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INSPECTOR GENERAL

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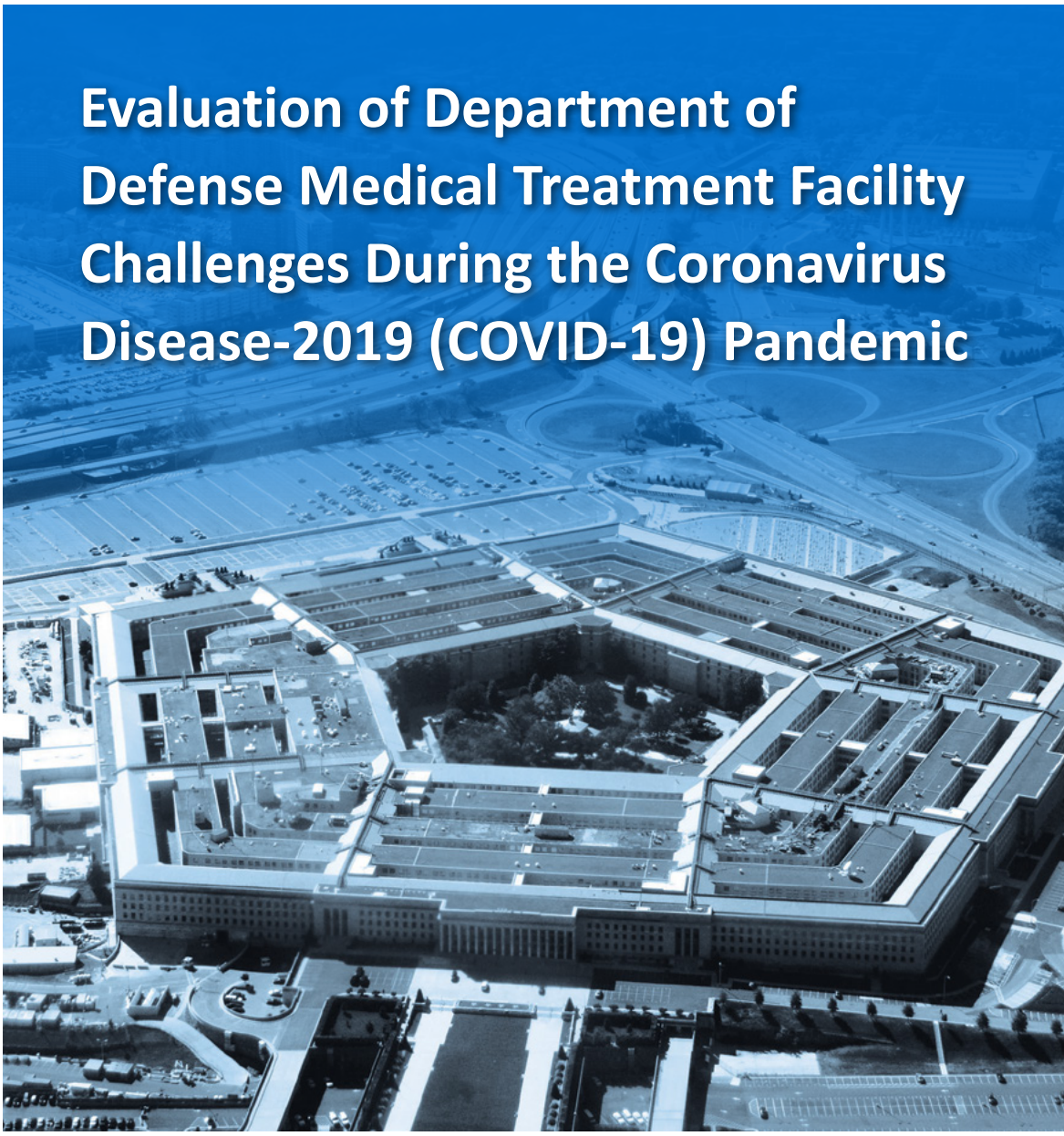
SEPTEMBER 30, 2020

Evaluation of Department of Defense Medical Treatment Facility Challenges During the Coronavirus Disease-2019 (COVID-19) Pandemic



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September 30, 2020

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
DIRECTOR, DEFENSE HEALTH AGENCY
AUDITOR GENERAL, DEPARTMENT OF THE NAVY
AUDITOR GENERAL, DEPARTMENT OF THE ARMY
AUDITOR GENERAL, DEPARTMENT OF THE AIR FORCE

SUBJECT: Evaluation of Department of Defense Medical Treatment Facility Challenges During the Coronavirus Disease-2019 (COVID-19) Pandemic (Report No. DODIG-2020-133)

This final report provides the results of the DoD Office of Inspector General's evaluation. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

Comments from the Under Secretary of Defense for Personnel and Readiness addressed all specifics of the recommendation to establish a working group to coordinate multi-Service medical treatment facility (MTF) staffing, create an informational website and toll-free number for pandemic-related information, issue clarifying guidance for identifying essential civilian healthcare workers, and update contracts for additional flexibility during extenuating circumstances. Therefore, these elements of the recommendation are resolved but will remain open. As described in the Recommendation, Management Comments, and Our Response section of this report, we will close these elements of the recommendation once we receive documentation to support the Military Health System COVID–19 After–Action Review working group's actions to establish milestones for each of the challenges identified. Therefore, please provide us within 90 days your response concerning specific actions in process or completed on the recommendations. Send your response to either [redacted] if classified SECRET.

Comments from the Under Secretary of Defense for Personnel and Readiness also addressed all specifics of the recommendation to establish a working group to consolidate COVID-19 reporting requirements. We reviewed additional documentation provided to us after the conclusion of our evaluation and determined that the Military Health System COVID–19 After–Action Review working group's analysis regarding consolidation of reporting requirements and recommendations to the Assistant Secretary of Defense for Health Affairs met the intent of our recommendation. Therefore, this element of the recommendation is resolved and closed.

We briefed this information to the Defense Health Agency, the Service Medical Commands, and the Assistant Secretary of Defense (Health Affairs) on July 23, July 28, and August 25, 2020, respectively, to enable them to take immediate corrective actions. We did not independently validate the statements made by MTF representatives during interviews. Where possible, we counted the number of MTFs that shared each challenge. We did not pose questions about potential specific challenges, but rather asked the MTFs to identify the challenges of most importance to them. Therefore, we may have underreported the number of MTFs encountering each of the challenges included in this report. This report provides DoD and other decision makers, such as the Defense Health Agency and the Service Medical Commands, information to address the MTFs' challenges and needs, where possible. We recognize that the DoD and the MTFs are in a unique and ever-changing situation, responding to the COVID-19 pandemic. However, this special report highlights the challenges and needs shared by representatives of multiple MTFs regarding their ability to perform their medical mission during COVID-19.

