



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

Reporting and Monitoring  
Personal Protective Equipment  
Inventory during the  
Pandemic

REVIEW

REPORT #20-02959-62

FEBRUARY 24, 2021



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## Executive Summary

The spread of COVID-19 drastically increased the demand for personal protective equipment (PPE) and significantly disrupted the global supply chain for items such as face coverings, gloves, and gowns. VA, which has the largest integrated healthcare system in the nation, was faced with competing for PPE both in its service to millions of veterans and as part of its fourth mission.<sup>1</sup> The VA Office of Inspector General (OIG) received allegations from its hotline that Veterans Health Administration (VHA) medical facilities could not acquire and maintain adequate inventory to keep pace with escalating needs. The OIG assessed how VHA reported and monitored its PPE supply levels during the pandemic and solicited information about whether facilities ran out of PPE or experienced significant shortages, as well as lessons learned. Without reliable information on its PPE inventory, VHA cannot effectively assess demand, monitor stock levels, or identify supply shortages at facilities.<sup>2</sup> Shortages can jeopardize the health of frontline personnel, patients, their families or caregivers, and the general public.

### What the Review Found

In assessing how VHA reported and monitored PPE, the OIG found VHA swiftly developed processes and tools to gather data that would help it navigate fluctuating facility demand during the COVID-19 pandemic. However, the OIG also identified several issues related to how expired supplies are recorded, the double counting of the use of some supplies redistributed among facilities, complications in leveraging data from a preexisting inventory management system, and inconsistent methods to verify facilities' self-reported inventory data into the new tool. The OIG found that VHA will need to be clear on the related data limitations when reporting to VA decision makers and other stakeholders to ensure accuracy and transparency.

In interviews of 22 people involved in VHA medical facility or Veterans Integrated Service Network (VISN) logistics operations at 42 facilities, the review team found no one reported running out of PPE supply items. While some individuals reported running low on PPE, they noted that risks of outages were mitigated by VHA shifting supplies among VISNs (a practice known as cross-leveling) or by acquiring additional PPE before the facility ran out.

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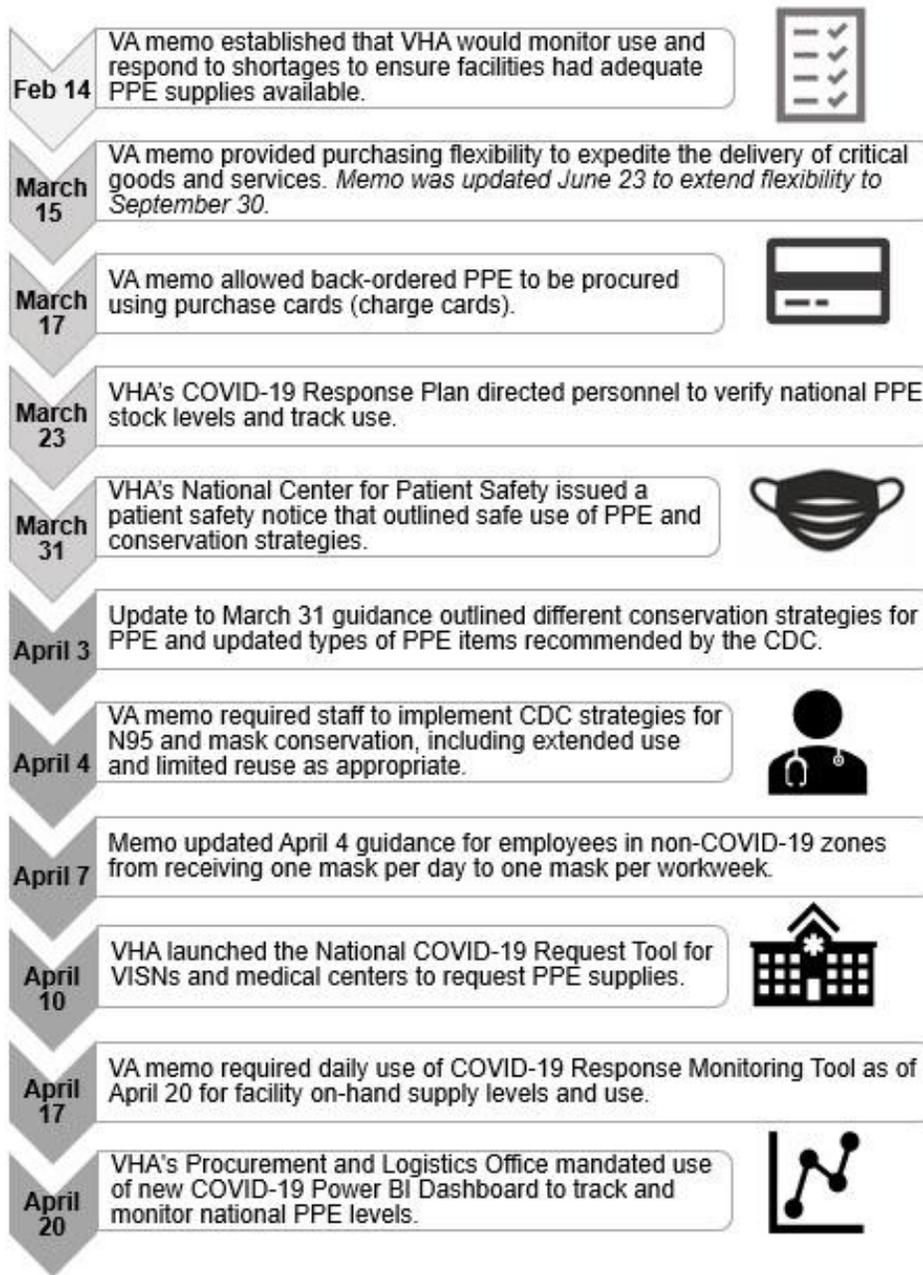
<sup>1</sup> VA's "fourth mission" is to support national, state, and local emergency management, public health, safety, and homeland security efforts while continuing to serve veterans.

<sup>2</sup> The OIG could not determine the reliability or accuracy of VHA-reported inventory data without conducting on-site visits to verify and physically count supplies at facilities and compare its findings with reported information. Due to the pandemic, on-site visits were not completed. Moreover, the term "shortages" was not defined. Facility staff provided varied responses to questions about sufficiency of supply levels and shortages that ranged from stating they experienced a "shortage" but never completely ran out of supplies, or defining a shortage as a lack of sufficient supply to conduct operations, to equating PPE supply level sufficiency to ability to meet demand.

## **VHA Quickly Developed PPE Supply Management Processes and Tools to Address Increased Demand by Navigating around a Limited Inventory System, but Can Improve Them Further**

According to VHA, its \$10 billion supply chain was inefficient, and the inventory management system it used had several significant limitations before the pandemic struck. As past OIG audits and reviews have demonstrated, VHA's facilities have often not shown supply chain discipline, including failing to comply with inventory process requirements, or inconsistently using VA's official inventory management system, the Generic Inventory Package (GIP). These problems led to inaccurate and unreliable GIP data at numerous facilities. Despite its limitations, however, GIP remains the inventory management system that VHA facilities are required to use until an alternative system is created and authorized.

VHA realized that it would need PPE inventory information in near real time to track PPE supply levels during the pandemic, something GIP was not able to provide. VHA responded swiftly and developed tools that would supplement GIP and help ensure that facilities could respond to increased PPE demand. In February 2020, VHA began issuing guidance to prepare for shortages and monitor PPE. VHA created new tools and guidance for procuring, tracking, and monitoring PPE supplies that drew on GIP data and processes. Figure 1 highlights key VHA guidance and tool development related to PPE supply management.



**Figure 1.** Overview of VHA actions regarding PPE from February through April 2020.

Source: OIG review team analysis of VHA policy and guidance.

Note: CDC stands for the Centers for Disease Control and Prevention.

Notably, VHA developed the National COVID-19 Request Tool for facilities to request needed supplies they were unable to procure through established supply chains. In addition, VHA made use of donations and shifted supplies among its facilities and VISNs to meet fluctuating demands. In April 2020, VHA implemented the COVID-19 Response Monitoring Tool, which relied on facility or VISN staff to manually enter on-hand supply levels for mission-critical PPE

and its usage daily. Using this self-reported information, the Response Monitoring Tool allowed VHA to compile near real-time information about PPE inventory at its facilities that it lacked before the pandemic.

