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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness

NATIONAL REVIEW | REPORT # 20-03076-217 | JULY 16, 2020

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Executive Summary

The COVID-19 pandemic has presented significant challenges to healthcare delivery worldwide.[1] While many healthcare systems have well-developed plans for regional disasters such as catastrophic weather events, a global pandemic that unpredictably targets patients, equipment supply chains, healthcare staff, and an economy, can crumble even the most thoughtful and comprehensive emergency management plans. This novel and highly contagious virus has challenged scientists, clinical providers, and policy makers due to the unpredictability of its course. Further complicating matters is that strategies aimed at reducing further transmission are continually evolving.

Like many healthcare systems, the Veterans Health Administration (VHA) developed a plan to mitigate the impact of COVID-19 on veterans, their families, and the staff charged with caring for them. VHA's Office of Emergency Management issued the *COVID-19 Response Plan Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* on March 23, 2020.[2] The plan describes a four-phase approach, with each phase detailing a series of strategies and actions to mitigate risk and impact related to the outbreak, limited resources, and recovery needs. Notably, because each geographic region, and thus each facility, may be facing unique burdens at any given time, one facility may be heavily engaged in an initial response, while another facility in a different region of the country could be focusing on recovery efforts.

On March 26, 2020, the OIG published its first COVID-19-focused report, *OIG Inspection of Veterans Health Administration COVID-19 Screening and Pandemic Readiness*.[3] In that report, the OIG evaluated processes related to screening, facility entry restrictions, and overall facility readiness to meet unpredictable but potentially overwhelming demands. To continue monitoring VHA's readiness, OIG teams engaged leaders from 70 selected facilities in discussions about patient-care services provided from March 11, 2020, through June 15, 2020, in three clinical settings: (1) inpatient (acute care) and outpatient care, (2) community care, and (3) community

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[1] COVID-19 (coronavirus disease) is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a newly discovered coronavirus. *The World Health Organization, Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It.* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causes-it. (The website was accessed on June 22, 2020.)

[2] Veterans Health Administration—Office of Emergency Management, *COVID-19 Response Plan Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, Version 1.6, March 23, 2020. Department of Veterans Affairs, *VA Releases COVID-19 Response Plan*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5405. While the document was issued for official use on March 23, 2020, it was not publicly available until March 27, 2020.

[3] VA OIG, *OIG Inspection of Veterans Health Administration COVID-19 Screening and Pandemic Readiness,* Report No. 19-09017-64, March 26, 2020.

living centers (CLCs). The discussions, guided by site-specific data related to primary and specialty care appointment management, covered the management of urgent and emergent care, the adequacy of equipment and supplies, testing capabilities, CLC admissions and discharges, testing protocols, and the engagement and response of community healthcare partners. Discussions also detailed Veterans Integrated Service Network leaders' involvement and overall support of facility operations.[4] Finally, the OIG team provided facility leaders the opportunity to comment on plans to manage anticipated COVID-19 surges.

During the time frame under review, VA-provided statistics indicated the following:

- The peak number of veterans with suspected or confirmed COVID-19 per day was 433 (on April 23, 2020).
- Of the veterans who received care at VA, 1,536 veterans died of the disease or complications related to it.[5]
- Despite a large number of veterans considered to be in high-risk categories as designated by the Centers for Disease Control and Prevention, most veterans who became ill with COVID-19 from March 11 through June 15, 2020, were convalescent.[6] Of the total number of 18,016 positive cases, 16,275 were convalescent.[7]

Similar to its March 26, 2020, report, the OIG found that VHA leaders and frontline staff exhibited a strong commitment and dedication to veterans and their families in an extremely dynamic and high-risk environment. Conversations with facility leaders indicated, and this report recounts, the enormous but necessary response on the part of VHA to carry out its mission to veterans, including potentially nonveteran patients as well. While "lessons learned" may be a premature concept for this evolving event, this report can and should serve as an opportunity for

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[4] VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020. Government Accountability Office. *Veterans Health Administration Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities, June 19, 2019*. https://www.gao.gov/reports/GAO-19-462/. (The website was accessed on June 30, 2020.) VHA facilities are organized into 18 Veterans Integrated Service Networks that manage day-to-day functions of medical centers as well as provide administration and clinical oversight.

[5] Department of Veterans Affairs National Surveillance Data, https://app.powerbigov.us/groups/me/apps/5b3696b5-ace4-44c8-9e0d-53eca3c29171/reports/93a22c14-7964-4b6f-93d2-ba853297fe4f/ReportSection3dd692a49dd2b508b812?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (The website was accessed on June 27, 2020. This is an internal website that is not accessible to the public.)

[6] Centers for Disease Control and Prevention. *People Who Are at Higher Risk for Severe Illness*. *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html*, June 25, 2020. Department of Veterans Affairs, *COVID-19 National Summary*, June 28, 2020. https://www.accesstocare.va.gov/Healthcare/COVID-1919NationalSummary. (The website was accessed on June 28, 2020.) Per National Summary definitions, convalescent cases include patients "tested or treated at a VA facility for known or probable COVID-19 who are either post-hospital discharge, or 14 days after their last positive test, whichever comes later."

[7] Department of Veterans Affairs, *COVID-19 National Summary*, June 28, 2020. https://www.accesstocare.va.gov/Healthcare/COVID-1919NationalSummary. (The website was accessed on June 28, 2020.)

VHA leaders as well as other healthcare leaders to share experiences that ultimately will make further responses more efficient and more effective should such a need arise.

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Abbreviations

CDC	Centers for Disease Control and Prevention
CLC	community living center
COVID-19	coronavirus disease
EHR	electronic health record
HCS	Health Care System or Healthcare System
OIG	Office of Inspector General
PPE	personal protective equipment
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) facility leaders' assessments of healthcare operations affected by COVID-19 from March 11, 2020, through June 15, 2020. The OIG engaged leaders from 70 selected facilities in discussions about patient-care services provided in three clinical settings: (1) inpatient (acute care) and outpatient care, (2) community care, and (3) community living centers (CLCs).[1] Facility leaders also commented on lessons learned and plans to manage anticipated COVID-19 surges.[2]

COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a newly discovered coronavirus.[3] Since its appearance in 2019, knowledge about the mode of transmission and the severity of associated illnesses has been evolving.[4] On March 11, 2020, due to its "alarming levels of spread and severity," the World Health Organization declared COVID-19 a pandemic.[5] The need to prepare for an influx of patients challenged VHA and the delivery of healthcare nationwide.

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[1] Department of Veterans Affairs, *Community Care Overview*. https://www.va.gov/communitycare/. (The website was accessed July 1, 2020.) "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans." VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. VA CLCs, formerly known as nursing homes or nursing home care units, provide a skilled nursing environment that offers a variety of specialty programs for persons needing short- and long-stay services.

[2] Within the context of this report, the OIG uses the term "surge" to indicate a significant increase in the number of patients with COVID-19. According to a June 25, 2020, Centers for Disease Control and Prevention teleconference, the U.S. is not experiencing a second wave. Centers for Disease Control and Prevention, *Transcript for the CDC Telebriefing Update on COVID-19, June 25, 2010*. Director Robert Redfield stated, "We're still in the first wave and that first wave is taking different shapes."

[3] World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It.* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causes-it. (The website was accessed on June 22, 2020.)

[4] Veterans Health Administration—Office of Emergency Management, *COVID-19 Response Plan Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6,* March 23, 2020. A pneumonia of unknown cause was first reported to a World Health Organization Country Office on December 31, 2019. The virus was later named SARS-CoV-2 and the disease it causes named coronavirus disease 2019 (COVID-19). Centers for Disease Control and Prevention, *How COVID-19 Spreads*, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-COVID-19-spreads.html. (The website was accessed on June 22, 2020.).

[5] World Health Organization, *WHO Director-General's Opening Remarks at the Media Briefing on COVID-19,* March 11, 2020. https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020. (The website was accessed on June 22, 2020.)

The National Center for Veterans Analysis and Statistics projections for fiscal year 2019 and VA's current enrollment data indicate that 6.6 million, of the approximately 20 million American veterans, use VA healthcare services.[6] From March 11 through June 15, 2020, the peak number of veterans with suspected or confirmed COVID-19 per day was 433 (on April 23, 2020). Of the veterans who received care at VA, 1,536 veterans died of the disease or complications related to it during the time frame under review (see figure 1).[7] Despite a large number of veterans considered to be in high-risk categories as designated by the Centers for Disease Control and Prevention (CDC), most veterans who became ill with COVID-19 from March 11 through June 15, 2020, were convalescent.[8]

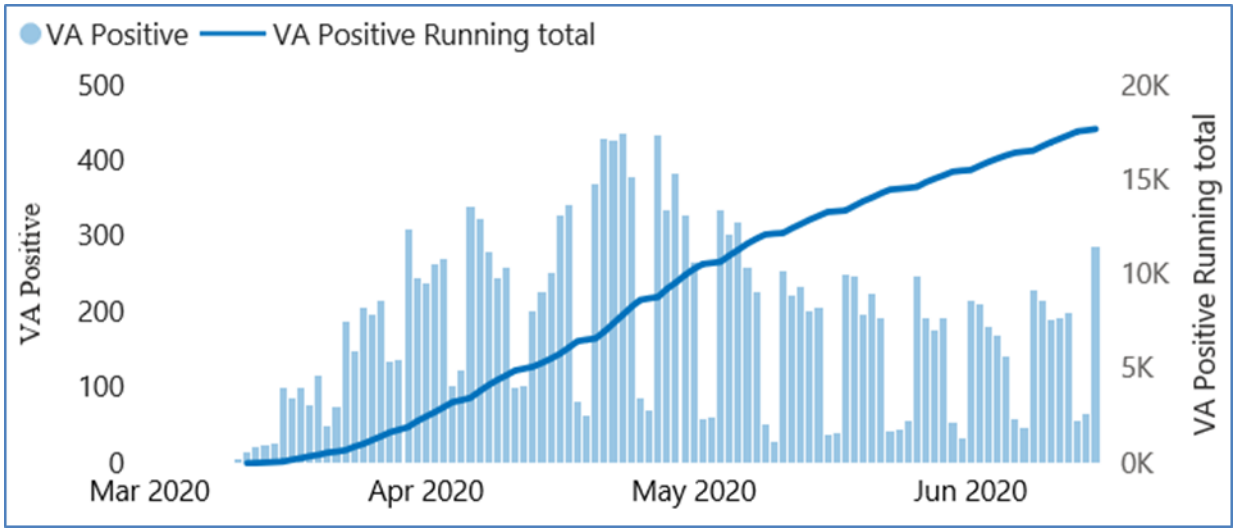

Figure 1. Number of positive COVID-19 cases by day and running total of positive cases (dark blue line) (March 11–June 15, 2020)
Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 National Summary[9]

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[6] Department of Veterans Affairs, *VA Utilization Profile, FY [Fiscal Year] 2017,* May 2020. https://www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile_2017.pdf. (The website was accessed on June 29, 2020.)

