outlined clear roles and expectations related to the oversight of its supplemental fund's purchases. As a result, the OIG reported an estimated \$187 million in questioned costs in CARES Act funds, and the OIG made nine recommendations to the Office of Management and VHA to resolve these problems. Notably, the OIG recommended that VA assess the financial system it is currently implementing, the Integrated Financial and Acquisition Management System (iFAMS), to determine whether integration with payroll subsystems can be accomplished to resolve some of the payroll-related expenditure transfers. VA concurred, noting that it would develop interfaces for an end-to-end automated solution by September 2030.¹¹

These reports echo the problems of the decentralized nature of governance seen in VA's financial management structure. Under the Chief Financial Officers (CFO) Act of 1990, the VA CFO has the

¹⁰ VA OIG, [VHA Can Improve Controls Over Its Use of Supplemental Funds](#), May 9, 2023.

¹¹ VA has also been attempting since the early 2000s to replace its financial management system. After several failed attempts in 2004 and 2010, VA used the lessons learned and established the Financial Management Business Transformation (FMBT) program. Central to the FMBT program's modernization efforts is the multiyear deployment of the iFAMS.

responsibility for establishing financial policy, systems, and operating procedures for all VA financial entities. VA administrations and other offices are responsible for implementing those policies and producing financial information, but they are not under the supervision of the VA CFO. This fragmented structure has been a consistent concern and finding in the audit of VA's consolidated financial statements.¹² Without active involvement from VA's senior leaders to overcome organizational silos and ensure collaboration, problems at the administration level may not be elevated for resolution.

VHA Can Improve Its Equipment Acquisition and Distribution Processes

Like healthcare systems across the globe, VA faced challenges in securing and distributing personal protective equipment (PPE) during the first weeks and months of the pandemic. The OIG determined that while VHA swiftly developed tools to gather supply and demand data at its medical facilities, it had issues with recording expired supplies, the double-counting of inventory, a limited inventory management system, and inconsistent data reporting.¹³

In addition to surges in the need for PPE, medical facilities were concerned about securing enough ventilators, which are used in the treatment of patients with severely impaired lung functions. In a report published last month, the OIG examined the acquisition and accountability process for ventilators procured for the Audie L. Murphy Memorial Veteran's Hospital in Texas from March 1, 2020, through November 30, 2021, and found the hospital acquired more ventilators than were needed for veteran care.¹⁴ Facility and VHA officials duplicated purchases, resulting in the facility obtaining 112 ventilators, while it usually had about 40. The 56 ventilators from the VHA purchase, worth about \$2.5 million, were left unused for more than 19 months, while other facilities reported insufficient ventilator stocks.¹⁵ The hoarding of ventilators occurred because leaders were concerned about a congested ventilator supply chain, and they also lacked a method to determine how many ventilators they needed. Contributing to these unnecessary purchases was VHA's lack of an inventory system that can identify excess inventory nationally. Later, the excess ventilators were redistributed to other VHA sites. The OIG recommended the facility determine the number of ventilators it needs and turn in excess equipment.

VHA facilities also had existing options to secure ready supplies. The four prime vendors of VHA's Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) program offered medical facilities a no-

¹² VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2022 and 2021](#), December 7, 2022.

¹³ VA OIG, [Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic](#), February 24, 2021.

¹⁴ VA OIG, [Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic](#), April 11, 2023.

¹⁵ For example, leaders in Veterans Integrated Service Networks 2 and 5 described having an inadequate number of ventilators during the pandemic. VA OIG, [Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6](#), April 7, 2022.

cost option to develop advance-order supply lists tailored to catastrophic events and contingency plans.¹⁶ Three of the four vendors also offered options to purchase and store medical supplies in advance. The OIG found none of the 16 medical facilities assessed took advantage of those emergency strategies, and most leaders did not know those plans existed. Most medical facilities reported maintaining their own contingency stocks, which were at risk of quickly depleting. That risk increased when prime vendors were unable to fulfill orders, leading staff to purchase medical supplies on the open market where VHA's data showed they paid higher prices. VA can apply lessons learned during the pandemic, and the OIG shaped its recommendations to address those lessons. VA can continue to refine its contract requirements for prime vendors to address catastrophes and ensure that chief logistics officers learn about existing contingency plans and ensure they understand how these can help mitigate supply shortages. The OIG also recommended clarifying for local facilities the intent of the emergency and continuous supply contract provisions.