Before COVID-19, all inventory information was accessible via the Supply Chain Common Operating Picture (SCCOP) dashboard and was used to manage the local and regional supply chain and analyze data from a national perspective. However, that information was not updated daily, or even weekly, limiting its utility during the pandemic. Instead, VHA developed the COVID-19e Power Business Intelligence (or Power BI) Dashboard to monitor PPE supply levels nationwide. The dashboard included data from the Response Monitoring Tool, such as self-reported daily usage and stock on-hand levels at facilities. The dashboard also included data collected from GIP, which helped identify outliers in the Response Monitoring Tool that could indicate important data discrepancies in supply levels.

Overall, the OIG found that VHA took swift steps to work around known limitations in its inventory management system, obtain near real-time information about PPE inventory, and ensure that its facilities would not run out of PPE.

## VHA Faces Ongoing Challenges

The OIG found, however, that VHA could improve the accuracy and consistency of collected information about PPE supplies in the Response Monitoring Tool and Power BI Dashboard by addressing the following issues:

- **Identifying expired supply inventory.** The Response Monitoring Tool did not distinguish between expired and nonexpired PPE, causing confusion at facilities as staff were uncertain about recording expired masks and other supplies in inventory.
- **Verifying facility self-reported inventory data for accuracy.** Because PPE data for on-hand supply levels and usage were manually entered, that information was vulnerable to error. VISNs used varying methods to verify the compiled data they reported. VHA did not provide guidance for verifying self-reported data in the Response Monitoring Tool.
- **Inflating usage and inconsistent item information in GIP.** In redistributing supplies among facilities and VISNs to meet needs, VHA could double count usage (first when items are transferred and then when the receiving facility uses them) due to limitations in GIP. In GIP, item names and information varied by facility, which could affect the accuracy of which items are included within a supply category.

The OIG recognizes the significant efforts and quick response of VHA staff to quickly identify, report, and monitor PPE levels and ensure supplies were available when and where they were needed. It is hoped that some of the lessons learned that are highlighted in this report will assist VHA in its continuous improvement efforts and in preparing for future crises.

## What the OIG Recommended

To help VHA improve the accuracy of its PPE reporting, the OIG recommended the under secretary for health provide guidance for facilities and VISNs to report expired on-hand quantities of PPE in the Response Monitoring Tool and to provide guidance on how to effectively verify information entered into the tool.<sup>3</sup> Although not a formal recommendation, or an external reporting requirement, the OIG also called on VHA to report any limitations in the data it collects to VA leaders until corrections can be made.

## Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with the recommendations and provided corrective action plans. The executive in charge stated that VHA considers recommendation 2 fully implemented and asked the OIG to consider closing it.

The OIG will close recommendation 2 when VHA provides evidence that additional verification measures have been communicated to facilities and VISNs. The OIG will monitor the implementation of all planned actions and will close recommendations 1 and 2 when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix C includes the full text of the executive in charge's comments.



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<sup>3</sup> Recommendations directed to the under secretary for health were submitted to the executive in charge, who had the authority to perform the under secretary's functions and duties. Effective January 20, 2021, he was appointed to acting under secretary for health with the continued authority to perform the functions and duties of the under secretary.

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## Abbreviations

CDC	Centers for Disease Control and Prevention
CLO	chief logistics officer
GIP	Generic Inventory Package
OIG	Office of Inspector General
PPE	personal protective equipment
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency for the United States due to the COVID-19 pandemic. Because the spread of COVID-19 drastically increased demand for personal protective equipment (PPE), the global supply chain for items such as face coverings, gloves, and gowns was significantly disrupted. By March 2020, the Veterans Health Administration (VHA), the largest integrated healthcare system in the nation, determined that pandemic-related demands for supplies and equipment would result in significant shortages.<sup>4</sup> In particular, on March 27, 2020, VA publicly issued its full *COVID-19 Response Plan*, citing the possibility of critical shortages of healthcare resources, including PPE.<sup>5</sup>

The VA Office of Inspector General (OIG) assessed VHA processes for facility reporting and national monitoring of PPE supply levels during the pandemic. Without reliable information to manage PPE supplies, VHA cannot effectively track demand, monitor stock levels, or identify supply shortages that risk the health of frontline personnel, patients, their families or caregivers, and the public.

## Personal Protective Equipment

PPE minimizes exposure to hazards that can cause serious illnesses among employees working directly with veterans and other patients. According to the Centers for Disease Control and Prevention (CDC), healthcare personnel use PPE every day to protect themselves, patients, and others when providing care.<sup>6</sup>

Given the high demand for PPE and concerns about supply shortages, the CDC issued guidance with strategies for when PPE supplies were stressed, running low, or absent.<sup>7</sup> VHA also disseminated conservation guidance that it stated was based on CDC crisis capacity strategies for masks and N95 respirators on April 7, 2020, due to the challenges in procuring adequate

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<sup>4</sup> “Veterans Health Administration: VA’s Fourth Mission Summary,” VHA website, accessed on November 25, 2020, <https://www.va.gov/health/coronavirus/statesupport.asp>. VHA offers care to approximately nine million enrolled veterans, and as part of its “fourth mission”—supporting national, state, and local emergency management, public health, safety, and homeland security efforts while continuing to serve veterans—has also admitted nonveteran US citizens for care at VA medical centers during COVID-19.

<sup>5</sup> “VA Releases COVID-19 Response Plan,” VA website, accessed November 17, 2020, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5405>. VHA signed the COVID-19 Response Plan on March 23, 2020. The document was released to the public on March 27, 2020.

<sup>6</sup> “Coronavirus Disease 2019 (COVID-19) Strategies to Optimize the Supply of PPE and Equipment,” CDC website, accessed May 18, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>.

<sup>7</sup> “Coronavirus Disease 2019 (COVID-19) Strategies to Optimize the Supply of PPE and Equipment”; VHA Memo, “Coronavirus (COVID-19) Facemask and N95 Respirator Use,” April 7, 2020.

supplies.<sup>8</sup> According to the guidance, employees performing high-risk procedures on suspected or confirmed COVID-19 patients were asked to wear the same N95 respirator for use with multiple patients. Employees participating in screening activities or providing care to COVID-19 positive patients in non-high-risk procedures were given one face mask per day. The memo encouraged staff to reuse face masks between patients, adding that extended use is preferred when possible.

Because of the potential negative impact on the safety of VHA staff and veterans, members of Congress questioned the austerity measures, having heard whistleblower complaints about the repeated reuse of masks.<sup>9</sup> This review addresses what the OIG considers to be the first step in the analysis of PPE availability, which includes reviewing VHA's processes for reporting and monitoring supply levels and examining the challenges. The team did not evaluate if conservation strategies were reasonable or sufficient, as this was outside the objective of the review.

## Inventory Supply Management

Facilities are required to use the Generic Inventory Package (GIP) for inventory supply management. This includes authorized staff managing and updating on-hand levels and identifying quantities of items needed for ordering. GIP must be used by facilities to enter all expendable supplies, such as PPE, unless a waiver has been approved.<sup>10</sup>

GIP uses a master file number for each supply item, which helps track its movement from the receiving area to a primary inventory location and then to a secondary inventory location. Primary inventory locations are used by VHA facilities to maintain supplies on hand until they are distributed to secondary inventory points, which are generally storage rooms in the clinical areas where the items are used. These primary and secondary inventory locations are annotated in GIP and, if properly and consistently recorded, help identify the quantity and location of specific supply items in stock. The supply movement from primary inventory locations to secondary inventory points is recorded as a distribution transaction in the inventory system and these quantities are how facilities identify how quickly supplies are used.

In past reports, the OIG determined that VHA staff were not fully or properly using GIP, and found inaccuracies in on-hand stock data and poor inventory control practices that led to

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<sup>8</sup> VA Memo, "Updated: Coronavirus (COVID-19) Facemask and N95 Respirator Use," April 7, 2020.

<sup>9</sup> Hearing on the Department of Veterans Affairs Response to the New Coronavirus, Before the Subcommittee on Military Construction and Veterans Affairs, House Committee on Appropriations, 116th Cong. (2020).

<sup>10</sup> VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

understocked items.<sup>11</sup> The limitations of the GIP inventory management system to generate real-time information on supply levels create challenges for VHA staff at all levels—from the medical facility to VA Central Office—to track PPE during the pandemic. Information regarding the roles and responsibilities of VA personnel follows.

