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 Networks 10 and 20

CHIP REPORT | REPORT #21-01116-98 | MARCH 16, 2021

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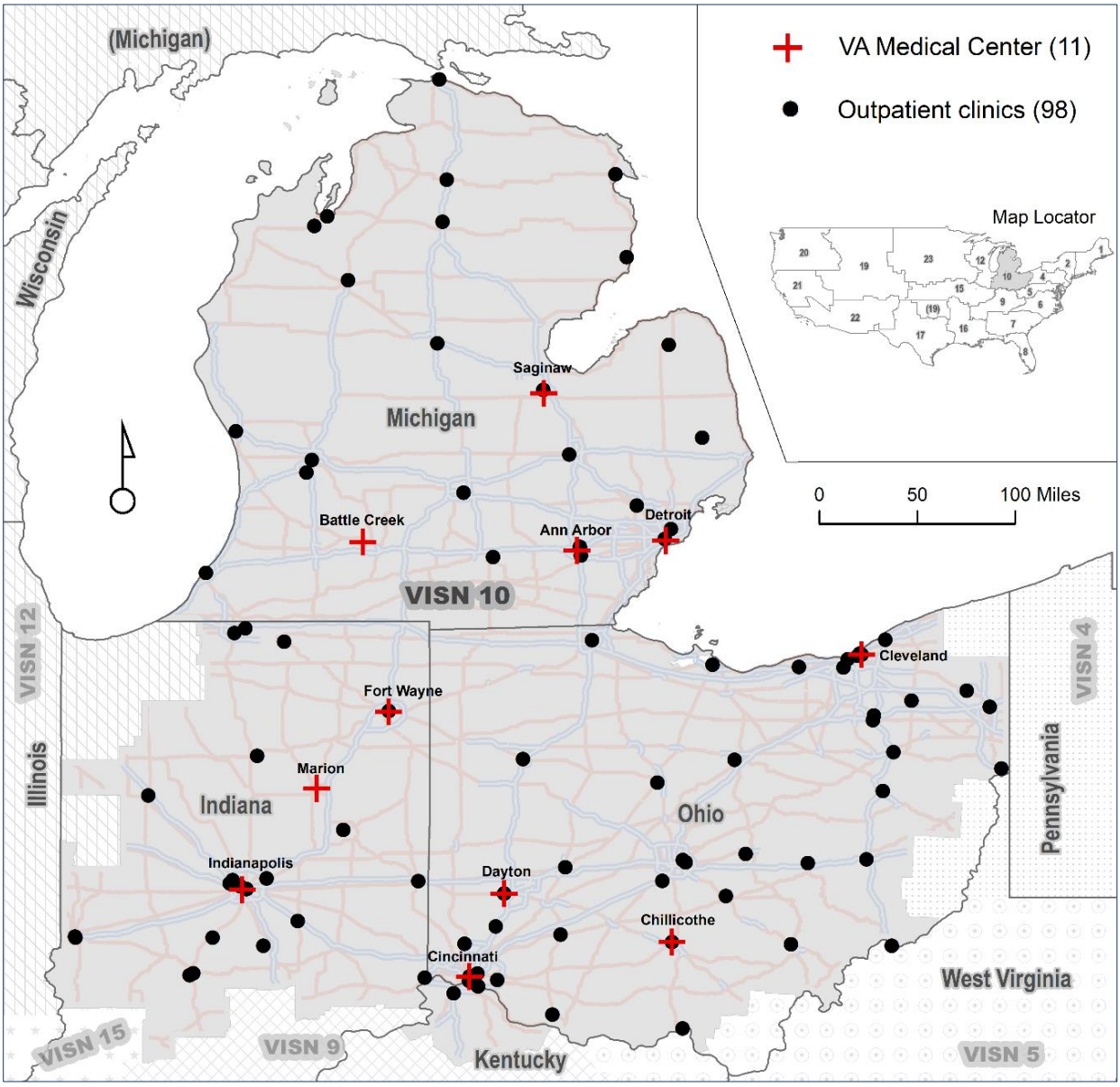

Figure 1. *Veterans Integrated Service Network 10: VA Healthcare System Serving Indiana, Ohio, and Michigan Veterans.*

Source: Veterans Affairs Site Tracking database (accessed July 22, 2020).

Note: Veteran care is provided through regional systems called Veterans Integrated Service Networks (VISNs). There are 18 VISNs that provide the administrative and clinical oversight of medical centers. This report focuses on VISNs 10 and 20.

