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OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness

March 19–24, 2020

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On March 11, 2020, due to the "alarming levels of spread and severity" of the novel coronavirus disease (COVID-19), the World Health Organization declared a pandemic.[1] Within two days, screening processes were implemented to assess veterans' and visitors' infection status at all Veterans Health Administration (VHA) facilities.[2]

VA also continued planning for its fourth mission, "the provision of hospital care and medical services during certain disasters and emergencies" to persons "who would otherwise not have eligibility to receive such care and services."[3] In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans. Within the context of the COVID-19 emergency, VA recognized the need to provide care for otherwise non-eligible individuals as part of a "rapid and effective response to and recovery from the domestic consequences" of the pandemic and a "need for federal government services that address the national health, safety, and welfare needs of the United States."[4]

Approximately one week after screening was initiated at all VHA facilities, the Office of Inspector General (OIG) conducted an inspection to evaluate expeditiously the process (including access to community living centers) and to meet with VHA medical facility leaders to collect data on preparations for an expected dramatic increase in patients with illnesses related to

[1] World Health Organization. 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 March 23, 2020.) Merriam Webster, *Definition of pandemic*. A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population. https://www.merriam-webster.com/dictionary/pandemic. (The website was accessed on March 24, 2020.)

[2] The screening process was instituted for people seeking entry to a VHA medical facility after the World Health Organization pandemic declaration included a set of six questions. Persons are granted entrance to the VA facility based on their responses to the questions.

[3] VA's missions include serving veterans through care, research, and training. A fourth mission for the provision of hospital care and medical services during certain disasters and emergencies was outlined by 38 CFR § 17.86 – [d]uring and immediately following a disaster or emergency…VA under 38 U.S.C §1785 may furnish hospital care and medical services (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency.

[4] VA Office of Operation, Security, and Preparedness, March 23, 2020.

COVID-19.[5] The unannounced visits to facilities were planned to minimize exposure and potential transmission of the novel coronavirus for both VA and OIG personnel as well as patients and visitors.[6] Every effort was made to ensure that the visits were not disruptive to facility activities or distracting from COVID-19 responses. The goal was to complete unobtrusive but effective oversight of screening and pandemic preparedness to glean critical information of immediate use to VA leaders at every level as they respond to the needs of veterans, their families, and other stakeholders.

At the outset, it should be noted that throughout this inspection process, the OIG encountered dedicated VHA leaders, frontline care providers, and support staff united in their mission to provide high-quality care to the veterans they serve. Even in times of relative calm, ensuring timely and quality provisions of care is challenging. The OIG recognizes and appreciates the efforts of all VHA personnel who are working in stressful conditions, and risking potential exposure, as they manage the needs of patients and personnel. The current global pandemic highlights the need for all healthcare systems to anticipate demand and leverage resources on a scale that potentially overwhelms even the largest integrated healthcare systems.

[5] On March 10, 2020, VA instituted a no visitors policy at community living centers (formerly referred to as nursing home care units) and spinal cord injury units. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5400. (The website was accessed on March 24, 2020.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. The handbook announced VA's decision to replace the term nursing home care unit with community living center. Community living centers are "typically located on, or near a VA medical facility and are VA-owned and operated but may be free-standing in the community." For this report, the OIG uses the term community living center to include nursing home, nursing home care units, or nursing home care.

[6] OIG inspectors screened themselves, using a process consistent with that approved by VHA management, before driving to medical facilities in an attempt to not introduce the coronavirus into the facility or spread the virus between communities.

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Methodology

OIG leaders and medical staff developed and refined a series of pandemic-related questions. Fifty-two OIG staff, most with clinical experience, volunteered to visit selected VHA facilities including medical centers, community-based outpatient clinics, and community living centers. Site selection depended on OIG inspectors' geographical proximity to the facility as the approved method of travel was by car to avoid potential exposure and transmission of COVID-19. A total of 237 facilities (58 medical centers, 125 community-based outpatient clinics and 54 community living centers) were visited.

Visits to selected facilities were completed from March 19 through March 24, 2020. OIG inspectors drove to VHA medical facilities that were close to their homes and observed or underwent the screening process or both. Interviews with facility leaders were brief and focused, in recognition of the demands for them to be fully engaged in preparing their facilities and staff for the expected increase in workload. Inspectors had a list of prepared questions, and most facility leader interviews took less than 45 minutes. If leaders could not readily respond to questions about current numbers or status of patients and equipment, OIG inspectors left a questionnaire for the facility to complete and submit to the OIG over the next 24 to 48 hours.

Upon arrival to a facility, OIG staff did not immediately make their identity known to VHA staff. After observing VHA personnel screen individuals who were seeking entrance or being screened themselves or both, OIG staff sought entrance to community living centers if one was located within the medical center or on medical center grounds to determine if they would be denied entrance as a visitor.[7] After completing those task(s), OIG inspectors proceeded to the medical center leadership suite, identified themselves, and conferred with leaders regarding the results of the screening observations and community living center access attempts. OIG staff also discussed the COVID-19 testing process, the availability of medications, supplies, equipment, and staffing, and current collaboration and coordination with healthcare organizations in the community. If leaders needed to provide written responses when requested data was not readily available during the interview, the information was generally provided within 48 hours.

[7] VHA's screening process included six questions: (1) what is the purpose of your visit today; (2) have you traveled to an area with widespread or sustained community transmission of coronavirus (within the last 14 days); (3) have you been in contact with a person that has confirmed coronavirus; (4) have you had or currently have a fever (greater or equal to 100.4 degrees Fahrenheit within the last 48–72 hours); (5) do you have a new or worsening cough or shortness of breath or both; and (6) do you have any flu-like symptoms (such as nasal congestion, sore throat or headache).

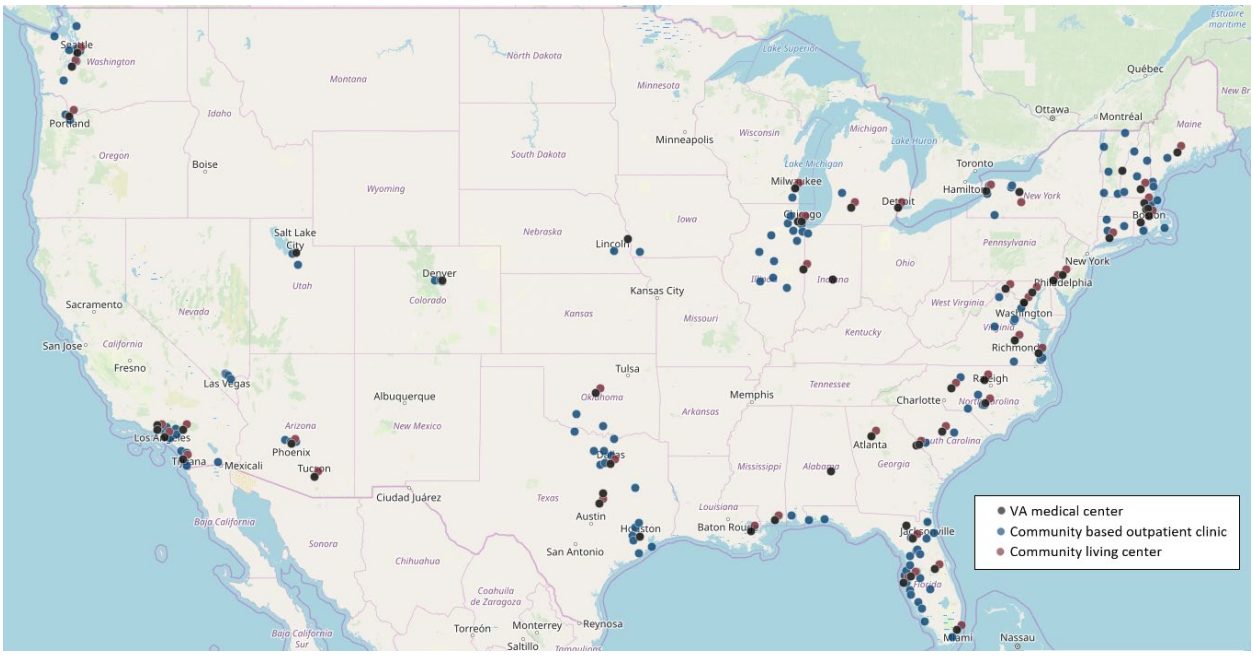

Figure 1: Map of selected VA medical facilities visited March 19–24, 2020

The numbers of facilities presented in the screening, access, and readiness data sets in this report vary based on the facilities' organizational structure. For instance, OIG staff interviewed 54 VHA facility directors, and/or their designees, who were responsible for the 58 medical centers visited, regarding readiness for COVID-19 care. For the directors who were 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. Data from each site were collected and made available in real time to senior leaders at VHA headquarters. Significantly, the OIG did not assess the data submitted by VHA leaders for accuracy or completeness.

Inspection Results

The inspection results first focus on screening and access issues. The facilities' response and readiness results follows. For several tables below, information related to VA's screening efforts, visitors' access to community living centers, and readiness capabilities reported by VHA leaders are arranged by Veterans Integrated Service Network (VISN). Aggregating results by VISN facility is meant to help readers locate information by area and to assist with identifying any possible trends within or across VISNs. As medical facilities were selected according to volunteer OIG staff's ability to drive to the destination, not all VISNs (and therefore the facilities within them) are represented.