## **Veterans Integrated Service Networks and VHA Medical Centers**

VA has 18 Veterans Integrated Service Networks (VISNs), or regional systems, working together to meet local healthcare needs.<sup>12</sup> VISN chief logistics officers (CLOs) report to VISN directors and work directly with VHA medical centers to effectively implement supply chain management policy, reporting, training, and operational requirements. There are also CLOs at the medical centers, who establish a local supply chain management program that uses GIP as the VHA-approved inventory management system to maintain automated inventories.

## **VHA's Procurement and Logistics Office**

With annual expenditures of more than \$15 billion and a contracting staff of 2,700, the Procurement and Logistics Office is one of the largest groups of its type within the federal government. The office staff also maintain a supply chain management program within VHA; provide operational oversight of VHA's supply chain operations; and serve as the primary agents for logistics and program management activities. Additionally, personnel disseminate policies and procedures, collect and manage data, perform quality assurance, and implement tools for corrective action for VHA's supply chain management program.

## **Emergency Management Coordination Cell**

The Emergency Management Coordination Cell is part of VHA's Office of Emergency Management and acts as the executive in charge's mechanism for organizing responses to and recovery from significant incidents or events that require national direction or support, or for responding to federal interagency requests for assistance.<sup>13</sup> The coordination cell leverages resources from across VHA and ensures VHA facilities have the appropriate resources to safely

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<sup>11</sup> VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, 17-02644-130, March 7, 2018; VA OIG, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, 17-05246-98, May 1, 2019; VA OIG, *Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia*, 19-00260-215, September 26, 2019.

<sup>12</sup> "Veterans Health Administration: About VHA," website accessed August 19, 2020, <https://www.va.gov/health/aboutVHA.asp>.

<sup>13</sup> Emergency Management Coordination Cell SharePoint, accessed on August 19, 2020, <https://dvagov.sharepoint.com/sites/VHAreprogs/EMSHG/EMCC>.

meet veterans' healthcare needs.<sup>14</sup> It also helps VHA plan, report, and coordinate logistical, administrative, and financial support as needed during emergency incidents.

## Concerns about Personal Protective Equipment Shortages

Facility leaders and others engaged with the veteran community reported their concerns to the OIG related to PPE supply levels during the COVID-19 pandemic. The review team received a compilation of interview responses from a related national review conducted by the OIG's Office of Healthcare Inspections.<sup>15</sup> That review, conducted in June 2020, examined facility performance during COVID-19, and the team contacted facility leaders, and the heads of community living centers and community care, at 70 VHA facilities.<sup>16</sup> Specifically, the OIG healthcare inspections team asked interviewees if they had enough PPE in their facility—in terms of masks, gloves, gowns, and eye and face protection. Individuals at 67 facilities responded that they felt they had enough PPE. Respondents at two facilities expressed concerns specifically related to N95 mask shortages, and one facility noted they were reusing gowns “until [the] supply chain catches up.”

The inspections team also asked interviewees if they were satisfied with their supply of PPE if a second wave occurred. Staff at 60 facilities responded they were satisfied, but staff at 10 facilities stated they were not satisfied with current supply levels. Some expressed uncertainty as to what would be needed going forward and responded that they

- always “want more” PPE for peace of mind;
- are unable to quantify the amount they would need for a second wave since the virus is so unpredictable and the number of future COVID-19 patients is unknown;
- currently have a 10- to 17-day stock of all PPE provided through collaboration with the VISN, but would prefer a 30-day supply and have a goal of a 60-day supply; and
- are searching very hard to find PPE, and if there was a second wave, manufacturers would need to make more N95 masks, gowns, and isolation supplies.

To provide context for this report, the review team also considered complaints received by the OIG hotline during the pandemic, specifically regarding concerns related to shortages of COVID-19 PPE at VHA medical facilities.

The OIG team identified 112 hotline contacts made between March 10 and June 2, 2020, that specifically related to concerns with PPE supply levels, availability, or staff use of PPE at

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<sup>14</sup> Emergency Management Coordination Cell SharePoint.

<sup>15</sup> VA OIG, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020.

<sup>16</sup> The Office of Healthcare Inspections team noted that only 59 of the 70 selected VA facilities had community living centers.

medical facilities.<sup>17</sup> The team categorized the 112 contacts into four groups based on the type of complaint: (1) a facility had a general PPE shortage, (2) clinical staff did not receive PPE, (3) employees (nonclinical staff or not specified) did not receive PPE, and (4) staff were discouraged from using PPE. Some hotline contacts raised several concerns and fell into multiple groups, leading to the following totals:

- 40 contacts related to general shortages at a facility
- 10 contacts related to clinical staff not receiving equipment
- 61 contacts related to employees (nonclinical staff or not specified) not receiving equipment
- 19 contacts related to staff being discouraged from using equipment<sup>18</sup>

Overall, most hotline contacts related to PPE involved nonclinical staff or identified employees not receiving equipment without specifying what type of staff they were. This review does not report on the validity or outcomes of these individual complaints. It does, however, examine underlying systems and processes that help determine the reliability of the data used in tracking supply levels and identifying shortages of particular PPE items. Table 1 shows the number of OIG hotline contacts related to PPE in states with four or more contacts from March 10 through June 2.<sup>19</sup> Figure 2 shows the trend of OIG hotline contacts related to PPE from March 10 through June 2.

**Table 1. OIG Hotline Contacts  
Related to PPE**

State	Number of contacts
Texas	12
Florida	11
New York	11
California	6
Georgia	5
Pennsylvania	5
Louisiana	4

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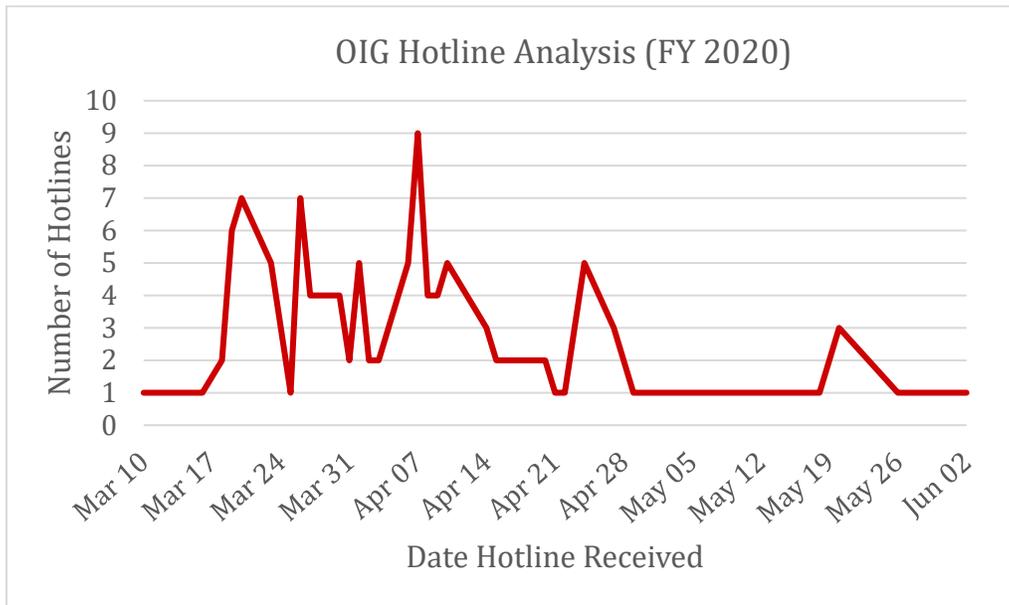
<sup>17</sup> The review team requested any contacts made to the OIG hotline regarding COVID-19 PPE concerns from February 1 through June 2, 2020. During that period, the first hotline contact regarding PPE concerns was made on March 10, 2020.

<sup>18</sup> For example, some contacts in this category noted staff were “discouraged/not allowed to use PPE,” told they could not “wear personal protection equipment,” or instructed “not to wear face coverings at work.”

<sup>19</sup> Contacts made to the OIG hotline did not always contain information on the specific facility or healthcare system. Therefore, the review team categorized the contacts by state to show geographical location.

