DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19

CHIP REPORT | REPORT #21-01699-175 | JULY 7, 2021

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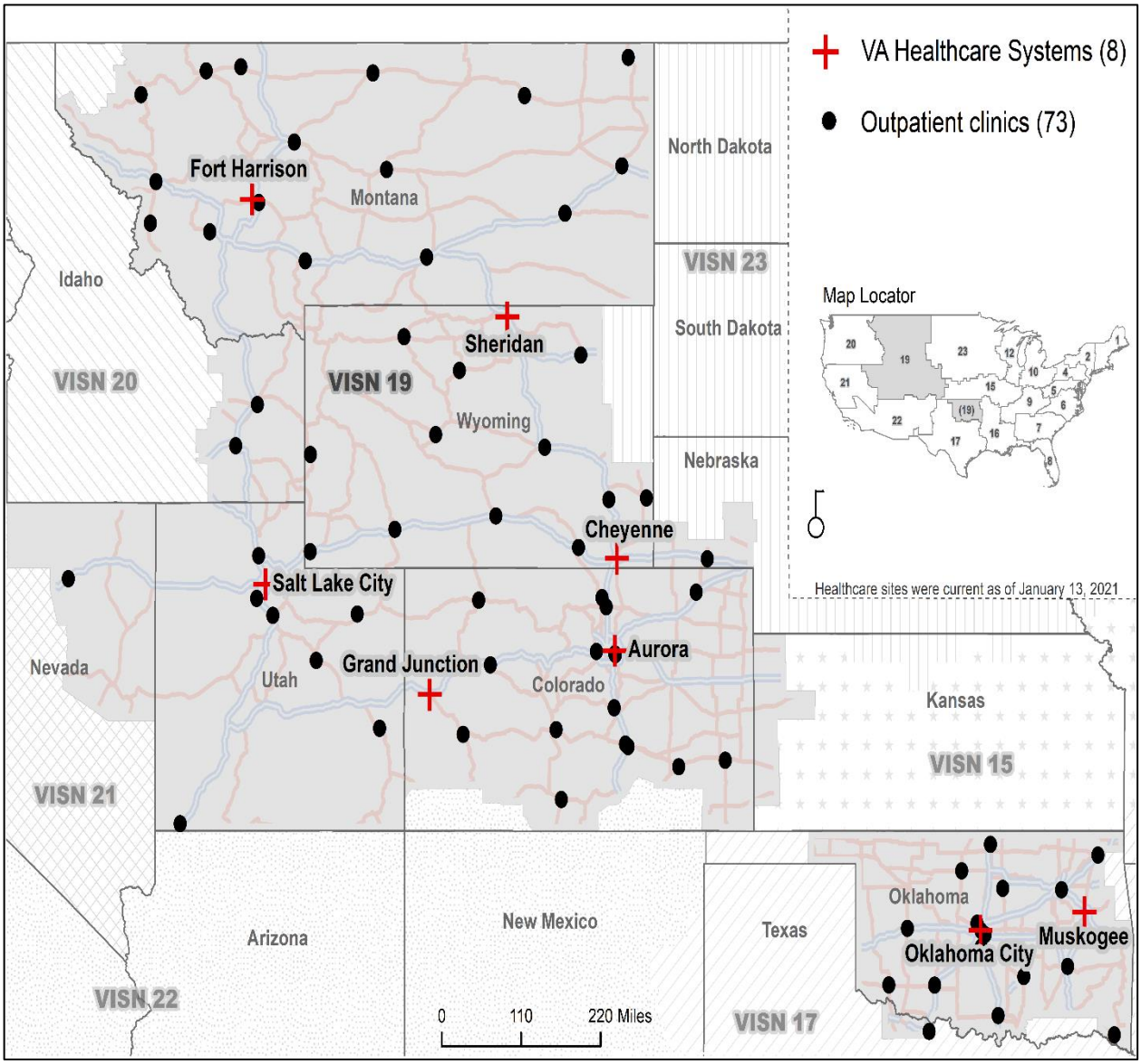

Figure 1. *Veterans Integrated Service Network 19: VA Rocky Mountain Network.*

Source: Veteran Affairs Site Tracking database (accessed January 13, 2021).

Note: Veteran care is provided through regional systems called Veterans Integrated Service Networks (VISNs). There are 18 VISNs that provide administrative and clinical oversight of medical centers. This report focuses on VISN 19.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FDA	Federal Drug Administration
HCS	Health Care System or Healthcare System
OIG	Office of Inspector General
PPE	personal protective equipment
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report examines key clinical and administrative processes that are associated with promoting quality care. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each medical facility. The OIG selects and evaluates specific areas of focus each year. Starting in July 2020, pandemic readiness and response was added as an issue for examination.

The CHIP staff have aggregated findings that relate to COVID-19 readiness and response from these routine inspections to ensure that the information is provided in a comprehensive and timely manner, given the constantly changing landscape as infection rates and demands on facilities continually shift. To promote this objective, CHIP staff have combined the findings of inspected medical facilities by Veterans Integrated Service Network (VISN), which are regional offices that provide oversight of medical centers in their area.[1]

This report is the second in a series. It provides a descriptive evaluation of VISN 19 facilities' responses to COVID-19. This examination is based on findings from healthcare inspections performed during the first quarter of fiscal year 2021 (October 1 through December 31, 2020). The report also provides a more recent snapshot of the pandemic's demands on these facilities' operations based on data compiled as of April 2021. Additionally, it includes information on VISN 19's COVID-19 vaccination efforts, based on data collected by an OIG survey of vaccination coordinators in February 2021 and a review of VA's vaccination statistics as of March 29, 2021. Interviews and survey results provide additional context on lessons learned and perceptions of readiness and responses.

Because of the COVID-19 pandemic, the OIG converted the November and December 2020 VISN 19 medical center and healthcare system (HCS) site visits to virtual reviews, without physical inspections, and completed a COVID-19 pandemic readiness and response evaluation. The OIG's evaluation covers emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; and community living center patient care and operations.[2] The OIG also surveyed facility staff to solicit their feedback and potentially identify any problematic trends or issues that may require follow-up.

[1] Veteran care is provided through regional systems called VISNs. There are 18 VISNs that provide the administrative and clinical oversight of medical centers.

[2] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. Community living centers provide skilled nursing environments and a variety of interdisciplinary programs for persons needing short- and long-stay services.

Inspection Results

These inspections took place during the Veterans Health Administration's (VHA's) third pandemic peak, which was longer and involved more patients than the previous peaks. VISN 19 facility leaders reported varying degrees of strain created by the number of patients with COVID-19. All facility leaders reported having an emergency operations plan prior to the pandemic and activating the plan during the pandemic.

When asked about the types of data that would be critical to have on hand or that would be beneficial to measure and/or monitor for future disaster plans, leaders shared that the following would be important:

- Supply tracking,
- Available staffing,
- Community hospital surge plans,
- Community hospital inpatient capacity and census, and
- COVID-19 patient projections (number of expected cases).

Facility leaders indicated few issues with the adequacy of supplies and equipment to support the treatment of patients with COVID-19. Some leaders reported implementing changes to expand inpatient capacity and address infrastructure inadequacies (for example, increasing the number of beds and converting rooms to negative pressure).[3]

Critical care staff at VISN 19 facilities largely indicated sufficient staffing to support the respiratory care of COVID-19 patients. However, staffing issues were reported by facility leaders and CLC personnel at Eastern Oklahoma (Muskogee), Montana (Fort Harrison), and Oklahoma City VA HCSs.

The COVID-19 pandemic has been disruptive to many VHA operations, particularly those requiring hands-on or face-to-face interactions, including surgical procedures and outpatient clinic visits. Leaders reported that they had adhered to VHA guidance by cancelling elective procedures. At the time of the inspections, all VISN 19 facilities, except Cheyenne VA Medical Center, reported resuming elective surgeries at varying capacities. Leaders universally reported

[3] "Background C. Air, Guidelines for Environmental Infection Control in Health-Care Facilities (2003)," Centers for Disease Control and Prevention, accessed March 22, 2021, https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/air.html. "Positive and negative pressures refer to a pressure differential between two adjacent air spaces (e.g., rooms and hallways). Air flows away from areas or rooms with positive pressure (pressurized), while air flows into areas with negative pressure (depressurized)…rooms are set at negative pressure to prevent airborne microorganisms in the room from entering hallways and corridors."

expanding telemedicine (virtual care) to maintain access to care. Despite ongoing efforts, a significant volume of cancelled appointments still required follow-up as of March 31, 2021.

VHA issued guidance to ensure the safety and well-being of its community living center residents during the pandemic. Facility leaders reported adherence to VHA requirements and recommendations but, similar to the experiences shared with the OIG during the VISN 10 and 20 inspections, some facility leaders described residents' frustration, stress, and feelings of isolation due to visitation restrictions.[4]

From the survey sent electronically to all VISN 19 facility staff, the OIG noted that 63–91 percent of staff who responded reported that leaders and immediate supervisors communicated how to ensure the safety of staff and patients during the pandemic. The OIG also identified general themes, including the importance of communication, flexibility, preparation, and teamwork, when staff were asked about lessons learned during their facility's pandemic response. Twelve to 25 percent of VISN 19 staff who responded reported not having access to appropriate personal protective equipment necessary to ensure their own safety at work during the COVID-19 pandemic.

Finally, VHA and VISN 19 have made progress in their effort to vaccinate veterans against COVID-19. VA announced initial COVID-19 vaccine distribution plans in December 2020.[5] According to VHA, two million veterans had been vaccinated with at least one dose as of the week of March 15, 2021.[6] As of March 29, 2021, VISN 19 had fully vaccinated over 64,000 or approximately 19 percent of its patients.[7]

This report provides data that illustrates the tremendous COVID-19-related demands on VA healthcare services. It shares leader and staff experiences, assessments, shared sentiments, and best practices to help improve operations and clinical care during public health crises. The OIG made no recommendations.

[4] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

[5] VA, "VA to begin COVID-19 vaccinations at 128 additional sites," news release, December 21, 2020, accessed March 18, 2021, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5591.

[6] VHA, email from the VHA Chief of Staff, received March 19, 2021.

[7] "Department of Veterans Affairs COVID-19 National Summary," VA, accessed June 22, 2021, https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary. VHA and VISN 19 had fully vaccinated 3,155,139 and 136,887 individuals, respectively, as of June 22, 2021. The totals include veterans, employees, and federal partners.

Comments

COVID-19 is reshaping the landscape of healthcare delivery worldwide, from how care is delivered on the front lines to overall operations of healthcare facilities. VHA, as the nation's largest integrated healthcare system, will be no exception.

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Contents

Introduction

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans and, when needed, in support of nonveterans during times of crisis.[1] Comprehensive healthcare inspections examine a broad range of key clinical and administrative processes associated with the quality of patient care.

On March 11, 2020, the World Health Organization declared COVID-19 a pandemic.[2] The Veterans Health Administration (VHA) subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on preventing viral transmission among veterans and staff, and for the appropriate care for sick patients.[3]

During this time, VA continued providing for veterans' healthcare needs and engaged its Fourth Mission, the "provision of hospital care and medical services during certain disasters and emergencies" to individuals "who otherwise do not have VA eligibility for such care and services."[4] VHA facilities provide a safety net for the nation's hospitals if they become overwhelmed.[5]

This report describes VISN 19 facilities' pandemic readiness and response and is the second in a series of aggregated pandemic-related information issued separate from other CHIP findings to promptly inform VA and its stakeholders.[6] Additionally, this report includes a more recent snapshot of the number and types of positive cases, and their effect on facility operations as of April 2021. Further, this report provides information on the VISN's COVID-19 vaccination efforts, based on data collected by an OIG survey of facility-level vaccination coordinators in February 2021 and a review of VA's vaccination statistics as of March 29, 2021. This report

[1] 38 C.F.R. § 17.86. "During and immediately following a disaster or emergency…VA under 38 U.S.C. 1785 may furnish hospital care and medical services to individuals (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."