If you have any questions, please contact [redacted].

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Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Under Secretary of Defense for Personnel and Readiness		1.a; 1.c; 1.d; 1.e	1.b

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.

Contents

Introduction

Objective

The objective of this evaluation was to determine challenges and needs encountered by personnel working at DoD Medical Treatment Facilities (MTFs) while responding to the coronavirus disease–2019 (COVID-19) pandemic.

Background

By December 2019, a novel infectious disease was identified in Wuhan, Hubei Province, China. The respiratory illness associated with this novel infectious disease was later identified as the novel COVID-19. On March 11, 2020, the World Health Organization (WHO) characterized the COVID-19 outbreak as a pandemic. On March 13, 2020, the President of the United States issued a Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. On March 27, 2020, the President issued an Executive Order mobilizing reserve and active duty forces to respond to the pandemic. According to the Centers for Disease Control and Prevention (CDC), as of July 2020, COVID-19 cases were detected in most countries worldwide.

The COVID-19 outbreak was detected in the United States in late January and early February 2020. As of July 20, 2020, the CDC reported that the United States had upwards of 3.7 million cases and over 140,000 deaths, with new cases each day. According to a U.S. Department of Health and Human Services Office of Inspector General Report issued in April 2020, the COVID-19 pandemic caused nationwide challenges in civilian hospitals, including severe shortages of COVID-19 testing supplies, widespread shortages of personal protective equipment (PPE), the inability to maintain hospital staffing levels, medical supply shortages, and changing and inconsistent COVID-19 guidance from Federal, State, and local authorities.[1]

Military Health System

According to the Defense Health Agency (DHA), the Military Health System (MHS) is the most comprehensive military healthcare enterprise in the world. The MHS provides direction, resources, health care providers, and other means necessary to foster, protect, sustain, and restore health to Service members, military retirees, and their family members. Currently, the MHS consists of 51 military hospitals, 424 clinics, and 248 dental clinics, serving 9.5 million service members, military retirees, and their families.

[1] U.S. Department of Health and Human Services Office of Inspector General Report OEI-06-20-00300, "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23-27, 2020," April 2020.

In 2013, the Secretary of Defense directed the establishment of the DHA as part of the DoD's effort to reform the MHS. The DHA supports the delivery of health care services to DoD beneficiaries and integrates clinical and business processes across the MHS. Section 702 of the National Defense Authorization Act of 2017 directed the DHA to assume authority, direction, and control of all the MTFs from the Military Services by October 1, 2018.[2] An MTF is an inpatient or outpatient facility (owned, staffed, and managed by the Military Departments) established for the purpose of furnishing medical and dental care to eligible individuals. On August 13, 2018, section 711 of the National Defense Authorization Act of 2019 amended the transition date for the DHA to assume authority, direction, and control of all MTFs from the Military Services to the DHA to no later than September 30, 2021.[3] As of October 25, 2019, the DHA assumed management and administration of all MTFs within the continental United States (CONUS), Hawaii, and Puerto Rico, with a plan to transition the remaining MTFs using a phased, conditions-based approach.

While the transition of the MTFs to the DHA continued, the COVID-19 pandemic adversely affected the DHA's ability to meet DHA transition milestones. Because of the COVID-19 pandemic, on March 31, 2020, the Under Secretary of Defense for Personnel and Readiness requested permission to pause the MTF transition to the DHA for 90 days. On April 2, 2020, the Deputy Secretary of Defense approved the pause, with an assessment at the 45-day mark to determine if the MTF transition could be restarted, or if the transition would require a further delay. As of July 2020, the remaining MTFs had not transitioned to the DHA and remained under their respective Service Military Medical Departments.

After field work concluded for this evaluation, a new memorandum dated August 5, 2020, from the Secretaries of the Army, Navy and Air Force, along with the Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force, Commandant of the Marine Corps and Chief of Space Operations, called for the return of all military hospitals and clinics already transferred to the DHA and suspension of any planned moves of personnel or resources.[4] The Deputy Secretary of Defense issued a response on September 3, 2020, reminding the Services that Congress directed the MHS reform in law.[5] He stated that if facts and data supported an adjustment to the law, the DoD would prepare and submit

[2] Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," Section 702, "Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities," December 23, 2016.

[3] Public Law 115-232, "John S. McCain National Defense Authorization Act for Fiscal Year 2019," section 711, "Improvement of Administration of the Defense Health Agency and Military Medical Treatment Facilities," August 13, 2018.

[4] Info Memo, Memorandum for Secretary of Defense, "Subject: Military Medical Health System Reform," August 5, 2020.

[5] Deputy Secretary of Defense Memorandum, "Service Memorandum on Military Medical Health System Reform," September 3, 2020.

a legislative proposal. The Deputy Secretary of Defense also stated that he would schedule follow-up meetings with each of the individuals who signed the memorandum so that he could better understand their concerns, and he requested updates on the status of the MHS reform and an analysis of the effects the COVID-19 pandemic has had on the MTFs and medical manpower.

COVID-19 and the Military Health System

The DoD and the MHS are broadly affected by the COVID-19 pandemic. Installations outside the continental United States (OCONUS) reported incidents of COVID-19 infection before installations within CONUS. On January 30, 2020, the Office of the Under Secretary of Defense published Force Health Protection guidance on how to respond to COVID-19. The guidance was general and recommended that DoD personnel follow CDC guidance, including washing hands, avoiding touching of the face, avoiding close contact with sick people, and frequently disinfecting objects and surfaces.[6] From February through June 2020, the DoD issued 11 Supplements to Force Health Protection guidance for responding to COVID-19.

On March 30, 2020, the DoD reported the first COVID-19-related death of a U.S. service member. As of August 5, 2020, the DoD reported 70 COVID-19 related deaths and more than 40,000 confirmed cases of COVID-19 (see table below).

Table. Department of Defense COVID-19 Cumulative Totals as of August 5, 2020

	Cases	Hospitalized	Recovered	Deaths
Military	29,415	505	15,006	4
Civilian	6,213	291	2,677	44
Dependent	3,984	113	2,110	7
Contractor	2,637	137	1,191	15
Total	**42,249**	**1,046**	**20,984**	**70**

Source: Department of Defense.

[6] Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Force Health Protection Guidance for the Novel Coronavirus Outbreak," January 30, 2020.