1. Screening for COVID-19 at Selected Medical Centers

OIG staff who self-screened prior to arriving at facilities to conduct the inspection observed and/or underwent VA screening processes at the selected medical centers (see table 1).

Table 1. Medical Center COVID-19 Screening

● = *generally adequate screening* ◉ = *opportunities exist to improve screening*
○ = *inadequate screening*

VISN	Facility	City, State	OIG Assessment of Screening Adequacy
1	Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA	●
1	Manchester VAMC	Manchester, NH	●
1	Providence VAMC	Providence, RI	●
1	VA Boston HCS: Jamaica Plain Campus	Jamaica Plain, MA	●
1	VA Boston HCS: West Roxbury Campus	West Roxbury, MA	◉
1	VA Boston HCS: Brockton Campus	Brockton, MA	●
1	VA Connecticut HCS: West Haven Campus	West Haven, CT	●
1	VA Maine HCS	Augusta, ME	●
1	White River Junction VAMC	White River Junction, VT	●
2	VA Finger Lakes HCS	Canandaigua, NY	●
2	VA Western New York HCS	Buffalo, NY	●
4	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia, PA	●
4	Wilmington VAMC	Wilmington, DE	●
5	Martinsburg VAMC	Martinsburg, WV	●

VISN	Facility	City, State	OIG Assessment of Screening Adequacy
5	VA Maryland HCS	Baltimore, MD	○
5	Washington VAMC	Washington, DC	●
6	Durham VA Medical Center	Durham, NC	●
6	Fayetteville VAMC	Fayetteville, NC	○
6	Hampton VAMC	Hampton, VA	●
6	Hunter Homes McGuire Hospital	Richmond, VA	●
6	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	Salisbury, NC	●
7	Atlanta VAMC	Decatur, GA	●
7	Central Alabama Veterans HCS: Montgomery VAMC	Montgomery, AL	●
7	Charlie Norwood Department of Veterans Affairs Medical Center	Augusta, GA	●
7	Charlie Norwood Department of Veterans Affairs Medical Center: Uptown Campus	Augusta, GA	●
7	William Jennings Bryan Dorn Department of Veterans Affairs Medical Center	Columbia, SC	○
8	Bay Pines VA HCS	Bay Pines, FL	○
8	Bruce W. Carter Department of Veterans Affairs Medical Center	Miami, FL	○
8	James A. Haley Veterans' Hospital	Tampa, FL	●
8	North Florida/Southern Georgia HCS: Lake City VAMC	Lake City, FL	●
8	Orlando VAMC	Orlando, FL	●
10	Battle Creek VAMC	Battle Creek, MI	●
10	John D. Dingell VAMC	Detroit, MI	●
10	Richard L. Roudebush VAMC	Indianapolis, IN	○
12	Clement J. Zablocki VAMC	Milwaukee, WI	●
12	Edward Hines Jr. VA Hospital	Hines, IL	●
12	Jesse Brown VAMC	Chicago, IL	○
12	VA Illiana HCS	Danville, IL	●
16	Gulf Coast Veterans HCS	Biloxi, MS	○
16	Michael E. DeBakey VAMC	Houston, TX	●
16	Southeast Louisiana Veterans HCS	New Orleans, LA	○
17	Central Texas Veterans HCS: Doris Miller VAMC	Waco, TX	●
17	Central Texas Veterans HCS: Olin E. Teague Veterans' Medical Center	Temple, TX	●

VISN	Facility	City, State	OIG Assessment of Screening Adequacy
17	VA North Texas Health Care System	Dallas, TX	●
19	Oklahoma City VA HCS	Oklahoma City, OK	●
19	VA Eastern Colorado HCS	Aurora, CO	◐
19	VA Salt Lake City HCS	Salt Lake City, UT	●
20	VA Portland HCS	Portland, OR	◐
20	VA Puget Sound HCS: American Lake Division	Tacoma, WA	●
20	VA Puget Sound HCS: Seattle Division	Seattle, WA	◐
21	VA Southern Nevada HCS	N. Las Vegas, NV	◐
22	Phoenix VA HCS	Phoenix, AZ	●
22	Southern Arizona VA HCS	Tucson, AZ	○
22	VA Greater Los Angeles HCS	Los Angeles, CA	●
22	VA Loma Linda HCS	Loma Linda, CA	●
22	VA Long Beach HCS	Long Beach, CA	◐
22	VA San Diego HCS	San Diego, CA	●
23	VA Nebraska-Western Iowa HCS	Omaha, NE	◐

Source: VA OIG analysis of March 19–24, 2020, VHA data
HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

The OIG determined that 41 of the 58 (71 percent) visited medical centers' screening processes were generally adequate; 16 of the 58 (28 percent) medical centers had some opportunities for improvement.[1] One facility, the Southern Arizona VA Health Care System, had inadequate screening processes.

Screening questions assessed patients' and visitors' risk for COVID-19 infection by reviewing a series of respiratory and other symptoms, travel history, and known or potential exposure to other positive patients. Inspectors noted that in many instances, screeners may have combined questions, used language not identical but consistent with the intent of the scripted questions, or may have not asked all the questions based on additional information presented by those being screened. Recognizing the intent of the scripted screening questions, the OIG understands that

[1] Facilities with generally adequate screening processes were those whose screeners missed 0–1 of the required screening questions. Facilities with some opportunities for improvement were those whose screeners missed 2–3 of the required screening questions.

staff conducting the screens may have used clinical judgment as well as geographical disease burden information to adjust the scripted questions without compromising the integrity of risk assessment and therefore considered these types of screenings adequate. Locations determined to have "opportunities to improve their screening processes" were those where screening was taking place, but screeners were eliminating one to three questions that specifically identified distinct risk factors.

At the Southern Arizona VA Health Care System, considered by OIG to have inadequate screening processes, OIG staff observed two individuals being screened and noted that only some of the screening questions were being asked. VHA staff told the two individuals to place a sticker with the date of screening on their shirts and wear face masks during their visit (both the sticker and masks were provided by the screeners). When the OIG staff approached the screening checkpoint, VHA staff gave the same instructions related to the sticker and face mask but did not ask the screening questions.

2. Screening for COVID-19 at Selected Community-Based Outpatient Clinics

OIG staff who self-screened prior to arriving at the facilities to conduct the inspection observed and/or underwent VA screening processes at the selected community-based outpatient clinics (see table 2).

Table 2. Community-Based Outpatient Clinic COVID-19 Screening

● *= screening process in place* ○ *= no screening process in place*

VISN	Outpatient Clinic	City, State	Screening Process in Place?
1	Edith Nourse Rogers Memorial Veterans' Hospital – Gloucester VA Clinic	Gloucester, MA	●
1	Edith Nourse Rogers Memorial Veterans' Hospital – Lynn VA Clinic	Lynn, MA	●
1	Manchester VAMC – Conway VA Clinic	Conway, NH	●
1	Manchester VAMC – Somersworth VA Clinic	Somersworth, NH	●
1	Manchester VAMC – Tilton VA Clinic	Tilton, NH	●
1	Providence VAMC – Hyannis VA Clinic	Hyannis, MA	●
1	Providence VAMC – Middletown VA Clinic	Middletown, RI	●
1	VA Connecticut HCS – Waterbury VA Clinic	Waterbury, CT	●
1	VA Connecticut HCS – Willimantic VA Clinic	Willimantic, CT	●
1	VA Connecticut HCS – Winsted VA Clinic	Winsted, CT	●
1	VA Maine HCS – Lewiston VA Clinic	Lewiston, ME	●

VISN	Outpatient Clinic	City, State	Screening Process in Place?
1	White River Junction VAMC – Burlington Lakeside VA Clinic	Burlington, VT	●
1	White River Junction VAMC – Littleton VA Clinic	Littleton, NH	●
1	White River Junction VAMC – Newport VA Clinic	Newport, VT	●
1	White River Junction VAMC – Rutland VA Clinic	Rutland, VT	●
2	VA Finger Lakes HCS – Rochester Calkins VA Clinic	Rochester, NY	●
2	VA Finger Lakes HCS – Rochester Westfall VA Clinic	Rochester, NY	●
2	VA Western New York HCS – Lackawanna VA Clinic	Lackawanna, NY	●
2	VA Western New York HCS – Lockport VA Clinic	Lockport, NY	●
2	VA Western New York HCS – Olean VA Clinic	Olean, NY	●
5	Martinsburg VAMC – Stephens City VA Clinic	Winchester, VA	●
5	Washington VAMC – Fort Belvoir VA Clinic	Fort Belvoir, VA	●
6	Fayetteville VAMC – Cumberland County VA Clinic	Fayetteville, NC	●
6	Fayetteville VAMC – Fayetteville VA Clinic	Fayetteville, NC	●
6	Fayetteville VAMC – Hamlet VA Clinic	Hamlet, NC	●
6	Fayetteville VAMC – Lee County VA Clinic	Sanford, NC	●
6	Hampton VAMC – Chesapeake VA Clinic	Hampton, VA	●
6	Hampton VAMC – Virginia Beach VA Clinic	Virginia Beach, VA	●
6	Hunter Homes McGuire Hospital – Charlottesville VA Clinic	Charlottesville, VA	●
6	Hunter Homes McGuire Hospital – Emporia VA Clinic	Emporia, VA	●
6	Hunter Homes McGuire Hospital – Fredericksburg 2 VA Clinic	Fredericksburg, VA	●
6	Hunter Homes McGuire Hospital – Fredericksburg VA Clinic	Fredericksburg, VA	●
6	W.G. (Bill) Hefner Salisbury VAMC – Kernersville VA Clinic	Kernersville, NC	●
7	Charlie Norwood VAMC – Aiken VA Clinic	Aiken, SC	●
7	William Jennings Bryan Dorn VAMC – Sumter VA Clinic	Sumter, SC	●
8	Bay Pines VA HCS – Bradenton VA Clinic	Bradenton, FL	●
8	Bay Pines VA HCS – Lee County VA Clinic	Cape Coral, FL	●
8	Bay Pines VA HCS – Naples VA Clinic	Naples, FL	●
8	Bay Pines VA HCS – Palm Harbor VA Clinic	Palm Harbor, FL	●
8	Bay Pines VA HCS – Port Charlotte VA Clinic	Port Charlotte, FL	●
8	Bay Pines VA HCS – Sarasota VA Clinic	Sarasota, FL	●
8	Bay Pines VA HCS – Sebring VA Clinic	Sebring, FL	●

