

Review of Personnel Shortages in Federal Health Care Programs During the COVID-19 Pandemic

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PANDEMIC RESPONSE
ACCOUNTABILITY COMMITTEE



Message from the Pandemic Response Accountability Committee

While personnel shortages existed in the health care community before the pandemic, the pandemic exacerbated these shortages. Maintaining an appropriate level of personnel in health care facilities is essential to providing a safe work environment for health care personnel and quality care to patients. The Pandemic Response Accountability Committee’s (PRAC) Health Care Subgroup developed this report to share insights into personnel shortages across four select federal health care programs, or the providers they reimburse (hereinafter referred to as “federal health care programs”). Together, these four programs provide health care services to approximately 20 million individuals.

This report provides Congress, federal and state agencies, health care organizations, and other policymakers with information to inform and raise awareness on health care shortages across the four federal health care programs. Specifically, this report summarizes the types of personnel shortages most commonly reported; factors that contributed to personnel shortages; impacts most commonly encountered; and the incentives and strategies used to recruit and retain personnel, and minimize burnout for existing personnel across the four federal health care programs.

OIGs identified the following key insights across the four federal health care programs reviewed.

- Nurses and medical officers were the most commonly reported positions that experienced shortages during the pandemic.¹
- A limited labor pool, noncompetitive pay, COVID-19 requirements, and a challenging hiring process were the most commonly reported factors that contributed to personnel shortages.
- A decrease in patient access to care and patient satisfaction; and an increase in health care personnel work hours and responsibilities were the most commonly reported impacts resulting from personnel shortages.
- Monetary incentives were the most commonly reported strategy to recruit and retain personnel.

The four Departments and facilities reviewed include:

1. **Department of Defense**
Medical Treatment Facilities
2. **Department of Justice**
Federal Bureau of Prisons
3. **Department of Veterans Affairs**
Veterans Health Administration Facilities
4. **Department of Health and Human Services**
Medicare- and Medicaid-Certified Nursing Homes^a

Source: Scope of the four federal health care programs.

- a. Medicare- and Medicaid-certified nursing homes are not federally operated, but rather receive reimbursement for services they provide to enrollees in Medicare and Medicaid programs.

Even though the federal health care programs have incentives and strategies to attract and retain health care personnel, the programs still experienced personnel shortages throughout the pandemic. Consequently, additional action is necessary to staff normal operations and to strategically plan for future surges in personnel needed to respond to pandemics and other health care emergencies. The PRAC encourages policymakers to further explore the impacts of personnel shortages within the federal health care programs for possible strategies to mitigate staffing shortages and help ensure high quality, safe, and timely health care is provided to the individuals the programs serve.

About the PRAC and its Health Care Subgroup

The CARES Act created the PRAC to coordinate oversight of the federal government's pandemic response and its historic level of emergency spending. The PRAC's Health Care Subgroup consists of OIGs that oversee the federal agencies that provide or reimburse for health care services. By working together and sharing data, the Health Care Subgroup provides coordinated oversight across agencies and programs.



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Insights on Shortages of Personnel Across Four Federal Health Care Programs

As the nation’s health care workforce has responded to the coronavirus disease–2019 (COVID-19) pandemic (hereinafter referred to as the “pandemic”), maintaining a sufficient level of personnel in health care facilities has been essential to providing a safe work environment for health care providers and safe and effective patient care. While personnel shortages existed in the health care community before the pandemic, the pandemic exacerbated these shortages. As the pandemic progressed, personnel illnesses, exposures to COVID-19, or the need to care for family members caused additional staffing shortages. Moreover, one of the federal departments reviewed provided personnel to assist in the National response to the pandemic, exacerbating shortages within its health care program.

This report provides Congress, federal and state agencies, health care organizations, and other policymakers with information on health care shortages across four federal health care programs, discussed in detail below. Specifically, the report provides insights into shortages in personnel positions most commonly reported; factors contributing to personnel shortages reported by facility officials; impacts to the health care personnel, the patients, and health care services provided by the federal health care programs; and strategies to mitigate personnel shortages caused by or exacerbated by the pandemic. These insights can help policymakers understand the challenges that federal health care programs experienced throughout the pandemic and determine the actions necessary to ensure sufficient staffing for ongoing health care needs and future pandemic response efforts.

How We Conducted This Review

Four of the Offices of Inspectors General (OIG) in the PRAC Health Care Subgroup participated in this review—the Department of Defense (DOD), the Department of Justice (DOJ), the Department of Veterans Affairs (VA), and the Department of Health and Human Services (HHS). The DOD, DOJ, and VA OIGs reviewed staffing within their internal health care programs while the HHS OIG reviewed staffing within Medicare- and Medicaid-certified nursing homes. Each OIG reviewed personnel in the facilities identified below, including clinical positions that deliver patient care and nonclinical positions such as administrative, logistical, or clerical positions that support patient care. See Exhibit 1 for more information about the scope of our review.

Exhibit 1: Scope of Review^a

	<i>DOD</i>	<i>DOJ</i>	<i>VA</i>	<i>HHS</i>
Facilities Reviewed	Medical Treatment Facilities (MTF)	Federal Bureau of Prisons (BOP) Institutions	Veterans Health Administration (VHA) Facilities	Medicare- and Medicaid-Certified Nursing Homes
Number of Health Care Staff	More than 128,000 Service members and civilian employees ^b	Approximately 3,000 BOP employees and U.S. Public Health Service officers ^c	More than 371,000 health care professionals	More than 686,000 direct care staff ^d
Population Served	9.6 million active military members and their families, military retirees and their families, dependent survivors, and certain eligible Reserve Component members and their families	Approximately 134,000 federal inmates and detainees housed in BOP institutions	More than 9 million enrolled veterans; qualifying family members, dependents, and survivors of veterans; and eligible active military and Reserve Component members	1.2 million Medicare and Medicaid enrollees who reside in nursing homes
Number of Facilities Within the Health Care Program	45 hospitals, 525 outpatient clinics, and 138 dental clinics	97 facilities encompassing 121 BOP institutions	140 facilities, encompassing over 1,200 sites of care including VA Medical Centers and outpatient settings	15,178 Medicare- and Medicaid-certified nursing homes nationwide
Number of Facilities Nonstatistically Sampled for this Review	24 hospitals	97 facilities encompassing 121 BOP institutions	139 facilities	50 nursing homes

Source: Analysis of data from the four federal health care programs.

- a. 2022 Data; Health care program information detailed above includes only the portions of the programs reviewed for this report.
- b. The Military Health System (MHS) also used contractors, tracked at the MTF or regional level not MHS-wide, and are not included in the total. See the section on the U.S. Department of Defense for more information about the MHS.
- c. The BOP also employs contract medical staff at some institutions who are not included in the total.
- d. Direct care staff include nursing home employees and staff hired under contract or through staffing agencies.

The data and insights are limited to the federal health care programs and the health care personnel that each OIG chose to review. Personnel data varied across the federal health care programs; therefore, OIGs collected and reported shortages of personnel based on the data available. The information provided includes what the federal health care programs experienced, such as experiences of existing health care personnel and their perceptions of former health care personnel experiences, during the period of review. The General Methodology section in this report and the more detailed methodologies in the appendices contain additional information on how each OIG conducted its analysis.

Shortages of Personnel

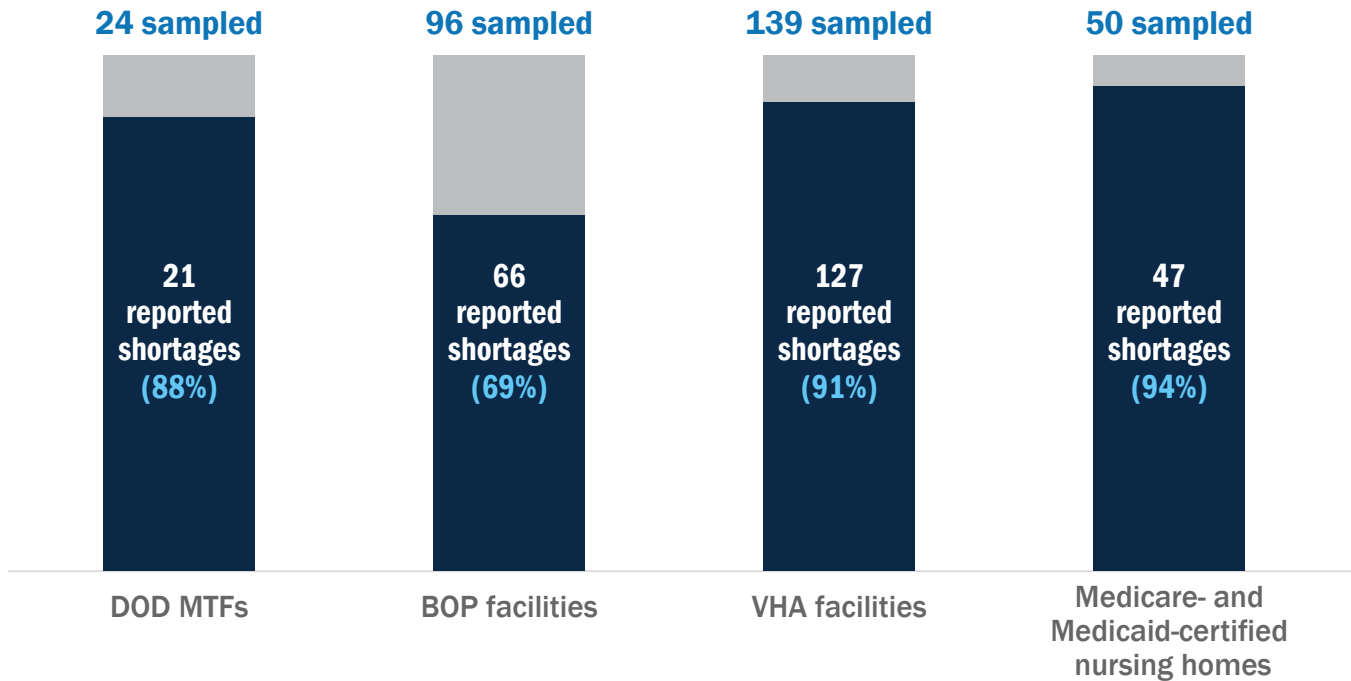
INSIGHT: The four federal health care programs each experienced shortages in personnel before and during the pandemic

The four federal health care programs experienced personnel shortages before and during the pandemic. According to data provided from or interviews with program officials, the pandemic exacerbated shortages for the health care programs. For example, officials from Medicare- and Medicaid-certified nursing homes reported shortages of nurses at 29 of the 50 nursing homes before the pandemic, compared to 47 nursing homes during the pandemic. Additionally, according to MTF officials, health care personnel shortages increased during the height of the pandemic and at the time of the MTF interviews the MTFs had not been able to fill many of the positions. The four federal health care programs we reviewed experienced shortages in some common positions during the pandemic.

Nursing positions and medical officers constituted the most commonly reported personnel shortages during the pandemic

Nursing was one of the most commonly reported positions that experienced shortages in the four federal health care programs reviewed. Exhibit 2 shows the percentage of sampled facilities in each federal health care program that reported a nursing shortage during the pandemic.

Exhibit 2: Percentage of Sampled Facilities by Federal Health Care Program that Reported a Nursing Shortage During the Pandemic



Source: Analysis of nursing shortages reported by facilities in the four federal health care programs.

Notes: Percentages in the chart were calculated using the number of nonstatistically sampled facilities identified in Exhibit 1.

Each OIG accounted for shortages in different ways based on the federal agency's available data; see each agency's appendix on how they reported nursing shortages.

VHA facility percentage is based off responses from the VA OIG's FY 2022 survey.

Three of the federal health care programs (BOP, MTFs, and VHA facilities) also reported shortages of medical officers during the pandemic. According to BOP staffing data, 13 of 96 BOP facilities did not have a medical officer on staff as of March 2022.² Additionally, officials at 12 of 24 MTFs interviewed reported medical officers as one of their highest positions in demand. Further, officials at 121 of 139 VHA facilities reported a shortage in the medical officer series.

In addition to nurses and medical officers, the health care programs experienced shortages in a variety of other positions that varied by each federal health care program. See Exhibit 3 for the most commonly reported positions with shortages by facility type.

Exhibit 3: Top Reported Positions with Shortages

<i>Department</i>	<i>Facility Type</i>	<i>Top Reported Positions with Shortages</i>
DOD	Medical Treatment Facilities	Nurses, Medical Officers, Behavioral Health personnel, Imaging Technicians, Laboratory Technicians, Medical Support Assistance personnel
DOJ	Bureau of Prisons Institutions	Nurses, Medical Officers, and Mid-level practitioners (such as Nurse Practitioners and Physician Assistants)
VA	Veterans Health Administration Facilities	Nurses, Medical Officers, Custodial Workers, Medical Support Assistance, Psychiatry (medical officer specialty), and Psychology
HHS	Medicare- and Medicaid- Certified Nursing Homes	Nurses and Aides

Source: Analysis of data from the four federal health care programs, April 2019 through January 2023.

Contributing Factors of Personnel Shortages

INSIGHT: The four federal health care programs faced challenges exacerbated by or caused by the pandemic that contributed to shortages of personnel

The four federal health care programs we reviewed faced various challenges that contributed to personnel shortages.

A limited labor pool, noncompetitive pay, COVID-19 requirements, and a challenging hiring process were the most commonly reported factors that contributed to personnel shortages

Officials from the four federal health care programs reported that the shortages stemmed from a limited labor pool of health care personnel such as doctors and nurses. The four federal health care programs also reported that noncompetitive pay compared to other health care facilities contributed to personnel shortages. According to BOP, MTF, and nursing home officials we interviewed, the facilities had difficulties recruiting or retaining their personnel because other health care facilities offered higher pay. For example, in an announcement obtained in January 2023, a private health care company posted a job paying \$81,120 annually for a vocational nurse, which was \$33,504 more than a vocational nurse position posted for an MTF at a location 7 miles away.³ Additionally, nursing home officials we interviewed stated that their facilities lost health care personnel during the pandemic to higher paying jobs in other industries.

Officials from two of the four federal health care programs (BOP and MTFs) also identified noncompetitive pay compared to other federal agencies as a contributing factor that led to personnel shortages. In 1975, Congress first authorized VA to offer higher salaries to physicians and dentists using title 38 authority. Since then, Congress has expanded the authority to offer higher salaries to other health care positions such as physician assistants, podiatrists, and nurses.⁴ The Office of Personnel Management (OPM) extended title 38 authority to the DOD and DOJ in 2012 and 2014, respectively; however, since then the Departments have applied title 38 authority to only a few medical positions.⁵ Both the BOP and MTFs have used title 38 authority to hire physicians and dentists. Additionally, the BOP has used the authority to hire psychiatrists. Officials at 13 MTFs stated that they had personnel shortages during the pandemic because the MTFs could not compete with nearby VHA facilities. Specifically, MTFs could not compete with VHA facilities that offered higher salaries for positions that the MTFs have not applied title 38 authority.

Officials from three of the federal health care programs (MTFs, BOP, and Medicare- and Medicaid-certified nursing homes) reported factors caused by the pandemic that contributed to personnel shortages, such as increased job requirements and COVID-19 quarantine. According to MTF officials, pulling health care personnel from their duties at the MTF to support pandemic requirements such as COVID-19 testing, vaccinations, and contact tracing, coupled with quarantine protocols and travel restrictions contributed to shortages of personnel in the MTFs. Additionally, according to officials from 26 of the sampled nursing homes, the requirement to quarantine personnel who contracted or were exposed to COVID-19 left nursing homes short-staffed during those periods. Nursing home officials also reported that some personnel were not able to work because they had to take care of family members that contracted COVID-19, or they quit their job after they contracted COVID-19. Finally, the BOP also experienced personnel shortages due to staff illness with COVID-19, with one of its institutions reporting that 75 percent of its health services unit had to take sick leave to recover from a COVID-19 outbreak.

Officials from three of the four federal health care programs (MTFs, BOP, and VHA) also reported that a challenging hiring process, made worse by the pandemic, contributed to personnel shortages. MTF officials stated that the hiring process sometimes took up to 6 months, with officials from one MTF stating that it took up to 24 months to hire personnel. Officials from other MTFs stated that they lost multiple applicants or had delays in the onboarding process because of the time it took for security and credentialing checks, as well as delays in obtaining common access cards because no one was working in-person at the identification card office during the height of the pandemic. According to BOP officials, the process to hire personnel to work for the federal government is different from the process that private sector health care professionals are accustomed to, taking more time, and involving nuances in the job postings and application process that may prevent applicants from applying to or being selected for available job opportunities. Officials from VHA facilities also reported recruitment challenges, including the hiring process, as a contributing factor for personnel shortages.

See Exhibit 4 for contributing factors reported by personnel from at least three of the four federal health care programs.

Exhibit 4: Most Commonly Reported Factors That Contributed to Personnel Shortages

<i>Contributing Factor</i>	<i>DOD MTFs</i>	<i>BOP Institutions</i>	<i>VHA Facilities</i>	<i>Medicare- and Medicaid-Certified Nursing Homes</i>
Limited Labor Pool	●	●	●	●
Noncompetitive Pay	●	●	●	●
COVID-19 Requirements	●	●		●
Challenging Hiring Process	●	●	●	

Source: OIGs’ interviews with or surveys of facility officials.

In addition, officials reported other factors contributing to personnel shortages unique to their federal health care program. For example, MTF officials reported that active duty health care personnel were pulled from the MTFs to provide support for the Nation’s pandemic response and other worldwide missions, creating additional shortages of health care personnel. BOP officials reported that providing health care to prisoners included requirements that private sector nurses do not have to deal with such as wearing a stab vest, carrying handfuls of keys, and carrying pepper spray. Additionally, officials at Medicare- and Medicaid-certified nursing homes reported that personnel quit their jobs because of their fear of COVID-19 infection while caring for nursing home residents.

Impacts of Personnel Shortages

INSIGHT: The four federal health care programs experienced a decrease in patient access to care and patient satisfaction, coupled with an increase in work hours and responsibilities as a result of personnel shortages

Patient Impacts. Officials from the four federal health care programs we reviewed reported personnel shortages that impacted patients. Officials from all 24 MTFs interviewed cited decreased patient access to care, decreased patient satisfaction, and reduced preventative screenings because of shortages of health care personnel. According to an April 2021 survey on federal inmates’ experiences during the pandemic, an estimated 80 percent of inmates rated BOP’s provision of medical care as poor during pandemic lockdowns, compared to an

Exhibit 5: Examples of Patient Impacts Reported

- Decreased access to care
- Decreased patient satisfaction
- Decreased face-to-face interactions with providers
- Delay of patient admissions or transfers from hospitals to nursing homes
- Overall decline in patient physical and mental health

Source: Analysis of data from the four federal health care programs.

estimated 41 percent of inmates who described the provision of medical care as “poor” before the pandemic. The VHA reported shortages in occupations considered essential to delivering safe care, meeting the growing demand for mental health care, and supporting the expansion of telehealth. Officials from 26 of the 50 Medicare- and Medicaid-certified nursing homes reported an overall decline in resident’s physical and mental health because of shortages of health care personnel and lower levels of care. Specifically, officials stated that the nursing homes had to adjust the level of care provided to residents, including reducing or stopping restorative care and physical rehabilitation services, and sending residents who needed wound care to the hospital.

Health Care Personnel Impacts. Officials from the four federal health care programs reported impacts to their personnel because of personnel shortages. Officials from all 24 MTFs sampled stated that shortages of health care personnel resulted in increased duties and work hours for the remaining personnel, decreased morale, and decreased access to medical cases that are necessary for providers to gain or maintain their medical skills. BOP officials reported an increase in workload for health care personnel at BOP institutions because they handled large numbers of inmate illnesses due to COVID-19, as well as taking on new responsibilities, such as screening and testing for COVID-19 and monitoring quarantine and isolation units. Officials from Medicare- and Medicaid-certified nursing homes stated that the personnel shortages resulted in: (1) personnel increasing their workloads, often working longer shifts and covering the shifts of other personnel, and (2) more staff calling out of work to avoid increased workloads. Officials also stated that these conditions led to burnout and increased levels of stress, anxiety, and depression. Directors from the VHA’s Veterans Integrated Service Networks reported burnout among human resources personnel because of the unanticipated workload associated with the hiring surge to address personnel shortages caused by the pandemic.

Exhibit 6: Examples of Personnel Impacts Reported

- Increased responsibilities
- Increased hours worked
- Decreased morale
- Increased burnout
- Increased risk of mental health illnesses

Source: Analysis of data from the four federal health care programs.

Financial Impacts. Three of the four health care programs (BOP, MTFs, and Medicare- and Medicaid-certified nursing homes) experienced financial impacts because of health care personnel shortages. The DOJ OIG assessed BOP’s overtime spending and found that BOP health services personnel worked more than 314,000 overtime hours during the first year of the pandemic, at a cost of \$15 million, an increase of 56 percent and 64 percent, respectively, compared to the overtime hours worked and costs expended in the year before the pandemic. Similarly, reports from one MTF show that overtime hours for its civilian employees increased almost 50 percent from 2019 to 2020 when the pandemic began, increasing from 1,200 hours in 2019 to 1,800 hours in 2020. Finally, officials from all 50 Medicare- and Medicaid-certified nursing homes that HHS OIG interviewed stated that they incurred higher costs for employee bonuses, overtime, and contracted agency staff.

Exhibit 7: Examples of Financial Impacts Reported

- Increased costs for overtime
- Increased costs for bonuses
- Increased costs for contracted agency staff

Source: Analysis of data from the four federal health care programs.

Strategies to Mitigate Personnel Shortages

INSIGHT: The four federal health care programs used incentives and other strategies to recruit new staff, retain existing staff, and minimize health care personnel burnout

The four federal health care programs we reviewed used incentives and other strategies to reduce personnel shortages and minimize personnel burnout. Many of these strategies existed prior to the pandemic and were similar across the four programs. Mitigation strategies implemented during the pandemic included awarding contracts with higher wages and implementing waivers to the onboarding process to hire personnel more quickly.

Monetary incentives were the most commonly reported recruiting and retention strategy used by the health care programs, followed by unique efforts developed by individual facilities, and increased work flexibilities

The four federal health care programs used monetary incentives, including bonuses and other programs to increase base pay, to recruit and retain health care personnel during the pandemic. Three of the four federal health care programs (BOP, MTFs, and VHA facilities) were authorized to use portions of title 38 for increased salaries and added flexibilities in hiring to recruit and retain employees in certain health care occupations; however, the MTFs and the BOP applied title 38 authority to two (physicians and dentists) and three occupations (physicians, dentists, and psychiatrists), respectively. Additionally, the BOP and Medicare- and Medicaid-certified nursing homes increased starting salaries for health care personnel and VHA facilities increased the maximum pay cap for nurses in accordance with Congressional legislation. The MTFs also used contracts offering higher pay to bring in additional personnel. Several BOP officials stated that the most effective recruitment incentive involved monetary compensation. However, BOP officials also stated that low pay was the main driver of turnover in their health care personnel. Similarly, the MTF officials stated that even with monetary incentives, DOD compensation still could not compete with the private sector or other federal agencies.

The four federal health care programs used student loan repayment or tuition assistance to encourage health care personnel to work for their programs. Additionally, three federal health care programs offered flexibility with work schedules and locations as a strategy to reduce personnel shortages. Personnel at Medicare- and Medicaid-certified nursing homes were offered flexible hours. Officials at BOP institutions approved compressed work schedules to allow employees additional flexibilities. Lastly, officials at the MTFs stated that they offered telework, virtual telehealth, remote opportunities, and alternative work schedules, when available, and provided personnel with scheduling flexibility so they could balance their patient workload with administrative tasks.

Strategies to minimize burnout varied across the federal health care programs

The four federal health care programs made efforts to retain existing staff and minimize personnel burnout. MTF officials stated that they encouraged employees to use leave, and stated that they recognized employees with time-off awards, command recognition, letters of appreciation, and early releases from work on special occasions, such as federal holidays. BOP officials stated that they encouraged personnel to access the BOP's Employee Assistance Program and encouraged management to monitor and support staff well-being. VHA established the Reduce Employee Burnout and Optimizing Organizational Thriving (REBOOT) Task Force to address drivers of burnout including unmanageable workload, perceived lack of fairness, lack of job control, low recognition or organizational support, interpersonal conflict, and mismatched values. At Medicare- and Medicaid-certified nursing homes, leadership tried to reduce provider burnout by reducing the number of new resident admissions, delaying new admissions, or admitting only residents who required less frequent or less intensive care. Additionally, the nursing home leadership created staff sharing agreements with facilities under the same corporate ownership and honored time-off requests when possible to reduce provider burnout.

Conclusion

The reported impacts to patients and health care personnel during the pandemic highlight the importance of identifying and understanding personnel shortages within federal health care programs. This report summarizes the most commonly reported positions with shortages, factors contributing to shortages, impacts most commonly encountered, and the incentives and other strategies used to recruit new personnel, and retain and minimize burnout for existing personnel across the four federal health care programs. Although this report does not represent a comprehensive review of personnel shortages in all federal health care programs, it could provide insights on similar circumstances across other federal health care programs in addition to the four federal health care programs reviewed.

The insights summarized below are intended to help Congress, federal and state agencies, health care organizations, and other policymakers—understand the most commonly reported positions with shortages, what contributed to those shortages, and how the shortages affected the programs' patients and health care personnel. OIGs identified the following key insights across the four federal health care programs reviewed.

- Nurses and medical officers were the most commonly reported positions that experienced shortages during the pandemic.⁶
- A limited labor pool, noncompetitive pay, COVID-19 requirements, and a challenging hiring process were the most commonly reported factors that contributed to personnel shortages.
- A decrease in patient access to care and patient satisfaction and an increase in health care personnel work hours and responsibilities were the most commonly reported impacts resulting from personnel shortages.
- Monetary incentives were the most commonly reported strategy to recruit and retain personnel.

These insights highlight that actions are necessary to ensure the federal health care programs are staffed sufficiently to continue normal operations, as well as strategically plan for surges of health care personnel needed to respond to future pandemics and other health care emergencies. The PRAC encourages policymakers to further explore the impacts of personnel shortages within the federal health care programs to develop strategies to mitigate staffing shortages and help ensure quality, safe, and timely health care is provided to the individuals the programs serve.

General Methodology

Each of the four participating OIGs selected a health care program within its Department, or providers it reimburses, to review staffing shortages before the pandemic (January 1, 2019 - February 29, 2020), and during the pandemic (March 1, 2020 - January 2023).

Data Collection and Analysis

Each OIG collected staffing shortage data from health care providers and administrators for their respective health care program to answer the following questions.

1. Does the federal health care program, or providers it reimburses, have shortages of health care personnel?
2. If there are health care personnel shortages, what were the causes of the shortages?
3. What were the impacts of the health care staffing shortages?
4. What strategies did the health care program, or providers it reimburses, have to attract new health care personnel, and retain and minimize burnout for existing health care personnel?