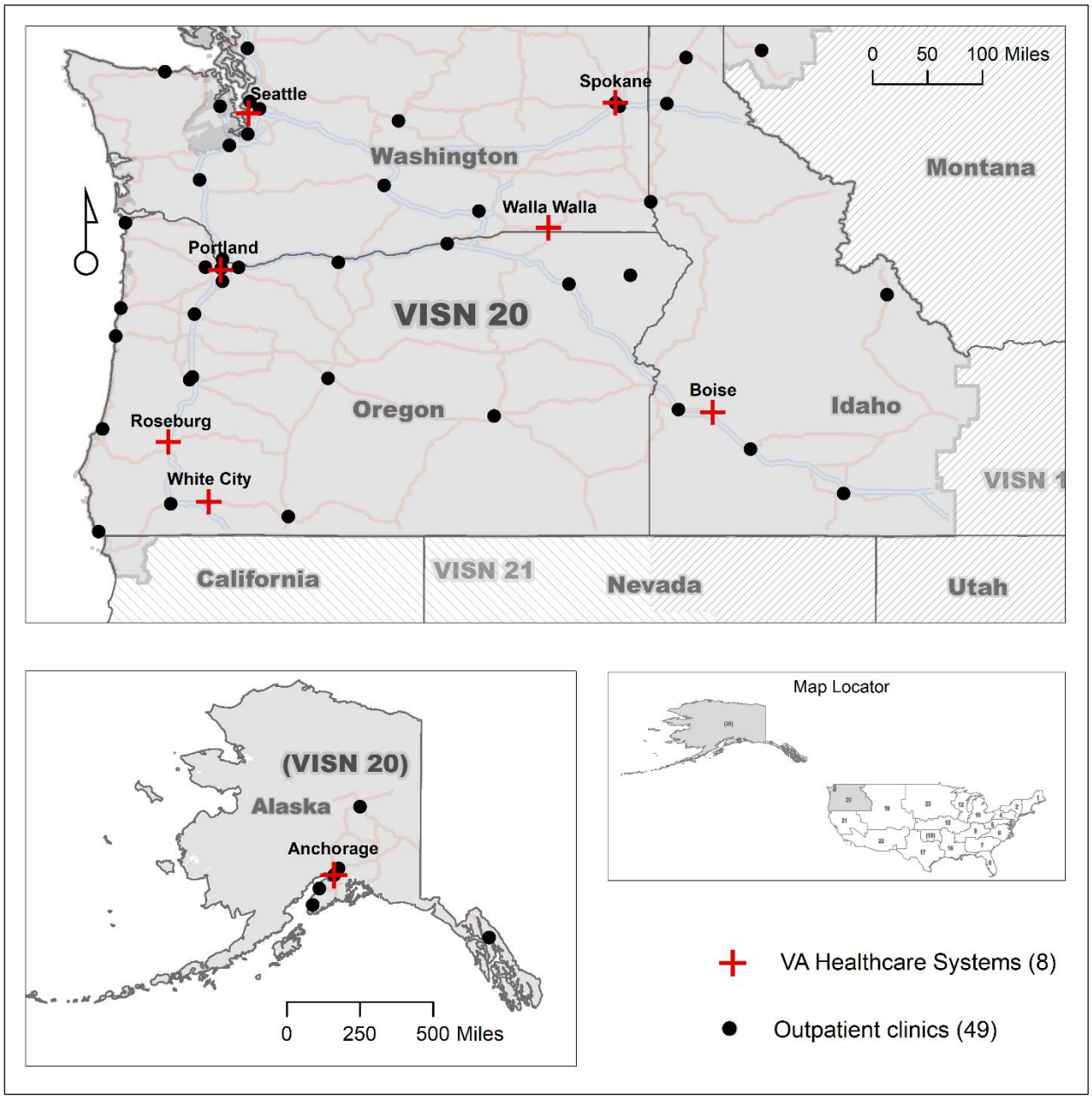

Figure 2. *Veterans Integrated Service Network 20: VA Northwest Health Network.*
Source: Veterans Affairs Site Tracking database (accessed September 17, 2020).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
HCS	Health Care 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 preparedness 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 first in a series. It provides a descriptive evaluation of facilities' responses to COVID-19 within VISNs 10 and 20. This examination is based on findings from healthcare inspections performed during the fourth quarter of fiscal year 2020 (July 1 through September 30, 2020). It also provides a more recent snapshot of the pandemic's demands on these facilities' operations based on data compiled as of December 31, 2020. Interviews and survey results provide additional context on lessons learned and perceptions of both preparedness and responses.