[2] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed January 12, 2021, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[3] VHA Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

[4] 38 U.S.C. § 1785. VA's missions and include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's Fourth Mission, the provision of hospital care and medical services during certain disasters and emergencies. "During and immediately following a disaster or emergency…VA under 38 U.S.C § 1785 may furnish hospital care and medical services to individuals (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."

[5] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, Report No. 20-02221-120, March 26, 2020.

[6] The first OIG report in the series is *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021. Veteran care is provided through regional systems called VISNs. There are 18 VISNs that provide the administrative and clinical oversight of medical centers.

focuses on VISN 19; the OIG's full survey results across VHA will be presented and discussed in a future OIG publication.

Methodology

Comprehensive healthcare inspections are performed approximately every three years for each VHA medical facility. Beginning in FY 2020, the OIG randomly selected facilities for inspection by VISN. However, because of the pandemic, the OIG converted its November and December 2020 site visits to virtual reviews.

The OIG inspection teams interviewed leaders and staff to assess COVID-19 pandemic readiness and response.[7] These virtual inspections were initiated during the weeks of November 30 and December 7, 2020, at the VISN 19: VA Rocky Mountain Network (Glendale, Colorado) office and its facilities:

- Cheyenne VA Medical Center (VAMC) (Wyoming)
- Eastern Oklahoma VA HCS (Muskogee)
- Montana VA HCS (Fort Harrison)
- Oklahoma City VA HCS (Oklahoma)
- Sheridan VAMC (Wyoming)
- VA Eastern Colorado HCS (Aurora)
- VA Salt Lake City HCS (Utah)
- VA Western Colorado HCS (Grand Junction)

As an element of the CHIP evaluation process, the OIG teams assessed the pandemic's effect on VISN 19 facilities and their leaders' subsequent responses and specifically focused on five areas related to emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; and community living center (CLC) patient care and operations.[8] The OIG also surveyed facility staff at the inspected facilities about their experiences with

- Communication,
- Access to personal protective equipment (PPE),
- Job-related training,
- Telework,

[7] VAMC and HCS leaders' interviews generally involved facility directors, chiefs of staff, associate directors for patient care services, and associate and assistant directors. Critical care and CLC leaders' interviews typically involved physician and nurse leaders who oversaw or provided patient care in their respective areas.

[8] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLCs provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

- Employee assistance, and
- Facility readiness and response.

Generally, the OIG coordinated email distribution of the survey and instructions to facility staff on Monday, the first day of the virtual inspections, and collected responses until 5:00 p.m. (local time) on the following Friday. The OIG summarized and shared survey results, including the number of respondents (overall, clinical, nonclinical, and those who did not make a selection) and responses by question and respondent type, with facility leaders and discussed any concerning issues or trends at that time. (See appendix C for the approximate number of staff surveyed during each CHIP review.) The survey findings discussed in this report focus on communication, access to PPE, and lessons learned regarding facility readiness and responses. Interviews and survey responses provided an overall picture of the facilities' pandemic-related challenges as well as lessons learned.

During the virtual reviews, the OIG did not receive any COVID-19-related complaints beyond the scope of the inspections.

In February 2021, the OIG initiated the first phase of a review of VHA's COVID-19 vaccination planning and implementation efforts. The initial phase of this review included a survey of facility-level vaccination coordinators. Although this report notes selected elements of completed surveys from VISN 19, the OIG's full survey results across VHA will be presented and discussed in a future OIG publication.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] 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 inspections in accordance with OIG procedures and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

[9] Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

Inspection Results

The CHIP team examined VA data to help determine COVID-19-related demands on VISN 19 facilities. Interviews with facility leaders and staff helped put those numbers in context and provided useful information on related activities. Specifically, this report examines the following for the OIG review periods provided:

- The number of positive cases in VA and the VISN during the review period (including related testing, status of recovery or death, veteran or employee status, and the age range of patients)
- The evaluation of the five focus areas examined for all VISN comprehensive healthcare inspections related to pandemic readiness and responses:
    - Emergency preparedness
    - Supplies, equipment, and infrastructure
    - Staffing
    - Access to care
    - CLC patient care and operations
- Summary of VISN vaccination efforts as of February 2021 and the number of partial and full vaccinations provided as of March 29, 2021 (veteran, employee, and federal partner)

This report also includes discussions with facility leaders and the summary results of the staff survey.

COVID-19 Cases Across VA and VISN 19

To assess the effect of COVID-19 on facility operations, the OIG reviewed VA surveillance data available at the time of the inspections. Given the ongoing nature of the pandemic and the difficulty of obtaining comprehensive longitudinal data, figures 2–3 provide snapshots of the number of new positive cases for VA and VISN 19 from March 11, 2020, through March 31, 2021.

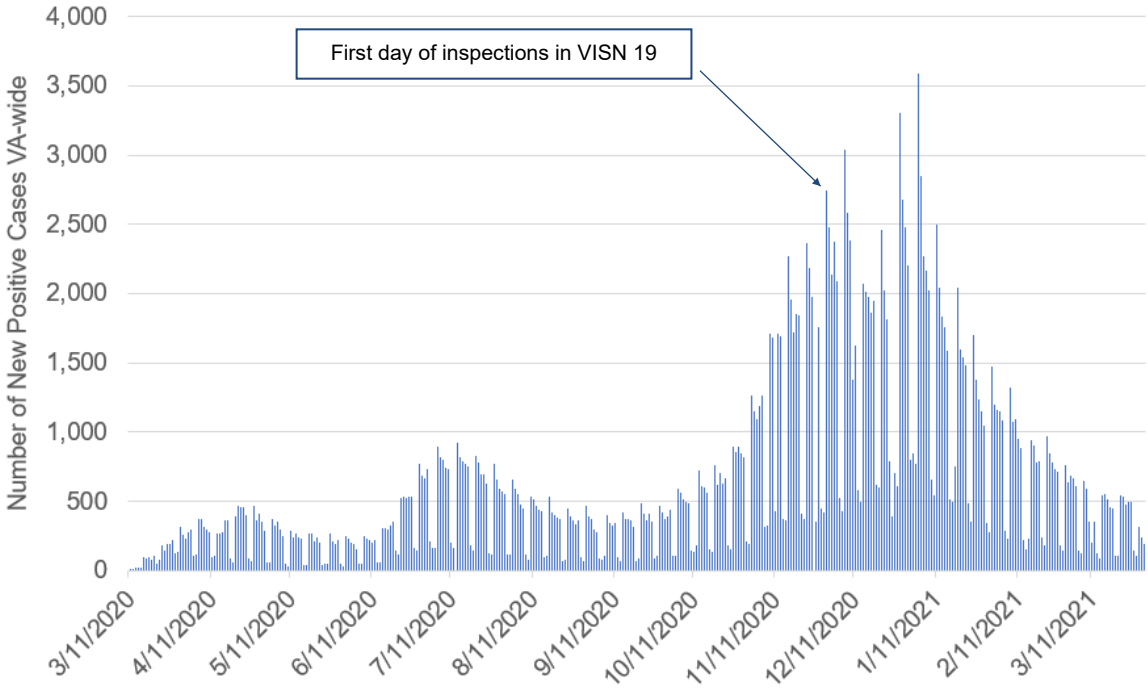

Figure 2. *Number of new positive VA cases nationwide per day (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. The number of new positive cases per day includes "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. This includes all positive labs (SARS-CoV-2019)…This also includes cases tested outside of the VA system but captured through the NST [National Surveillance Tool] classification system, which incorporates both artificial intelligence and human review. A recurrent case may occur if a patient has another positive test after a testing gap of more than 30 days."

The figure makes clear that VA saw a peak surge of more than 3,500 new COVID-19 cases in January 2021. Although there was considerable fluctuation, demands on medical services began rising significantly during the fall of 2020.

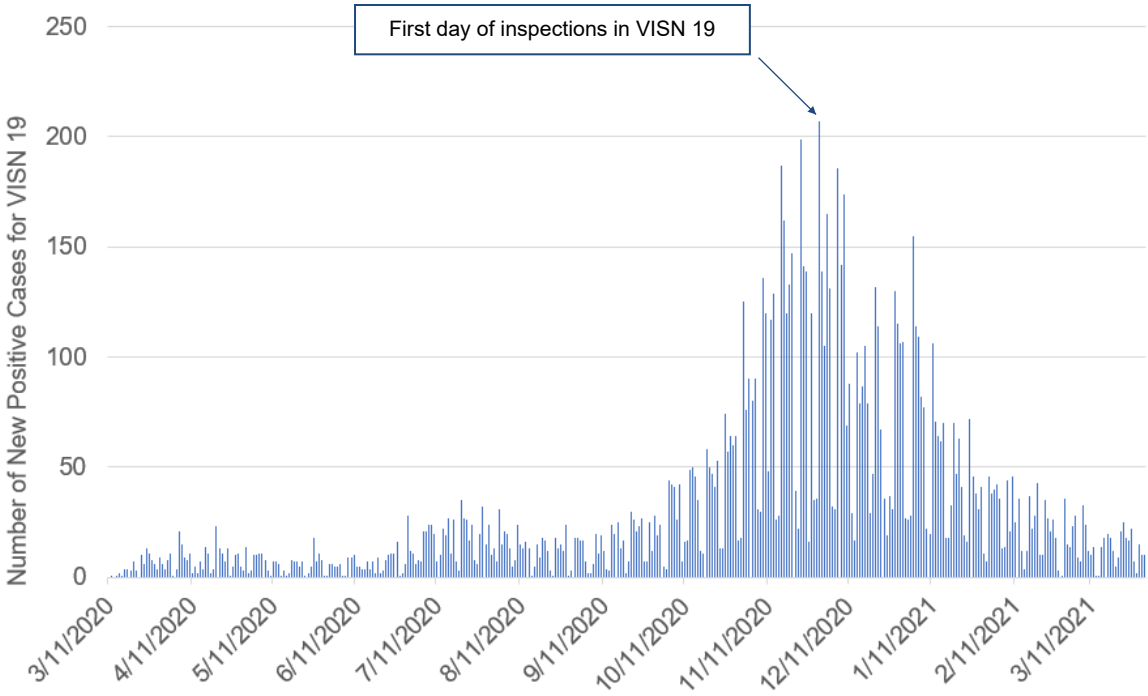

Figure 3. *Number of new positive VISN 19 cases per day (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness. The definition of new positive cases is included below figure 2.

At the time of the OIG's VISN 19 inspections, the network of facilities was experiencing its highest numbers of new positive cases per day since the beginning of the pandemic, topping out at 207 new cases. This figure also reflects the high variability in the number of new cases from one day to another.

Facility leaders reported varying degrees of strain created by the number of COVID-19-positive patients. Some leaders reported minimal or no undue burden on their facilities; however, this was not the experience for all inspected facilities. Additionally, these reports must be evaluated within the context that VA's third pandemic peak was longer and involved more patients than the previous peaks. At the time of the inspections, the Oklahoma City VA HCS Director reported that the intensive care unit was full, the system was currently ranked third in the nation for the number of inpatient COVID-19 cases, and the system was only one of two hospitals in the community with a surge plan.

Testing for COVID-19 and then triaging the positive cases were among the many pandemic-related demands. Tables 1–3 and figures 4 and 5 examine the testing conducted VA-wide and by VISN 19.