Data Collection

To ensure a level of standardization and consistency, the DOD OIG, in collaboration with the other participating OIGs and the PRAC, developed a framework to guide data collection and analysis. Because the federal health care programs vary, each OIG determined which data sources to use in its analyses and coordinated, as necessary, with officials from its federal health care program to obtain this data. OIGs collected data about health care personnel levels and shortages, specialties or positions most affected by shortages, causes and impacts of shortages, and actions health care programs are taking to mitigate shortages.

Data Analysis

Each OIG analyzed health care personnel shortages, causes, impacts, and mitigating strategies for its federal health care program and provided the DOD OIG with the results of its analysis. The DOD OIG then reviewed the findings from the four federal health care programs to provide broader insights and shared the insights with the other OIGs for review of information related to their respective section. For agency-specific details about the data and analysis, refer to the methodology section in the appendix.

Data Reviewed for Each of the Federal Health Care Programs

MTF. The results reported in this review include the expertise and experiences of officials from 24 nonstatistically selected MTFs, as well as officials from the Defense Health Agency (DHA), office of

the Assistant Secretary of Defense (Health Affairs), and Service medical commands. Information and examples were collected during interviews with the MTF officials, such as the MTF directors, hiring officials, manpower personnel, and others. Sources of data used to corroborate statements made are cited throughout the report. Our scope included active duty Service members, civilians, and contractors in the MTFs, or DOD direct care; however, staffing data provided for authorized and filled positions is only for civilian personnel under the DHA as of January 2023, and does not include active duty Service members or contractors employed at the MTFs, or civilians employed by the Military Departments.

BOP Health Care Services. The health care personnel data discussed in this review include information about BOP civil service employees and commissioned officers of the U.S. Public Health Service who work in the health services units at BOP's institutions; however, it does not include the BOP's psychology services staff, who are considered separate from health services in the BOP's organizational structure. This review does not include information about contract health care providers who deliver specialized care to BOP inmates at community facilities or on-site at BOP institutions or who are hired on a short-term basis to fill vacancies. Although there are 121 BOP-managed institutions, BOP considers the federal correctional complexes, in which multiple institutions are co-located, to be a single facility when reporting staffing data. Therefore, the total number of facilities described in the staffing data and this review is 97. When examining only clinical staffing, the total facilities decreases to 96 because FCC Beaumont uses only contract clinical staff.

VHA. The health care personnel shortages discussed in this review include only occupations employed by VHA. This review summarizes information on shortages in health care personnel at 139 VHA facilities for FYs 2020-2022, including data gathered through an annual VA OIG survey.

Nursing Homes. This review includes the experiences of staff who were employed or contracted by Medicare- and Medicaid-certified nursing homes. Information obtained for this review included data on:

- staffing shortages that nursing homes reported to the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) for the weeks ended May 24, 2020, through September 11, 2022;
- nursing home staffing information based on payroll and other verifiable and auditable data that nursing homes reported in the Centers for Medicare & Medicaid Services' (CMS's) Payroll-Based Journal (PBJ) system for the quarters ended June 30, 2019, through June 30, 2022; and
- interviews with officials from 50 selected nursing homes about their experiences with staffing shortages both before and during the pandemic.⁷

Limitations

This report does not present a comprehensive review of health care personnel shortages before and during the pandemic across all health care programs either provided through or administered by the Federal Government. The data and insights are limited to the federal health care programs and the types of health care personnel that each OIG chose to review. Personnel data varied across the federal health care programs; therefore, OIGs collected and reported shortages of health care personnel based on the data available to them. The information provided reflects the experiences of existing health care personnel and their perceptions of former health care personnel experiences, during the period of review. Therefore, officials may not have captured all reasons for shortages in health care personnel, the impacts of the shortages, or their efforts to attract and retain staff, or minimize staff burnout. Additionally, OIGs did not verify the accuracy of the contributing factors, impacts, or efforts with shortages in health care personnel that were shared by officials during interviews. For agency-specific limitations, see each OIG's detailed methodology in the corresponding appendix.

Standards

The DOD OIG and HHS OIG conducted their work in accordance with the generally accepted government auditing standards (GAGAS) issued by the U.S. Government Accountability Office, and the DOJ OIG and VA OIG conducted their work in accordance with the Quality Standards of Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). Each OIG followed its own processes to ensure that its contributions to this report met GAGAS or CIGIE standards, and they provided an attestation to the PRAC stating that it met those standards. This review was conducted under CIGIE's Quality Standards of Inspection and Evaluation.

Glossary

Alternative work schedule: Both flexible work schedules and compressed work schedules.

Augmentation: The practice of assigning non-custody staff, such as teachers or health care professionals, to temporarily assume the duties of a correctional officer. BOP staff are considered correctional workers first, regardless of their occupation.

Authorized position: Billet or position for which the quality of the requirement has been validated and authorized to perform the billet functions.

Billet: A specific military or civilian manpower space, which is assigned qualifiers that define the duties, tasks, and functions to be performed and the specific skills and skill level required to perform the delineated functions.

Bureau of Prisons (BOP) facilities: Federal correctional institutions, detention centers, U.S. penitentiaries, and correctional complexes that house federal inmates and pre-trial detainees. Federal correctional complexes are facilities in which multiple institutions of varying security level are co-located.

Burnout: A result of chronic workplace stress characterized by feelings of energy depletion or exhaustion, increased mental distance from one's job or feelings of negativism or cynicism, and a sense of ineffectiveness.

Clinical staff/personnel: Clinical staff are health care personnel who deliver patient care.

Contact tracing: A process to identify people that came in close contact with a person infected by COVID-19.

Compressed work schedule: A fixed work schedule that enables a full-time employee to complete an 80-hour biweekly basic work requirement in less than 10 workdays.

Department of Defense medical treatment facilities: Military hospitals or clinics that provide direct care for beneficiaries.

Direct hire authority: The authority to make noncompetitive appointments based on a determination by OPM or the Secretary of that Department that a severe occupational shortage of highly qualified candidates exist for applicable occupations.

Filled position: Occupied billet or position performing the functions of the authorized position; the number of staff onboard.

Flexible work schedule: A flexible work schedule allows an employee with an 80-hour biweekly basic work requirement to determine their own schedule within the limits set by the agency.

General schedule: The general schedule (GS) pay system covers the majority of civilian white-collar federal employees in professional, technical, administrative, and clerical positions, with grades ranging from GS-1 (lowest) to GS-15 (highest).

Health care personnel: Personnel that provide clinical or nonclinical services in a health care setting.

Lockdown: In BOP institutions, periods of time during which inmate movement is restricted, generally to their cells or housing units, to address safety and security issues within the facilities. During the COVID-19 pandemic, the BOP imposed inmate movement restrictions, sometimes called “Shelter in Place” or “modified lockdown” as a strategy to mitigate exposure to and spread of COVID-19.

Medical officer: Positions with duties that advise on, administer, supervise or perform professional and scientific work in one or more fields of medicine, and when the degree of Doctor of Medicine or Doctor of Osteopathy is a fundamental requirement.

Medicare- and Medicaid-certified nursing homes: Nursing homes that are required to comply with health and safety requirements in federal regulations (42 C.F.R. part 483, subpart b) to participate in the Medicare and Medicaid programs.

Nonclinical staff/personnel: Health care personnel whose responsibilities are administrative, logistical, or clerical in nature to support clinical staff who provide care or medical treatment to patients.

Nursing homes: Facilities that provide services to individuals whose capacity for self-care is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related conditions.

Occupational Series Code: OPM codes used to group positions with a similar specialized line of work and qualification requirements. For example, GS-0610 is the Nursing Series.

Regional health services administrators: Regional Health Systems Administrators (HSA) serve as principal advisors to the Regional Director and Deputy Regional Director in all matters related to health care delivery. The primary responsibilities of the regional HSAs include developing suggestions for policy revisions, perform management assessments, and responding to health care problems at all institutions within the region (including Residential Reentry Centers). There are six regional HSAs positions corresponding with the BOP’s six regions.

Shortages: Positions with vacancies or positions that are difficult to fill, to meet a desired or statutory level, which may or may not impact the level of care provided.

Sick call: Within the BOP, the process by which inmates request and receive routine or preventative medical care.

Title 38 authority: Personnel authorities for health care occupations primarily available to VA, with some personnel authorities delegated by OPM for discretionary use by other federal agencies.

Veterans Health Administration facilities: Sites of care including VA Medical Centers and outpatient settings that provide services to veterans; qualifying family members, dependents, and survivors of veterans; and eligible active military and Reserve Component members.

U.S. Department of Defense (DOD)



According to the DHA, the Military Health System (MHS) is the most comprehensive military health care enterprise in the world. The MHS provides direction, resources, health care providers, and other means necessary to foster, protect, sustain, and restore health to over 9.6 million active duty Service members, military retirees, and their families. Health care services are delivered through two systems—the direct care system consisting of the DOD’s MTFs, located worldwide, and the purchased care system consisting of partnerships with civilian health care provider facilities operated through TRICARE regional contracts (referred to as the “civilian network” throughout this review).⁸

Medical Treatment Facility Personnel

The MTFs, or military hospitals and clinics, are critical to military medicine, where military, civilian, and contract personnel provide direct care for beneficiaries and gain the skills and training to support operational units. As of December 2, 2022, the DOD’s direct care system consisted of 45 military hospitals, 525 outpatient and occupational health clinics, and 138 dental clinics. The MTFs are led by an MTF Director or Commander, and include personnel in areas such as administration, medical delivery, and ancillary support. The MTFs vary in size and offer different services; therefore, personnel staffing these facilities range from primary care providers to a wide range of specialists, including providers for mental health, obstetrics, urology, and dermatology.

Military Health System Transition

According to the DHA FY 2022-2026 campaign plan, by 2026, the DHA will be a joint operational headquarters responsible for managing, executing, and delivering high-quality health care, medical education and training, military medical research and development, and public health support to the MHS’ beneficiaries and the Services. Section 702 of the FY 2017 National Defense Authorization Act (NDAA) and sections 711 and 712 of the FY 2019 NDAA required that the Military Departments transition the administration of all the MTFs to the DHA for the purpose of implementing an integrated system of readiness and health.⁹

The Deputy Secretary of Defense paused the MHS transition from April 2, 2020, through November 9, 2020, to realign personnel and resources to support the pandemic mission. The transition resumed after the pause and in a February 24, 2022, memorandum, the Deputy Secretary of

Defense directed the continued implementation of the MHS organizational reform by directing the DHA to assume authority, control, and direction of military hospitals, clinics, and dental treatment facilities, to include the MTFs located overseas. At the time of our interviews, the MTFs transitioned or were in the process of transitioning their civilian personnel to the DHA. According to officials in the Human Capital Division at the DHA, the DHA completed the transition of the MTFs on October 23, 2022. The last milestone of the MTF transfer included transferring the MTF civilian personnel from the Military Departments to the DHA. However, active duty Service members working in the MTFs will remain the responsibility of their respective Military Departments.

COVID-19's Impact on the Military Health System

The pandemic had a major impact on the DOD and the MHS. Early in the pandemic, the MTF officials reported facing challenges delivering health care at the MTFs with inadequate amounts of COVID-19 testing supplies and personal protective equipment while also having to adapt to delivering health care virtually for many patients. As the pandemic progressed and the Nation experienced shortages of health care personnel, DOD officials confirmed that the MTFs were experiencing shortages as well.

On January 12, 2022, the Under Secretary of Defense for Personnel and Readiness submitted a report to Congress addressing the shortage of behavioral health providers in the DOD, using data available from before the pandemic.¹⁰ The report identified recruitment challenges facing the direct care network including active duty authorizations, dedicated funding and personnel for recruitment, salary caps, lengthy hiring processes, insufficient compensation packages for remote locations, and national behavioral health provider shortages. The report identified that the law limits compensation for civilians and active duty providers, making recruitment and retention difficult. Although the report to Congress supported recruitment challenges prior to the pandemic, the MTF officials reported that recruiting behavioral health providers was even more difficult during the pandemic.

Additionally, in April 2022, the DOD OIG highlighted shortages of health care personnel in the direct care network, citing that officials at 26 of 30 MTFs reported staffing shortages as the most serious challenge encountered by medical personnel during the pandemic. The MTF officials reported that while the staffing shortages, in part, were not a direct result of the pandemic, the additional requirements that accumulated over the course of the pandemic, with decreased staff for pandemic response, resulted in health care providers and clinical personnel being overworked and feeling burned out.¹¹

Scope of DOD OIG Review

This review provides information on shortages of active duty, civilian, and contractor health care personnel at 24 of the DOD's 45 hospitals and their associated clinics in the direct care system, as of December 2022. We conducted interviews with key MTF officials on clinical and nonclinical personnel working at the MTFs.¹² Our review includes data on health care personnel in the direct care system before the pandemic, March 1, 2019, to February 29, 2020, and during the pandemic, March 1, 2020, to January 2023.

This review does not include shortages of health care personnel in the purchased care, or civilian network of providers that provide health care services beyond the MTFs. Additionally, the DHA provided staffing data for authorized and filled positions for only civilian personnel under the DHA's authority, direction, and control, as of January 2023. The data does not include active duty Service members or contractors employed at the MTFs, or civilians employed by the Military Departments. See Appendix A: DOD for the DOD OIG's methodology.

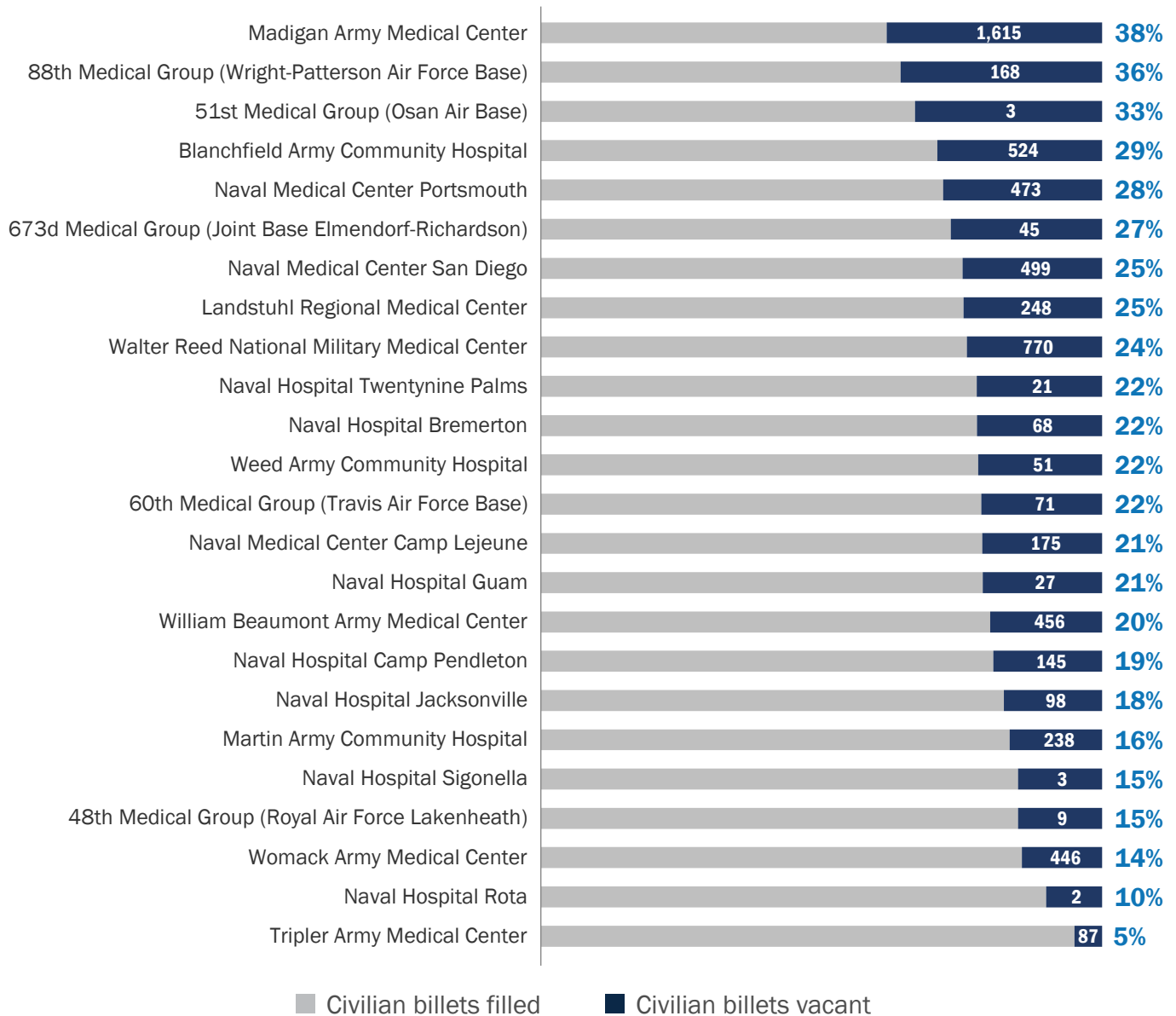
Health Care Personnel Shortages Before and During the Pandemic

The MTFs experienced shortages of health care personnel before and during the pandemic. In April 2022, we reported that officials from 26 of 30 MTFs sampled indicated staffing challenges and shortages were the most serious challenges encountered by medical personnel working at the MTFs during the pandemic.¹³ Additionally, we reported that officials from 11 of the 30 MTFs indicated staff burnout and fatigue were the most serious concern that they would encounter in the future. During that effort, we conducted interviews with the MTF officials from September 9, 2021, through October 4, 2021, where the MTF responses reflected a point in time with personnel in place at the MTF before or during the height of the pandemic. To determine whether shortages of health care personnel were still a concern for this review in support of the PRAC, we obtained data and conducted interviews with officials working at 24 of the MTFs that previously reported, as part of the April 2022 report, staffing shortages or burnout as the most serious challenge or future concern.

The MTFs did not provide consistent data to compare authorized and filled positions, before and during the pandemic, across our sample. However, the DHA provided personnel data as of January 2023 for the civilians under the DHA's management and administration. These personnel accounted for only a portion of health care personnel within the MTFs, and they did not include active duty Service members, contractors, or civilians under the Military Departments' management and control. Generally, the MTFs outside the continental United States employ more active duty Service members, as it is more challenging to hire civilians in those facilities. Therefore, the vacant civilian billets and percentages unfilled reported in Exhibit 1 represent only a portion of the MTF workforce.

Based on the DHA staffing data, there were over 6,000 civilian positions across the MTFs we sampled that were vacant as of January 2023. The data provided was not broken down by position to determine what civilian health care personnel positions had the largest shortages. However, over 80 percent of the civilian vacancies were positions within medical centers, which are the DOD's largest MTFs that provide a range of specialty and subspecialty care, serve as trauma centers for the Military and the community, and usually participate in General Medical Education and medical research programs. Additionally, many of the vacancies were at hospitals located in or near large metropolitan areas, such as Seattle, Washington; Washington, DC; and San Diego, California. See Exhibit 1 for the DHA civilian billets that were filled and vacant, as of January 2023, for the 24 MTFs we sampled.

Exhibit 1: January 2023 DHA Civilian Billets Authorized and Vacant for the 24 Sampled MTFs



Source: Data provided by the DHA from the Defense Civilian Personnel Data system and the DHA's Joint Table of Distribution, January 2023.

There were eight MTFs that had 25 percent or more of their DHA civilian positions vacant. These MTFs were generally located in or near large metropolitan areas or located in areas outside of the continental United States. Table 1 lists the MTFs that had 25 percent or more of their DHA civilian positions vacant.

Table 1: The MTFs That Had 25 Percent or More of Their DHA Civilian Positions Vacant

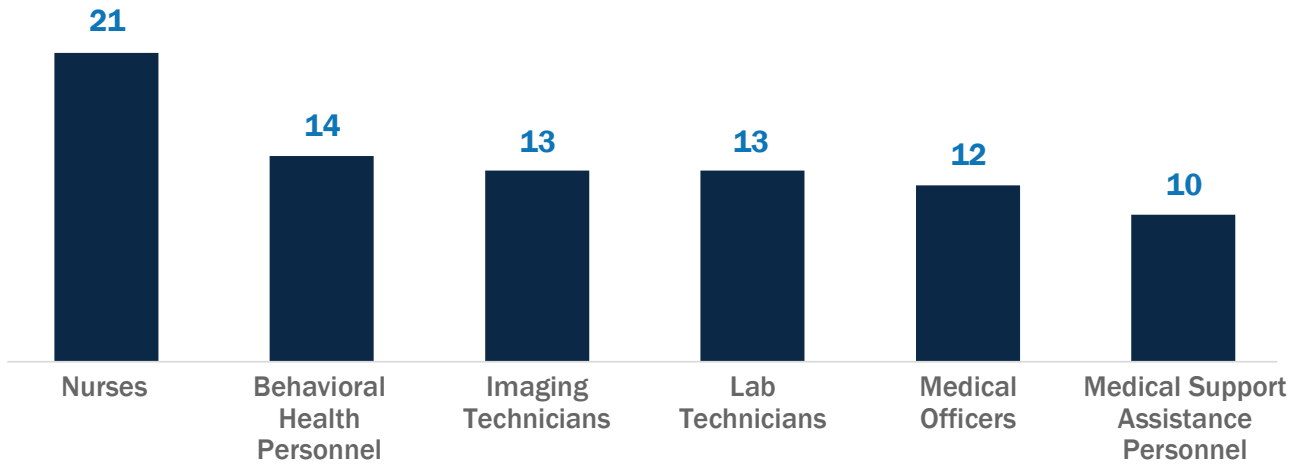
<i>MTF</i>	<i>% of DHA Civilian Billets Unfilled</i>
Madigan Army Medical Center	38
88th Medical Group (Wright-Patterson Air Force Base)	36
51st Medical Group (Osan Air Base)	33
Blanchfield Army Community Hospital	29
Naval Medical Center Portsmouth	28
673d Medical Group (Joint Base Elmendorf-Richardson)	27
Naval Medical Center San Diego	25
Landstuhl Regional Medical Center	25

Source: DOD OIG analysis of data provided by the DHA from the Defense Civilian Personnel Data system and the DHA's Joint Table of Distribution, January 2023.

Note: Percentages are rounded.

We interviewed 220 officials at the 24 MTFs to obtain their input and obtain documentation to determine the health care positions that the MTFs were experiencing the largest shortages. Officials we interviewed at all 24 MTFs reported that as of September 2022 their MTFs were experiencing shortages of health care personnel. The MTF officials stated that nurses, medical officers, behavioral health personnel, imaging technicians, laboratory technicians, and medical support assistants were in highest demand.¹⁴ According to the MTF officials, health care personnel shortages increased during the height of the pandemic and at the time of the MTF interviews, held between August and September 2022, the MTFs had not been able to fill many of the positions. See Exhibit 2 for the highest reported shortages by position type for the 24 MTFs interviewed.

Exhibit 2: Number of MTFs That Reported Staffing Shortages Before or During the Pandemic, by Position



Source: DOD OIG interviews with officials from sample of MTFs, August through September 2022.

Note: The totals represent the number of MTFs out of 24 that officials reported the position types. Officials interviewed did not always indicate whether the positions were short before or during the pandemic, so they are not specified in this figure.

Contributing Factors That Led to Shortages of Health Care Personnel

DOD officials from the 24 MTFs we interviewed identified various contributing factors for shortages of health care personnel during the pandemic. See Exhibit 3 for the most commonly reported contributing factors of health care personnel shortages reported by the MTF officials.

Exhibit 3: Number of MTFs That Reported the Top Contributing Factors That Led to Personnel Shortages



Source: DOD OIG interviews with officials from sample of the MTFs, August through September 2022.

Note: The totals represent the number of the MTFs out of 24 that officials reported the cause.

Noncompetitive Pay

The MTF officials reported that pay offered by the DOD was not competitive with pay provided by the private sector and VHA facilities, which was exacerbated by the pandemic, resulting in health care personnel shortages.

Private Sector Competition | Officials at 19 MTFs stated they lost personnel, such as physicians, nurse practitioners, physicians’ assistants, nurses, technicians, and even housekeepers to civilian hospitals in the area for higher pay. For example, one MTF provided salary data for housekeepers in their area, quoting that a corporate hotel offered pay of \$33,408 to \$73,080 annually, a civilian hospital could offer \$64,728 to \$68,904 annually, and the MTF could only offer \$32,635 to \$38,544 annually.

Officials at another MTF stated that civilian hospitals in the network were paying nurses \$71 an hour in an inpatient unit, while an inpatient nurse at their MTF made \$43 to \$44 an hour as a GS-11 civilian position, which resulted in a significant pay gap. Furthermore, an MTF job announcement obtained in January 2023 for a vocational nurse offered \$47,616 annually as a GS-6, while a private sector facility that was seven miles away, offered \$81,120 annually, or \$33,504 more than the DOD position. Additionally, the Director of Medical Services at one MTF stated that a trauma surgeon could make \$1 million dollars a year in the public sector. However, DOD and federal requirements prohibit personnel in the Federal Government from making more than the President's salary of \$400,000 a year.¹⁵ The MTF officials at one location stated that the cost of living in their area had increased dramatically during the pandemic and the stagnant pay scales within the DOD could not compete with the private sector. The Deputy Commander for Clinical Services for one MTF stated that they received job offer letters every day from civilian hospitals offering less work for more pay.

The MTFs attempted to recruit additional temporary staff during the pandemic to assist with personnel shortages and the additional workload requirements added by the pandemic by using surge contracts. However, according to the MTF officials, the surge contracts that offered higher pay still could not compete with the pay offered in the public sector. Further, an official from one MTF stated that there was nothing in the surge contracts to prevent the existing contract staff from applying. Therefore, the contract staff that already worked in the MTF moved to the surge contract to obtain higher wages, which did not help the MTF with hiring during the pandemic.

VHA Facility Competition | Officials at 13 MTFs stated that they had personnel shortages during the pandemic because the MTFs could not compete with nearby VHA facilities. Specifically, according to the MTF manpower personnel, the VHA can offer positions with pay one grade higher than the MTFs based on the use of title 38 authority.¹⁶ For example, an official from one MTF stated that they lost licensed practical nurses to the VHA because the VHA could offer them a position at a higher grade, resulting in a higher salary. An official from another MTF stated that they lost eight primary care providers to the VHA because of the differences in pay. While the DOD currently has title 38 authorities for pay for physicians and dentists, it cannot compete with title 38 salaries offered for other disciplines because the DOD has not fully taken advantage of its title 38 authorities.