[7] Department of Veterans Affairs National Surveillance Data, https://app.powerbigov.us/groups/me/apps/5b3696b5-ace4-44c8-9e0d-53eca3c29171/reports/93a22c14-7964-4b6f-93d2-ba853297fe4f/ReportSection3dd692a49dd2b508b812?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (The website was accessed on June 27, 2020. This is an internal website not accessible to the public.)

[8] CDC. *People Who Are at Higher Risk for Severe Illness.* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. (The website was accessed on June 25, 2020.)

[9] Department of Veterans Affairs National Surveillance Tool Data Definitions. https://app.powerbigov.us/groups/me/apps/5b3696b5-ace4-44c8-9e0d-53eca3c29171/reports/93a22c14-7964-4b6f-93d2-ba853297fe4f/ReportSection3dd692a49dd2b508b812?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (The website was accessed on June 27, 2020. This is an internal website not accessible to the public.) "Cases include all VA confirmed and presumptive positive Veterans, Veteran employees, employees, and civilian humanitarian cases whose results have been included in VA data or who were tested in the VA system."

As of June 15, 2020, VA reported a total number of 18,016 positive cases; there were 138 active cases and 16,275 were convalescent.[10] On the same day, the CDC reported 2,104,346 total cases in the U.S. The CDC reported approximately 110,546 U.S. deaths related to COVID-19 that week.[11]

According to the CDC, the disease is mainly spread person-to-person through close contact with someone infected with SARS-CoV-2.[12] The most common way the virus is transmitted is through the exhalation of respiratory droplets (coughing, sneezing, or talking) that are inhaled by others in close proximity. Less commonly, the droplets may land on surfaces, where the virus survives for varying lengths of time. If a person touches an infected surface, then touches their eyes, nose or mouth, they may become infected.

Current evidence suggests that the risk of transmission is highest from close, prolonged contact with someone who is symptomatic. It is also possible for the virus to be spread by someone who has been infected but is without symptoms.[13] On June 4, 2020, the CDC indicated that the period of time individuals can remain infectious with COVID-19 is not yet known.[14]

The CDC provides infection prevention and control recommendations for healthcare personnel caring for patients with suspected or confirmed COVID-19.[15] The CDC recommends healthcare personnel utilize standard and transmission-based precautions, including the use of personal protective equipment (PPE) such as facemasks, eye protection, gloves, and gowns, when caring for patients with suspected or confirmed COVID-19.[16] VHA developed a

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[10] Department of Veterans Affairs, *COVID-19 National Summary*, June 28, 2020, https://www.accesstocare.va.gov/Healthcare/COVID-1919NationalSummary. (The website was accessed on June 28, 2020.) Per National Summary definitions, convalescent cases include patients "tested or treated at a VA facility for known or probable COVID-19 who are either post-hospital discharge, or 14 days after their last positive test, whichever comes later."

[11] CDC. *Trends in Number of COVID-19 Cases in the US Reported to CDC, by State/Territory.* https://www.cdc.gov/covid-data-tracker/#trends. (The website was accessed on July 1, 2020.)

[12] CDC. *How COVID-19 Spreads*. Close contact is considered to be within about six feet.

[13] CDC. *How COVID-19 Spreads*.

[14] CDC. *Clinical Questions about COVID-19: Questions and Answers.* https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html. (The website was accessed on June 22, 2020.)

[15] CDC. *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: Updated June 16, 2020*. https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html. (The website was accessed on June 23, 2020.)

[16] CDC. *Interim Infection Prevention and Control Recommendations, Updated June 16, 2020.* Occupational Safety and Health Administration, *Personal Protective Equipment.* Personal protective equipment, commonly referred to as "PPE" is equipment worn to minimize exposure to hazards that cause serious workplace injuries or illnesses. https://www.osha.gov/SLTC/personalprotectiveequipment/. (The website was accessed on June 22, 2020).

COVID-19 response plan (Response Plan) that was consistent with CDC guidance on the matter and issued it for official use on March 23, 2020.[17]

Prior OIG Report

During a March 2020 inspection to evaluate VHA's COVID-19 screening processes and pandemic readiness at selected medical facilities, the OIG observed VHA staff conducting screening at acute care facilities and CLCs, and interviewed VHA leaders on their facilities' readiness capabilities.[18] This current review continues the OIG's monitoring and oversight of VHA's efforts to provide safe quality healthcare to veterans and other patients in VHA facilities while also protecting VHA employees and preparing for anticipated surges and a crisis response during the pandemic.

Scope and Methodology

The OIG initiated the review on June 8, 2020. Two and three-person teams conducted virtual interviews with leaders at 70 facilities from June 15 through June 23, 2020. To understand the intent and scope of recommendations in the Response Plan, VHA leaders from the high-consequence infection workgroup that was convened in early 2020 and the Office of Emergency Management were also interviewed. OIG leaders and medical staff developed and refined a series of pandemic-related questions about facility operations for the period covering March 11, 2020, through June 15, 2020. These questions were presented as a series of yes, no, and open-ended questions. Due to the open-ended format for some of the questions, the issues that facility leaders focused on during the interviews varied.[19]

The facility leaders were interviewed on facility performance, community care engagement and coordination, and CLC operations during the time frame under review.[20] For the facility leaders responsible for more than one medical center (or campus), the OIG considered their response collectively for all the medical centers (or campuses) under their jurisdiction. The OIG did not assess the responses from facility leaders for accuracy or completeness.

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[17] VHA *Response Plan*, March 23, 2020. Department of Veterans Affairs, *VA Releases COVID-19 Response Plan*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5405. While the Response Plan was issued for official use on March, 23, 2020, it was not publicly available until March 27, 2020.

[18] VA OIG, *OIG Inspection of Veterans Health Administration COVID-19 Screening and Pandemic Readiness*, Report No. 19-09017-64, March 26, 2020. OIG staff drove to the selected sites and self-screened prior to the facility visits. To prevent the spread of COVID-19, OIG staff did not enter CLCs even if access was granted.

[19] For open-ended questions, the OIG generally did not tabulate responses quantitatively.

[20] Within the context of this review, the OIG uses the term facility to include healthcare systems, medical centers, and ambulatory care centers.

The Washington, DC, facility and at least one facility from each state and each Veterans Integrated Service Network (VISN) participated in the interviews (see appendix A for a list of participating facilities and figure 2 for an illustration of geographical locations).[21] Fifty-nine of the 70 selected facilities had CLCs located in 43 different states or the District of Columbia.[22]

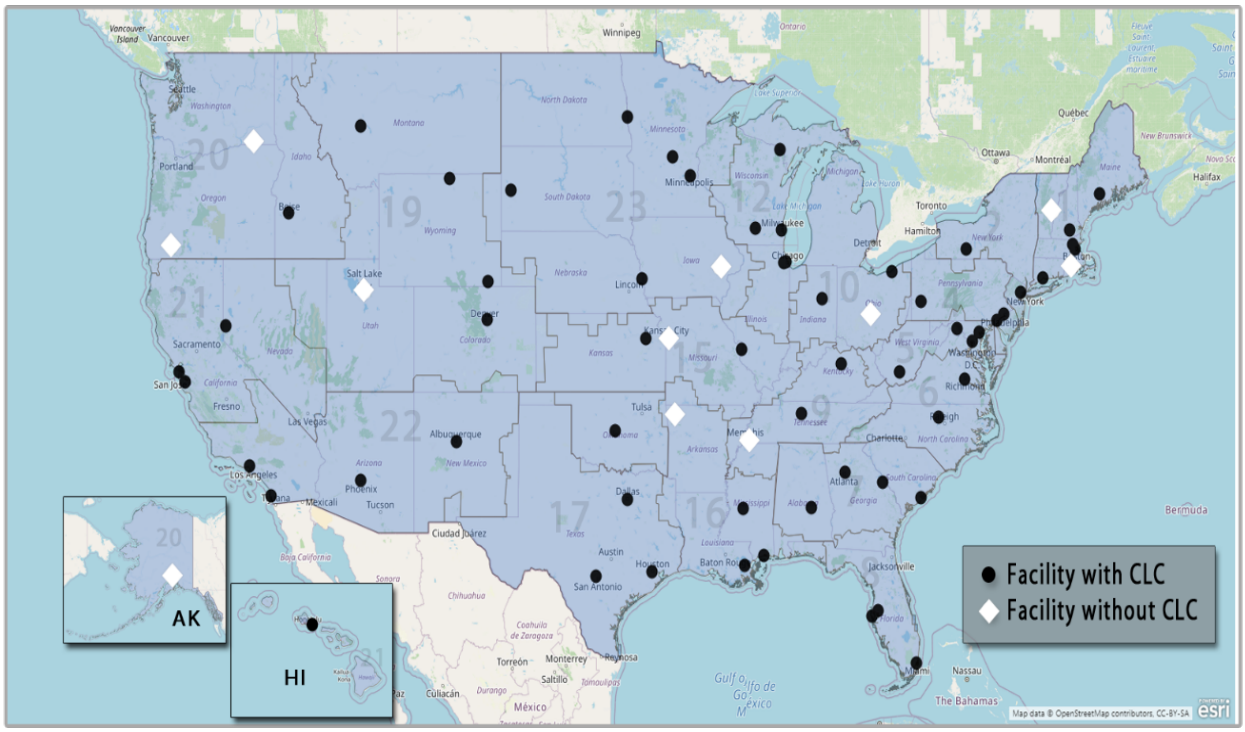

Figure 2. Map of VISNs (regions outlined in gray and numbered) as well as VHA facilities and CLCs virtually interviewed from June 15 through June 23, 2020
Note: VISN numbers are not consecutive; in the current categorization scheme, numbers 3, 11, 13, 14, and 18 are not in use.
Source: VA OIG

In advance of each scheduled interview, the OIG sent VHA data to facility leaders on certain outpatient procedures between February and May 2020, and on CLC admissions, discharges, and deaths between the end of March and as of May 2020, if applicable and available. This

[21] The OIG will continue to monitor VHA's response to other aspects of veterans' care during the COVID-19 crisis with a specific focus on telehealth, telemental health, emergency care, the Veterans Crisis Line, and community-based outpatient clinic operations. Other topics under review include the management of appointments and personal protective equipment inventory, financial oversight of supplemental funds, and the impact on homeless veterans with transitional housing assistance. In addition, responses to the COVID-19 crisis will be assessed as part of the OIG's Comprehensive Healthcare Inspection Program, a regularly scheduled review of each VHA facility's key clinical and administrative processes that occurs approximately every three years. https://www.va.gov/oig/publications/default.asp. (The website was accessed on June 27, 2020.)