The problems that have plagued the VA supply chain, however, are not new. Prior to the pandemic, OIG reports and congressional testimonies identified long-standing IT, contracting, and staffing problems that contributed to some VA medical centers not consistently having supplies when and where they needed them for patient care.¹⁷ Facilities have long experienced barriers to real-time tracking of inventory, purchasing, distribution, storage, and other supply management functions, leading to operational breakdowns and the need for work-arounds that sometimes lack compliance with VA policies and procedures. These work-arounds are often the result of dedicated VA clinical staff on the front lines doing whatever is necessary to meet the needs of patients under difficult circumstances.

THE OIG IDENTIFIED AND TERMINATED ATTEMPTS TO DEFRAUD VA OF SUPPLEMENTAL FUNDS

From the beginning of the pandemic, the OIG's Office of Investigations redirected resources to detect and prevent attempts to defraud VA of supplemental funds, particularly cases involving the safety and care of veterans and medical staff. These efforts were first marked by stopping those attempting to profit from scarce PPE supplies at start of the pandemic. Kenneth Ritchey was charged with conspiracy to commit wire fraud and mail fraud, conspiracy to defraud the United States, conspiracy to commit hoarding of designated scarce materials, and hoarding of designated scarce materials.¹⁸ After the first US-confirmed case of COVID-19, Ritchey participated in a scheme to defraud healthcare providers, including VA, of more than \$1.8 million by acquiring PPE and other designated materials from all

¹⁶ VA OIG, [Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available before the COVID-19 Pandemic](#), June 14, 2021.

¹⁷ VA OIG, [Statement of Leigh Ann Searight, Hearing on "Examining the U.S. Department of Veterans Affairs Supply Chain"](#), November 18, 2021.

¹⁸ U.S. Department of Justice, [Businessman Charged in Scheme to Hoard Personal Protective Equipment and Price Gouge Health Care Providers](#), January 27, 2021.

possible sources, including home improvement stores and online retailers, and ultimately hoarding the same. Due to nationwide PPE shortages and COVID-19-related fears, Ritchey directed sales representatives to solicit healthcare providers, including VA, to purchase PPE and other designated materials at excessively inflated prices through high-pressure sales tactics and misrepresenting sourcing and actual costs. Ritchey sold PPE to healthcare providers desperate to acquire it at incredible markups. For instance, he sold N-95 masks to VA and other companies for as much as \$25 a mask, despite acquiring such masks at much lower prices. Ritchey pleaded guilty in March 2023.

In addition to these challenges, VA was also forced to deal immediately with individuals intent on fraudulently obtaining government contracts for PPE. For example, Robert Stewart Jr. was the owner and president of Federal Government Experts LLC.¹⁹ In this capacity, between April 1, 2020 and May 14, 2020, he made false statements to the Federal Emergency Management Agency (FEMA) and VA to obtain lucrative contracts to provide PPE. In addition to the false statements to FEMA and VA, he fraudulently obtained loans under the federal Paycheck Protection Program and the Economic Injury Disaster Loan Program. Stewart also defrauded VA by falsely claiming to be entitled to veteran's benefits for serving in the US Marine Corps despite never having served. He was sentenced to 21 months in prison with three years of supervised release for making false statements to multiple federal agencies to fraudulently obtain multimillion-dollar government contracts, COVID-19 emergency relief loans, and undeserved military service benefits.

In a particularly egregious case, Christopher Parris was sentenced to 244 months in prison and restitution of approximately \$106 million after pleading guilty to wire fraud in connection with a COVID-19 scam and an unrelated Ponzi scheme.²⁰ Importantly, this investigation came about after a VA senior official from VA's Office of Acquisition, Logistics, and Construction referred their concerns to the OIG. Parris also agreed to forfeit approximately \$3.2 million that was seized by the VA OIG and Homeland Security Investigations. In March 2020, Parris made fraudulent misrepresentations in an attempt to secure orders from VA for PPE that would have totaled more than \$806 million. Parris promised that he could obtain millions of genuine 3M masks from domestic factories but knew this would not be possible. He attempted to acquire an upfront payment from VA of over \$3 million and received approximately \$7.4 million from state governments and private entities by making similar false representations regarding his ability to get PPE.

