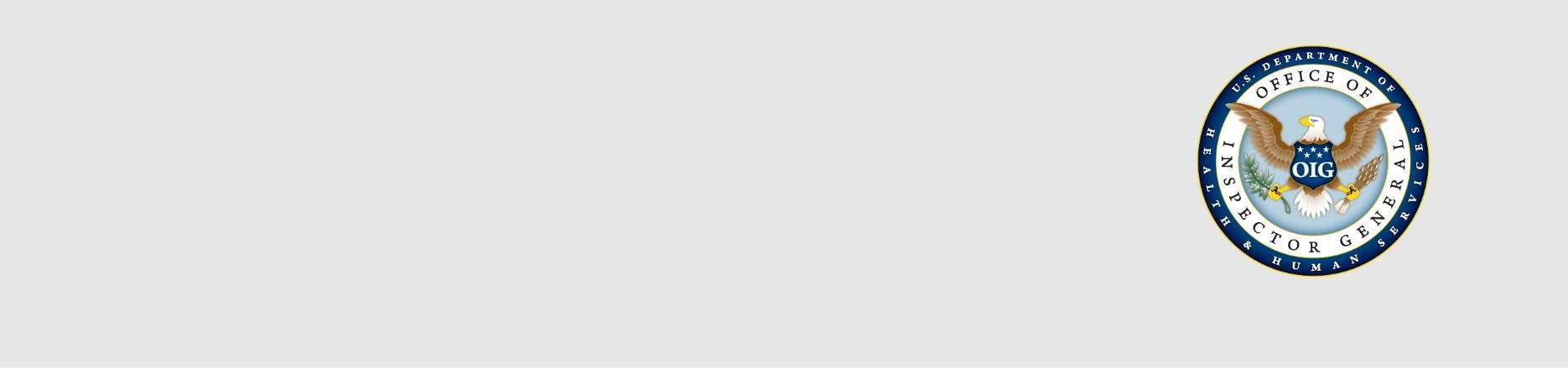
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Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020



U.S. Department of Health and Human Services

**Office of Inspector General**

**Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020**

**Purpose of the Review**

This review provides the Department of Health and Human Services (HHS) and other decision-makers (e.g., State and local officials and other Federal agencies) with a national snapshot of hospitals’ challenges and needs in responding to the coronavirus 2019 (COVID-19) pandemic. This is not a review of HHS response to the

COVID-19 pandemic. We have collected this information as an aid for HHS as it continues to lead efforts to address the public health emergency and support hospitals and other first responders. In addition, hospitals may find the information about each other’s strategies useful in their efforts to mitigate the challenges they are facing.

The hospital input that we describe reflects their experiences and perspectives at a point in time—March 23–27, 2020. The pandemic is fast-moving, as are the efforts to address it. We recognize that HHS, Congress, and other government entities across the Federal, State, local, and Tribal levels are taking substantial actions on a continual basis to support hospitals in responding to COVID-19. HHS has already taken and continues to take actions related to each of the challenges that hospitals identified in our survey, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act provides the basis for additional actions. We present this information for HHS’s and other decision-makers’ consideration as they continue to respond to the COVID-19 pandemic.

**Key Takeaway**

Hospitals reported that their most significant challenges centered on testing and caring for patients with known or suspected COVID-19 and keeping staff safe. Hospitals also reported substantial challenges maintaining or expanding their facilities’ capacity to treat patients with COVID-19. Hospitals described specific challenges, mitigation strategies, and needs for assistance related to personal protective equipment (PPE), testing, staffing, supplies and durable equipment; maintaining or expanding facility capacity; and financial concerns.

**How OIG Did This Review**

This information is based on brief telephone interviews (“pulse surveys”) conducted March 23–27, 2020, with hospital administrators from 323 hospitals across 46 States, the District of Columbia, and Puerto Rico, that were part of our random sample. Our rate of contact was 85 percent. Interviews focused on three key questions:

1. What are your most difficult challenges in responding to COVID-19?
2. What strategies is your hospital using to address or mitigate these challenges?
3. How could government best support hospitals responding to COVID-19?

