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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Health
Administration's Emergency
Department and Urgent
Care Center Operations
during the COVID-19
Pandemic

On December 18, 2020, this report was revised to make corrections on pages ii-iii, 14, 22, 23, and 24 with explanatory footnotes.



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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of the Veterans Health Administration's (VHA) response to anticipated demand and use of emergency department and urgent care center services when faced with an influx of patients needing evaluation during the COVID-19 pandemic. A survey questionnaire was deployed to selected emergency department and urgent care center directors to learn what steps VHA emergency medicine leaders took from March to July 2020, as well as plans they intend to take should a future need arise.¹

COVID-19 is a multifaceted infectious disease that can cause a wide spectrum of presentations ranging from asymptomatic (without symptoms) to displaying severe multisystem illness. Beyond the flu-like symptoms that may characterize early presentation with COVID-19, patients can develop serious systemic problems. Making a diagnosis of COVID-19 in the emergency department or urgent care center setting may provide critical information to practitioners on the management of patient symptoms.

OIG staff conducted virtual interviews with 63 directors from 49 emergency departments and 14 urgent care centers from July 13 through July 28, 2020, to collect the directors' survey responses on various COVID-19-related topics.

Emergency department and urgent care center directors were asked what impact, if any, there was on patients without COVID-19 symptoms presenting to VHA's emergency departments and urgent care centers during the pandemic. Most directors reported, and data reviewed by the OIG supported, that there was a decreased number of patient visits to the emergency departments (19.8 percent decline) and to the urgent care centers (28.6 percent decline) for January–June 2020 when compared with the same time frame in 2019.²

When asked about the need to repurpose space in the emergency department or urgent care centers for patients with COVID-19, directors discussed the small number of rooms with negative pressure or anterooms, which made it difficult to isolate patients with known or suspected COVID-19, and small waiting areas that did not allow for separation of patients and

¹ For the purposes of this report, the OIG uses the term emergency department and urgent care center directors to mean medical directors of the respective departments.

² Emergency department visits declined from 1,150,746 to 922,722 and urgent care center visits declined from 136,148 to 97,162.

social distancing.³ To address issues with patient flow and limits to physical space while dealing with the separation of patients with known or suspected COVID-19, emergency department and urgent care center directors took various actions, including the use of tents and parking lots, to increase the number of beds and space.

The emergency department and urgent care center directors were questioned about staffing. Of the sites surveyed, 43 of 63 emergency department and urgent care center directors acknowledged staffing concerns, with the majority reporting a need for additional registered nurses and technicians. Twenty-three emergency department and urgent care center directors reported a loss of staff due to providers testing positive for the virus, transfers, resignations, or retirements. One facility reported an employee COVID-19-related death.

Also cited was the need for additional providers, nurse practitioners, and anesthesia providers certified to perform airway management. Emergency department and urgent care center directors further stated a need for housekeeping and environmental staff.

Thirty-seven emergency department and urgent care center directors stated there was no impact on staffing partly because the pandemic was not as severe as initially anticipated, the volume of patients was down, and staff were available for reassignments from other areas of the facility because normal operations were curtailed.

According to the emergency department and urgent care center directors, COVID-19 testing was generally available at the selected facilities and test results assisted with patient-care plans. Some directors reported a lack of personal protective equipment (PPE) (see appendix A).⁴ For example, one emergency department director and one urgent care center director noted they “ran out” of

³ Centers for Disease Control and Prevention, *Airborne Infections Isolation (AII) Room*. https://www.cdc.gov/tb/webcourses/course/chapter7/7_infection_control_7_infection_control_program_airborne_infection_isolation_ait_room.html. Air flow is controlled in a negative pressure room so that air flows from the corridors into the room; the air inside the room does not escape into other parts of the facility when the door is closed and may be vented directly to the outdoors or to a special filter that prevents the spread of airborne droplets. Merriam Webster, *Definition of anteroom*. <https://www.merriam-webster.com/dictionary/anteroom>. An anteroom is a small outer room that leads to another. (The websites were accessed on November 17, 2020.)

⁴ VA OIG, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020. “Personal protective equipment, commonly referred to as PPE is equipment worn to minimize exposure to hazards that cause serious workplace injuries or illnesses.”

PPE.⁵ Eighteen emergency departments and two urgent care centers did not run out of PPE, but had to ration some PPE.⁶

Most of the surveyed emergency department and urgent care center directors reported frequent and supportive interactions with their facility executive leaders as well as regular, informative discussions and meetings with the National Director for Emergency Medicine that included dissemination of up-to-date treatment guidelines. Routine communications occurred via emails, Skype meetings, and podcasts during which subject matter experts addressed the most recent COVID-19 topics, informational sessions, and continuing medical education.

A survey question was asked about what data were considered to be helpful to measure and monitor for COVID-19 and future pandemics and whether critical data were readily available for use. The pertinent data collection deemed critical to emergency department directors included data related to supplies, clinical treatment, COVID-19 epidemiology, and hospital utilization. Of the 63 survey responses, 58 directors affirmed that data were readily available for their use. Three facilities indicated that the number of rapid COVID-19 tests on hand was not readily available, one facility noted having to wait 48 hours after patients were admitted to the hospital through the emergency department for COVID-19 final results, and one facility indicated COVID-19 test results could have a quicker turn-around-time.

The OIG asked about programs or activities used to assess and screen staff for stress, physical and emotional fatigue, and burnout. Virtually all respondents stated that they closely monitored staff for signs of fatigue and burnout. Programs cited to improve employee resilience and decrease stress included the Employee Assistance Program, the VHA chaplain service, as well as whole health education and training focused on emergency department providers. The directors noted communication during the rapidly evolving pandemic was vital to disseminating critical and reliable information to VHA emergency departments and urgent care centers.

The OIG heard some recurrent themes from emergency department and urgent care center directors when asked about lessons learned including the provision of COVID-19 education to patients and providers, rethinking how emergency or urgent care can be delivered in a pandemic, and redesigning the day-to-day operations of the workplace. Specific examples included an increase in space with the use of mobile units that were technologically equipped with video and intercoms for remote monitoring and the pursuit of telehealth options with distribution of

⁵ Merriam Webster, *Definition of ration*. <https://www.merriam-webster.com/dictionary/ration>. (The website was accessed on November 13, 2020.) After publication, corrections were made on December 18, 2020, to modify the statement that two emergency departments (VA Maryland HCS in Baltimore and G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi) reported running out of PPE to one emergency department (Martinsburg VA Medical Center in West Virginia) reported running out of PPE (see appendix A). One urgent care center (Carl Vinson VA Medical Center in Dublin, Georgia) indicated running out of PPE but did not specifically identify the type of PPE; they began limiting the use of new masks to once a week.

⁶ After publication, corrections were made on December 18, 2020, to indicate the number of facilities was 18 rather than 17 that did not report running out of PPE but had to ration some items.

monitoring devices to patients for home monitoring including pulse oximetry to measure oxygenation levels and thermometers to measure temperature. The directors also noted the need to preserve the capability to provide emergency or urgent care for non-COVID-19 patients while attending to the special care needs of patients with COVID-19.

Similar to other COVID-19-related projects, the OIG found that emergency department and urgent care center directors exhibited and described a strong commitment and dedication to veterans and their families during the extremely dynamic and high-risk COVID-19 healthcare environment.