Challenges Reported by Medical Treatment Facilities

The challenges and needs reported below are testimonial evidence based on interviews we conducted with respondents from 54 MTFs from June 22, 2020, through July 24, 2020. We did not validate the information provided by key personnel responsible for the MTFs' operations and COVID-19 response. Summarizing the MTF challenges expressed by key MTF personnel provides timely and relevant information to assist DoD leadership in improving the MTFs' ability to respond to COVID-19. Because this report is based on testimony, the DoD should consider validating the reported challenges as part of any planned response. Identifying the challenges faced at the MTF level will provide the DoD with further information about its capability for addressing the evolving COVID-19 pandemic. Additionally, increased visibility will enable the DoD to address the MTFs' needs and thereby mitigate risks to beneficiaries' health and safety. MTF respondents reported challenges within five main areas.

- Personnel
- Supplies
- Testing capabilities
- Information technology
- Guidance and lines of authority

We discuss MTF best practices and mitigating strategies for responding to COVID-19 later in the report.

MTFs Reported Personnel Challenges

Respondents from 51 of 54 MTFs reported concerns with MTF staffing levels during COVID-19. The MTF respondents stated that, as the DHA instructs the MTFs to return to full operations during COVID-19, the MTFs do not have enough staff to support the medical mission and the additional COVID-19 requirements. In addition, MTF respondents explained that additional staff that initially helped with the COVID-19 response mission are returning to their specialties, leaving the MTFs with fewer personnel to fulfill the increased COVID-19 screening and testing requirements.[7] Specifically, MTF respondents reported that, during the beginning of the COVID-19 response, the MTFs leveraged specialty providers not performing elective procedures to assist with unique COVID-19 requirements, such as manning testing tents, screening patients and personnel entering the MTF, and performing contact-tracing duties.

[7] DHA Administrative Instruction 3020.01, "Return to the Workplace Staffing Plan in the Coronavirus Disease 2019 (COVID-19) Environment," June 4, 2020.

For example, respondents at one MTF stated that dental personnel assisted in the diagnostic testing center, other MTF personnel assisted the airlift reception team screening passengers arriving from other countries, and immunization personnel assisted with contact tracing and supported public health. Respondents from another MTF reported that their MTF had 12 dental providers helping with the 24/7 mission of screening at the passenger terminal and another 7 to 9 personnel working 12-hour shifts screening patients entering the MTF.

In addition to the strain on medical personnel due to the additional duties of responding to COVID-19, MTF staff experienced childcare challenges as well. In response to COVID-19, childcare centers and schools on installations and in local communities implemented social distancing and safety guidance procedures. As a result, some of the childcare centers and schools closed or no longer accepted new enrollees. This created a challenge for MTF personnel who could not find care for their children so they could return to work.

Deployed Medical Personnel

Respondents from 26 of 54 MTFs we interviewed stated that there were challenges with processes regarding Deployed Medical Personnel. Respondents from MTFs we interviewed stated that many of their MTF staff were reassigned and deployed because of the COVID-19 pandemic, leaving the MTFs with fewer staff members to perform the MTFs' core medical mission. The respondents stated that the unexpected deployment of medical staff with unique specialties was a significant problem because their deployments reduced or removed the MTFs' ability to provide care in their specialty areas. A Director of Clinical Support Services at one MTF stated that the expectations set by the DHA for the support capabilities did not account for the MTF losing personnel to the national pandemic response. One MTF commander stated that critically needed medical personnel, including an emergency room doctor, one of two critical care doctors, and the MTF's only infectious disease specialist, were deployed from his facility. According to the MTF representative, the hospital had a daily average of three to five positive COVID-19 cases, and, at one point, nine "very sick" intensive care unit (ICU) patients who could have benefitted from the care of an infectious disease specialist. A respondent from another major medical center MTF stated that both of the MTF's infectious disease specialists deployed at the beginning of the COVID-19 pandemic, leaving the MTF without any infectious disease specialists.

MTF respondents stated that there were challenges with the Modification Table of Organization and Equipment (MTOE) assigned personnel for staffing MTFs during the COVID-19 pandemic. The MTOE assigned personnel are deployable personnel assigned to MTFs and other facilities. When their units deploy, the MTOE assigned

personnel leave the MTF to support their units. According to one MTF respondent, the MTOE assigned personnel system did not consider a pandemic scenario and did not give the MTFs operational flexibility regarding staffing. Specifically, the MTF respondent explained that 84 MTOE assigned personnel, including critically needed specialists, were pulled from the MTF for 1 month to prepare for deployment, which left the MTF with limited staffing to implement their bed expansion plan. In addition, according to the MTF respondent, the MTF was unable to request reconsideration of the Service's decision to pull these personnel, even if the MTF was in critical need of that specialty. The MTF spokesperson explained that this was far from optimal because the hospital was in a COVID-19 hotspot while the locations the deployed personnel supported were not.

Coordination by DHA and the Services for Staffing Specific Multiservice MTFs

Leadership at MTFs with personnel from multiple Services stated that coordination between the DHA and the Services regarding staffing decisions made for the MTFs during the COVID-19 pandemic was problematic. Specifically, a respondent from one multi-Service MTF stated that there seemed to be no coordination between Services regarding deployed personnel so the Services pulled personnel out of the MTF for other missions without considering the continuing medical care needed at the MTF. MTF representatives stated that with fewer medical personnel available to work in the MTF, the MTF could accommodate fewer patients. Representatives also stated that this negatively affected access to care for those who could potentially require hospitalization. Another MTF spokesperson stated that 56 of the MTF's ICU nurses mobilized over a 2-week period, which led to reduced capability within the MTF. Specifically, the representative stated that the loss of the mobilized personnel hurt the MTF's ability to provide COVID-related specialty care.[8]

Another interviewee pointed out that the DHA implemented budget cuts for 9 months prior to the COVID–19 pandemic, preventing the multi-Service MTF from hiring medical personnel. Specifically, the MTF representative stated that their major medical center MTF had decreased by 45 nursing personnel from inpatient services in the months preceding the COVID-19 pandemic.

Retirees and Reservists

Spokespersons from five MTFs stated that they received medical augmentation from military retirees recalled to active duty. According to one MTF interviewee, the retirees arrived without orders. Interviewees stated that some retirees did not receive their salaries and had to pay out of pocket for expenses during their activation.

[8] Specialty care providers focus on particular areas of care in which they have extensive training and education.