[22] Selected facilities located in Alaska, Arkansas, Iowa, Oregon, Rhode Island, Utah, Vermont, and Washington did not have CLCs.

information was provided to guide discussions with facility leaders. There was no expectation for facility leaders to analyze or validate the information. The data are not discussed further in this report.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

VHA Office of Emergency Management COVID-19 Response Plan

VHA developed and issued the Response Plan on March 23, 2020, to mitigate COVID-19's impact on veterans, staff, and visitors at the facility level. According to VHA leaders who were interviewed, the Response Plan outlined what needed to be accomplished but did not prescribe specific actions. It focused on a four-phase approach.[23]

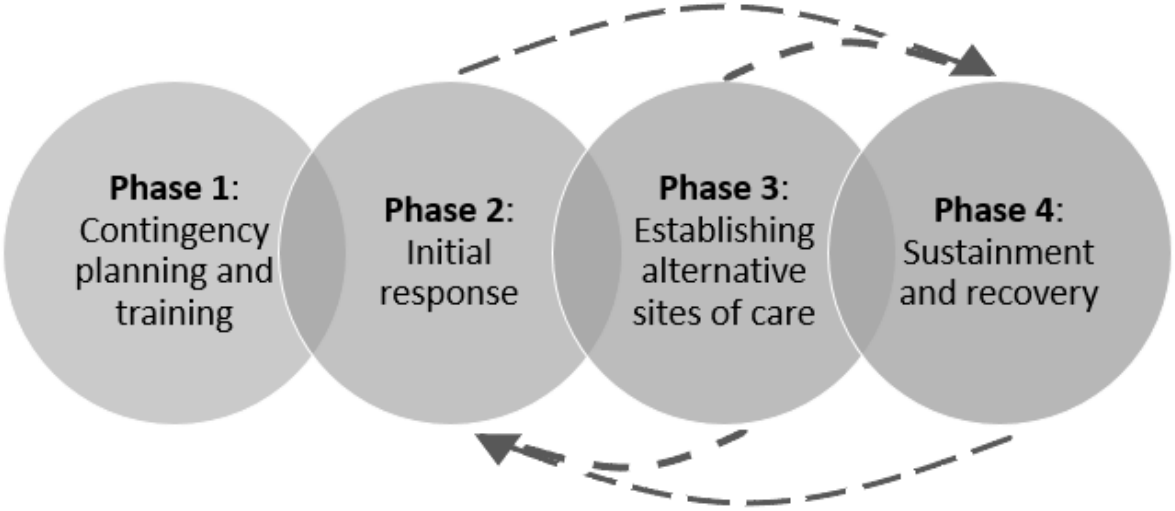

Figure 3: The four phases of the VHA Response Plan
Source: VHA Response Plan—individual facilities may be in different phases simultaneously. Due to the unknown course of COVID-19 or other events, a return to a previous phase may be necessary. Similarly, a facility may skip a phase as operations stabilize.

While this review was conducted during the time that many VHA facilities were in phase 2 (initial response), the OIG noted all facilities were expected to implement VHA's phase 1 plans to be ready to mount an initial response if and when outbreaks occurred.[24] Based on increases in knowledge and subject matter expertise, VHA national leaders frequently updated, revised, and issued additional guidance that reflected Response Plan, phase 1 strategies:

- Protect those not yet infected
- Shift priorities to prepare for an influx of patients

[23] VHA Office of Emergency Management, *COVID-19 Response Plan Incident-Specific Annex to the VHA High Consequence Infection (HCI) Base Plan,* March 23, 2020.

[24] VHA *Response Plan,* March 23, 2020. "The focus of the VHA's preparedness model has been to maintain an 'all hazards' core High Consequence Infection (HCI) response capability at all VA medical facilities."

- Leverage technology
- Coordinate with community partners to deliver supportive care to large populations of patients[25]

Two of the five strategies outlined in the Response Plan phase 2 focused on leadership responsibilities:

- Situational awareness
- Transparent communication across the enterprise[26]

Consistent with those strategies and a January 2020 VHA directive that assigned VISN directors the duty of maintaining continuity of operations during an emergency, the Response Plan specifically delegated some communication responsibilities as well as oversight of equipment and supplies to VISN directors.[27]

As noted specifically in the Response Plan, the other phase 2 strategies focused on the care and treatment of patients:

- Receive and triage veterans with suspected or confirmed COVID-19 infection.
- Provide acute and outpatient care for veterans with COVID-19.
- Maintain care for veterans without COVID-19 through telehealth services, a preferred delivery system, if possible.[28]

Should patient-care needs outpace capability, Response Plan phase 3 calls for activating alternate sites of care such as field hospitals or outlying wards to meet demand, adjusting activities to meet limited capabilities, and supporting local communities as possible.[29]

Response Plan phase 4 sustainment and recovery strategies address actions to take when the initial outbreak begins to wane and clinical operations begin to stabilize. Top priorities during

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[25] VHA *Response Plan*, March 23, 2020.

[26] VHA *Response Plan*, March 23, 2020.

[27] VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020. Government Accountability Office. *Veterans Health Administration Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities, June 19, 2019*. https://www.gao.gov/reports/GAO-19-462/. (The website was accessed on June 30, 2020.) VHA facilities are organized into 18 networks that manage day-to-day functions of medical centers as well as provide administration and clinical oversight. Department of Veterans Affairs, *2019 Functional Organizational Manual, Version 5, 2019.* Operational direction and guidance to each of the 18 VISNs is provided by the Deputy Under Secretary for Health for Operations and Management, VHA's designated focal point for the flow of information and guidance between the VA central office (VACO) and the field.

[28] VHA *Response Plan,* March 23, 2020.

[29] VHA *Response Plan,* March 23, 2020.

the stabilization phase would be preparing for a second wave; reinitiating services that had been curtailed; monitoring staff well-being; and rehabilitating (clean, service, and renew) rooms, equipment, and resources used in the response phase.[30]

Review Results

This review focused on actions taken by VHA after the World Health Organization's pandemic declaration on March 11, 2020, when facility leaders were transitioning from the planning and training phase of the Response Plan (phase 1) to focusing on an initial response and caring for patients (phase 2). The OIG recognizes that practices evolved as knowledge of COVID-19 increased over the time frame under review.

There was no pandemic plan specific to COVID-19 when VHA was first informed of a potential new infectious disease in January 2020.[31] A high-consequence infection workgroup of subject matter experts was established to address VHA's response.[32] On March 21, 2020, guidance on the management of patients with COVID-19, derived mainly from World Health Organization interim guidance, was issued by VHA's Deputy Under Secretary for Operations and Management to all VISNs.[33] In that document, VHA noted that knowledge about COVID-19 was rapidly evolving and urged clinicians to consult authoritative sources for information.[34]

Inpatient (Acute Care) and Outpatient Operations from March 11, 2020–June 15, 2020

VHA provides inpatient and outpatient care at more than 1,200 facilities in the U.S.[35] The facilities whose leaders participated in this review were located in areas with varied

[30] VHA *Response Plan*, March 23, 2020.

[31] VA Executive in Charge Letter to Senator Tester, March 4, 2020.

[32] Pelletier, Mark, *Conquering High Consequence Infections in a VA Hospital*. February 7, 2020. https://www.jointcommission.org/en/resources/news-and-multimedia/blogs/on-infection-prevention-control/2020/02/07/conquering-high-consequence-infections-in-a-va-hospital/. (The website was accessed on June 27, 2020.) A high-consequence infection is a moderate to highly contagious infection for which no known vaccine exists and which is a concern to public safety because of the morbidity and or mortality rate.

[33] Deputy Under Secretary for Health for Operations and Management, *Veterans Health Administration Standard Operating Procedure, Interim Guidance for Medical Management of Hospitalized COVID-19 Patients*, March 21, 2020.

[34] Deputy Under Secretary for Health for Operations and Management, *Veterans Health Administration Standard Operating Procedure, Interim Guidance for Medical Management of Hospitalized COVID-19 Patients*, March 21, 2020. The World Health Organization and CDC were considered authoritative sources.

[35] VA. *About VA Veterans Health Administration*. https://www.va.gov/health/. (The website was accessed on July 3, 2020.) The facilities consist of 170 medical centers and over 1,050 outpatient sites of care.

- Population densities (see table A.1 in appendix A for the number of enrolled patients, which ranged from approximately 20,000 to 195,000 veterans);
- Facility resources (for example, clinical services offered);
- Community restrictions (varying stay-at-home orders); and [36]
- Numbers of patients who presented with suspected or confirmed COVID-19 (see table A.1 in appendix A).

VHA Guidance

Specific actions outlined in the Response Plan to accomplish phase 2 patient-care strategies included establishing separate areas for patients with suspected and confirmed COVID-19 from those who were in need of standard health care (the two-zone approach).[37] In addition to postponing elective procedures and surgeries, facilities were advised to discharge patients from inpatient settings and limit inpatient admissions as possible. Other guidance included repurposing units to accommodate an influx of patients with COVID-19 and evaluating staff for reassignment and training. Triage stations would be located at main entrances for screening and directing patients and visitors to the proper zone.[38] According to VHA leaders who were interviewed, facilities were expected to adapt their practices to accomplish Response Plan goals based on local circumstances and resources. VHA leaders further stated that in the early weeks of the pandemic, actions taken by VISN and facility leaders were communicated to national leaders during daily calls.

For the outpatient setting, the Response Plan recommended postponing appointments for patients without symptoms of COVID-19 or at high risk of exposure, and educating patients to call before going to a clinic appointment.[39]

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[36] National Academy for State Health Policy, *Chart: Each State's Stay-at-Home Orders and Reopening Dates.* https://www.nashp.org/governors-prioritize-health-for-all/. (The website was accessed on June 26, 2020.)

[37] VHA *Response Plan*, March 23, 2020.

[38] VHA *Response Plan*, March 23, 2020. Deputy Under Secretary for Health for Operations and Management, *Coronavirus (COVID-19)—Guidance for Elective Procedures,* March 15, 2020. Deputy Under Secretary for Health for Operations and Management, *Guidance on Access to Care for Veterans*, March 30, 2020. VA OIG, *OIG Inspection of Veterans Health Administration COVID-19 Screening and Pandemic Readiness*, Report No. 19-09017-64, March 26, 2020. During the OIG's March 2020 inspection, visits to selected facilities were completed from March 19 through March 24, 2020. The OIG found that 41 of the 58 (71 percent) visited medical centers' screening processes were generally adequate; and 16 of the 58 (28 percent) medical centers had some opportunities for improvement. One facility, the Southern Arizona VA Health Care System, had inadequate screening processes.