VISN	Outpatient Clinic	City, State	Screening Process in Place?
8	Bay Pines VA HCS – St. Petersburg VA Clinic	St. Petersburg, FL	●
8	Bruce W. Carter VAMC – Homestead VA Clinic	Homestead, FL	●
8	James A. Haley Veterans' Hospital – Brooksville VA Clinic – Brooksville	Brooksville, FL	●
8	James A. Haley Veterans' Hospital – Lakeland VA Clinic – Lakeland	Lakeland, FL	●
8	James A. Haley Veterans' Hospital – Lecanto VA Clinic – Lecanto	Lecanto, FL	●
8	James A. Haley Veterans' Hospital – New Port Richey VA Clinic – New Port Richey	New Port Richey, FL	●
8	James A. Haley Veterans' Hospital – Zephyrhills VA Clinic – Zephyrhills	Zephyrhills, FL	●
8	North Florida/Southern Georgia HCS – Gainesville Sixteenth Street VA Clinic	Gainesville, FL	●
8	North Florida/Southern Georgia HCS – Jacksonville 1 VA Clinic	Jacksonville, FL	●
8	North Florida/Southern Georgia HCS – Ocala VA Clinic	Ocala, FL	●
8	North Florida/Southern Georgia HCS – Palatka VA Clinic	Palatka, FL	●
8	North Florida/Southern Georgia HCS – Saint Augustine VA Clinic	Saint Augustine, FL	●
8	North Florida/Southern Georgia HCS – The Villages VA Clinic	The Villages, FL	●
10	Battle Creek VAMC – Wyoming VA Clinic – Wyoming	Wyoming, MI	●
12	Clement J. Zablocki VAMC – Union Grove VA Clinic	Union Grove, WI	●
12	Edward Hines Jr. VA Hospital – Aurora VA Clinic	North Aurora, IL	●
12	Edward Hines Jr. VA Hospital – Hoffman Estates VA Clinic	Hoffman Estates, IL	●
12	Edward Hines Jr. VA Hospital – Joliet VA Clinic	Joliet, IL	●
12	Edward Hines Jr. VA Hospital – Kankakee County VA Clinic	Bourbonnais, IL	●
12	Edward Hines Jr. VA Hospital – LaSalle VA Clinic	Peru, IL	●
12	Jesse Brown VAMC – Adam Benjamin Jr., Veterans' Administration Outpatient Clinic	Crown Point, IN	●
12	Jesse Brown VAMC – Auburn Gresham VA Clinic	Chicago, IL	○
12	Jesse Brown VAMC – Chicago Heights VA Clinic	Chicago Heights, IL	●
12	Jesse Brown VAMC – Lakeside VA Clinic	Chicago, IL	○
12	VA Illiana HCS – Bloomington VA Clinic	Bloomington, IL	●
12	VA Illiana HCS – Bob Michel Department of Veterans Affairs Outpatient Clinic	Peoria, IL	●
12	VA Illiana HCS – Decatur VA Clinic	Decatur, IL	●
12	VA Illiana HCS – Mattoon VA Clinic	Mattoon, IL	●
12	VA Illiana HCS – Springfield VA Clinic	Springfield, IL	●

VISN	Outpatient Clinic	City, State	Screening Process in Place?
16	Gulf Coast Veterans HCS – Eglin Air Force Base VA Clinic	Eglin Air Force Base, FL	●
16	Gulf Coast Veterans HCS – Mobile VA Clinic	Mobile, AL	●
16	Gulf Coast Veterans HCS – Pensacola VA Clinic	Pensacola, FL	●
16	Michael E. DeBakey VAMC – Conroe VA Clinic	Conroe, TX	●
16	Michael E. DeBakey VAMC – Galveston County VA Clinic	Galveston, TX	●
16	Michael E. DeBakey VAMC – Katy VA Clinic	Katy, TX	●
16	Michael E. DeBakey VAMC – Lake Jackson VA Clinic	Lake Jackson, TX	●
16	Michael E. DeBakey VAMC – Richmond VA Clinic	Richmond, TX	●
16	Michael E. DeBakey VAMC – Tomball VA Clinic	Tomball, TX	●
17	Central Texas Veterans HCS – Palestine VA Clinic	Palestine, TX	●
17	VA North Texas HCS – Grand Prairie VA Clinic	Grand Prairie, TX	●
17	VA North Texas HCS – Plano VA Clinic	Plano, TX	●
19	Oklahoma City VA HCS – Ardmore VA Clinic	Ardmore, OK	●
19	Oklahoma City VA HCS – Lawton North VA Clinic	Fort Sill, OK	●
19	Oklahoma City VA HCS – Wichita Falls VA Clinic	Sheppard AFB, TX	●
19	VA Eastern Colorado HCS – Aurora VA Clinic	Aurora, CO	●
19	VA Eastern Colorado HCS – Denver VA Clinic	Denver, CO	●
19	VA Eastern Colorado HCS – Golden VA Clinic	Golden, CO	●
19	VA Salt Lake City HCS – Orem VA Clinic	Orem, UT	●
19	VA Salt Lake City HCS – Western Salt Lake VA Clinic	West Valley City, UT	●
20	VA Portland HCS – Hillsboro VA Clinic	Hillsboro, OR	●
20	VA Portland HCS – Portland VA Clinic	Portland, OR	●
20	VA Portland HCS – West Linn VA Clinic	West Linn, OR	●
20	VA Puget Sound HCS – Bellevue VA Clinic	Bellevue, WA	●
20	VA Puget Sound HCS – Federal Way VA Clinic	Federal Way, WA	●
20	VA Puget Sound HCS – Mount Vernon VA Clinic	Mount Vernon, WA	●
20	VA Puget Sound HCS – North Olympic Peninsula VA Clinic	Port Angeles, WA	●
20	VA Puget Sound HCS – North Seattle VA Clinic	Seattle, WA	●
20	VA Puget Sound HCS – Silverdale VA Clinic	Silverdale, WA	●
20	VA Puget Sound HCS – South Sound VA Clinic	Chehalis, WA	●
21	VA Southern Nevada HCS – Northeast Las Vegas VA Clinic	Las Vegas, NV	●

VISN	Outpatient Clinic	City, State	Screening Process in Place?
21	VA Southern Nevada HCS – Northwest Las Vegas VA Clinic	Las Vegas, NV	●
21	VA Southern Nevada HCS – Southeast Las Vegas VA Clinic	Henderson, NV	●
22	Phoenix VA HCS – Northeast Phoenix VA Clinic	Scottsdale, AZ	●
22	Phoenix VA HCS – Northwest VA Clinic	Surprise, AZ	●
22	Phoenix VA HCS – Thunderbird VA Clinic	Phoenix, AZ	●
22	VA Greater Los Angeles HCS – East Los Angeles VA Clinic	Commerce, CA	●
22	VA Greater Los Angeles HCS – Los Angeles VA Clinic	Los Angeles, CA	●
22	VA Greater Los Angeles HCS – San Gabriel Valley VA Clinic	Arcadia, CA	●
22	VA Greater Los Angeles HCS – Sepulveda Outstation	Sepulveda, CA	●
22	VA Loma Linda HCS – Corona VA Clinic	Corona, CA	●
22	VA Loma Linda HCS – Loma Linda VA Clinic	Redlands, CA	●
22	VA Loma Linda HCS – Rancho Cucamonga VA Clinic	Rancho Cucamonga, CA	●
22	VA Long Beach HCS – Anaheim VA Clinic	Anaheim, CA	●
22	VA Long Beach HCS – Santa Ana VA Clinic	Santa Ana, CA	●
22	VA Long Beach HCS – Santa Fe Springs VA Clinic	Santa Fe Springs, CA	●
22	VA San Diego HCS – Chula Vista VA Clinic (mental health clinic)	Chula Vista, CA	○
22	VA San Diego HCS – Escondido VA Clinic	Escondido, CA	●
22	VA San Diego HCS – Imperial Valley VA Clinic	El Centro, CA	○
22	VA San Diego HCS – Mission Valley VA Clinic	San Diego, CA	●
22	VA San Diego HCS – Oceanside VA Clinic	Oceanside, CA	●
22	VA San Diego HCS – Rio VA Clinic	San Diego, CA	●
23	VA Nebraska– Western Iowa HCS – Lincoln VA Clinic	Lincoln, NE	●
23	VA Nebraska– Western Iowa HCS – Shenandoah VA Clinic	Shenandoah, IA	●

Source: VA OIG analysis of March 19–24, 2020, VHA data
HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

The OIG determined that 121 of the 125 (97 percent) visited community-based outpatient clinics had screening processes in place. Overwhelmingly, OIG staff observed screening questions asked to assess patient and visitor health, and possible exposure to COVID-19. These screenings took place in a variety of

settings, including from cars, outdoor tents, clinic vestibules and anterooms, and lobbies. OIG staff noted signs and banners at many locations notifying visitors of COVID-19 screening procedures, concerns, and symptoms.