Respondent hospitals included Special Pathogen Centers, critical access hospitals, and a range of hospitals nation-wide of various sizes and characteristics. At the time of our surveys, most hospitals reported they were treating patients with confirmed or suspected COVID-19, but some were not currently treating any patients with confirmed or suspected COVID-19. (See Methodology on pages 18–20 for additional information.)

## Findings at a Glance: Hospital Challenges

|  |
| --- |
| **Severe Shortages of Testing Supplies and Extended Waits for Results** |
| Hospitals reported that severe shortages of testing supplies and extended waits for test results limited hospitals’ ability to monitor the health of patients and staff. Hospitals reported that they were unable to keep up with COVID-19 testing demands because they lacked complete kits and/or the individual components and supplies needed to complete tests. Additionally, hospitals reported frequently waiting 7 days or longer for test results. When patient stays were extended while awaiting test results, this strained bed availability, personal protective equipment (PPE) supplies, and staffing. |
| **Widespread Shortages of PPE** |
| Hospitals reported that widespread shortages of PPE put staff and patients at risk. Hospitals reported that heavier use of PPE than normal was contributing to the shortage and that the lack of a robust supply chain was delaying or preventing them from restocking PPE needed to protect staff. Hospitals also expressed uncertainty about availability of PPE from Federal and State sources and noted sharp increases in prices for PPE from some vendors. |
| **Difficulty Maintaining Adequate Staffing and Supporting Staff** |
| Hospitals reported that they were not always able to maintain adequate staffing levels or offer staff adequate support. Hospitals reported a shortage of specialized providers needed to meet the anticipated patient surge and raised concerns that staff exposure to the virus may exacerbate staffing shortages and overwork. Hospital administrators also expressed concern that fear and uncertainty were taking an emotional toll on staff, both professionally and personally. |
| **Difficulty Maintaining and Expanding Hospital Capacity to Treat Patients** |
| Capacity concerns emerged as hospitals anticipated being overwhelmed if they experienced a surge of patients, who may require special beds and rooms to treat and contain infection. Many hospitals reported that post-acute-care facilities were requiring negative COVID-19 tests before accepting patients discharged from hospitals, meaning that some patients who no longer required acute care were taking up valuable bed space while waiting to be discharged. |
| **Shortages of Critical Supplies, Materials, and Logistic Support** |
| Hospitals reported that shortages of critical supplies, materials, and logistic support that accompany more beds affected hospitals’ ability to care for patients. Hospitals reported needing items that support a patient room, such as intravenous therapy (IV) poles, medical gas, linens, toilet paper, and food. Others reported shortages of no-touch infrared thermometers, disinfectants, and cleaning supplies. Isolated and smaller hospitals faced special challenges maintaining the supplies they needed  and restocking quickly when they ran out of supplies.  *(Note: this document was modified from original for demo purposes)* |

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FINDINGS

## Hospitals reported that their most significant challenges centered on testing and caring for patients with COVID-19 and keeping staff safe

Hospitals across the country reported facing similar challenges, regardless of which stage of the process

they were in—treating patients with coronavirus 2019 (COVID-19), testing patients who were potentially infected, or preparing to treat COVID-19 patients in the near future. The most commonly reported challenges centered on hospitals’ efforts to confirm cases of COVID-19, to keep health care staff safe, and to provide needed services to patients requiring hospital care for a wide array of medical reasons, including COVID-19. Challenges included difficulties related to testing, lack of personal protective equipment (PPE), and staffing, including specialized staffing.

### Hospitals reported that severe shortages of testing supplies and extended waits for test results limited hospitals’ ability to monitor the health of patients and staff

#### Hospitals explained that they were unable to keep up with testing demands because they lacked complete kits and/or the individual components and supplies needed to complete tests, such as nasal swabs, viral transfer media, and reagents used to detect the virus.

These shortages left hospitals unable to effectively test staff, patients, and others in the community who

reported that they were concerned about possible exposure. One hospital administrator said that across the industry, “millions [of tests] are needed, and we only have hundreds." Without access to needed testing materials, some hospitals described dividing the media in COVID-19 kits in half to double their capacity and resorting to using the transfer media in flu and strep kits to provide testing.