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. Moving forward, the operations and the delivery of emergent and urgent care will likely evolve further. VHA, as the nation's largest integrated healthcare system, will be no exception.



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Abbreviations

CDC	Centers for Disease Control and Prevention
EDIS	Emergency Department Integrated Software
OIG	Office of Inspector General
PPE	personal protective equipment
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a review of the Veterans Health Administration's (VHA) response to anticipated demand and use of emergency department and urgent care center services when faced with an influx of patients needing evaluation after the World Health Organization declared COVID-19 a pandemic in March 2020.⁷ To assist in its evaluation, the OIG deployed a survey questionnaire to selected emergency department and urgent care center directors to learn what steps VHA emergency medicine leaders took and plan to take should a future need arise.⁸

VHA Emergency Departments and Urgent Care Centers

VHA operates 110 emergency departments and 31 urgent care centers. Clinicians in emergency departments "provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and mental health disorders" 24 hours a day, 7 days a week (24/7) as well as resuscitation and stabilization in life-threatening emergencies.⁹ Clinicians at urgent care centers "provide acute medical care for patients without a scheduled appointment who need immediate attention for an acute medical or mental health illness or a minor injury."¹⁰ In general, urgent care centers do not operate 24/7 and do not accept patients who arrive by ambulance.¹¹

Unique to VHA emergency departments and urgent care centers, an independent licensed mental health practitioner must be available to provide safe and secure mental health services during all hours of operation.¹²

⁷ World Health Organization, *WHO Director-General's Opening Remarks at the Media Briefing on COVID-19*, March 11, 2020. <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. (The website was accessed on August 8, 2020.) World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*. COVID-19 is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)." [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(COVID-19\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19)-and-the-virus-that-causes-it). (The website was accessed on September 26, 2020.)

⁸ For the purposes of this report, the OIG uses the terms emergency department and urgent care center directors to mean medical directors of the respective departments.

⁹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. Ward M, Collins S, Pines J, Dill C, Tyndall G, Kessler C. "Emergency Medicine in the Veterans Health Administration-Results from a Nationwide Survey," *Am J Emerg Med* 2015 899-903.

¹⁰ VHA Directive 1101.05(2).

¹¹ VHA Directive 1101.05(2). VHA may grant a waiver for a UCC to operate 24/7.

¹² VHA Directive 1101.05(2). The licensed mental health practitioner (psychiatrist, psychologist, social worker, physician assistant, or advanced practice nurse) may be either on-site or on call.

COVID-19

COVID-19 is a multifaceted infectious disease that can cause a wide spectrum of presentations ranging from asymptomatic (without symptoms) to displaying severe multisystem illness.¹³ Patients presenting to emergency departments and urgent care centers often have a combination of fever, dry cough, shortness of breath, nausea, vomiting, diarrhea, muscle aches, and pain.¹⁴ They may also complain of headache, confusion, sore throat, rhinorrhea (runny nose), nasal congestion, and loss of taste or ability to smell.¹⁵ “Complications of COVID-19 include impaired function of the heart, brain, lungs, liver, kidneys, and coagulation (blood clotting) systems.”¹⁶ Beyond the flu-like picture that may characterize early presentation with COVID-19, patients can develop serious systemic problems including obstruction of blood vessels leading to heart attacks, brain-related complications, and loss of limbs.¹⁷ Patients with COVID-19 who have comorbidities, such as diabetes mellitus, high blood pressure, or heart disease, are particularly vulnerable.¹⁸

Guidelines issued by the U.S. Centers for Disease Control and Prevention (CDC) may assist with identifying at-risk patients and provide infection prevention and control recommendations for

¹³ Centers for Disease Control and Prevention, *Symptoms of Coronavirus*. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>. (The website was accessed on August 9, 2020.) Summer Chavez et al., “Coronavirus Disease (COVID-19): A primer for emergency physicians.” *American Journal of Emergency Medicine*, (March 22, 2020).

¹⁴ Chavez, “Coronavirus Disease (COVID-19): A primer for emergency physicians.”

¹⁵ Chavez, “Coronavirus Disease (COVID-19): A primer for emergency physicians.” Centers for Disease Control and Prevention, *Symptoms of Coronavirus*. Giacomo Spinato, Cristoforo Fabbris, Jerry Polesel, et al. “Alterations in Smell or Taste in Mildly Symptomatic Outpatients with SARS-CoV-2 Infection,” *JAMA*. Merriam-Webster Dictionary, *Medical definition of rhinorrhea*. Rhinorrhea is excessive mucous secretion from the nose.. <https://www.merriam-webster.com/medical/rhinorrhea>. (The website was accessed on August 9, 2020.)

¹⁶ Joost Wiersinga, Andrew Rhodes, Allen C. Cheng, Sharon j. Peacock, Hallie C. Prescott, “Pathophysiology, Transmission, Diagnosis and Treatment of Coronavirus Disease 2019 (COVID-19) A Review.” *JAMA*, published online July 10, 2020. United Press International. “40% of people with severe COVID-19 experience neurological complications.” https://www.upi.com/Health_News/2020/04/10/40-of-people-with-severe-COVID-19-experience-neurological-complications/2491586526495/. (The website was accessed on August 25, 2020.)

¹⁷ Raffaello Bellosta, et al., “Acute limb ischemia in patients with COVID-19 pneumonia.” *Journal of Vascular Surgery*. <https://www.sciencedirect.com/science/article/pii/S0741521420310806>. (The website was accessed on November 18, 2020.) Wiersinga et al, E1; Merriam Webster, *Medical definition of thromboembolism*. Thromboembolism occurs from a blocking of a blood vessel by a piece of blood clot located in a different area of the body. <https://www.merriam-webster.com/dictionary/thromboembolism>. (The website was accessed on August 24, 2020.) Mayo Clinic, “COVID-19 (coronavirus) vs. flu: Similarities and differences” <https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-vs-flu/art-20490339>. (The website was accessed October 22, 2020.)

¹⁸ Chavez, “Coronavirus Disease (COVID-19): A primer for emergency physicians.”

healthcare personnel caring for patients with suspected or confirmed COVID-19.¹⁹ Current literature suggests

An emergency medicine approach to COVID-19 should focus on identifying and isolating patients at risk for infection, informing hospital infection prevention and local public health authorities, and engaging infectious disease and other specialties early in care.²⁰

VHA issued guidance to facilities on March 23, 2020, the *Office of Emergency Management, COVID-19 Response Plan Incident-Specific Annex to the VHA High Consequence Infection (HCI) Base Plan* (Response Plan), that outlined a four-phased approach to mitigate the impact of COVID-19 on veterans, employees, and healthcare operations. Overarching principles included shifting priorities to accommodate a large influx of patients, separation of patients with suspected or confirmed COVID-19 from those who have not been exposed, and leveraging “technology and communications to minimize exposure.”²¹

Making a diagnosis of COVID-19 in the emergency department or urgent care center setting may provide critical information to manage patients’ symptoms. In cases where COVID-19 infection is present, the clinical management may change based on the severity of infection. For moderate to severe disease, inpatient admission may be required. If a patient’s symptoms do not warrant inpatient admission, but a COVID-19 infection was confirmed while in the emergency department, instructing the patient to initiate self-isolation is paramount to stemming COVID-19 in the community.²²

Prior OIG Reports

On March 26, 2020, the OIG reported on its inspection of 237 VHA healthcare facilities (medical centers, community-based outpatient clinics, and community living centers) conducted to evaluate COVID-19 screening processes and pandemic preparations. Visits made to VHA were planned to minimize exposure and potential transmission of COVID-19 for patients, visitors, and staff (both VA and OIG). The report highlighted a multitude of actions taken by VHA, Veterans Integrated Service Network (VISN), and facility leaders to maintain operations during a national emergency. The report also described strategies that various facilities had

¹⁹ CDC, *People with Certain Medical Conditions*. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>. (The website was accessed on August 4, 2020.) CDC, *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic Updated July 15, 2020*. <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>. (The website was accessed on October 22, 2020.)