Table 1. Testing and Results
(March 11, 2020, through March 31, 2021)

Surveillance Element	VHA	VISN 19
Total Cases	1,407,533	64,206
• Positive Cases*	243,008	11,578
• Negative Cases	1,107,959	51,053
• Pending Cases†	56,566	1,575

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. Additional details about the types of care provided by VHA and within VISN 19 can be found in appendix A.

**Positive 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. This includes all positive labs (SARS-CoV-2019)…This also includes cases tested outside of the VA system but captured through the NST [National Surveillance Tool] classification system, which incorporates both artificial intelligence and human review. A recurrent case may occur if a patient has another positive test after a testing gap of more than 30 days."*

†Pending cases include "patients with orders placed for COVID-19 tests."

Table 2. Status of Positive Cases
(March 11, 2020, through March 31, 2021)

Surveillance Element	VHA	VISN 19
Active*	3,940	167
Convalescent	227,767	10,846
Known Death‡	11,301	565
• Inpatient	3,825	225
• Other	7,476	340

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. Additional details about the types of care provided by VHA and within VISN 19 can be found in appendix A.

*****Active cases include patients "tested or treated at a VA facility for known or probable COVID-19 who have neither died nor reached convalescent status." Convalescent cases represent the patients "tested or treated at a VA facility for known or probable COVID-19 who are either a post-hospital discharge or 14 days past their first positive test, whichever comes later."*

‡Known deaths are "all deaths (all cause), among patients tested or treated at a VA facility, that occur within 30 days of a known COVID positive determination… 'Inpatient' indicates that the death occurred in a 'VA' hospital." "Other" indicates "the death was reported to VA but occurred elsewhere."

Table 3. Patient Types of Positive Cases
(March 11, 2020, through March 31, 2021)

Surveillance Element	VHA	VISN 19
Veteran	218,061	10,654
Employee	18,381	831
Veteran-Employee	799	31
All Other*	5,767	62

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. Additional details about the types of care provided by VHA and within VISN 19 can be found in appendix A.

*****"All Other" includes "civilians admitted to VA hospitals as humanitarian cases, Tricare patients, Active Duty Military, and other groups."*

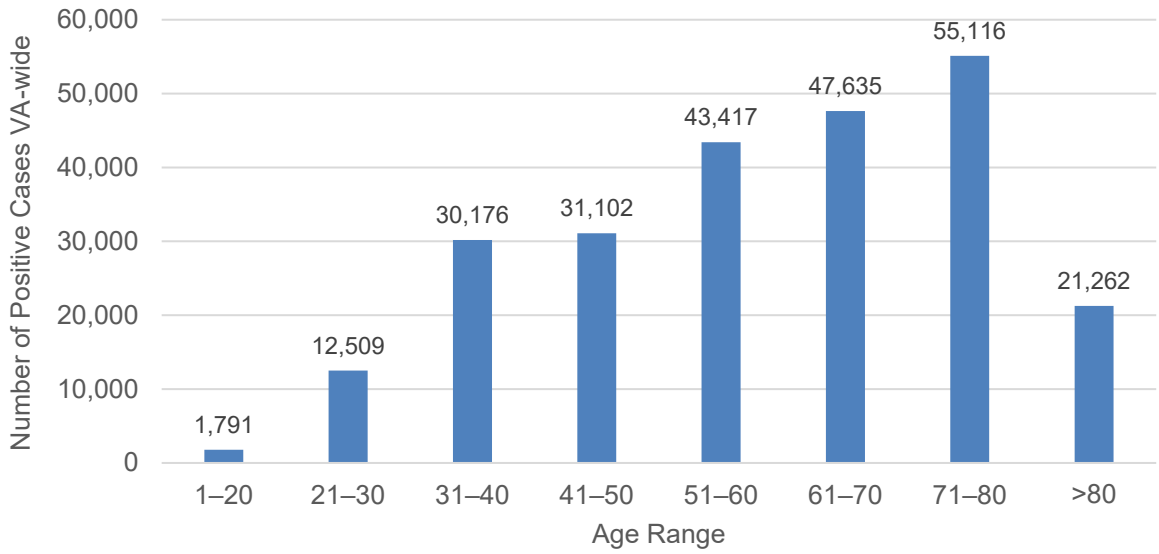

Figure 4. *Age range of VA positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

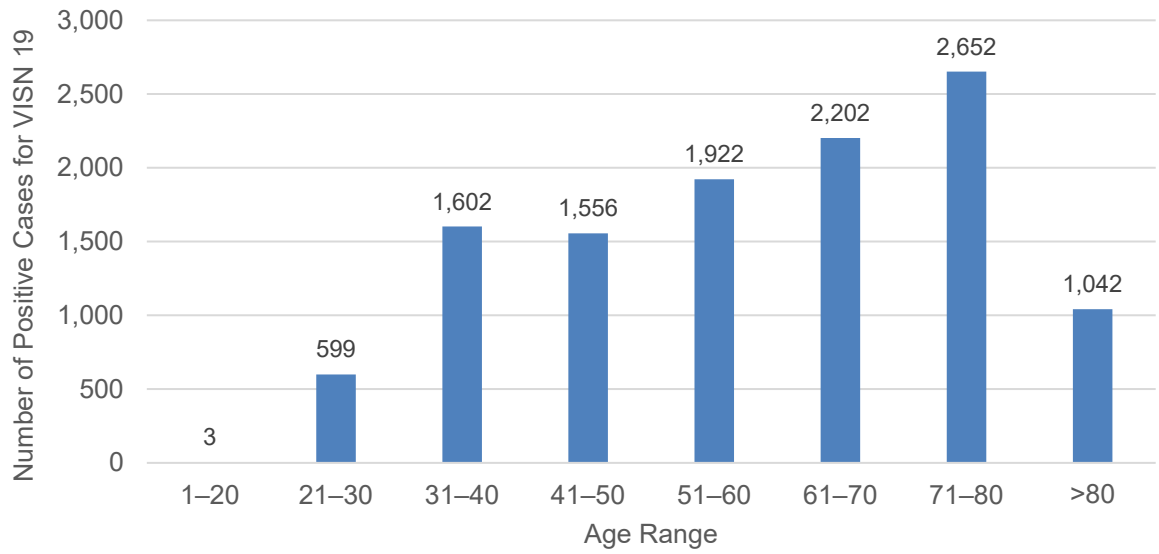

Figure 5. *Age range of VISN 19 positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

Facility-specific data for VISN 19 from March 11, 2020, through March 31, 2021, are presented in appendix B. Typically, most positive cases were among patients 71–80 years of age.

VISN 19 Facilities' Readiness and Response

The following subsections detail the OIG's findings for the five pandemic-related focus areas examined for all VISN 19 facilities and the summary results of the staff survey.

Emergency Preparedness

During interviews with OIG staff, VISN 19 leaders reported implementing their emergency operations plan and establishing the VISN Incident Command Center. The Incident Command Center met multiple times per day to handle COVID-19 issues and convey VHA information and direction to medical center- and system-level Incident Command Centers. VISN 19 Network Director also described actively communicating with the state health departments and Federal Emergency Management Agency and reportedly responded to inquiries from Congress, veterans service organizations, local media, and veterans. VISN 19 facility leaders universally reported that VHA Central Office and VISN 19 communication and guidance was timely and adequate.

Most VISN 19 facility leaders reported feeling generally prepared for the pandemic. However, leaders from two of the facilities expressed feeling only partially prepared given the lack of data and PPE early in the pandemic and the limited number of existing negative pressure rooms, single-occupancy rooms, and intensive care beds at their facilities.[10]

All facility-level leaders reported having an emergency operations plan prior to the pandemic, activating the plan during the pandemic, establishing ongoing communications with the local public health department, and establishing relationships with key community partners and stakeholders. When asked about the types of data that would be critical to have or beneficial to measure or monitor for future disaster plans, facility leaders shared various thoughts, including supply tracking, available staffing, community hospital surge plans, community hospital inpatient capacity and census, and COVID-19 patient projections (number of expected cases).

The Oklahoma City VA HCS Director provided the OIG with multiple documents that highlighted the system's best practices and strategies implemented during the pandemic. The documents included examples of the daily email communication to staff regarding patient census and updates on supplies, staffing, and other resources. The Director described this communication as a critical component to keeping staff updated during ever-changing times. Additional strategies included conducting virtual Town Hall meetings; opening a daycare with staff volunteers; establishing labor pools; training staff for cross-coverage; visiting homeless camps; and establishing partnerships with the Indian Health Service, Tinker Air Force Base, and rural community hospitals.

[10] VA Salt Lake City HCS and VA Western Colorado HCS.

Supplies, Equipment, and Infrastructure

VISN leaders cited limited issues with the adequacy of supplies, equipment, and infrastructure to support treatment of patients with COVID-19. The VISN Incident Command Center reportedly directed cross-leveling—movement of resources between VISN facilities—of PPE, ventilators, and staff; implemented VA's Fourth Mission by supporting state veteran homes in Oklahoma and Utah; and established a mobile intensive care unit to provide extra critical care beds when needed.

Facility leaders also indicated few issues with the adequacy of supplies and equipment to support the treatment of patients with COVID-19. Oklahoma City VA, VA Eastern Colorado, and VA Salt Lake City HCSs were inspected as part of the OIG's previous healthcare review resulting in a report on *COVID-19 Screening Processes and Pandemic Readiness*.[11] In that report, published on March 26, 2020, leaders described shortages of supplies, including viral media for testing, N95 masks, masks with face shields, and isolation gowns at the Oklahoma City VA HCS; surgical masks and gowns at the VA Eastern Colorado HCS; and hand sanitizer, small-sized N95 masks, and surgical masks at the VA Salt Lake City HCS. On follow-up during this virtual comprehensive healthcare inspection, these HCS leaders reported no issues with the adequacy of supplies.

Eastern Oklahoma VA HCS leaders described how a shortage of dental powered air-purifying respirators had resulted in roughly 7,000 cancelled and rescheduled appointments between March 15, 2020, and August 20, 2020.[12] Additionally, the Cardiopulmonary Section Chief at VA Western Colorado HCS reported requesting and ordering ventilator circuits as an emergent need on October 22, 2020. The circuits had not been received as of the OIG's virtual review (November 30 through December 4, 2020).[13]

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[11] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, Report No. 20-02221-120, March 26, 2020. "N95 Respirators, Surgical Masks, and Face Masks," U.S. Food & Drug Administration, accessed January 18, 2021, https://www.fda.gov/medical-devices/personal-protective-equipment-infection-control/n95-respirators-surgical-masks-and-face-masks. N95 masks are close-fitting facial respirators that filter out 95 percent of airborne particles.

[12] "Considerations for Optimizing the Supply of Powered Air-Purifying Respirators (PAPRs)," Centers for Disease Control and Prevention, accessed March 22, 2021, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/powered-air-purifying-respirators-strategy.html. A powered air-purifying respirator "uses a blower to force air through filter cartridges or canisters and into the breathing zone of the wearer…When used properly, PAPRs [powered air-purifying respirators] provide increased protection and decrease the likelihood of infection transmission to the wearer as compared to FFRs [filtering facepiece respirators] and half face reusable elastomeric respirators."

[13] "The Ventilator Circuit," UpToDate®, accessed March 22, 2021, https://www.uptodate.com/contents/the-ventilator-circuit. A "ventilator circuit refers to the tubing that connects the ventilator to the patient, as well as any devices that might be connected to the circuit." On May 25, 2021, the Cardiopulmonary Section Chief confirmed that the circuits needed for newly-acquired ventilators had been received and that the system had sufficient circuits for existing ventilators to care for the surge of patients experienced from December 2020 through March 2021.