Four facilities were observed as having no screening procedures in place.[2] At three locations, OIG staff presented themselves as visitors and were politely greeted but not asked any COVID-19 screening questions. At the fourth facility, the VA San Diego HCS—Imperial Valley VA Clinic, patients and visitors were permitted to freely enter the waiting room. The OIG team entered, stood in the waiting room for 10 minutes, and were not greeted or screened by VHA staff.

3. Community Living Center Access

OIG staff who self-screened prior to arriving at facilities to conduct the inspection attempted to gain access to community living centers to test VA's no visitors policy (see table 3).

Table 3: Community Living Centers Found Accessible

● = *no* ○ = *yes*

VISN	Facility	City, State	VHA Staff Were Prepared to Allow OIG Staff Entry
1	Edith Nourse Rogers Memorial Veterans' Hospital – Building 4	Bedford, MA	○
1	Edith Nourse Rogers Memorial Veterans' Hospital – Building 2	Bedford, MA	○
1	Edith Nourse Rogers Memorial Veterans' Hospital – Building 6 (A/B)	Bedford, MA	○
1	Edith Nourse Rogers Memorial Veterans' Hospital – Building 6 (C/D)	Bedford, MA	○
1	Manchester VAMC	Manchester, NH	●
1	VA Boston HCS: Jamaica Plain Campus	Jamaica Plain, MA	○
1	VA Connecticut HCS: West Haven Campus	West Haven, CT	●
1	VA Maine HCS	Augusta, ME	●
2	Buffalo VAMC	Buffalo, NY	●
2	VA Finger Lakes HCS	Canandaigua, NY	●
4	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia, PA	●

[2] Jesse Brown VAMC—Lakeside VA Clinic, Jesse Brown VAMC——Auburn Gresham VA Clinic, VA San Diego HCS—Imperial Valley VA Clinic, and VA San Diego HCS—Chula Vista VA Clinic.

VISN	Facility	City, State	VHA Staff Were Prepared to Allow OIG Staff Entry
4	Wilmington VAMC	Wilmington, DE	●
5	Martinsburg VAMC	Martinsburg, WV	●
5	VA Maryland HCS	Baltimore, MD	●
5	Washington VAMC	Washington, DC	●
6	Durham VA Medical Center	Durham, NC	●
6	Fayetteville VAMC	Fayetteville, NC	●
6	Hampton VAMC	Hampton, VA	●
6	Hunter Homes McGuire Hospital	Richmond, VA	●
6	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	Salisbury, NC	●
7	Atlanta VAMC	Decatur, GA	○
7	Charlie Norwood Department of Veterans Affairs Medical Center	Augusta, GA	●
7	William Jennings Bryan Dorn Department of Veterans Affairs Medical Center	Columbia, SC	●
8	Bay Pines VA HCS	Bay Pines, FL	●
8	Bruce W. Carter Department of Veterans Affairs Medical Center	Miami, FL	●
8	James A. Haley Veterans' Hospital	Tampa, FL	●
8	North Florida/Southern Georgia HCS: Lake City VAMC	Lake City, FL	●
8	North Florida/Southern Georgia HCS: Malcom Randall VAMC	Gainesville, FL	●
8	Orlando VAMC	Orlando, FL	●
10	Battle Creek VAMC – Building 82	Battle Creek, MI	●
10	Battle Creek VAMC – Building 84	Battle Creek, MI	●
10	John D. Dingell VAMC – 6N/S	Detroit, MI	●
10	John D. Dingell VAMC – A5101	Detroit, MI	○
12	Clement J. Zablocki VAMC	Milwaukee, WI	●
12	Edward Hines Jr. VA Hospital	Hines, IL	●
12	Jesse Brown VAMC	Chicago, IL	●
12	VA Illiana HCS	Danville, IL	●
16	Gulf Coast Veterans HCS	Biloxi, MS	●
16	Southeast Louisiana Veterans HCS	New Orleans, LA	●
17	Central Texas Veterans HCS: Olin E. Teague Veterans' Medical Center - Temple	Temple, TX	●

VISN	Facility	City, State	VHA Staff Were Prepared to Allow OIG Staff Entry
17	Central Texas Veterans HCS: Olin E. Teague Veterans' Medical Center - Waco	Waco, TX	●
17	VA North Texas Health Care System	Dallas, TX	●
17	VA North Texas Health Care System - Bonham	Bonham, TX	●
19	Oklahoma City VA HCS	Oklahoma City, OK	●
20	VA Portland HCS	Portland, OR	●
20	VA Puget Sound HCS: American Lake	Tacoma, WA	●
20	VA Puget Sound HCS: Seattle Division	Seattle, WA	●
22	Phoenix VA HCS	Phoenix, AZ	●
22	Southern Arizona VA HCS	Tucson, AZ	○
22	VA Greater Los Angeles HCS – Los Angeles	Los Angeles, CA	●
22	VA Greater Los Angeles HCS - Sepulveda	Sepulveda, CA	●
22	VA Loma Linda HCS	Loma Linda, CA	●
22	VA Long Beach HCS	Long Beach, CA	○
22	VA San Diego HCS	San Diego, CA	●

Source: VA OIG analysis of March 19–24, 2020, data
HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

On March 10, 2020, VA announced a no visitors policy in community living centers and spinal cord injury units to decrease COVID-19 exposure to those patients who are considered high-risk.[3] OIG staff tested the policy by attempting to visit 54 VA community living centers.[4]

Nine community living centers located on six different campuses were accessible. All observations were immediately reported to facility leaders.

- Two of the locations, Edith Nourse Rogers Memorial Hospital – Building 4 (Bedford, Massachusetts) and the John D. Dingell VA Medical Center (Detroit, Michigan) lacked signage barring visitors and did not have barriers preventing entry.

[3] An exception to the no visitors policy was allowed for veterans are in their last stages of life on hospice units. In those cases, visitors were limited to a specific veteran's room. For this inspection, access to spinal cord injury units was not tested.

[4] If no one was checking visitors at the entrance to the community living center or if access was granted, OIG staff were instructed to not enter to avoid exposure and prevent potential transmission.

- At five locations, including the other three community living centers on the grounds of the Edith Nourse Rogers Memorial Hospital (Building 2, Building 6-A/B, and Building 6-C/D), and the community living centers contained within the Atlanta VA Medical Center and the Southern Arizona Health Care System, access to the units was not well monitored.[5] VHA personnel at those locations were either not present at the entrance, willing to screen visitors for entry, or were ready to allow entry because visitors had already been screened at the medical center entrance.
- While inspectors were not instructed to test access at all entry points to a facility, OIG staff who visited the Jamaica Plain VA Medical Center and the Tibor Rubin VA Medical Center community living centers found several unlocked and unobserved doors that were accessible.

4. Readiness: Availability of COVID-19 Testing[6]

Facility leaders were asked to tabulate the number of veterans, employees, or others who were tested, tested positive, and/or were admitted. Additional questions were related to COVID-19 testing at the facilities and, if available, which laboratory conducted the testing (see table 4).

Table 4. COVID-19 Testing

Testing Center	Number of VA Medical Facilities Using the Testing Center
County or State Health Department	29
Commercial Lab	26
VA Palo Alto	20
University Lab	6

Source: VA OIG collection of data for March 19–24, 2020, as reported by VA facilities

[5] After being screened at the main entrance to the Atlanta Medical Center and granted access, OIG staff proceeded to the community living center that was located within the same building. A sign was posted on the door to the community living center indicating it was a restricted area. VHA staff opened the door, saw that OIG staff had a sticker provided at the main screening area with the date of screening and were ready to allow entry. After being screened at the main entrance to the Southern Arizona Health Care System, OIG staff proceeded to the community living center that was located within the same building. No barriers were present in the entrance hallways leading to the community living centers and VHA staff were not immediately available to hinder access. OIG staff did not enter these community living centers to avoid exposure.

[6] OIG considers the availability of COVID testing as an important part of the provision of healthcare services. Diagnostic results guide VA providers and patients in their care planning and treatment decision-making processes.

Analysis and Summary

Of the 54 VHA medical facility leaders OIG interviewed, 52 reported collecting COVID-19 specimens.[7] One facility, Manchester VA Medical Center, reported that specimens were not collected or processed, but people who needed testing were referred to the state health department. As of March 19, 2020, none of the facilities visited had the capabilities to process COVID-19 specimens on site. Other medical facility leaders reported the use of county and state health departments and commercial laboratories as the main testing centers used for processing COVID-19 specimens. VA Palo Alto was the only cited VA location that was processing specimens as of March 19, 2020. Five facilities that anticipated having processing capabilities on their campuses were waiting for a needed supply item (reagents).[8] One facility estimated that specimen processing time could be reduced from several days down to four hours by processing at an on-site laboratory.