Because of the COVID-19 pandemic, the OIG converted the scheduled site visits of VISN 10 and 20 facilities in July and September 2020, respectively, to virtual reviews without physical inspections, and initiated 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 and/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. They are not numbered sequentially due to prior mergers or reorganizations.

[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. They are associated with Veterans Health Administration medical facilities.

Inspection Results

At the time of the inspections, the Veterans Health Administration (VHA) and the VISNs had not yet experienced the full force of the pandemic peaks in November and December but had valuable information to share about their experiences to date. All leaders reported having an emergency operations plan prior to March 2020 and activating the plan during the pandemic.

During interviews, medical facility leaders cited communication elements as key to effective preparation, and several recognized that efforts by leadership at VA Central Office and VISNs 10 and 20 provided needed information and up-to-date guidance.

Facility leaders indicated few issues with the adequacy of supplies, equipment, or infrastructure to support the treatment of patients with COVID-19 at the time of their respective inspections. Some leaders reported implementing changes to address infrastructure inadequacies (such as the conversion of hallway space into isolation areas) and to expand inpatient capacity.

Facility leaders and community living center personnel generally reported no systemic staffing issues or concerns related to ongoing pandemic response efforts. Critical care staff largely indicated sufficient staffing to support the respiratory care of COVID-19 patients.

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 in interviews that they had been adhering to VISN and VHA guidance by cancelling elective procedures. At the time of the inspections, all facilities had resumed elective surgeries at varying capacities, except Mann-Grandstaff VA Medical Center in Spokane, Washington, where a backlog of semi-urgent surgeries were being addressed before continuing elective procedures. Leaders universally reported expanding telemedicine (virtual care) to reduce the number of cancelled outpatient appointments. Despite ongoing efforts, a significant volume of cancelled appointments still required follow-up as of December 30, 2020.

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 described the frustration and stress experienced by the residents due to visitation restrictions. Some leaders described difficulty with maintaining social distancing when residents were dining, keeping residents active and engaged, and maintaining a "home-like" environment.

From the survey, the OIG noted that 56–79 percent of VISN 10 staff who responded and 69–90 percent of VISN 20 respondents reported that leaders and immediate supervisors communicated how to ensure the safety of staff and patients during the pandemic. The OIG also identified several general themes, including the importance of preparation, communication, teamwork, and flexibility and adaptability when staff were asked about lessons learned during their facility's pandemic response.

Although leaders indicated few issues with the adequacy of supplies, 20–40 percent of VISN 10 and 10–25 percent of VISN 20 staff who responded reported not having access to appropriate personal protective equipment necessary to ensure their own safety at work at the time of the virtual reviews. During follow-up discussions, some facility leaders shared their thoughts on the reasons for the employees' perceptions which included administrative staff's denial of masks dedicated to clinical staff and sign-out procedures to ensure staff had access to and used appropriate supplies in accordance with Centers for Disease Control and Prevention and VHA guidance.

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.

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 "[p]rovision 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 effectively provide a safety net for the nation's hospitals if they become overwhelmed.[5]

Because of the pandemic, the OIG converted its scheduled July and September 2020 CHIP in-person site visits for facilities in Veterans Integrated Service Networks (VISNs) 10 and 20, respectively, to virtual reviews.[6] The CHIP team instead conducted a remote evaluation of the pandemic's effect on VISN medical facilities' and their leaders' subsequent responses. The OIG evaluated five issue areas related to emergency preparedness: supplies, equipment, and infrastructure; staffing; access to care; and community living center (CLC) patient care and

[1] "Provision of hospital care and medical services during certain disasters and emergencies under 38 U.S.C. 1785." *Code of Federal Regulations*, title 38, section 17.86 (38 CFR § 17.86).

[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] Veterans Health Administration – Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

[4] 38 U.S.C. § 7301–7303 defines VHA's missions and includes serving veterans through care, research, and training. A fourth mission for the "Provision of hospital care and medical services during certain disasters and emergencies" is outlined by 38 CFR § 17.86 – "[d]uring and immediately following a disaster or emergency…VA under 38 U.S.C. §1785 may furnish hospital care and medical services 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*, *March 19–24, 2020,* Report No. 20-02221-120, March 26, 2020.