Some of the leaders reported implementing various changes to expand inpatient capacity and address infrastructure inadequacies. For example, Eastern Oklahoma VA HCS leaders reported adding intensive care beds, creating additional negative pressure rooms, and taking steps to (1) allow for the ability to activate an additional 25 medical and surgical beds, and (2) use the atrium and two climate-controlled tents to house patients during a possible surge if needed.[14]

Montana VA HCS leaders described establishing a seven-bed unit for COVID-19-positive patients and an additional seven beds for patients with pending test results. They also reported converting rooms for post-anesthesia and intensive care to be under negative pressure.[15]

The Oklahoma City VA HCS reported infrastructure alterations that included converting inpatient rooms to negative pressure, relocating high-traffic services to a centralized location on the ground floor, implementing a drive-through pharmacy, relocating outpatient clinics to tented parking areas, and utilizing the VISN-established mobile intensive care unit. According to interviewed leaders and staff, the implementation of a centralized area for screening and high-traffic services (such as the laboratory, pharmacy, hearing aid repair, and flu and allergy shot clinic) proved to be an effective and efficient way to enhance patient and staff safety. The Director also cited the system as the first to fully use the COVID-19 mobile intensive care unit for the overflow of COVID-19 patients.

Sheridan VAMC operates a ten-bed medical unit, which reportedly includes two negative pressure rooms. In anticipation of a surge, facility leaders reported adding four beds, upgrading the ventilation system, reconfiguring specialty clinics for overflow, and obtaining platform beds to accommodate inpatients as needed.

In April 2020, VA Eastern Colorado HCS critical care staff reportedly implemented a best practice to prevent admissions. The practice, envisioned during the first surge of COVID-19 admissions, involves providing stable COVID-19-positive patients, who meet certain criteria, a

[14] "Background C. Air, Guidelines for Environmental Infection Control in Health-Care Facilities (2003)," Centers for Disease Control and Prevention, accessed March 22, 2021, https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/air.html. "Positive and negative pressures refer to a pressure differential between two adjacent air spaces (e.g., rooms and hallways). Air flows away from areas or rooms with positive pressure (pressurized), while air flows into areas with negative pressure (depressurized)…rooms are set at negative pressure to prevent airborne microorganisms in the room from entering hallways and corridors."

[15] "Standards for Postanesthesia Care," American Society of Anesthesiologists, accessed March 22, 2021, https://www.asahq.org/standards-and-guidelines/standards-for-postanesthesia-care. A post-anesthesia care unit is an area where patients are observed and monitored after receiving anesthesia. Monitoring typically includes "oxygenation, ventilation, circulation, level of consciousness and temperature."

pulse oximeter to self-monitor oxygen saturation at home. Assigned HCS staff then contact the patients daily and evaluate their status.[16]

Staffing

Critical care staff at VISN 19 facilities largely reported sufficient support for the respiratory care needs of COVID-19 patients. However, facility leaders and CLC personnel at the Eastern Oklahoma, Montana, and Oklahoma City VA HCSs reported staffing issues.

Eastern Oklahoma VA HCS leaders reported sending nursing staff to help care for veterans at the Claremore Veterans Center for approximately six weeks. The leaders reported contacting VHA's Disaster Emergency Medical Personnel System for deployment of nurses to assist with the needs of staffing two facilities (Eastern Oklahoma VA HCS and the Claremore Veterans Center).[17] Leaders reported being proud of the teamwork and staff efforts to care for patients and each other.

A few weeks before the OIG's review, Montana VA HCS leaders reported observing an increase in COVID-19 cases and staff shortages in several areas, including inpatient, call centers, surgery, and the residential rehabilitation and treatment program. Leaders attributed the shortage to a surge in COVID-19 admissions affecting the system and surrounding areas and reported requesting assistance from the VISN, activating a contingency staffing plan, and detailing community-based outpatient clinic staff to assist with inpatient care. Interviewed leaders asserted that the detailed clinic staff received training as needed and worked collaboratively with permanent inpatient unit staff.

Oklahoma City VA HCS leaders and staff reported issues related to ongoing pandemic response efforts. They reported obtaining temporary employees with assistance from the VISN and recruiting emergency department physicians and Emergency Medical Services staff. System leaders also described relocating nurses, nurse practitioners, and physician assistants to support the intensive care units and assigning call center staff to assist patients with cancelling and rescheduling appointments. CLC leaders reported utilizing VHA's COVID-19 expedited hiring process to recruit a nurse practitioner, palliative care provider, and part-time nurse practitioner.

[16] "Pulse Oximeter Accuracy and Limitations: FDA Safety Communication," U.S. Food & Drug Administration, accessed March 22, 2021, https://www.fda.gov/medical-devices/safety-communications/pulse-oximeter-accuracy-and-limitations-fda-safety-communication. "A pulse oximeter is a device that is usually placed on a fingertip. It uses light beams to estimate the oxygen saturation of the blood and the pulse rate. Oxygen saturation gives information about the amount of oxygen carried in the blood. The pulse oximeter can estimate the amount of oxygen in the blood without having to draw a blood sample."

[17] VHA Handbook 0320.03, *Disaster Emergency Medical Personnel System (DEMPS) Program and Database*, March 26, 2008. This handbook describes the processes and procedures by which VHA can deploy registered employed or retired staff to support facilities during emergencies.

They also described how geriatrics and home-based primary care clinicians provided temporary support to the CLC to lessen the burden of ongoing staffing shortages.

At the Cheyenne VAMC, some respiratory staff were quarantined for COVID-19 exposure. Respiratory therapists, nurses, providers, laboratory, and release of information staff were detailed to support patient care activities or cross-trained for other roles. CLC leaders reported that personnel from the residential rehabilitation treatment program, telemedicine, and community-based outpatient clinics were detailed to assist while CLC staff were quarantined.

During the first two months of the pandemic, Sheridan VAMC leaders entered into staffing contracts to provide facility entry-point screening and additional cleaning support. The leaders indicated that they mobilized nurses from primary and specialty care to work in the Urgent Care Center. To prevent burnout, the leaders reported implementing biweekly staff rotations between COVID-19 and non-COVID-19 activities. Additionally, leaders reported supporting VA's Fourth Mission by sharing supplies with Sheridan Memorial Hospital and deploying facility staff to Arizona to assist with the state's first surge in COVID-19 cases.

The VA Eastern Colorado HCS's Pueblo CLC, which is approximately two hours from the main healthcare campus, experienced intermittent staffing shortages. However, the CLC reportedly had a long-term relationship with a local contract staffing agency, which assigned staff to only work in the Pueblo CLC.

In preparation for possible staffing shortages, the VA Western Colorado HCS Associate Director reported training approximately 100 military medics to assist nurses. The Executive Director also shared that Canteen Service staff helped the system meet COVID-19 screening requirements. Additionally, the Chief of Staff reported that 15 community doctors assisted with patient care.

Access to Care

The COVID-19 pandemic has been disruptive to many VHA operations, particularly those requiring hands-on care or face-to-face interactions, such as surgical procedures and outpatient clinic visits. On March 15, 2020, VHA issued field guidance to facilities to "cease non-urgent elective procedures no later than Wednesday, March 18, 2020…[to] reduce unnecessary hospitalizations and ICU [Intensive Care Unit] use and…free up resources to address the increasing number of veterans under evaluation and diagnosed with COVID-19."[18] On May 22, 2020, VHA distributed *Moving Forward: Guidance for Resumption of Procedures for Non-Urgent and Elective Indications* to present the minimum factors for facilities and VISNs to consider when deciding to resume elective procedures.[19]

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

[19] VHA Assistant Under Secretary for Health for Operations Memorandum, *Moving Forward: Guidance for Resumption of Procedures for Non-Urgent and Elective Indications*, May 22, 2020.

Facility leaders reported adhering to VHA guidance and cancelling elective procedures.[20] At the time of the inspections, all VISN 19 facilities, except Cheyenne VAMC, reported resuming elective surgeries at varying capacities.

Facility leaders universally reported expanding telemedicine (virtual care) to maintain access to care. Some leaders acknowledged encountering barriers such as staff and patients' lack of familiarity with virtual care and poor high-speed internet access in mountainous areas.

Despite these efforts, significant numbers of cancelled appointments still required follow-up as of March 31, 2021 (see table 4 and appendix B).[21] The OIG previously performed a review of VHA data on cancelled appointments, conversions to telehealth, and follow-up during the COVID-19 pandemic. The review identified various deficiencies, including the need for VHA to take appropriate follow-up action on cancelled or discontinued consults.[22]

[20] According to the Sheridan VA Medical Center Chief of Staff, surgeries are not performed at the facility.

[21] Cancellation data does not include "non-count" appointment cancellations. VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016 (amended January 7, 2021). This directive defines non-count as workload that "does not meet the definition of an encounter or an occasion of service."

[22] VA OIG, *Appointment Management During the COVID-19 Pandemic*, Report No. 20-02794-218, September 1, 2020. The results of this review were based on data obtained from VHA's Corporate Data Warehouse for time periods ranging from February 1, 2020, through May 1, 2020. The OIG also obtained and analyzed data from VHA Support Service Center reports from March 2020 through May 2020. The report's analyses primarily focused on March 15, 2020, through May 1, 2020.

Table 4. VISN 19 Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)

Clinic	Total Cancellations*	Cancellations Due to COVID-19	Follow-Up Found‡	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up§
Primary Care/ Medicine	271,422	74,488	255,974	15,448	6
Mental Health Individual Clinic	123,943	28,545	118,783	5,160	4
Telephone Primary Care	86,329	4,784	81,307	5,022	6
Dental	58,147	26,029	53,890	4,257	7
General Internal Medicine	45,390	3,345	32,357	13,033	29

Source: VHA Support Service Center (accessed April 1, 2020). COVID-19 Cancellations definitions (accessed January 11, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness. Additional details about the types of care provided within VISN 19 can be found in appendix A.

***** *"Total Cancellations" are "[t]he number of appointments with COVID in the cancellation remarks or was cancelled/no showed on or after 3/1/2020."*
"Cancellations Due to COVID-19" include those with "COVID" in the cancellation remarks.
‡ *"Follow-Up Found" refers to when "One or more of the following is found: Clerk indicated conversion, Has Rescheduled Appt, Has Visit, Has RTC [return to clinic] Entered, Has Recall Activity, Has Consult Activity, Has Appt or Visit in Same Location, Has Appt or Visit in Same Stop Code Combo, Has Factor, [or] Has Closure Factor."*
§ *The OIG calculated the "Percent of Cancelled Appointments Without Follow-Up."*

Table 4 shows the top five clinics in VISN 19 with the highest number of cancellations. For example, the highest number of cancellations is seen for the primary care/medicine clinics, which had 6 percent or over 15,000 clinic appointments requiring follow-up. The mental health individual clinic had the next highest number of cancellations with 4 percent or over 5,000 clinic appointments requiring follow-up. The general internal medicine clinic had the lowest number of cancellations among the top 5 clinics but still had 29 percent, or over 13,000 clinic appointments, requiring follow-up.

Facility-specific data for VISN 19 as of March 1, 2020, through March 31, 2021, are presented in appendix B.

Impact of COVID-19 on Community Living Center Patients and Operations

VHA issued guidance to ensure the safety and well-being of its CLC residents during the pandemic.[23] This included but was not limited to

- Limited admissions to those patients who are already in a VA medical facility;
- Restriction on admissions from the community;
- Completion of 14 days of observation in the acute care facility for veterans requiring admission for emergencies prior to transfer to the CLC;
- Screening of all CLC staff at the beginning of their shifts for fever and respiratory symptoms;
- Daily screenings of CLC residents for fever and symptoms of COVID-19; and
- Closure of the CLC to visitors, except for certain compassionate care situations.