Additionally, MTF personnel expressed challenges regarding reservists. Leadership from one MTF stated that they received 60 reservists for 1 month, with specialties that the MTF needed, including 4 to 5 reservists with anesthesiology experience. MTF respondents explained that some of the anesthesiology providers volunteered to stay at the MTF after their initial activation tour ended. However, the respondents explained that, based on the Reserve Component activation and orders process, the reservists would have to return home, have a 2-week restriction of movement period required due to COVID-19, get new orders to come back to the MTF, and then undergo another 2-week restriction of movement period before returning to work in the MTF. This process presented further staffing challenges and limitations for the MTFs.

Contract Personnel

MTF respondents at 11 of 54 MTFs reported challenges with processes related to contract personnel. One MTF respondent reported challenges with processes related to using existing contracted medical personnel in different departments or specialties other than the departments or specialties for which they were hired. Specifically, one MTF spokesperson stated that many contracts did not allow flexibility for contracted personnel to work in other departments of the hospital. An MTF interviewee stated that they could move active duty personnel to other areas of the hospital where they needed additional personnel to respond to COVID-19, but that the contracted personnel were required to remain in the specialty for which they were hired. In addition, according to one MTF interviewee, contracted personnel could not work additional hours to backfill active duty providers deployed for outside missions. Furthermore, one MTF representative stated that they had difficulties hiring contracted personnel during COVID-19 because they were competing with the local hospitals for the same medical personnel. An MTF spokesperson also stated that contracts used to hire MTF healthcare personnel initially prohibited the contracted employees from teleworking. Therefore, the MTF had to issue contract modifications, which added an administrative burden, in order to allow contracted employees to telework during the COVID-19 pandemic.

Civilian Personnel

Respondents from 17 of 54 MTFs expressed challenges with the availability of DoD civilian staff. Specifically, MTF interviewees mentioned challenges with staffing levels because some civilian staff position descriptions did not have "mission-essential" designations, and some MTFs had critical civilian positions on extended administrative or "weather and safety" leave during the COVID-19

pandemic.[9] For example, a Director of Clinical Support Services stated that all of his civilian staff pharmacists were placed on weather and safety leave. Another MTF interviewee stated that a clinical psychologist stated she did not intend to return to work at the MTF until a COVID-19 vaccine was approved.

The reported lack of mission-essential designations in the civilian position description created challenges for MTF management. One MTF interviewee explained that management must work with human resources and collective bargaining units in order to designate those positions as mission-essential. According to documents provided to us by MTF representatives, although registered nurse, licensed practical nurse, and nursing assistant positions meet the definition of mission essential personnel as defined by DoD guidance, their position descriptions did not always include mission-essential information.[10] *Documentation provided by the MTF recommended that the DHA standardize all MTF position descriptions to have consistent mission-essential designations.* MTF personnel explained that the personnel shortages caused available personnel to experience "burn out" and the operational tempo required for responding to the pandemic was not sustainable.

MTFs Reported Supply Challenges

Overall, MTF respondents reported challenges with medical and COVID-19 testing supplies, including challenges such as supply shortages and expired and unusable supplies. MTF respondents also reported concerns with the sustainability of resources used to respond to the COVID-19 pandemic.

Medical Supplies

MTF respondents from 51 of 54 MTFs we interviewed reported challenges with PPE and other medical supplies throughout the COVID-19 pandemic. Because of the critical medical shortages across the supply system, respondents from several MTFs reported that they had to leverage any available means to obtain supplies for the COVID-19 response, such as purchasing supplies from the local economy on unit credit cards, producing 3D-printed supplies, and accepting donations from local emergency medical services. One MTF representative stated that supplies as simple as batteries and filters for medical equipment were backordered for 120 to 180 days.

[9] Congress enacted the Administrative Leave Act of 2016, which provides OPM with the authority to regulate certain types of leave, including "weather and safety leave," and provides Federal agencies with the authority to approve employees without loss or reduction in pay, if employees are prevented from safely traveling to or performing work at an approved location.

[10] DoD Instruction 3020.42, "Defense Continuity Plan Development," (Certified current as of April 27, 2011), February 17, 2006.

Some MTF respondents reported that they received supplies from the National Stockpile or other reserves that were unusable because the supplies were expired, dry rotted, or moldy. For example, one MTF stated that it had to discard 21,000 N95 masks received from the National Stockpile because the masks were wet and covered in mold. Respondents at another MTF reported that masks were expired and the elastic on the masks was dry-rotted so the MTFs could not use them. MTF interviewees reported that because of the uncertainty with PPE supply replenishment, they were forced to use some of the PPE that was maintained as part of the DoD's war reserve inventory. However, they also stated that when they started to use the PPE from the war reserve inventory they discovered that much of the war reserve PPE was expired. It is DoD policy that it acquire and maintain, in peacetime, war materiel inventories such as PPE.[11]

Figure. National Stockpile cases of dry rotted and expired N95 masks.
Source: MTF interviewed by DoD OIG.

MTF respondents reported concerns with the supply lines for and replenishment rates of PPE, disinfecting cleaners, and testing supplies. According to one MTF respondent, cleaning supplies that were crucial in combatting the spread of the virus were difficult to acquire through the normal supply channels. *Respondents from another MTF stated that it would have been helpful if the DoD identified suitable alternatives for items in high demand because it took a lot of resources to research and identify supply alternatives when items were out of stock.* According to MTF representatives, the lack of supplies caused leadership at the MTFs to accept risk in using expired PPE or masks that did not fit.

[11] DoD Instruction 3110.06, "War Reserve Materiel (WRM)," January 7, 2019.

COVID-19 Testing Supplies

Respondents from 42 of 54 MTFs reported shortages of COVID-19 testing supplies. For example, representatives from one MTF, a medical center, reported a critical shortage of COVID-19 testing supplies and stated that the Defense Logistics Agency and Service Medical Command informed the MTF that there was a 60-day shortage of the assays, swabs, and viral transport media necessary to perform COVID-19 testing.[12] Furthermore, the MTF spokesperson reported that the MTF is on an installation that requires the MTF to test hundreds of additional personnel that travel to the installation. Lastly, MTF personnel stated that, at one point, the MTF had a backorder of 800 assays and that the MTF had reported the supply shortage to seven different DoD entities. A representative from another MTF clinic stated that the clinic received the equipment necessary to process its own COVID-19 tests but ran out of the supplies necessary to run the tests within 1 to 2 weeks. The MTF representative explained that the MTF then sent its COVID-19 specimens for processing to its parent hospital, but the hospital also ran out of supplies. The clinic now ships their tests to a large medical center that is further away, causing a longer lag time to receive test results.