Pandemic Requirements

The MTF officials stated that pulling health care personnel from their duties at the MTF to support pandemic requirements such as COVID-19 vaccinations, testing, and contact tracing, as well as protocols for quarantine and travel restrictions contributed to shortages of personnel in the MTFs. According to the MTF officials, the MTFs lacked staff to perform the additional responsibilities created by the pandemic, such as COVID-19 testing and vaccinations, resulting in the use of existing staff to perform these duties. An official from one MTF stated that COVID-19 testing required the

MTF lab staff, patient administration staff, and providers to work 12-hour shifts to enable 24-hour operations.

An official from another MTF stated that the MTF used 24 personnel to staff a COVID-19 testing and vaccination tent from September 1, 2020, through July 31, 2022, which pulled their personnel away from their normal duties for a total of 16,776 personnel days. The MTF officials also cited contact tracing, a process to identify people that came in close contact with a person infected by COVID-19, as a task that removed the MTF personnel from their normal duties. The MTF officials stated it was a significant administrative burden during the pandemic because contact tracing was not the MTF's responsibility before the pandemic.

Further, an MTF official stated COVID-19 protocols such as quarantining and travel restrictions prevented personnel from reporting to work, resulting in shortages of health care personnel. For example, the MTF official stated that at one point during the pandemic, 25 nurses could not report to work because of COVID-19 exposure and that the MTF had to follow travel policies requiring staff to quarantine for 14 days on both the beginning and end of leave.

Hiring Timelines

The MTF officials reported that the hiring process was very long, taking 6 months or longer because of security and credential checks, time to obtain an identification badge, or overseas screening requirements, which was made worse by the pandemic.¹⁷ In April 2022, the DOD OIG reported that at one MTF, the earliest it could complete a hiring action before the pandemic was 7 months, but during the pandemic it took 12 months.¹⁸ An official from another MTF stated that during the pandemic it took the MTF 24 months to hire a medical technician and an official at another MTF stated that they lost multiple nursing applicants because of the amount of time it took for credentialing checks. An MTF official at an MTF located overseas stated they had at least six candidates in FY 2022 that withdrew from the process because of the length of the security clearance process. Additionally, officials at one MTF stated that no one was working in-person at the identification card office to process common access cards during the height of the pandemic, delaying the onboarding process for new personnel.

The Acting Deputy Commander of Quality and Safety from one MTF explained that they worked in the private sector for 19 years and could hire nurses and have them on board, on average, within two weeks. They explained that the MTF had four people at its last orientation, and it took the MTF 6 months to get each candidate on board after they were selected for their positions.

Limited Labor Pool

The MTF officials stated that there are shortages of health care personnel because there is a limited labor pool to recruit from because of worldwide shortages of health care providers. Officials from one MTF stated the ability of the contractor to provide staff was affected by a depleted pool

of personnel who were taking advantage of travel opportunities for more money in other parts of the country, while officials from another MTF stated that there was a limited number of qualified applicants in their remote area.

At another MTF, a contractor responded to a contract discrepancy report stating that because the contract was written before the pandemic, the contractor would not be able to fill the contracted positions without a pay rate increase.¹⁹ According to the contractor, the mental health workers were demanding higher salaries because there was a shortage of mental health workers, which was worsened by the pandemic.

Mission Support

The MTF officials supported various COVID-19 and worldwide missions, such as Operation Allies Welcome, and providing support for additional personnel in support of Ukraine, during the pandemic, which the MTF officials stated created additional personnel shortages.²⁰ For example, the Federal Emergency Management Agency requested assistance for the civilian hospitals throughout the United States, and the Government provided support through the Defense Support of Civil Authorities missions. These missions assigned health care personnel from the MTFs to assist civilian facilities in support of the nation's pandemic response efforts. For example, an official from one MTF stated that 300 military personnel from their MTF left on the U.S. Naval Ship Mercy in support of the Defense Support of Civil Authorities mission, which provided medical support in Los Angeles, CA, which was significantly affected by the pandemic. According to the MTF officials, this required the remaining providers to perform additional work and work additional hours.

An official at another MTF stated that the MTF's intensive care unit and medical surgical unit was significantly impacted when the MTF needed to send 43 of its nurses to support the U.S. Naval Ship Comfort. Additionally, because of the increased operations with Ukraine and Russia, an official from one overseas MTF stated that the MTF personnel provided audiology, optometry, and dental services at the pier to support the ships and other operational forces who were not enrolled beneficiaries in their area.

The MTF officials have the ability to request temporary backfills from the Service Medical Commands or the DHA when there are personnel shortages or personnel are pulled to support missions outside the MTF. However, according to the MTF and Service Medical Command personnel, the MTFs received very few to no replacements for the Service members supporting the Defense Support of Civil Authorities and worldwide missions because all of the MTFs and Services were strained during the pandemic. An official from one Service Medical Command stated that although their Services could provide the MTFs with replacement Service members for 2 months, the Services were less prone to approve a support request if it would create a shortage problem at another site.

Federal and DOD-Imposed Restrictions

The MTF officials reported that federal and DOD-imposed restrictions contributed to shortages of health care personnel at the MTFs during the pandemic. The MTF officials explained that experience requirements for registered nurses (RN) hindered the MTFs' ability to hire. The DOD uses OPM's requirements that require the MTFs to hire an RN at the GS-5 level if the applicant has a bachelor's degree with no nursing experience or has a diploma or associate degree in professional nursing with 1 year of professional nursing experience. However, while RNs can be hired without 1 year of experience at the GS-5 level, an official at one MTF commented that it was an ineffective and nonsensical process because an RN with 1 year of experience or more, can be hired at the MTF as a GS-11, or six grades above what the DOD offers RNs that do not meet the experience requirement. Further, an MTF official stated that a licensed practical nurse, a position that requires less education than an RN, are rated at the MTF as a GS-6, or one level above the grade that the DOD hires its RNs who do not meet the 1-year experience requirement. The DOD MHS is noncompetitive because of the low pay, hindering DOD's ability to compete for nursing candidates.

The MTF officials also mentioned that active duty members retiring from Service must wait 180 days before beginning work in a civilian position at the MTFs. Specifically, section 3326, title 5, United States Code, requires Service members to wait 180 days before being appointed to a civilian position, even though the Service member is already familiar with the MTF's policies and systems and would not require as much training as someone newly-hired to the MTF. An MTF official stated that they would prefer to continue working as a civilian; however, they could not wait 180 days to be considered for employment and, therefore, would leave the MTF to work for the private sector after retirement where they can find a job more quickly. Although there is a waiver process to exempt retired Service members from the 180-day waiting period, an MTF official reported that the process to obtain a waiver and be onboarded was still over 120 days.

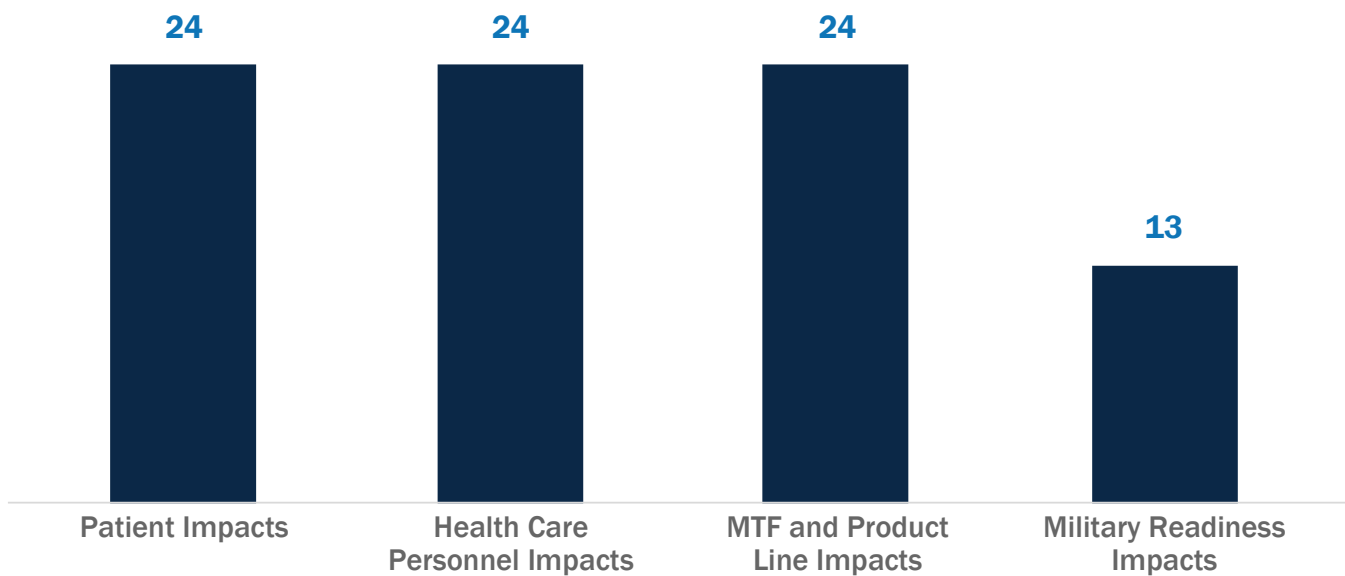
Officials at two MTFs located outside the continental United States stated that civilian employees are limited in how long they can work in overseas assignments, affecting their ability to hire and retain health care personnel. The MTF officials stated that civilian personnel would like the option to extend beyond 5 years at overseas locations. DOD Instruction 1400.25 limits civilian employment in foreign areas to five continuous years but allows the Head of the DOD component to grant extensions in 2-year increments, with the support of a documented business case analysis.²¹ However, an MTF official explained that the process to extend civilian assignments takes too long because the MTF must demonstrate it has actively recruited for the position with no successful hires before the end of the individual's 5-year appointment.

The DOD OIG plans to further address the causes above with recommendations in a separate DOD OIG report.

Impacts of Shortages of Health Care Personnel

The MTF officials from the 24 MTFs we interviewed reported impacts to the MTF's patients, the availability of specialty care, the health care personnel, and Military readiness because of health care personnel shortages during the pandemic. See Exhibit 4 for the number of MTFs that had personnel report that they experienced these impacts.

Exhibit 4: Number of MTFs That Reported the Top Impacts of Health Care Personnel Shortages



Source: DOD OIG interviews with officials from sample of MTFs, August through September 2022.

Note: Totals represent the number of MTFs out of 24 that had officials reporting the impact.

Patient Impacts

Officials from all 24 MTFs cited impacts to patient care because of health care personnel shortages, such as decreased patient access to care, satisfaction, and preventative screenings or routine maintenance care for patients. For access to care, an official from one MTF explained that a patient's ability to get an appointment in the MTF during the pandemic decreased anywhere from 10 to 50 percent, which lengthened the time for beneficiaries to receive care. According to the MHS website, the access to care metrics for another MTF, with a benchmark of 7 days for routine appointments, jumped from 2.6 days in November 2020 to 10.2 days in November 2022.

Health care personnel vacancies at the MTFs outside the continental United States can lead to reduced or no specialty services for beneficiaries, where the civilian network is already limited or nonexistent. For example, an official at one overseas MTF stated that there are no behavioral health civilian network services for children in their area. The Child and Family Behavioral Health Service

at the MTF closed in March 2022 because the MTF had difficulty hiring behavioral health personnel and lost behavioral health personnel whose extension requests were denied, as well as usage of behavioral health care increased. Additionally, all of the licensed clinical social workers were pulled from the behavioral health program to support the active duty clinic, resulting in no behavioral health services for children. The MTF official further stated that continued closure of the behavioral health network services for beneficiaries would increase the number of denials for the Exceptional Family Member Program, which would decrease the number of Service members eligible to be assigned to locations outside of the continental United States.²²

The MTF officials also stated that patient satisfaction decreased during the pandemic. According to one MTF's patient satisfaction report, the scores declined during the pandemic, every year from 2020 through 2022. Specifically, in 2020, patients rated the ease of making an appointment at one MTF at 70.7, with a MHS benchmark of 74.0.²³ However, in 2022, patients rated that same category for the MTF approximately 14 percent lower at 56.3, well below the MHS benchmark of 78.2 for that year.

Officials from another MTF stated they had both sentinel and adverse events that were reported to the DHA Patient Safety Office due to low staffing or increased workload for staff.²⁴ Based on a comprehensive systematic analysis provided by the Patient Safety Program Manager, a pediatric patient had significant delays with diagnosis because of personnel shortages. Specifically, during the patient's need for care, four of five pediatricians from the MTF were deployed for missions in support of the pandemic, leaving one dedicated pediatrician and one family medicine provider with pediatric training to oversee the entire child dependent population at the MTF. As a result, pediatric operations were limited for 2 months, including deferred wellness visits, and the patient was seen virtually, which led to a delay in diagnosis and treatment for a metastasized tumor.

Additionally, the Patient Safety Program Manager provided an example of a patient that committed suicide within 72 hours of being seen in the emergency department that, according to the MTF officials, had low staffing. The MTF officials explained that the patient was seen by a provider who was unaware of the patient's history because the provider was temporarily assisting while the MTF was experiencing personnel shortages. The MTF officials also stated that psychiatrists were not evaluating patients in-person in the emergency department at that time because of pandemic protocols. According to the comprehensive systematic analysis, the sentinel event was attributed to various root causes, including task oversaturation for providers.

Health Care Personnel Impacts

Officials from all 24 MTFs stated that shortages of health care personnel during the pandemic impacted the personnel remaining at the MTF, including increased work hours, decreased morale, increased duties, and decreased access to medical cases that are necessary for providers to gain or maintain skills. The MTF officials explained that because the DOD tasked health care personnel for other missions or because the MTF had long-standing vacancies, the personnel left to work in the MTF were required to work significantly more hours than normal. For example, an official at one MTF stated that Service members were working between 80 to 100 hours per week and, as a result, some providers were treated for mental health issues because of burnout. An official at another MTF stated that health care personnel were tasked for Defense Support of Civil Authorities missions resulting in the remaining personnel working up to 120 hours in a 2-week period.

According to an overtime report for civilian personnel working at one MTF, overtime hours increased almost 50 percent from 2019 through 2020 when the pandemic first began, increasing from 1,233 hours in 2019 to 1,816 hours in 2020. The MTF officials also stated that pay for increased overtime hours comes from their budget and limits their ability to hire additional personnel. Further, the MTF officials reported an increased use of behavioral health providers to treat the health care providers who were seeking care for their own mental health because of burnout.

Additionally, the MTF officials stated that performing duties outside of their normal job function was required because of shortages in health care personnel. For example, the MTF officials stated that providers checked patients in, recorded patient vitals, and cleaned their own areas because of shortages in support personnel, such as medical support assistance and housekeeping personnel. An official at another MTF stated that an enlisted pharmacy technician performed the MTF's emergency management functions, a role normally performed by a GS-13 civilian position, in addition to their pharmacy duties.

The MTF officials also discussed how shortages in health care personnel and reduced elective procedures decreased their ability to gain and maintain experience and skills. Specifically, personnel were not able to get the experience they needed to maintain their knowledge, skills, and abilities because the MTFs were not able to bring in a high volume of medical cases to learn from, and personnel were tasked to conduct tasks, such as overseas screening assignments or periodic health assessments as a result of the pandemic and health care personnel shortages. The MTF officials explained that they had to send some providers to civilian hospitals to maintain their knowledge, skills, and abilities.

The MTF officials also had concerns with tasking faculty who oversee the graduate medical education program to provide mission support. According to the MTF officials, a majority of the MTF's inpatients were cared for by the graduate medical education students who were medical residents under the supervision of the MTF faculty that have specific qualifications. Because faculty-to-student ratios must be maintained for the graduate medical education students to provide care, when the supervising faculty were tasked to support missions outside of the MTF, the MTF had to

reduce the number of patients who could be admitted and cared for safely, which also reduced the number of cases from which the residents could learn.

The MTF and Product Service Impacts

Officials from all 24 MTFs stated that health care personnel shortages impacted health care services that were available in the MTF. Specifically, the MTF officials reported that their MTFs had to:

- reduce or suspend some specialty services and defer patients to the civilian network,
- decrease the number of patient visits, and
- reduce the capacity of inpatients because of the decreased health care personnel available during the pandemic.

For example, an official from one MTF stated that because of staffing shortages the MTF's inpatient "bed space" (capacity) decreased by 30 percent, outpatient access to care decreased by 50 percent, and the emergency room unit was downgraded to an emergent care clinic. The MTF officials stated that "shutting off" (suspending) or reducing services because of staffing issues resulted in diverting more health care services to the civilian network. For example, an official from one MTF stated that demand for mental health increased dramatically during the pandemic, and that because of staffing issues, most referrals were diverted to the civilian network. The MTF official provided data from the Composite Health Care System and MHS GENESIS showing that in 2020, the MTF had 2,600 mental health referrals, and the MTF was able to treat approximately 2,500 (95 percent) patients, only diverting less than 125 patients to the civilian network. However, in 2021 and 2022, mental health referrals increased significantly to 6,240 and 8,576, respectively, and because of the pandemic and staffing losses, the MTF was only able to treat approximately 1,200 (less than 20 percent) of the referred patients, diverting the remaining 80 to 85 percent of patients to the civilian network.

An official from another MTF stated that their MTF was authorized 41 enlisted laboratory technicians but explained that they would be down to only 4 technicians in February 2023. The official stated that pharmacy and laboratory operations were staffed 50 percent lower than they were 4 years ago so the MTF had to reduce laboratory and pharmacy services. The MTF officials also expressed concerns for increased risks to patient safety in the MTF. For example, one MTF official stated that not having experienced nurses to train new nurses led to safety concerns for patients. The senior enlisted leader at another MTF stated that the enlisted health care personnel and providers were exhausted from all of the work because of the shortages of personnel, and they were worried that it was only a matter of time before a provider would "miss something."

Military Readiness Impacts

Officials from 13 MTFs reported operational force readiness and deployment delays because of health care personnel shortages. According to an official from one MTF, an MTF lab processed COVID-19 testing requirements in direct support of their operational forces. However, because of the limited availability of personnel in the MTF lab and the limited availability of lab services in the network to meet COVID-19 testing requirements, the operational force did not deploy as scheduled.

An official at another MTF stated that because of shortages in civilian lab technicians, active duty lab technicians had to work 12-hour shifts, 6 days per week, to test Service members in basic training for COVID-19. According to the Deputy Commander for Clinical Services, the laboratory technicians became burnt out and were provided mental health treatment because of stress. An MTF official stated that the MTF Commander cut back on testing and informed the operational commanders that the MTF would not be able to turn testing around fast enough for their Service members to deploy for their missions.

Efforts to Recruit New Staff, Retain Existing Staff, and Minimize Personnel Burnout During the Pandemic

The DOD has several monetary programs to recruit and retain health care personnel; however, the MTF officials stated that even with monetary incentives, DOD compensation still could not compete with the private sector and other federal agencies. Based on interviews, efforts to minimize burnout varied by the MTF.

Recruitment Incentives

The DOD has several monetary programs to recruit health care personnel. See Table 2 for a list of DOD recruitment incentives.

Table 2: DOD Recruitment Incentives

Surge Contracts	Contracts awarded by the MTFs with higher hourly wages to recruit personnel to temporarily assist the MTFs during the height of the pandemic.
Direct Hire Authority	DOD’s ability to recruit and appoint qualified persons directly, without competitive procedures, for occupations designated by the Secretary of Defense as a shortage category, or critical need occupation, including psychologists, physicians, and nurses. ^a This authority was delegated to the Secretaries of the Military Departments, Directors of the Defense agencies, and Directors of DOD field activities.
Loan Repayment	The federal student loan repayment program permits the DHA to repay federally insured student loans. Active Duty Health Professions Loan Repayment Program (ADHPLRP) pays for the degrees of commissioned officers qualified in health professions.
Monetary Bonus	The DHA may pay a recruitment incentive if an employee is newly appointed to a position that is difficult to fill, and the employee is not receiving incentive payments from a service agreement required for another incentive during the period of employment. Medical officers are entitled to a signing bonus if they have graduated from an accredited school in a health care profession, are qualified for appointment as a commissioned officer, and have been honorably discharged for at least 24 months, if a former health professions officer. ^b

Source: DOD OIG review of the USD (P&R) Memorandums, DOD Instructions, DHA Instructions, and interviews with officials from sample of the MTFs.

- a. USD (P&R) Memorandum, Expansion of Direct Hire Authority for Certain Personnel of the Department of Defense, October 15, 2021.
- b. A health care professional officer is an officer designated as a medical officer, dental officer, veterinary officer, medical service officer or biomedical sciences officer, medical specialist, or a nurse.

Retention Incentives

The DOD has several incentives to retain health care personnel. See Table 3 for a list of DOD retention incentives.

Table 3: DOD Retention Incentives

Monetary Bonus	Authorized if the position is difficult to fill or the employee has unique qualifications, there is a high risk that the employee would leave the federal Service; the employee is rated at least “Fully Successful,” and the employee is a GS employee for at least 1 year. The bonus is up to 25 percent of the employee’s salary and is paid from the MTF’s budget. Medical officers are entitled to a multi-year retention bonus if they remain on active duty for 2 years or more after any other commitment.
Student Loan Repayment	The federal student loan repayment program permits the DHA to repay federally insured student loans.
Special Salary Pay Tables	The MTFs can submit a packet through the DHA to the OPM to request a special salary rate to combat pay inequities. Physicians and dentists are on a “GP” pay scale and can receive title 38 market pay instead of locality pay. ^a Medical officers are entitled to a special rate based on rank and experience, including board certification.
Recognition	Set aside time for employee appreciation, appraisal bonuses, time-off awards, early departure, command coins, contractor letters of appreciation.
Flexibility	Offer telework, virtual telehealth, remote opportunities, and alternative work schedules where available.

Source: The DOD OIG review of the DHA Instructions and interviews with officials from sample of the MTFs.

a. GP is a pay plan code under the General Schedule pay system and includes physicians and dentists who receive title 38 market pay instead of locality pay.

Efforts to Minimize Burnout

The MTFs and the DHA have developed ways to address and avoid staff burnout. See Table 4 for a list of efforts used by the MTFs to minimize burnout.

Table 4: MTF Efforts to Minimize Burnout

Mental Health	Making counseling and behavior health sessions, meditation spaces, and chaplain services available to health care personnel.
Time-off	Encouraging the use of leave (except during the height of the pandemic when leave was denied because of mission requirements).
Leadership Efforts	Leadership providing flexibility for providers with their patient scheduling, including administrative time or down time for providers to catch up on their workload.
Resiliency Training	Training to help staff learn ways to relax and deal with burnout.
Ready, Reliable Care^a	The DHA's campaign to leverage the entire workforce. Whether personnel are in clinical or administrative roles, all personnel are responsible for helping.

Source: DOD OIG review of the DHA Instructions and interviews with officials from sample of the MTFs.

a. Ready, Reliable Care is guidance that is not yet finalized or published, but is a DHA initiative to standardize care across the MHS to help reduce burnout.

U.S. Department of Justice (DOJ)



The Federal Bureau of Prisons (BOP) is responsible for the safekeeping, care, and subsistence of federal offenders. As part of this mission, the BOP provides medical care to the over 134,000 federal inmates and pre-trial detainees housed in BOP-managed institutions.²⁵ According to the BOP, it aims to effectively deliver medically necessary health care to inmates in accordance with proven standards of care without compromising public safety concerns inherent to the BOP's overall mission. The BOP uses a medical care level classification system to help match inmate health needs with institutions that can meet those needs. The classifications range from Care Level 1 for generally healthy inmates to Care Level 4 for inmates who require enhanced medical services or limited inpatient care. Institution care levels are based on the clinical capabilities and resources of the institution and the surrounding community.

Each of the BOP's 121 institutions operates an on-site health services unit that provides urgent and routine health care services. Additionally, each institution has procedures to handle medical emergencies during hours that health care providers are not on site. Seven of the BOP's 121 institutions are medical centers, which offer 24-hour inpatient care units and a variety of specialized services, such as dialysis, oncology, prosthetics and orthotics, and dementia care.

As of March 2022, a total of 2,998 personnel, worked in BOP's institution health services units, including 2,478 BOP-employed civil service employees and 520 commissioned officers of the U.S. Public Health Service.²⁶ The number and type of health services positions authorized at an institution vary based on the institution care level, population size, and special medical missions of the institution. In Table 1 below we present the nine most common health services positions at BOP institutions. Together, these position types account for about 84 percent of all institution-based health services positions within the BOP.²⁷ Registered nurse positions make up almost one-third of all institution health services positions.

Table 1: Most Common Health Services Positions at BOP Institutions

<i>Position Type</i>	<i>General Description of Responsibilities</i>	<i>% of Health Services Positions^a</i>
Clinical		
Registered Nurse	Delivers physician-ordered care, performs nursing assessments and procedures, administers medications at designated pill lines, conducts triage and clinics, performs intake screening of newly admitted inmates, and delivers emergency nursing care.	32%
Mid-level Practitioner	Certified nurse practitioners, certified physician assistants, and international medical graduates who assess, diagnose, and treat medical conditions under the license of a physician. Conducts physical examinations, emergency care, chronic care clinic evaluations, and preventive health care.	12%
Medical Officer	Physicians with the authority to assess, diagnose, treat, and educate patients and to and prescribe medications. Performs physical examinations, orders diagnostic testing, provides treatment and prescribes medications as required, and refers patients to consultant specialists or community hospitals when necessary. Provides clinical oversight for mid-level practitioners and other clinical personnel.	8%
Health Aid and Technician	Includes paramedic positions (manages emergencies and injuries, administers medications at designated pill lines, and performs intake screening and clinic duties during off-shifts) and medication technician positions (administers medications at pill lines, prepares medications, assists with pharmacy inventory.)	7%
Pharmacist	Adjudicates medication orders, dispenses medication, counsels and educates staff and patients, and monitors the safe and appropriate use of medications.	6%
Dental Officer	Responsible for the full range of dental care provided to inmates, including prevention, diagnosis and treatment of diseases, injury, and deformities of the mouth.	5%
Nonclinical		
Health Services Administrator	Functions as the department head for the health services units. Plans, directs, and manages the health services unit operations.	6%
Health Information Specialist	Manages electronic and paper medical records and collects, stores, retrieves, and protects the confidentiality of health information.	5%
Health Services Assistant	Schedules appointments; coordinates external medical trips; files medical information; manages correspondence, reports, and purchase cards.	5%

Source: DOJ OIG summary of BOP guidance and data.

a. Total does not equal the 84 percent reported above because of rounding.

Impact of COVID-19 on the BOP

There have been over 60,000 inmate cases of COVID-19 since March 2020, according to the BOP's 2023 Congressional Budget Submission. The pandemic created challenges for the BOP as it worked to prevent and manage the spread of the disease in its institutions. The CDC noted that, due to the congregate nature of correctional environments, "the risk of COVID-19 transmission is higher in these settings compared with the general population." The BOP implemented a series of modified operations intended to help mitigate the spread of COVID-19 inside BOP facilities, including movement restrictions, limiting capacity for group activities, suspending in-person social visiting, and enhanced cleaning procedures.