VHA also recommended that facilities

- Minimize staff entering CLC space,
- Use dedicated CLC staff to address as many duties as possible,
- Use telehealth in lieu of consults and clinic visits outside the CLC, and
- Cancel communal dining and all group activities.

Facility leaders reported adherence to VHA requirements for restricting admissions from the community and screening all CLC residents for fever and symptoms at least daily.[24] The OIG noted the considerable efforts reported to ensure the safety of vulnerable CLC residents, which had reportedly resulted in only one positive case at the VA Western Colorado HCS at the time of the inspections.

Oklahoma City VA HCS leaders described relocating the system's fourth floor CLC to a temporary location to allow for more beds to support acute medical/surgical patients. Prior to the pandemic, the CLC had 33 beds, whereas the relocated CLC had 25 beds—20 designated for rehabilitation and 5 for palliative care—and was operating at full capacity.

Similar to the experiences shared with the OIG during the VISN 10 and 20 inspections, some facility leaders described CLC residents' frustration, stress, and feelings of isolation due to

[23] VHA DUSHOM Memorandum, *Coronavirus (COVID-19) Community Living Centers – Revised 3/17/2020*, March 17, 2020.

[24] Eastern Oklahoma VA and VA Salt Lake City HCS leaders were not interviewed on this topic since the systems do not have a CLC.

visitation restrictions.[25] For example, the Montana VA HCS's CLC is located in Miles City, Montana, approximately 350 miles from the parent facility in Fort Harrison, Montana. CLC leaders reported that residents often expressed frustrations at being isolated from other residents following medical appointments, a safety procedure enacted to protect other residents from possible exposure to COVID-19. Consequently, CLC staff described the difficult task of managing clinical appointments for residents who refused to attend their scheduled appointments because of the known isolation to follow.

Some CLC leaders and personnel reported using technology to support CLC residents' need for social interaction with loved ones and implementing other strategies to engage patients. For example, VA Western Colorado HCS CLC staff described setting up a parade outside the CLC to boost patient morale. VA Eastern Colorado HCS CLC staff reported implementing additional recreation and restorative activities and encouraging socialization via the "Man Cave," a family room setting where patients can watch TV, play games, socialize, and have videoconference calls with family, while remaining socially distant. Cheyenne VAMC CLC leaders and staff described the system's use of "CLC DoorDash" and dedicated shopping hours for CLC residents in the Veterans Patriot Store. These creative efforts reportedly allowed residents to have their canteen orders delivered to the CLC and to shop more safely in the Veterans Patriot Store.

Facility Staff Feedback

There were 3,945 respondents to the OIG's COVID-19 survey of employees at the VISN 19 medical facilities inspected. Of those, 2,291 (58 percent) identified themselves as clinical staff, 1,632 (41 percent) identified themselves as nonclinical staff, and 22 respondents (1 percent) made no selection. The overall response rate by location was approximately 18–36 percent.[26]

When asked whether leaders and immediate supervisors communicated how to ensure the safety of patients and staff during the pandemic, 63–91 percent of respondents answered affirmatively (see appendix C for related questions and response rates). Additionally, when asked about lessons learned during their facility's pandemic response, the OIG identified several general themes among the staff's comments, including the importance of communication, flexibility, preparation, and teamwork. Twelve to 25 percent of VISN 19 staff who responded reported not having access to appropriate PPE necessary to ensure their own safety at work during the COVID-19 pandemic (see appendix C, table C.2).

[25] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

[26] The response rate was approximated using the number of respondents and unique staff employed at the time of the virtual review according to VHA Support Service Center's Personnel and Accounting Integrated Data (PAID) cube, accessed March 16, 2021, https://vssc.med.va.gov/VSSCMainApp/. (This is an internal VA website not publicly accessible.) Although the lowest VISN 19 facility response rate was approximately 18 percent, this represented 521 respondents from the Oklahoma City VA Health Care System.

VA and VISN 19 Vaccination Efforts

According to the *COVID-19 Vaccination Plan for the Veterans Health Administration*, VHA chartered a team in September 2020 "to plan for the availability of a COVID-19 vaccine as early as October 2020."[27] The plan provides guidance on the management of vaccines "that have, or will have received FDA [Food and Drug Administration] EUA [Emergency Use Authorization]" and outlines three operational goals:

- "Develop and implement a plan to procure, distribute, and administer COVID-19 vaccine for Veterans and VA staff.
- Develop a population-based risk stratification plan for COVID-19 vaccine administration and implement as required by vaccine supply limitations.
- Implement solutions to track and report vaccine supply, administration, course completion, safety and outcomes for internal and external stakeholders."

At the time of this report's publication, "there is no FDA-approved vaccine to prevent COVID-19."[28] However, the FDA has authorized three vaccines for emergency use:

- Pfizer-BioNTech (Pfizer) COVID-19 Vaccine[29]
- Moderna COVID-19 Vaccine[30]
- Janssen (Johnson & Johnson) COVID-19 Vaccine[31]

According to the FDA, an emergency use authorization is an "emergency access mechanism…to justify the emergency use of drugs and biological products."[32] Drugs and biological products are authorized for emergency use when "there are no adequate, approved, and available

[27] VHA, *COVID-19 Vaccination Plan for the Veterans Health Administration*, December 14, 2020.

[28] FDA, Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of the Janssen COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 Years of Age and Older, February 27, 2021.

[29] FDA, letter to Pfizer, Inc., February 25, 2021, accessed March 18, 2021, https://www.fda.gov/media/144412/download.

[30] FDA, letter to ModernaTX, Inc., February 25, 2021, accessed March 18, 2021, https://www.fda.gov/media/144636/download.

[31] FDA, letter to Janssen Biotech, Inc., February 27, 2021, accessed March 18, 2021, https://www.fda.gov/media/146303/download. FDA, "Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of the Janssen COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 Years of Age and Older," February 27, 2021. The Janssen vaccine is produced by Janssen Biotech, Inc., a Janssen Pharmaceutical Company of Johnson & Johnson.

[32] FDA, "Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of the Janssen COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 Years of Age and Older."

alternatives."[33] The Pfizer, Moderna, and Janssen vaccines received emergency use authorization on December 11, 2020; December 18, 2020; and February 27, 2021; respectively.[34]

The Pfizer vaccine is authorized for emergency use in individuals 16 years of age or older and "is administered as a 2-dose series, 3 weeks apart."[35] The Moderna vaccine is authorized for emergency use in individuals 18 years of age or older and "is administered as a 2-dose series, 1 month apart."[36] The Janssen vaccine is authorized for emergency use in individuals 18 years of age or older and "is administered as a single dose."[37]

VA announced initial COVID-19 vaccine distribution plans in December 2020.[38] During the first two weeks of vaccine administration (December 14–27, 2020), VA administered the first dose "to more than 5,000 Veterans residing in its Community Living Centers and Spinal Cord Injury and Disorders Centers and more than 50,000 health care employees."[39] Approximately seven weeks later on February 17, 2021, VA reported vaccinating its one millionth veteran with their initial dose.[40] As of the week of March 15, 2021, VA reported vaccinating two million veterans with at least one dose of the vaccine.[41] Table 6 summarizes VISN 19's vaccinations efforts as of March 29, 2021.

[33] "Emergency Use Authorization for Vaccines Explained," U.S. Food & Drug Administration, accessed May 21, 2021, https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained.

[34] FDA, letters to Pfizer, Inc., ModernaTX, Inc., and Janssen Biotech, Inc.

[35] FDA, "Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of the Pfizer-BioNTech COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 16 Years of Age and Older," February 25, 2021.

[36] FDA, "Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of the Moderna COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 Years of Age and Older," December 2020.

[37] FDA, "Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of the Janssen COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 Years of Age and Older."

[38] VA, "VA to begin COVID-19 vaccinations at 128 additional sites," news release, December 21, 2020, accessed March 18, 2021, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5591. VA, "VA receives Janssen COVID-19 vaccine," news release, March 4, 2021, accessed March 18, 2021, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5632.

[39] VA, "VA Administers Over 55,000 COVID-19 Vaccine Doses in Two Weeks," news release, December 30, 2020, accessed March 18, 2021, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5596. VA OIG, *Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents*, Memorandum No. 21-00913-91, April 14, 2021. The OIG issued a management advisory memorandum noting opportunities for VHA to provide national guidance for more comprehensive and consistent data collection to ensure CLCs routinely track COVID-19 vaccination refusals and contraindications in a consistent manner.

[40] VA, "VA Reaches Milestone Vaccinating its 1 Millionth Veteran," news release, February 17, 2021, accessed March 18, 2021, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5622.

[41] VHA, email from the VHA Chief of Staff, received March 19, 2021.

Table 6. VISN 19 COVID-19 Vaccine Administrations (as of March 29, 2021)

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)*	Dose 2 of 2 (Pfizer or Moderna)†	Dose 1 of 1 (Janssen)‡
Veteran	87,973	61,846	2,555
Employee	13,391	11,831	150[l]
Federal Partner[§]	<20	<10	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021). Department of Veterans Affairs COVID-19 National Summary Definitions (accessed March 18, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

** "Dose 1 of 2" are the number of "initial dose[s] of a 2-dose vaccine series, that is, Pfizer or Moderna."*

† "Dose 2 of 2" are the number of "final dose[s] of a 2-dose series."

‡ "Dose 1 of 1" are the number of "single dose[s] needed for the Janssen vaccine."

§ "Federal Partners include Front Line Staff and First Responders that work in other agencies and were directed to receive their vaccination at a VA facility."

[l] This is an approximated value based on reported vaccinations by facility (see appendix B).

Although the OIG's February 2021 survey of facility vaccination coordinators determined that most VISN 19 medical facilities were administering the Moderna vaccine, all facilities were using a combination of vaccines as of March 29, 2021 (see appendix B, tables B.12–B.19), and had fully vaccinated over 64,000 or approximately 19 percent of patients within the VISN (see appendix A, table A.1 for the number of unique patients in VISN 19).[42]

[42] At the time of the OIG's February 2021 survey, only VA Eastern Colorado HCS was administering the Pfizer vaccine. *Department of Veterans Affairs COVID-19 National Summary* (accessed June 22, 2021). VHA and VISN 19 have fully vaccinated 3,155,139 and 136,887 individuals, respectively, as of June 22, 2021.

Conclusion

The OIG examined the pandemic readiness and response of VISN 19 and its facilities based on healthcare inspections performed from October 1, 2020, through December 31, 2020. Although facility leaders described varying degrees of strain created by the number of COVID- 19-positive patients at the time of the OIG's inspections, VISN 19 was in the midst of VA's third pandemic peak, which was longer and involved more patients than the previous peaks.

The intent of this report is to provide some useful snapshots of the fluctuating and unprecedented demands posed by the pandemic on VA medical facilities. It also shares leader and staff experiences, assessments, shared sentiments, and staff-identified best practices to help improve ongoing and future operations and clinical care during health crises. COVID-19 is reshaping the landscape of healthcare delivery worldwide. As the nation's largest integrated healthcare system, VHA needs to be armed with as much information as possible to lead the charge at the forefront of that transformation.

Appendix A: VHA and VISN Profiles

The table below provides general background information for VHA and VISN 19.