**Hospitals described extended waits for COVID-19 test results.** Hospitals reported frequently waiting 7 days or longer for test results. According to one hospital, 24 hours would typically be considered a long turnaround time for virus testing. Hospitals’ reliance on external laboratories contributed to delays, particularly as these laboratories became overwhelmed with tests to process from around the State or country. Hospitals also reported delays related to infrequent specimen pickups, mailing delays, and labs’ restrictive business hours. Some hospitals described success getting results more quickly by using commercial labs, whereas others received more timely results from public sources. Still others experienced inconsistent turnaround times, leaving them unable to predict when results would arrive or advise patients on how long they should self-quarantine or undertake other measures while awaiting results.

**Testing challenges exacerbated other challenges, including bed availability, PPE supplies, and staffing shortages.** Hospitals reported that to prevent the spread of the virus in the hospital and community, they were treating symptomatic patients as presumptive positive cases of

COVID-19 (i.e., an individual with symptoms that strongly indicate COVID-19 and tests have ruled out

similar conditions, but without a positive COVID-19 test result). The scarcity of COVID-19 tests and length of time it took to get test results back meant presumptive positive patients greatly strained bed availability, PPE supplies, and staffing, as noted in Exhibit 1.

#### Exhibit 1 is a chart showing that hospitals reported that the lack of testing supplies and delays in receiving test results caused additional challenges. [first block] Patients stayed in beds longer and experienced delays in transfers while they waited for tests and/or test results. [second block] Staff used PPE in interactions with patients that they may not have needed to use. [third block] Staff may not have known whether they were exposed to patients with the virus or if they had the virus. To avoid potentially spreading the virus, staff may have stopped providing clinical care while unsure if they were contagious. Exhibit 1: Hospitals reported that the lack of testing supplies and delays in receiving test results caused additional challenges.

Hospitals reported that some presumptive positive patients remained in the hospital for days while awaiting test results, which reduced the hospitals’ availability of beds for other patients. One hospital that was holding presumptive positive patients in intensive care unit beds reported that testing with a quick turnaround would free up bed availability and increase patient and staff safety. An administrator at another hospital noted that the sooner the hospital knows whether patients are negative, the faster it can move them to a lower level of care that consumes fewer resources. As one administrator put it, "sitting with 60 patients with presumed positives in our hospital isn't healthy for anybody."

### Hospitals raised concerns that widespread shortages of PPE put staff and patients at risk

Hospitals across the country reported that a shortage of PPE was threatening their ability to keep staff

safe while they worked to treat patients with COVID-19. The most commonly needed PPE items reported were masks (including N95 masks, surgical masks, and face shields), followed by gowns and gloves.

**Hospitals reported that heavier than normal use of PPE contributed to shortages.** The administrator of one hospital stated that before COVID-19, the hospital’s medical center used around 200 masks per day and that it was now using 2,000 per day. Delays in test results led to heavier use of PPE until a patient’s status was confirmed. Another hospital administrator noted the “fear factor” associated with COVID-19, which led to all staff wearing masks instead of only a subset. One hospital administrator reported that some supply distributors limited the quantity of supplies that any one hospital could order, which meant that even with no COVID-19 patients, the hospital was depleting PPE faster than it could restock. Even among hospitals that reported that they currently had enough PPE, some noted that a surge in patients would quickly deplete their supplies. One hospital noted that with its high “burn” rate (i.e., rate of use), its inventory of PPE would last only 3 more days. Another hospital administrator expressed a common concern: not wanting to put employees in a position that “endangers their lives and the lives of their families because [they] do not have PPE.”

*(Note: this document was modified from original for demo purposes)*

### Communication and information

Hospitals told us that they thought the Federal Government could play a central role in messaging and communications to mitigate what they perceived to be conflicting or inconsistent guidance across levels of government, as discussed in the challenges.

Hospitals wanted the government to:

* + provide evidence-based guidance (and as an example, they highlighted the usefulness of CDC’s

guidance on conserving N95 masks);

* + provide reliable predictive models and data that would help them plan and prepare; and
  + provide a single place to find the information they need, including information on the

COVID-19 disease, guidance from agencies, and instructions for processes they need to follow, such as how to apply for waivers from certain requirements.