[39] VHA *Response Plan*, March 23, 2020.

As noted above, telehealth was identified as the preferred delivery of care in all settings.[40]

Facility Leaders' Reported Actions

Through interviews with leaders from 70 facilities, the OIG learned of a multitude of actions taken to implement phase 2 strategies. Immediate actions were needed to assess the care needs of patients and determine whether procedures or appointments could be rescheduled or converted to virtual modalities. Facility leaders discussed distinct challenges in adapting available resources such as staffing, supplies, and environmental infrastructure in order to separate, isolate, and quarantine patients.[41]

Management of Nonurgent and Nonemergent Procedures

All facility leaders reported deprioritizing nonurgent and nonemergent procedures, which was consistent with the March VHA guidance that directed facilities to shift resources from elective procedures to only urgent and emergent ones.[42] Several facility leaders specifically mentioned clinically triaging appointments to determine if they were urgent or emergent.

As these examples indicate, facility leaders reported different strategies to meet patient-care needs while also prioritizing the safety of patients and staff:

- Leaders at the VA Connecticut Healthcare System in West Haven reported adjusting work hours and utilizing different workspaces to allow for spacing and distancing.
- Iowa City VA Medical Center (VAMC) leaders reported the use of thermal camera thermometers to take the temperatures of patients and staff as they entered the facility from a distance.
- Leaders at the Hunter Holmes McGuire VAMC in Richmond, Virginia, reported using iPads to communicate with patients on the COVID-19 ward to decrease unnecessary contact between patients and staff.
- Some facility leaders reported providing services to individuals in vehicles:
    - Leaders from the VA Pittsburgh Healthcare System in Pennsylvania and the Boston Healthcare System in Massachusetts reported swab testing from individuals in cars.

[40] VHA *Response Plan*, March 23, 2020.

[41] VHA *Response Plan*, March 23, 2020. Isolation is used to restrict the movement of ill persons. Quarantine is used to restrict the movement of well persons who may have been exposed to see if they become ill.

[42] Deputy Under Secretary for Health for Operations and Management, *Coronavirus (COVID-19) - Guidance for Elective Procedures,* March 15, 2020.

  - Leaders from the Beckley VAMC in West Virginia; the Fort Meade VAMC in South Dakota; and the VA Pacific Islands Health Care System in Honolulu, Hawaii, all reported establishing a drive-up pharmacy.
  - Leaders from the Durham VAMC in North Carolina reported offering pharmacy as well as some dermatology and laboratory services from the car.
  - Leaders from the VA Eastern Colorado Health Care System in Denver created a drive-through emergency department/urgent care clinic.
- Some facility leaders reported setting up areas specifically to support patients with suspected and confirmed COVID-19:
  - Leaders from the St. Cloud VAMC in Minnesota reported developing an acute respiratory clinic, separate from the regular facility patient population, that served as an isolation area for patients who were potentially positive for COVID-19.
  - Washington DC VAMC leaders reported setting up a respiratory evaluation center with a ward designated for COVID-19 patients.
  - Leaders from the James A. Haley Veterans' Hospital in Tampa, Florida, reported moving their emergency department triage outside the facility into the parking garage where patients would be evaluated and tested for COVID-19 before entry.

Virtual Care Modalities

Many facility leaders reported the use of virtual care modalities, such as telephone, VA Video Connect, or FaceTime, to provide care. Some facility leaders reported a huge increase in the use of this type of care. For example, leaders from one facility stated calls using VA Video Connect increased from 79 to over 1,100 per week. Some of the facility leaders who reported using virtual modalities cited challenges to these types of care delivery, including issues with bandwidth, scheduling, and users' comfort and knowledge about how to operate technology.

Staffing

When asked about staffing shortages, most facility leaders reported sufficient overall staffing to meet increased patient-care demands related to COVID-19.[43] Leaders from one VAMC reported that unplanned leave was flat (unchanged from pre-COVID-19 conditions).

While 63 of 70 facility leaders responded that they had enough clinical staff to meet increased patient-care demands, seven facilities mentioned a clinical shortage. Most notably, leaders from three facilities—the Southeast Louisiana Veterans Health Care System in New Orleans; the VA New Jersey Health Care System in East Orange; and the Gulf Coast Veterans Health Care System in Biloxi, Mississippi—specifically mentioned a shortage of emergency department nurses, intensive care unit nurses, or both.[44] The remaining four facilities stated there were clinical shortages of certain types of physicians, including intensivists and emergency department providers, as well as respiratory therapists, social workers, and pharmacy staff.

When asked about nonclinical shortages, 53 of 70 leaders reported having enough nonclinical staff to meet increased patient-care demands related to COVID-19. For those facilities that cited a shortage, the most commonly mentioned occupations were housekeeping/environmental management and VA police. This is consistent with what was reported by facilities during the prior OIG inspection conducted March 19–24, 2020, of VHA COVID-19 screening processes and pandemic readiness.[45] Similarly, in the OIG *Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2019*, VHA facilities identified custodial workers and police in the top five severe occupational shortages.[46]

Facility leaders reported using a variety of methods to address staffing shortages, most notably with contract staff, reassigning staff to higher areas of need, and utilizing staff from other VHA

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[43] *VHA Response Plan,* March 23, 2020. The VA projected the rate of absenteeism to be 40 percent due to illness, the need to care for family members, or fear of infection. To address potential clinical staffing shortages, VHA instituted mechanisms to hire temporary staff, establish on-call groups, explore hiring authorities, and deploy emergency medical personnel. Deputy Under Secretary for Health Operations and Management Memos, *Office of Nursing Services Recruitment—Retired Annuitants and Travel Nurse Corps,* March 26, 2020; *COVID-19: Supporting Critical Care Demand Surges through Tele-Critical Care,* March 25, 2020; *Guidance for the Hiring, Compensation and Utilization of Alternate Nurse and Unlicensed Assistive Personnel Staffing*, March 31, 2020; *Request for Disaster Emergency Medical Personnel System (DEMPS) for COVID-19*, March 25, 2020.

[44] As noted in appendix A, table A.1, the Southeast Louisiana Veterans Health Care System in New Orleans and VA New Jersey Health Care System in East Orange had the highest number of patients with COVID-19 of the 70 participating facilities. The Gulf Coast Veterans Health Care System in Biloxi, Mississippi, had one of the lowest number of patients with COVID-19.

[45] VA OIG, *OIG Inspection of Veterans Health Administration COVID-19 Screening and Pandemic Readiness*, Report No. 19-09017-64, March 26, 2020.

[46] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2019*, September 30, 2019.

facilities.[47] For example, leaders from one facility (the Corporal Michael J. Crescenz VAMC in Philadelphia, Pennsylvania) described a shortage of housekeeping staff and medical support assistants as a result of increased absenteeism due to variables outside the facility, such as lack of childcare and transportation. The leaders reported relying on nontraditional shifts, overtime, and redeployment of staff from areas with reduced activity. In addition, leaders from this facility initiated efforts to contract for administrative and police staff on a temporary basis from other VHA facilities.

Other leaders reported using expedited hiring during the pandemic for anticipated increased patient-care needs. For example, leaders from the Wilmington VAMC in Delaware hired 62 staff, including physicians, registered nurses, respiratory therapists, and medical support assistants.

Equipment and Supplies

The initial COVID-19 surge strained non-VA hospital supplies of PPE and testing capabilities.[48] In the OIG's previous report, 33 of 54 facility leaders interviewed stated that they did not have adequate supplies or equipment or both including some specific items of PPE.[49] Also noted in the March 2020 OIG report, none of the facilities conducted testing on site. Moreover, some leaders reported difficulties obtaining needed supplies for testing.[50] During the current review, the majority of leaders reported having sufficient PPE as well as testing supplies and capabilities for their patient populations and staff.

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[47] Facility leaders reported pursuing several approaches when reassigning staff that included cross-training, completing new competencies, and matching staff to areas previously worked.

[48] 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*, April 3, 2020. https://www.oig.hhs.gov/oei/reports/oei-06-20-00300.pdf. (The website was accessed on June 28, 2020.) Hospitals reported widespread shortages of PPE, severe shortages of testing supplies, and extended wait times for test results. The shortages placed patients at risk. CDC, *Strategies to Optimize the Supply of PPE and Equipment*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. (The website was accessed on June 28, 2020.)

[49] VA OIG, *Report No. 19-09017-64,* March 26, 2020. Specifically, 23 facility leaders reported an inadequate supply of masks and 13 facility leaders reported a shortage of gowns.

[50] VA OIG, *Report No. 19-09017-64*, March 26, 2020. None of the 54 medical facilities that were visited in March 2020 reported processing COVID-19 specimens on site; rather, specimens were being sent primarily to county and state health departments, and commercial laboratories. Only one VA facility (the VA Palo Alto Health Care System in California) was reported to be processing specimens. According to one facility leader who was interviewed, specimen processing time could be reduced from several days to hours using an on-site laboratory.

Personal Protective Equipment

Sixty-seven of the 70 facility leaders reported having sufficient supplies of PPE. The three facility leaders who reported a shortage of PPE specifically mentioned the lack of gowns and properly fitting N95 masks.[51]

Testing

All participating facilities in this review reported collecting specimens for testing and 64 of 70 reported the ability to analyze tests on site.[52] In addition, some facility leaders reported using other VHA facilities as well as state and private laboratories to analyze test results.

The OIG noted that facilities that performed on-site analysis reported remarkably shorter testing result turnaround times (the interval between collection of a specimen and the availability of results) than when they utilized off-site locations to analyze facility-collected specimens such as other VHA facilities, the state laboratory, or private laboratories. Facilities without on-site testing and analysis capabilities typically waited 48 hours for results reporting. Leaders at the Fargo VA Health Care System in North Dakota noted that having adequate testing capabilities was critical to managing COVID-19. The leaders further indicated that the quick turnaround testing was particularly helpful in the assessment of patients scheduled for surgeries.

Coordinating with VISN Leaders

Due to the rapidly evolving nature of COVID-19 knowledge and patient-care experiences, facility leaders faced a barrage of directives and communications with frequent updates from national leaders. The Deputy Under Secretary for Health for Operations and Management disseminated over 200 memorandums addressing actions related to COVID-19 during the time frame under review.[53] Facility leaders reported that VISNs frequently communicated with

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[51] CDC. *Personal Protective Equipment: Questions and Answers.* An N95 filtering facepiece respirator (FFR) removes particles from the air that are breathed through it. These respirators filter out at least 95% of very small (0.3 micron) particles. N95 FFRs are capable of filtering out all types of particles, including bacteria and viruses. https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html. (The website was accessed on July 10, 2020.)