Table A.1. Profiles for VHA and VISN 19
(October 1, 2019, through September 30, 2020)

Profile Element	VHA	VISN 19
Total medical care budget	$81,870,319,580	$4,122,423,032
Number of:		
• Unique patients	6,447,211	332,916
• Outpatient visits	81,305,962	3,734,780
Type and number of operating beds:		
• Blind rehabilitation	243	0
• Community living center	13,053	209
• Domiciliary	7,219	201
• Intermediate	152	0
• Medicine	6,885	264
• Mental Health	3,434	134
• Neurology	99	5
• Rehabilitation medicine	439	30
• Residential rehabilitation	548	16
• Spinal cord injury	1,222	20
• Surgery	2,661	70
Average daily census:		
• Blind rehabilitation	75	n/a*
• Community living center	7,622	142
• Domiciliary	3,320	102
• Intermediate	37	n/a*
• Medicine	4,518	187
• Mental Health	1,830	82
• Neurology	40	2
• Rehabilitation medicine	184	17
• Residential rehabilitation	268	11
• Spinal cord injury	596	12

Profile Element	VHA	VISN 19
• Surgery	860	34

Source: VHA Support Service Center (accessed March 16, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**n/a = not applicable*

Appendix B: VISN 19 Facility-Specific Data

Table B.1. VISN 19 Testing and Results
(March 11, 2020, through March 31, 2021)

Surveillance Element	Cheyenne, WY	Sheridan, WY	Aurora, CO	Muskogee, OK	Fort Harrison, MT	Oklahoma City, OK	Salt Lake City, UT	Grand Junction, CO
Total Cases	3,938	1,388	19,984	8,790	4,681	10,892	10,861	3,672
• Positive Cases*	690	357	2,890	2,249	1,222	2,067	1,633	470
• Negative Cases	3,247	960	16,418	6,433	3,391	8,533	8,934	3,137
• Pending Cases †	1	71	676	108	68	292	294	65

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness.

*****The number of positive cases includes "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. This includes all positive labs (SARS-CoV-2019)…This also includes cases tested outside of the VA system but captured through the NST [National Surveillance Tool] classification system, which incorporates both artificial intelligence and human review. A recurrent case may occur if a patient has another positive test after a testing gap of more than 30 days."*

†Pending cases include "patients with orders placed for COVID-19 tests."

Table B.2. Status of VISN 19 Positive Cases (March 11, 2020, through March 31, 2021)

Surveillance Element	Cheyenne, WY	Muskogee, OK	Fort Harrison, MT	Oklahoma City, OK	Sheridan, WY	Aurora, CO	Salt Lake City, UT	Grand Junction, CO
Active*	19	12	8	22	4	60	35	7
Convalescent†	643	2,089	1,161	1,898	347	2,739	1,533	436
Known Death‡	28	148	53	147	6	91	65	27
• Inpatient	8	62	12	90	0	20	23	10
• Other	20	86	41	57	6	71	42	17

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness.

**The number of active cases are patients that were "tested or treated at a VA facility for known or probable COVID-19 who have neither died nor reached convalescent status."*

†*Convalescent cases represent the patients "tested or treated at a VA facility for known or probable COVID-19 who are either a post-hospital discharge or 14 days past their first positive test, whichever comes later."*

‡*Known deaths are "all deaths (all cause), among patients tested or treated at a VA facility, that occur within 30 days of a known COVID positive determination…'Inpatient' indicates that the death occurred in a 'VA' hospital." "Other" indicates "the death was reported to VA but occurred elsewhere."*

Table B.3. Patient Types of VISN 19 Positive Cases (March 11, 2020, through March 31, 2021)

Surveillance Element	Cheyenne, WY	Muskogee, OK	Fort Harrison, MT	Oklahoma City, OK	Sheridan, WY	Aurora, CO	Salt Lake City, UT	Grand Junction, CO
Veteran	618	2,131	1,110	1,987	250	2,624	1,496	438
Employee	68	105	100	70	103	240	114	31
Veteran-Employee	2	6	8	5	1	6	3	0
All Other*	2	7	4	5	3	20	20	1

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021). COVID-19 National Summary & Moving Forward Report Definitions (accessed December 3, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness.

** "All Other" includes "civilians admitted to VA hospitals as humanitarian cases, Tricare patients, Active Duty Military, and other groups."*

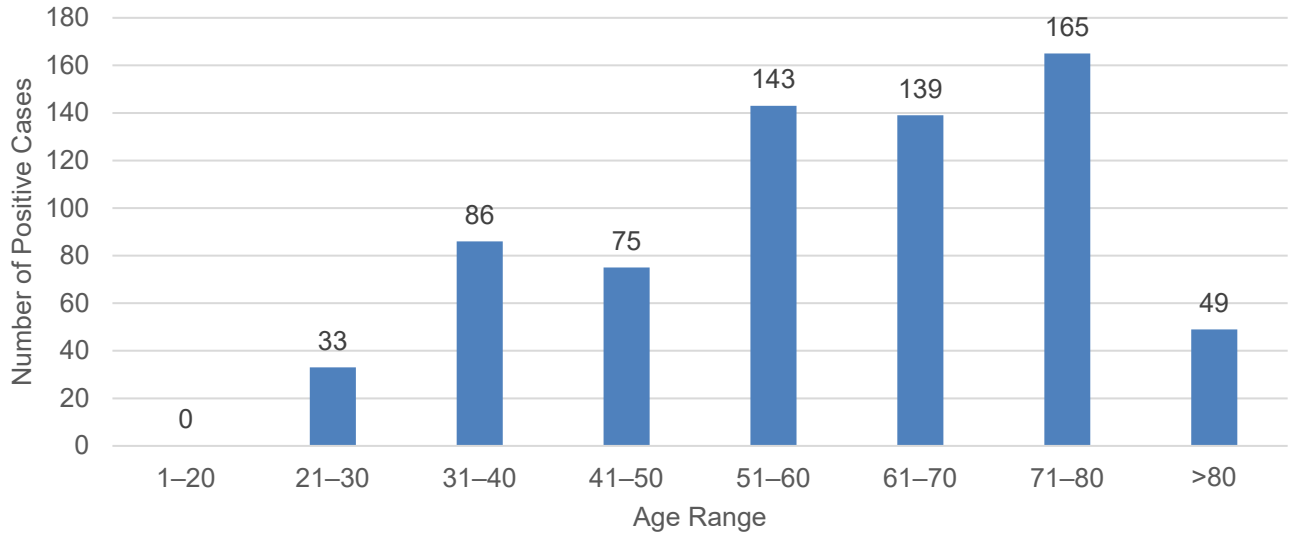

Figure B.1. *Age range of Cheyenne VA Medical Center positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

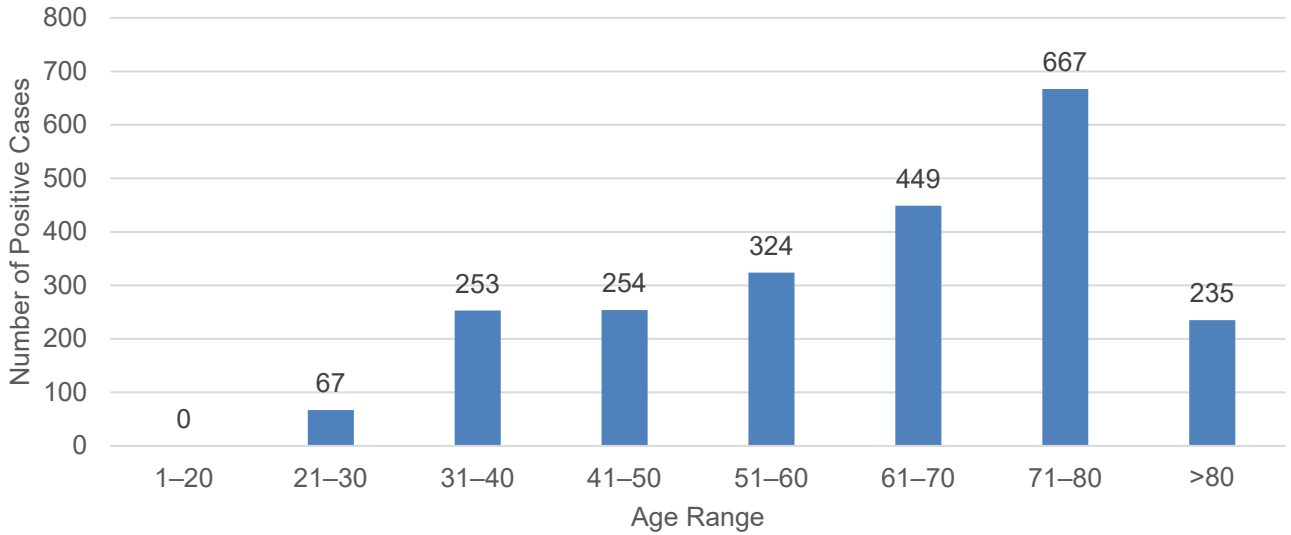

Figure B.2. *Age range of Eastern Oklahoma VA Health Care System positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

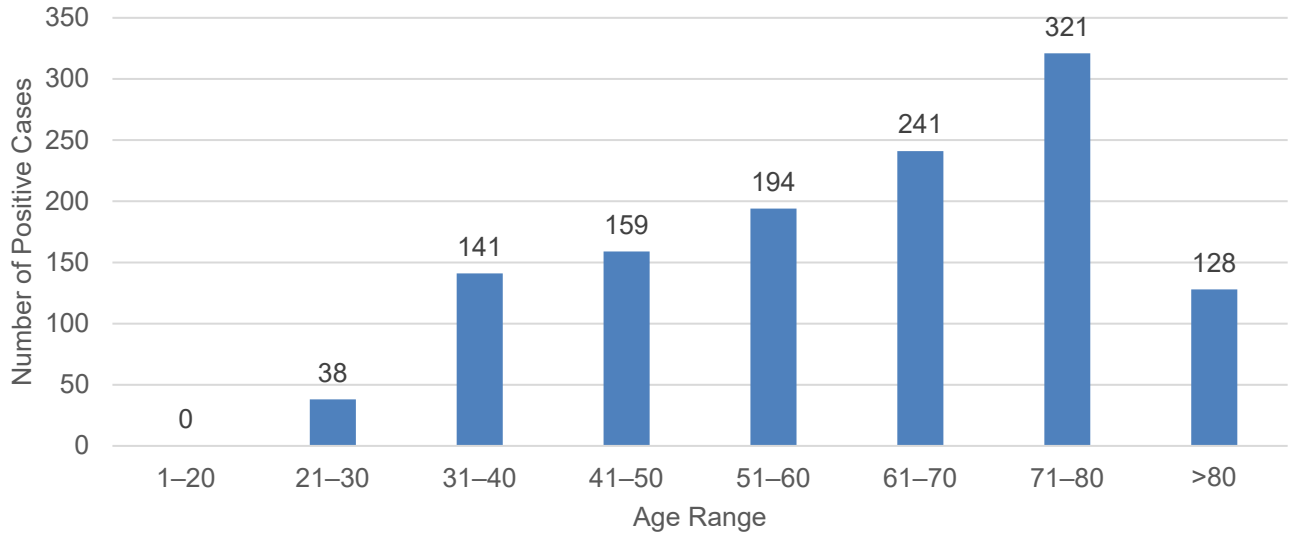

Figure B.3. *Age range of Montana VA Health Care System positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