5. Readiness: Medication Shortages, Supplies, and Equipment

Facility leaders were asked about current and anticipated shortages of medications within the next 14 or 28 days (see table 5a), personal protective equipment, specifically, gloves, gowns, masks including N95s, and face/eye protectors, and the availability of ICU beds, ventilator capable beds, and quarantine beds for both ventilator and non-ventilator patients (see table 5b). Medications listed by facility leaders in anticipated short supply included antibiotics, sedatives, pain, and antiviral medications. Of critical importance in managing infected patients with respiratory symptoms are medications used to treat the potentially severe breathing problems that can occur. Leaders anticipated increased demand of inhaled respiratory therapies.

Table 5a. Anticipated Medication Shortages by Medical Center

● *= no anticipated medication shortages* ○ *= anticipated medication shortage (within the next 14 or 28 days)*

VISN	Facility	City, State	Anticipated Medication Shortage	Anticipated Medication Needs
1	Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA	●	

[7] Jesse Brown VA Medical Center (Chicago, Illinois) declined to provide OIG the requested data.

[8] Bay Pines HCS (Bay Pines, Florida), Greater Los Angeles HCS (Los Angeles, California), James A. Haley Veterans' Hospital (Tampa, Florida), William Jennings Bryan Dorn Department of Veterans Affairs Medical Center (Columbia, South Carolina), and W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center (Salisbury, North Carolina).

VISN	Facility	City, State	Anticipated Medication Shortage	Anticipated Medication Needs
1	Manchester VAMC	Manchester, NH	●	
1	Providence VAMC	Providence, RI	●	
1	VA Boston HCS	Jamaica Plain, MA	●	
1	VA Connecticut HCS	West Haven, CT	○	14-day: Kaletra, chloroquine, and hydroxychloroquine 28-day: Kaletra, chloroquine, and hydroxychloroquine
1	VA Maine HCS	Augusta, ME	●	
1	White River Junction VAMC	White River Junction, VT	●	
2	Buffalo VAMC	Buffalo, NY	●	
2	VA Finger Lakes HCS	Canandaigua, NY	●	
4	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia, PA	●	
4	Wilmington VAMC	Wilmington, DE	●	
5	Martinsburg VAMC	Martinsburg, WV	○	14-day: Hydroxychloroquine 28-day: Hydroxychloroquine
5	VA Maryland HCS	Baltimore, MD	○	14-day: Sterile 70% isopropyl alcohol 28-day: Acetaminophen (325mg and 500mg tablets), IV Piggyback solutions in 50ml, 100ml and 250ml normal saline (NS) and dextrose (placed on allocation by Baxter Health Care Products), and various nebulizer products (due to increased demands for respiratory treatments)
5	Washington VAMC	Washington, DC	●	
6	Durham VA Medical Center	Durham, NC	○	14-day: Calcium chloride abbojects, amiodarone injections, epinephrine abbojects, atrovent inhalers, regular insulin 100u, NPH (Neutral Protamine Hagedorn) insulin, propofol (50ml and 100ml), ipratropium

VISN	Facility	City, State	Anticipated Medication Shortage	Anticipated Medication Needs
				mdi,[9] ephedrine, and rocuronium 28-day: Fentanyl 50mcg/ml injections (all sizes), Tylenol tabs, hydroxychloroquine, heparin, epinephrine, clonazepam, hydromorphone 2mg/ml injections, Midazolam injection, and spacers
6	Fayetteville VAMC	Fayetteville, NC	●	
6	Hampton VAMC	Hampton, VA	●	
6	Hunter Homes McGuire Hospital	Richmond, VA	●	
6	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	Salisbury, NC	●	
7	Atlanta VAMC	Decatur, GA	●	
7	Central Alabama Veterans HCS	Montgomery, AL	●	
7	Charlie Norwood Department of Veterans Affairs Medical Center	Augusta, GA	●	
7	William Jennings Bryan Dorn Department of Veterans Affairs Medical Center	Columbia, SC	○	14-day: Hydroxychloroquine 28-day: Hydroxychloroquine
8	Bay Pines VA HCS	Bay Pines, FL	●	
8	Bruce W. Carter Department of Veterans Affairs Medical Center	Miami, FL	●	
8	James A. Haley Veterans' Hospital	Tampa, FL	○	28-day: Fentanyl
8	North Florida/Southern Georgia HCS: Lake City VAMC	Lake City, FL	●	
8	North Florida/Southern Georgia HCS: Malcom Randall VAMC	Gainesville, FL	●	
8	Orlando VAMC	Orlando, FL	●	
10	Battle Creek VAMC	Battle Creek, MI	●	
10	John D. Dingell VAMC	Detroit, MI	○	14-day: Not specified[10] 28-day: Not specified
10	Richard L. Roudebush VAMC	Indianapolis, IN	●	
12	Clement J. Zablocki VAMC	Milwaukee, WI	●	

[9] Within the context of this report, "mdi" is defined as metered dose inhaler.

[10] Facility leaders reported a general concern about shortages of nationally unavailable medications.

VISN	Facility	City, State	Anticipated Medication Shortage	Anticipated Medication Needs
12	Edward Hines Jr. VA Hospital	Hines, IL	●	
12	Jesse Brown VAMC	Chicago, IL	●	
12	VA Illiana HCS	Danville, IL	●	
16	Gulf Coast Veterans HCS	Biloxi, MS	●	
16	Michael E. DeBakey VAMC	Houston, TX	●	
16	Southeast Louisiana Veterans HCS	New Orleans, LA	●	
17	Central Texas Veterans HCS	Temple, TX	○	14-day: Hydroxychloroquine, alcohol-based preps, sterile alcohol, acyclovir, acetaminophen, and lopinavir/ritonavir 28-day: Intravenous immunoglobulin (IVIG)
17	VA North Texas HCS	Dallas, TX	●	
19	Oklahoma City VA HCS	Oklahoma City, OK	○	14-day: Hydroxychloroquine, lopinavir/ritonavir, and tocilizumab 28-day: Azithromycin
19	VA Eastern Colorado HCS	Aurora, CO	○	14-day: Medications manufactured in China
19	VA Salt Lake City HCS	Salt Lake City, UT	●	
20	VA Portland HCS	Portland, OR	●	
20	VA Puget Sound HCS	Seattle, WA	○	14-day: Albuterol and combivent 28-day: Hydroxychloroquine, remdesivir (possibly), and acetaminophen
21	VA Southern Nevada HCS	N. Las Vegas, NV	●	
22	Phoenix VA HCS	Phoenix, AZ	○	28-day: Atrovent inhalers, albuterol inhalers, proair inhalers, kaletra (lopinavir/ritonavir), actemra (tocilizumab), prezcobix (darunavir/cobicistat), hydroxychloroquine 200 mg, and chloroquine (250 mg and 500 mg)
22	Southern Arizona VA HCS	Tucson, AZ	●	
22	VA Greater Los Angeles HCS	Los Angeles, CA	●	
22	VA Loma Linda HCS	Loma Linda, CA	●	
22	VA Long Beach HCS	Long Beach, CA	●	

VISN	Facility	City, State	Anticipated Medication Shortage	Anticipated Medication Needs
22	VA San Diego HCS	San Diego, CA	●	
23	VA Nebraska-Western Iowa HCS	Omaha, NE	●	

Source: VA OIG collection of March 19–24, 2020, data as reported by VA facilities
HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

Challenges exist in determining adequate supplies of medication to care for COVID-19 infected patients. In that no medications are currently proven to treat COVID-19, several medications are under active investigation, and if proven effective, may significantly increase the demand of medications typically stocked in low volumes. Additionally, the inventory of medications used to (1) manage symptoms, (2) treat critically ill patients to support cardiovascular functions, and (3) sedate intubated patients may be insufficient.

Table 5b. Reported Adequacy of Supplies and Equipment by Medical Center

● *= adequate supplies and/or equipment* ○ *= inadequate supplies and/or equipment*

VISN	Facility	City, State	Adequate Supplies	Supply and Equipment Needs
1	Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA	●	
1	Manchester VAMC	Manchester, NH	●	
1	Providence VAMC	Providence, RI	○	Sanitizer
1	VA Boston HCS	Jamaica Plain, MA	●	
1	VA Connecticut HCS	West Haven, CT	●	
1	VA Maine HCS	Augusta, ME	●	
1	White River Junction VAMC	White River Junction, VT	○	Powered air purifying respirators
2	Buffalo VAMC	Buffalo, NY	○	Masks and gloves
2	VA Finger Lakes HCS	Canandaigua, NY	○	N95 masks
4	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia, PA	●	
4	Wilmington VAMC	Wilmington, DE	●	
5	Martinsburg VAMC	Martinsburg, WV	●	
5	VA Maryland HCS	Baltimore, MD	○	N95 masks and face/eye protection