Unfortunately, some VHA employees also took the early days of the pandemic as an opportunity to steal from VA. From 2019 to 2020, the assistant chief of supply chain management for the Gulf Coast Veterans Healthcare System in Biloxi, Mississippi, stole N-95 masks, electronics, and medical devices. He received 12 months of incarceration, 36 months of probation, restitution of more than \$23,000, and a

¹⁹ US Department of Justice, [Former CEO Sentenced for Defrauding Multiple Federal Agencies](#), June 16, 2021.

²⁰ US Department of Justice, [Former Rochester Man Going To Prison For More Than 20 Years For His Role In Ponzi And COVID-19 Fraud Schemes](#), December 20, 2022.

fine of \$40,000.²¹ A respiratory therapist at the VA medical center in Seattle who stole a ventilator and other respiratory medical equipment during the pandemic was later sentenced to three months in prison, nine months of home confinement, and restitution of more than \$132,000.²²

OIG OVERSIGHT OF VHA’S HEALTHCARE RESPONSE TO THE COVID-19 PANDEMIC

VA’s COVID-19 response plan issued March 23, 2020, included providing most outpatient care using telehealth when appropriate. The OIG recognizes VHA has been a pioneer in the development of telehealth delivery, particularly in using clinical video telehealth, which allowed VA providers to diagnose and often treat veterans in real time via interactive, live video.²³ In 2016, VA established the Office of Connected Care (OCC) to administer telehealth programs throughout VA. In 2017, VA launched its VA Video Connect (VVC) mobile app to provide a secure environment for patients and providers to carry out video telehealth visits, regardless of where the veteran and provider were located. VHA clinicians also provide telehealth care via telephone. Starting in March 2020, VHA took actions to expand telehealth delivery to patients. They expedited the credentialing and privileging of healthcare providers in anticipation of staffing shortages and authorized VHA clinicians to use any third-party audio or video communication technology with privacy features for telehealth appointments. In the first year of the pandemic, VHA doubled the number of patients with a telehealth encounter.

Opportunities and Challenges with Increased Utilization of Telehealth

The OIG recently assessed the implementation and use of VVC prior to and during the pandemic.²⁴ Specifically, the review team explored factors affecting why primary and specialty care providers used telephone communication more frequently than VVC at the onset of the pandemic and in lieu of in-person encounters, and how VHA resolved technology issues. The OIG also examined VHA provider experience with VVC prior to and during the pandemic to identify benefits of and barriers to VVC use. When the pandemic started, VHA was not readily able to support the increased demand of VVC use, leading providers to perform patient care through telephone encounters. This occurred despite VHA having developed telehealth strategic plans, which focused on improving technology to support VVC, increasing provider capability, and identifying emergency preparations for disaster scenarios.

Notably, OCC’s chief officer said video visits increased from 2,000 to 40,000 per day and emphasized that, “the technical infrastructure was not scaled to that kind of . . . unexpected and unplannable [*sic*] for

²¹ US Department of Justice, [Former Biloxi VA Employee Sentences to Prison for Stealing VA Property](#), January 7, 2022.

²² US Department of Justice, [Veterans Affairs respiratory therapist pleads guilty to stealing and selling COVID-19 respiratory supplies](#), October 5, 2020.

²³ Pandemic Response Accountability Committee, [Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic](#), December 2022.

²⁴ VA OIG, [Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic](#), April 26, 2023.

growth.” As the pandemic continued, providers continued to use VVC, recognizing its value in increasing access to care, and enabling more comprehensive evaluations than telephone encounters could offer. There were identifiable barriers, however, including patient difficulties with technology, lack of clinical and administrative support during the encounters, and challenges with scheduling VVC appointments. VHA concurred with the OIG’s three recommendations to address those barriers.

Veterans also received more telehealth through community care.²⁵ In the 12 months before the pandemic (March 2019 through February 2020), less than one percent of veterans who received care in the community did so at least once via telehealth. From March 2020 through February 2021, however, about 19 percent of the 871,000 veterans who received care in the community did so at least sometimes via telehealth. Fewer veterans received at least some telehealth care in the community from March 2021 through December 2021—only 8 percent of about 1.1 million veterans.