[52] A few facilities reported that they were unable to process specimens due to issues with testing equipment: four facility leaders (White River Junction VAMC in Vermont, Alaska VA Healthcare System, Phoenix VA Health Care System in Arizona, and VA Pacific Islands Health Care System in Honolulu, Hawaii) stated that they did not have the necessary equipment to analyze collected specimens. Leaders at the Jonathan M. Wainwright Memorial VAMC in Walla Walla, Washington, reported they had the necessary equipment but not the reagent, and leaders at the Sheridan VAMC in Wyoming said they had the necessary equipment and reagents but were awaiting equipment inspection/calibration.

[53] Department of Veterans Affairs, *2019 Functional Organizational Manual, Version 5*, 2019. Operational direction and guidance to each of the 18 VISNs is provided by the Deputy Under Secretary for Health for Operations and Management, the VHA-designated focal point for the flow of information and guidance between the VA central office (VACO) and the field.

them, provided support for procuring equipment and supplies, assisted with navigating updated guidance from VHA leadership, and helped to address staffing or training needs (see table 1).

Table 1. VISN Assistance Reported by Facility Leaders

Type of Assistance	Number of Times Mentioned
Held daily calls or communicated regularly with facilities	62
Helped to secure or reallocate PPE, equipment, or testing supplies	41
Provided updates or assisted facilities in understanding VHA national guidance or policies	16
Assisted with issues related to facility staffing or training	14

Source: OIG analysis of facility leaders' responses

Facility leaders cited several examples of VISN assistance with procuring needed supplies and equipment:

- Leaders at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts, reported the VISN assisted in obtaining negative air pressure machines and powered air-purifying respirators (PAPRs).[54]
- Washington DC VAMC leaders stated that the VISN was helpful with procuring additional ventilators.[55]
- Facility leaders at the Jesse Brown VAMC in Chicago reported relying on their VISN to help get PPE, when they were down to a three-day supply. Facility leaders reflected that, being part of the VISN, they were better positioned to get PPE than similar Chicago community hospitals that were not as fortunate.
- Leaders from the John Cochran Veterans Hospital in St. Louis, Missouri, reported that the VISN placed large orders for PPE as well as testing kits.

[54] VHA Handbook 0320.04, *Department of Veterans Affairs and Department of Defense Emergency Contingency Plan*, May 13, 2014. Patients with certain types of infections require a separate room or area with negative airflow and respiratory isolation. CDC, *Considerations for Optimizing the Supply of Powered Air-Purifying Respirators (PAPRs),* updated April 19, 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/powered-air-purifying-respirators-strategy.html. (The website was accessed on June 28, 2020.) A powered air-purifying respirator removes gases, vapors, aerosols (droplets and solid particles), or a combination of contaminants from the air through the use of filters, cartridges, or canisters. Those powered by battery pull air through attached filter or cartridges.

[55] VHA Directive 1761(2), *Supply Chain Management Inventory*, October 24, 2016, amended October 26, 2018. Supply chain management is "the integration and alignment of people, processes, and systems across the supply chain to manage all product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities."

- Leaders from the Southeast Louisiana Veterans Health Care System in New Orleans stated that the VISN helped secure PPE and ventilators.
- Leaders from the South Texas Veterans Health Care System in San Antonio reported the VISN helped procure ventilators through a national order and was able to obtain them faster than if the facility had placed the order.
- Leaders from the VA Salt Lake Health Care System in Utah stated that they received help from the VISN in procuring negative pressure tents so they could move screenings outdoors to reduce the footprint in the facility.
- Facility leaders at the Boise VAMC in Idaho reported that they received assistance from the VISN to obtain masks and testing equipment.

Facility leaders cited several examples of VISN assistance with addressing the large volume of national guidance:

- Facility leaders stated that VISN 8 leaders provided written guidance and helped to clarify areas of ambiguity that were not covered by VHA directives or CDC guidance.
- An open chat box was reported to be available from 6:00 a.m. to 6:00 p.m. for facilities in VISN 10 to use for reporting challenges; subject matter experts were available to weigh in.
- Facility leaders stated that VISN 22 leaders helped with understanding constantly changing CDC guidance on COVID-19 and antibody testing.
- Facility leaders reported that VISN 23 leaders provided written guidance that helped to streamline communications and provided facilities access to infectious disease and epidemiology subject matter experts.

Facility leaders provided examples that demonstrated VISN leaders' help to coordinate staffing needs:

- The VISN 1 Director allowed facilities within the VISN to provide personnel support to other VISN facilities. Employees were eligible for a $5,000 special contribution award if they completed a 14-day physical deployment to another VISN facility. Leaders from the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts, a VISN 1 facility, reported that the VISN assisted them in filling staffing needs.
- Leaders from the Chalmers P. Wyle Ambulatory Care Center in Columbus, Ohio, reported that during the daily VISN 10 facility call, staffing and supply challenges were noted at the Detroit VAMC in Michigan and as a result, Columbus deployed nurses and PPE to that facility.

- According to facility leaders, VISN 16 leaders maintained communication with the VAMCs in their network about assisting and sending staff to the Southeast Louisiana Veterans Health Care System in New Orleans, if needed.

VA's Fourth Mission

VA fulfills its responsibility to veterans via the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery Administration. Its fourth mission is "to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts." [56]

On March 13, 2020, the COVID-19 pandemic was declared to be of sufficient severity and magnitude to warrant an emergency determination under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, a federal law that authorizes federal agencies to provide assistance to a state in response to an emergency or disaster.[57] Five days later, VA Secretary Robert Wilkie agreed to provide such assistance.[58]

Although facility leaders were not specifically asked about VA's fourth mission during interviews, several reported they provided assistance to non-VA facilities or patients during the time frame under review:

- Leaders from the Phoenix VA Health Care System in Arizona stated that they deployed 16 nursing staff to facilities in California and Arizona.
- Leaders from three facilities reported that they provided services to nonveterans:
    - At the VA New Jersey Health Care System in East Orange, leaders stated care was provided to 15–20 nonveterans.
    - Leaders at the Edward Hines, Jr. VA Hospital in Illinois indicated that 20 nonveteran patients were admitted.

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[56] Department of Veterans Affairs, *About VA Mission Statement.* https://www.va.gov/about_va/. (The website was accessed on June 28, 2020.)

[57] *Letter from President Donald J. Trump on Emergency Determination Under the Stafford Act,* March 13, 2020. https://www.whitehouse.gov/briefings-statements/letter-president-donald-j-trump-emergency-determination-stafford-act/. (The website was accessed on June 28, 2020.) VHA Directive 0320.02.

[58] *Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Briefing,* March 18, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-5/. (The website was accessed on June 28, 2020.)

  - Leaders at the New Mexico VA Health Care System in Albuquerque said that care was provided for patients from the Navajo Nation.
- Leaders from two facilities reported providing support to state veterans homes:
  - VA Salt Lake City Health Care System leaders reported that they shared a negative air pressure tent with a Utah state veterans home.[59]
  - Leaders from the VA Greater Los Angeles Health Care System said they assisted a California state veterans home by providing supplies and guidance on COVID-19 testing.

Coordination and Access to Community Care from March 11, 2020–June 15, 2020

At the time of the pandemic declaration, VHA was implementing changes to its community care options for veterans pursuant to the 2018 Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act.[60] The changes included the establishment of a community care network managed by third-party administrators, implementation of access standards for community care, and increased coordination of community care by VHA staff.[61]

VHA leaders anticipated that access to community care providers would decrease during the pandemic as non-VA providers modified their practices to comply with CDC and state-issued

[59] VA Geriatrics and Extended Care, *State Veterans Homes*. https://www.va.gov/GERIATRICS/pages/State_Veterans_Homes.asp. (The website was accessed on June 28, 2020.) State veteran homes are facilities that provide nursing home, domiciliary or adult day care. They are owned, operated, and managed by state governments, not by VA. The state veteran home under discussion was located on the facility's campus but not affiliated with it.

[60] Department of Veterans Affairs, *Community Care Overview*. https://www.va.gov/communitycare/. (The website was accessed on July 8, 2020.) "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VHA care, and the needs and circumstances of individual Veterans." Prior to 2018, veterans received care in the community mainly via the Veterans Choice Program, a temporary program, that was established under the Veterans Access, Choice, and Accountability Act of 2014. VHA Directive 1700, *Veterans Choice Program*, October 25, 2016. It was succeeded by the MISSION Act that provides veterans access to health care in the community. Deputy Under Secretary for Health for Operations and Management, *Guidance on Access Standards in Response to Coronavirus (COVID-19),* A temporary pause from the MISSION Act Access Standards was initiated due to an anticipated decreased capacity in the community.

[61] *VA MISSION Act Upcoming Improvements to Veteran Community Care and What to Expect*. https://www.blogs.va.gov/VAntage/57722/va-mission-act-what-is-the-latest-on-community-care/. (The website was accessed on July 3, 2020.) National Academy for State Health Policy, *Chart: Each State's Stay-at-Home Orders and Reopening Dates*. https://www.nashp.org/governors-prioritize-health-for-all/. (The website was accessed on June 26, 2020.)

guidelines.[62] VHA leaders were also concerned about sending patients "into an environment with uncertain capacity and protections, especially when the majority of the population served by VA is of the age known to be most at risk with COVID-19."[63]

VHA Guidance

In response to the pandemic, VHA provided guidance that referral to the community for emergent or urgent needs would continue, and routine care that could not be completed via VHA telehealth or telephone would be scheduled in the community on a case-by-case basis. Certain types of "routine" community care such as maternity, pain management therapies, and other chronic medical conditions would continue.[64] Instructions were also issued related to the rescheduling and prioritization of appointments canceled due to COVID-19.[65]

Facility Leaders' Reported Actions

Assessing Patient-Care Needs

In accordance with VHA guidance, facility leaders reported evaluating the urgency of patient-care needs. While not asked about the use of virtual care modality, some facility leaders specifically reported that patients with nonurgent needs were evaluated and considered for the use of this type of care delivery by VHA and community providers.

Several facility leaders confirmed decreased access to community care providers and identified challenges with care coordination due to limited services in the community. Leaders from one facility noted workload and care coordination during the pandemic required a significant amount of time and follow-up contact with community providers.

Rescheduling Efforts

Facility leaders were asked about their plans for ensuring that patients who had community care appointments received the needed services and for addressing challenges related to community care moving forward.

Facilities were instructed by VHA to prioritize and regularly review community care appointments that had been canceled by patients due to COVID-19 and not immediately

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[62] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance on Access Standards in Response to Coronavirus (COVID-19),* March 20, 2020.

[63] *Guidance on Access Standards in Response to Coronavirus (COVID-19),* March 20, 2020.