[6] Veteran care is provided through regional systems called Veterans Integrated Service Networks (VISNs). There are 18 VISNs that provide the administrative and clinical oversight of medical centers.

operations.[7] The OIG also surveyed medical facility staff to solicit their feedback and identify any potentially problematic trends or issues that may require follow-up.

This report collects information about VHA's COVID-19 actions from the OIG's overall comprehensive healthcare inspection findings. It is the first in a series meant to aggregate pandemic-related information promptly for VA instead of waiting for the full CHIP results in the OIG's routine published reports. This report provides a descriptive evaluation of facilities' pandemic readiness and responses within VISNs 10 and 20, as determined by inspections conducted during the fourth quarter of fiscal year (FY) 2020 (July 1 through September 30, 2020), and a more recent snapshot of the number and types of positive cases on facility operations as of December 30, 2020.

[7] 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. They are associated with VHA medical facilities.

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.[8] However, because of the pandemic, the OIG converted its scheduled July and September 2020 in-person site visits to virtual reviews.

The OIG inspection teams interviewed leaders and staff to learn more about the five issue areas mentioned above.[9] These virtual inspections were initiated across VISN 10 the weeks of July 20 and 27, 2020, and across VISN 20 the weeks of September 14 and 21, 2020, at the following facilities:

- VISN 10: VA Healthcare System
  - Aleda E. Lutz VA Medical Center (VAMC) (Saginaw, Michigan)
  - Ann Arbor VAMC (Michigan)
  - Battle Creek VAMC (Michigan)
  - Chillicothe VAMC (Ohio)
  - Cincinnati VAMC (Ohio)
  - Dayton VAMC (Ohio)
  - John D. Dingell VAMC (Detroit, Michigan)
  - VA Northern Indiana Health Care System (HCS) (Marion)
- VISN 20: VA Northwest Health Network
  - Boise VAMC (Idaho)
  - Mann-Grandstaff VAMC (Spokane, Washington)
  - Roseburg VA HCS (Oregon)
  - VA Portland HCS (Oregon)
  - VA Puget Sound HCS (Seattle, Washington)

[8] The OIG did not inspect three VISN 10 facilities (Chalmers P. Wylie VA Ambulatory Care Center, Louis Stokes Cleveland VA Medical Center, and Richard L. Roudebush VA Medical Center) and three VISN 20 facilities (Alaska VA Healthcare System, Jonathan M. Wainwright Memorial VA Medical Center, and VA Southern Oregon Rehabilitation Center and Clinics) due to recently-performed comprehensive healthcare inspections in FY 2019.

[9] Medical center and healthcare system leaders' interviews generally involved facility directors, chiefs of staff, associate directors for patient care services, and associate and/or assistant directors. Critical care and community living center leaders' interviews typically involved physician and nurse leaders who oversaw or provided patient care in their respective areas.

The OIG also surveyed staff at the inspected medical facilities about their experiences related to several factors:

- Communication
- Access to personal protective equipment (PPE)
- Job-related training
- Telework
- Employee assistance
- Facility readiness and response

The OIG coordinated email distribution of the survey and instructions to facility staff on the Monday beginning the virtual inspections and collected responses until 5:00 p.m. (local time) on the following Friday. The OIG summarized and shared survey results with facility leaders and discussed any concerning issues or trends at that time. 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 useful lessons learned and details about some challenges.

During the virtual reviews, when the OIG identified concerns beyond the scope of the inspections, those matters were referred to the OIG's hotline management team for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[10] 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.

[10] 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 facilities within VISNs 10 and 20. 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 VISNs 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 issue areas examined for all VISN comprehensive healthcare inspections related to pandemic preparedness and responses:
    - Emergency preparedness
    - Supplies, equipment, and infrastructure
    - Staffing
    - Access to care
    - CLC patient care and operations

Discussions with facility leaders are also included, as well as results of surveyed staff at inspected medical facilities within VISNs 10 and 20.

Impact of COVID-19 on VISN 10 and 20 Medical Facilities

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 3–5 provide snapshots of the number of positive cases for VA, VISN 10, and VISN 20 from March 11 through July 20, 2020 (the first day of virtual inspections in VISN 10), and September 14, 2020 (the first day of virtual inspections in VISN 20).