State	Number of contacts
Maryland	4
North Carolina	4
Ohio	4
Wisconsin	4

Source: *OIG analysis of hotline contacts made from March 10 through June 2, 2020.*



**Figure 2.** *OIG hotline contacts related to PPE by week in 2020.*

Source: *OIG analysis of hotline contacts made between March 10 and June 2, 2020.*

## Results and Recommendations

### **Finding: VHA Quickly Developed PPE Supply Management Processes and Tools to Address Increased Demand by Navigating around a Limited Inventory System, but Can Improve Them Further**

VHA adapted its supply chain management to address increased demands associated with the COVID-19 pandemic and disruptions in global supplies. As requirements and guidance for PPE use were changing frequently due to the pandemic, VHA was facing known problems with limitations of its inventory supply system, GIP. In response, VHA developed additional processes and tools, implemented new guidance, communicated requirements to staff, and focused on maintaining PPE supply levels. For example, VHA created a manual-entry reporting tool for PPE to overcome lags in GIP data. VHA also implemented a national dashboard to monitor PPE supply levels in near real time and to ensure facilities' supply inventory met demand. VHA also implemented guidance on strategies to optimize PPE supplies, including reusing certain items; using some items past their expiration date; and limiting who would receive particular PPE, under what conditions, and with what frequency.<sup>20</sup>

Based on interviews with 22 staff members who were involved in VHA medical facility or VISN logistics operations at 42 facilities, the OIG found that no individual noted running out of PPE. Some VHA staff interviewed by the review team stated they experienced shortages—that is, they were “running low” on supplies at various points.<sup>21</sup> A VISN CLO said the hardest-hit locations reached as low as three days' stock on hand for some PPE items. A facility CLO from a different VISN also said there had been instances of three-day PPE supply levels. Employees at several facilities mentioned that receiving donations and shifting supplies among VISNs (a practice known as cross-leveling) helped facilities acquire needed supplies.

The OIG found that although VHA adapted swiftly, the administration's facility reporting and national monitoring of PPE supplies with new tools could be improved to enhance the accuracy of PPE inventory. The review team considered the following issues in making its finding:

- VA's existing supply chain management was deficient.
- VHA had to develop new processes to report PPE inventory levels.
- VHA's monitoring of national inventory moved to a new dashboard.

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<sup>20</sup> VA Memo, “Updated: Coronavirus (COVID-19) Facemask and N95 Respirator Use.”

<sup>21</sup> The term “shortages” was not defined. Facility staff provided varied responses to questions about sufficiency of supply levels and shortages that ranged from stating they experienced a “shortage” but never completely ran out of supplies, defining a shortage as a lack of sufficient supply to conduct operations, or equating PPE sufficiency to ability to meet demand.

- Challenges were associated with new inventory reporting and monitoring processes.
- VHA staff shared lessons learned to help improve responses to future pandemics.

## What the OIG Did

Given the importance of VHA medical facilities' need to acquire and maintain adequate PPE inventory and keep pace with increased demand, the OIG assessed how VHA reported and monitored PPE supply levels during the pandemic. The team reviewed VHA's guidance and inventory processes for managing its PPE supplies before the public health emergency was declared in January 2020, and then examined new policies and procedures developed in response to the pandemic.<sup>22</sup>

The team interviewed VHA and Procurement and Logistics Office officials, as well as 22 individuals involved in VHA medical facility or VISN logistics operations at 42 facilities. This included field service representatives, regional VISN CLOs, and medical facility CLOs and their deputies.<sup>23</sup>

The review team did not analyze the adequacy or sufficiency of VHA's COVID-related procurement and distribution practices, but instead focused on the PPE supply management process changes as part of overall reforms during the pandemic. Appendix A contains information on VHA's procurement and distribution changes, and appendix B provides additional details on the review scope and methodology.

## VA's Existing Supply Chain Management Was Deficient

In early 2020, VHA faced the possibility that its facilities would need to weather the pandemic without an inventory system capable of quickly reporting the quantity of PPE on hand. Before the COVID-19 crisis, VHA acknowledged its approximately \$10 billion annual supply chain was inefficient and had several significant limitations. Past audits and reviews have identified VHA's lack of supply chain discipline at the facility level, including staff failing to meet inventory requirements and using GIP inconsistently, if at all. These problems led to inaccurate and unreliable GIP data. Nonetheless, GIP remains VA's authorized inventory management system, and VHA facilities are required to use it.

Despite the requirement, the OIG review team found ongoing problems with the use of GIP for PPE. A lead program manager told the OIG review team that they were not aware of any

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<sup>22</sup> The OIG could not determine the reliability or accuracy of VHA-reported inventory data because the team did not conduct on-site visits during the pandemic to verify and physically count supplies at facilities and compare its findings with reported information.

<sup>23</sup> According to VHA, field service representatives are responsible for managing local and enterprise-wide PPE supply levels, providing shipment notification for nationally provided PPE supplies, and reviewing self-reported data for their respective VISNs to help identify possible issues.

facilities not using an inventory system, and that all facilities have GIP. However, the team interviewed two CLOs who reported their facilities were not using GIP to track PPE. Instead, these facilities relied on spreadsheets and physical inventory counts:

- The first CLO explained that she was not using GIP because it made consolidating data on PPE usage for multiple campuses cumbersome. She also stated that maintaining physical control of PPE was difficult since the centralized warehouse the facility used to distribute supplies to each campus did not have an inventory point established in GIP.
- The second CLO reported not using GIP to track critical items such as PPE because staff could not keep up with the receipt of supplies coming into the facility. Instead, staff used a spreadsheet to track the PPE inventory and used GIP to manage noncritical items.

The facility CLOs told the review team they had not requested waivers from using GIP, and VHA officials confirmed to the audit team that they had not received any such requests during fiscal year 2020. As a result, any inventory system information for those facilities could be inaccurate.

The OIG concluded that using GIP posed challenges for managing PPE inventory during the pandemic and that facility staff responded with workarounds. When the pandemic struck, the agency was forced to quickly develop new processes to establish stock visibility and maintain PPE levels.

## **VHA Facilities Developed New Processes to Report PPE Inventory Levels**

As facilities began using spreadsheets to track PPE supplies rather than relying on GIP, VHA's Procurement and Logistics Office responded in April 2020 by requiring facilities to use a new COVID-19 Response Monitoring Tool to report on mission-critical PPE levels and daily consumption.<sup>24</sup> VISNs and VHA consolidated this information to make allocation determinations based on facilities' reported inventory levels and rates of use.

VHA officials explained that they created the Response Monitoring Tool to supplement GIP because of the aging system's limitations. They cited issues with the GIP "1970's vintage, function-key driven" system and lags between offline requests, order processing, shipping, and receipt. They said there was a significant lag when staff added "the received product to the official inventory." Additionally, they noted GIP lacked information on government purchase

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<sup>24</sup> VA Memo, "Reporting Personal Protective Equipment (PPE) Levels and Daily Consumption," April 17, 2020. Although this tool is also referred to as the Response Validation Tool or VHA Support Service Center Capital Assets (VSSC) Tool, the OIG has referred to it as the Response Monitoring Tool throughout this report. VHA also referred to the COVID-19 Response Monitoring Tool as the Response Field Validation Tool, VSSC Tool, or the Healthcare Operation Center Tool.

card orders and inventory history. A former VHA official also reported that GIP lacked visibility into what a facility had on hand in all inventory locations, and that inventory system data quality was a “challenge.”

In its April 2020 memo outlining the use of the COVID-19 Response Monitoring Tool, VHA describes the new tool as a reporting template that would be used to reduce variances by standardizing the calculation method in reporting PPE inventory levels and usage. The memo dictated that facility supply chain management enter on-hand primary and contingency stock levels and calculate usage by integrating information from sources including inventory sales reports, manual counts, and picking tickets.<sup>25</sup> This initial guidance also noted that VISNs or facilities should self-report PPE supply levels and facility usage into the tool daily.<sup>26</sup> Figure 3 provides a screenshot of the Response Monitoring Tool entry screen used to enter self-reported PPE supply data.

PPE : Masks	N95 Masks		Non N95		Eye Protection		Respirators	
	N95	N95 Small	Surgical	Generic	Goggles	Face Shield	PAPR	CAPR
Total Stock on Hand (in eaches)	10120	5560	385200	30250	110	39068	54	0
Daily Usage (midnight to midnight)	20	20	1100	0	0	24		
Assistance (Y/N)	Yes	Yes	No	No	No	No	No	No

Success! PPE Masks Edited .