COVID-19 Response Supplies

MTF respondents reported concerns with using resources such as tents, trailers, or vehicles to support the shift to COVID-19 medical operations outside their MTF. They stated that these solutions were temporary and that they required a more sustainable solution given the continued strain of the COVID-19 pandemic response. For example, respondents from several MTFs reported implementing drive-through or curbside delivery pharmacies, where pharmacy personnel delivered prescriptions to the MTF beneficiaries in their vehicles. This allowed MTFs without a drive-through pharmacy window to reduce COVID-19 exposure to patients and personnel by keeping beneficiaries out of the pharmacy. In addition, MTF respondents reported using adjacent empty parking structures or tents in empty parking lots to set up drive-through COVID-19 testing. However, MTF representatives stated that, because of weather and safety conditions, more sustainable solutions are required. Furthermore, some MTF respondents explained that the tents or spaces they used for the COVID–19 response were resources previously dedicated to the influenza response plan. They stated that they were concerned that, with COVID-19 numbers continuing to rise and influenza season approaching, the MTF would not have enough resources to fight both illnesses.

[12] Viral transport media or medium is a substance used to carry and maintain the viability of specimens to a microbiology lab for identification and analysis of disease-producing viruses. Assay is an analysis to determine the presence, absence, or quantity of one or more components.

MTFs Reported Challenges with COVID-19 Testing Capabilities

Respondents at 47 of 54 MTFs reported that they had limited or no testing capability because they did not have the necessary testing equipment or supplies or had insufficient staffing to process the COVID-19 tests. Specifically, respondents from four MTFs indicated that they did not have testing capabilities at the time of our interviews, and other MTF representatives indicated that they had very limited testing capabilities, such as the ability to process 10 or fewer tests per day.

For MTFs that reported not having sufficient COVID-19 testing capabilities, MTF representatives reported several mitigating strategies to attempt to meet their beneficiaries' demand for COVID-19 testing. MTF representatives stated that the MTFs collected specimens and relied on other MTFs or commercial laboratories to process their COVID-19 tests. Personnel from one OCONUS MTF shared that their Service leadership dedicated flights for the MTF to send COVID-19 tests to MTFs in other countries for processing. Representatives at another OCONUS MTF stated that sending testing samples to other countries was a significant financial burden. MTF respondents also stated that they encouraged beneficiaries to use state and local COVID-19 testing because, according to MTF representatives, the MTF could not meet the COVID-19 testing demands of Force Health Protection Supplement 11 guidance (Supplement 11 guidance) testing requests.[13]

Operational Screening and Sentinel Surveillance

Respondents from 27 of 54 MTFs reported challenges with meeting testing demands required by the Supplement 11 guidance for operational screening and sentinel surveillance. Supplement 11 guidance outlines the DoD's screening and surveillance strategy that, according to the guidance, is designed to break the chain of disease transmission to reduce risk to the force and to DoD missions. Specifically, Supplement 11 guidance requires COVID-19 testing of asymptomatic service members prior to deployments and start of training events. Although Supplement 11 states that the testing will be conducted based on test availability, MTF representatives reported that senior leaders are requesting whole units, such as battalions, vessels, or squadrons, be tested prior to and after returning from deployments. According to representatives at one MTF, one battalion would require 1,200 tests for pre-deployment and another 1,200 test post-deployment. However, a representative from the MTF reported that the MTF could process only 5 to 7 COVID-19 samples per day. The MTF representatives further stated that

[13] Under Secretary of Defense for Personnel and Readiness Memorandum, "Force Health Protection Guidance (Supplement 11) – Department of Defense Guidance for Coronavirus Disease 2019 Surveillance and Screening with Testing," June 11, 2020.

when the MTF experienced a cluster of 60 patients needing COVID-19 testing, the MTF had to rely upon a larger MTF, which was resourced with a maximum testing capability of up to 120 COVID-19 tests per day. The MTF representatives stated that they do not have the capability to conduct the number of tests required by Supplement 11 guidance.

Supplement 11 guidance also requires random surveillance COVID-19 testing every 2 weeks, including 1 percent of the entire base population, 10 percent of medical personnel, and 10 percent of individuals in crowded settings, such as ships and training sites. Sentinel surveillance requires actively testing for infections in select asymptomatic service member populations to detect disease early and direct public health action.[14] However, representatives at one MTF stated that they could not even meet their symptomatic COVID-19 testing demand. *A respondent from one MTF recommended that the DoD issue a contract to perform the additional COVID-19 testing. The MTF leaders interviewed requested that the DoD or the DHA put out additional guidance to explain who should be providing this surveillance testing and how it is being staffed and resourced.*

Contact Tracing

According to the CDC, contact tracing is an evidence-based way to slow the spread of infectious disease. MTFs that were able to adequately locate and contact individuals who encountered COVID-19–positive individuals attributed their successful contact tracing, in part, to having adequate staffing and agreements or relationships in place with the local or state authorities for contact tracing. A respondent from one MTF stated that successful contact tracing has helped reduce the spread of COVID-19 positive cases on their installation. However, representatives from 16 of 54 MTFs reported challenges with contact tracing. Specifically, MTF representatives reported that the MTFs did not have enough personnel to effectively trace COVID-19 cases.

MTF respondents reported not having enough personnel to address the requirements established by Supplement 11 guidance for tracking individuals that had contact with COVID-19 positive patients.[15] MTF leadership pulled personnel from clinics that had reduced operations due to the pandemic to assist in contact tracing, but MTF representatives stated that, as those personnel return to their normal duties, additional personnel would be required to continue the contact tracing. At one MTF, the lab officer stated that the July's testing data showed that, on average, a COVID-19 positive patient encountered eight other individuals.

[14] Sentinel surveillance is the monitoring of rate of occurrence of specific conditions to assess the stability or change in health levels of a population.

[15] USD(P&R) Memorandum, "Force Health Protection Guidance (Supplement 11)," June 11, 2020.

However, he stated that recently they have found much higher contact rates, such as a case where a COVID-19–positive patient encountered 48 other individuals, requiring more personnel to locate and notify the individuals.

MTFs Reported Issues with Information Technology Resources

Respondents at 51 of 54 MTFs reported concerns related to information technology (IT) resources. IT resources supporting virtual health care and internal and external communications are essential to providing patient care during the COVID-19 pandemic. IT resources allow health care providers to conduct virtual health care and beneficiaries to engage with health care providers from their own home. Using IT resources prevents the in–person spread of COVID–19 and helps ensure that health care can continue to be provided.