# CONCLUSION

This report provides information about hospitals’ experiences and perspectives in responding to COVID-19 at a point in time—March 23–27, 2020. The pandemic is fast-moving, as are the efforts to address it. Since our interviews, some hospital challenges may have worsened and others may have improved. Hospitals reported that their most significant challenges centered on testing and caring for

patients with known or suspected COVID-19 and keeping staff safe. Hospitals also reported substantial

challenges maintaining or expanding their facilities’ capacity to treat patients with COVID-19.

We recognize that HHS, Congress, and other Federal, State, local, and Tribal entities are taking substantial action on a continual basis to support hospitals as they work on the frontlines to treat patients, ensure the safety of the health care workforce, and protect communities. We present this information for HHS’s and other decision-makers’ consideration as they continue to respond to the COVID-19 pandemic. In addition, hospitals may find the practical information about other hospitals’ strategies useful as they confront the many challenges they face in fulfilling their mission.

# BACKGROUND

## Hospital Response to the COVID-19 Pandemic

The emergence of COVID-19 has created unprecedented challenges for the U.S. hospital system.3 As frontline responders, hospitals have significant responsibilities for identifying and treating patients with COVID-19. Hospitals around the country are adapting to the constantly changing face of the

COVID-19 pandemic by adopting both expected and novel strategies to tackle the crisis. (See Appendix A on pages 21–25 for a list of hospital strategies reported.)

## The Emergence of COVID-19

Four main sub-groupings of coronaviruses commonly circulate among humans worldwide, typically causing mild to moderate upper respiratory tract illnesses, and their incidence usually peaks annually in the United States during the winter months.4, 5, 6 COVID-19 is a highly contagious coronavirus.7 Common symptoms include fever, tiredness, dry cough, and shortness of breath, and it can be fatal in some cases.8

The first reported instances of COVID-19 occurred in Wuhan, Hubei Province, China, in December 2019 and January 2020.9 On January 13, 2020, the first patient with COVID-19 was reported outside of China, and the first patient in the U.S. was reported 7 days later.10 In late-February 2020, a hospital in California documented the first community spread transmission of COVID-19, meaning the illness was acquired through an unknown exposure in the community in the U.S.11

On March 11, 2020, the World Health Organization characterized COVID-19 as a pandemic, which refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.12, 13 As of April 3, 2020, CDC reported 239,279 confirmed cases in the U.S. and 5,443 deaths.14

## Role of HHS in Emerging Infectious Disease Preparation and Response

HHS is the lead federal agency responsible for medical support and coordination during public health

emergencies, such as emerging infectious disease (EID) outbreaks. HHS operating divisions involved in the Federal response to EIDs, including the current COVID-19 response, include the Office of the Assistant Secretary for Preparedness and Response (ASPR), CDC, CMS, and the Food and Drug Administration (FDA).15

*(Note: this document was modified from original for demo purposes)*

# METHODOLOGY

## Data Collection and Scope

We conducted a “pulse survey” (i.e., quick, point-in-time questions) by telephone (or in a few cases, by email) with administrators from a random sample of Medicare-certified hospitals across the nation and in some cases, their parent corporations. These conversations focused on three key issues regarding their COVID-19 response: 1) challenges responding to the COVID-19 pandemic, 2) strategies to mitigate the challenges, and 3) needs for government assistance.

We conducted the surveys on March 23–27, 2020 with one or more administrators. The positions of these hospital administrators were typically Chief Executive Officer, Chief Medical Officer, or representatives from teams and departments dedicated to emergency preparedness or incident command. In some cases, leadership from the relevant hospital networks participated in the interviews alongside hospital administrators or on the hospitals’ behalf.