**Figure 3.** Screenshot of the Response Monitoring Tool (Response Monitoring Tool entry fields).

Source: Received from a VISN chief logistics officer on July 15, 2020.

Note: The term “eaches” in figure above is defined as the lowest unit of measure. For example, one case of gloves equals 10 boxes of gloves; one box of gloves equals 100 pairs of gloves; 100 pairs of gloves equals 200 eaches of gloves.

By implementing the COVID-19 Response Monitoring Tool as a supplement to GIP, VHA provided facilities a viable means of reporting their PPE inventory on hand, which would help ensure that VHA could respond to the increased demand. (For more on challenges associated with these new tools, see the section beginning on page 133.)

## VHA’s Monitoring of National Inventory Moved to a New Dashboard

Before the pandemic, VHA decision makers did not have real-time information concerning PPE inventory at the agency’s facilities. According to VHA, national inventory information was accessible via the Supply Chain Common Operating Picture (SCCOP) dashboard and was used

<sup>25</sup> When items are requested on a distribution order, GIP generates a picking ticket, providing item information, location, and quantities needed for distribution.

<sup>26</sup> According to a lead program manager, the Procurement and Logistics Office no longer required reporting on weekends as of May 1, 2020.

to manage the local and regional supply chain and analyze data nationally. Further, VHA noted that the SCCOP dashboard included data on 32 metrics, such as days of stock on hand and average daily use and could be filtered by facility, VISN, or national views. However, information in SCCOP was not updated daily, limiting its use during the pandemic.

In response, VHA officials noted they began using the COVID-19e Power Business Intelligence (or Power BI) Dashboard in April 2020 to facilitate monitoring near real-time supply levels. This dashboard provides a national picture of PPE supply information and includes views showing data obtained from the Response Monitoring Tool and from GIP for both daily usage and stock-on-hand levels at facilities. It is intended to be an efficient way to identify locations where additional supplies are needed and to calculate usage rates for essential PPE throughout VHA. VHA identified key parameters in the dashboard to indicate facilities that might be in urgent need of PPE supplies. VHA reported to the review team that it specifically looked at metrics such as “quantity on hand, daily burn rate, projected demand, quantity due in vs. quantity delivered” and provided guidance on ways to optimize PPE supplies.<sup>27</sup> In June 2020, VHA separated the views and created a second dashboard for GIP information. Language included on the GIP Power BI Dashboard states that this was done to “reduce confusion and condense resources for future [VHA Support Service Center Capital Assets] reports.”<sup>28</sup> Figure 4 provides an image from the COVID-19e Power BI Dashboard depicting reported data from the tool.

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<sup>27</sup> VHA reported to the review team that it considered ways to optimize PPE supplies based on CDC guidance.

<sup>28</sup> VHA separated the VHA Support Service Center Capital Assets (VSSC) and GIP data into two dashboards. One is called the COVID-19e VSSC Power BI Dashboard and includes information from the Response Monitoring Tool, and the other is called the COVID-19 IFCAP GIP Power BI Dashboard and includes data from GIP.



**Figure 4.** Screenshot of the COVID-19e VSSC Power BI Dashboard.

Source: OIG review team screenshot of August 17 data accessed from VHA’s COVID-19e VSSC Power BI Dashboard on August 18, 2020.

Note: VSSC stands for VHA Support Service Center Capital Assets.

To help identify potential data variances, the dashboard compares PPE information on supply levels from GIP with the facility inventory information reported in the Response Monitoring Tool. According to VHA, these comparisons identify outliers or potential errors that require further discussion or analysis, but they do not identify inaccuracies. While this verification method is useful, it may not identify all errors or discrepancies in the data because VHA cannot determine the accuracy of information reported by facilities. Both GIP and the Response Monitoring Tool, as discussed in the next section, sometimes included potentially inaccurate information.

## **There Are Challenges Associated with New Inventory Reporting and Monitoring Processes**

The OIG recognizes that the Response Monitoring Tool and the COVID-19e Power BI Dashboard were swiftly developed under unprecedented circumstances. These tools helped VHA monitor its PPE inventory in near real time and better respond to the COVID-19 crisis. In the course of its review, however, the OIG review team identified several challenges relating to the accuracy of information reported. By addressing these challenges, VHA can further improve how it responds to the ongoing pandemic and future crises.

### **Identifying Expired Supply Inventory**

In certain circumstances, some PPE items with expiration dates or a manufacturer-designated shelf life can be used even after that date has passed.<sup>29</sup> However, VHA did not provide guidance concerning how facilities should enter expired PPE inventory into the COVID-19 Response Monitoring Tool. Specifically, the tool does not allow facilities the option to disclose how much of their reported on-hand stock is expired.<sup>30</sup>

The review team received contradictory responses from VHA regarding whether expired items such as N95 masks should be included in PPE daily reporting. On July 8, 2020, a Procurement and Logistics Office manager said facilities included expired items in their daily reporting. A few weeks later, VHA officials reiterated to the team that guidance dictated including expired items in facility and VISN reports. However, in August 2020, VHA officials responded to the review team that guidance “does not direct the field to report expired material.”

Likewise, VISNs and facilities were inconsistent regarding whether they reported expired supply items. The materiel management manager at one facility said the facility normally did not report the expired items because the Response Monitoring Tool did not have an option to input the information. An acquisition program specialist at another facility also indicated the facility had expired inventory on hand but did not have a method to report how much of the inventory was expired given that the tool only asks for amounts, and there is no comment section. Conversely, a VISN CLO said that expired items were included in reported PPE numbers for their facilities, but the tool cannot distinguish between expired and unexpired PPE. Individuals the team interviewed

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<sup>29</sup> “GSA Shelf Life Management Program,” GSA website, accessed on November 24, 2020, <https://www.gsa.gov/buying-selling/purchasing-programs/requisition-programs/gsa-global-supply/supply-standards/gsa-shelf-life-management-program>. According to the General Services Administration, “Shelf life items are products that are effective, useful or suitable for consumption for a limited time period. They are expected to deteriorate or become unstable to the degree that a storage period must be assigned to assure that the material will perform satisfactorily in service.”

<sup>30</sup> VHA distributed guidance to follow CDC recommendations related to extending the use of PPE that may have passed its expiration date. Additionally, according to a letter from the Department of Health and Human Services, N95 masks that had exceeded their shelf life could still be used outside of surgical settings.

also noted the tool could misrepresent supply levels and show that they had available, usable items when that information was not accurate. If facilities have usable, expired supplies on hand and are not including them in daily reporting, it diminishes the accuracy of the information in the tool and the Power BI Dashboard.

The lack of guidance indicating whether facilities and VISNs should report expired PPE caused confusion and, ultimately, inconsistent PPE supply reporting. As VHA facilities reported receiving expired PPE supplies and having them on hand—and because CDC guidance supports the use of expired supplies in some situations as a conservation strategy—the OIG concluded that expired supplies should be included in the Response Monitoring Tool.

Recommendation 1 emphasizes the need for VHA to clearly articulate how facilities and VISNs should report expired PPE items and refine the Response Monitoring Tool to allow the entry of expired supply levels on hand. Making this distinction in PPE reporting will provide the national program office with a better understanding of how much PPE it has on hand.

### **Verifying Facility Self-Reported Inventory Data for Accuracy**

Manual data entry and differing methods for verifying the data increase the potential for inaccurate PPE information. One goal of the newly developed tools is to provide a picture of PPE supply levels that allows for cross-leveling and to identify facilities that need supplies. With this in mind, VHA needs assurance that the data have been consistently entered and verified, regardless of who performs the actions, to provide uniformity and increase reliability.

The April 2020 VHA memo outlining the use of the Response Monitoring Tool does not provide guidance or suggested methods for verifying the self-reported data. VISN CLOs interviewed by the review team stated that they used a range of approaches when reviewing inventory levels reported by facilities through the Response Monitoring Tool, including

- conducting “morning huddles” with facility staff to review supply inventory numbers and compare them with GIP before submitting the information;
- performing a quality check of the manually entered information and discussing any mistakes with facility staff to adjust the information if appropriate;
- reviewing SCCOP, entering the data for their facilities, and trying to be as “accurate as possible”; and
- pulling the inventory numbers directly from GIP.