VISN	Facility	City, State	Adequate Supplies	Supply and Equipment Needs
5	Washington VAMC	Washington, DC	○	Testing kits, powered air purifying respirators, gowns, and face/eye protection
6	Durham VA Medical Center	Durham, NC	○	Ventilators, N95 masks (small and extra small sizes), gowns, and face/eye protection
6	Fayetteville VAMC	Fayetteville, NC	●	
6	Hampton VAMC	Hampton, VA	○	Hand sanitizer, powered air purifying respirators, masks, and other personal protective equipment
6	Hunter Homes McGuire Hospital	Richmond, VA	○	Test kits and personal protective equipment
6	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	Salisbury, NC	○	N95 masks
7	Atlanta VAMC	Decatur, GA	○	Test kits, N95 masks, surgical masks, and eye protection
7	Central Alabama Veterans HCS: Montgomery VAMC	Montgomery, AL	○	Hand sanitizer (small bottles)
7	Charlie Norwood Department of Veterans Affairs Medical Center	Augusta, GA	●	
7	William Jennings Bryan Dorn Department of Veterans Affairs Medical Center	Columbia, SC	●	
8	Bay Pines VA HCS	Bay Pines, FL	○	N95 masks and blood bank supplies
8	Bruce W. Carter Department of Veterans Affairs Medical Center	Miami, FL	○	N95 masks, powered air purifying respirators, gloves, gowns, and face/eye protection
8	James A. Haley Veterans' Hospital	Tampa, FL	○	Testing reagents, swabs, N95 masks, surgical masks, face shields, and surgical gowns
8	North Florida/Southern Georgia HCS: Lake City VAMC	Lake City, FL	●	
8	North Florida/Southern Georgia HCS: Malcom Randall VAMC	Gainesville, FL	●	
8	Orlando VAMC	Orlando, FL	●	
10	Battle Creek VAMC	Battle Creek, MI	○	Hand sanitizer (wall unit and individual use) and level 4 gowns
10	John D. Dingell VAMC	Detroit, MI	○	Ventilators, testing swabs, viral media, hand sanitizer (wall unit and individual use), N95 masks, masks, face shields, goggles, disposable stethoscopes, and disposable blood pressure cuffs
10	Richard L. Roudebush VAMC	Indianapolis, IN	○	Gowns (all sizes) and personal protective equipment
12	Clement J. Zablocki VAMC	Milwaukee, WI	○	3/4 surgical drapes
12	Edward Hines Jr. VA Hospital	Hines, IL	○	Face shields and surgical masks

VISN	Facility	City, State	Adequate Supplies	Supply and Equipment Needs
12	Jesse Brown VAMC	Chicago, IL	●	
12	VA Illiana HCS	Danville, IL	●	
16	Gulf Coast Veterans HCS	Biloxi, MS	○	N95 masks, surgical masks, accessories for powered air purifying respirators, gowns, and goggles
16	Michael E. DeBakey VAMC	Houston, TX	○	Hand sanitizer, N95 masks, surgical masks, isolation gowns
16	Southeast Louisiana Veterans HCS	New Orleans, LA	●	
17	Central Texas Veterans HCS	Temple, TX	○	N95 masks, powered air purifying respirators, generic masks, goggles and face protection, isolation gowns, and disinfecting/sanitizing wipes
17	VA North Texas HCS	Dallas, TX	○	Hand sanitizer, N95 masks, and disinfecting/sanitizing wipes
19	Oklahoma City VA HCS	Oklahoma City, OK	○	Viral media (testing), N95 masks, masks with face shields, and isolation gowns
19	VA Eastern Colorado HCS	Aurora, CO	○	Surgical masks and disposal gowns
19	VA Salt Lake City HCS	Salt Lake City, UT	○	Hand sanitizer, N95 masks (small size), and surgical masks
20	VA Portland HCS	Portland, OR	○	Flu swabs (testing), N95 masks (small size), and generic masks
20	VA Puget Sound HCS	Seattle, WA	○	Hand sanitizer (wall unit and individual use)
21	VA Southern Nevada HCS	N. Las Vegas, NV	●	
22	Phoenix VA HCS	Phoenix, AZ	○	Face shields for droplet precautions
22	Southern Arizona VA HCS	Tucson, AZ	●	
22	VA Greater Los Angeles HCS	Los Angeles, CA	●	
22	VA Loma Linda HCS	Loma Linda, CA	○	N95 masks and powered air purifying respirators
22	VA Long Beach HCS	Long Beach, CA	●	
22	VA San Diego HCS	San Diego, CA	○	Hand sanitizer, N95 respirators, disposable level 4 gowns, surgical masks, and disinfecting/sanitizing wipes
23	VA Nebraska-Western Iowa HCS	Omaha, NE	○	Hand sanitizer, bleach (cleaning), masks, eye shields, powered air purifying respirators, gowns

Source: VA OIG collection of March 19–24, 2020, data as reported by VA facilities
HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

Anticipating equipment and supply needs is challenging as it is unclear when COVID-19 will reach its peak in the United States and ultimately test the capacity of healthcare systems to care for patients who require prolonged, high-level inpatient, and often, intensive care. At the time of this OIG inspection, facility leaders expressed concerns related to supplies needed to test patients for COVID-19. They also acknowledged low inventory of personal protective equipment for staff. Of note, leaders at two facilities—Durham VA Medical Center, and John D. Dingle VA Medical Center, Detroit, Michigan—reported shortages of mechanical ventilators.

6. Readiness: Staffing

Facility leaders were asked to report on the adequacy of staffing of licensed independent practitioners (LIPs), nurses, police, and environmental management. Other questions related to the impact of any employee absenteeism (see table 6).[11]

Table 6. Staffing Adequacy of LIPs, Nurses, Police, and Environmental Management at Selected VHA Medical Centers

● = *adequate* ○ = *inadequate* ▬ = *facility declined to provide data*

VISN	Facility	City, State	LIP Staffing to Optimize Care in Wards and ICUs	Nurse Staffing to Optimize Care in Wards and ICUs	Police Staffing[12]	Environmental Management Staffing
1	Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA	N/A	N/A	●	○
1	Manchester VAMC	Manchester, NH	N/A	N/A	●	●
1	Providence VAMC	Providence, RI	●	●	●	●
1	VA Boston HCS: Jamaica Plain Campus	Jamaica Plain, MA	●	●	○	○

[11] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. An LIP is an "individual permitted by law…and the facility to provide patient care services independently, [that is], without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges. VHA Directive 1850, *Environment Program Services*, March 31, 2017. Environmental Services is responsible for "ensuring a state of physical and biological cleanliness."

[12] The OIG included an evaluation of VA Police staffing, which is deemed critical because of the 100% screening of all visitors and emergent response needed to mitigate risks of further transmission of COVID-19 infections.

VISN	Facility	City, State	LIP Staffing to Optimize Care in Wards and ICUs	Nurse Staffing to Optimize Care in Wards and ICUs	Police Staffing[12]	Environmental Management Staffing
1	VA Connecticut HCS: West Haven Campus	West Haven, CT	●	○	●	●
1	VA Maine HCS	Augusta, ME	●	●	○	○
1	White River Junction VAMC	White River Junction, VT	●	●	●	○
2	Buffalo VAMC	Buffalo, NY	●	●	●	●
2	VA Fingers Lakes HCS	Canandaigua, NY	●	●	●	●
4	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia, PA	●	●	●	●
4	Wilmington VAMC	Wilmington, DE	●	●	●	●
5	Martinsburg VAMC	Martinsburg, WV	●	○	○	●
5	VA Maryland HCS	Baltimore, MD	●	●	●	●
5	Washington VAMC	Washington, DC	●	●	○	○
6	Durham VA Medical Center	Durham, NC	●	●	○	○
6	Fayetteville VAMC	Fayetteville, NC	●	●	●	●
6	Hampton VAMC	Hampton, VA	●	●	●	●
6	Hunter Homes McGuire Hospital	Richmond, VA	●	●	●	○
6	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	Salisbury, NC	●	●	●	○
7	Atlanta VAMC	Decatur, GA	●	○	○	○
7	Central Alabama Veterans HCS: Montgomery VAMC	Montgomery, AL	●	●	●	●
7	Charlie Norwood Department of Veterans Affairs Medical Center	Augusta, GA	●	●	●	●
7	William Jennings Bryan Dorn Department of Veterans Affairs Medical Center	Columbia, SC	●	●	●	●
8	Bay Pines VA HCS	Bay Pines, FL	●	○	○	○
8	Bruce W. Carter Department of Veterans Affairs Medical Center	Miami, FL	●	●	○	○
8	James A. Haley Veterans' Hospital	Tampa, FL	●	●	●	●
8	North Florida/Southern Georgia HCS: Lake City VAMC	Lake City, FL	●	●	●	●
8	North Florida/Southern Georgia HCS: Malcom Randall VAMC	Gainesville, FL	●	●	●	●

VISN	Facility	City, State	LIP Staffing to Optimize Care in Wards and ICUs	Nurse Staffing to Optimize Care in Wards and ICUs	Police Staffing[12]	Environmental Management Staffing
8	Orlando VAMC	Orlando, FL	●	○	●	○
10	Battle Creek VAMC	Battle Creek, MI	N/A	N/A	●	●
10	John D. Dingell VAMC	Detroit, MI	●	●	○	○
10	Richard L. Roudebush VAMC	Indianapolis, IN	●	●	○	●
12	Clement J. Zablocki VAMC	Milwaukee, WI	●	●	–	–
12	Edward Hines Jr. VA Hospital	Hines, IL	●	●	●	●
12	Jesse Brown VAMC	Chicago, IL	●	●	–	–
12	VA Illiana HCS	Danville, IL	●	●	●	●
16	Gulf Coast Veterans HCS	Biloxi, MS	●	○	●	●
16	Michael E. DeBakey VAMC	Houston, TX	●	●	○	○
16	Southeast Louisiana Veterans HCS	New Orleans, LA	●	○	●	●
17	Central Texas Veterans HCS: Olin E. Teague Veterans' Medical Center	Temple, TX	●	●	●	●
17	VA North Texas HCS	Dallas, TX	○	●	●	●
19	Oklahoma City VA HCS	Oklahoma City, OK	●	●	○	○
19	VA Eastern Colorado HCS	Aurora, CO	●	●	●	●
19	VA Salt Lake City HCS	Salt Lake City, UT	●	●	●	●
20	VA Portland HCS	Portland, OR	●	●	●	○
20	VA Puget Sound HCS: Seattle Division	Seattle, WA	●	●	○	○
21	VA Southern Nevada HCS	N. Las Vegas, NV	●	●	●	●
22	Phoenix VA HCS	Phoenix, AZ	●	●	●	●
22	Southern Arizona VA HCS	Tucson, AZ	●	●	●	●
22	VA Greater Los Angeles HCS	Los Angeles, CA	●	●	●	●
22	VA Loma Linda HCS	Loma Linda, CA	●	○	●	●
22	VA Long Beach HCS	Long Beach, CA	●	●	○	○
22	VA San Diego HCS	San Diego, CA	●	○	●	●
23	VA Nebraska-Western Iowa HCS	Omaha, NE	●	●	○	○