The pandemic increased the workload for BOP institution health services personnel. COVID-19 symptom screening, testing, and monitoring and caring for inmates in quarantine and medical isolation added significant responsibilities to the BOP's health services units. Modified operations put in place to help manage the pandemic also increased workloads. For example, as a result of restrictions on inmate movement, some institutions conducted sick calls, that is the process by which inmates request and receive routine or preventative medical care, and delivered medication in multiple discrete housing units that are located across large compounds. This is in contrast to the standard practice wherein large numbers of inmates from multiple housing units could report to a single, centralized location to receive those services.

Further, some modified operations directly affected health care delivery during the pandemic. For example, at some institutions where operations were severely disrupted due to the pandemic the BOP postponed routine services in order to focus on urgent health care needs, postponed routine and elective external medical trips, and suspended routine dental care at institutions where there was widespread COVID-19 transmission.

Scope of DOJ OIG Review

This review provides information on BOP civil service employees and commissioned officers of the U.S. Public Health Service who work in the health services units at BOP institutions. Although there are 121 BOP-managed institutions, the BOP considers the federal correctional complexes, in which multiple institutions are co-located, to be a single institution when reporting staffing data instead of counting each constituent facility separately. Therefore, the total number of facilities described in the March 2022 BOP staffing data used in this review is 97. When looking at only clinical positions, the total facilities decreases to 96 because the 97th facility, FCC Beaumont uses only contract clinical staff.

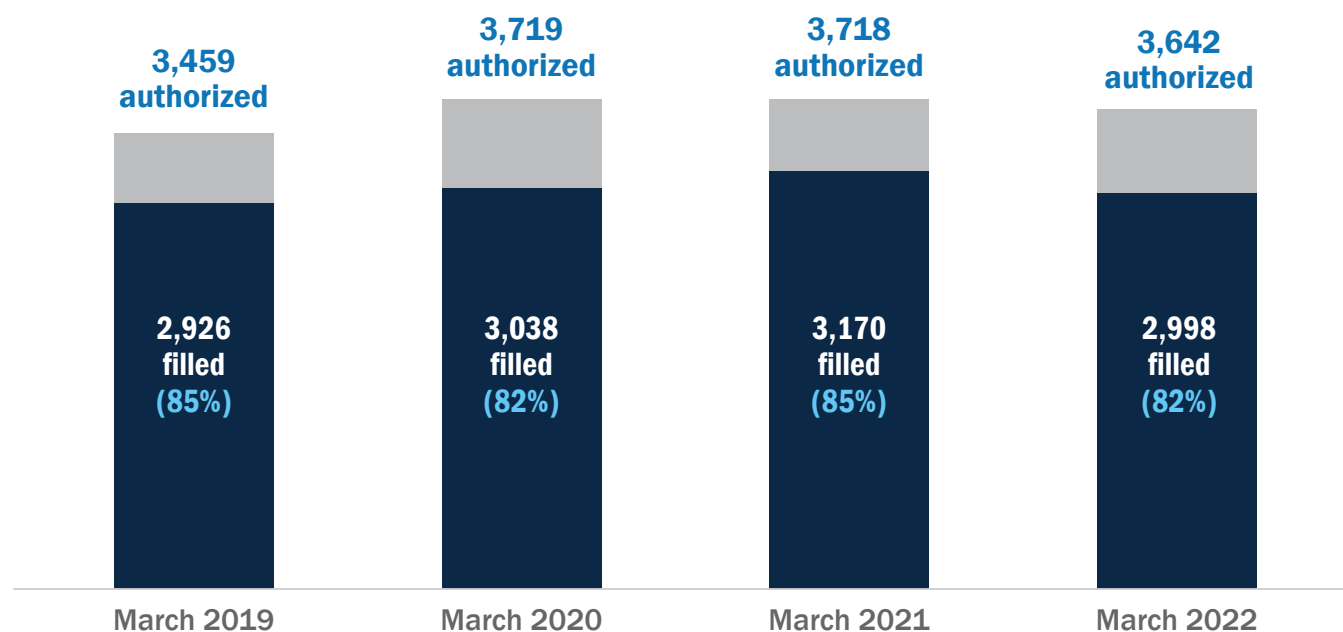
This review does not include BOP's psychology staff because they are not part of the BOP's health services units. Additionally, this review does not include information about contract health care providers who may provide specialized on-site care at BOP institutions, cover institution vacancies

on a short-term basis, or deliver care to BOP inmates at community facilities not operated by the BOP. (See Appendix B: BOP for DOJ OIG’s methodology.)

Health Care Personnel Shortages Before and During the Pandemic

Health services personnel shortages have been a long-standing challenge for the BOP. As of September 2014, health services positions at BOP institutions were only 83 percent filled overall, according to a DOJ OIG report on the BOP’s medical staffing challenges, published in March 2016.²⁸ As shown in Exhibit 1 below, from March 2019 through March 2022, the BOP experienced similar fill rates for health services personnel positions, both before and during the pandemic. Although the number of authorized health services positions, or total positions BOP could fill, varies by year, the BOP has consistently struggled to fill health services positions at its institutions.

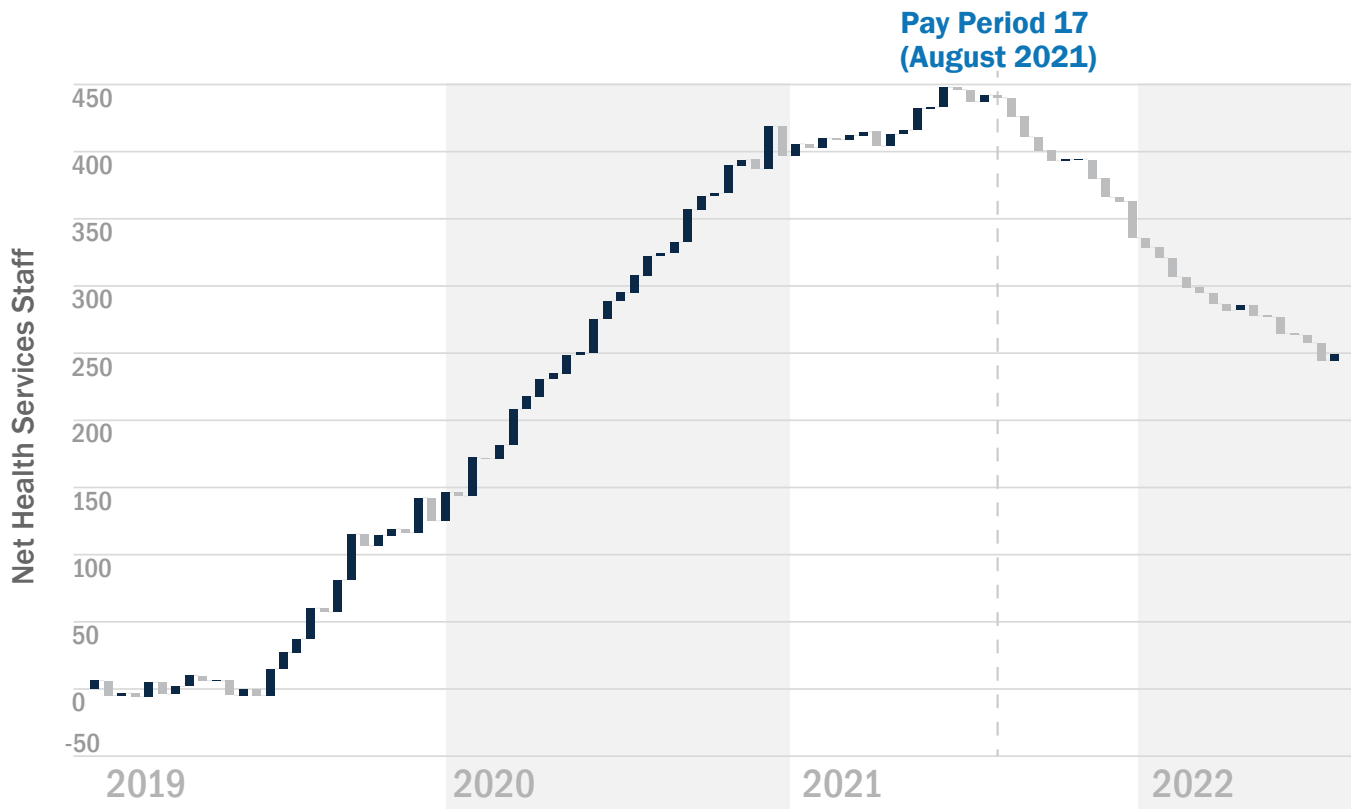
Exhibit 1: Percent of Institution Health Services Positions Filled



Source: DOJ OIG analysis of BOP data.

From mid-2019 through mid-2021, the BOP made progress toward addressing its shortages of health services personnel. Despite the pandemic, the BOP increased the number of filled health services positions during this time, as shown in Exhibit 2 below. However, based on available data, the overall fill rate for institution health services positions never exceeded 85 percent, and the fill rate declined from August 2021 through at least July 2022. The decrease in health services staff appears to be driven both by a decrease in hiring and an increase in resignations.

Exhibit 2: Net Increases and Decreases in Health Services Staffing, by Pay Period, January 2019 Through July 2022

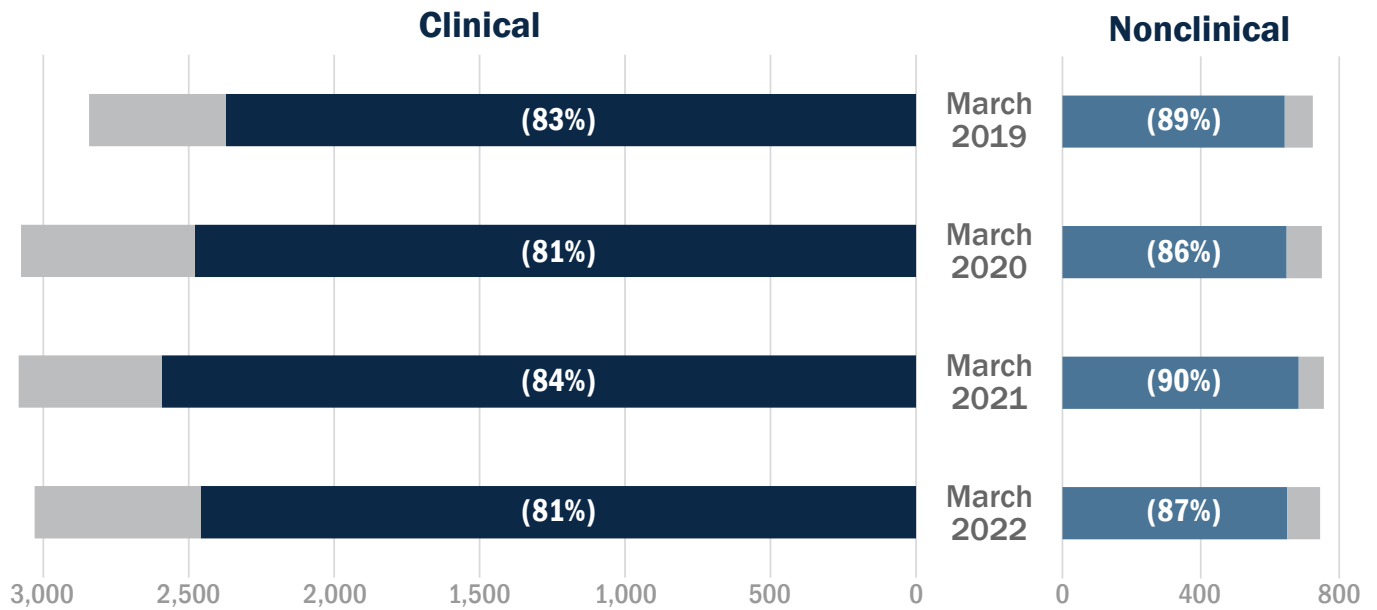


Source: DOJ OIG analysis of BOP data.

Note: Each rectangle represents the net increase or decrease in staffing for the pay period. There are 26 pay periods each calendar year.

During this period, the staffing levels of individual institutions ranged from fully staffed down to only 37 percent staffed. Regional Health Services Administrators (HSA) generally identified a fill rate of 80 to 85 percent for health services positions as a threshold of concern, although some emphasized that even institutions with a higher overall filled percentage could still have specific critical vacancies that drastically hinder health services operations. There are often only one to two authorized positions for each type of position, especially at smaller institutions, which means that a single dental officer vacancy, for example, could render an institution unable to offer on-site dental care. Further, clinical staff who provide direct inmate care often have specialized roles and licensing requirements so other health service staff often cannot cover the responsibilities of those vacant positions. While clinical staff can cover administrative tasks, nonclinical staff cannot assist with tasks such as medication delivery. As shown in Exhibit 3 below, BOP health care staffing has been consistently lower on the clinical side.

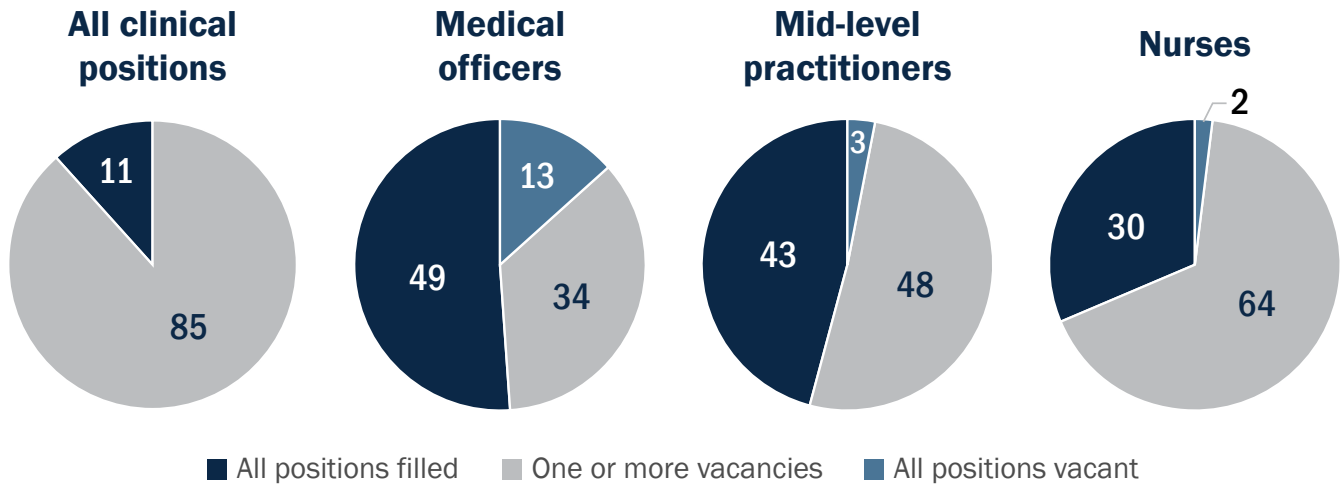
Exhibit 3: Fill Rates for Clinical and Nonclinical Health Services Positions



Source: DOJ OIG analysis of BOP data.

Regional HSAs we interviewed also identified specific clinical positions that they have found to be particularly challenging to fill, including medical officers (physicians), mid-level practitioners (such as nurse practitioners and physician assistants), and nurses. (See Table 1 above for descriptions of these roles.) These challenges are apparent in our analysis of BOP’s staffing data for March 2022. As shown in Exhibit 4 below, 85 of the 96 (89 percent) BOP facilities had one or more clinical position vacancies. These shortages are especially concerning for the 13 facilities that did not have a medical officer on staff as of March 2022. The responsibilities of medical officers (physicians) generally include diagnosing and treating patients, prescribing medications, referring patients for specialist care, and overseeing other clinicians. Although direct patient care responsibilities can be covered by mid-level practitioners, these types of critical vacancies may require the BOP to bring in staff from other locations on temporary duty assignments, or to use short term emergency contracts to fill the gaps.

Exhibit 4: Number of Facilities with Vacancies in Select Clinical Positions, March 2022



Source: DOJ OIG analysis of BOP data.

Note: There are 96 facilities represented in this data because the BOP’s staffing data considers all institutions within a federal correctional complex together. The 97th facility, FCC Beaumont, is not included in this data because it relies solely on contracted clinical staff. The facility total for mid-level practitioners is 94 because there were two additional facilities without authorized mid-level practitioner positions in March 2022.

Additional analysis of the positions that regional HSAs identified as hard to fill reveals that despite an increase in staffing between 2020 and 2021, staffing fill rates for nurses and mid-level practitioners decreased between 2021 and 2022. See Table 2 below. In particular, in March 2022, the filled rate for nurses fell below early pandemic levels. At that time, 69 percent (66 of 96 facilities) had vacant nurse positions, as shown in Exhibit 4. With respect to filled medical officer positions across BOP institutions, the percentage remained critically low during the pandemic. On top of these shortages, the current number of authorized clinical positions may not reflect the actual health services staffing needs at institutions, according to several Regional Health Services Administrators (HSA). One Regional HSA we interviewed said that the number of nurses authorized for his region is not sufficient to meet inmate health care demand. Therefore, BOP position shortages may be even more critical than the data shows.

Table 2: Fill Rates for the BOP’s 3 Most Common Clinical Positions During the Pandemic

Position	March 2020	March 2021	March 2022
Medical Officers	68%	69%	69%
Mid-Level Practitioners	76%	82%	80%
Nurses	84%	87%	82%

Source: DOJ OIG analysis of BOP data.

Contributing Factors That Led to Shortages of Health Care Personnel

Although it is not reflected in the overall staffing data, staff illnesses contributed to health services staffing shortages during the pandemic as health services personnel contracted COVID-19 and needed to take sick leave to recover. For example, FCI Milan reported that 50 percent of its medical staff contracted COVID-19 and had to take sick leave in the first week of its first COVID-19 outbreak in April 2020.²⁹ Overall, FCI Milan reported that 75 percent of its health services staff contracted COVID-19 and had to take sick leave at some point during that outbreak. As a result, one Mid-level Practitioner reported that they and another clinical staff member worked alone for weeks, taking on the responsibilities of the other staff on sick leave.

Additionally, we identified numerous factors that impair the BOP's ability to recruit and retain health services personnel, including several challenges the BOP has reported as longstanding issues, as well as additional reasons identified by regional HSA and human resources staff we interviewed:

Limited labor pool: The BOP needs mostly primary care physicians, but medical school graduates increasingly pursue medical specialty fields over primary care medicine.

Location: Many BOP institutions are located in rural areas, and the BOP has found it challenging to recruit health care professionals in these areas because of limited availability locally and difficulty recruiting these professionals from outside the area. Conversely, in urban areas, the BOP faces competition with other health care employers.

Noncompetitive pay: In addition to the location-driven challenges described above, interviewees identified further hiring and retention issues in urban locations due to higher cost of living in urban areas for which BOP salaries may not be commensurate (equal or adequate).

Some federal agencies have title 38 authority, which allows them to offer higher salaries across all licensed medical disciplines. While the BOP currently has title 38 authorities for three disciplines – psychiatrists, physicians, and dentists – it cannot compete with title 38 salaries offered for other disciplines.

During the pandemic, health care professionals, especially nurses, were in high demand and often were offered higher-than-usual pay rates that the BOP could not match.

Hiring process: Aspects of the hiring process can be challenging for health care recruiting. Specifically, the federal hiring process is different than what health care professionals may be used to in the private sector, and it can be time consuming for both applicants and the BOP. Nuances in the job postings and application process may prevent applicants from applying to or

being selected for available job opportunities. Additionally, not filling vacancies fast enough can lead to a “domino effect” of resignations as workloads are distributed to remaining staff.

Limited promotion opportunities: Limited opportunities for career advancement in some health services positions can result in clinical personnel moving into nonclinical supervisory roles and experienced nonclinical personnel leaving to take other opportunities that would allow them to qualify for supervisory roles in the future.

Challenges of the job: Working in the correctional health care setting may not be a preferred workplace for everyone. The correctional setting has additional stressors and responsibilities that health care workers do not have to contend with in other settings. For example, a regional HSA stated that nurses in the community did not have the same requirements as employees who work in correctional facilities, such as requirements to wear stab vests, carry a “big wad of keys,” or carry oleoresin capsicum (pepper) spray. Because of these added challenges, one interviewee stated that the BOP’s total compensation may need to exceed what other employers are offering to attract and retain health care staff.

Available schedules: 40 health services exit survey respondents mentioned that having a different schedule would have allowed them to stay with the BOP, including compressed schedules, part-time options, and telework.

Impacts of Shortages of Health Care Personnel

Shortages of health care personnel had effects on inmate care, as well as personal and professional effects on health care staff during the pandemic. Staffing shortages also had financial impacts on the BOP, as staff worked overtime to manage increased workloads.

Patient Impacts

Decreased Patient Satisfaction

According to an April 2021 survey on federal inmates’ experiences during the pandemic, inmates generally perceived that the quality of health care made available to them decreased during the pandemic, particularly during restrictions of inmate movement through lockdowns that the BOP implemented to prevent the spread of COVID-19.³⁰ Specifically, an estimated 80 percent of inmates rated BOP’s provision of medical care as poor during pandemic lockdowns, compared to an estimated 41 percent of inmates who described the provision of medical care as poor before the pandemic.

Delays in Routine and Preventative Care

As COVID-19 outbreaks disrupted normal operations at BOP institutions, health services units also had to adjust their operations. BOP's pandemic response plan recommended that, depending on the COVID-19 level in the institution and the community, BOP institutions reduce or postpone preventative health care services, postpone care for low priority health problems, and focus on life-saving care.

At some institutions, health care staffing shortages affected the BOP's ability to provide routine medical care. For example, staff at the Metropolitan Detention Center Brooklyn reported that severe staffing shortages resulted in challenges responding to sick call requests. Sick call wait-times increased significantly as the institution received a much higher number of sick-calls due to COVID-19. An official from the Metropolitan Detention Center Brooklyn reported that in late September 2020, there were 160 inmate sick call requests dating back to early July 2020 that had not been scheduled or completed. One regional HSA we interviewed reported that the region had observed a backlog of nursing tasks during the pandemic; for instance, one of the institutions in their region had a backlog of 170 electrocardiograms.

Increase in Telehealth Use

During the first year of the pandemic, the BOP expanded access to telehealth services, which can help promote access to medical care generally, while also mitigating the risk of COVID-19 transmission. The proportion of inmates in BOP-operated institutions using telehealth more than doubled compared to the prior year. Telehealth services were used for both external visits delivered by outside providers, as well as clinical encounters with internal providers. Psychiatry visits with internal BOP providers were the leading type of telehealth visit for specialty care, accounting for 41 percent of specialty care visits. For more information on the BOP's use of telehealth during the pandemic see the PRAC report [Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic](#).

Health Care Personnel Impacts

Increased Workloads

The pandemic increased health services staff workloads as they handled large numbers of inmate illnesses due to COVID-19, as well as took on new responsibilities including screening and testing for COVID-19 and monitoring of quarantine and isolation units. Two regional HSAs noted that mass-testing initiatives, in which entire housing units had to be tested for COVID-19, were extremely labor intensive for health services staff.

In addition to the pandemic, health service staff workloads are also routinely increased due to augmentation, which is the practice of assigning non-custody staff, such as teachers or health care professionals, to temporarily assume the duties of a correctional officer. Regional HSAs that we interviewed stated that clinical providers were often exempt from augmentation based on institution-level agreements. However, one regional HSA emphasized that augmenting staff from any health services role can cause work to accumulate.

We assessed augmentation hours and found that that BOP health services personnel worked over 11,300 augmentation hours during the first year of the pandemic. In Table 3 below, we provide the augmentation hours for BOP's health services personnel by pandemic year. Although total augmentation hours for health services personnel were lower in the first year of the pandemic than in other years, the practice still increased health services staff workloads during the pandemic, as staff either needed to delay the completion of their regular responsibilities, or transfer them to other health services staff, when asked to take on temporary correctional officer duties. The use of augmentation was accompanied by a 56 percent increase in overtime hours, which we discuss below.

Table 3: BOP Health Services Personnel Augmentation Hours by Pandemic Year

<i>Pandemic Year</i>	<i>Augmentation Hours</i>	<i>Number of Employees</i>
Before Pandemic (March 2019 - February 2020)	15,636	416
First Year of Pandemic (March 2020 - February 2021)	11,386	296
Second Year of Pandemic (March 2021 - February 2022)	11,877	315
Third Year of Pandemic (March 2022 – August 2022)	11,486 ^a	307
Total	50,386^b	659

Source: DOJ OIG analysis of BOP augmentation hours.

- a. This sum represents a partial year. At the time of our data request, the last date available for overtime data was August 2022.
- b. Total does not equal the actual sum because of rounding.

Additionally, we found that augmentation is not standardized across the health services occupational series at the BOP. Of the 50,386 augmentation hours worked by health services staff from March 2019 through August 2022, 38 percent of those hours were performed by medical records technicians, 10 percent by health technicians, and 6 percent by assistant health service administrators.

Well-Being

Regional HSAs we interviewed described the experience of health services personnel during the pandemic a variety of ways, including “arduous” and “stressful.” They also said that health services personnel were “severely overworked” and often “scared” and “exhausted.” In response to a 2021 survey of institution staff, 75 percent of health services personnel respondents (583 of 775) reported experiencing increased stress or anxiety at work because of the pandemic, and 34 percent of respondents (262 of 775) reported considering leaving the BOP because of the pandemic.³¹

Financial Impacts

Overtime Costs

One of the tools that the BOP uses to supplement shortages of personnel is authorizing BOP employees to work overtime. We assessed BOP’s overtime spending and found that that BOP health services personnel worked over 314,000 overtime hours during the first year of the pandemic, at a cost of \$15 million, which represented an increase of 56 percent and 64 percent, respectively, compared with the overtime hours and costs in the year before the pandemic. In Table 4 below, we provide the overtime hours and costs for BOP’s health services personnel by year of the pandemic.

Table 4: BOP Health Services Personnel Overtime Hours and Costs by Pandemic Year

<i>Pandemic Year</i>	<i>Overtime Hours</i>	<i>Overtime Costs</i>
Before Pandemic (March 2019 - February 2020)	201,007	\$9,164,471
First Year of Pandemic (March 2020 - February 2021)	314,498	\$15,044,010
Second Year of Pandemic (March 2021 - February 2022)	198,299	\$9,419,537
Third Year of Pandemic (March 2022 - October 2022) ^a	136,245	\$6,577,194
Total	850,049	\$40,205,212

Source: DOJ OIG analysis of BOP overtime data.

a. At the time of our data request, the last date available for overtime data was October 2022.

In addition, we found that overtime is not standardized across occupational series at the BOP; rather, a small number of position types account for a large percentage of health services overtime. For example, nurses accounted for nearly 55 percent of all overtime hours worked by BOP health services personnel from March 2019 through October 2022, which we calculated to be the equivalent of approximately 61 full time positions per year.