Virtual Health Care

Respondents reported shortages of IT equipment and stated that the MTFs lacked the IT infrastructure necessary to optimize telework and conduct virtual health care appointments. MTF respondents reported not having enough IT hardware, such as webcams and common access card readers, and stated that they could not obtain laptops from the DHA when needed. MTF representatives also reported not being able to effectively telework or conduct virtual health care because of challenges with bandwidth and access to the virtual private network.

DoD guidance authorized MTF personnel to use a broader range of IT platforms for provider-patient interactions during the pandemic.[16] MTF respondents stated that some providers used their personally owned electronic devices to conduct virtual health appointments and used platforms commonly available to the public, which were temporarily approved by DHA. MTF representatives stated that providers used their personally owned electronic devices because they had a shortage of IT equipment, and the alternative platforms were more user-friendly and reliable for patients and providers than the DHA-approved platform, Adobe Connect. *MTF representatives stated that the DHA should allow the MTFs to use the alternative platforms after the COVID-19 pandemic because providers reported more positive outcomes of care, or replace the currently approved platform with a more reliable and user-friendly platform for patients and providers.*

Some MTF providers reported using audio-only appointments instead of having access to the enhanced video appointment capability. This was a concern, especially for behavioral or mental health appointments, where MTF providers

[16] DHA memorandum, "Tiered Telehealth Health Care Support for COVID-19," March 27, 2020.

reported that telephone appointments were less effective. A representative from one MTF reported that the lack of virtual capability was also a challenge for residency program requirements, as residents needed to see patients and participate in educational lectures.

In addition, as providers transitioned from in-person visits to virtual health care, an MTF respondent stated that providers experienced a learning curve using secure messaging and Adobe Connect to care for patients. MTF representatives stated that clinicians need additional training and standard operating procedures (SOPs) to continue conducting virtual appointments. *An MTF representative stated that now that there is patient and provider buy-in for virtual appointments, it is the optimal time to provide additional training and SOPs to ensure that virtual appointments are effective and continue after the COVID-19 pandemic has passed.*

Internal and External Communications

MTF respondents stated that beneficiaries and installation personnel overloaded the MTF phone lines with pandemic-related calls. For example, a respondent from one MTF stated that the MTF was overwhelmed with calls from beneficiaries for guidance related to preventive medicine, isolation, quarantine, and appointment status. The MTF respondent stated that it took the MTF 6 weeks to establish a hotline, which the MTF staffed with hospital personnel already tasked with patient care. Additionally, public affairs officers stated that the MTFs did not have robust public affairs office messaging plans within and among the MTFs. Therefore, messaging was not consistent early in the pandemic, which added to confusion among patients, staff members, and the community, resulting in communication delays and patient complaints.

MTF representatives also stated that they encountered challenges with technology for internal and external communication, including Virtual Private Networks (VPNs) that could not sustain the amount of personnel teleworking. For example, one MTF respondent stated that she started logging on at 4:00 a.m. to get a VPN connection before they were all taken. According to MTF respondents, the Services have increased VPN for some of the MTFs; however, a few MTF respondents reported still experiencing shortfalls. Additionally, MTF representatives stated that phone lines provided a challenge for MTF communication. According to MTF representatives, antiquated MTF phone lines, the inability to forward phone lines from the hospital to personal devices, and overloaded bridges and conference lines all required providers to use their personal devices to conduct MTF business. MTF respondents stated that many providers were uncomfortable with using personal devices but had to use them out of necessity.

MTF representatives stated that internal communication was key to their response to the COVID-19 pandemic. Many MTF representatives reported holding daily meetings within their MTFs and weekly meetings with other DoD healthcare organizations, including other MTFs and the DHA. *Additionally, MTF representatives stated that the use of group chat software applications for team collaboration has been an asset for internal communication between providers.*

MTFs Reported Challenges With Guidance and Lines of Authority

Guidance

Respondents from 50 of 54 MTFs stated that the volume and unclear or contradictory nature of guidance for responding to COVID-19 was a challenge. Specifically, MTF representatives stated that they were flooded with guidance—often conflicting guidance— from the DHA, the Service Medical Commands, Regional Commands, Combatant Commands, and even their specialty line leads on how to test for, respond to, and treat COVID-19. MTF contacts stated that this was in addition to all of the information put out by the CDC and other professional societies. According to MTF respondents, the MTFs followed guidance provided by the CDC and other professional societies early in the pandemic before the DoD issued and disseminated DoD-specific guidance.

According to MTF representatives, DoD issued COVID-19-related guidance from multiple levels. MTF representatives stated that guidance seemed to be communicated without a planned or controlled communication strategy. According to the MTF respondents, this led to a high volume of communications and guidance, without time to fully review the information before it was replaced or obsolete. MTF respondents stated that, at times, the MTF had to create its own local guidance or the guidance provided did not apply to the MTF. For example, representatives from OCONUS MTFs stated that a lot of the guidance they received was CONUS-based and could not be applied to their MTFs or the guidance conflicted with host nation requirements. *MTF representatives stated that the DoD should synchronize authority and guidance for COVID-19 and create a centralized guidance repository and reporting chain so that clear information can be pushed out to everyone at once.*

Excessive COVID-19 Reporting Requirements

MTF respondents at 28 of 54 MTFs discussed excessive COVID-19 reporting requests from leadership, most with different requirements and formats. MTF respondents reported that different levels of leadership required them to send between four and eight reports daily. The respondents stated that this caused a

significant strain on already overstretched personnel. One MTF representative stated that the MTF set aside a dedicated team of people just to respond to these taskers, while other MTF representatives said that these reporting requirements took them away from their primary mission of caring for patients. Another MTF representative stated that reports to different commands appeared to be conflicting because commands requested different information and had different criteria for the requirements. Specifically, MTF personnel stated that reports had different inclusion and exclusion criteria. For example, MTF personnel stated that one report included Neonatal ICU bassinets in the bed counts, while others did not. The MTF representatives further stated that the information included in the reports was not always realistic for various reasons, including formulas to calculate inpatient capabilities that did not account for personnel pulled for deployment missions or personnel placed on restriction of movement orders.

Assistant Secretary of Defense for Health Affairs Established an MHS–Wide COVID–19 After–Action Review

The Office of the Under Secretary of Defense for Personnel and Readiness provided documentation, in response to the draft report, to support that the Assistant Secretary of Defense for Health Affairs directed an MHS–wide COVID-19 after–action review to identify lessons learned and prepare the MHS to enhance its support for the next major public health emergency. On August 20, 2020, members of the working group discussed their in–depth review of the top five lessons learned and potential recommendations with the Assistant Secretary of Defense for Health Affairs. The working group's top five areas and recommendations included challenges identified in this report, such as unified and consistent guidance, addressing personnel shortages created by deployments, increasing technology capabilities, synchronizing leadership reporting and data requirements, and identifying roles and responsibilities within the MHS.