One respondent noted that any system involving humans has errors, but said that for the most part the data have been “good” and “effective.” Still, the respondent expressed a preference for systems that could track supply items automatically.

Effective verification is needed to ensure VHA has information that is as accurate as possible. VHA requires high-quality data on supply levels to help facilities determine if they have enough supplies to meet patient care demands and keep staff safe. Additionally, VISN involvement with verifying data can mitigate the risk that some facilities underreport or overstate on-hand supply levels and are inaccurately tracking usage. Although in-person verification processes may be limited or not achievable during the pandemic, effective methods of verification are needed VHA-wide.

Recommendation 2 calls on VHA to communicate acceptable verification measures for facilities and VISNs to improve the reliability and consistency of self-reported PPE on-hand quantity and usage information.

### **Reallocating Supplies across Facilities or VISNs Could Inflate Usage Data, and Having Inconsistent GIP Information Undermined Reliability**

While the Power BI Dashboard was created to provide an efficient and comprehensive way for VHA to monitor PPE supply levels nationwide, there are still limitations that could diminish the accuracy of the data it displays. Specifically, the dashboard could include inflated usage information as a result of how it records shifting (cross-leveling) supplies and might not include some PPE supply items at facilities.

When VHA cross-levels supplies among facilities and across VISNs, those supplies could be double counted in usage data. A VHA lead program manager explained that if VHA distributes items from one facility to another facility, those items are designated as “used” in GIP. When those items are received by the requesting facility, they will be distributed to clinics and reported in that facility’s inventory system as used. Because usage information for the same items is reported in the inventory systems at both facilities, cross-leveling could misrepresent the original facility’s data relied on to determine need. Double counting in the dashboard also could inflate overall usage data and prompt VHA to believe that it used more PPE than it actually did. VHA acknowledged this issue and noted that this was a limitation in GIP. VHA cannot correct the problem as long as it continues to use GIP. The OIG consequently concludes that VHA needs to state this limitation when reporting PPE information.

GIP poses another unresolved problem. GIP uses item master file numbers to store supply item information. According to a Procurement and Logistics Office lead program manager, this information is unique to each facility. While multiple facilities may have the same supply item, its name or description and the master file number used to identify it in GIP may differ at each facility. One VISN CLO confirmed data in the Power BI Dashboard may be misleading because the dashboard includes GIP item master file numbers to identify which items to track, but facility staff may be tracking items with various other identification numbers, which may show a different picture of on-hand supplies. A facility CLO also noted that a facility may appear to be

low on a supply item if only certain item master file numbers from GIP are used to pull supply levels.

This variability presented a challenge for how VHA has been monitoring its PPE inventory during the pandemic. VHA has been relying on a combination of information (including item name keywords and manufacturers) to pull GIP data for the Power BI Dashboard. In other words, a lead program manager stated VHA processed initial supply data to determine groupings for supplies, such as taking several types of masks and putting them into a “mask” category together. According to the manager, this process helps mitigate issues when facilities have different descriptions and item master file numbers for the same items, and “lines everything up.” Figure 5 presents an image of the Power BI view that shows specific categories that are tracked.

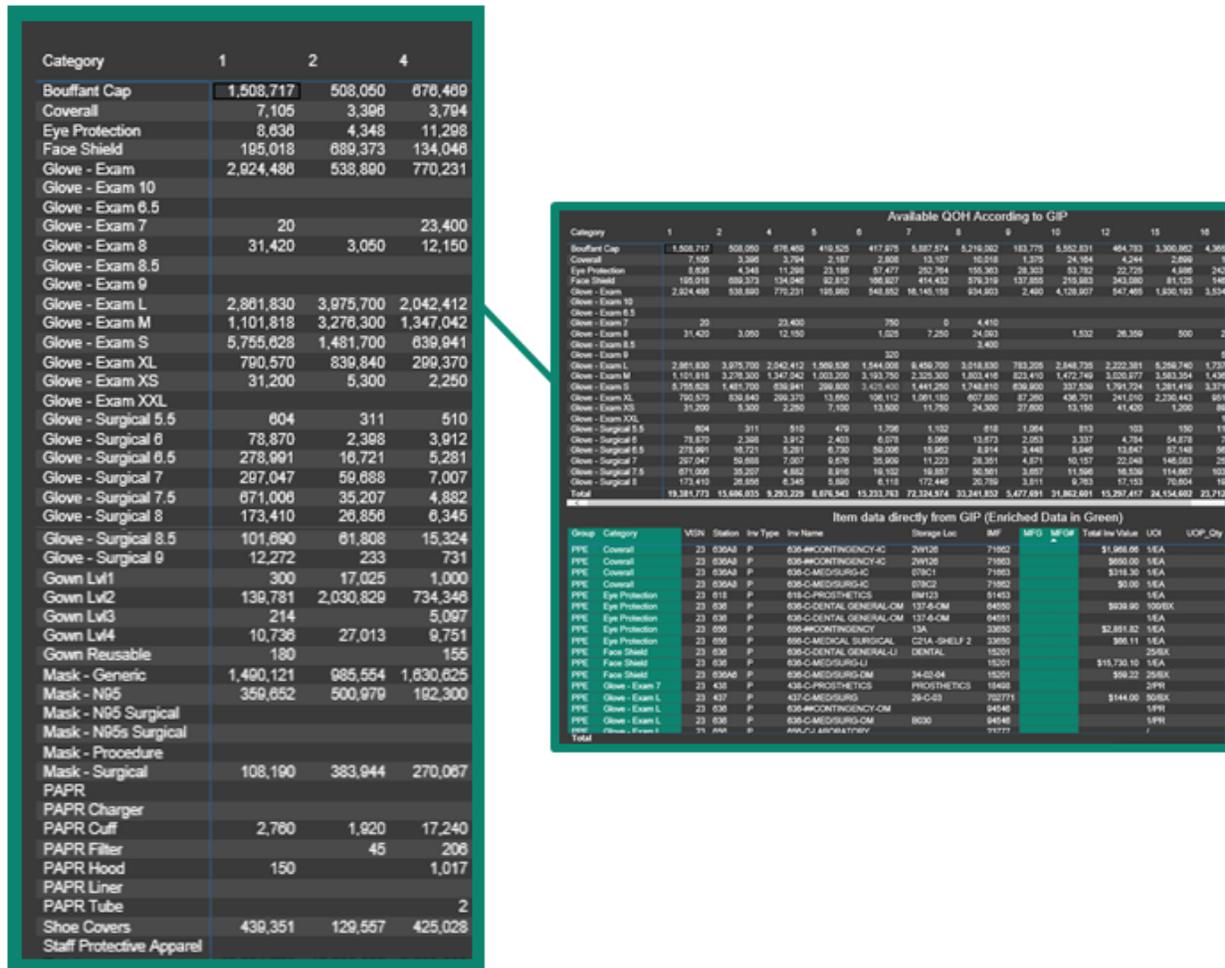


Figure 5. Screenshot of the COVID-19 IFCAP GIP Power BI Dashboard.

Source: OIG review team view of COVID-19 IFCAP GIP Power BI Dashboard on October 21, 2020.

Note: GIP is a module of the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system (IFCAP).

However, because facility staff have not been involved in identifying the supply items that are included in specific categories or groupings for the Power BI Dashboard, there could be discrepancies between GIP data displayed on the dashboard and facility-reported supply levels. For example, a VISN CLO mentioned that there were items not considered part of the PPE supply, such as chemotherapy gloves for the oncology pharmacy. Because the Power BI Dashboard includes supply items that say “glove” in their reported data, there could be a discrepancy between what the facility self-reports as COVID-19 PPE, and what the Power BI Dashboard shows.

The OIG acknowledges the difficulty and complexity of maintaining an accurate and near real-time inventory of these critical items during a pandemic. However, because VHA uses this information to distribute PPE supplies, accuracy is essential, and any limitations should be made clear to VHA leaders and other key stakeholders.