Efforts to Recruit New Staff, Retain Existing Staff, and Minimize Personnel Burnout During the Pandemic

From January 1, 2019, through December 31, 2021, the BOP spent about \$27.8 million in incentive payments to over 1,300 health services employees in an effort to attract and retain its medical personnel. For several decades, BOP policy has authorized the use of recruitment, relocation, and retention incentives either to encourage prospective employees to accept a position or retain current employees with high or unique qualifications who would likely leave BOP without an additional incentive to stay. The BOP increased its use of incentive payments in 2020, during the pandemic.

Recruitment Initiative

From April 2020 through January 2021, the BOP ran an advertising and marketing campaign to hire health services staff through expanded recruitment efforts. This hiring campaign represented an attempt to rebrand and market the BOP for new recruits and included the use of online recruiting, social media, and web analytics. For example, the BOP held live social media events geared toward the recruitment of nurses to reach wider audiences and drive applicants to the BOP application portal. Data on incoming BOP employees indicates that the BOP hired more new health service staff in 2020 than it did in either 2019 or 2021.

Recruitment Incentives

The BOP can offer monetary and non-monetary incentives, which can help recruit health care personnel. Several of BOP's regional HSAs and regional human resources administrators stated that the most effective recruitment incentives involved monetary compensation. Specific incentives they listed included recruitment bonuses, relocation incentives, student loan repayments, salary above the minimum step of the candidates qualifying grade, and use of title 38 pay. In Table 5 below, we provide additional detail on these five monetary recruitment incentives.

Table 5: Monetary Recruitment Incentives for BOP Health Care Personnel

<i>Incentive</i>	<i>Description</i>	<i>Service Agreement</i>
Monetary Bonus	Lump-sum payment, up to 25 percent of pay, to a newly appointed employee in a position that is difficult to fill with a high-quality candidate.	24 months
Relocation	Lump-sum payment, up to 25 percent of pay, to current BOP employees who relocate to a designated hard-to-fill location.	24 months
Student Loan Repayment	Up to \$10,000 per calendar year for up to six years, not to exceed a maximum amount of \$60,000.	36 months
Starting Pay	Appointed at a salary rate above the minimum step of a candidate’s qualifying grade, based on superior qualifications for non-attorney positions.	None
Title 38	Special pay authority for all BOP physicians, dentists, and psychiatrists.	None

Source: BOP, Program Statement 3530.02: Compensation.

Our analysis showed that from January 1, 2019, through December 31, 2021, BOP paid \$8.45 million in recruitment bonuses, relocation incentives, and student loan repayments. Table 6 summarizes the number of employees and amounts paid for each of these three types of incentives by calendar year.

Table 6: Number of Employees and Dollar Amounts of BOP Recruitment Incentive Payments for Calendar Years 2019 Through 2021

Calendar Year	Recruitment Bonus		Relocation Incentives		Student Loan Repayment	
	Number of Employees	Amount Paid	Number of Employees	Amount Paid	Number of Employees	Amount Paid
2019	89	\$1,556,658	6	\$74,432	148	\$1,378,111
2020	95	\$1,901,926	5	\$98,412	126	\$1,207,059
2021	39	\$707,014	5	\$71,432	158	\$1,463,735
Total	223	\$4,165,599^a	16	\$244,276	278^b	\$4,048,905

Source: DOJ OIG analysis of BOP data.

- a. Total does not equal the actual sum because of rounding.
- b. Employees may receive student loan incentive payments over several years and increments. As a result, the total amount depicted in the Table represents a unique count of any employee receiving student loan repayment from 2019 to 2021, as opposed to a cumulative total of the employee count for each year.

Additionally, the BOP used its title 38 personnel authorities to hire 34 medical officers and 20 dental officers between January 1, 2019, and December 31, 2021. A regional HSA stated that expanding title 38 authorities from psychiatrists to physicians and dentists in 2019 was a “significant improvement” that helped the BOP to compete with the private sector and other governmental agencies. Finally, BOP officials cited a pay-setting authority known as above the minimum rate (AMRs) that helped hire health care personnel. Based on our analysis of AMR incentives for health care personnel, we found that the BOP used this authority 540 times to attract candidates from outside government service between January 1, 2019, and December 31, 2021. Further, 385 of 540 (71 percent) of all AMR incentives applied to health care personnel were given to nurses.

In addition to the above monetary incentives, BOP officials cited both direct hire authority and the negotiation of annual leave credits as helpful, non-monetary recruitment tools. Through authority granted by the OPM, the BOP can leverage government-wide direct hire authorities for five types of health services positions at all its institutions.³² However, a senior BOP human resources official stated that the BOP did not have the human resources staff with the necessary skills to leverage this authority enterprise-wide. Our analysis revealed that from 2019 to 2021, the BOP only used direct hire authorities for health services personnel at three of its institutions, all medical centers, for a total of 71 health care direct hires.

Retention Incentives

BOP officials reported that one of the main factors contributing to turnover in health services personnel was BOP’s low compensation compared to other federal agencies and the private sector. Our analysis of exit surveys for health services staff from FY 2019 through FY 2022 found that pay was the most frequently cited factor for why employees were leaving. To improve health services retention, BOP spent \$19.39 million in retention incentives to over 1,100 health care employees from January 1, 2019, through December 31, 2021. Table 7 summarizes the number of employees and amounts paid for retention incentives, by calendar year.

Table 7: Number of Employees and Dollar Amounts of BOP Retention Incentive Payments for Calendar Years 2019 Through 2021

<i>Calendar Year</i>	<i>Number of Employees</i>	<i>Amount Paid</i>
2019	469	\$6,311,308
2020	461	\$6,918,848
2021	420	\$6,162,232
Total	1,107^a	\$19,392,388

Source: DOJ OIG analysis of BOP data.

a. Employees may receive retention incentives for multiple years. As a result, the columns showing the total number of employees receiving retention incentives by year and the cumulative total number of employees who received retention incentive payments over the 3 years do not total.

In addition to monetary incentives, BOP officials reported the following efforts to retain existing health care personnel.

- Approving compressed work schedules
- Awarding time-off incentives
- Granting permission for outside employment
- Emphasizing the ability to retire with law enforcement benefits after 20 years of service at age 50

Efforts to Minimize Burnout

According to both BOP officials we interviewed and exit surveys from separated health services employees, numerous staff left the BOP because of the increased workload resulting from the pandemic and lower staffing levels. One regional HSA stated that BOP's health services personnel worked very hard during the pandemic and experienced burnout, which in turn caused a lot of turnover.

To reduce health care personnel burnout, BOP officials stated that they encouraged personnel to access the BOP's Employee Assistance Program and encouraged management to monitor and support staff well-being. During the pandemic, BOP institutions also activated Correctional Support Teams, previously called Crisis Support Teams, which provided peer support to staff in response to critical incidents. However, the Correctional Support Team model, which entailed peer support staff walking throughout facilities and talking to staff members, were limited because of the pandemic modifications, such as social distancing and staff movement restrictions.

U.S. Department of Veterans Affairs (VA)



The Veterans Health Administration (VHA) runs the largest integrated health care network in the United States, providing services through 140 facilities encompassing over 1,200 sites of care, including VA Medical Centers and outpatient settings. More than 371,000 health care professionals provide comprehensive health services, including telehealth.³³ As of September 2022, over 9 million veterans were enrolled. In addition to caring for veterans, VHA also serves qualifying family members, dependents, and survivors of veterans; and eligible active military and Reserve Component members.

COVID-19's Impact to the VHA

The COVID-19 pandemic altered the delivery of health care in the VHA in several ways. For example, VHA facilities began shifting care from in-person to telehealth to limit face-to-face interaction. The demand for inpatient care also increased as COVID-19 hospitalizations grew, whereas the demand for elective and outpatient care decreased. In addition to facing these alterations in the delivery of health care during the pandemic, VA serves as the nation's support system during times of emergencies.³⁴

Scope of VA OIG Review

This review summarizes information on shortages at 139 of 140 VHA facilities for FYs 2020-2022, including data gathered through an annual VA OIG survey. The Manila facility was excluded because its staff were foreign nationals employed by the State Department. For the survey, VHA-identified facility points of contact reported severe occupational shortages among both clinical and nonclinical occupations employed by VHA. Severe occupational shortages should not be confused with vacancies. A severe occupational shortage refers to particular occupations that are difficult to fill, and a shortage exists when criteria set forth in 5 C.F.R. § 337.204, Severe Shortage of Candidates, are applied. Vacancy refers to an unoccupied position and is distinct from the designation of a severe occupational shortage. For example, a facility could identify an occupation as a severe occupational shortage, which could have no vacant positions or 100 vacant positions. (See Appendix C: VA OIG methodology and Appendix E: Shortages Reported by at least 20 percent of VHA Facilities)

Health Care Personnel Shortages Before and During the Pandemic

In response to VA OIG concerns related to access to VHA care, scheduling practices, and excessive wait times at the Phoenix Health Care System, Congress passed the Veterans Access, Choice, and Accountability Act (VACAA) of 2014.³⁵ VACAA and the subsequent VA Choice and Quality Employment Act (VCQEA) of 2017 required the VA OIG to provide annual determinations of VHA occupations with the largest shortages.³⁶ VACAA and VCQEA also established authority for the Secretary of Veterans Affairs to directly recruit and appoint qualified personnel to occupations determined to have staffing shortages by the VA OIG. For each of the time periods discussed in this review, the VA OIG found widespread shortages across VHA facilities.³⁷

Severe Occupational Shortages from FY 2020 Through FY 2022

All 139 VHA facilities reported at least one severe occupational shortage in FY 2022, a departure from the FYs 2020–2021 VA OIG reports in which several facilities reported no severe occupational shortages.³⁸ The total number of severe occupational shortages reported by facilities in FY 2022 survey responses increased comparatively as seen in Table 1. For the first time since reporting to the facility level, there was a net increase in severe occupational shortages suggesting it was more difficult to fill positions in VHA. Additionally, 22 occupations were identified as a severe occupational shortage by at least 20 percent of facilities in FY 2022. This was an increase of occupations from 19 in FY 2021 and 17 in FY 2020. See Appendix E for shortages reported by at least 20 percent of facilities from FYs 2020-2022.

Table 1: Changes in Total VHA Facility-Designated Severe Occupational Shortages from the Prior Fiscal Year

<i>Fiscal Year</i>	<i>Number of Severe Occupational Shortages</i>	<i>Net Change from Prior Fiscal Year</i>	
		<i>Number</i>	<i>Percent</i>
2020	2,430	-255	-9.5
2021	2,152	-278	-11.4
2022	2,622	470	21.8

Source: VA OIG analysis of VHA facilities’ responses to the VA OIG’s FYs 2019 through 2022 staffing surveys.

Most Frequently Reported Severe Occupational Shortages

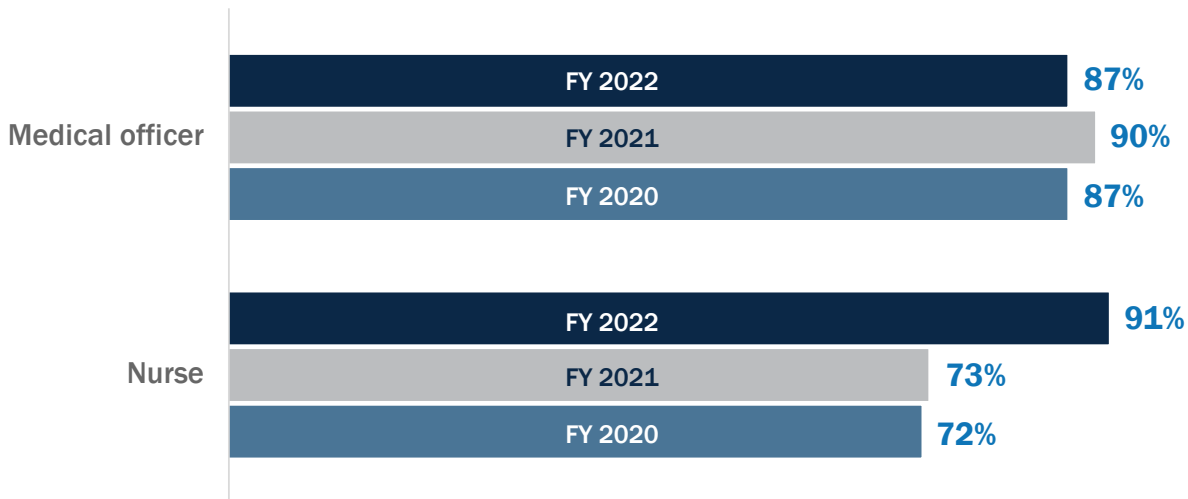
Medical Officer and Nurse Severe Occupational Shortages

Medical officer and nurse occupational series were analyzed separately from the other occupations, because VHA uses assignment codes to designate specialties within the two OPM occupational series. VA OIG derived medical officer and nurse severe occupational shortages for the series if the facility indicated either the OPM occupational series or any of its related VHA assignment codes as shortages.

In FY 2022, 87 percent of facilities reported the medical officer OPM occupational series or a related VHA assignment code as a severe occupational shortage. This shortage was a decrease from FY 2021, when 90 percent of facilities listed a shortage for the occupation. In FY 2020, 87 percent of facilities listed the medical officer OPM occupational series or a related VHA assignment code as a severe occupational shortage.

In FY 2022, 91 percent of facilities reported the nurse OPM occupational series or a related VHA assignment code as a severe occupational shortage. This was up from FY 2021, when 73 percent of facilities listed the nurse occupation as a shortage. In FY 2020, the nurse OPM occupational series or a related VHA assignment code was reported as a severe occupational shortage by 72 percent of facilities.

Exhibit 1: Percent of VHA Facilities Reporting Shortages for Medical Officer and Nurse Occupations, FYs 2020-2022



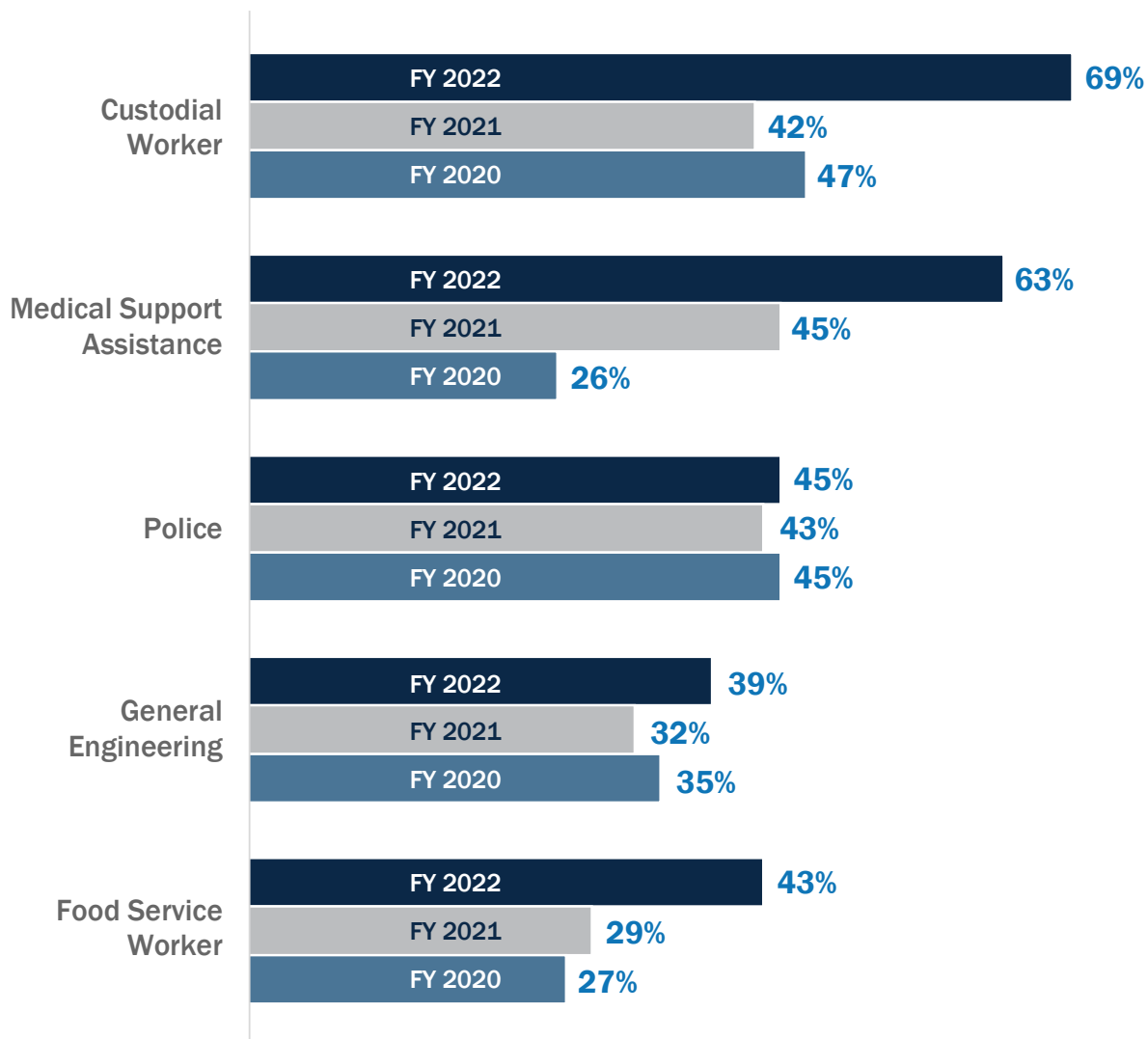
Source: VA OIG analysis of VHA facilities' responses to the VA OIG's FYs 2020, 2021, and 2022 staffing surveys.

VA OIG also assessed severe occupational shortages at the assignment code level to assess severe shortages for the medical officer and nurse series in more detail as compared to other occupations.

Shortages in Nonclinical Occupations

As with the top five clinical occupations, the same five occupations were listed as the top nonclinical shortages for all three FYs in the review period. In FY 2022, for the first time since the VA OIG began reporting both the top five clinical and nonclinical occupational shortages in 2018, nonclinical occupations represented the top two severe occupational shortages. In FY 2021, medical support assistance was the most frequently reported nonclinical shortage occupation, which 45 percent of facilities designated as a severe occupational shortage. Custodial worker was the most frequently reported nonclinical shortage occupation in FY 2020, with 47 percent of facilities designated as a severe occupational shortage. See Exhibit 3 below.

Exhibit 3: Percent of VHA Facilities Reporting Top Five Nonclinical Occupational Shortages, FYs 2020-2022



Source: VA OIG analysis of VHA facilities' responses to the VA OIG's FYs 2020, 2021, and 2022 staffing surveys.

Contributing Factors that Led to Shortages of Health Care Personnel

As part of the FY 2020 occupational shortage survey, the VA OIG asked VHA facilities to provide a reason for each designated shortage. The VA OIG identified themes among free text responses to summarize the most common reasons for shortages. The most frequently cited reasons for severe occupational shortages among the top five clinical and top five nonclinical occupations were: (1) lack of qualified applicants, (2) noncompetitive compensation, (3) staff turnover, (4) recruitment challenges, and (5) geographical recruitment challenges.³⁹ The lack of qualified applicants theme was used to identify those responses that referred to a limited number of applicants, a lack of applicants, as well as a limited number of qualified applicants. The noncompetitive compensation theme was used to identify responses that referred to noncompetitive salaries, benefits, and incentives. The staff turnover theme was used to identify responses that mentioned turnover of staff and included references to retention, retirement, and promotion. The recruitment challenges theme was used to identify responses that referred to recruitment difficulties, hard to fill positions, and extended time to fill positions. The geographic recruitment challenges theme was used to identify responses that referred to recruitment difficulties driven by a facility's location.

Exhibit 4: Percentage of Top Reasons Reported by VHA Facilities for Shortages in Top Five Clinical and Top Five Nonclinical Shortage Occupations in FY 2020⁴⁰



Source: OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.

Impacts of Shortages of Health Care Personnel

Examples of impacts identified by VHA officials are listed below. While these examples are attributed to staffing shortages, they may also be associated with additional factors related to changes in the delivery of health care as part of the response to COVID-19.

Health Care Personnel Impacts

For FY 2020, human resources management was reported as a shortage by 22 percent of VHA facilities. While the human resources occupational series were not reported as severe occupational shortages by more than 20 percent of facilities in FYs 2021 and 2022, those occupations were consolidated from the facility to the Veterans Integrated Service Network (VISN) level as part of VHA's HR Modernization effort.⁴¹ When asked about impacts of a hiring surge to address shortages related to COVID-19, VISN directors reported the unanticipated workload compounded existing shortages and burnout among human resources personnel.

VHA's Reduce Employee Burnout and Optimizing Organizational Thriving (REBOOT) Task Force, established in Fall 2021, found that staffing challenges were reported by employees as the top contributor to burnout, followed by COVID-19 and pay issues.

Patient Impacts

In each of the VA OIG's annual shortages reports during the time periods for this review, the VHA identified severe occupational shortages in medical officer and nurse occupations. These two occupations are key to the delivery of health care and have been the most commonly cited shortages since 2014.⁴² A 2022 report by ECRI summarized research identifying health care personnel shortages as the top patient safety concern, showing such shortages caused for longer waits for care, including in life-threatening situations.⁴³ Similarly, CDC guidance used by VHA for mitigating personnel shortages during the COVID-19 pandemic indicates that appropriate staffing is essential for safe patient care.⁴⁴

Psychiatry and psychology were both in the top five clinical occupations reported by VHA facilities in VA OIG staffing shortage reports for FYs 2020 through 2022. These two occupations are key to the delivery of mental health services for patients, including in VHA's Primary Care Mental Health Integration (PCMHI) model of care. A December 2022 GAO report reviewed annual VHA surveys and found that 43 percent of facilities reported staffing as the most significant challenge to implementing PCMHI programs in 2022.⁴⁵ The GAO concluded that a "full complement of mental health professionals is imperative for VA to be able to meet the rapid growth in demand for VA Mental Health services" and recommended a comprehensive evaluation and implementation of strategies to mitigate PCMHI staffing challenges.

Nearly twice as many facilities reported medical support assistance as a severe occupational personnel shortage in FY 2021 than in FY 2020 (62 versus 36, respectively). More facilities may have reported medical support assistance as a severe occupational shortage in FY 2021 as a result of the pandemic. During the first year of the pandemic, VHA doubled the number of patients utilizing telehealth and other virtual modalities, compared to the prior year, relying heavily on medical support assistance to cancel, reschedule, and facilitate virtual appointments between patients and providers.⁴⁶ VHA providers reported that availability of medical support assistance led to more success in completing telehealth appointments.⁴⁷ Other VA OIG work identified that about 7.3 million VHA appointments were canceled early in the pandemic from March 15 through May 1, 2020.⁴⁸ The VA OIG concluded that schedulers would likely be in demand as VHA worked to reschedule the canceled appointments.

Operational Impacts

As part of the pandemic response, VHA also used the medical support assistance occupation in outpatient administrative positions for screening protocols, adding additional impact of any shortages in the occupation. Custodial worker was the most cited nonclinical severe occupational shortage in FYs 2020 and 2022, and among the top five most frequently reported shortages overall for FYs 2020 through 2022. In FY 2020, VHA's COVID-19 Response Plan required both routine cleaning, as well as additional cleaning and disinfection, if someone presented with COVID-19 symptoms or is exposed, making an already vital occupation more important during a pandemic.⁴⁹

Efforts to Recruit New Staff, Retain Existing Staff, and Minimize Burnout During the Pandemic

Widespread occupational shortages across VHA predate the pandemic, and so do efforts and approaches aimed at reducing those shortages. Such efforts include the use of direct hire authority available to VA with OPM approval, as well as VA-specific direct hire authority based in part on VA OIG annual shortage determinations.⁵⁰ VHA also gained resources and flexibilities created in direct response to the pandemic. Additionally, VHA received legislative relief and made use of other approaches to reduce shortages not necessarily tied to the pandemic. In October 2022, the Under Secretary for Health announced hiring faster and more competitively as one of VHA's six priorities. The examples provided below should not be considered an all-inclusive list of the VHA efforts to mitigate shortages of health care personnel.

Recruitment and Retention Incentives

Direct Hire Authority

VA has authority to make noncompetitive appointments based on a determination by OPM that a severe occupational shortage of highly qualified candidates exists for applicable occupations.⁵¹ The VA Secretary also has the authority to directly recruit and appoint qualified individuals to applicable occupations based upon a determination of occupations with the largest shortages by the VA OIG.⁵²

After the World Health Organization declared COVID-19 a worldwide pandemic, VA sought and obtained direct hire authority for several occupations from OPM beginning on March 23, 2020. OPM subsequently extended the direct hire authority for occupations covered by those requests through the end of the pandemic.

Onboarding Processes

To expedite hiring of new staff during the pandemic, VHA implemented changes and waivers in the onboarding process. These changes included delaying fingerprinting, physical exams, drug testing, and portions of the credentialing processes until after employees began work. VHA also began starting employment for new employees throughout the pay period, rather than waiting for the next two-week pay period to begin.

Pandemic Staffing Strategies

VHA's COVID-19 Operational Plan uses CDC guidance providing for conventional, contingency, and crisis capacity staffing strategies. These strategies are implemented on the authority of facility leadership "in a targeted fashion," such as for a single clinic critical to supporting the facility.⁵³ Contingency staffing includes targeted implementation of recruitment and retention flexibilities or strategies, along with the activation of Clinical Deployment Teams (CDT).⁵⁴ Crisis staffing includes implementing all recruitment and retention flexibilities or strategies, contracting for additional staff, activating CDT, and activating the Disaster Emergency Management Personnel System (DEMPS).⁵⁵ Additionally, VHA responded to changes in workload and personnel demands associated with COVID-19 in various ways such as training outpatient doctors and elective procedure nurses in competencies necessary to deliver care in inpatient settings.

CARES Act

Through the Coronavirus Aid, Relief, and Economic Security Act, Congress appropriated money for VA to increase staffing levels.⁵⁶ In an April 2020 press release, the VA's Office of Public and Intergovernmental Affairs noted that VA was moving "aggressively" to hire staff who could provide care for the rising number of patients as a result of the pandemic.

VA Nurse and Physician Assistant RAISE Act of 2022

As part of the Consolidated Appropriations Act, 2022, the Department of Veterans Affairs Nurse and Physician Assistant Retention and Income Security Enhancement Act, also known as the VA

Nurse and Physician Assistant RAISE Act. The Act increased pay caps for certain Registered Nurses (RN) by \$27,400 and Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) by \$50,000.⁵⁷

Honoring Our PACT Act of 2022

The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022, or the Honoring our PACT Act of 2022, contained various provisions for the improvement of the VA workforce. Some of these enhancements include:

- buying out non-VA service contracts of certain health care professionals in rural settings;
- increasing pay caps and waiving annual pay limitations for certain VHA employees;
- removing preference eligible requirements for housekeeping aid positions; and
- providing additional authorities to provide bonuses, awards, incentives, and student loan repayments.⁵⁸

Loan Forgiveness and Employee Educational Resources

VA provides several of its own loan forgiveness and reduction programs in addition to the Public Service Loan Forgiveness Program, as well as scholarship opportunities to recruit and retain employees.