[64] *Guidance on Access Standards in Response to Coronavirus (COVID-19),* March 20, 2020.

[65] Deputy Under Secretary for Health for Operations and Management, *Outpatient Clinic Appointment Scheduling Management in Response to COVID-19 Pandemic*, March 20, 2020.

rescheduled. Leaders reported that cancellations came at patient request, community provider request, or because of local stay-at-home orders.[66] Leaders from one facility (the Durham VAMC in North Carolina) mentioned that they encountered a community dialysis provider who refused to treat a patient with COVID-19. Facility officials stated that they brought the patient into the VHA facility to receive treatment. In comparison, 12 facility leaders reported no change in the ability to schedule community care appointments and suggested all appointments were kept as scheduled.

Several facility leaders reported hard-to-reschedule appointments in certain clinics. For example, leaders at the VA Connecticut Healthcare System in West Haven noted difficulties scheduling patients in the community for ultrasounds, and in mammography and gastroenterology clinics. Three facilities (the Hunter Holmes McGuire VAMC in Richmond, Virginia; the Fargo VA Health Care System in North Dakota; and the Minneapolis VA Health Care System in Minnesota) reported scheduling problems with community dental providers.

Some facility leaders reported additional scheduling complications relating to the establishment of new community care networks. Six geographical regions were developed—each managed by a third-party administrator.[67] The six regions were to be implemented in phases over time. Facility leaders reported the phased implementation coincided with the tumultuous demands created by the COVID-19 pandemic, which became a challenge. For example, facility leaders from the Durham VAMC in North Carolina stated that the pandemic paused negotiations for contract services and effectively reduced the number of available network community providers. This was echoed by the leaders at the Kansas City VAMC in Missouri who also said that due to the transition to a new community care network, they did not have as many available providers. Facility leaders reported trying to extend existing community care authorizations and working to process community partners into the new community care network.

Operations at Community Living Centers from March 11, 2020–June 15, 2020

In March 2020, the CDC noted that COVID-19 could "cause severe illness and death, particularly among older adults with chronic health conditions" and advised that long-term care

[66] Beginning in March 2020, state governors issued stay-at-home orders that paused business activity to encourage social distancing and minimize coronavirus exposure. Restrictions and time frames of the restrictions differed from state to state.

[67] Department of Veterans Affairs. *Community Care Network Fact Sheet,* September, 17, 2019. Each network serves as a contract vehicle for VA to purchase care in the community. Under this system, a veteran who is eligible for community care when care is not available at VA, may be referred directly to a community care provider.

facilities take steps to protect the health of the patients and the workforce.[68] VHA leaders issued guidance to VISNs on March 5, 2020, to institute screening and limit access to veterans in community living centers.[69] This was done in accordance with CDC guidance to prevent the spread of COVID-19 in long-term care settings. As reported in OIG's previous March 2020 inspection report, OIG staff tested the screening and limited access policy at 54 VHA CLCs. Nine CLCs located on six different campuses were found to be accessible, contrary to the March 5, 2020, guidance.[70]

VHA Guidance

Revised CLC guidance, issued by VHA on March 17, 2020, further restricted admissions to veterans from VHA facilities.[71] More specific guidelines regarding telehealth were issued in April 2020 that required the availability of telehealth for CLC patients and facilitated completion of telehealth service agreements and CLC staff training to learn the "tele-presenter role."[72]

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[68] CDC Morbidity and Mortality Weekly Report (MMWR), *COVID-19 in a Long-Term Care Facility—King County, Washington, February 27–March 9, 2020 Weekly* / March 27, 2020 / 69(12);339-342. A long-term residential care facility in Washington reported positive COVID-19 cases among 81 residents, 34 staff members, and 14 visitors; 23 people died. Limitations in effective infection control and prevention were cited. https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm. (The website was accessed on July 3, 2020.) CDC, *People Who are at Higher Risk for Severe Illness.* June 25, 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html. (The website was accessed on June 25, 2020.)

[69] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. VA CLCs, formerly known as nursing homes or nursing home care unit, provide a skilled nursing environment that offers a variety of specialty programs for persons needing short- and long-stay services. CLCs are "typically located on, or near a VA medical facility and are VA-owned and operated but may be free-standing in the community. Department of Veterans Affairs Geriatrics and Extended Care. *Community Living Centers*. There are over 100 CLCs in the U.S. https://www.va.gov/GERIATRICS/pages/VA_Community_Living_Centers.asp. (This website was accessed on July 7, 2020.) Deputy Under Secretary for Health for Operations and Management, *VA Response to COVID-19 Guidance for VA Community Living Centers,* March 5, 2020 (effective March 6, 2020). Admission was restricted to veterans from settings without COVID-19. Patients who were admitted were to be quarantined for 14 days, the number of staff accessing the CLC would be limited, all visitors would be screened, surveillance initiated, isolation plans developed, and social activities limited.

[70] VA OIG, Report No. 19-09017-64*,* March 26, 2020. Although approved for entry at some CLCs, OIG staff did not access the units.

[71] Deputy Under Secretary for Health for Operations and Management, Coronavirus*(COVID-19) Community Living Centers-Revised 03/17/2020,* March 17, 2020. Admission was allowed only to patients from VA facilities and a 14-day observation period was required upon return of a CLC patient treated in an acute care facility for an emergency. Facilities were advised to (a) use dedicated (assigned specifically to CLC) staff to provide care, (b) minimize the number of ancillary staff who enter the CLC for other reasons, and (c) screen staff at the beginning of every shift.

[72] Deputy Under Secretary for Health for Operations and Management, COVID-19: *Telehealth to Community Living Centers and State Veterans Homes,* April 24, 2020.

As testing became more available and plans for reopening were proposed, VHA guidance regarding CLC patient testing for COVID-19 evolved. In April 2020, testing was initiated for all patients in a CLC or those with planned admissions, as well as staff who worked in CLCs.[73] In June 2020, additional guidelines were issued that were consistent with CDC goals to "Keep COVID-19 Out, Detect Cases Quickly, and Stop Transmission," and recommended routine testing as well as testing all patients after any newly diagnosed case.[74]

Facility Leaders' Reported Actions

CLCs with No Patients Positive for COVID-19

Leaders from 34 of the 59 facilities with CLCs reported that none of their patients were found to be positive for COVID-19 during the March 11–June 15, 2020, time frame. Leaders noted that operating procedures were adapted to reduce exposure and spread of the virus, including 14-day quarantines, staff being assigned specifically to the CLC, and implementation of the two-zone approach:

- The 111-bed CLC at Clement J. Zablocki VAMC in Milwaukee, Wisconsin, continued to admit patients during the height of the pandemic to support the facility. Leaders stated that only essential staff were granted access to the CLC and only CLC-specific staff provided care. Patients who were admitted had to complete a 14-day quarantine within the facility before moving to the CLC.
- The VA Connecticut Healthcare System CLC in West Haven, a 40-bed unit, continued to accept admissions. There were no patients with COVID-19 in the CLC during the time frame under review. Leaders reported several actions:
    - Nurses coordinated care tasks to reduce the time spent in patient rooms.
    - Staff were specifically assigned to the CLC.
    - Nurses performed phlebotomy duties.[75]
    - Specialty care appointments were completed by video.

[73] Deputy Under Secretary for Health for Operations and Management, *Coronavirus (COVID-19) Community Living Center (CLC) and Spinal Cord Injury and Disorder Unit (SCI/D) Veteran and Staff Testing Guidance*, April 14, 2020. More than 190 CLC patients at 12 locations had been diagnosed with COVID-19,

[74] Deputy Under Secretary for Health for Operations and Management, *Guidance on COVID-19 testing for Community Living Centers and Spinal Cord Injury and Disorder Units,* June 11, 2020.

[75] Merriam Webster, *Definition of phlebotomy*, Phlebotomy is the drawing of blood (as by venipuncture) for transfusion, diagnostic testing, or experimental procedures. https://www.merriam-webster.com/dictionary/phlebotomy. (The website was accessed in June 30, 2020.)

  - Linen was washed within the CLC to reduce in-and-out movement by non-essential staff.

- The CLC at VA Pacific Islands Health Care System in Honolulu, Hawaii, did not have patients who tested positive for COVID-19. However, leaders stated that the CLC was uniquely situated to implement a two-zone approach for patients as it had two units with separate air circulation systems. The plan was to move patients with suspected or confirmed COVID-19 into one unit to decrease exposure to non-COVID-19 patients.

CLCs with Patients Positive for COVID-19

Leaders from 25 of the 59 facilities with CLCs reported having patients with COVID-19 and had to determine how to best reduce the spread of the virus while providing care to all the CLC patients. Facility leaders reported using two different strategies in managing CLCs with COVID-19 patients. One included a combination of separation or isolation of COVID-19 patients and quarantine within the CLC and the second included transferring patients to other locations. In addition, some facility leaders described modifications to their CLCs to meet the needs of patients with COVID-19:

- The CLC at Durham VAMC in North Carolina had a low census when the pandemic started. Leaders reported that CLC staff placed patients into separate rooms, that engineering staff made structural changes to convert all rooms to single-patient rooms, and that CLC staff, including providers, were available 24 hours, 7 days per week to meet patient-care needs.
- Leaders at the Corporal Michael J. Crescenz VAMC in Philadelphia, Pennsylvania, reported that they opened a previously closed hospice unit and created a specific COVID-19 CLC unit.
- Leaders from the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts, stated that they created five temporary units within the CLC—one for quarantine and four for patients positive for COVID-19. As patients convalesced, the temporary units were converted into recovery units for continued care.
- Leaders from the Cheyenne VAMC in Wyoming said they used one wing of the facility's CLC unit for COVID-19 patients, as it had a separate entrance and a separate air-handling system.
- The VA New Jersey Health Care System in East Orange had the first COVID-19 case in the CLC on March 25, 2020. The CLC was quarantined on March 27, 2020. Facility leaders reported that three CLC units were dedicated to the care of patients with COVID-19. During March 2020, the CLC had 207 patients that included 127 patients with COVID-19 and there were 42 COVID-19-related deaths.