²⁰ Chavez, “Coronavirus Disease (COVID-19): A primer for emergency physicians.”

²¹ VHA, Office of Emergency Management, *COVID-19 Response Plan Incident-Specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, March 23, 2020.

²² Chavez, “Coronavirus Disease (COVID-19): A primer for emergency physicians.”

implemented at the time with the hope to promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.²³

Approximately four months later, on July 16, 2020, the OIG reported on VHA's continued response to the pandemic after engaging leaders from 70 selected facilities in discussions about patient-care services provided from March 11, through June 15, 2020, in three clinical settings: (1) inpatient (acute care) and outpatient care, (2) community care, and (3) community living centers.²⁴ As in the March 26, 2020, report, the OIG found that VHA leaders and frontline staff exhibited a strong commitment and dedication to veterans and their families in an extremely dynamic and high-risk environment. The report described actions taken and strategies that various facilities had implemented.²⁵

Scope and Methodology

The OIG initiated a review of select aspects of VHA emergency departments and urgent care centers in January 2020. The review was refocused in March 2020 with an emphasis on the care of patients who presented to a VHA emergency department or urgent care center after the World Health Organization declared COVID-19 a pandemic on March 11, 2020.

OIG leaders and medical staff developed a survey instrument to assess multiple COVID-19-related topics:

- Decrease in emergency department and urgent care center patient visits
- Physical space and design
- Emergency department and urgent care center staffing needs
- Availability of COVID-19 testing and personal protective equipment (PPE)
- Communication with facility leaders and interactions with VHA's National Program Office of Emergency Medicine
- COVID-19 critical data
- Support measures to improve staff morale and psychological well-being

²³ VA OIG, *OIG Inspection of Veterans Health Administration COVID-19 Screening Processes and Pandemic Readiness*, Report No. 20-02221-120, March 26, 2020. OIG staff drove to the selected sites and self-screened prior to the facility visits. To prevent the spread of COVID-19, OIG staff did not enter community living centers even if access was granted.

²⁴ VA OIG, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report # 20-03076-217, July 16, 2020.

²⁵ VA OIG, Report # 20-03076-217, July 16, 2020.

- Lessons learned
- Preparation for possible COVID-19 resurgences²⁶

Due to the pandemic, two-person teams conducted virtual interviews with 63 directors from 49 emergency departments and 14 urgent care centers from July 13 through July 28, 2020.²⁷ The survey questions were presented as a series of yes, no, and open-ended questions. In advance of each scheduled interview, the OIG sent the emergency department and urgent care center directors a copy of the survey questions. Due to the open-ended format for some of the questions, the issues that emergency department and urgent care center directors focused on during the interviews varied.²⁸ The OIG did not assess the responses from emergency department and urgent care center directors for accuracy or completeness.

²⁶ Emergency department and urgent care center directors were not specifically asked about VA's fourth mission; however, two directors reported during interviews that they provided assistance to non-VHA facilities or patients. See discussion of VA's fourth mission in Review Results.

²⁷ An emergency department was selected from each state, the District of Columbia, and the Territory of Puerto Rico. Three states (Alaska, Hawaii, and New Hampshire) did not have a VHA emergency department. In Alaska, services are provided at the Elmendorf Air Force Base and through purchased care arrangements with the community hospitals. <https://www.alaska.va.gov/about/index.asp>. (The website was accessed on August 28, 2020.) In Hawaii, services are provided at the Tripler Army Medical Center and through non-VA care providers in the community. <https://www.hawaii.va.gov/about/index.asp>. (The website was accessed on August 28, 2020.) New Hampshire has a VHA UCC.

²⁸ For open-ended questions, the OIG generally did not tabulate responses quantitatively.

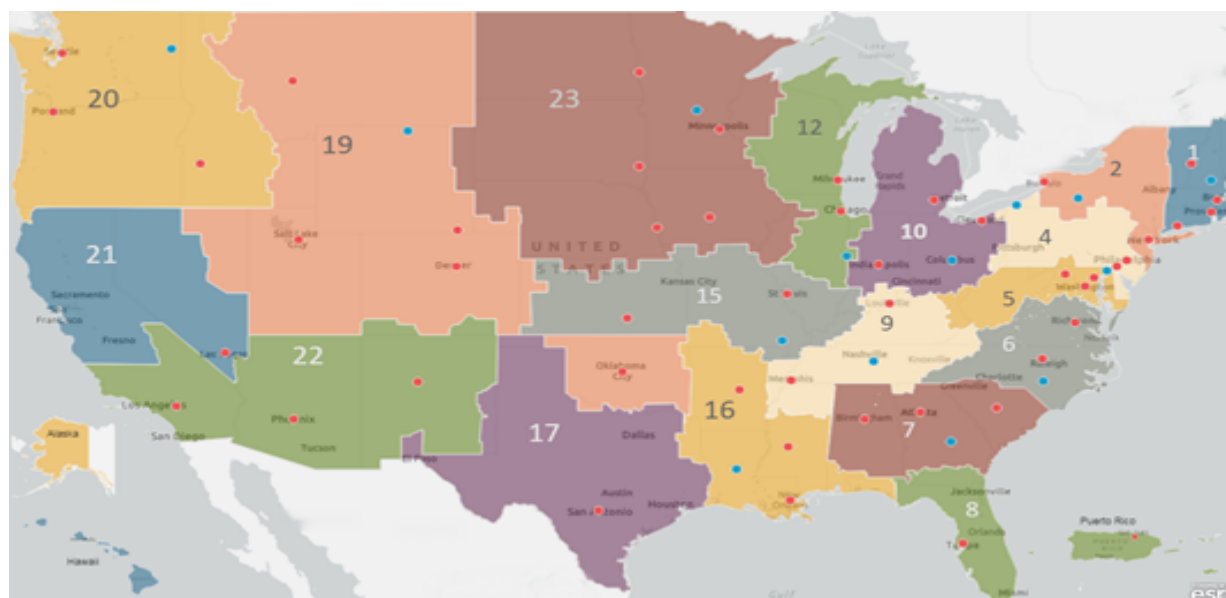


Figure 1. Map of VISNs (regions outlined in colors and numbered) as well as the emergency departments (red) and urgent care centers (blue) whose directors were interviewed.

Note: VISN numbers are not consecutive; in the categorization scheme that was current at the time of the OIG’s review, numbers 3, 11, 13, 14, and 18 were not in use.