Table 2. VA Loan Forgiveness and Employee Educational Resources

Education Debt Reduction Program	Provides student loan reduction to employees who provide direct patient care.
Student Loan Repayment Program	Provides loan repayments to highly qualified candidates who enter into a service obligation.
Employee Incentive Scholarship Program	Provides scholarships for permanent employees who agree to a service obligation to obtain education that would qualify them for certain occupations.
National Nursing Education Initiative	Funds education for nurses who agree to a service obligation to obtain a bachelor's or advanced degree in nursing.
VA National Education for Employees Program	Covers education expenses for permanent employees who agree to a service obligation to obtain education that would qualify them for certain occupations.

Source: VA OIG Review of VA Loan Forgiveness and Employee Educational Resources

Addressing Burnout

The VHA Reduce Employee Burnout and Optimizing Organizational Thriving (REBOOT) Task Force was established in fall of 2021. Its goal is to implement actions in response to issues identified by VHA employees, including “staffing concerns, impacts of COVID-19, pay, recruitment, time off, scheduling flexibilities, the ability to work part time and other challenges.” The initiative is structured into workgroups to address drivers of burnout including unmanageable workload, perceived lack of fairness, lack of job control, low recognition or organizational support, interpersonal conflict, and mismatched values.⁵⁹ To address unmanageable workload, one of REBOOT’s main objectives is to maximize use of hiring policies and flexibilities including incentives for recruitment, retention, and relocation of personnel for shortage occupations.

U.S. Department of Health and Human Services (HHS)



HHS's CMS administers the Medicare and Medicaid programs.⁶⁰ The Medicare program provides health care coverage to people aged 65 and older, people with disabilities, and people with end-stage renal disease (permanent kidney failure). Medicare covers short-term skilled nursing and rehabilitative care for Medicare enrollees in a nursing home after a hospital stay. The Medicaid program provides health care coverage to individuals who have limited income and resources, regardless of their age. Medicaid covers skilled, rehabilitation, and long-term care services in a nursing home when other payment options are not available and when the individual is eligible for Medicaid.

Nursing Homes

Nursing homes provide services to individuals whose capacity for self-care is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related conditions. Services are provided to help individuals improve or maintain an optimal level of physical functioning and quality of life. Services can include skilled rehabilitation, including physical, occupational, and speech therapy, and assistance with daily tasks, such as dressing, bathing, eating, medication management, and health maintenance tasks. As of July 1, 2022, there were 15,178 Medicare- and Medicaid-certified nursing homes nationwide, with 1.6 million beds and 1.2 million residents.⁶¹

COVID-19's Impact on Nursing Homes

The pandemic has had a significant impact on nursing homes. As of the week ended September 11, 2022, nursing home residents had accounted for more than 1.2 million confirmed COVID-19 cases and more than 156,000 COVID-19-related deaths, and nursing home staff had accounted for more than 1.3 million confirmed cases and more than 2,600 deaths.⁶²

The Assistant Secretary for Planning and Evaluation (ASPE) for HHS wrote in an October 2020 report that the pandemic imposed high demands on nursing homes because they had to respond quickly to suppress the threat and transmission of COVID-19, make rapid changes in how they delivered care to residents, and implement new guidelines and measures to safeguard residents and nursing home staff. According to the ASPE, during the pandemic, nursing homes grappled with how to retain adequate staffing while rapidly making operational changes to ensure the safety of

residents and staff. At the same time, according to the ASPE, staff have balanced concerns about their own safety, the well-being of the residents under their care, and their own financial stability.⁶³

Nursing Home Staff

Nursing home staff include staff who provide direct care to nursing home residents, as well as staff who manage and maintain the nursing home. These staff can be employees of the nursing home or hired under contract or through a staffing agency. According to the staffing categories that nursing homes use to report staffing shortage data to the NHSN, nursing home staff consist of nurses, clinical staff (such as physicians), aides, and other staff (such as social workers and housekeeping staff).

Nurses

Nurses include RNs and licensed nurses. RNs are responsible for overseeing the care provided to nursing home residents by other staff, such as licensed nurses and aides. An RN's duties can include initiating resident treatment plans, ensuring that residents are receiving proper care, preparing intravenous lines, administering medications through injections, and interacting with residents' families. Licensed nurses also provide direct care and are typically responsible for residents' day-to-day care and personal hygiene. A licensed nurse's duties can include taking resident vital signs (such as blood pressure and body temperature), administering medications, inserting catheters, and recording any changes in residents' health or vital signs.

Clinical Staff

Clinical staff include physicians, physician assistants, and advanced practice RNs. A physician is responsible for examining residents; taking resident medical histories; prescribing medications; and ordering, performing, and interpreting diagnostic tests. A physician assistant typically provides the same services as a physician but performs these services under the supervision of a physician. An advanced practice RN can provide direct care to residents and often serves in leadership roles and may educate and advise other nursing staff.

Aides

Aides include certified nurse assistants (CNAs), nurse aides, medication aides, and medication technicians. Aides provide or assist residents with basic care and support under the direction of onsite licensed nursing staff. An aide's duties can include feeding, bathing, dressing, and grooming residents; assisting residents with walking; and performing any other tasks that an RN or a licensed nurse assigns to the aide. Aides in some states, in accordance with state law, can also administer medications to residents.

Other Staff

Other staff include nursing home staff who are not included in the prior three categories, such as respiratory therapists, occupational and physical therapists, social workers, feeding assistants, and staff responsible for a nursing home's administration, housekeeping, and maintenance.

Federal Reporting Requirements Related to Nursing Home Staffing

In response to the pandemic, CMS required nursing homes to report whether they had a staffing shortage for each type of staff position to CDC's NHSN on a weekly basis from May 11, 2020, through December 31, 2024.⁶⁴

Federal regulations require nursing homes to report staffing information in CMS's PBJ system quarterly, such as the number of staff who provide direct care and services to residents, including information for contract and agency staff. The reported information is based on payroll and other verifiable and auditable data and must include the category of work for each person who provides direct care and services to residents, and information on hours of care provided by each category of staff per resident, per day.⁶⁵ The data must also include the number of hours that each staff member was paid to work each day within the quarter.⁶⁶

Scope of HHS OIG Review

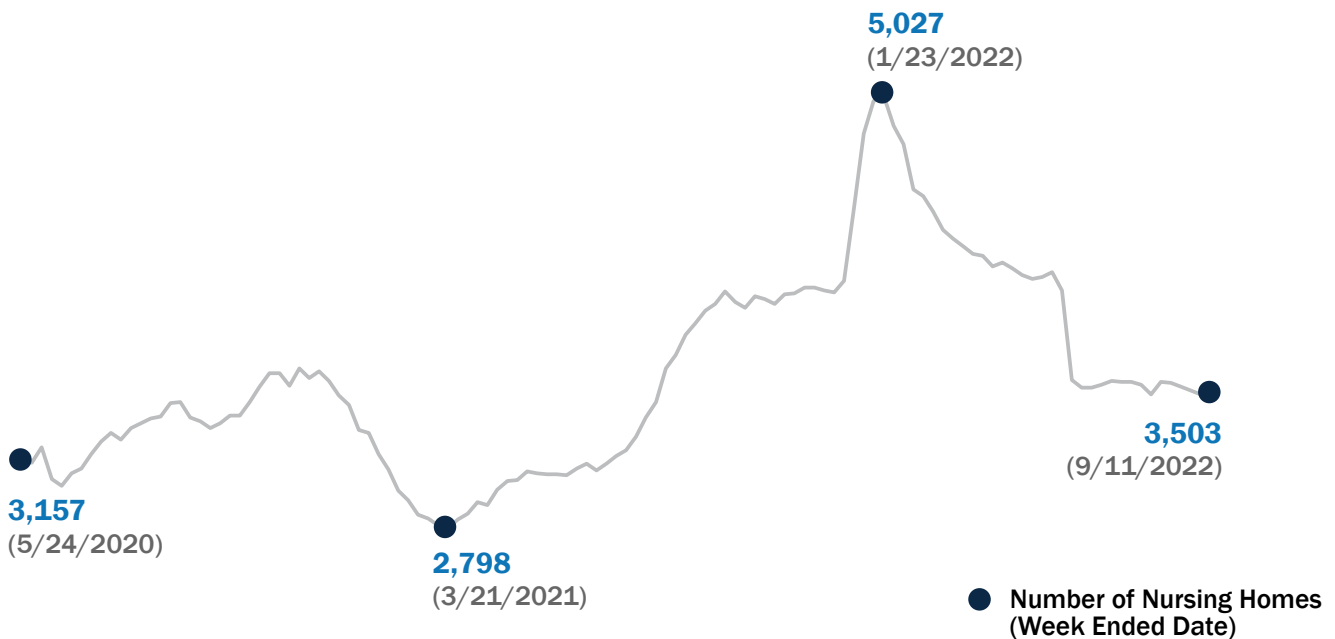
To understand nursing homes' staffing experiences before and during the pandemic, the HHS OIG interviewed officials from 50 nonstatistically selected nursing homes in 44 states. To provide information on nursing homes' staffing experiences during the pandemic, the HHS OIG analyzed staffing shortage data from the NHSN that were available from the week ended May 24, 2020, through the week ended September 11, 2022. Although CMS initially required nursing homes to report staffing shortage data beginning the week ended May 17, 2020, CMS allowed nursing homes to submit their first set of staffing shortage data beginning with the week ended May 24, 2020. The HHS OIG also analyzed nursing home staffing data from the PBJ that were available for the quarters ended June 30, 2019, through June 30, 2022, which encompassed periods before and during the pandemic. For HHS OIG's methodology, see Appendix D: HHS.

Nursing Home Staffing Shortages Before and During the Pandemic

For the 50 nonstatistically selected nursing homes, officials from 35 nursing homes stated that their nursing homes had a staffing shortage at some point before the pandemic. In addition, officials from all 50 nursing homes stated that their nursing homes had a staffing shortage at some point during the pandemic.

Nationwide staffing shortage data for the weeks ended May 24, 2020, through September 11, 2022, showed that 12,500 nursing homes, or 80 percent of all nursing homes, reported a staffing shortage at some point during the pandemic. Overall, there was an increase in the number of nursing homes that reported a shortage for the weeks ended May 24, 2020 (3,157 nursing homes) through September 11, 2022 (3,503 nursing homes). The number of nursing homes that reported a shortage ranged from a low of 2,798 for the week ended March 21, 2021, to a high of 5,027 for the week ended January 23, 2022. Exhibit 1 shows the number of nursing homes that reported a staffing shortage anytime during the weeks ended May 24, 2020, through September 11, 2022.

Exhibit 1: Number of Nursing Homes Nationwide That Reported a Staffing Shortage During the Pandemic

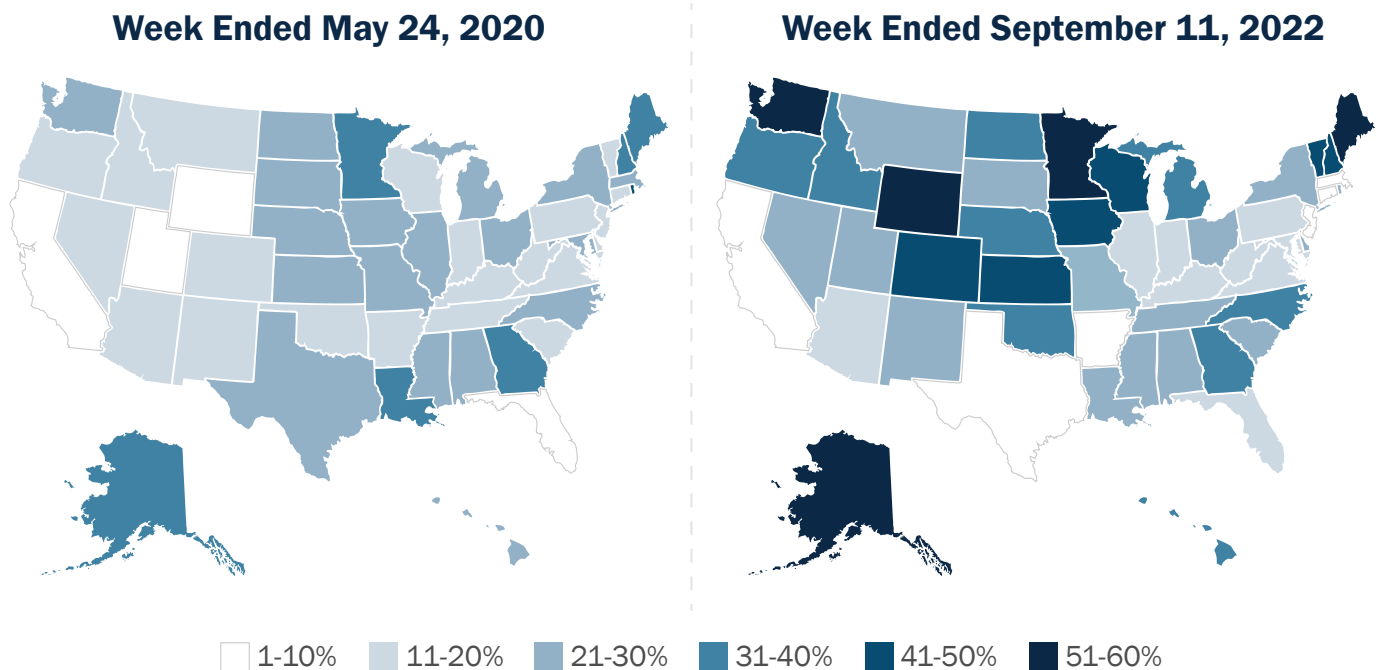


Source: HHS OIG analysis of nursing home staffing shortage data reported to the NHCN.

Staffing Shortage Data by State

Nationwide staffing shortage data for the weeks ended May 24, 2020, through September 11, 2022, showed that the percentage of nursing homes that reported staffing shortages during the pandemic varied by state. Across all states, the average percentage of nursing homes that reported a shortage during the pandemic increased from 22 percent to 28 percent. For the week ended May 24, 2020, the percentage of nursing homes in each state that reported a shortage ranged from 3 percent to 44 percent, including 8 states in which at least 30 percent of nursing homes reported a shortage. For the week ended September 11, 2022, the percentage of nursing homes in each state that reported a shortage ranged from 1 percent to 60 percent, including 11 states in which at least 40 percent of nursing homes reported a shortage. Exhibit 2 shows maps that indicate the percentage of nursing homes in each state that reported a staffing shortage for the weeks ended May 24, 2020, and September 11, 2022.

Exhibit 2: Percentage of Nursing Homes in Each State That Reported a Staffing Shortage for the Weeks Ended May 24, 2020, and September 11, 2022

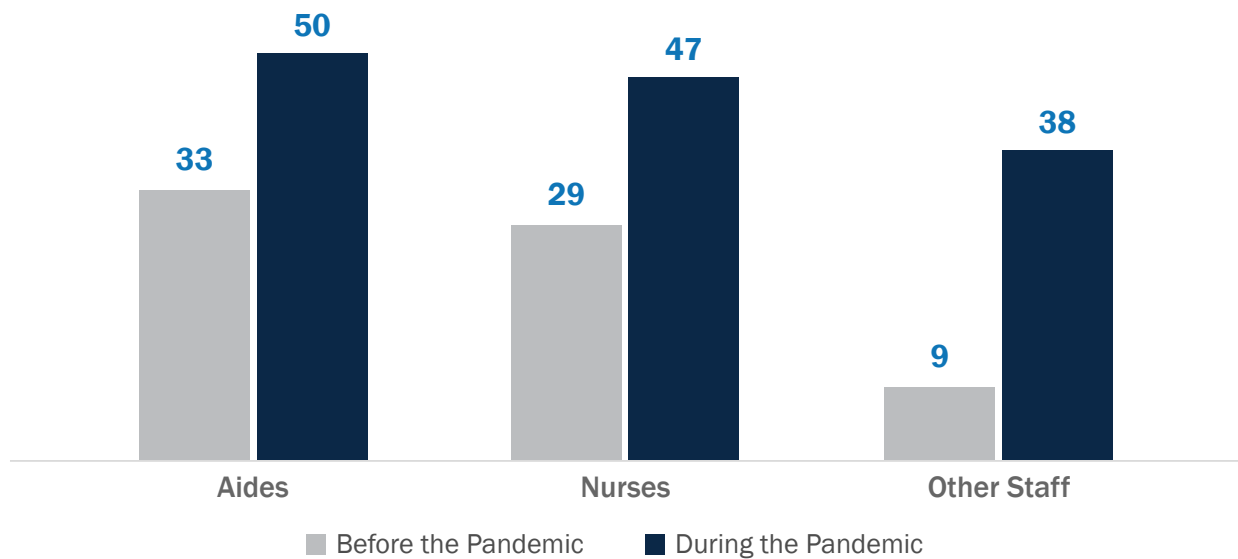


Source: HHS OIG analysis of nursing home staffing shortage data reported to the NHSN.

Positions Most Affected by Nursing Home Staffing Shortages

Aides and nurses were the two positions most affected by staffing shortages, both before and during the pandemic. Exhibit 3 shows, by position, how many of the nonstatistically selected 50 nursing homes reported staffing shortages before and during the pandemic.

Exhibit 3: Number of the 50 Nonstatistically Selected Nursing Homes That Reported Staffing Shortages Before and During the Pandemic, by Position

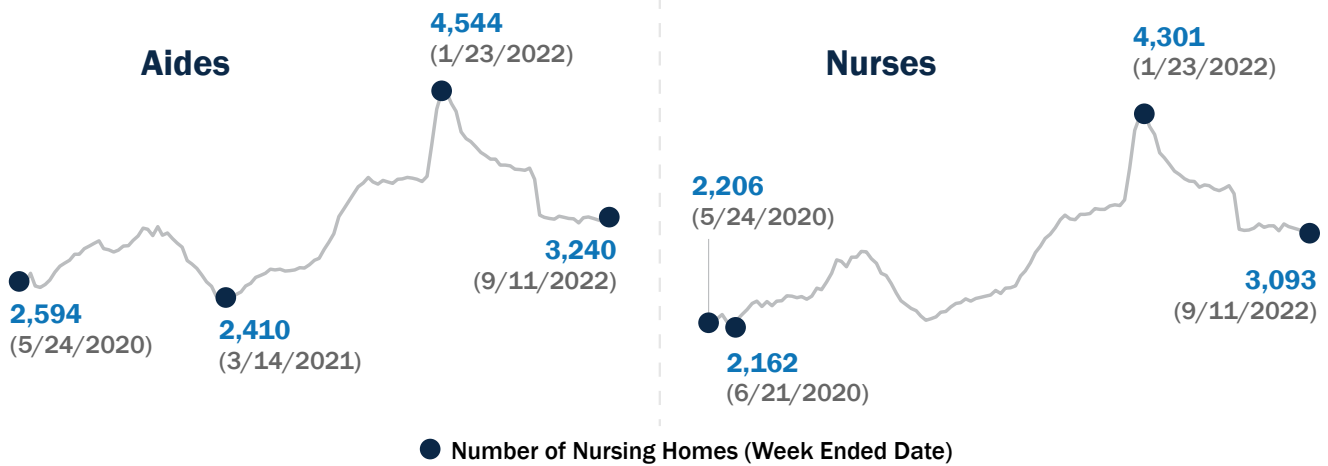


Source: HHS OIG interviews of officials from 50 nonstatistically selected nursing homes.

Note: Nursing home officials did not indicate whether they experienced a shortage of clinical staff before or during the pandemic.

Nationwide staffing shortage data for the weeks ended May 24, 2020, through September 11, 2022, showed that the number of nursing homes that reported shortages of aides and nurses varied weekly and increased overall during the pandemic. For aides, the number of nursing homes that reported a shortage was lowest at 2,410 during the week ended March 14, 2021 and highest at 4,544 during the week ended January 23, 2022. For nurses, the number of nursing homes that reported a shortage was lowest at 2,162 during the week of June 21, 2020 and highest at 4,301 during the week ended January 23, 2022. Exhibit 4 shows the number of nursing homes nationally that reported a shortage of aides and nurses during the weeks ended May 24, 2020, through September 11, 2022.

Exhibit 4: Number of Nursing Homes Nationwide That Reported a Shortage of Aides and Nurses

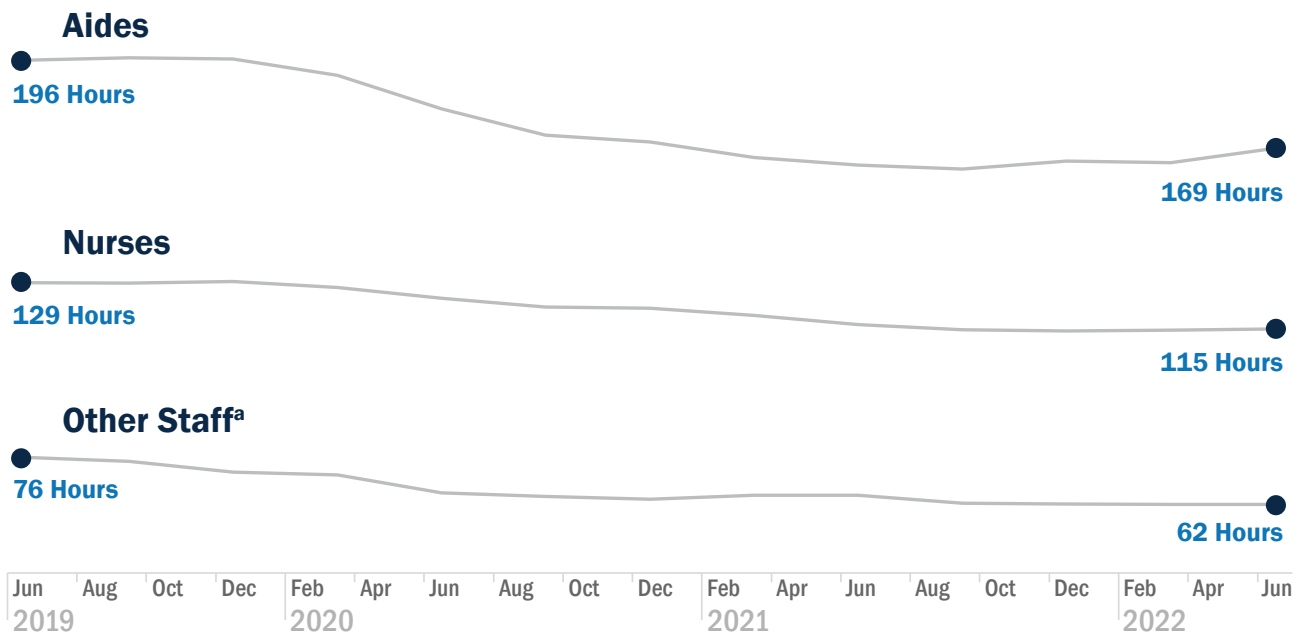


Source: HHS OIG analysis of nursing home staffing shortage data reported to the NHSN.

Number of Hours Worked by Nursing Home Staff

Staffing data from the PBJ for the quarters ended June 30, 2019, through June 30, 2022, showed a decrease in the average daily number of hours worked by nursing home staff per nursing home. Specifically, the average daily number of hours worked by aides decreased the most of any staff, by 27 hours (13.8 percent). Additionally, the average daily number of hours worked by nurses and other staff each decreased by 14 hours (10.9 percent and 18.4 percent, respectively). For clinical staff, the decrease in the average daily number of hours worked per nursing home was not material.⁶⁷ Exhibit 5 shows the changes in the average daily number of hours worked by aides, nurses, and other staff for the quarters ended June 30, 2019, through June 30, 2022.

Exhibit 5: Average Daily Number of Hours Worked Per Nursing Home, by Position



Source: HHS OIG analysis of nursing home staffing data reported in the PBJ system.

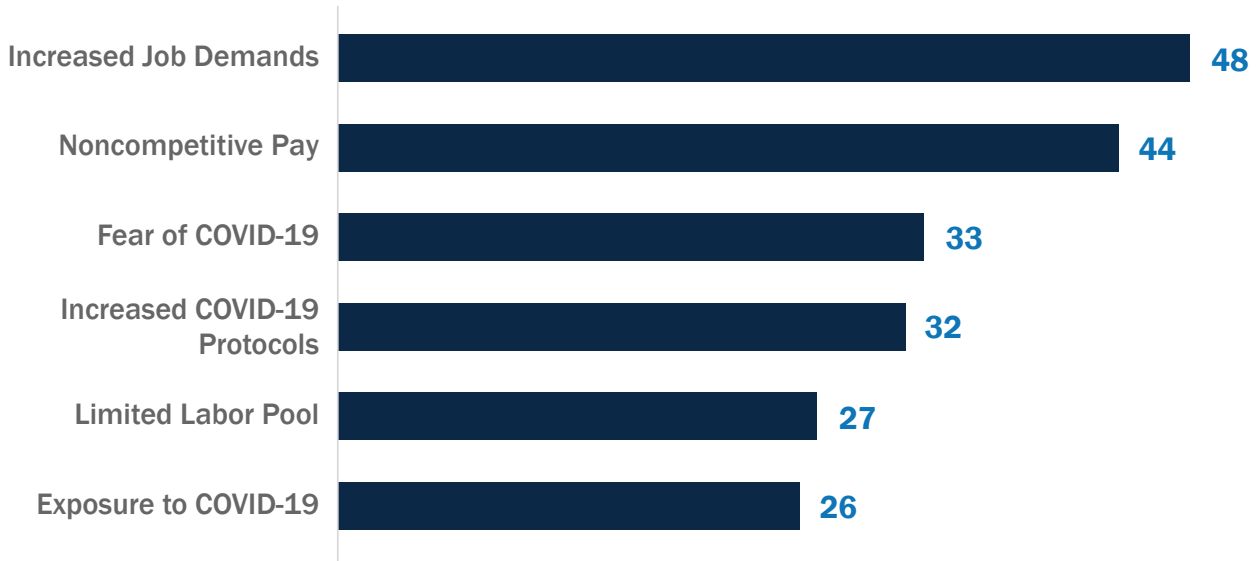
a. Hours for other staff does not include hours that nursing homes' housekeeping and maintenance staff worked.

Note: The decrease in the average daily number of hours that clinical staff worked was not material and is not presented in this exhibit.

Contributing Factors That Led to Shortages of Nursing Home Staff During the Pandemic

Officials from the 50 nonstatistically selected nursing homes identified various reasons for shortages of nursing home staff during the pandemic. See Exhibit 6 for the top six reasons for staffing shortages that these nursing homes identified and the number of nursing homes that reported each reason.