Recommendation, Management Comments, and Our Response

Recommendation 1

We recommend that the Under Secretary of Defense for Personnel and Readiness, in conjunction with the Assistant Secretary of Defense for Health Affairs and Secretaries of the Military Departments, establish a working group within 30 days of this report's publication, to address the personnel, supplies, testing capabilities,

information technology, communication, and lines of authority challenges that we identified during the COVID-19 pandemic that exist between the Services and the Defense Health Agency. The working group should establish milestones to:

a. Develop guidance for coordinating the staffing of multi-Service MTFs during a pandemic,

b. Consolidate COVID-19 reporting requirements and recipients to reduce duplication and inconsistent requirements,

c. Create a pandemic-related informational website and a toll-free number for beneficiaries to find COVID-19-related information and ensure the website and toll-free number are advertised and maintained,

d. Issue clarifying guidance for defining essential personnel for civilian healthcare workers, and

e. Update contracts to allow for more flexibility regarding the use of contracted personnel during extenuating circumstances, such as a pandemic.

Under Secretary of Defense for Personnel and Readiness Comments

The Under Secretary of Defense for Personnel and Readiness agreed with the recommendation, stating that the Assistant Secretary of Defense for Health Affairs has already established a formal MHS COVID-19 After–Action Review (AAR), comprised of representatives from across the MHS, which is addressing the types of issues included in the recommendations. He stated that the Offices of the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs would use the AAR working group to address and respond to the OIG report findings and act to accomplish the OIG milestones.

Our Response

Comments from the Under Secretary of Defense for Personnel and Readiness addressed all specifics of the recommendation to establish a working group to coordinate multi-Service MTF staffing, create an informational website and toll-free number for pandemic-related information, issue clarifying guidance for identifying essential civilian healthcare workers, and update contracts for additional flexibility during extenuating circumstances.

Therefore, these elements of the recommendation are resolved but will remain open. We will close these elements of the recommendation once we receive documentation to support the MHS COVID–19 AAR working group's actions to establish milestones for each of the challenges identified.

Comments from the Under Secretary of Defense for Personnel and Readiness also addressed all specifics of the recommendation to establish a working group to consolidate COVID-19 reporting requirements. We reviewed additional documentation provided to us after the conclusion of our evaluation and determined that the MHS COVID–19 AAR working group's analysis regarding consolidation of reporting requirements and recommendations to the Assistant Secretary of Defense for Health Affairs met the intent of our recommendation. Therefore, this element of the recommendation is resolved and closed.

MTF Best Practices and Mitigation Strategies Established for Responding to COVID-19

MTF representatives told us that during the COVID-19 pandemic they created processes and procedures to enhance their capabilities for responding to COVID-19. Therefore, MTF respondents shared several best practices and mitigation strategies with us that we believe other MTFs could replicate. Some examples of these best practices and mitigation strategies include the following.

- **Drive-Through COVID-19 Testing.** Respondents from several MTFs stated that the MTF set up testing sites outside the facility to reduce the infection rates of both patients and personnel. For example, representatives at one MTF stated that an outdoor, drive-through testing option allowed MTF personnel to reduce patient exposure to COVID-19, thus preventing further spread of the virus.
- **Drive-Through Pharmacy.** Respondents from several MTFs stated that the MTF established drive-through pharmacies or used parking lots to deliver medications to patients. The respondents stated that this eliminated large numbers of people congregating inside the MTF. MTF personnel stated that they are working with the installation leadership to continue this practice and create a more permanent structure for drive-through pharmacies.
- **Supplies.** MTFs collaborated with on-base and off-base organizations and obtained essential PPE through donations within the local area. For example, respondents at one MTF stated that the installation Emergency Medical Service, fire department, and other units provided face masks, gowns, and face shields. Additionally, representatives from one MTF stated that the MTF created 3D-printed face shields to compensate for the lack of face shields in their PPE inventory.
- **Guidance.** In the absence of clear guidance on a COVID-19 response from the DoD, the respondents at several MTFs stated that they developed internal hospital practices based on guidance from outside the DoD, such as the CDC and WHO. For example, a respondent at one MTF stated

that they used a pre-existing disease containment plan (not built for a pandemic) as a baseline for operations and adjusted the plan, where necessary, to apply it to the COVID-19 pandemic.

- **Communication.** One MTF respondent stated that the MTF created a Public Health Emergency Working Group, had daily meetings, and created a COVID-19–specific hotline to disseminate the correct and most updated information. One MTF Commander stated that the MTF placed a medical representative at the installation level for the crisis action team, which helped with communication to the leadership during the COVID-19 response and ensured information flowed from the base to the crisis action team. Additionally, according to respondents, MTFs utilized Facebook and other social media platforms to disseminate COVID-19 related information.
- **Emergency Operations Center.** Representatives from one MTF stated that they activated their hospital command center within their Emergency Operations Center to channel all things concerning COVID-19 through a centralized operations cell.

Scope and Methodology

We conducted this evaluation from May 2020 through August 2020 in accordance with the "Quality Standards for Inspection and Evaluation," published in January 2012 by the Council of Inspectors General on Integrity and Efficiency. Those standards require that we adequately plan the evaluation to ensure that objectives are met and that we perform the evaluation to obtain sufficient, competent, and relevant evidence to support the findings, conclusions, and recommendations. We believe that the evidence obtained was sufficient, competent, and relevant to lead a reasonable person to sustain the findings, conclusions, and recommendations.

We did not independently verify the testimonial evidence provided by the MTF respondents. Rather, we summarized the challenges and needs most widely reported across the MTF respondents that we interviewed for the DoD's information and consideration. We only collected testimonial evidence from personnel at the MTFs and did not interview or include the perspectives of other stakeholders, such as the DHA. We did not pose questions about potential specific challenges, but rather asked the MTFs to identify the challenges of most importance to them. Where possible, we counted the number of MTFs that shared each challenge. Therefore, we may have underreported the number of MTFs encountering each of the challenges included in this report. Hospital responses reflect a point in time, but the COVID-19 pandemic is fast moving, as are the DoD's efforts to address it. Since our interviews, some MTF challenges and needs may have worsened and others may have improved.

We selected a non-statistical sample of 56 MTFs that considered the following characteristics.