Source: VA OIG

If there was more than one emergency department in a state, the one with the highest volume of Emergency Department Integration Software (EDIS) patient encounters from October 1, 2018, through September 30, 2019, was chosen, unless choosing that emergency department caused a VISN to not have representation.²⁹ Fourteen urgent care centers were selected so that all VISNs with an urgent care center were represented. If a VISN had more than one urgent care center, the selection was of the urgent care center with the highest volume of EDIS patient encounters from October 1, 2018, through September 30, 2019.³⁰

The OIG reviewed relevant VHA policies and procedures, including VHA’s March 23, 2020, COVID-19 Response Plan, data from VHA Support Service Center Capital Assets, literature on emergency department and urgent care center practices, and evolving literature on COVID-19.³¹

²⁹ VHA Directive 1101.05 (2). EDIS is a tracking program used for recording and managing the delivery of care to patients in the emergency department and urgent care centers. In VISN 16, the Michael E. DeBakey VA Medical Center in Houston, Texas, had the highest EDIS patient encounters for Texas. However, choosing the Houston facility would have left VISN 17 without representation; therefore, the South Texas Veterans Health Care System Audie L. Murphy Memorial Veterans’ Hospital in San Antonio in VISN 17 was selected. VISN 16 was represented with selected VHA emergency departments in Arkansas, Louisiana, and Mississippi.

³⁰ The Manchester VA Medical Center Urgent Care Center in New Hampshire was selected and represented VISN 1 as there were no VHA emergency departments in New Hampshire.

³¹ Per the VHA Support Service Center, data are provided for the purpose of health care delivery analysis and evaluation. <http://vssc.med.va.gov/VSSCAgreements/Default.aspx?locn=vssc.med.va.gov>. (The website was accessed on October 21, 2020. This is an internal VA website not publicly accessible.) The OIG did not independently verify VHA Support Service Center data. VHA, *Response Plan*, March 23, 2020.

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

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

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

Review Results

The OIG found that in order to meet the clinical and operational challenges to providing care in emergency departments and urgent care clinics after the World Health Organization declared a pandemic in March 2020, VHA leaders took a variety of actions that were focused on structural, clinical, and operational adjustments and were consistent with the Response Plan. The OIG found that emergency department and urgent care center directors exhibited and described a strong commitment and dedication to veterans and their families during the extremely dynamic and high-risk COVID-19 healthcare environment.

Emergency Department and Urgent Care Center Patient Visits

From October 1, 2019, through June 30, 2020, there were 1,631,238 combined emergency department and urgent care center patient encounters. VHA’s first emergency department and urgent care center COVID-19 patient encounters occurred in March 2020 and have continued to date. As of December 8, 2020, VHA had diagnosed 122, 987 cases of COVID-19. There were 5,378 known deaths reported with 2,072 of the deaths occurring among inpatients at VA medical centers.³²

Emergency department and urgent care center directors were asked what impact, if any, there was on patients without COVID-19 symptoms presenting to VHA’s emergency departments and urgent care centers during the pandemic. Most responded that there were decreases in patient encounters. EDIS data showed that emergency department and urgent care center patient encounters from January 1, 2020, to June 30, 2020, were decreased as compared to the same period from the previous year (see table 1). This finding is consistent with reports from across the entire U.S. healthcare system and may have public health implications due to untreated illness and delayed (routine) screening.

Table 1. Decrease in Patient Encounters during the COVID-19 Pandemic

Encounter Location	Jan 1–June 30, 2019	Jan 1–June 30, 2020	% Decline
Emergency Departments	1,150,746	922,722	19.8
Urgent Care Centers	136,148	97,162	28.6

Source: OIG data analysis

Physical Space and Design

As noted above, Veterans Health Administration’s Office of Emergency Management issued guidelines (Response Plan) that delineated VA level roles and responsibilities. Medical facility

³² VA, *COVID-19 National Summary*, <https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary>. (The website was accessed on December 8, 2020.)

directors were responsible for “designating space to care for COVID-19 patients while minimizing the risk of contagion to non-infected patients and visitors.”³³ All facilities were expected to shift priorities and resources to accommodate a large influx of infectious patients, and were also expected to “physically and functionally separate suspected or confirmed COVID-19 patients from individuals who have not been exposed to the virus.”³⁴

Emergency department and urgent care center directors’ survey responses noted two specific challenges with physical space and design—a small number of rooms with negative pressure or anterooms that made it difficult to isolate patients with known or suspected COVID-19, and small waiting areas that did not allow for separation of patients and social distancing.³⁵

Respiratory pathogens, like COVID-19, spread in the air, and invasive procedures such as intubation, aerosolized procedures, or use of bilevel positive airway pressure (BiPAP), may promote increased dispersal of COVID-19 into the room and immediate nearby areas. A room with negative pressure prevents respiratory pathogens from contaminating outside areas, thus protecting staff and other patients.

When asked about physical space, 25 emergency department and six urgent care center directors surveyed cited the need for more negative pressure rooms. Several emergency department directors reported the need for space upgrades that were in progress or near completion prior to the pandemic. In addition, they indicated that in light of the specific needs of patients with COVID-19, having more negative pressure rooms or the ability to switch a room or an entire unit to negative pressure would be useful. To address issues with patient flow and limits to physical space while dealing with the separation of patients with known or suspected COVID-19, emergency department and urgent care center directors took various actions:

- Installation of tents to increase emergency department beds
- Installation of tents for COVID-19 screening or treating respiratory illnesses
- Use of parking areas to test, treat, or provide additional waiting rooms
- Institution of separate entry points into the hospital
- Repurposing of space and re-opening of those areas

³³ VHA, *Response Plan*, March 23, 2020.

³⁴ VHA, *Response Plan*, March 23, 2020.

³⁵ Centers for Disease Control and Prevention, *Airborne Infections Isolation (AII) Room*. https://www.cdc.gov/tb/webcourses/course/chapter7/7_infection_control_7_infection_control_program_airborne_infection_isolation_ii_room.html. Air flow is controlled in a negative pressure room so that air flows from the corridors into the room; the air inside the room does not escape into other parts of the facility when the door is closed and may be vented directly to the outdoors or to a special filter that prevents the spread of airborne droplets. Merriam Webster, *Definition of anteroom*. <https://www.merriam-webster.com/dictionary/anteroom>. An anteroom is a small outer room that leads to another. (The websites were accessed on November 17, 2020.)

Staffing

VHA requires that “appropriately educated and qualified emergency care professionals must be present in the Department to staff the ED/UCC [emergency department/urgent care center] during all hours of operation.”³⁶ At a minimum, there must be two registered nurses with emergency department or urgent care center experience and competencies and a licensed physician with appropriate credentials and privileges.³⁷ According to the OIG’s 2020 report on staffing, facility directors identified physicians and nurses as severe shortage occupations within VHA. The OIG also noted the increased frequency of a severe shortage for custodial workers (housekeeping) that could affect VHA’s ability to provide care safely during the COVID-19 pandemic.³⁸ VHA noted in the Response Plan that up to 40 percent employee absenteeism could occur during peak weeks of a severe COVID-19 outbreak.³⁹

The OIG asked emergency department and urgent care center directors what their greatest staffing needs were during the COVID-19 pandemic (see table 2).

Table 2. Reported Additional Staffing Needed during the COVID-19 Pandemic

Additional Staffing	Emergency Department	Urgent Care Center
Yes	36	7
No	13	7

Source: OIG data analysis

Of the sites surveyed, 43 of 63 (68 percent) acknowledged staffing concerns, with the majority reporting a need for additional registered nurses and technicians. Also cited was the need for additional providers, nurse practitioners, and anesthesia providers certified to perform airway management. Emergency department and urgent care center directors further stated a need for housekeeping and environmental staff. Of the remaining facilities, 20 (32 percent) reported no identified staffing needs.