Exhibit 6: Top 6 Reasons for Staffing Shortages That 50 Nonstatistically Selected Nursing Homes Identified



Source: HHS OIG interviews with officials from 50 nonstatistically selected nursing homes.

Increased Job Demands

Officials from 48 nursing homes stated that increased job demands contributed to staffing shortages during the pandemic. Specifically, the officials commented that nursing homes are high-stress and high-risk work environments, even with mitigation efforts in place. Staffing shortages resulted in staff having less flexibility in their work schedules and having to work longer hours, work extra shifts, and perform tasks that were not part of their regular duties. For example, administrative staff, who were also licensed or certified as nurses or aides, assisted with resident care or helped with laundry or janitorial duties. The increased demands led to staff burnout and greater staffing shortages. The officials also commented that staff would rather work in jobs that are less physically and mentally demanding for the same or similar pay rather than work extra hours or carry excess workloads in a nursing home.

Noncompetitive Pay

Officials from 44 nursing homes commented that noncompetitive pay contributed to staffing shortages during the pandemic. Officials from 40 of these 44 nursing homes stated that some of their staff left their nursing home to take jobs with nurse staffing agencies, hospitals, other health care providers, or other industries for higher pay. In addition, officials from 16 of the 44 nursing homes commented that some of their staff chose to stop working after stimulus payments and unemployment benefits were made available or were increased.

Fear of COVID-19

Officials from 33 nursing homes stated that some staff quit their jobs or refused to work because of their fear of COVID-19 infection. Specifically, the officials commented that some staff had underlying health conditions and were afraid of getting sick themselves or spreading COVID-19 to family members. Additionally, officials stated that other staff did not want to work directly with residents who had contracted COVID-19 or work if cases of COVID-19 were reported in the building.

Increased COVID-19 Protocols

Officials from 32 nursing homes stated that the pandemic regulations and protocols contributed to staffing shortages during the pandemic. Specifically, the officials commented that the increased use of personal protective equipment, such as masks, regular COVID-19 testing, and COVID-19 vaccination requirements for health care workers caused some nursing home staff to leave their jobs and seek employment at companies that did not have the same protocols and requirements.

Limited Labor Pool

Officials from 27 nursing homes stated that a limited labor pool had contributed to staffing shortages. Officials from 23 of the 27 nursing homes commented that they had fewer applicants for open positions and attributed the cause to fewer people wanting to work in nursing homes or having a limited number of qualified applicants in their geographical area from which to recruit and hire.

Exposure to COVID-19

Officials from 26 nursing homes stated that staff exposure to COVID-19 led to staffing shortages. Specifically, the officials commented that staff who contracted or were exposed to COVID-19 were required to quarantine for a period of time, which left nursing homes short-staffed during those periods. Additionally, officials from 4 of the 26 nursing homes stated that some staff were not able to work because they had to take care of a family member who had contracted COVID-19. Also, officials from 3 of the 26 nursing homes stated that some staff quit their nursing home jobs after contracting COVID-19.

Impacts of Shortages of Nursing Home Staff During the Pandemic

Officials from the 50 nonstatistically selected nursing homes stated that staffing shortages had an impact on remaining nursing home staff, nursing home operations, and nursing home residents during the pandemic. Exhibit 7 shows the number of nursing homes from which officials stated they had experienced these impacts.

Exhibit 7: Number of 50 Nonstatistically Selected Nursing Homes That Experienced the Impacts of Staffing Shortages



Source: HHS OIG interviews with officials from nonstatistically selected nursing homes.

Impacts on Nursing Home Staff

Officials from all 50 nursing homes reported impacts on nursing home staff. Nursing home officials stated that the staffing shortages resulted in: (1) staff increasing their workloads, often working longer shifts and covering the shifts of other staff, and (2) more staff calling out of work to avoid increased workloads. The officials also stated that these conditions led to burnout and increased levels of stress, anxiety, and depression. Officials further stated that, although nurse staffing agencies played a crucial role in helping fill aide and nursing shortages, the use of agency staff caused employee morale to decline among the nursing homes' own staff because they worked alongside agency staff who were paid more for the same work.

Impacts on Nursing Home Operations

Officials from all 50 nursing homes stated that staffing shortages had an impact on nursing home operations, specifically on resident admissions and nursing home finances. The officials commented that the shortages caused the nursing homes to reduce the overall number of new

resident admissions, delay new admissions or transfers from hospitals for residents needing rehabilitative care, and admit only residents who required less frequent or less intensive care.

Staffing shortages also caused nursing homes to incur higher costs for overtime pay and bonuses for nursing home staff, as well as for agency staff whose wages were much higher than nursing home staff. Officials stated that they also incurred costs for agency staff for “COVID pay” (additional pay for working with COVID-19-positive residents), weekend hours, travel reimbursement, and housing expenses.

Impacts on Nursing Home Residents

Officials from 26 nursing homes stated that staffing shortages had an impact on nursing home residents. The officials commented that the shortages caused nursing homes to adjust the level of care provided to residents. Adjustments included reducing or stopping restorative care, such as bedside strength building and endurance activities that aides could provide without the expertise of a licensed physical therapist, reducing physical rehabilitation services, and sending residents who needed wound care to the hospital.

Nursing home officials stated that there was an overall decline in residents’ physical and mental health because of staffing shortages and lower levels of care. The officials also stated that there was an increase in the number of falls when residents attempted to stand on their own, an increased number of pressure ulcers and infections, and longer wait times when residents called for assistance.

Residents’ schedules and routines were also changed because of staffing shortages. According to officials, having fewer staff resulted in residents receiving sponge baths in place of full showers or baths, receiving necessary medications and getting put to bed at times different from their normal schedules, and waiting longer for meals. In addition, officials stated that residents experienced frustration and anxiety from having to interact with staff who were not familiar with their medical histories or personalities.

Efforts To Recruit New Staff, Retain Existing Staff, and Minimize Staff Burnout During the Pandemic

Officials from the 50 nonstatistically selected nursing homes identified a variety of actions they took to recruit and retain staff and minimize staff burnout during the pandemic. In addition, CMS helped nursing homes respond to staffing shortages by waiving and modifying certain regulatory requirements so that nursing homes could focus on resident care.

Recruitment Incentives

Nursing home officials commented that they took a variety of actions to recruit new staff. Officials stated that they expanded their recruitment efforts by posting job openings on job recruiting websites, in local newspapers, and on social media; attending job fairs; and working with local colleges, local Chambers of Commerce, and health care associations to attract potential applicants for positions. In addition to broadening their recruitment efforts, nursing homes provided incentives to attract potential applicants. Table 1 shows examples of recruitment incentives offered by nursing homes.

Table 1: Recruitment Incentives

Monetary Bonus	Offered sign-on and recruitment bonuses
Starting Pay	Offered increased starting wages
Continuing Education	Offered tuition assistance or reimbursement for education and certification programs, such as nursing degrees, CNA certification, and classes for those seeking the CNA certification
Training Programs	Implemented temporary nurse-aide training programs for staff who had not met the CNA training and certification requirements
Flexible Schedules	Offered flexible hours
Restructured Compensation Packages	Offered restructured compensation packages with higher pay and fewer fringe benefits and the option to receive daily pay

Source: HHS OIG interviews with officials from nonstatistically selected nursing homes.

Retention Incentives

Nursing home officials stated that they took various actions to retain existing staff. Table 2 shows examples of retention incentives offered by nursing homes.

Table 2: Retention Incentives

Monetary Bonus	Offered retention bonuses and other bonuses to staff who worked with residents who had COVID-19 or worked extra shifts
Increased Pay	Increased wages, including wages for those who worked night shifts and weekends
Recognition	Showed employees more appreciation by providing free meals, gift cards, and employee recognition events
Continuing Education	Offered tuition assistance or reimbursement for education and certification programs, such as nursing degrees and CNA certification
Flexible Schedules	Offered flexible schedules when possible and reduced the number of hours that staff were required to work to qualify for full-time benefits
Restructured Compensation Packages	Offered restructured compensation packages with higher pay and fewer fringe benefits, and the option to receive daily pay

Source: HHS OIG interviews with officials from nonstatistically selected nursing homes.

Efforts To Minimize Burnout

Nursing home officials stated that they took various actions to minimize burnout. Table 3 shows examples of efforts to minimize burnout by nursing homes:

Table 3: Efforts to Minimize Burnout

Contract Staff	Increased the use of nurse staffing agencies to fill shortages
Cross-Training	Employed an “all-hands-on-deck” approach, in which staff from various departments in the nursing home stepped in to help departments with staffing shortages, and cross-trained staff to perform other duties
Resident Admissions	Reduced the number of new resident admissions, delayed new admissions, or admitted only residents who required less frequent or less intensive care
Flexible Schedules	Offered flexible and compressed work schedules
Time-off	Tried to honor requests for time off
Staff Sharing Agreements	Made staff-sharing agreements with facilities under the same corporate ownership or with contracted facilities that were short-staffed during COVID-19 breakouts and when staffing shortages peaked
Mental Health	Offered psychological support onsite through health insurance or through the local health department

Source: HHS OIG interviews with officials from nonstatistically selected nursing homes.

CMS’s Efforts to Help Nursing Homes Respond to Staffing Shortages

During the pandemic, CMS enacted a number of temporary emergency waivers to requirements for nursing homes related to staff training, the performance of specific tasks, and administrative reporting requirements, among others. These waivers provided nursing homes with extra flexibilities as they responded to the challenges of the pandemic, and helped nursing homes respond to staffing shortages.⁶⁸ Table 4 shows examples of efforts implemented by CMS.

Table 4: Examples of CMS’s Efforts to Help Nursing Homes Respond to Staffing Shortages

<p>Waived Nurse Aide Employment Requirements</p>	<p>CMS waived the requirement that a nursing home may not employ anyone for longer than 4 months unless the individual has met the training and certification requirements of 42 C.F.R § 483.35(d). The waiver allowed nursing homes to employ an individual in a nurse aide role for longer than 4 months even if the individual had not completed a state-approved Nurse Aide Training and Competency Evaluation Program. The nurse aide could continue to work as long as the nursing home ensured that the individual could demonstrate competency in skills and techniques needed to care for residents.</p>
<p>Postponed Training Deadlines</p>	<p>CMS modified the nurse aide training requirements that required nursing assistants to receive at least 12 hours of in-service training annually by postponing the deadline for completing the training requirement.</p>
<p>Allowed Physicians to Delegate Tasks</p>	<p>CMS waived the requirement that prevents a physician from delegating certain tasks that are otherwise required to be performed specifically by the physician. The waiver allowed a physician to delegate certain tasks to a physician assistant, nurse practitioner, or clinical nurse specialist, but it specified that the delegated task must continue to be under the supervision of the physician.</p>
<p>Reduced Required Training Hours</p>	<p>CMS reduced the training requirements for paid feeding assistants from a minimum of 8 hours to a minimum of 1 hour.</p>

Source: HHS OIG analysis of temporary COVID-19 emergency waivers enacted by CMS.

APPENDIX A:

Department of Defense



Section 1: Methodology

Scope. As of December 2022, the DOD had 45 military hospitals. The DOD OIG's review focused on shortages of health care personnel at 24 nonstatistically selected MTFs, or DOD hospitals. Our review focuses on the MTF personnel experiences from March 1, 2019, through September 30, 2022.

The DOD OIG conducted this audit from July 2022 to May 2023.

Data Sources. The DOD OIG review used multiple sources of data, including the following.

- Interviews with officials from the 24 DOD medical treatment facilities that we selected for review, the DHA, office of the Assistant Secretary of Defense for Health Affairs, and Service medical commands.
- Manpower and recruiting data, where available, to corroborate interview statements. The DHA provided personnel data for the civilians under its authority, direction, and control as of January 2023 from the Defense Civilian Personnel Data system and the DHA Joint Table of Distribution. The MTFs provided personnel data for military, civilians, and contractors under their authority, direction, and control before the DHA transition from the Defense Medical Human Resources System – internet; Activity Manpower Documents for Navy facilities extracted by the MTFs from the Navy's Total Force Manpower Management System; unit manpower documents from the Air Force's Manpower Programming & Execution System and Medical Planning and Programming Tool; the MTF generated gain-loss rosters; recruitment personnel actions; and staffing tables of distribution and allowances maintained by the MTFs and extracted from each service's databases, such as the Fourth Estate Manpower Tracking System.
- Additional data, such as deployment trackers, staffing assist requests, civilian sector pay surveys, and government and civilian sector job postings, to report reasons for shortages in health care personnel.
- Additional data, such as access to care reports, premium hour reports, patient satisfactory surveys, comprehensive systematic analyses, requests for personnel actions, and others, to report examples of impacts of health care personnel shortages.

- The DOD and the DHA guidance to identify mitigation strategies used by the DHA to recruit and retain providers within the DOD.

Methodology. The DOD OIG selected a nonstatistical sample from the 26 MTFs that the DOD OIG reported as a result of the MTF interviews that had “staffing and manpower shortages” as a serious challenge in DOD OIG Report No. DODIG-2022-081, “Evaluation of Department of Defense Military Medical Treatment Facility Challenges During the Coronavirus Disease–2019 (COVID-19) Pandemic in Fiscal Year 2021,” April 5, 2022. To compare like facility types, we excluded three MTFs that were not an inpatient hospital or medical center. We also added one additional MTF that identified staffing and manpower as a serious future concern, for a total of 24 MTFs to determine if they were still experiencing shortages of health care personnel. See Table 1 for the locations of the 24 MTFs we nonstatistically sampled.

Table 1: Names and Locations of the 24 Nonstatistically Selected MTFs

673d Medical Group - Joint Base Elmendorf-Richardson	Elmendorf Air Force Base, Alaska
60th Medical Group - Travis Air Force Base	Travis Air Force Base, California
Naval Hospital Camp Pendleton	Camp Pendleton, California
Naval Medical Center San Diego	San Diego, California
Naval Hospital Twentynine Palms	Twentynine Palms, California
Naval Hospital Jacksonville	Jacksonville, Florida
Martin Army Community Hospital	Fort Benning, Georgia
Tripler Army Medical Center	Honolulu, Hawaii
Blanchfield Army Community Hospital	Fort Campbell, Kentucky
Walter Reed National Military Medical Center	Bethesda, Maryland
Womack Army Medical Center	Fort Bragg, North Carolina
Naval Medical Center Camp Lejeune	Camp Lejeune, North Carolina
88th Medical Group - Wright-Patterson Air Force Base	Wright-Patterson AFB, Ohio
William Beaumont Army Medical Center - Fort Bliss	Fort Bliss, Texas
Naval Medical Center Portsmouth	Portsmouth, Virginia
Madigan Army Medical Center	Tacoma, Washington
Naval Hospital Bremerton	Bremerton, Washington

Army Community Hospital Weed-Irwin	Fort Irwin, California
Landstuhl Regional Medical Center	Landstuhl, Germany
Naval Hospital Rota	Rota, Spain
Naval Hospital Guam	Agana, Guam
Navy Medicine Readiness & Training Command Sigonella, Italy	Sigonella, Italy
48th Medical Group – Royal Air Force Lakenheath	RAF Lakenheath, United Kingdom
51st Medical Group - Osan Air Base	Osan Air Base, South Korea

Source: The DOD OIG.

We conducted virtual interviews with officials from the MTFs, the DHA, Office of the Assistant Secretary of Defense for Health Affairs, and Service medical commands between August 11, 2022, and March 17, 2023. We did not require specific personnel to participate in our interviews, but rather requested that the MTF officials identify personnel they thought would offer the best insights into staffing challenges, impacts, and mitigation strategies. Participants included individuals such as the MTF commanders, public health emergency officers, hiring authorities, leaders for the MTF administration and nursing, logisticians, among others. We asked open-ended questions about the specialties or positions most affected by shortages of health care personnel; the causes of the shortages; the impacts of the shortages; and any mitigating strategies used by the MTFs, the DHA, or Services to recruit new personnel, retain existing personnel, and reduce burnout in health care personnel.

We did not verify or confirm interview responses but requested, where available, that the DHA and the MTF officials provide documentation to support their statements. If data provided by the MTFs indicated shortages in a specific position, we included that position in our shortages analysis, even if it was not mentioned by the MTF officials during our interviews. Following our interviews and analysis of documentation, we counted the number of the MTFs that shared each health care position shortage, cause, or impact.

Section 2: Limitations

The MTFs did not provide consistent, complete data to allow a comparison of authorized and filled positions across our sample. However, the DHA provided personnel data for its civilians as of January 2023. These personnel accounted for only a portion of health care personnel within the MTFs, and did not include active duty Service members, contractors, or civilians working for the Military Departments. Where available, we used the data that the MTF officials provided from different systems and tracking mechanisms available to them to support statements or examples they provided during interviews. Therefore, we may have underreported the number of the MTFs encountering each position shortage, cause, or impact included in the report. We did not review

incentives or strategies used to recruit or retain staff hired under contracts, as those incentives or strategies would be developed by each contractor and not under the purview of the DOD.

At the time of our interviews, the MTFs transitioned or were in the process of transitioning their civilian personnel to the DHA in line with section 702 of the FY 2017 National Defense Authorization Act (NDAA) and sections 711 and 712 of the FY 2019 NDAA that required the Military Departments transition the administration of all the MTFs to the DHA for the purpose of implementing an integrated system of readiness and health.⁶⁹ Additionally, some officials within the MTFs we interviewed may not have been located at the MTF we interviewed them at in earlier periods of the pandemic because Service members move regularly for training or job assignments, with most rotations lasting 2 to 4 years. The information provided reflects the experiences of existing health care personnel and their perceptions of former health care personnel experiences. Therefore, officials may not have captured all reasons for shortages in health care personnel, the impacts of the shortages, or efforts to recruit and retain health care personnel or minimize staff burnout.

Section 3: Standards

We conducted this review in accordance with generally accepted government auditing standards issued by the Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We relied on the testimonies of the MTF personnel to form our overall findings and conclusions. We did not test or rely on the validity of computer-processed data provided but, rather used the data to corroborate the personnel shortages that were stated during the interviews. We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective.

APPENDIX B:

Department of Justice



Section 1: Methodology

Scope. The review describes staffing levels of BOP civil service employees and commissioned officers of the U.S. Public Health Service who worked in the health services units at BOP institutions from January 2019 to July 2022. This review does not include the BOP’s psychology staff because they are not part of BOP’s health services units. Additionally, this review does not include information about contract health care providers who may provide specialized on-site care at BOP institutions, cover institution vacancies on a short-term basis, or deliver care to BOP inmates at community facilities not operated by the BOP.

We conducted fieldwork for this review from August 2022 through January 2023.

Data Sources. The DOJ OIG’s review included multiple data sources, including BOP policies, guidance, and memorandums; BOP waivers; BOP documentation and written responses to OIG requests; statutes related to recruitment and retention incentives; interviews with BOP central office staff, BOP regional office staff, and BOP institution staff; the BOP’s human resources information system for staffing data; BOP exit surveys; DOJ OIG Hotline complaints; BOP public website population data; and a review of previously published OIG work.

Methodology. Our fieldwork included interviews, data collection, and analyses. Additionally, we conducted document reviews of relevant policies, guidance, and workforce planning documents.

To understand health services staffing over time, we received and analyzed staffing data provided by BOP’s Human Resources, Workforce Systems and Evaluation Section. Specifically, we obtained individual records of health services staffing records of each authorized health services position, including PHS positions, at every BOP institution for pay period 6 in 2019, 2020, 2021, and 2022. We used the staffing data, in aggregate, to determine the distribution of health services position types as well as to calculate fill rates enterprise-wide and for specific positions. We also reviewed and analyzed hiring and separation data by pay period between January 2019 and June 2022.

To determine the extent to which augmentation was used during the pandemic, we analyzed augmentation data by location and position type from January 2019 through August 2022, as provided by the BOP. To determine the extent to which health services personnel worked overtime

and the associated costs, we analyzed overtime transaction data from the National Finance Center. For the overtime analysis, we considered health care occupational series codes (0600 series), as well as the occupation series code for Social Workers (0185).

To examine the use of recruitment and retention incentives, we analyzed data provided by the BOP on recruitment bonuses, relocation bonuses, retention incentives, and student loan repayments given to health services staff between January 2019 and December 2021.

To help understand the causes and impacts of staffing shortages, and to learn about the BOP's efforts to recruit and retain staff, we interviewed regional and central office staff, including the regional health services administrator or acting health services administrator, from each of the BOP's six regions; two regional human resources administrators; a central office human resources official; and a national recruitment specialist. We also reviewed exit surveys from departing health services personnel to understand the reasons for staff departure and suggestions for what could have prevented them from leaving the BOP.

Finally, we summarized and incorporated information from oversight work previously published by the DOJ OIG on the BOP's response to the pandemic, including remote inspections of 16 facilities housing BOP inmates, 2 surveys of BOP staff, 1 survey of inmates, and a COVID-19 Capstone report that highlighted themes identified through the DOJ OIG's COVID-19 oversight work and examined COVID-19 themes that emerged following that work.

Section 2: Limitations

As discussed in the scope section of this appendix, this review does not include information about contract health care providers who may provide specialized on-site care at BOP institutions, cover institution vacancies on a short-term basis, or deliver care to BOP inmates at community facilities not operated by the BOP. Additionally, the data did not cover staff availability during the period, including whether staff were on sick leave or annual leave,

Section 3: Standards

We conducted this evaluation in accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX C:

Department of Veterans Affairs



Section 1: Methodology

Scope. The VA Choice and Quality Employment Act (VCQEA) of 2017 requires the VA OIG to report an annual determination of VHA occupations that have the largest shortages at each medical facility.⁷⁰ As part of this determination, we administer and analyze an annual survey of all VHA facilities. The survey identifies severe occupational shortages across 139 VHA facilities.⁷¹ We also reviewed VA and VHA directives, policies, memorandums, and documentation; and researched staffing flexibilities granted by the OPM during the pandemic.

We used data collected between February 2020 and February 2022 for previously published reports, as well as additional data collected for this review between July 2022 and May 2023.

Data Sources. Our review used multiple sources of data, including:

- survey data from VHA facilities to report occupational shortages and reasons for those shortages;
- interviews with 18 VISN directors to report examples of impacts of occupational shortages; and
- additional data, such as VHA guidance and fact sheets to identify mitigation strategies used by the VHA to recruit, retain, and reduce burnout of employees within the VHA.

Methodology.

Survey Development and Distribution

For the annual determination of VHA's occupational staffing shortages summarized in this report, we conducted surveys to identify severe occupational staffing shortages at each facility across VHA. VHA-identified facility points of contact reported severe occupational staffing shortages as defined in 5 Code of Federal Regulations (C.F.R.) Section (§) 337.204.

The survey listed occupations categorized by: (1) OPM occupational series codes, (2) VHA assignment codes, and (3) clinical or nonclinical designation.⁷² We further categorized the occupations into three groups (medical officer, nurse, and other occupation) to facilitate

identification of VHA assignment codes and titles for medical officer and nurse. We requested, and the VHA provided, the points of contact who would be completing the survey on behalf of the facility.⁷³ Facility points of contact used a drop-down list within the survey to identify all occupations they considered severe occupational staffing shortages.⁷⁴ Facility points of contact also had the option to report that they did not consider any of the occupations as severe occupational staffing shortages. We reviewed submissions as received and, when necessary, worked with the facility points of contact to clarify responses and answer questions.

Survey Analysis

We identified an occupation as a severe occupational staffing shortage when it was designated as such by the VHA-identified facility point of contact. We counted the total number of times the occupation was identified as a severe occupational staffing shortage across all facilities to determine shortages across the VHA.

We derived the frequency of severe occupational shortages for medical officer and nurse because facility points of contact could identify severe shortages at the OPM occupational series level, VHA assignment code level, or both. As a result, we considered medical officer and nurse severe occupational staffing shortages if the facility points of contact indicated either the OPM occupational series or any of the related VHA assignment codes as shortages.⁷⁵

We used Braun and Clarke's thematic analysis approach to generate themes for the free text responses received in the survey.⁷⁶ Upon initial review of the data, we discovered that many of the responses were brief and lacked detail thereby making it difficult to understand the underlying meaning in the free text responses. As a result, we analyzed the data for content, not meaning. Additionally, some facilities designated multiple reasons for a given occupational shortage, while other facilities provided only one reason per occupational shortage.

We derived theme assignments for the medical officer and nurse occupations because the survey was constructed to allow responses at the OPM occupational series level, the VHA assignment code level, or both. We assigned a theme to one of these occupations if the theme showed up either at the occupational series or VHA assignment code level. For example, if "Lack of qualified applicants" was the theme for how a facility determined that Medical Officer (an OPM occupational series job title) and Psychiatry (a VHA assignment code job title falling under Medical Officer) were both severe occupational staffing shortages, "Lack of qualified applicants" would be counted once for the theme in Medical Officer.

We did not assess the validity of the survey responses.

Interviews

In addition to the annual surveys, We conducted interviews with all 18 VISN directors between October 15, 2020, and November 10, 2020, to review hiring during the pandemic.

We did not assess the validity of the responses provided in the interviews.

Section 2: Limitations

The shortages discussed in this review represent the frequency of occupations designated as a severe occupational shortage in the VA OIG's annual surveys as defined by 5 C.F.R. Section (§) 337.204, but they do not necessarily represent vacancies and should not be considered the sole measure of VHA-wide severe occupational shortages.⁷⁷ A severe occupational shortage refers to particular occupations that are difficult to fill, whereas vacancy refers to an unoccupied position and is distinct from the designation of a severe occupational shortage. For example, a facility could identify an occupation as a severe occupational shortage, which could have no vacant positions or 100 vacant positions. Defining shortages in this manner does not account for other dimensions that could be used to determine shortages such as the priority of a severe occupational shortage at a given facility. For example, one facility may consider an occupation as its number one shortage, while another facility may consider that same occupation as its number 30 shortage. Facility priority was not considered when determining the frequency of occupations being reported as severe occupational shortages across the VHA. Further, the impact that reducing a shortage might have on a facility cannot be assessed by the survey results.

Section 3: Standards

We conducted the review in accordance with Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX D:

Department of Health and Human Services



Section 1. Methodology

Scope. As of July 1, 2022, there were 15,178 Medicare- and Medicaid-certified nursing homes nationwide. Our review focused on the staffing experiences at these nursing homes from April 1, 2019, through September 11, 2022 (audit period).

We conducted our audit from July 2022 to January 2023.

Data Sources. We used nursing home staffing shortage data that nursing homes report weekly to CDC's NHSN to identify the number of nursing homes that reported a staffing shortage for the weeks ended May 24, 2020, through September 11, 2022, and to nonstatistically select nursing homes from which to interview officials about their experiences with staffing shortages before and during the pandemic. We also used nursing home staffing data that nursing homes report quarterly in CMS's PBJ system to analyze the number of hours that nursing home staff worked during the quarters ended June 30, 2019, through June 30, 2022. In addition, we obtained verbal testimony from officials from the nonstatistically selected nursing homes.