Overcoming the Digital Divide

During the summer of 2020, VA introduced a new consult process called the digital divide consult, where patients are issued a video-capable device after obtaining a referral from their care team, licensed independent practitioner, or designee, and the approval of a social worker who has conducted a socioeconomic assessment. The process also allowed veterans experiencing homelessness who were enrolled in the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program to receive devices. The CARES Act gave VA the authority to expand mental health services to isolated veterans through telehealth and required VA to ensure that telehealth capabilities were available to HUD-VASH participants.²⁶

The OIG found that the VA’s digital divide program was successful in distributing devices to veterans but identified several gaps in oversight and guidance preventing the program from fully meeting its intended purpose for patients to receive virtual care via VVC.²⁷ After introducing the digital divide consult, VA issued devices (iPads) to about 41,000 patients during the first three quarters of fiscal year 2021. These devices were not always used to connect to video telehealth, as only an estimated 20,300 of those patients (about 49 percent) with issued devices completed a VVC appointment. The remaining patients (about 51 percent) had not used the devices for VVC appointments. An estimated 10,700 patients never had a VVC appointment scheduled, as there was no requirement to schedule, and neither the patient nor the staff initiated scheduling a VVC appointment. The OIG also estimated that more than 10,000 patients had a VVC appointment scheduled but not completed for various reasons, such as technical issues or a cancellation, and a subsequent VVC appointment was not completed.

²⁵ Pandemic Response Accountability Committee, [Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic](#), December 2022.

²⁶ VA OIG, [Purchases of Smartphones and Tablets for Veterans’ Use during the COVID-19 Pandemic](#), May 4, 2022.

²⁷ VA OIG, [Digital Divide Consults and Devices for VA Video Connect Appointments](#), August 4, 2022.

There were also lapses in device issuance and management during the review of VA’s tablet dashboard data. VA staff did not retrieve about 8,300 unused devices (valued at \$6.3 million) for other patients’ use when they did not have VVC activity, as required by the standard operating procedures. As of January 2022, there was a backlog of about 14,800 returned devices pending refurbishment before they could be redistributed. The returned devices accumulated primarily because of technical issues with the refurbishment system VA used. Despite the backlog, VA did not suspend purchases of new devices from its contractor and placed a purchase order for additional new devices in August 2021. As of December 2, 2021, VA bought 9,720 devices under this purchase order, totaling about \$8.1 million.

The program does have positive value, with VHA noting an April 2022 study that found veterans with a history of mental healthcare use and in receipt of a video-enabled tablet were associated with increased use of telemental health services, increased psychotherapy visits, and reduced suicidal behavior and emergency department visits.²⁸ VA-loaned devices represent a sizeable investment, and their use should be monitored closely. The OIG’s recommendations included revising the program’s standard operating procedures, implementing an alert system that notifies the requesting clinic that a patient has received a device and can now be scheduled a VVC appointment, and updating and enabling systems to check for and initiate retrieval activities for duplicate devices and augment tracking mechanisms.

Assuring Access to Care

Taking advantage of telehealth’s opportunity requires VA to schedule appointments timely. At the onset of the pandemic, VHA was challenged to track and follow-up on millions of canceled appointments.²⁹ While VHA had made progress in tracking canceled appointments, it had opportunities to strengthen monitoring of follow-up of care, particularly in specialty care.³⁰ In another inspection, the OIG found that inadequate staffing within the Martinsburg, West Virginia, VA medical center’s Care in the Community Service led to delays in scheduling community consults.³¹ Sixty-two percent of the COVID Priority 1 cardiology consults during a one-year period were scheduled more than 30 days beyond the clinically indicated date, which is the date the patient needs to be seen based on their clinical status. To meet workload demands, the facility needed a minimum of 23 schedulers and 11 clinical employees. At the time of the inspection, they had only 10 scheduling and four clinical staff, with facility leaders reporting significant staff turnover and a lack of training as contributing factors.

²⁸ Kritee Gujral, James Van Campen, Josephine Jacobs, etc., “Mental Health Service Use, Suicide Behavior, and Emergency Department Visits Among Rural US Veterans Who Received Video-Enabled Tablets During the COVID-19 Pandemic,” *JAMA Network Open* (April 6, 2022), <https://doi.org/10.1001/jamanetworkopen.2022.6250>.

²⁹ VA OIG, *Appointment Management During the COVID-19 Pandemic*, September 1, 2020.

³⁰ VA OIG, *VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics*, November 3, 2022.

³¹ VA OIG, *Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia*, February 16, 2022.