Some leaders described a strategy to manage COVID-19 patients that involved transferring them out of the CLC into a different part of the facility and in some cases, to other VHA facilities:

- Some CLCs, such as the Louis Stokes Cleveland VAMC in Ohio, reported transferring patients who were positive for COVID-19 from the CLC to a dedicated COVID-19 inpatient acute care ward within the facility.
- When the CLC at the VA Greater Los Angeles Healthcare System in California had two patients test positive for COVID-19 on March 28, 2020, leaders reported that all CLC patients (99 patients) and staff underwent testing. Nineteen patients and eight staff tested positive for COVID-19. The 19 patients were transferred from the CLC to the hospital at the VA Greater Los Angeles Healthcare System for more intensive care. Of the positive patients and staff, 14 patients and 4 staff did not show symptoms at the time of testing. The CLC performed subsequent testing on April 13, April 22, and April 23, 2020, but identified no additional patients with COVID-19.
- Leaders from the VA Palo Alto Health Care System in California reported transferring half of their CLC patients to another California CLC in Menlo Park so the vacated ward at the Palo Alto CLC could be used as a COVID-19 isolation unit.
- The Southeast Louisiana Veterans Health Care System in New Orleans admitted its first patient with COVID-19 approximately two weeks after Mardi Gras celebrations ended. Leaders were concerned that the number of patients with COVID-19 post-Mardi Gras would increase exponentially. Facility leaders stated that they offered CLC patients the choice of being discharged home or transferred to another VHA facility within the VISN. VA CLCs located in Biloxi, Mississippi; Alexandria, Louisiana; Jackson, Mississippi; and Houston, Texas, accepted CLC patients from the New Orleans facility.
- Leaders from the Central Alabama Veterans Health Care System in Montgomery discussed the transfer of a patient who was admitted to their CLC, underwent rapid assessment for COVID-19, and was transferred to another VA facility with a designated COVID-19 unit within four hours after testing positive. The patient required dialysis, which was not available at Central Alabama Veterans Health Care System CLC.
- Leaders at the CLC in the St. Cloud VAMC in Minnesota stated that they admitted 30–40 patients from the Minneapolis VA Health Care System to help open beds at the Minneapolis CLC.

Staffing

Leaders from 13 facilities reported staffing shortages at CLCs prior to the pandemic declaration and eight facilities reported staffing shortages during the period of the review. The most frequently cited shortage was nursing staff. Measures reported by facility leaders to

resolve shortages included reassignment of staff (both acute care and CLC) and increased hiring activities.

Some facility leaders stated they reassigned facility staff to work in the CLC. The majority of these staff were from outpatient clinics, but staff were also reassigned from the operating room/post-anesthesia recovery unit, Home-Based Primary Care, behavioral health units, spinal cord units, and Quality Management and Education Departments to support the CLC.

Many facilities reported hiring staff from March 11, 2020, through June 15, 2020. The positions filled were mostly in the nursing service and included registered nurses, licensed vocational/practical nurses and certified nursing assistants. For example, leaders from VA Pittsburgh Healthcare System in Pennsylvania reported hiring 8 nurse practitioners, 41 registered nurses, 7 licensed vocational nurses, and 12 certified nursing assistants.

Challenges Specific to the CLC Population

The most common challenge cited by facility leaders for CLC patients involved difficulties associated with social isolation and maintaining social distancing. Visitors to the CLCs were restricted in early March 2020. As weeks and then months passed, staff reported increased signs and symptoms of anxiety and depression in not only the CLC patients, but in the staff caring for them. Leaders described examples of staff members' struggles to get patients with reduced cognitive function or dementia to understand the restrictions on visitors and other social or recreational gatherings.

Other challenges cited included rapidly changing guidance and testing requirements. As noted above, knowledge about the virus and experience taking care of patients with COVID-19 evolved simultaneously. Guidance was frequently modified as understanding about the disease process increased. In the CLC setting, facility leaders reported that staff found it difficult to keep families up-to-date with the guidance and changes in CLC processes and restrictions.

VA initiated testing for all CLC patients and staff in April 2020. However, obtaining testing supplies and conducting mass testing was challenging.[76] Facility leaders also reported dealing with false positive results, which increased staff unease.

[76] Deputy Under Secretary for Health for Operations and Management, *Guidance on COVID-19 testing for Community Living Centers and Spinal Cord Injury and Disorder Units*, June 11, 2020. VHA recognized possible testing capacity issues and noted: "When appropriate, or if testing capacity is limited, testing may be limited to a smaller subset of residents as part of an organized contact tracing effort, or to residents and staff that reside or work in the same neighborhood or floor. If testing supplies are inadequate to test a floor or neighborhood, VISN leadership should identify and transfer enough supplies to conduct floor/neighborhood level testing."

Moving Forward

Contact Tracing

The CDC has issued guidance on contact tracing, which is used to help identify people who have been exposed to an infectious disease because they were in close proximity to someone with a confirmed diagnosis. The goal is to slow and prevent the spread of an infectious disease by separating those who may have it from others who do not and breaking the chain of transmission.[77] VHA's current Response Plan does not specifically address contact tracing. When interviewed, a VHA leader informed the OIG that contact tracing guidance will be incorporated into the next Response Plan update.

Almost all facility leaders indicated that they were reporting patients with COVID-19 to state, city, or local health departments for contact tracing. However, leaders from four VAMCs—Fort Meade, South Dakota; Beckley, West Virginia; Manchester, New Hampshire; and White City, Oregon—responded that they had not reported patients with COVID-19 for contact tracing.

While nearly all the facilities reported patients with COVID-19 for contact tracing, a few facility leaders reported challenges related to reporting:

- There was a large volume of paperwork associated with reporting patients with COVID-19 to the state.
- It was challenging to locate the correct county in which patients with COVID-19 lived in order to report them for contact tracing.
- State health departments were having difficulty hearing back from patients with COVID-19 who they tried to contact.

VHA Plans to Return to Pre-COVID-19 Operations

In this review, facility leaders did not indicate that demands outpaced resources or a need to activate alternate sites of care, as outlined in Response Plan phase 3.[78] At the time of the OIG interviews, some facilities were beginning to reinitiate services and move into Response Plan phase 4 recovery while also considering preparations for a potential increase in the number of patients with COVID-19.

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[77] CDC, *Interim Guidance on Developing a COVID-19 Case Investigation &Contact Tracing Plan,* https://www.cdc.gov/coronavirus/2019-ncov/downloads/case-investigation-contact-tracing.pdf. (The website was accessed on July 1, 2020.)

[78] VHA *Response Plan*, March 23, 2020. During interviews, some facility leaders reported preparing units designated for COVID-19 patients but there were no reports of activating alternate sites to meet surge demands.

In late April and early May 2020, VHA developed a plan for resumption of pre-COVID-19 services and operations that included conducting a risk assessment after a review of

- National, state, and local guides to inform decision-making,
- Testing and screening capability,
- Available personal protective equipment, pharmaceuticals, and cleaning supplies, and
- The status of schools, daycares, and mass transit.[79]

Challenges and Lessons Learned Reported by Facility Leaders

According to the CDC, daily trends of newly reported cases of COVID-19 decreased in May 2020 (see figure 3).[80] Governors began to relax stay-at-home orders and businesses began to reopen.[81] In June, the trend of new cases began to increase and exceed previous numbers. As of July 10, 2020, there were 3,106,931 total cases reported and 132,855 deaths in the U.S.[82] The OIG asked facility leaders about challenges and lessons learned to determine whether and how their experiences responding to the COVID-19 crisis may prepare them for an increased number of COVID-19 patients.

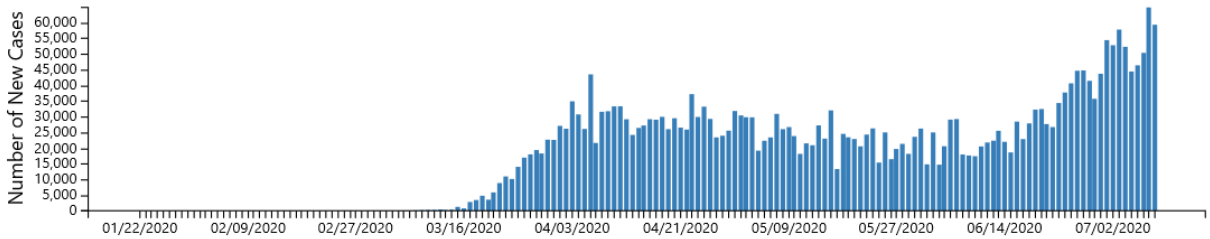

Figure 4. Daily trends in number of COVID-19 cases in the United States reported to CDC (January 22, 2020–July 10, 2020)
Source: CDC[83]

[79] VHA, *Moving Forward Guidebook: **Safe** Care is Our Mission,* v1.1, June 15, 2020.

[80] CDC, *Coronavirus Disease 2019 (COVID-19) Cases in the U.S.* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. (The website was accessed on July 1, 2020.)

[81] CDC, *Reopening Guidance for Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes*. https://www.cdc.gov/coronavirus/2019-ncov/community/reopen-guidance.html. (The website was accessed on July 1, 2020.) National Academy for State Health Policy, *Chart: Each State's Stay-at-Home Orders and Reopening Dates*. https://www.nashp.org/governors-prioritize-health-for-all/. (The website was accessed on June 26, 2020.)

[82] CDC, *Coronavirus Disease 2019 (COVID-19) Cases in the U.S.* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. (The website was accessed on July 11, 2020.)

[83] CDC, *Coronavirus Disease 2019 (COVID-19). Cases in the US*. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. (The website was accessed on July 11, 2020.)

Inpatient (Acute Care) and Outpatient Operations

As facilities began increasing operations, leaders noted challenges when rescheduling nonurgent and nonemergent procedures. Due to the reduction of these types of appointments during the pandemic, there was a backlog of appointments that needed to be rescheduled. Dental procedures were cited by facility leaders as one of the hardest to reschedule. Some facility leaders stated that difficulties rescheduling dental procedures were due to the increased need for PPE and the aerosolizing nature of dental procedures.

When asked about the standout lessons learned for the inpatient and outpatient settings, facility leaders most frequently identified the importance of internal and/or external communication. Many facility leaders described the importance of communicating with both staff and veterans using virtual meeting formats, including online townhalls and emails. One facility created a crisis support team to assist communications between family members and hospitalized relatives and one facility started a program that targeted support staff well-being.[84] Facility leaders also identified the need for careful planning and preparation as an important lesson learned. The vast majority (60 of 70) of facility leaders reported that they were well positioned with PPE in the event of a surge in numbers of COVID-19-positive patients.

Other lessons learned included these needs:

- Flexibility and capability to shift to meet the changing demands, such as having contingency plans for increasing bed capacity or staffing
- Improvement to the supply chain, including increasing contingency storage and the number of days' supply of PPE
- Increased telehealth/virtual modalities

Community Care

Seven of the VHA community care leaders identified a need for more staffing to prepare for a potential surge of hospital demand related to COVID-19. For example, leaders at the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts, who reported detailing nursing assistants to community care during the pandemic to help review cases and provide follow-up on the increased number of emergency consult requests, indicated that additional staffing in case of a surge of patients would be helpful. Several leaders highlighted the need to continue to work with community partners and third-party administrators to build and maintain a strong provider network. Some leaders lauded the flexibility provided by telework options and opined that such capabilities would assist in their ability to meet the demand of a surge.