Source: VA OIG collection of data for March 19–24, 2020, as reported by VA facilities
N/A= these facilities do not have an ICU

HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

Facility leaders at selected VA medical facilities were asked about the adequacy of staffing for LIPs, nurses, police, and environmental management (including housekeeping). One facility, the VA North Texas HCS in Dallas, Texas, reported inadequate staffing for LIPs if there were to be a surge and need to shift staff from one area to another. The leader specifically mentioned that if residents and fellows were to be moved, LIP staffing would be short, as not all physicians are trained in ICU/critical care. Nine facility leaders reported deficient ICU nurse staffing. Of those, four reported that they were currently staffed but would not be in the event of a surge of patients. The other five reported needing additional nurses for various reasons, including school closures, spring break, staff absences, and the fact that nursing staff are being asked to operate screening stations. One facility said it is currently managing by using overtime pay.

Shortages in police staffing are often cited by facilities. In the FY 2019 OIG *Determination of Veterans Health Administration's Occupational Staffing Shortages*, 65 facilities identified this as a severe occupational shortage.[13] During this OIG inspection on readiness, police staffing was cited as inadequate by 15 of 54 medical facility leaders. Thirteen of the facilities reported low staffing numbers due to training, recruitment, and retention challenges, as well as the additional strain caused by the need for additional police presence for COVID-19-related screenings. The remaining two facilities were concerned with the potential need for additional police presence in a surge and budget-related issues. In order to address staffing sufficiency, some facility leaders reported moving to 12-hour shifts and attempting to get contract security services.

Environmental management and housekeeping are also known to have staffing challenges. In the FY 2019 OIG staffing report, 56 of 140 (40 percent) of VHA facilities identified either Custodial Worker or Hospital Housekeeping Management as severe occupational shortages. Facility leaders from 19 VA medical centers that were visited cited staffing below their full-time staffing levels. The staffing gap ranged from 20 to 51 open positions. Facility leaders reported difficulty with recruitment and retention due to several factors, including complex hiring practices, lower wages than the private sector, and an increased workload due to COVID-19. For example, one facility was deploying staff to clean high-touch areas, such as elevators, doorknobs, and railings, with greater frequency. Some facilities were looking into establishing contracts to try and address staffing gaps.

While almost half (25 of 54) of the facilities reported a rise in absenteeism of staff, facility leaders reported being able to provide coverage so that the impact was minimal. Half of the

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

facilities reported a rise in absentee staff due to childcare issues, school closures, and planned spring break absences. One facility reported absenteeism of older employees due to concerns with their own safety in light of COVID-19 risks. Facility leaders reported allocating staff from to needed areas, moving towards telehealth, and offering overtime pay to address staff absences.

7. Readiness: Coordination between Facility and Community

Facility leaders were asked about plans to share intensive care unit (ICU) beds or personal protective equipment with community hospitals, whether there was a written agreement for transfer of COVID-19 patients to non-VA community hospitals when a higher level of care was needed, sharing of VA staff with non-VA facilities (see table 7a), and referral patterns (see table 7b).

Table 7a. Coordination with Community Facilities

● = *reported plans to share with community providers*
○ = *no reported plans to share with community providers*
▬ = *facility declined to provide data*

VISN	Facility	City, State	Plans to Share ICU Beds	Plans to Share Personal Protective Equipment Supplies
1	Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA	N/A	○
1	Manchester VAMC	Manchester, NH	N/A	●
1	Providence VAMC	Providence, RI	●	○
1	VA Boston HCS: Jamaica Plain Campus	Jamaica Plain, MA	○	○
1	VA Connecticut HCS: West Haven Campus	West Haven, CT	○	○
1	VA Maine HCS	Augusta, ME	○	○
1	White River Junction VAMC	White River Junction, VT	●	○
2	Buffalo VAMC	Buffalo, NY	○	○
2	VA Finger Lakes HCS	Canandaigua, NY	○	○
4	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia, PA	○	○
4	Wilmington VAMC	Wilmington, DE	●	●
5	Martinsburg VAMC	Martinsburg, WV	○	○
5	VA Maryland HCS	Baltimore, MD	●	○

VISN	Facility	City, State	Plans to Share ICU Beds	Plans to Share Personal Protective Equipment Supplies
5	Washington VAMC	Washington, DC	○	○
6	Durham VA Medical Center	Durham, NC	○	○
6	Fayetteville VAMC	Fayetteville, NC	●	○
6	Hampton VAMC	Hampton, VA	●	○
6	Hunter Homes McGuire Hospital	Richmond, VA	○	○
6	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	Salisbury, NC	○	○
7	Atlanta VAMC	Decatur, GA	○	○
7	Central Alabama Veterans HCS: Montgomery VAMC	Montgomery, AL	●	○
7	Charlie Norwood Department of Veterans Affairs Medical Center: Uptown Campus	Augusta, GA	○	○
7	William Jennings Bryan Dorn Department of Veterans Affairs Medical Center	Columbia, SC	○	○
8	Bay Pines VA HCS	Bay Pines, FL	○	○
8	Bruce W. Carter Department of Veterans Affairs Medical Center	Miami, FL	○	○
8	James A. Haley Veterans' Hospital	Tampa, FL	●	○
8	North Florida/Southern Georgia HCS: Lake City VAMC	Lake City, FL	○	○
8	North Florida/Southern Georgia HCS: Malcom Randall VAMC	Gainesville, FL	○	○
8	Orlando VAMC	Orlando, FL	○	●
10	Battle Creek VAMC	Battle Creek, MI	N/A	●
10	John D. Dingell VAMC	Detroit, MI	●	●
10	Richard L. Roudebush VAMC	Indianapolis, IN	●	●
12	Clement J. Zablocki VAMC	Milwaukee, WI	○	●
12	Edward Hines Jr. VA Hospital	Hines, IL	○	○
12	Jesse Brown VAMC	Chicago, IL	▬	▬
12	VA Illiana HCS	Danville, IL	●	○
16	Gulf Coast Veterans HCS	Biloxi, MS	○	○
16	Michael E. DeBakey VAMC	Houston, TX	●	●

VISN	Facility	City, State	Plans to Share ICU Beds	Plans to Share Personal Protective Equipment Supplies
16	Southeast Louisiana Veterans HCS	New Orleans, LA	●	○
17	Central Texas Veterans HCS: Olin E. Teague Veterans' Medical Center	Temple, TX	○	○
17	VA North Texas HCS	Dallas, TX	○	○
19	Oklahoma City VA HCS	Oklahoma City, OK	●	●
19	VA Eastern Colorado HCS	Aurora, CO	●	●
19	VA Salt Lake City HCS	Salt Lake City, UT	○	○
20	VA Portland HCS	Portland, OR	○	○
20	VA Puget Sound HCS: Seattle Division	Seattle, WA	○	○
21	VA Southern Nevada HCS	N. Las Vegas, NV	●	●
22	Phoenix VA HCS	Phoenix, AZ	●	○
22	Southern Arizona VA HCS	Tucson, AZ	●	○
22	VA Greater Los Angeles HCS	Los Angeles, CA	●	○
22	VA Loma Linda HCS	Loma Linda, CA	○	○
22	VA Long Beach HCS	Long Beach, CA	○	○
22	VA San Diego HCS	San Diego, CA	○	○
23	VA Nebraska-Western Iowa HCS	Omaha, NE	○	○

Source: VA OIG collection of data for March 19–24, 2020, as reported by VHA facilities
N/A= these facilities do not have an ICU
HCS = health care system or healthcare system
VAMC = VA medical center

Analysis and Summary

OIG staff asked facility leaders about plans to share ICU beds and personal protective equipment supplies with community providers. As of March 19, 2020, 23 of the 54 (43 percent) facility leaders reported plans to share ICU beds, personal protective equipment supplies, or both, with community providers.

COVID-19 is not a challenge unique to VA medical centers. Communities across the country are faced with preparing for a surge of patients who will need critical care due to illness and complications. There may be a need for VA medical centers to refer patients to other VA

facilities or community providers or be asked to provide care to community patients. The OIG inspectors examined planned referral patterns (see table 7b).