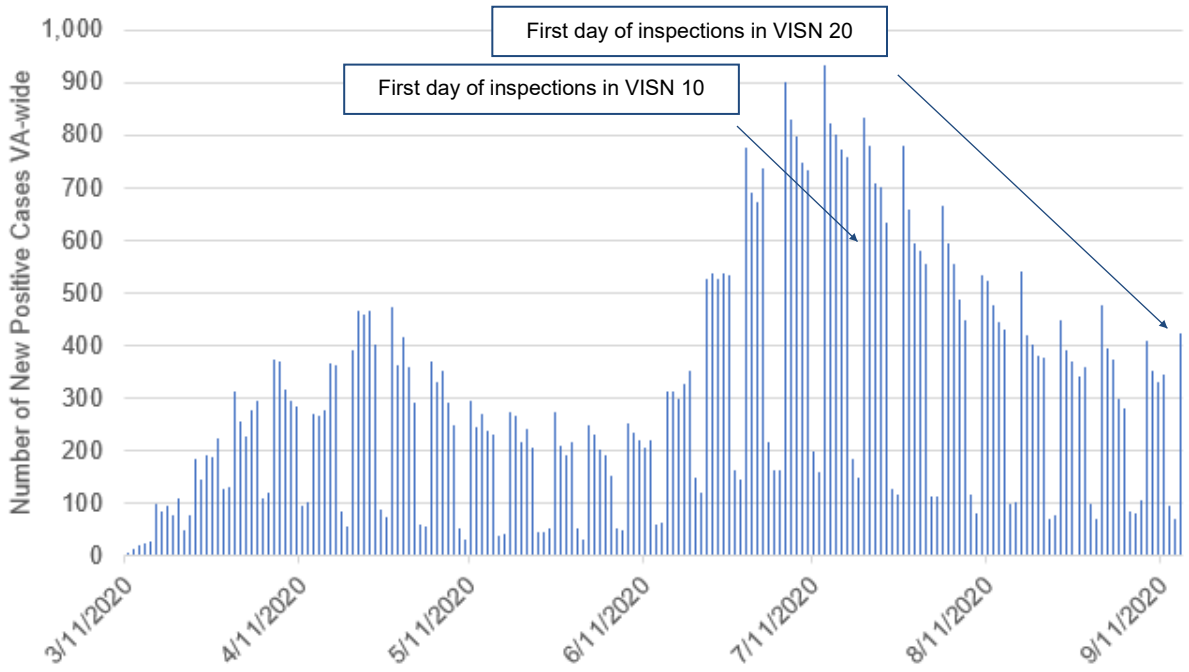

Figure 3. *Number of new positive VA cases nationwide per day (March 11 through September 14, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed December 31, 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 surge of COVID-19 cases in July 2020 that topped 900 new positive patients per day. Although there was considerable fluctuation, demands on medical services significantly rose during the summer. The VISN 10 visits began during peak demand on VA whereas the VISN 20 visits began as VA was experiencing less than half the number of new positive cases.