- CONUS and OCONUS MTFs
- MTF size (Medical Center, Community Hospital, Branch Clinic)
- MTFs with and without inpatient capabilities
- Areas with high and low COVID-19 prevalence according to the WHO, CDC, and DoD data

From June 22, 2020, through July 24, 2020, we conducted 1-hour interviews, by telephone, with key personnel responsible for the MTFs' operations and COVID-19 response at 54 MTFs who responded to our interview requests. The 54 MTFs included 41 MTFs in CONUS and 13 OCONUS, representing 20 states and 6 countries.

Participants from the MTFs included individuals such as MTF Commanders, Public Health Emergency Officers, logisticians, infectious disease physicians, emergency department physicians, critical care personnel, and others. We asked the following four predetermined questions.

- What challenges has your facility faced in responding to COVID-19?
- What strategies are you using to mitigate these challenges?
- What support have you received from the DoD in responding to COVID-19?
- How could the DoD best support you in the immediate future (30-90 days) in responding to COVID-19?

To provide timely information, we briefed our preliminary results to the DHA, the Service Medical Commands, and the Assistant Secretary of Defense (Health Affairs) on July 23, July 28, and August 25, 2020, respectively, to enable them to take actions.

Appendix

Personnel Interviewed from Listed MTFs

MTF	Location
11th Medical Group	Joint Base Andrews Naval Air Facility, Maryland
31st Medical Group	Aviano Air Force Base, Italy
36th Medical Group	Andersen Air Force Base, Guam
48th Medical Group	Royal Air Force Lakenheath, England
51st Medical Group	Osan Air Base, South Korea
60th Medical Group	Travis Air Force Base, California
61st Medical Squadron	Los Angeles Air Force Base, California
66th Medical Group	Hanscom Air Force Base, Massachusetts
81st Medical Group	Keesler Air Force Base, Mississippi
86th Medical Group	Ramstein Air Base, Germany
87th Medical Group	Joint Base McGuire-Dix-Lakehurst, New Jersey
88th Medical Group	Wright-Patterson Air Force Base, Ohio
96th Medical Group	Eglin Air Force Base, Florida
99th Medical Group	Nellis Air Force Base, Nevada
375th Medical Group	Scott Air Force Base, Illinois
436th Medical Group	Dover Air Force Base, Delaware
673rd Medical Group	Joint Base Elmendorf-Richardson, Alaska
Barquist Army Health Clinic	Frederick, Maryland
Blanchfield Army Community Hospital	Fort Campbell, Kentucky
Boone Branch Health Clinic	Joint Expeditionary Base Little Creek—Fort Story, Virginia
Branch Health Clinic China Lake	Naval Air Weapons Station China Lake, California
Brooke Army Medical Center	Fort Sam Houston, Texas
CPT Jennifer Moreno Primary Care Clinic	Fort Sam Houston, Texas
Darnell Army Medical Center	Fort Hood, Texas
Dumfries Health Center	Dumfries, Virginia
Earle Branch Health Clinic	Colts Neck, New Jersey
Eisenhower Army Medical Center	Fort Gordon, Georgia
Fort Belvoir Army Community Hospital	Fort Belvoir, Virginia
Keller Army Community Hospital	U.S. Army Garrison West Point, New York
Kimbrough Ambulatory Care Center	Fort Meade, Maryland

Personnel Interviewed from Listed MTFs (cont'd)

MTF	Location
Landstuhl Regional Medical Center	Rheinland-Pfalz, Germany
Madigan Army Medical Center	Joint Base Lewis-McChord, Washington
Martin Army Community Hospital	Fort Benning, Georgia
Naval Branch Health Clinic Belle Chasse	Naval Air Station Joint Reserve Base New Orleans, Louisiana
Naval Branch Health Clinic Naval Base San Diego	Naval Base San Diego, California
Naval Branch Health Clinic Temecula	Temecula, California
Naval Health Clinic Annapolis	Annapolis Area Naval Complex, Maryland
Naval Hospital Bremerton	Bremerton, Washington
Naval Hospital Camp Pendleton	Camp Pendleton, California
Naval Hospital Guam-Agana	Agana Heights, Guam
Naval Hospital Naples	Naval Support Activity Naples, Italy
Naval Hospital Pensacola	Pensacola, Florida
Naval Hospital Rota	Rota Naval Base, Spain
Naval Hospital Sigonella	Naval Air Station Sigonella, Italy
Naval Hospital Twentynine Palms	Marine Corps Air Ground Combat Center, California
Naval Medical Center Camp Lejeune	Marine Corps Base Camp Lejeune, North Carolina
Naval Medical Center Portsmouth	Portsmouth, Virginia
Naval Medical Center San Diego	Naval Base San Diego, California
Tripler Army Medical Center	Honolulu, Hawaii
U.S. Army Health Clinic Vilseck	Rose Barracks, Germany
Walter Reed National Military Medical Center	Naval Support Activity Bethesda, Maryland
Weed Army Community Hospital	Fort Irwin, California
William Beaumont Army Medical Center	El Paso, Texas
Womack Army Medical Center	Fort Bragg, North Carolina

Management Comments

Under Secretary of Defense for Personnel and Readiness

PERSONNEL AND READINESS

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SEP - 9 2020

MEMORANDUM FOR DEPARTMENT OF DEFENSE OFFICE OF THE INSPECTOR GENERAL

SUBJECT: Review of Department of Defense Inspector General Evaluation of Department of Defense Medical Treatment Facility Challenges During the Coronavirus Disease 2019 (Project No. D2020-DEV0PB-0136.000)

This memorandum is in response to the request from the Department of Defense Office of the Inspector General (OIG) to review and comment on the subject draft report, "Evaluation of Department of Defense Medical Treatment Facility Challenges During the Coronavirus Disease-2019" (Project No. D2020-DEV0PB-0136.000). I appreciate the OIG review of challenges and needs DoD medical treatment facilities (MTFs) encountered in responding to the coronavirus disease 2019 (COVID-19) pandemic.

I concur with the OIG recommendations. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) has already established a forum, the formal Military Health System (MHS) COVID-19 After Action Review (AAR), comprised of representatives from across the MHS that is addressing the types of issues included in the recommendations. My office and the Office of the ASD(HA) will use the AAR as the vehicle to address and respond to the OIG reports findings and act to accomplish the OIG milestones.

To date, the AAR has identified lessons learned associated with challenges to the DoD revealed by the pandemic, has assessed the preparedness of the DoD for sustained pandemic response, and has provided recommendations to improve DoD's capabilities to operate in a pandemic environment and support civil authorities.

My point of contact for this effort is [redacted]

Matthew P. Donovan


INSPECTOR GENERAL
INTEGRITY
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