## Hospital selection and response

We had previously selected a stratified random sample of 410 hospitals for an October 2018 report examining hospital preparedness for EIDs.39 We selected the 410 hospitals from

4,489 Medicare-certified hospitals with emergency departments in 2016, located in 47 States, the District of Columbia, and Puerto Rico. The sample was comprised of two strata: (1) all

10 ASPR-designated Special Pathogen Centers, and (2) 400 other hospitals with emergency departments.

For this review, we used the same sample, but removed 12 hospitals that were no longer in operation or no longer providing inpatient care, and 18 hospitals that were under investigation by OIG. This left a total sample of 380 hospitals that we attempted to survey.

We received responses from 323 of these 380 hospitals, for an 85 percent rate of contact. Among the hospitals that did not respond, 9 chose not to participate, and we were unable to contact 48 after a minimum of three attempts during the 5-day data collection period.40

The responding hospitals are located across 46 States, the District of Columbia, and Puerto Rico. Most survey responses were provided directly by an administrator for a single hospital. However, for

46 sampled hospitals, we spoke with administrators from their parent corporation instead of, or in addition to, the hospital administrators. We considered the interviews with the administrators from the parent companies to be responses for each of the hospitals in our sample that were owned by those companies. These 46 hospitals were spread across 16 hospital networks.

The following two pages provide additional information about the hospitals that responded.

#### Exhibit 2: Hospital Respondents, March 24-27, 2020 is a 2-part graph. Chart 1 is a stacked bar graph showing most hospitals that we interviewed were currently treating patients with confirmed or suspected Coronavirus Disease 2019 (COVID-19): 117 hospitals reported they were treating one or more patients with confirmed COVID-19; 130 hospitals reported they were treating one or more patients with suspected COVID-19; 32 hospitals reported not treating any patients with confirmed or suspected COVID-19 at the time; 44 hospitals did not report this hospital-specific information. Chart 2 is a horizontal bar graph -- We interviewed hospitals with a range of bed counts: More than 500 beds„29; 101-500 beds„131; 51-100 beds--39; 1-50 beds„124. Exhibit 2: Hospital Respondents, March 23–27, 2020.

**Exhibit 3: The 323 hospitals that we interviewed were located in 46 States, as well as the District of Columbia and Puerto Rico.**



**Exhibit 4: Among the 323 hospitals that we interviewed, some are designated as specialized hospitals.**

**Limitations**

We have three limitations: 1) hospital responses reflect a point in time (March 23–27, 2020), but the pandemic is fast-moving, as are efforts to address it. Since our interviews, some hospital challenges may have worsened and others may have improved; 2) we did not independently verify the information reported by hospital administrators. Rather, we report on hospitals’ experiences and perceptions as they were conveyed to OIG; and 3) our analysis found some evidence of response bias. Specifically, larger hospitals appear to be under-represented in the pool of respondents and as a result, their views may be under-represented.

**Standards**

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

# APPENDIX A – STRATEGIES REPORTED BY HOSPITALS

The following are specific strategies reported by hospitals divided by topic areas: 1) securing PPE, other

equipment, and supplies for staff; 2) ensuring adequate staffing to treat patients with COVID‑19;

3) reducing employee anxiety and stress; 4) managing patient flow and hospital capacity; and

5) securing ventilators and alternative equipment to support patients. We note that these strategies are self-reported by the hospitals and OIG has not validated their effectiveness or safety.

## Strategies to secure the necessary PPE, equipment, and supplies for staff

|  |
| --- |
| **Seeking Alternative Sources of PPE** |
| To supplement limited supplies, hospitals reported improvising PPE and reaching out to non-traditional sources or the community to acquire PPE.   * Using non-traditional sources of PPE, such as online retailers, home supply stores, paint stores, autobody supply shops, and beauty salons. * Using 3D printers and office supplies to make PPE (e.g., masks). * Repurposing masks from other industries such as dentists, veterinarians, construction workers, nail salons, etc. * Purchasing expired PPE. * Considering other materials to substitute for needed supplies (e.g., sandwich bags as thermometer covers, blending ultrasound gel and alcohol from a local distillery to make hand sanitizer). * Creating supply by accepting handmade gowns and masks from community volunteers or local businesses. |
| **Implementing Methods to Extend PPE Usage** |
| To conserve existing PPE, hospitals reported implementing procedures to extend and/or reuse PPE.   * Reusing PPE (e.g., disposable masks, face shields, and gowns). * Sanitizing PPE (e.g., face shields and masks) between use. * Reducing the extent and frequency of patient interaction to reduce PPE burn. * Physically securing PPE to prevent theft or misuse. * Limiting use of PPE to certain staff or patients (e.g., intensive care unit staff or patients). |

*(Note: this document was modified from original for demo purposes)*

APPENDIX B - GLOSSARY OF KEY TERMS

**Office of the Assistant Secretary for Preparedness and Response (ASPR):** HHS staff division that leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR is assisting organizations to prepare for and respond to the COVID-19 outbreak.