Emergency department and urgent care center directors reported the following staffing information:

³⁶ VHA Directive 1101.05(2).

³⁷ VHA Directive 1101.05(2).

³⁸ VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

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

- An emergency department staff member at the Minneapolis VA Healthcare System in Minnesota deployed to New York.
- An urgent care center staff member at the Bath VA Medical Center in New York volunteered and was sent to New Jersey.
- The Washington DC VA Medical Center Emergency Department Director noted that the emergency department had been dangerously short staffed; the staff pulled together, and the situation improved as additional staff was hired.
- An emergency department director reported staff were out sick due to COVID-19; facility leaders brought in nurses from other states to care for emergency department patients.
- The VA New Jersey Health Care System Emergency Department Director in East Orange indicated that the emergency department had been short staffed; the Disaster Emergency Medical Personnel System was activated.⁴⁰

Several directors reported staff were not available due to COVID-19 (either sick or quarantined) but did not report actions taken, if any, related to the absenteeism:

- Two urgent care center providers were out sick due to COVID-19.
- Five emergency department providers were out sick due to COVID-19.
- Eight emergency department nurses and eight emergency department providers had to be quarantined due to COVID-19.
- Four facilities indicated that emergency department staff members were not able to report to duty due to COVID-19.

COVID Impact on Staffing

Emergency department and urgent care center directors were asked if COVID-19 had an impact on staffing (see table 3).⁴¹

⁴⁰ VHA Office of Emergency Management, *Disaster Emergency Medical Personnel System (DEMPS)*. “DEMPS is the Veterans Health Administration's main deployment program for clinical and non-clinical staff due to an emergency or disaster.” https://www.va.gov/VHAEMERGENCYMANAGEMENT/CEMP/CEMP_DEMPS.asp. (The website was accessed on September 28, 2020.)

⁴¹ The OIG considered “impact” to include staff transfers, resignations, retirements, and hiring from the community.

Table 3. Reported Staffing Impact Related to the COVID-19 Pandemic

Staffing Impact	Emergency Department	Urgent Care Center
No	27	10
Yes	22	4

Source: OIG data analysis.

Thirty-seven emergency department and urgent care center directors stated there was no impact on staffing. Several reasons provided were that the pandemic was not as severe as initially anticipated, the volume of patients was down, and the emergency departments and urgent care centers were able to cover department staffing with reassignments from other areas of the facility because normal operations were curtailed. Several emergency department directors commented that it could be a challenge for staff to feel comfortable caring for COVID-19 patients. There was a need to train staff in emergency and urgent care skills after re-assignment from other clinical areas.

Twenty-six emergency department and urgent care center directors reported that COVID-19 affected staffing changes (see table 4).

Table 4. Reported Staffing Changes due to the COVID-19 Pandemic

Staffing Change	Emergency Department	Urgent Care Center
Loss of staff	21	2
Increase in hiring from the community	1	2

Source: OIG data analysis

Several reasons were provided for the loss of emergency department and urgent care center staff:

- Providers with positive tests⁴²
- Transfers to different clinical areas⁴³
- Resignations⁴⁴

⁴² A facility reported five physicians tested positive for COVID-19; a second facility reported several nursing staff tested positive.

⁴³ Four directors reported changes due to pregnancies: (1) a pregnant emergency department staff member was assigned to another area of the hospital, (2) a pregnant physician was reassigned to administrative duties, (3) a pregnant staff member was transferred to the nursing tip line, and (4) a pregnant nurse requested transfer out of the emergency department.

⁴⁴ At one facility, a new mother resigned; at another facility, nurses resigned because they were infected with COVID-19.

- Retirements⁴⁵
- A death⁴⁶

Availability of COVID-19 Testing

All participating emergency department and urgent care center directors reported the capability to collect specimens for COVID-19 testing. All but three facilities were able to conduct rapid testing.⁴⁷

Emergency department and urgent care center directors reported that testing for the virus that causes COVID-19 was typically conducted on nasopharyngeal samples obtained from a patient's respiratory system. Rapid or point of care testing allowed results to be available in approximately one hour. Other types of COVID-19 testing were sent to an outside lab, potentially increasing the time interval for results by days.⁴⁸

Several emergency department directors reported that they had expanded COVID-19 testing to patients who presented to the emergency department with non-COVID-19 symptoms. Testing patients admitted to the facility and those scheduled for procedures allowed staff to avoid spread of the disease to other patients or staff.⁴⁹

Based on emergency department and urgent care center directors' responses, the OIG concluded that COVID-19 testing was available and the test results assisted with patient-care plans.

Personal Protective Equipment

The CDC provides infection prevention and control recommendations for healthcare personnel caring for patients with suspected or confirmed COVID-19.⁵⁰ The CDC recommends healthcare

⁴⁵ Two facility directors reported nursing retirements due to the COVID pandemic and one director reported three physicians retired because of the COVID pandemic.

⁴⁶ One facility reported a staff member death due to COVID-19.

⁴⁷ The Cheyenne VA Medical Center Emergency Department in Wyoming and two urgent care centers (Bath VA Medical Center in New York and VA Maryland Health Care System in Perry Point) did not have rapid testing capability.

⁴⁸ CDC, *Overview of Testing for SARS-CoV-2 (COVID-19)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html>. (The website was accessed on October 29, 2020.) Antibody testing is not FDA-approved for making a diagnosis of COVID-19 infection.

⁴⁹ The facilities that expanded COVID-19 testing services were Louis Stokes Cleveland VA Medical Center in Ohio, Durham VA Medical Center in North Carolina, GV (Sonny) Montgomery VA Medical Center in Jackson, Mississippi, VA St. Louis Health Care System in Missouri, and White River Junction VA Medical Center in Vermont.

⁵⁰ CDC, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*: Updated June 16, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>. (The website was accessed on October 22, 2020.)

personnel use standard and transmission-based precautions, including the use of PPE such as face masks, eye protection, gloves, gowns, and N95 respirators when caring for patients with suspected or confirmed COVID-19.⁵¹

The OIG noted the following results from the interview survey responses (additional details are outlined in appendix A):

- Eighteen emergency department and two urgent care center directors stated their facilities did not run out of PPE; however, they noted rationing of some items such as N95 masks.⁵²
- Sixteen emergency departments and two urgent care center directors stated their facilities did not run out of PPE but did not indicate whether rationing occurred.
- Fourteen emergency departments and nine urgent care center directors said their facilities did not run out of PPE and did not ration PPE.
- One emergency department and one urgent care center ran out of PPE; the same urgent care center director indicated there was a need to ration masks.⁵³

Communication with Facility Leaders and Interactions with VHA's National Program Office of Emergency Medicine

The VHA Response Plan outlined roles and responsibilities of VA officials during the pandemic. VHA program offices, such as the National Program Office of Emergency Medicine, were charged with leadership and support responsibilities for the COVID-19 preparedness and response. The VISN Director was responsible to “communicate VISN response efforts to local media, the Congress, Veteran Service Organizations, and Veterans.”⁵⁴ Facility directors were responsible for providing education and training to those staff members who would be involved

⁵¹ Occupational Safety and Health Administration, *Personal Protective Equipment*. <https://www.osha.gov/SLTC/personalprotectiveequipment/>. (The website was accessed on August 26, 2020.) “Personal protective equipment, commonly referred to as “PPE” is equipment worn to minimize exposure to hazards that cause serious workplace injuries or illnesses.” VA OIG, Report No. 20-03076-217, July 16, 2020.