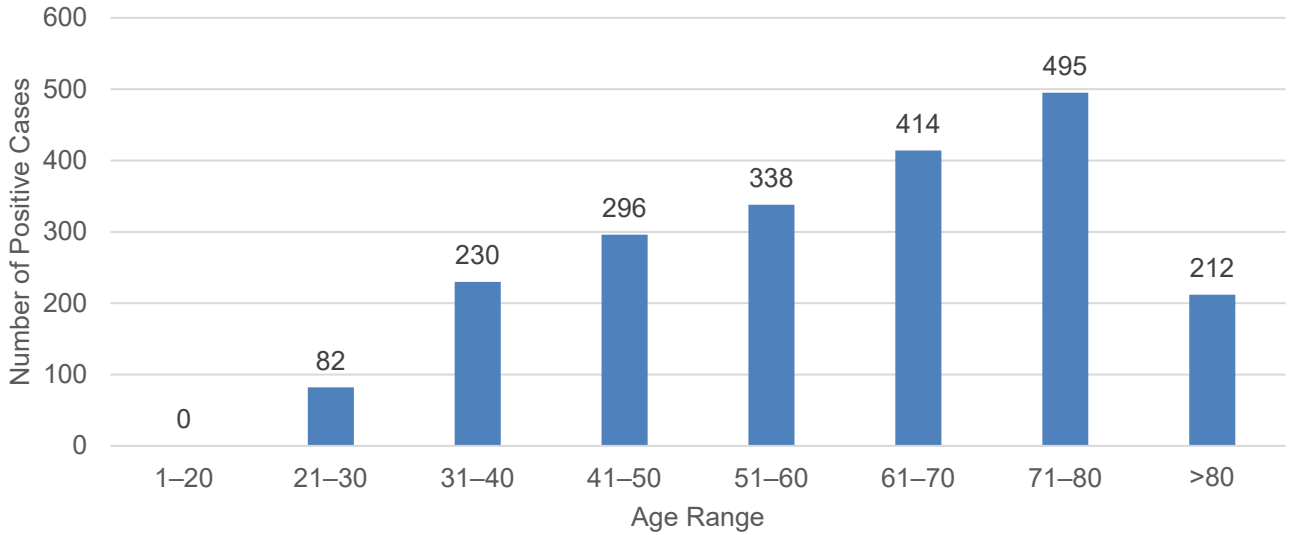

Figure B.4. *Age range of Oklahoma City VA Health Care System positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

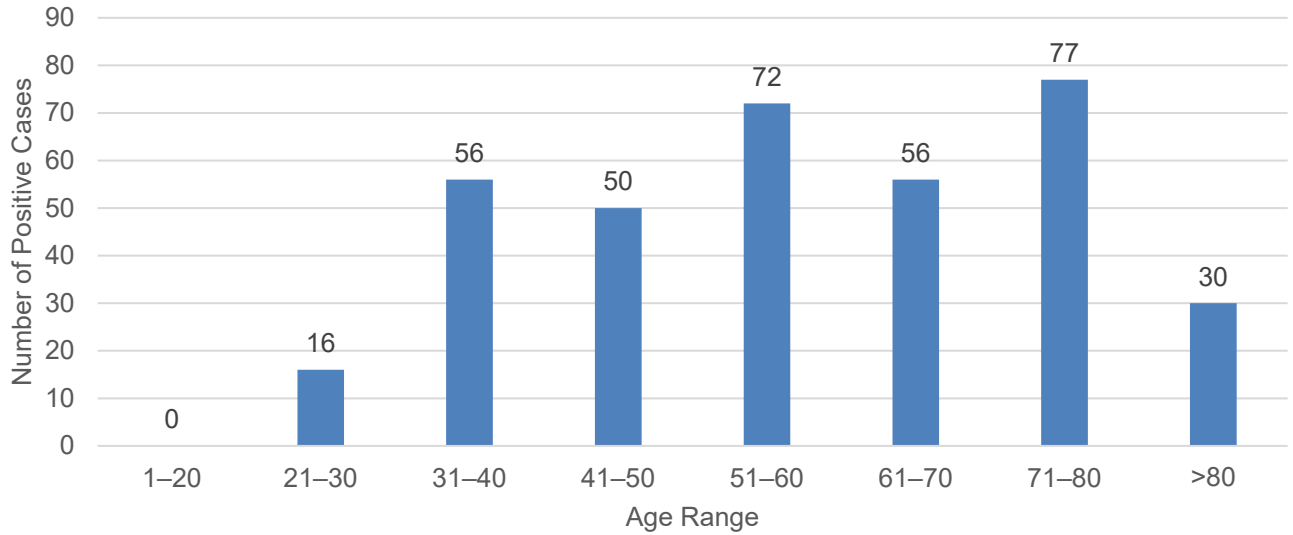

Figure B.5. *Age range of Sheridan VA Medical Center positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

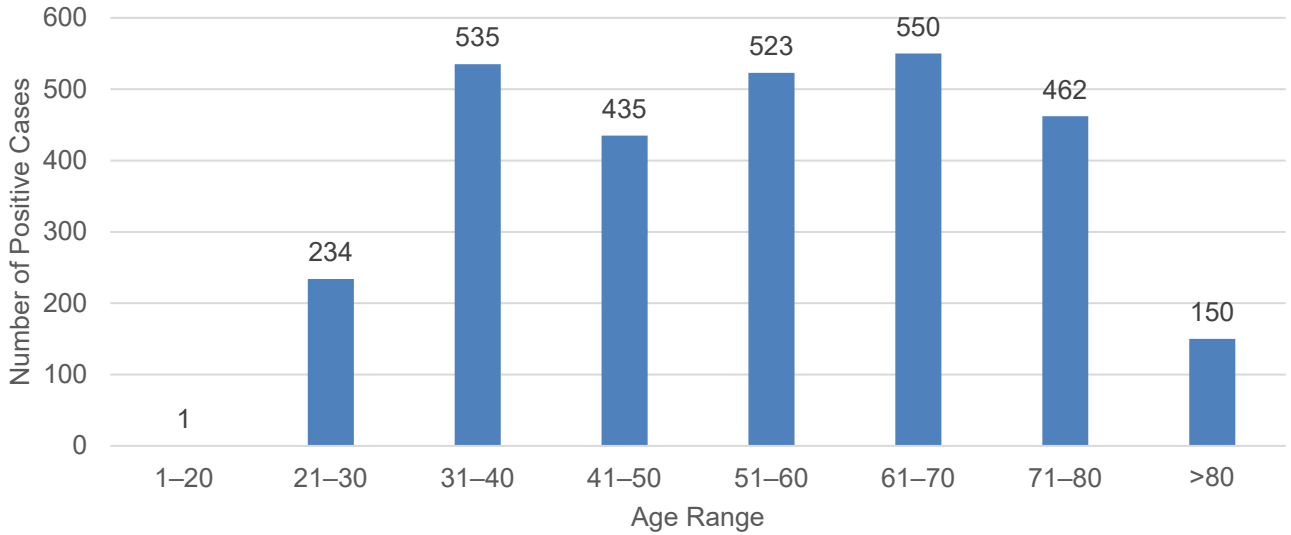

Figure B.6. *Age range of VA Eastern Colorado Health Care System positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

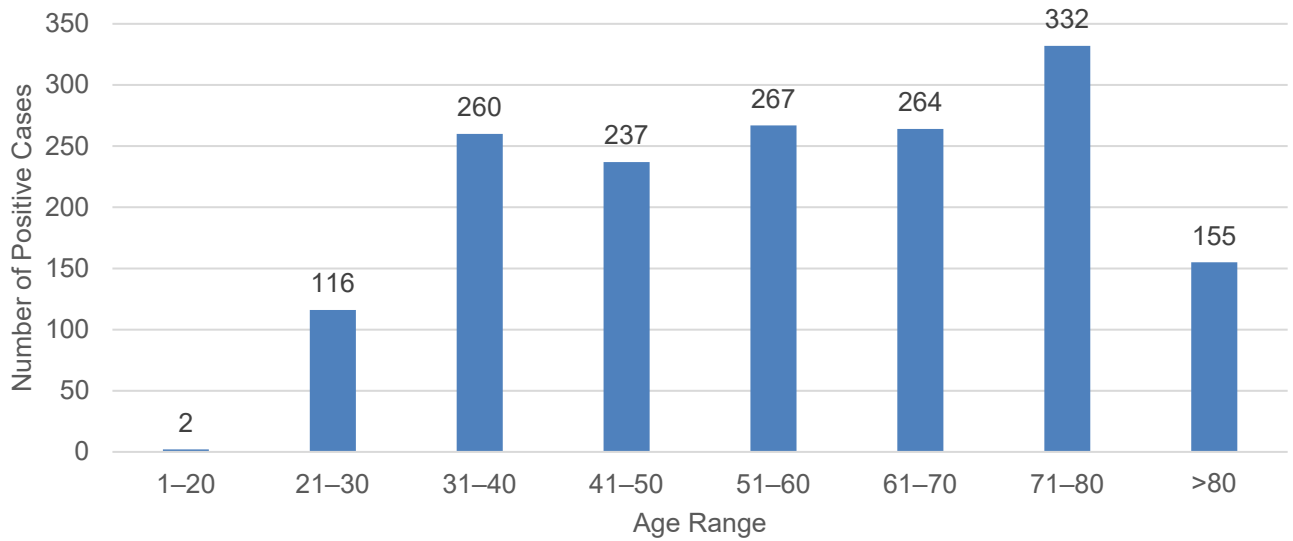

Figure B.7. *Age range of VA Salt Lake City Health Care System positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

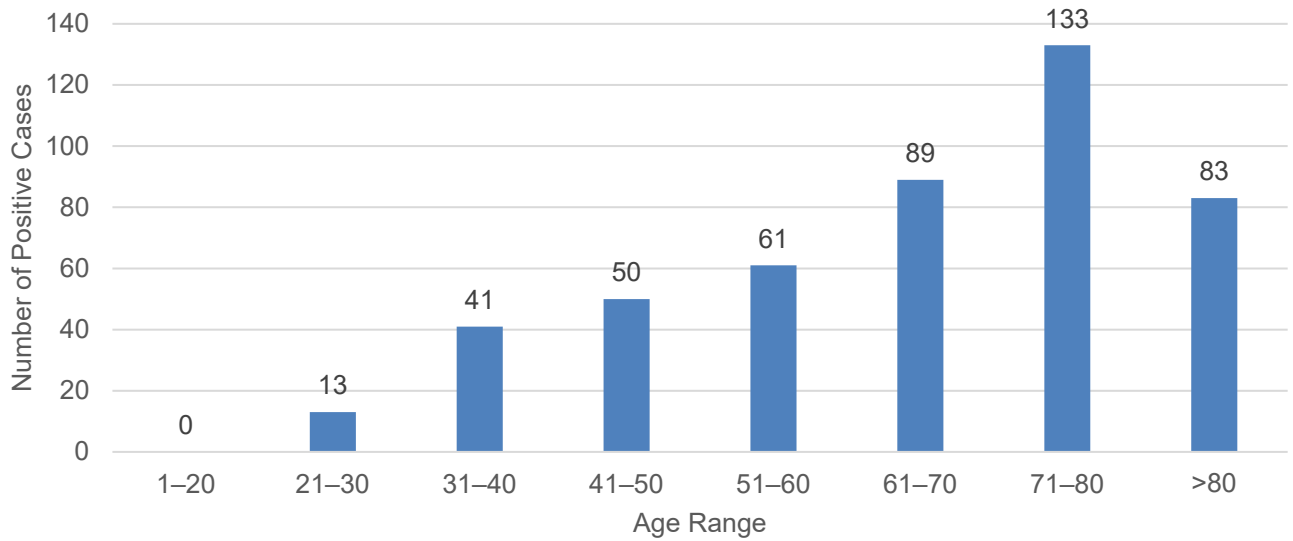

Figure B.8. *Age range of VA Western Colorado Health Care System positive cases (March 11, 2020, through March 31, 2021).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