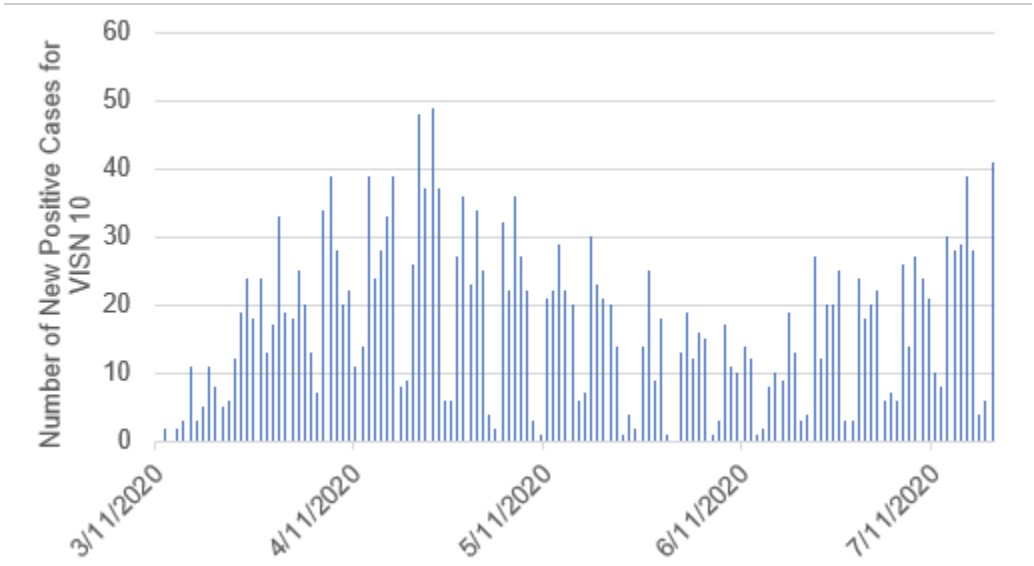

Figure 4. *Number of new positive cases per day in VISN 10 (March 11 through July 20, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. The definition of new positive cases is included below figure 3.

At the time of the OIG's July 2020 inspections in VISN 10, the network had experienced its highest numbers of new positive cases per day in April 2020, with close to 50 new cases. This figure also reflects the high variability in the number of new cases from one day to another.

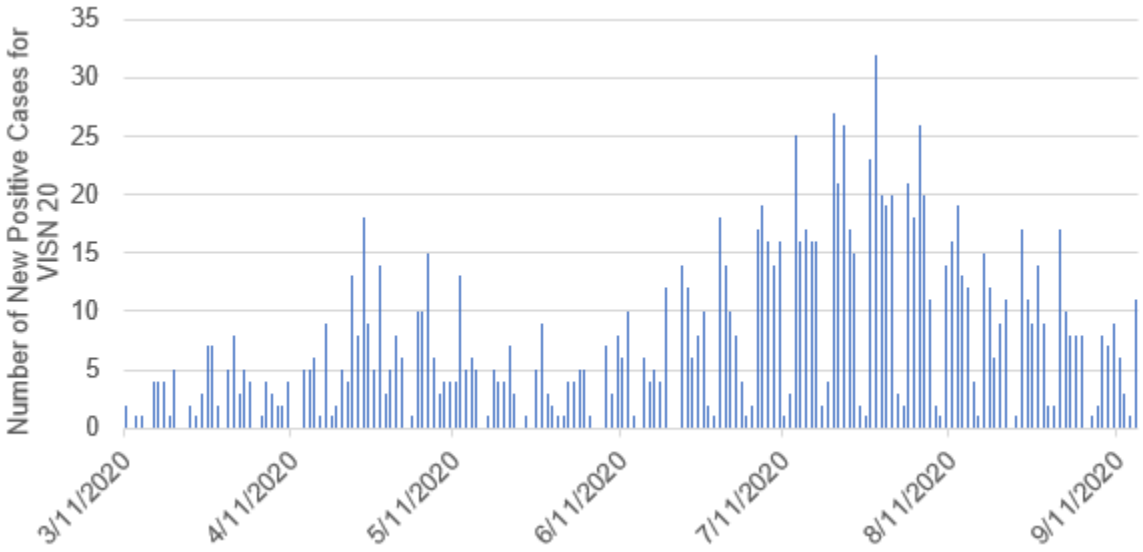

Figure 5. *Number of new positive cases per day in VISN 20 (March 11 through September 14, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. The definition of new positive cases is included below figure 3.

Figure 5 indicates that at the time of the OIG's virtual inspection, VISN 20, like VA overall, had experienced two surges in the number of new cases in April and July. The highest number of new positive cases per day was experienced in July 2020 with more than 30 new positive cases.

At the time of the OIG inspections, 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 systems; however, this was not the experience for all inspected facilities.

Inspection team interviews with leaders at the Ann Arbor and John D. Dingell (Detroit, Michigan) VAMCs within VISN 10, for example, described some difficult situations. The City of Ann Arbor and surrounding communities in Michigan experienced earlier exposure to COVID-19, prompting a state of emergency declaration on March 10, 2020. This allowed the medical center to provide community support by carrying out VA's fourth mission of providing care to nonveteran patients. Beginning on April 5, the Ann Arbor VAMC admitted 35 nonveterans and took steps to safeguard veteran patients and staff. In anticipation of a spike in cases, leaders reported that they transferred CLC (nursing home) patients to the Aleda E. Lutz VAMC in Saginaw, Michigan, and transformed the medical center into an acute care-only hospital with COVID-19 and COVID-19-free zones. This reportedly better positioned the hospital to provide care to patients, regardless of COVID-19 status.