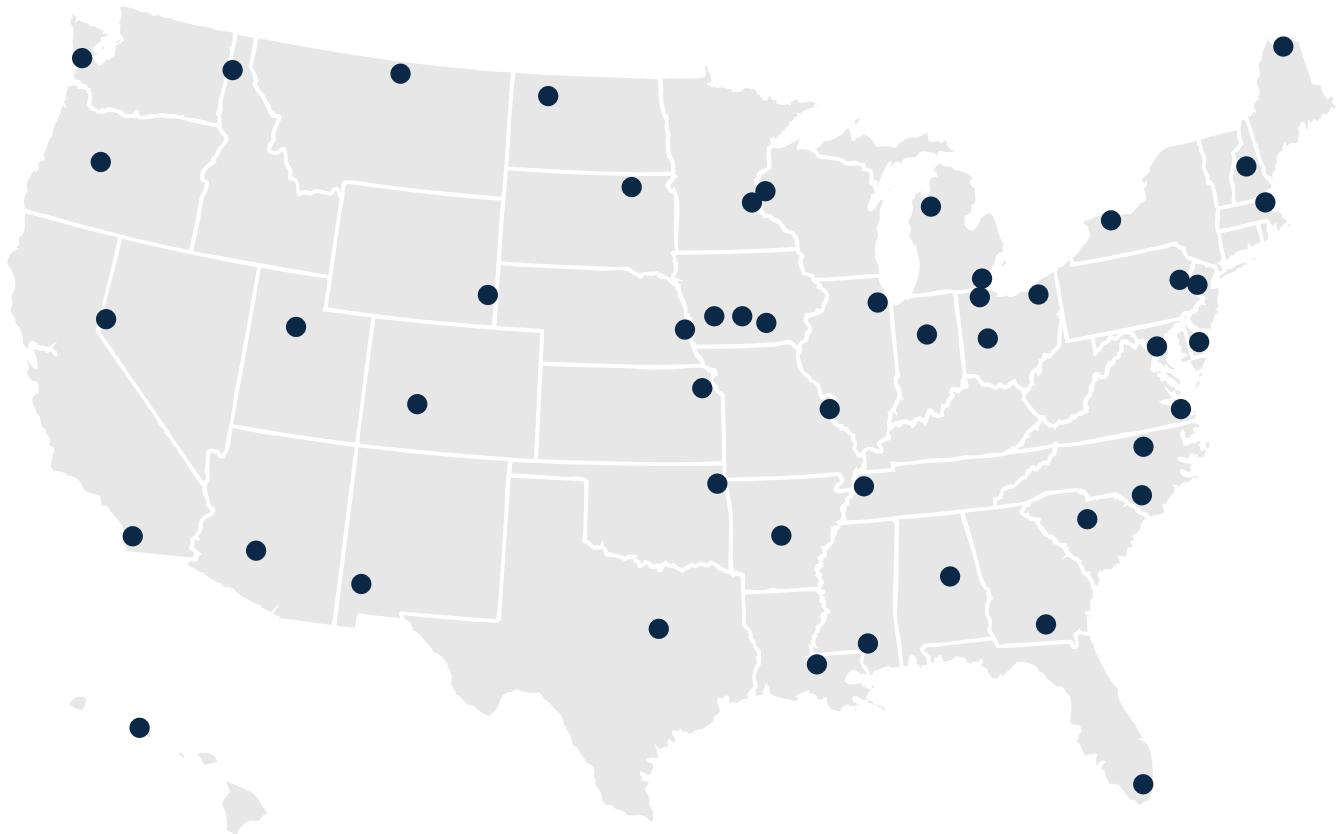
Methodology. We reviewed staffing shortage data that nursing homes reported weekly to CDC's NHSN for the weeks ended May 24, 2020, through September 11, 2022, and staffing data that nursing homes reported quarterly in CMS's PBJ system for the quarters ended June 30, 2019, through June 30, 2022.

From the 3,556 nursing homes that reported a staffing shortage in at least one of the four categories of nursing home staff (nurses, clinical staff, aides, or other staff) for the week ended July 10, 2022, we nonstatistically selected 50 nursing homes in 44 states. To select the nursing homes, we considered factors, such as the number of weeks that nursing homes reported a shortage (during the weeks ended May 24, 2020, through July 10, 2022) and the locations of the nursing homes.

We interviewed officials, such as nursing home administrators and directors of nursing, from the selected nursing homes during the period August 17, 2022, through September 13, 2022, to understand the nursing homes' experiences with shortages of health care personnel. During each interview, we requested that the nursing home officials speak about their staffing experiences

through a series of open-ended questions focused on the positions that were most affected by the staffing shortages; reasons for the shortages; impact that the shortages had on the nursing home's staff, operations, and residents; and actions that the nursing home took to address the shortages and minimize staff burnout. The blue dots on the map in Exhibit 1 show the locations of the 50 nonstatistically selected nursing homes.

Exhibit 1: Locations of the 50 Nonstatistically Selected Nursing Homes



Source: The HHS OIG.

We also discussed with CMS officials their oversight of nursing home staffing and actions that CMS took to help nursing homes lessen the impact of staffing shortages during the pandemic.

Section 2: Limitations

A limitation of using staffing shortage data and staffing information reported by nursing homes is that some nursing homes may not have submitted the required data or the submitted data may not have passed CMS's or CDC's quality assurance checks. Our review did not include an assessment of nursing homes' compliance with the requirements to report staffing shortage data or staffing information, CMS's oversight of nursing homes' compliance with these requirements, or the

accuracy of the shortage data or staffing information that nursing homes reported to the NHSN and reported in the PBJ system. As a result, we did not assess the nursing homes' or CMS's internal controls related to these requirements.

Additionally, the reasons for the 50 nonstatistically selected nursing homes' staffing shortages and the impacts of those shortages as stated in this report reflect the nursing homes' experiences and perceptions as they were conveyed to us. We did not verify the accuracy of the information that nursing home officials provided, obtain perspectives from existing or former nursing home staff, or corroborate the impact that staffing shortages had on the selected nursing homes. Further, nursing home officials may not have shared with us all of the reasons for staffing shortages at their nursing homes, the impacts of the shortages, or their efforts to attract and retain staff or minimize staff burnout. Therefore, the information in this report may not represent everything that nursing homes experienced, or all the actions they took during the audit period. This information is provided for informational purposes only and, therefore, we did not provide any recommendations.

Section 3: Standards

We conducted this review in accordance with generally accepted government auditing standards issued by the Government Accountability Office.

APPENDIX E:

Shortages Reported by at Least 20 Percent of VHA Facilities

Table 1: Frequency of Most Common Facility-Designated Severe Occupational Shortages, FY 2020

<i>Occupational Series or Assignment Codes^b</i>	<i>Occupation</i>	<i>Clinical or Nonclinical</i>	<i>Number of Facilities That Identified the Occupation as a Severe Shortage</i>
31	Psychiatry ^a	Clinical	83
3566	Custodial Worker	Nonclinical	65
0083	Police	Nonclinical	62
P1	Primary Care ^a	Clinical	51
0620	Practical Nurse	Clinical	49
0801	General Engineering	Nonclinical	48
0180	Psychology	Clinical	47
0644	Medical Technologist	Clinical	45
25	Gastroenterology ^a	Clinical	41
7408	Food Service Worker	Nonclinical	37
0679	Medical Support Assistance	Nonclinical	36
88	RN Staff Nurse-Inpatient ^b	Clinical	36
K6 ^a	Hospitalist	Clinical	34
0647	Diagnostic Radiologic Technologist	Clinical	33
N4	Nurse Practitioner – Mental Health/ Substance Use Disorder ^b	Clinical	31
Q6	RN/Staff-Inpatient Community Living Center ^b	Clinical	31
0201	Human Resources Management	Nonclinical	30

Source: VA OIG analysis of VHA facilities' responses to the VA OIG's FY 2020 staffing survey.

a. Assignment codes within the Medical Officer occupational series.

b. Assignment codes within the Nurse occupational series.

Note: Only occupations designated by at least 20 percent of the facilities were included in this table.

Table 2: Frequency of Most Common Facility-Designated Severe Occupational Personnel Shortages, FY 2021

<i>Occupational Series or Assignment Codes^b</i>	<i>Occupation</i>	<i>Clinical or Nonclinical</i>	<i>Number of Facilities That Identified the Occupation as a Severe Shortage</i>
31	Psychiatry ^a	Clinical	70
0679	Medical Support Assistance	Nonclinical	62
0083	Police	Nonclinical	60
0180	Psychology	Clinical	60
3566	Custodial Worker	Nonclinical	59
P1	Primary Care ^a	Clinical	57
0620	Practical Nurse	Clinical	51
0644	Medical Technologist	Clinical	50
0801	General Engineering	Nonclinical	45
7408	Food Service Worker	Nonclinical	40
0647	Diagnostic Radiologic Technologist	Clinical	34
0858	Biomedical Engineering	Nonclinical	32
0675	Medical Records Technician	Nonclinical	31
12	Urology ^a	Clinical	31
0185	Social Work	Clinical	30
0645	Medical Technician	Clinical	30
25	Gastroenterology ^a	Clinical	30
0621	Nursing Assistant	Clinical	28
88	RN Staff Nurse-Inpatient ^b	Clinical	28

Source: VA OIG analysis of VHA facilities' responses to the VA OIG's FY 2021 staffing survey.

a. Assignment codes within the Medical Officer occupational series.

b. Assignment codes within the Nurse occupational series.

Note: Only occupations designated by at least 20 percent of the facilities were included in this table.

Table 3: Frequency of Most Common Facility-Designated Severe Occupational Shortages, FY 2022

<i>Occupational Series or Assignment Codes^b</i>	<i>Occupation</i>	<i>Clinical or Nonclinical</i>	<i>Number of Facilities That Identified the Occupation as a Severe Shortage</i>
3566	Custodial Worker	Nonclinical	96
0679	Medical Support Assistance	Nonclinical	88
0620	Practical Nurse	Clinical	86
0180	Psychology	Clinical	73
31	Psychiatry ^a	Clinical	71
0644	Medical Technologist	Clinical	65
0083	Police	Nonclinical	62
7408	Food Service Worker	Nonclinical	60
P1	Primary Care ^a	Clinical	60
0801	General Engineering	Nonclinical	54
0621	Nursing Assistant	Clinical	53
88	RN Staff Nurse-Inpatient ^b	Clinical	51
0185	Social Work	Clinical	44
0647	Diagnostic Radiologic Technologist	Clinical	36
0649	Medical Instrument Technician	Clinical	36
CM	RN Staff-Critical Care ^b	Clinical	36
Q6	RN/Staff-Inpatient Community Living Center ^b	Clinical	33
CR	RN Staff-Emergency Dept/Urgent Care ^b	Clinical	32
0645	Medical Technician	Clinical	30
CQ	RN Staff-Inpatient Mental Health ^b	Clinical	30
25	Gastroenterology ^a	Clinical	30
0858	Biomedical Engineering	Nonclinical	29

Source: VA OIG analysis of VHA facilities' responses to the VA OIG's FY 2022 staffing survey

a. Assignment codes within the Medical Officer occupational series.

b. Assignment codes within the Nurse occupational series.

Note: Only occupations designated by at least 20 percent of the facilities were included in this table.

Endnotes

- 1 Medical officers are positions with duties that advise on, administer, supervise, or perform professional and scientific work in one or more fields of medicine, and when the degree of Doctor of Medicine or Doctor of Osteopathy is a fundamental requirement.
- 2 There are only 96 BOP facilities represented here because the 97th facility, FCC Beaumont, relies solely on contracted clinical staff, who were not included in the scope of this review.
- 3 A licensed vocational nurse position does not require full professional nurse education.
- 4 Title 38, United States Code, Veterans' Benefits, enacted September 2, 1958, includes a special pay authority used to recruit and retain employees in certain health care occupations.
- 5 Delegation Agreement, U.S. Office of Personnel Management and Department of Defense, effective July 1, 2012, and U.S. Office of Personnel Management Title 38 Delegation Agreement with Department of Justice, effective June 30, 2014.
- 6 Medical officers are positions with duties that advise on, administer, supervise, or perform professional and scientific work in one or more fields of medicine, and when the degree of Doctor of Medicine or Doctor of Osteopathy is a fundamental requirement.
- 7 The NHSN is a CDC system for tracking health-care-associated infections. Nursing homes are required to report COVID-19-related data to the NHSN on a weekly basis. The PBJ system is a CMS system designed to collect staffing information, including the category of work for each person who provides direct care and services to residents and information on hours of care provided by each category of staff per resident, per day from nursing homes on a quarterly basis.
- 8 TRICARE regional contracts provide health care services and support beyond what is available at military hospitals and clinics.
- 9 Public Law 115-232, John S. McCain National Defense Authorization Act for Fiscal Year 2019, August 13, 2018; Public Law 114-328, National Defense Authorization Act for Fiscal Year 2017, December 23, 2016.
- 10 DOD's response to House Report 116-442, page 150, accompanying H.R. 6395, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 on Behavioral Health Requirements of the Department of Defense.
- 11 DOD OIG Report No. DODIG-2022-081, "Evaluation of Department of Defense Military Medical Treatment Facility Challenges During the Coronavirus Disease-2019 (COVID-19) Pandemic in Fiscal Year 2021," April 5, 2022.
- 12 DOD clinical personnel are DOD health care providers that provide medical and other patient care services to DOD beneficiaries. DOD nonclinical personnel are in administrative, logistical, or clerical positions that are not involved in direct patient care.
- 13 DOD OIG Report No. DODIG-2022-081, "Evaluation of Department of Defense Military Medical Treatment Facility Challenges During the Coronavirus Disease-2019 (COVID-19) Pandemic in Fiscal Year 2021," April 5, 2022.
- 14 Although these positions were the highest reported by the MTF personnel, positions may be underreported because military occupational specialties for Service members did not easily translate to the occupational series for civilian personnel established by the OPM.
- 15 DOD Instruction 1400.25, Volume 543, "DOD Civilian Personnel Management System: DOD Civilian Physicians and Dentists Pay Plan," February 12, 2018, requires that the sum of payments subject to the Executive Level I annual limitation plus market pay will not exceed the annual salary of the President of the United States, excluding expenses, established by Section 102 of title 3, United States Code. Section 102, title 3, United States Code, Compensation of the President, establishes that the President shall be paid monthly for compensation in the aggregate amount of \$400,000 a year, for services during the elected term.
- 16 A "grade" refers to the General Schedule (GS) pay scale, or the pay level for the job. Title 38, United States Code, Veterans' Benefits.
- 17 A common access card is used as an identification badge, or a standard identification card used to physically access buildings and access DOD computer networks and systems.

- 18 Report No. DODIG-2022-081, “Evaluation of Department of Defense Military Medical Treatment Facility Challenges During the Coronavirus Disease–2019 (COVID–19) Pandemic in Fiscal Year 2021,” April 5, 2022.
- 19 A contract discrepancy report is used to record contract discrepancies or problems when contractor performance is judged unsatisfactory.
- 20 Operation Allies Welcome assisted vulnerable Afghan nationals, to include those who worked alongside the United States in Afghanistan for the past two decades, as they safely resettled in the United States.
- 21 DOD Instruction 1400.25, Volume 1230, “DOD Civilian Personnel Management System: Employment in Foreign Areas and Employee Return Rights,” July 26, 2012 (Incorporating Change 1, July 29, 2022).
- 22 Exceptional Family Member Program is a process that documents and evaluates the medical and educational needs of family members to determine whether the family member can be supported at a specific location.
- 23 The Joint Outpatient Experience Survey collects data on beneficiary views of outpatient care recently received at the MTF.
- 24 A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof, while an adverse event is an unintended occurrence or condition associated with care or services that reach the patient and that may or may not result in harm to the patient.
- 25 Federal inmates in BOP custody are also housed in residential reentry centers (halfway houses) or in home confinement; inmates in these settings receive medical care from community providers. Previously, the BOP also housed some inmates in privately-operated prisons, which were responsible for providing health care to those inmates; however, in November 2022, the BOP ended its use of privately-operated prisons to house inmates in compliance with Executive Order 14006 which eliminated the use of these facilities.
- 26 The Commissioned Corps of the U.S. Public Health Service is a branch of the uniformed services committed to the service of health. Officers serve in agencies across the Federal Government.
- 27 Other clinical positions include social workers, dental hygienists and assistants, physical and occupational therapists, and radiologic technologists. Other nonclinical positions include medical supply technicians, and additional administrative and support roles.
- 28 See Department of Justice Office of the Inspector General, “Review of the Federal Bureau of Prisons’ Medical Staffing Challenges,” Evaluation and Inspections Division 16-02 (March 2016).
- 29 Department of Justice Office of the Inspector General, “Remote Inspection of Federal Correctional Institution Milan,” Evaluation and Inspections Division 21-032 (January 2021).
- 30 Department of Justice Office of the Inspector General, Inmate Perceptions of the Federal Bureau of Prisons’ Management of the Coronavirus Disease 2019 Pandemic, Evaluation and Inspections Division 23-067 (May 2023).
- 31 Department of Justice Office of the Inspector General, “Staff Perceptions of the Federal Bureau of Prisons’ Management of the Coronavirus Disease 2019 Pandemic: A Follow-Up Survey of BOP Staff,” Evaluation and Inspections Division 21-126 (September 2021).
- 32 The U.S. OPM granted BOP direct hire authorities for five health care occupational series: 0610 (nurse), 0620 (licensed practical nurse), 0602 (medical officer), 0660 (pharmacist), and 0647 (diagnostic radiologic technologist).
- 33 VA medical benefits package includes inpatient and outpatient care, primary and specialty care, preventive care, diagnostic and treatment services, long term care, mental health care, pharmacy benefits, and other services. https://www.va.gov/healthbenefits/resources/publications/hbco/hbco_medical_benefits_package.asp (The website was accessed April 29, 2022).
- 34 VHA, Coronavirus Disease 2019 (COVID-19) Response Report, October 27, 2020, states, “In emergency situations, VA avails itself to national, state, territorial, tribal, and local [civilian] governments to prepare and support relief efforts. This service is known as VA’s Fourth Mission.”
- 35 Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1754 (2014).
- 36 VA Choice and Quality Employment Act, Pub. L. No. 115-46, 131 (2017).

- 37 VA OIG: [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020](#), Report No. 20-01249-259, September 23, 2020; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2021](#), Report No. 21-01357-271, September 28, 2021; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2022](#), Report No. 22-00722-187, July 7, 2022.
- 38 Seven facilities reported no severe occupational staffing shortages in FY 2020, which dropped to three in FY 2021.
- 39 The VA OIG counted the number of times a theme showed up for each of the top five clinical and top five nonclinical occupations.
- 40 Some facilities designated multiple reasons for a given occupational shortage, while other facilities provided only one reason per occupational shortage resulting in the sum of the percentage of responses exceeding 100 percent.
- 41 Department of Veterans Affairs Functional Organizational Manual Version 7.0, 2021. Operational control of VHA facilities is organized under 18 VISNs, intended as “shared system(s) of care working together to better meet local health care needs and provide Veterans greater access to care.”
- 42 VA OIG: [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages](#), Report No. 15-00430-103, January 30, 2015; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages](#), Report No. 15-03063-511, September 1, 2015; [OIG Determination of VHA Occupational Staffing Shortages](#), Report No. 16-00351-453, September 28, 2016; [OIG Determination of VHA Occupational Staffing Shortages, FY 2017](#), Report No. 17-00936-385, September 27, 2017; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018](#), Report No. 18-01693-196, June 14, 2018; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2019](#), Report No. 19-00346-241, September 30, 2019; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020](#), Report No. 20-01249-259, September 23, 2020; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2021](#), Report No. 21-01357-271, September 28, 2021; [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2022](#), Report No. 22-00722-187, July 7, 2022.
- 43 ECRI, “ECRI Reports Staffing Shortages and Clinician Mental Health are Top Threats to Patient Safety,” news release March 14, 2022, <https://www.ecri.org/press/ecri-reports-staffing-shortages-and-clinician-mental-health-are-top-threats>.
- 44 “Strategies to Mitigate Health care Personnel Staffing Shortages,” CDC, accessed January 27, 2023 www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html.
- 45 GAO, Veterans Health Care Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services, GAO-23-105372, December 15, 2022.
- 46 PRAC, Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic (as reported by Offices of Inspectors General across government) (Washington, D.C.; December 2022).
- 47 VA OIG, Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic, Report No. 20-02794, Awaiting Publication.
- 48 VA OIG, Appointment Management During the COVID-19 Pandemic, Report No. 20-02794-218, September 1, 2020.
- 49 COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, March 23, 2020.
- 50 Various available direct hire authorities as discussed allow for the noncompetitive appointments in certain shortage occupations notwithstanding competitive service and preference eligibility standards.
- 51 5 U.S.C. § 3304.
- 52 38 U.S.C. § 7412.
- 53 Veterans Health Administration COVID-19 Operational Plan, Version 1.5, January 27, 2023.
- 54 The CDT program, targeted for implementation in quarter four of FY 2023, was influenced by the COVID-19 pandemic to support internal and Fourth Mission emergencies and disasters and will be composed of 360 permanent deployment-ready clinical staff trained in emergency response.

- 55 VHA's DEMPS program uses a database of volunteer clinical and nonclinical staff who are matched and deployed to meet the needs of internal and external Fourth Mission emergency response missions.
- 56 Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136 (2020).
- 57 VA Nurse and Physician Assistant RAISE Act Pub L. No 117-103, 136 Stat. 822. (2022).
- 58 Honoring our PACT Act of 2022 Pub. L. 117-168, 136 Stat. 1808, (2022).
- 59 VHA Reduce Employee Burnout and Optimizing Organizational Thriving (REBOOT), Reducing Employee Burnout Fact Sheet, March 3, 2022 (www.va.gov/HEALTH/docs/REBOOT_Task_Force_Fact_Sheet_030122_508.pdf).
- 60 Medicaid is a state-run program that is jointly funded and administered by the Federal and state governments. Although each state has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements.
- 61 Nursing homes are required to comply with health and safety requirements in federal regulations (42 C.F.R part 483, subpart b) to participate in the Medicare and Medicaid programs. The list of nursing homes was downloaded from CMS's provider data catalog at <https://data.cms.gov/provider-data/archived-data/nursing-homes>. Accessed on September 20, 2022.
- 62 This data may vary from week to week because nursing homes have the opportunity to submit corrected data for previously-reported weeks. Available at <https://data.cms.gov/covid-19/covid-19-nursing-home-data>. Accessed on September 29, 2022.
- 63 HHS Assistant Secretary for Planning and Evaluation, Behavioral Health, Disability, and Aging Policy; *COVID-19 Intensifies Nursing Home Workforce Challenges*; October 18, 2020. Available at <https://aspe.hhs.gov/reports/covid-19-intensifies-nursing-home-workforce-challenges>. Accessed on December 12, 2022.
- 64 CMS required nursing homes to report staffing shortages and other COVID-19 facility data beginning with the week ended May 17, 2020, to support surveillance of COVID-19 cases and increase transparency for nursing home residents, their representatives, and their families. CMS memo to state survey agency directors, QSO-20-29-NH (May 6, 2020); 42 C.F.R § 483.80(g).
- 65 Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to residents to allow them to attain or maintain the highest practicable physical, mental, and psychosocial well-being. See 42 C.F.R § 483.70(q)(1). 42 C.F.R § 483.70(q)(2).
- 66 CMS, "Electronic Staffing Data Submission Payroll-based Journal Long-term Care Facility Policy Manual," version 2.6, June 2022. Available at <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/pbj-policy-manual-final-v25-11-19-2018.pdf>. Accessed on June 3, 2022.
- 67 The average daily number of hours worked by clinical staff per nursing home decreased by .1 hour, or 6 minutes.
- 68 A list of enacted waivers specific to nursing homes and their current status can be found at: <https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf>. Accessed on June 21, 2022.
- 69 Public Law 115-232, John S. McCain National Defense Authorization Act for Fiscal Year 2019, August 13, 2018; Public Law 114-328, National Defense Authorization Act for Fiscal Year 2017, December 23, 2016.
- 70 VA Choice and Quality Employment Act, Pub. L. No. 115-46, 131 (2017).
- 71 The Manila station was excluded, beginning with the [OIG Determination of Veterans Health Administration Occupational Staffing Shortages, FY 2018](#) report, as its staff were not composed VA employees but employed by the State Department and were foreign nationals.
- 72 The list of 489 occupations included those provided by VHA Workforce Management and Consulting and historically used in prior OIG Determination of VHA's Occupational Staffing Shortages reports. This list included occupations VHA facilities did not have staff in at the time of the reviews. These occupations were included because facilities have previously identified severe staffing shortages in occupations without any staff. Separately, VHA reported that some occupations included in the surveys were consolidated at the VISN level, national level, or may have been employed at both the facility and VISN levels.
- 73 Prior to the [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2021](#), Report No. 21-01357-271, September 28, 2021 report, medical center directors were asked to submit the survey on behalf of their facility.

- 74 Hiring authority for the respective occupations populated in the survey as severe occupational staffing shortages were identified.
- 75 For purposes of this report, we used the term occupation when referencing either OPM occupational series or VHA assignment codes.
- 76 Virginia Braun and Victoria Clarke, "Using thematic analysis in psychology," *Qualitative Research in Psychology*, 3(2), 77–101. July 2006.
- 77 5 C.F.R. § 337.204, Severe Shortage of Candidates, states:
- (a) OPM will determine when a severe shortage of candidates exists for particular occupations, grades (or equivalent), and/or geographic locations. OPM may decide independently that such a shortage exists, or may make this decision in response to a written request from an agency.
 - (b) An agency when requesting direct-hire authority under this section, or OPM when deciding independently, must identify the position or positions that are difficult to fill and must provide supporting evidence that demonstrates the existence of a severe shortage of candidates with respect to the position(s). The evidence should include, as applicable, information about:
 - (1) The results of workforce planning and analysis;
 - (2) Employment trends including the local or national labor market;
 - (3) The existence of nationwide or geographic skills shortages;
 - (4) Agency efforts, including recruitment initiatives, use of other appointing authorities (e.g., schedule A, schedule B) and flexibilities, training and development programs tailored to the position(s), and an explanation of why these recruitment and training efforts have not been sufficient;
 - (5) The availability and quality of candidates;
 - (6) The desirability of the geographic location of the position(s);
 - (7) The desirability of the duties and/or work environment associated with the position(s); and
 - (8) Other pertinent information such as selective placement factors or other special requirements of the position, as well as agency use of hiring flexibilities such as recruitment or retention allowances or special salary rates.

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