## **VHA Personnel Shared Lessons Learned to Help Improve Responses to Future Pandemics**

VISN and facility CLOs told the OIG review team about gaps in planning that occurred during the beginning of the pandemic and discussed potential preparations for additional waves. During interviews, some facility and VISN CLOs offered “lessons learned” or suggested best practices to improve VHA’s ability to manage PPE in the future that include the following:

- Keeping a 30-day supply of stock on hand for operational use and a 60-day supply for contingencies to keep the supply chain in order
- Having logistics staff coordinate with clinicians to help explain how an item will be used
- Having clinical staff determine what PPE was necessary for clinical procedures at the start of COVID-19
- Having field service representatives contribute to the success of acquiring supplies that would not be readily available through the regular supply chain
- Reporting all sizes of hand sanitizer, rather than just one size (One VISN appeared to be critically low on hand sanitizer, even though facilities reported being well-stocked with other sizes not captured in the dashboard.)

By July 2020, VHA recommended that facilities increase PPE inventory levels to 60 days of stock on hand. VHA’s Procurement and Logistics Office said this guidance was communicated through leaders at all levels. VISN and facility staff confirmed they were increasing stock levels to 30 days of operational inventory and 30 days of contingency inventory.

Looking forward, VHA faces an uncertain environment and the demand for PPE continues. In addition to the new tools, VHA leaders said they work to determine sufficient PPE supply levels

at facilities based on the demand on the global PPE supply chain, as well as “pre-COVID-19 demand, COVID-19 peak demand, and projected demand,” which included predicted patient illness severity and number of patients.

Among the challenges in meeting demand are differences by facility and varying perceptions of what constitutes a shortage. PPE supply levels can vary at each facility based on factors such as the number of clinical and nonclinical staff, types of care provided, and number of positive COVID-19 patients being treated at a given time. For example, one VISN CLO defined a shortage as less than seven days of inventory on hand. This CLO established a categorization system for supply items ranging from zero to 60 days stock on hand as a method to keep track of levels. Another facility supervisory logistics management specialist simply defined a supply shortage as a lack of sufficient supply on hand to conduct operations.

VHA reported to the review team that, on November 12, 2020, it had an average of 379 days of supply on hand for gloves, 588 days of supply on hand for isolation gowns, and 3,415 days of supply on hand for N95 respirators.<sup>31</sup> These numbers reflected supply levels across the enterprise and were based on the three-day use rate at that time.<sup>32</sup> In July 2020, VHA leaders said that in preparation for possible increased demand, they would continue working with government and private sector partners, and shifting supplies from areas with low demand for PPE to those with high demand. VHA leaders also noted they have set up decontamination strategies, which align with CDC guidance, for N95 masks until additional supply is available. In addition, VHA is establishing four Regional Readiness Centers to act as a central source for management and resupply of PPE.<sup>33</sup> The Regional Readiness Centers will carry up to 120 days of supply and are intended to mitigate supply availability issues and enable VHA to sustain continuous services. As of October 2020, VHA stated that the centers were all in different stages of completion.

## Conclusion

VHA developed PPE supply chain management processes and tools to address increased demands during the pandemic and the limited global availability of supplies. It swiftly implemented a manual-entry reporting tool and a national dashboard to monitor PPE supply levels under unprecedented circumstances. The new tools VHA developed help compensate for limitations in its GIP supply inventory management system. There are, however, some remaining challenges in leveraging and reconciling that data. Other identified challenges relate to accurately tracking usage for supplies redistributed among facilities and identifying PPE supply items in GIP, as well as providing better accounting and guidance related to expired supplies that

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<sup>31</sup> Per VHA, gloves are reported as one each, and not pairs.

<sup>32</sup> According to the acting assistant under secretary for health for support services, the provided metrics are an average and will vary by site based on COVID-19 and other case load.

<sup>33</sup> According to VHA, the Regional Readiness Centers are located in Susquehanna, Pennsylvania; Birmingham, Alabama; San Joaquin, California; and Marengo, Indiana.

may still be of use. The information the review team gathered did not include evidence that VHA facilities ran out of PPE, although some VHA staff stated they experienced shortages or were running low on supplies at various points. The OIG has made two recommendations to support VHA efforts to improve how it tracks and reports PPE inventory and usage. These recommendations are meant to further improve the reliability of information used to report and monitor the availability of critical PPE.

## Recommendations 1–2

The OIG made two recommendations to the under secretary for health:<sup>34</sup>

1. Provide specific guidance for personnel in facilities and Veterans Integrated Service Network offices to report expired personal protective equipment supplies into the Response Monitoring Tool and refine the tool to allow the entry of expired supply levels on hand.
2. Communicate effective verification measures for facilities and Veterans Integrated Service Networks to improve the reliability and consistency of reported personal protective equipment on-hand quantity and usage information.

## Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with the recommendations and provided corrective action plans. To address recommendation 1, the executive in charge reported that VHA will develop specific guidance on how facilities and VISNs report expired PPE items, and explore refining the Response Monitoring Tool to allow the entry of expired supply levels on hand to differentiate between operational stock and US Centers for Disease Control and Prevention crisis strategy stock.

For recommendation 2, the executive in charge reported that “VHA developed and implemented verification measures to verify self-reported data in the Response Monitoring Tool.” VHA agreed that effective verification methods improve the reported PPE on-hand quantity and usage information. The executive in charge further stated that Procurement & Logistics Office field service representatives review data variances and averages from the tool’s reporting metrics to identify significant anomalies requiring attention. The executive in charge stated that “deployment and summarization of the verification measures began in May 2020 and continues.” For these reasons, VHA considered recommendation 2 fully implemented and asked the OIG to consider closing it.

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<sup>34</sup> Recommendations directed to the under secretary for health were submitted to the executive in charge, who had the authority to perform the under secretary’s functions and duties. Effective January 20, 2021, he was appointed to acting under secretary for health with the continued authority to perform the functions and duties of the under secretary.

## OIG Response

The executive in charge's corrective action plans are responsive to the intent of recommendation 1. Regarding recommendation 2, the OIG review team does not consider the stated actions and guidance in VHA's April 2020 memorandum sufficient to provide adequate additional verification methods that facilities and VISNs could use after compiling their self-reported PPE supply information. After VHA provided its action plans, VHA leaders and the OIG review team discussed these concerns. VHA stated they would update guidance for facilities to provide VISNs with their required supply level information and ensure VISNs are responsible for entering this information into the Response Monitoring Tool. This process would facilitate an added layer of review by the VISNs before entry into the tool, thereby helping to identify any issues or errors. The OIG will close recommendation 2 when VHA provides evidence that these measures have been updated and communicated to facilities and VISNs.

The OIG will monitor the implementation of all planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix C includes the full text of the executive in charge's comments.

## Appendix A: Procurement and Distribution Processes and Tools

Before the pandemic, facilities established the average on-hand supply levels for all expendable items (typically single use), including PPE, based on reported levels and usage included in the inventory management system. When supply levels fell at or below this threshold, medical centers would submit requests to replenish the stock. Facilities used contracts and government purchase cards to place these orders, and supplies were sent directly to facilities for distribution. These established, on-hand limit thresholds are imperative to avoid interruptions to care caused by supply shortages.

According to officials, VHA began procuring PPE items needed for COVID-19 protection in January 2020. A memo issued in February 2020 stated that VHA would monitor PPE and respond to shortages as quickly as possible and instructed staff to report to the Emergency Management Coordination Cell any PPE used in caring for a COVID-19 patient.<sup>35</sup> VA issued a memo on March 15, 2020, that provided purchasing flexibility through June 30, 2020.<sup>36</sup> These flexibilities included increasing the emergency acquisition threshold for government purchase cards and contracts to expedite the delivery of goods and services.<sup>37</sup>

The March 15 memo also noted that any purchases made outside the United States would be approved on a case-by-case basis. (VA provided an update to this memo in June 2020 that extended the emergency acquisition flexibilities threshold increases through September 30, 2020.) Two days later, prior restrictions on using purchase cards for back-ordered goods were lifted to facilitate purchases.

VHA determined that it needed to acquire supplies as availability dwindled, and it established new national contracts to acquire PPE for its facilities. These supplies were shipped and stored in a centralized warehouse known as the VHA Service and Distribution Center. In partnership with the Office of Acquisition, Logistics and Construction, the center helped distribute PPE to medical facilities that had difficulty procuring the supplies locally.