**Centers for Disease Control and Prevention (CDC):** HHS operating division tasked with protecting the public health and safety through the control and prevention of disease, injury, and disability in the U.S. and internationally. CDC is studying COVID-19 worldwide and helping communities prepare and respond locally.

**Centers for Medicare & Medicaid Services (CMS):** HHS operating division that administers the Medicare program and works in partnership with State governments to administer Medicaid, the Children's Health Insurance Program, and health insurance portability standards. CMS is issuing clinical and technical guidance for providers and beneficiaries about COVID-19.

**Community spread:** Spread of an illness for which the source of the infection is unknown.

**Coronavirus disease 2019 (COVID-19):** An illness of the respiratory tract that is highly contagious. Symptoms include a cough, a high temperature (fever), and shortness of breath, and can be fatal in some cases. Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is the virus that causes COVID-19 and is often called the COVID-19 virus; its prior name was the 2019 novel coronavirus (2019- nCoV).

**Critical Access hospital (CAH):** Rural primary health care hospital that gives limited outpatient and inpatient hospital services to people in rural areas. CAHs are designated by CMS, and to qualify these facilities must meet certain conditions such as: furnishing 24-hour emergency care services 7 days a week, having no more than 25 inpatient beds, and having an average length of stay of 4 days or less per patient for acute-care services. CMS is waiving requirements that CAHs limit the number of beds to 25 and length of stay of 4 days.

**Emerging infectious disease (EID):** Infections that have recently appeared within a population or those whose incidence or geographic range is rapidly increasing or threatens to increase in the near future.

**Epidemic:** Refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area.

**Federal Emergency Management Agency (FEMA):** Federal agency under the U.S. Department of Homeland Security that coordinates responses to natural disasters with State and local governments and provides Federal assistance.

*(Note: this document was modified from original for demo purposes)*

# ACKNOWLEDGMENTS AND CONTACT

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This report was prepared under the direction of Blaine Collins and Ruth Ann Dorrill, Regional Inspectors General for Evaluation and Inspections in the San Francisco and Dallas regional offices, and Abby Amoroso and Amy Ashcraft, Deputy Regional Inspectors General.

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# ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

**The Office of Audit Services (OAS)** provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

**The Office of Evaluation and Inspections (OEI)** conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

**The Office of Investigations (OI)** conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

**The Office of Counsel to the Inspector General (OCIG)** provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG’s internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# ENDNOTES

1 Coronavirus Aid, Relief and Economic Security (CARES) Act of 2020, P.L. No. 116-136 (enacted Mar. 27, 2020).

2 Actions that HHS has taken related to significant hospital challenges and suggestions include, but are not limited to, the following examples. Pursuant to the CARES Act, CMS will allow hospitals, critical access hospitals, and other Medicare providers and suppliers to request advance payment for 3 to 6 months of future Medicare claims. On March 30, 2020, CMS announced an array of regulatory changes to increase hospitals’ and other health care providers’ flexibility in responding to this pandemic. This includes enabling hospitals to leverage alternative sites (such as ambulatory surgical centers, hotels, and dormitories) to provide hospital services. CMS also made changes to increase the services that can be provided via telehealth and to make Medicare payments for services provided via telehealth equal to the traditional payment rates. In addition, CMS has temporarily waived certain regulations that may restrict how hospitals use physicians or contracted staff due to business or financial relationships. Specific information about these and many other HHS actions and resources is available at [https://www.hhs.gov/about/news/coronavirus/index.html.](https://www.hhs.gov/about/news/coronavirus/index.html)

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