Table B.4. Cheyenne VA Medical Center Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)

Clinic Group	Total Cancellations*	Cancellations Due to COVID-19†	Follow-Up Found‡	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up§
Primary Care/Medicine	16,564	5,487	15,894	670	4
Mental Health Individual Clinic	8,927	2,748	8,649	278	3
General Internal Medicine	8,301	287	5,851	2,450	30
Optometry	8,210	3,024	7,520	690	8
Mental Health Individual Integrated Care Clinic	5,519	1,557	5,375	144	3

Source: VHA Support Service Center (accessed April 1, 2021). COVID-19 Cancellations definitions (accessed January 11, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

* *"Total Cancellations" are "[t]he number of appointments with COVID in the cancellation remarks or was cancelled/no showed on or after 3/1/2020."*

† *"Cancellations Due to COVID-19" include those with "COVID" in the cancellation remarks.*

‡ *"Follow-Up Found" refers to when "One or more of the following is found: Clerk indicated conversion, Has Rescheduled Appt, Has Visit, Has RTC [return to clinic] Entered, Has Recall Activity, Has Consult Activity, Has Appt or Visit in Same Location, Has Appt or Visit in Same Stop Code Combo, Has Factor, [or] Has Closure Factor."*

§ *The OIG calculated the "Percent of Cancelled Appointments Without Follow-Up."*

Table B.5. Eastern Oklahoma VA Health Care System Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	37,136	5,125	33,931	3,205	9
Dental	15,488	6,665	15,080	408	3
Telephone Primary Care	14,619	584	13,852	767	5
Optometry	13,225	5,518	11,586	1,639	12
Mental Health Individual Clinic	12,885	1,020	12,032	853	7

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.6. Montana VA Health Care System Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	45,660	7,148	43,195	2,465	5
Mental Health Individual Clinic	9,475	579	9,227	248	3
Physical Therapy	7,801	2,283	7,597	204	3
Podiatry	5,857	1,535	5,481	376	6

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Dental	5,159	1,605	4,968	191	4

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.7. Oklahoma City VA Health Care System Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	59,169	13,743	54,385	4,784	8
Mental Health Individual Clinic	17,144	1,545	15,521	1,623	9
Dental	14,143	6,005	12,528	1,615	11
Optometry	13,093	3,777	11,045	2,048	16
Dermatology	8,993	1,707	6,923	2,070	23

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.8. Sheridan VA Medical Center Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	8,551	1,483	8,005	546	6
Mental Health Individual Clinic	3,847	382	3,789	58	2
Telephone Primary Care	2,724	69	2,580	144	5
Physical Therapy	2,161	168	2,096	65	3
Podiatry	1,306	475	1,221	85	7

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.9. VA Eastern Colorado Health Care System Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	67,789	32,141	65,683	2,106	3
Mental Health Individual Clinic	43,020	18,537	41,863	1,157	3
Telephone Primary Care	28,408	1,892	26,298	2,110	7
Dental	14,681	8,236	13,812	869	6

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
General Internal Medicine	12,769	2,002	9,048	3,721	29

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.10. VA Salt Lake City Health Care System Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	29,026	7,703	27,612	1,414	5
Mental Health Individual Clinic	23,766	2,538	22,953	813	3
Laboratory	9,704	2,889	8,038	1,666	17
Physical Therapy	7,035	1,963	6,423	612	9
Optometry	5,731	1,617	4,427	1,304	23

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.11. VA Western Colorado Health Care System Top Five Clinic Cancellations (March 1, 2020, through March 31, 2021)*

Clinic	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Primary Care/Medicine	7,527	1,658	7,269	258	3
Podiatry	5,693	3,179	4,994	699	12
Mental Health Individual Clinic	4,879	1,196	4,749	130	3
Telephone Primary Care	3,621	109	3,505	116	3
Physical Therapy	2,385	589	2,196	189	8

Source: VHA Support Service Center (accessed April 1, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for appointment cancellation and follow-up terms are provided in notes for Table B.4.*

Table B.12. Cheyenne VA Medical Center COVID-19 Vaccine Administrations (as of March 29, 2021)

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)*	Dose 2 of 2 (Pfizer or Moderna)†	Dose 1 of 1 (Janssen)‡
Veteran	6,020	4,290	43
Employee	876	760	60
Federal Partners§	0	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021). Department of Veterans Affairs COVID-19 National Summary Definitions (accessed March 18, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

* *"Dose 1 of 2" are the number of "initial dose[s] of a 2-dose vaccine series, that is, Pfizer or Moderna."*
† *"Dose 2 of 2" are the number of "final dose[s] of a 2-dose series."*
‡ *"Dose 1 of 1" are the number of "single dose[s] needed for the Janssen vaccine."*
§ *"Federal Partners include Front Line Staff and First Responders that work in other agencies and were directed to receive their vaccination at a VA facility."*

Table B.13. Eastern Oklahoma VA Health Care System COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	10,434	7,087	450
Employee	1,140	955	16
Federal Partners	0	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

* *Definitions for doses and federal partners are provided in notes for Table B.12.*

Table B.14. Montana VA Health Care System COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	9,312	6,323	262
Employee	1,103	1,029	24
Federal Partners	0	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for doses and federal partners are provided in notes for Table B.12.*

Table B.15. Oklahoma City VA Health Care System COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	18,739	14,695	804
Employee	2,063	1,825	<10
Federal Partners	0	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for doses and federal partners are provided in notes for Table B.12.*

Table B.16. Sheridan VA Medical Center COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	3,375	2,682	37
Employee	411	386	16
Federal Partners	0	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for doses and federal partners are provided in notes for Table B.12.*

Table B.17. VA Eastern Colorado Health Care System COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	22,384	14,365	192
Employee	4,057	3,585	<10
Federal Partners	<10	<10	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for doses and federal partners are provided in notes for Table B.12.*

Table B.18. VA Salt Lake City Health Care System COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	12,973	8,411	559
Employee	2,931	2,588	0
Federal Partners	<10	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for doses and federal partners are provided in notes for Table B.12.*

Table B.19. VA Western Colorado Health Care System COVID-19 Vaccine Administrations (as of March 29, 2021)*

Individuals Receiving Vaccinations	Dose 1 of 2 (Pfizer or Moderna)	Dose 2 of 2 (Pfizer or Moderna)	Dose 1 of 1 (Janssen)
Veteran	4,736	3,993	208
Employee	810	703	24
Federal Partners	0	0	0

Source: Department of Veterans Affairs COVID-19 National Summary (accessed April 2, 2021).

Note: The OIG did not assess VA's data for accuracy or completeness.

**Definitions for doses and federal partners are provided in notes for Table B.12.*

Appendix C: VISN 19 OIG Survey Results

Table C.1. VISN 19 OIG Survey Respondents

Respondent Indication	Aurora, CO	Cheyenne, WY	Fort Harrison, MT	Grand Junction, CO	Muskogee, OK	Oklahoma City, OK	Salt Lake City, UT	Sheridan, WY
Clinical	561	238	230	137	281	317	387	140
Nonclinical	345	153	200	140	160	201	307	126
No Selection	2	6	3	2	2	3	4	0
Total	**908**	**397**	**433**	**279**	**443**	**521**	**698**	**266**
Approximate Number of Staff at the Time of Inspection	3,931	1,089	1,480	951	1,727	2,901	3,093	773
Approximate Response Rate (%)	**23**	**36**	**29**	**29**	**26**	**18**	**23**	**34**

Source: VA OIG and VHA Support Service Center's Personnel and Accounting Integrated Data cube (accessed March 16, 2021).

Table C.2. VISN 19 Respondents' Assessment of Communication and Personal Protective Equipment Availability

Question	Aurora, CO	Cheyenne, WY	Fort Harrison, MT	Grand Junction, CO	Muskogee, OK	Oklahoma City, OK	Salt Lake City, UT	Sheridan, WY
Communication: Do you feel that you received adequate communication about how to ensure your own safety at work during the COVID-19 pandemic from facility leaders?	78%	78%	68%	76%	63%	70%	91%	67%

Question	Aurora, CO	Cheyenne, WY	Fort Harrison, MT	Grand Junction, CO	Muskogee, OK	Oklahoma City, OK	Salt Lake City, UT	Sheridan, WY
Communication: Do you feel that you received adequate communication about how to ensure your own safety at work during the COVID-19 pandemic from your immediate supervisor?	80%	88%	78%	82%	78%	75%	84%	76%
Communication: Do you feel that you received adequate communication about how to ensure the safety of patients during the COVID-19 pandemic from facility leaders?	78%	78%	71%	77%	64%	69%	87%	64%
Communication: Do you feel that you received adequate communication about how to ensure the safety of patients during the COVID-19 pandemic from your immediate supervisor?	80%	87%	76%	80%	77%	73%	83%	73%
PPE: Did you have access to appropriate PPE necessary to ensure your own safety at work during the COVID-19 pandemic?	88%	82%	80%	81%	81%	75%	87%	85%

Source: VA OIG.

Note: Values represent the percent of "yes" responses across all respondents (clinical, nonclinical, and no selection).

Table C.3. Identified Trends Among VISN 19 Respondents' Comments on Facility Readiness and Response

Question	Aurora, CO	Cheyenne, WY	Fort Harrison, MT	Grand Junction, CO	Muskogee, OK	Oklahoma City, OK	Salt Lake City, UT	Sheridan, WY
What lessons were learned during the facility's pandemic response?	• Importance of communication and flexibility • Importance of preparation and being proactive • Telehealth can be a viable delivery of patient care	• Importance of communication and flexibility • All need to practice infection control protocols (wearing masks and washing hands)	• Importance of communication and flexibility • Importance of preparation • Importance of on-hand inventory of PPE and cleaning supplies	• Importance of flexibility • Importance of preparation • Importance of teamwork	• Importance of preparation • There is a disconnect between leadership and front-line employees • Importance of proper hygiene protocols and social distancing • Importance of teamwork	• Importance of flexibility • Importance of communication • Importance of proper hygiene protocols and social distancing • Need for sufficient staffing • Importance of teamwork	• Importance of flexibility • Importance of communication • Importance of preparation • Importance of teamwork • Telework is effective	• Importance of communication • Importance of preparation • Importance of teamwork • Telework is effective

Source: VA OIG.

Note: Summarized responses include general themes identified by the OIG among free-text comments made by all respondents.

Appendix D: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: June 9, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19 (VIEWS 5221833)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network (VISN) 19.

2. The Veterans Health Administration has reviewed the document and would like to share some accomplishments at VISN 19 during the COVID-19 Pandemic.

3. The Oklahoma City VA Medical Center (VAMC) identified the need to prepare for the potential impact of COVID-19 by converting outpatient clinic space for inpatient use, increasing the capacity of its Intensive Care Unit, creating dozens of negative pressure rooms to care for COVID-19 positive patients, hiring additional staff, and shifting current staff from outpatient to inpatient care by using a Mobile Medical Unit to create additional inpatient space.

4. The Muskogee VA Medical Center participated in a collaboration with the local State Veterans Home to assist in the combat of COVID-19. The Muskogee VAMC provided total care to Veterans at the Claremore State Veterans Home that were assigned to the COVID unit. Muskogee staff, including engineering and Emergency Medical Services, helped build this COVID-19 unit. Additional staff then took shift assessments to conduct wound care, medication administration, activities of daily living, coordinated telehealth calls, therapy, and any treatment needed. Muskogee had approximately 60 staff members who worked with the State Veterans Home during this time.

5. Comments regarding the contents of this memorandum may be directed to VHA's GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

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