Table 7b. Potential Referrals for COVID-19 Patients

Hospitals	Number of Times Cited by VA Medical Centers
Other VA Medical Center	13
Private, Community, or University Hospital	46
Department of Defense Hospital	5

Source: VA OIG collection of data for March 19–24, 2020, as reported by VA facilities

Analysis and Summary

Facility leaders were asked where they would send VA patients if they were unable to meet care needs due to COVID-19. Forty-nine of the 54 VHA leaders stated they would send patients to either another VA medical center, a private, community, university, or Department of Defense hospital.[14] The vast majority (46 of 54) of leaders cited consideration of the option to send a sick COVID-19 patient, for whom they could not provide care, to a private, community, or university hospital. Forty-nine of the 54 facility leaders provided alternative care options, if needed, and 26 of these facilities had written agreements in place. Thirty of the 54 facility leaders indicated that there were no barriers that existed that limited the coordination with community resources.

[14] Four facilities provided alternative reasons for not transferring patients. Two facilities stated transfer was not an option. In one case, the facility reported that hospitals, in the surrounding counties, were not taking new admissions. Another facility indicated a tiered approach to move patients into new wards, reactivate old wards, and putting up a tent ward, if needed. The fourth facility leader discussed being a designated site for referrals from other facilities within the VISN, and therefore, would not refer patients to other facilities.

Summary of OIG Findings

The OIG recognizes that conditions at VHA facilities and veterans' needs related to the COVID-19 pandemic may change rapidly. The OIG will continue monitoring VHA in its efforts to provide safe quality healthcare to veterans while also protecting the health of VA employees and preparing for a national crisis response during this pandemic. It is hoped that the findings in this report will assist VHA leaders to gain a better assessment of screening, access, and emergency preparedness at its facilities. This may also be a useful reference for facilities that were not visited to gauge their status.

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Appendix A: Management Comments and OIG Response

Management Comments

Veterans Health Administration
OIG Inspection of VHA's COVID-19 Screening Processes and Pandemic Readiness
Communications Summary

March 26, 2020

Summary

From March 19-24, VA Office of Inspector General (OIG) conducted site visits to VA medical centers, community based outpatient clinics (CBOC) and community living centers (CLC) to determine if VHA facilities were using proper screening in accordance with VHA policy, their ability to test, and readiness in the areas of staffing, supplies/equipment and coordination with the community.

A total of 237 facilities (58 medical centers, 54 CLC, and 125 CBOC) were visited. Sites were selected based on physical location of OIG reviewers.

Response to findings:

In these unprecedented times requiring tightly coordinated development and deployment of new and unique processes across the nation, we acknowledge receipt of this report.

We are, however, deeply concerned that these investigators (many of them clinicians) did not abide by CDC guidelines regarding social distancing, and their movement from one VA hospital and Community Clinic to the next could very possibly make them COVID-19 vectors and put our patients and staff at risk.

Finally, we object to OIG's assertions that a 14-day supply of chloroquine or hydroxychloroquine would have any merit. This is both inaccurate and irresponsible. There are active investigations into these drugs and many others, as discussed by Dr. Anthony Fauci. Yet no conclusions have been made on their effectiveness. To insist that a 14 days' supply of these drugs is appropriate or not appropriate displays this dangerous lack of expertise on COVID-19 and Pandemic response.

Findings:

1. Screening for COVID-19 at 58 medical centers
    - 41 were found to be adequate; 16 had opportunity for improvement;
    - 1 had inadequate screening process

    RESPONSE: VHA has been preparing for the COVID-19 pandemic since January. On January 22, 2020 the Emergency Management Coordination Cell conducted the first nCoV2019 planning session and convened the High Consequence Infection (HCI) workgroup. On March 11, the World Health Organization (WHO) declared COVID-19 a pandemic. Within two days, VA implemented measures to combat COVID-19. Screening guidance went out March 16. OIG conducted this report between March 19 and 24, 2020, thus, VHA had just begun screening measures four days prior to the beginning of the investigation.

2. Screening for COVID-19 at 125 CBOCs
    - 121 had process in place;
    - 4 did not

    RESPONSE: VHA has been preparing for the COVID-19 pandemic since January. On January 22, 2020 the Emergency Management Coordination Cell conducted the first nCoV2019 planning session and convened the High Consequence Infection (HCI) workgroup. On March 11, the WHO declared COVID-19 a pandemic. Within two days, VA implemented measures to combat COVID-19. Screening guidance went out March 16. OIG conducted this report between March 19 and 24, 2020; thus, VHA had just begun screening measures four days prior to the beginning of the investigation.

3. Community Living Center access (54 CLCs)
    - 9 were prepared to allow OIG staff to enter;
    - 45 were not

    RESPONSE: VHA has been preparing for the COVID-19 pandemic since January. On January 22, 2020 the Emergency Management Coordination Cell conducted the first nCoV2019 planning session and convened the High Consequence Infection (HCI) workgroup. On March 11, the WHO declared COVID-19 a pandemic. Within two days, VA implemented measures to combat COVID-19. On March 10, one day before the pandemic was declared, VHA published guidance to limit admissions and staffing at CLCs, institute screening and reduce visitors to palliative care patients only. OIG conducted this report between March 19 and 24, 2020; thus, VHA had just begun COVID-19 CLC measures 9 days prior to the beginning of the investigation.

4. Availability of COVID-19 testing at VAMC (54 facility leaders interviewed)
    - 52 reported collecting specimens;
    - 1 reported not collecting;
    - 1 was collecting and processing

    RESPONSE: As of Friday, March 13, 2020, two days after the WHO declared COVID-19 a pandemic, VA had 3,000 test kits available, 1,000 of which were provided by CDC and an additional 2,000 VA-developed tests that would only be used if necessary. As of March 25, 2020, VA has administered over 3,378 COVID-19 tests nationwide as of March 24, while taking aggressive steps to prevent COVID-19 transmission.

5. Readiness – medication shortages, supplies and equipment at VAMC
    - 33 reported inadequate supplies/equipment;
    - 21 reported adequate supplies/equipment

    B VA is equipped with essential items and supplies to handle an influx of coronavirus cases and is monitoring the status of those items daily. VA is coordinating with HHS regarding VHA prioritization of Personal Protective Equipment.

6. Readiness – staffing
    - Shortages were reported in the areas of nursing, police and environmental management

RESPONSE: VA is actively recruiting permanent and temporary employees across the nation in both clinical non-clinical positions. VHA is particularly interested in rapid re-employment of retired VA clinicians and Federal health care providers. OPM recently granted VA emergency authorities to use dual compensation waivers to ensure that recently retired employees can rejoin our team with no loss to their retirement annuities. VA has active announcements on USA Jobs for all varieties of nurses, engineers, students, laborers, and other occupations. VA is especially looking for health care professionals with interest and expertise in Tele/Virtual Care, National Call Center, Travel Nurse Corps and Direct Patient Care/Support (at VA Medical Centers).

VA is constantly reviewing staffing levels to ensure facilities have what they need to ensure safe, effective, compassionate health care. We are a large health care system and are working with our sister hospitals in VA to pool resources when necessary as well as preparing for expedited hiring if needed.

7. Readiness – coordination between facility and community
    - 49 of 54 stated they would send patients to another VA facility or a private, community, university or Department of Defense hospital.
    - The vast majority (46 of 54) cited consideration of the option of sending a sick COVID-19 patient that they could not care for to a private, community, or university hospital.
    - Forty-nine of the 54 facility leaders provided alternative care options, if needed, and 26 of these facilities had written agreements in place.
    - Thirty of the 54 facility leaders cited that there were no barriers that existed that limited the coordination with community resources.

    RESPONSE: VA stands ready support the department's "Fourth Mission" to bridge the gap into civilian health care systems in the event those systems encounter capacity issues. Those requests would come from the Department of Health and Human Services (HHS), so we refer you to HHS for further comment. In addition, VA is working with community providers in our COVID-19 response plan and published a fact sheet on March 13, 2020 with guidance for community providers.

OIG Response

The OIG welcomes comments from VA and appreciates the tremendous challenges facing personnel at VHA medical facilities. Some of the comments, however, appear to reflect a basic misunderstanding of the methodology, findings, and intent.

First, the genesis of this inspection was a meeting between the Inspector General and the Executive in Charge for the Veterans Health Administration. They discussed how the OIG could be helpful to VHA leaders with respect to the pandemic at the national, regional, and local levels. They agreed that the OIG independently checking on screening practices would be beneficial to VHA. To further assist VHA, all findings were shared in real time with facility leaders to take corrective action as needed and with VA Central Office staff as soon as data were available. All work was conducted in coordination and cooperation with VA at the time of its implementation.

Second, the "investigators" were nearly all clinicians who volunteered to drive to facilities to conduct the inspections. To leverage that opportunity, OIG leaders determined that asking some questions about readiness and medication, supply, and equipment needs would be of immediate use to both VA and other

stakeholders. All OIG staff screened for conditions before traveling to facilities and did observe CDC guidelines on site. Any inference to the contrary is inaccurate. The staff did not access CLCs even when entry was permitted or unfettered. Testing access to CLCs, which care for high-risk patients, and providing results of that testing immediately to local leaders provided the opportunity for staff to promptly reduce infection risk to veterans and staff. In addition, such findings were shared with VHA leaders in real time to ensure appropriate actions had been implemented.

Finally, the needs for medication, equipment, supplies, and staffing were offered by VHA medical facility leaders. For example, OIG inspectors asked facility leaders about supplies of medications. They provided VHA staff the opportunity to identify their needs, which OIG inspectors simply reported. Those responses were not validated or assessed for appropriateness or accuracy. All information in the report on these items were the views of leaders at VHA medical facilities.

The remaining responses reflect the many steps that VHA is undertaking and reflect the very fluid and varied actions underway that the OIG applauds and will continue to monitor.

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