⁵² Within the context of this report, rationing means to use sparingly. <https://www.merriam-webster.com/dictionary/ration>. (The website was accessed on November 13, 2020.) After publication, corrections were made on December 18, 2020, to indicate the number of facilities was 18 rather than 17 that did not report running out of PPE but had to ration some items.

⁵³ After publication, corrections were made on December 18, 2020, to modify the statement that two emergency departments (VA Maryland HCS in Baltimore and G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi) reported running out of PPE to one emergency department (Martinsburg VA Medical Center in West Virginia) reported running out of PPE (see appendix A). One urgent care center (Carl Vinson VA Medical Center in Dublin, Georgia) indicated running out of PPE but did not specifically identify the type of PPE; they began limiting the use of new masks to once a week.

⁵⁴ VHA, *Response Plan*, March 23, 2020.

with COVID-19 patients.⁵⁵ Most of the emergency department and urgent care center directors who were surveyed reported frequent and supportive interactions with their facility executive leaders that occurred at least weekly. In addition, they reported regular discussions and meetings with the National Director for Emergency Medicine.

The emergency department and urgent care center directors who reported meetings with the program office indicated the interactions with the National Director for Emergency Medicine were informative. Routine communications occurred via emails, Skype meetings, and “COVID in 20” podcasts during which subject matter experts addressed the most recent COVID-19 topics, informational sessions, and continuing medical education.

Emergency department directors stressed the importance of having up-to-date treatment guidelines. In emerging pathogens such as COVID-19, treatment data are often limited, and some are anecdotal. Several emergency department directors told the OIG that treatment guidelines were readily available, and they found it helpful to hear about other clinical and treatment experiences from colleagues in high volume COVID-19 areas.

Critical Data

Emergency department and urgent care center directors responded to survey questions related to what they considered as critical data to measure and monitor for COVID-19 and future pandemics. They were also asked if the data were readily available for their use. The pertinent data collection deemed critical to emergency department directors included data related to supplies, clinical treatment, COVID-19 epidemiology, and hospital utilization. Of the 63 survey responses, 58 directors affirmed that the data were readily available for their use. Three facilities indicated that the number of rapid COVID-19 tests on-hand was not readily available, one facility noted having to wait 48 hours for COVID-19 final results after patients were admitted to the hospital through the emergency department, and one facility indicated COVID-19 test results could have had a quicker turn-around-time.

Emergency department directors stated that local data on the number of COVID-19 cases and hospitalization rates in VHA and non-VHA hospitals nearby were available and important to operating their emergency departments. The local hospitalization rate represented the utilization of community inpatient beds, use of ventilators, and helped plan where patients were to be admitted or transferred from VHA emergency departments during periods of peak incidence.

Fourth Mission

VA supports the promise to care for veterans through specific missions: the Veterans Health Administration for health care, the Veterans Benefits Administration for transitioning veterans

⁵⁵ VHA, *Response Plan*, March 23, 2020.

out of military service, and the National Cemetery Administration for providing lasting tributes of veterans service. Its fourth mission is “to improve the Nation’s preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts.”⁵⁶

The COVID-19 pandemic triggered the VA’s fourth mission. Although emergency department and urgent care center directors were not specifically asked about VA’s fourth mission during interviews, two directors reported that they provided assistance to non-VHA facilities or patients during the time frame under review:

- Per the Mann-Grandstaff VA Medical Center Urgent Care Center Director in Spokane, Washington, between 36-41 individuals were re-located to the facility’s community living center for several weeks and were treated as needed in the urgent care center.
- According to Michigan’s Ann Arbor VA Medical Center Emergency Department Director, facility staff provided care to 34–35 non-veterans.

Support Measures to Improve Staff Morale and Psychological Well-Being

In the OIG’s survey, emergency department and urgent care center directors were asked if they had any specific measures, programs, or activities to assess and screen staff for stress, physical and emotional fatigue, and burnout. The OIG found that employee stress correlated with local COVID-19 incidence. For example, several emergency department and urgent care center directors in low incidence areas stated that these issues were not a major concern. However, in high incidence COVID-19 areas, emergency department and urgent care center directors recognized the issue and acknowledged its relevance. Virtually all stated that they closely monitored their staff for signs of fatigue and burnout.

One emergency department director reported that staff initially had a tremendous amount of fear and a high resistance to caring for patients with COVID-19 because of the possibility of transmission of the virus. Huddles and support for one another were implemented so staff could acknowledge and talk about their fears.⁵⁷

Another emergency department director reported that staff had increasingly felt overburdened and that understanding and responding to burnout was important as staff faced demands of work,

⁵⁶ VA, *About VA Mission Statement*. https://www.va.gov/about_va/. (The website was accessed on August 28, 2020.)

⁵⁷ Institute for Healthcare Improvement, *Huddle*. <http://www.ihl.org/resources/Pages/Tools/Huddles.aspx>. “A short, stand-up meeting—10 minutes or less—that is typically used once at the start of each workday in a clinical setting.” (The website was accessed on November 17, 2020.)

family, and community issues. The director further stated that it would be difficult to find staff who had not been dealing with some level of burnout during the pandemic.

The emotional toll taken on staff in evaluating and treating patients with COVID-19 has been documented. A recent contribution to the mental health literature concluded that “There is increasing evidence that suggests that COVID-19 can be an independent risk factor for stress in HCW [healthcare workers].”⁵⁸ This author advocated that “Regular screening of medical personnel involved in treating, diagnosing patients with COVID-19 should be done for evaluating stress, depression and anxiety by using multidisciplinary Psychiatry teams.”⁵⁹ The Institute for Healthcare Improvement has referred to this concept as “Psychological PPE.”⁶⁰

Nineteen of 63 (30 percent) emergency department and urgent care center directors interviewed cited the availability of the Employee Assistance Program. Five of 63 emergency department and urgent care center directors interviewed cited the availability of chaplain services.

Other resources cited by emergency department and urgent care centers directors included a VHA-implemented program entitled “Self-Care Resources for Your Whole Health,” which comprises a variety of modalities directed toward improving and maintaining morale and health for multiple VA stakeholders including “veterans, family members, caregivers, employees, and the public.”⁶¹ The program, as it particularly pertained to VHA’s emergency departments and urgent care centers, and as implemented by VHA’s National Program Office of Emergency Medicine included various activities:

- An EM-Chat, which highlighted a whole health approach to pain management in the emergency medicine setting. A recorded panel discussion centered around a personalized approach to caring for veterans, which created fulfillment for providers as well.
- A COVID-20 podcast, led by the VHA National Director of Emergency Medicine, featured clinician subject matter experts on whole health and well-being. According to the VHA National Director of Emergency Medicine, the podcast reached a wide audience throughout VHA and received very positive feedback. The twice-a-week program provided a consistent forum to discuss and learn from COVID-19 treatment experiences.

⁵⁸ Spoorthy MS, Pratapa SK, and Mahant S. “Mental health problems faced by healthcare workers due to the COVID-19 pandemic-A review,” *Asian J Psychiatr.* June 2020; 51: 102119. Published online 2020 Apr 22.