After directing that PPE stock levels and use be tracked, VHA developed the National COVID-19 Request Tool (national request tool) so VHA facilities could formally ask for these much-needed supplies stored in the Service and Distribution Center. Requests through the tool

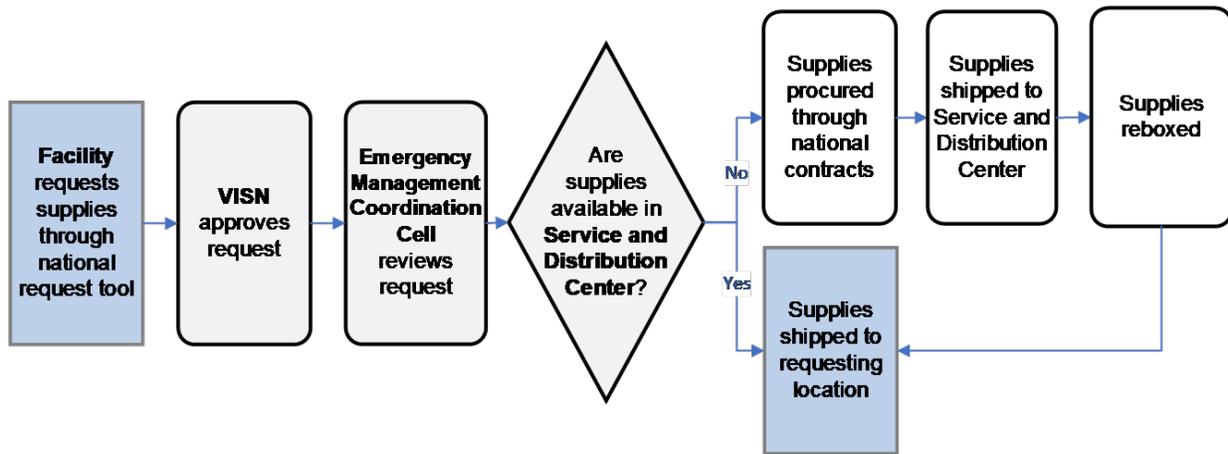
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<sup>35</sup> VA Memo, “Personal Protective Equipment,” February 14, 2020.

<sup>36</sup> VA Memo, “Emergency Acquisition Flexibilities—Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19),” March 15, 2020.

<sup>37</sup> VA Memo, “Emergency Acquisition Flexibilities.” These flexibilities also included increasing the micropurchase threshold to \$20,000 for goods and services purchased in the United States, increasing the simplified acquisition threshold to \$750,000 for any contract awarded and performed in the United States, and increasing the threshold for simplified procedures for certain commercial items to \$13 million.

were to be made only if facilities were unable to procure critical supplies through established supply chain channels. Figure A.1 presents an overview of the process.



**Figure A.1.** Overview of National COVID-19 Request Tool process.  
 Source: OIG review team analysis of VHA policy and guidance.

After supply management staff requested PPE supplies using the tool, the VISN reviewed and approved the request, then the Emergency Management Coordination Cell. According to VHA, if the requests were approved and the items were available through the Service and Distribution Center, the items were shipped to the facilities.<sup>38</sup> If the requested supplies were not readily available, VHA would establish national contracts to procure the items, and the supplies would be shipped to the center. Here, the cumulative orders were broken up according to individual supply requests. The individual supply orders were then reboxed and shipped to the requesting locations. In addition, field service representatives reviewed self-reported supply data for their respective VISNs to help identify possible issues, advocate on the VISNs’ behalf to support national request tool requests, and provide shipment notification updates.

To help simplify the request process through the national request tool, VHA’s Procurement and Logistics Office developed a catalog of supply items (referred to as the COVID-19 catalog) that were available through national contracts. The COVID-19 catalog contained supply items that facilities had previously identified as difficult to obtain; VHA expects the catalog to expand as facilities identify additional supply chain shortages and needs. Facilities can request critical supplies not listed in the COVID-19 catalog through the national request tool, and this information is also used to update the catalog supply listing.

<sup>38</sup> In October 2020, VHA officials stated they planned to transition out of the Service and Distribution Center by the end of 2020, turning their focus to Regional Readiness Centers.

## Appendix B: Scope and Methodology

### Scope

The review team performed its work from May 2020 through December 2020. The scope of the review focused on assessing VHA's process for reporting and monitoring PPE supply levels during COVID-19.

### Methodology

The OIG coordinated with and interviewed officials and staff in VHA's Procurement and Logistics Office and individuals involved in VHA medical facility or VISN logistics operations. The OIG reviewed VHA's inventory management criteria and guidance distributed to VHA medical centers and VISNs during the pandemic and outlined process changes between January 2020 and August 2020.

### Office of Healthcare Inspection Interviews

The review team requested information from a prior review conducted by the Office of Healthcare Inspections on facility performance during COVID-19, and reviewed interview responses from leaders at 70 medical facilities.<sup>39</sup> The inspections team developed a series of pandemic-related questions about facility operations between March 11 and June 15, 2020, and interviewed personnel at one or more facilities in each VISN. The information was used to understand issues related to the performance of the facility during the pandemic, including gathering a more comprehensive view of facility concerns regarding PPE supply levels.

### Hotline Contacts Analysis

To help identify PPE supply concerns at medical centers, the team reviewed contacts made to the OIG's hotline between February 1 and June 2, 2020, regarding COVID-19 and identified 112 contacts that specifically related to PPE concerns. The first contact related to COVID-19 PPE was made on March 10, 2020. The team categorized the complaints into four groups: (1) facility had a general PPE shortage, (2) clinical staff did not receive PPE, (3) employees (nonclinical staff or not specified) did not receive PPE, and (4) staff were discouraged from using PPE.

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<sup>39</sup> VA OIG, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*.

## **Fraud Assessment**

The review team assessed the risk that fraud, noncompliance with legal and regulatory requirements, and abuse could occur during this review by exercising due diligence in staying alert to any fraud indicators in its data analysis.

The OIG did not identify any instances of fraud or potential fraud during this review.

## **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: Management Comments

### Department of Veterans Affairs Memorandum

Date: January 12, 2021

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report-Reporting and Monitoring Personal Protective Equipment during the Pandemic (2020-02959-R3-0001) (VIEWS #4275021)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report *Reporting and Monitoring Personal Protective Equipment during the Pandemic*. The Veterans Health Administration (VHA) concurs with the recommendations and provide the attached action plan.

*The OIG removed point of contact information prior to publication.*

(Original signed by)

Richard A. Stone, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)**

**Action Plan**

**Reporting and Monitoring Personal Protective Equipment during the Pandemic**

**(2020-02959-R3-0001)**

**Recommendation 1. Provide specific guidance for personnel in facilities and Veterans Integrated Service Network offices to report expired personal protective equipment supplies into the Response Monitoring Tool and refine the tool to allow the entry of expired supply levels on hand.**

**VHA Comments:** Concur. The Veterans Health Administration (VHA) will develop specific guidance on how facilities and Veterans Integrated Service Networks (VISN) report expired Personal Protective Equipment (PPE) items with National Institute for Occupational Safety and Health approved shelf life extensions in the Response Monitoring Tool. VHA will issue guidance from the Assistant Under Secretary for Health for Operations. VHA will also explore the possibility of refining the Response Monitoring Tool to allow the individual entry of expired supply levels on hand to differentiate between operational stock and U.S. Centers for Disease Control and Prevention crisis strategy stock.

Status: In Progress

Target Completion Date: May 2021

**Recommendation 2. Communicate effective verification measures for facilities and Veterans Integrated Service Networks to improve the reliability and consistency of reported personal protective equipment on-hand quantity and usage information.**

**VHA Comments:** Concur. VHA developed and implemented verification measures to verify self-reported data in the Response Monitoring Tool. In-person verification of self-reported data is not achievable during the COVID-19 pandemic; however, effective verification methods improve the reliability and consistency of reported personal protective equipment on-hand quantity and usage information. The Response Monitoring Tools report metrics, including the percentage of reported items undergoing change as well as graded data variances, and compares them against the national average in order to indicate problem areas. Procurement & Logistics Office (P&LO) Field Service Representatives use these reporting metrics to review reported data variances and averages in order to alert customers of significant anomalies requiring attention. The COVID-19 edashboard is accessible by all Veterans Integrated Service Networks and facility stations, as is P&LO provided training on how to use the dashboard, including review of the above stated verification measures. The deployment and summarization of the verification measures began in May 2020 and continues. VHA completed its work for this recommendation and requests the OIG consider closure.

Status: Completed

Completion Date: May 2020

*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

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