[84] The two facilities respectively were James A. Haley Veterans' Hospital in Tampa, Florida, and Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts.

A practice suggested by leaders from one facility—the addition of social workers to their community care staff—was reported to be helpful for case management and should be an asset if there are increased COVID-19-related care demands.

Community Living Centers

In general, facility leaders considered actions taken to separate and care for CLC patients during the time frame under review to be successful and replicable should the numbers of CLC patients with COVID-19 increase. They also opined that a future response would be much quicker due to the experience and knowledge about the virus gained to date.

Facility leaders offered a few suggestions to improve CLC operations if faced with an increased number of COVID-19 infections, but due to the success of past efforts, most did not think current processes needed to be greatly modified:

- Gain familiarity with the existing infrastructure of the CLC(s) to inform quarantine or isolation decisions.
- Maintain single-patient rooms.
- Cross-train facility staff to work in the CLC and CLC staff to work in other areas of the facility.
- Improve communication with community nursing home partners to ensure safe and appropriate patient care.

Conclusion

COVID-19 is reshaping the landscape of healthcare delivery worldwide, from how care is delivered on the frontline to overall operations of healthcare facilities. Moving forward, the operations and the delivery of care will likely evolve further from previous models. VHA, as the largest integrated healthcare system in this country, will be no exception.

This OIG report on VHA's response to the pandemic details the evolving challenges faced by VHA in caring for the nation's veterans. While many facilities may have been spared from a state of resource depletion or unmanageable disease burden, preparing for an influx of patients was in itself a significant undertaking for each facility.

The OIG applauds the unwavering dedication of leaders and frontline staff to deliver care amidst evolving science and the need to adjust practice as guidance was updated on a frequent basis by subject matter experts. Overall, this report highlights a multitude of actions taken by VHA, VISN, and facility leaders to maintain operations during a national emergency. With the uncertainty of timing and magnitude of possible recurrent outbreaks, this review presented strategies that various facilities put into place over the past several months that will hopefully promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.

Appendix A: Counts of Patients with COVID-19 in Selected Facilities

Table A.1. List of Reviewed Facilities by VISN and Number of Patients with COVID-19 Enrolled in the VA as of June 15, 2020

VISN	Facility	Active COVID-19 Patients	Convalescent Patients	Deaths	Total VA Positive Cases	Total Number of Enrolled Patients*	Percentage of Enrolled Patients who are COVID-19 Positive
1	Edith Nourse Rogers Memorial Veterans Hospital in Bedford, MA	0	235	34	269	22,466	1.2%
1	Manchester VAMC, NH	0	52	8	60	33,310	0.2%
1	Providence VAMC, RI	2	112	19	133	43,094	0.3%
1	VA Boston HCS and Jamaica Plain Division, MA	0	485	73	558	55,942	1.0%
1	VA Maine HCS – Togus VAMC	1	23	2	26	51,710	0.1%
1	White River Junction VAMC, VT	0	12	2	14	29,285	0.0%
1	VA Connecticut HCS – West Haven Campus	2	344	29	375	69,281	0.5%
2	Bath VAMC, NY	1	18	1	20	39,658	0.1%
2	VA New Jersey HCS – East Orange Campus	4	787	108	899	90,412	1.0%
4	Corporal Michael J. Crescenz VAMC in Philadelphia, PA	0	489	35	524	71,685	0.7%
4	VA Pittsburgh HCS - University Drive Campus, PA	0	69	3	72	54,087	0.1%
4	Wilmington VAMC, DE	0	132	13	145	46,460	0.3%
5	Martinsburg VAMC, WV	2	89	11	102	52,271	0.2%
5	Washington DC VAMC	3	474	58	535	120,470	0.4%
5	Beckley VAMC, WV	0	2	0	2	14,500	0.0%
5	VA Maryland HCS - Baltimore VAMC	7	208	18	233	80,745	0.3%

VISN	Facility	Active COVID-19 Patients	Convalescent Patients	Deaths	Total VA Positive Cases	Total Number of Enrolled Patients*	Percentage of Enrolled Patients who are COVID-19 Positive
6	Durham VAMC, NC	3	117	6	126	70,328	0.2%
6	Hunter Holmes McGuire VAMC in Richmond, VA	1	157	14	172	78,863	0.2%
7	Atlanta VAMC, GA	1	299	23	323	169,484	0.2%
7	Charlie Norwood VAMC in Augusta, GA	1	65	9	75	50,643	0.1%
7	Ralph H Johnson VAMC in Charleston, SC	1	86	0	87	88,368	0.1%
7	Central Alabama Veterans HCS – West Campus, Montgomery	1	99	4	104	70,984	0.1%
8	Bay Pines VA HCS – CW Bill Young VAMC, FL	2	130	4	136	133,429	0.1%
8	James A Haley Veterans' Hospital, Tampa, FL	1	89	5	95	112,997	0.1%
8	Miami VA HCS – Bruce W Carter VAMC, FL	1	219	8	228	68,340	0.3%
9	Memphis VAMC, TN	0	66	6	72	68,076	0.1%
9	Lexington VAMC, KY	0	21	2	23	42,796	0.1%
9	Tennessee Valley HCS – Nashville Campus	1	96	3	100	134,695	0.1%
10	Chalmers P. Wyle Ambulatory Care Center in Columbus, OH	0	65	6	71	51,895	0.1%
10	Louis Stokes Cleveland VAMC, OH	1	281	44	326	134,666	0.2%
10	VA Northern Indiana HCS – Marion Campus	0	69	6	75	60,338	0.1%
12	Milwaukee VAMC– Clement J. Zablocki VAMC, WI	1	132	7	140	69,883	0.2%
12	Edward Hines, Jr. VA Hospital in Hines, IL	1	271	25	297	75,372	0.4%
12	Jesse Brown VAMC in Chicago, IL	1	377	25	403	55,154	0.7%

VISN	Facility	Active COVID-19 Patients	Convalescent Patients	Deaths	Total VA Positive Cases	Total Number of Enrolled Patients*	Percentage of Enrolled Patients who are COVID-19 Positive
12	Oscar G. Johnson VAMC in Iron Mountain, MI	0	10	0	10	24,571	0.0%
12	William S. Middleton Memorial Veterans Hospital in Madison, WI	1	45	6	52	44,082	0.1%
15	Kansas City VAMC, MO	0	109	4	113	56,665	0.2%
15	VA Eastern Kansas HCS – Colmery-O'Neil VAMC in Topeka, KS	0	33	0	33	44,799	0.1%
15	VA St. Louis HCS – John Cochran Division, MO	0	190	19	209	75,586	0.3%
16	G.V. (Sonny) Montgomery VAMC in Jackson, MS	2	126	15	143	58,404	0.2%
16	Michael E. DeBakey VAMC in Houston, TX	0	214	12	226	155,516	0.1%
16	Southeast Louisiana Veterans HCS in New Orleans, LA	1	516	48	565	64,522	0.9%
16	Gulf Coast Veterans HCS in Biloxi, MS	0	33	3	36	104,785	0.0%
16	Veterans HCS of the Ozarks in Fayetteville, AR	0	16	2	18	61,353	0.0%
17	South Texas Veterans HCS – Audie L. Murphy Memorial Veterans' Hospital in San Antonio, TX	3	141	8	152	138,240	0.1%
17	VA North Texas HCS – Dallas VAMC	2	139	12	153	195,886	0.1%
19	Oklahoma City VAMC, OK	0	53	8	61	90,354	0.1%
19	Cheyenne VAMC, WY	0	26	2	28	30,602	0.1%
19	Sheridan VAMC, WY	0	3	0	3	15,385	0.0%
19	VA Eastern Colorado HCS – Denver VAMC	0	316	26	342	136,626	0.3%
19	VA Montana HCS, Fort Harrison	0	8	1	9	46,978	0.0%
19	VA Salt Lake City HCS – George E. Wahlen VAMC, UT	0	85	7	92	71,619	0.1%

VISN	Facility	Active COVID-19 Patients	Convalescent Patients	Deaths	Total VA Positive Cases	Total Number of Enrolled Patients*	Percentage of Enrolled Patients who are COVID-19 Positive
20	Alaska VA HCS - Anchorage VAMC	0	17	0	17	33,764	0.1%
20	Jonathan M. Wainwright Memorial VAMC in Walla Walla, WA	0	36	2	38	28,283	0.1%
20	White City VAMC, OR	0	0	0	0	20,236	0.0%
20	Boise VAMC, ID	0	28	1	29	39,272	0.1%
21	San Francisco VA HCS – San Francisco VAMC, CA	1	40	3	44	37,840	0.1%
21	VA Pacific Islands HCS – Spark M Matsunaga VAMC in Honolulu, HI	0	12	0	12	54,525	0.0%
21	VA Sierra Nevada HCS – Ioannis A. Lougaris VAMC in Reno, NV	0	42	5	47	35,928	0.1%
21	VA Palo Alto HCS – Palo Alto Division, CA	0	51	7	58	78,833	0.1%
22	New Mexico VA HCS – Raymond G Murphy VAMC, Albuquerque	1	65	12	78	68,727	0.1%
22	Phoenix VA HCS – Carl T Hayden VAMC, AZ	5	168	20	193	127,180	0.2%
22	VA Greater Los Angeles HCS – West Los Angeles VAMC, CA	5	138	13	156	132,432	0.1%
22	VA San Diego HCS – San Diego VAMC, CA	1	115	5	121	120,246	0.1%
23	Fargo VA HCS – Fargo VAMC, ND	0	38	13	51	40,939	0.1%
23	Iowa City VA HCS – Iowa City VAMC, IA	1	38	2	41	63,837	0.1%
23	Minneapolis VA HCS – Minneapolis VAMC, MN	1	162	34	197	134,628	0.1%
23	St Cloud VA HCS – St Cloud VAMC, MN	0	37	1	38	30,117	0.1%
23	VA Black Hills HCS – Fort Meade Campus, SD	0	6	0	6	22,098	0.0%
23	VA Nebraska-Western Iowa HCS – Omaha VAMC	0	151	22	173	68,853	0.3%

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed July 2, 2020). VHA Support Service Center (VSSC), "Current Enrollment – Users and Enrollees (VISN)" cube, accessed July 2, 2020. The number of enrolled veterans is as of April 2020.
HCS = Health Care System or Healthcare System
VAMC = Veterans Affairs Medical Center
**Note: The number of enrolled patients was extracted from VHA Support Service Center (VSSC), "Current Enrollment – Users and Enrollees (VISN)" cube, accessed July 2, 2020. The number of enrolled veterans is as of April 2020.*

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