⁵⁹ Spoorthy MS et al, June 2020.

⁶⁰ Institute for Healthcare Improvement. “Psychological PPE:” *Promote Health Care Workforce Mental Health and Well-Being.* https://www.aapd.org/globalassets/media/covid-19/ihitool_psychologicalppe_healthcareworkforcementalhealthwellbeing.pdf. (The website was accessed on October 28, 2020.)

⁶¹ VA Benefits and Health Care, *Employee Whole Health Self-Care Resources for Your Whole Health.* <https://www.va.gov/WHOLEHEALTH/professional-resources/EWH-resources.asp>. (The website was accessed on November 17, 2020.)

- The VHA Office of Patient-Centered Care and Cultural Transformation partnered with the VHA National Program Office of Emergency Medicine to adapt whole health education and training to emergency department providers. The training provided a large focus on well-being, resiliency, and the experience of whole health for them.

Several emergency department and urgent care center directors established innovative programs and approaches to staff mental health. Below is a sampling of these activities:

- For mental health concerns, the New Mexico VA Health Care System in Albuquerque mental health providers were available to talk anonymously with staff. At the VA Eastern Colorado Health Care System, experts in counseling were available.
- At the Robley Rex VA Medical Center in Louisville, Kentucky, guided relaxation therapy was available to staff on Skype.
- Daily observation, mindful moments, daily prayer, and email messages were provided by the facility chaplain at the VA Nebraska-Western Iowa Health Care System in Omaha.
- At the James A. Haley Veterans' Hospital in Tampa, Florida, regular meetings and townhalls were conducted to ensure staff were educated to protect themselves using N95s and masks; and infectious disease staff provided up-to-date COVID-19 information. Emergency department directors supported decreased total number of clinical hours on the floor; telework was allowed for some tasks to decrease staff exposure and burnout.
- At the VA Tennessee Valley Healthcare System in Murfreesboro, employee health had 24 hour, 7 days a week telephone contact available to staff to call if they had any health concerns.

Lessons Learned

The OIG asked emergency department and urgent care center directors for information they deemed important to share with others in managing emergency departments and urgent care centers during COVID-19 and future pandemics. Their comments included their retrospective thoughts, lessons learned, and how their care changed during the COVID-19 pandemic. Recurrent themes included providing COVID-19 education to patients and providers, rethinking how emergency or urgent care can be delivered in a pandemic, and redesigning the day-to-day operations of the workplace. Below are comments and suggestions from emergency department and urgent care center directors:

General Operations

- The Urgent Care Center Director at the Bath VA Medical Center, New York, commented: “[We] [M]oved as much care outside the building as possible to decrease risk of exposure. We also installed the intercom with video at the UCC [urgent care

center]. We also looked at using the mobile RV [recreational vehicle] that has two exam rooms but was not as functional due to connection of wireless services.”

- The Emergency Department Director at the Providence VA Medical Center in Rhode Island reported “Have separate emergency department bays for persons not under investigations to treat for myocardial infarction and other clinical issues not COVID-19 related.”⁶²
- Multiple emergency department and urgent care center directors noted the need for additional negative pressure rooms according to the size and volume of the facility.
- Data availability is critical for the evaluation, treatment, and admission of patients (local, state, and national).

Adjunct or Alternative Care Modalities

- The Emergency Department Director at the Louis Stokes Cleveland VA Medical Center in Ohio shared that telemedicine was utilized for non-COVID-19 patients and stated, “From a non-emergency perspective, we were able to provide really excellent longitudinal care both in primary care and specialty medicine.”
- The Urgent Care Center Director at the Manchester VA Medical Center in New Hampshire commented “We also have pulse oximetry machines and thermometers to give out to patients. Also had iPads for patients who were then enrolled in COVID-19 telehealth and gave out about 100 iPads.”
- Emergency department and urgent care center directors from VA facilities located in Little Rock, Arkansas; Manchester New Hampshire; Durham, North Carolina; and Ann Arbor, Michigan; reported that patients with COVID-19 who were sent home for self-care were provided pulse oximeters and smart tablets to monitor oxygen levels and clinical conditions.

Preparation for Possible Resurgences

Many medical experts forecast a resurgence of COVID-19. VHA emergency department and urgent care center directors surveyed indicated that COVID-19 in conjunction with flu season will be challenging. The emergency system may be stressed.

Several emergency department and urgent care center directors stated that the capability to diagnose a panel of respiratory pathogens quickly would be very helpful. Some VHA emergency

⁶² A person under investigation is an individual with a fever, pneumonia or acute respiratory distress syndrome; a history of foreign travel; or persons in contact with anyone diagnosed with COVID-19. <https://www.health.mil/Military-Health-Topics/Health-Readiness/Pandemic-Diseases/MERS-CoV/Patient-Under-Investigation-Definition>. (The website was accessed on October 23, 2020.)

departments have the technology ready for use, while others are waiting to add this capability. Some do not have the necessary equipment.

Emergency department and urgent care center directors mentioned they also needed to ensure that abundant PPE and testing supplies such as reagents are available.⁶³

Several emergency department directors commented on plans to continue or expand respiratory and non-respiratory areas to manage patients. Others stressed the need to relook at emergency department flow and possibly set up overflow areas, drive-through clinics, repurpose mobile units, initiate fast track care, and initiate telehealth delivery to allow for virtual emergency care. An example of relooking at flow included a facility that realized patients discharged on medications went to the pharmacy located beyond the emergency department areas. Rather than patients with suspected or confirmed COVID-19 going to the pharmacy, pharmacy services were provided in the emergency department.

In addition to ensuring staff, supplies, and processes are in place to care for patients in the coming months, a common theme among several emergency department and urgent care directors was to continue to heighten awareness and preparedness for COVID-19.

Conclusion

This report on VHA's emergency department and urgent care center operations during the COVID-19 pandemic details actions taken during a global pandemic and evolving challenges faced by VHA in caring for the nation's veterans. While VHA facilities may generally have been spared from a state of resource depletion or unmanageable disease burden, caring for the influx of COVID-19 patients to its emergency departments and urgent care centers was a significant undertaking.

Overall, this report highlights a multitude of actions taken by VHA and facility leaders to maintain emergency department and urgent care center operations during a national emergency. With the uncertainty of timing and magnitude of possible recurrent outbreaks, this review presented strategies that various VHA emergency departments and urgent care centers put into place at the start of the pandemic that will hopefully promote discussion, consideration of lessons learned, and best practices among facility and community healthcare leaders.

Emergency department and urgent care center directors discussed the need to repurpose space to accommodate the specific needs of infected patients, the rearranging of staff when indicated to cover additional staffing needs, and the use of community COVID-19 data to estimate VHA emergency medicine needs and resource allocation. The directors further indicated that there was

⁶³ Arkansas Center for Healthcare Improvement, *COVID-19 in Arkansas*. <https://achi.net/newsroom/defining-covid-19-terms-reagent/>. (The website was accessed on October 22, 2020.) Reagents are used in a lab to test patient swab samples to determine a positive or negative COVID-19 result.

consistent, open communication with the VHA National Program Office of Emergency Medicine. The National Program Office of Emergency Medicine's streamlined communication provided a consistent platform to guide emergency departments and urgent care centers during this ongoing crisis. Communication during a rapidly evolving pandemic was vital to disseminating critical and reliable information to VHA emergency departments and urgent care centers.