CONCLUSION

The OIG appreciates the supplemental funds Congress provided to increase oversight and will continue to make recommendations that assist VA in achieving the most from its resources. The COVID-19 pandemic stressed all aspects of every healthcare system in the country, and the existing problems and limitations within each healthcare system were further exposed and tested. This includes the limitations of systems and processes that are critical to VA operations, and whose deficiencies continue to impact patient care, supply management, as well as stewardship of taxpayer dollars. Congress provided VA with significant regular and supplemental funds to respond to the COVID-19 pandemic, while requesting clarity into their use. The OIG has repeatedly found that VA's failure to effectively modernize its systems leads to significant challenges in assuring accountability and transparency in how it obligates and expends any funds; makes it difficult for VA staff to plan, order, and track the expenditure of supplies; and hampers transparency and oversight into VA's use of these funds. The OIG recognizes that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, as well as answering the call for assistance from their local communities in times of crisis. However, their efforts are undermined by aging systems that create additional hurdles.

APPENDIX: COVID 19-RELATED OIG PUBLICATIONS FROM 2023 TO 2020

1. [*VHA Can Improve Controls Over Its Use of Supplemental Funds*](#), May, 9, 2023.
2. [*Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic*](#), April 26, 2023.
3. [*Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic*](#), April 11, 2023.
4. [*VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023*](#), March 21, 2023.
5. [*Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada*](#), January 25, 2023.
6. [*Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic*](#), December 1, 2022. Published in conjunction with the Pandemic Response Accountability Committee.
7. [*VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics*](#), November 3, 2022.
8. [*VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2022*](#), September 22, 2022.
9. [*The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic*](#), May 10, 2022.
10. [*Purchases of Smartphones and Tablets for Veterans' Use during the COVID-19 Pandemic*](#), May 4, 2022.
11. [*Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*](#), April 7, 2022.
12. [*VA's Compliance with the VA Transparency & Trust Act of 2021*](#), March 22, 2022.
13. [*Audit of Community Care Consults during COVID-19*](#), January 19, 2022.
14. [*Systems and Tools Implemented to Track COVID-19 Vaccine Data*](#), December 7, 2021.
15. [*Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8*](#), November 18, 2021.
16. [*Deficiencies in Select Community Care Consult \(Stat\) Processes During the COVID-19 Pandemic*](#), November 10, 2021.
17. [*Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*](#), September 30, 2021.
18. [*Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers*](#), September 30, 2021.

19. [*Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers*](#), September 30, 2021.
20. [*Failure to Mitigate Risk of and Manage a COVID-19 Outbreak at a Community Living Center at VA Illiana Health Care System in Danville, Illinois*](#), September 28, 2021.
21. [*Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina*](#), September 27, 2021.
22. [*Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*](#), July 7, 2021.
23. [*Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available before the COVID-19 Pandemic*](#), June 14, 2021.
24. [*Review of VHA's Financial Oversight of COVID-19 Supplemental Funds*](#), June 10, 2021.
25. [*Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic*](#), June 9, 2021.
26. [*Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents*](#), April 14, 2021.
27. [*Review of Community-Based Outpatient Clinics Closed Due to the COVID-19 Pandemic*](#), April 6, 2021.
28. [*Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*](#), March 16, 2021.
29. [*Potential Risks Associated with Expedited Hiring in Response to COVID-19*](#), March 11, 2021.
30. [*Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*](#), March 11, 2021.
31. [*Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic*](#), February 24, 2021.
32. [*Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines*](#), January 28, 2021.
33. [*Added Measures Could Reduce Veterans' Risk of COVID-19 Exposure in Transitional Housing*](#), December 18, 2020.
34. [*Review of Veterans Health Administration's Emergency Department and Urgent Care Center Operations During the COVID-19 Pandemic*](#), December 17, 2020.
35. [*Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams*](#), November 19, 2020.
36. [*Veterans Crisis Line Challenges, Contingency Plans, and Successes During the COVID-19 Pandemic*](#), October 28, 2020.

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37. [*Date of Receipt of Claims and Mail Processing during the COVID-19 National State of Emergency*](#), September 17, 2020.
 38. [*Appointment Management During the COVID-19 Pandemic*](#), September 1, 2020.
 39. [*Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon*](#), August 27, 2020.
 40. [*Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*](#), July 16, 2020.
 41. [*Review of Highly Rural Community-Based Outpatient Clinics' Limited Access to Select Specialty Care*](#), July 7, 2020.
 42. [*OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*](#), March 26, 2020.