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. Moving forward, the operations and the delivery of emergent and urgent care will likely evolve further from previous models. VHA, as the nation's largest integrated healthcare system, will be no exception.

Appendix A: PPE and Rationing of PPE⁶⁴

**Table A.1. List of Reviewed Facility Emergency Departments and Urgent Care Centers by VISN, PPE, and Rationing of PPE
March–July 2020**

VISN	Facility	Ran Out Of PPE	Type of PPE	Rationed PPE	Type of PPE Rationed	No PPE Shortage and No Ration of Supplies
1	Manchester VAMC in New Hampshire (Urgent Care Center)			X	N95 masks Regular masks	
1	Providence VAMC in Rhode Island					X
1	VA Boston HCS in Massachusetts					
1	VA Maine HCS in Togus					
1	White River Junction VAMC in Vermont					
1	VA Connecticut HCS in West Haven			X	N95 masks	
2	Bath VAMC in New York (Urgent Care Center)					X
2	VA Western New York HCS in Buffalo			X	Surgical masks	
2	VA New Jersey HCS in East Orange			X		
4	Corporal Michael J. Crescenz VAMC In Philadelphia, Pennsylvania					
4	Erie VAMC in Pennsylvania (Urgent Care Center)					X
4	Wilmington VAMC in Delaware			X	N95 masks	
5	Martinsburg VAMC in West Virginia	X	Surgical Masks N95 masks Gowns	X		

⁶⁴ After publication, the appendix was changed on December 18, 2020, to reflect that the Carl Vinson VA Medical Center did not specifically identify the type of PPE they did not have (see page 23, VISN 7) and Southeast Louisiana VA HCS in New Orleans did not report running out of PPE (see page 24, VISN 16).

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VISN	Facility	Ran Out Of PPE	Type of PPE	Rationed PPE	Type of PPE Rationed	No PPE Shortage and No Ration of Supplies
			Face shields Gloves			
5	Washington DC VAMC			X	N95 masks	
5	VA Maryland Health Care System in Perry Point (Urgent Care Center)					X
5	VA Maryland HCS in Baltimore			X	N95 masks Sanitizing wipes	
6	Durham VAMC in North Carolina					X
6	Fayetteville VAMC in North Carolina (Urgent Care Center)			X	Surgical masks N95 masks Gowns	
6	Hunter Holmes McGuire Hospital in Richmond, Virginia			X	N95 masks	
7	Columbia VA HCS in South Carolina					X
7	Atlanta VA HCS in Decatur, Georgia			X	Masks Gowns	
7	Birmingham VAMC in Alabama					
7	Carl Vinson VAMC in Dublin, Georgia (Urgent Care Center)	X	Did not specifically identify	X	Masks	
8	James A Haley Veterans' Hospital in Tampa, Florida					
8	VA Caribbean HCS in San Juan, Puerto Rico					X
9	Memphis VAMC in Tennessee					
9	Tennessee Valley HCS in Murfreesboro (Urgent Care Center)					
9	Robley Rex VAMC in Louisville, Kentucky					X
10	Chalmers P. Wylie Ambulatory Care Center in					X

Review of Veterans Health Administration's Emergency Department and
Urgent Care Center Operations during the COVID-19 Pandemic

VISN	Facility	Ran Out Of PPE	Type of PPE	Rationed PPE	Type of PPE Rationed	No PPE Shortage and No Ration of Supplies
	Columbus, Ohio (Urgent Care Center)					
10	Louis Stokes Cleveland VAMC in Ohio					X
10	Richard L. Roudebush VAMC in Indianapolis, Indiana					
10	Ann Arbor HCS in Michigan					X
12	Clement J. Zablocki VAMC in Milwaukee, Wisconsin			X	N95 masks	
12	VA-Ilhiana HCS in Danville, Illinois (Urgent Care Center)					X
12	Edward Hines, Jr. VA Hospital in Illinois					X
15	John J. Pershing Medical Center in Poplar Bluff, Missouri (Urgent Care Center)					X
15	VA St. Louis HCS in Missouri			X	Masks	
15	Robert J. Dole VAMC in Wichita, Kansas					X
16	Central Arkansas Veterans HCS - John L. McClellan Memorial Veterans Hospital- in Little Rock			X	N95 masks Masks Gowns	
16	Alexandria VA HCS in Pineville, Louisiana (Urgent Care Center)					X
16	G.V. (Sonny) Montgomery VAMC in Jackson, Mississippi			X	Face masks Face shields Goggles	
16	Southeast Louisiana Veterans HCS in New Orleans			X	Gowns Surgical masks	
17	South Texas Veterans HCS – Audie L. Murphy Memorial Veterans' Hospital in San Antonio					
19	Oklahoma City VA HCS in Oklahoma					

Review of Veterans Health Administration's Emergency Department and
Urgent Care Center Operations during the COVID-19 Pandemic

VISN	Facility	Ran Out Of PPE	Type of PPE	Rationed PPE	Type of PPE Rationed	No PPE Shortage and No Ration of Supplies
19	Cheyenne VAMC in Wyoming					X
19	Sheridan VAMC in Wyoming (Urgent Care Center)					X
19	VA Eastern Colorado HCS in Aurora, Colorado			X		
19	VA Montana HCS in Fort Harrison					
19	VA Salt Lake City HCS in Utah			X	N95 masks	
20	Boise VAMC in Idaho					
20	VA Portland HCS in Oregon					X
20	Mann-Grandstaff VA Medical Center in Spokane, Washington (Urgent Care Center)					
20	VA Puget Sound HCS in Seattle, Washington					
21	VA Southern Nevada HCS in North Las Vegas					
22	New Mexico VA HCS in Albuquerque					
22	Phoenix VA HCS in Arizona			X	N95 masks	
22	VA Loma Linda HCS in California					X
23	VA Central Iowa HCS in Des Moines			X	N95 masks Face shields	
23	Fargo VA HCS in North Dakota					X
23	Sioux Falls VA HCS in South Dakota					X
23	Minneapolis VA HCS in Minnesota			X		
23	St Cloud VA HCS in Minnesota (Urgent Care Center)					X
23	VA Nebraska-Western Iowa HCS in Omaha					

Source: VA OIG survey tool

HCS = health care system or healthcare system

VAMC = Veterans Affairs medical center

Appendix B: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: December 16, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG National Review: Veterans Health Administration's Emergency Department and Urgent Care Center Operations during the COVID-19 Pandemic

To: Assistant Inspector General for Healthcare Inspections

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report *Veterans Health Administration's (VHA) Emergency Department and Urgent Care Center Operations during the COVID-19 Pandemic*.
2. I personally want to take this opportunity to recognize our Emergency Department and Urgent Care Center personnel for their devotion to helping Veterans and for all the hard work they have done and continue to do.
3. The 134 emergency rooms we have around the country are the front line in our fight against COVID-19. It is difficult and critical work. We know that bringing an ill loved one to the emergency room may be a deeply stressful and emotional experience. Our staff's compassionate efforts make a vast difference with helping to alleviate concerns. We use every means available to communicate with families when they can't be by their loved one's side due to social distancing. We are looking forward to the benefits of COVID-19 vaccination for all health care workers and Veterans.
4. Comments regarding the content of this memorandum may be directed to Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10BGOALAction@va.gov.

//Original signed by://
Richard A. Stone, M.D.

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