Leaders at the John D. Dingell VAMC in Detroit reported essentially transforming the medical center into a COVID-19 hospital during the initial peak of the pandemic. According to the

Deputy Chief of Staff, this included increasing the intensive care unit capacity to 30 beds, which were filled to maximum capacity for a few days during this time.

VA reported that the first veteran died from COVID-19 at the VA Portland HCS on March 14, 2020. Healthcare system leaders described activating the system's emergency operations plan at the beginning of March because Portland experienced earlier exposure to COVID-19. This reportedly allowed the healthcare system to expand their bed capacity for both veteran and nonveteran patient admissions in the pursuit of VA's fourth mission.

VA Puget Sound HCS leaders explained that their communities were affected early during the pandemic and they learned a great deal while navigating the ongoing changes and expectations. Leaders reported they could readily secure supplies at the beginning of the pandemic when other areas of the United States had not yet been heavily affected. The leaders had developed an internal reporting system to monitor real-time data, including staffing, bed capacity, PPE and testing supply levels, seven-day test positivity average, and emergency department patient symptoms. The leaders also reported providing COVID-19 testing support to local homeless shelters, as well as testing, infection prevention, and engineering staff support to the state veterans' home.

The facility leaders reported accepting 41 state veterans and community skilled nursing home patients for six weeks to mitigate the spread of COVID-19. Despite preparations, this created a strain on the medical center. However, leaders took time to consider lessons learned from facilities with higher volumes of patients to improve their preparedness.

Given the observed increases in COVID-19-positive patients beginning in the fall of 2020, the OIG reassessed the pandemic's potential impact on facility operations as of December 30, 2020. Figures 6–11 and tables 1–3 provide data for VHA, VISN 10, and VISN 20 from March 11 through December 30, 2020.

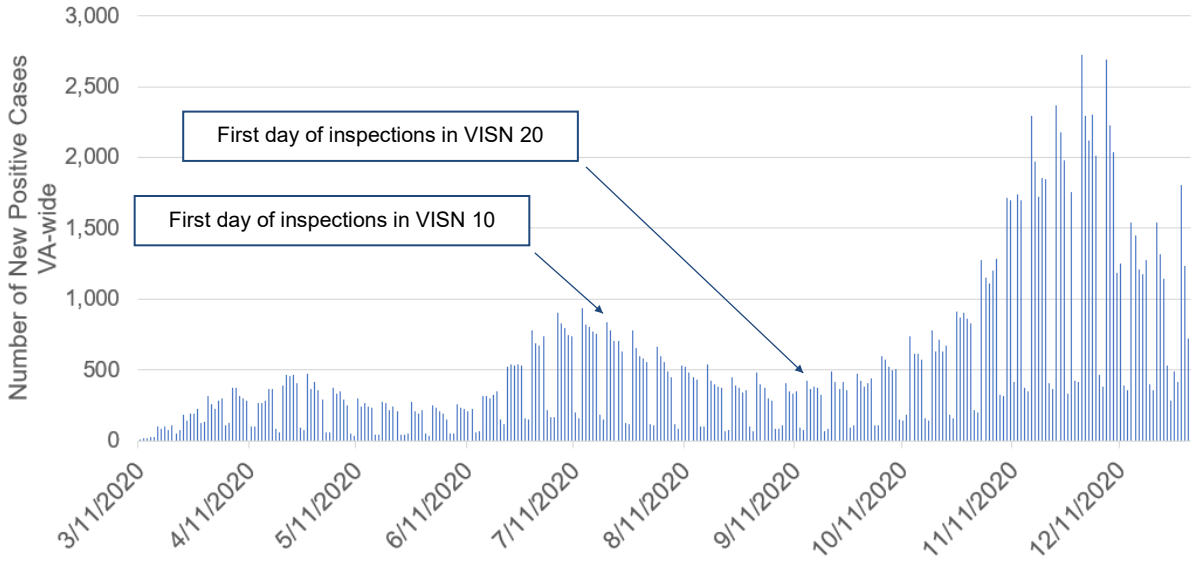

Figure 6. *Number of new positive VA cases per day (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. The definition of new positive cases is included below figure 3.

When compared with earlier data (see figure 3) that shows a July 2020 surge of more than 900 new cases per day, by November 2020 the peak number of new positive cases exceeded 2,500. From September through the end of the year, VA continued to see significant fluctuations but with much higher numbers that often spiked between 1,500 and more than 2,000 new positive cases per day.

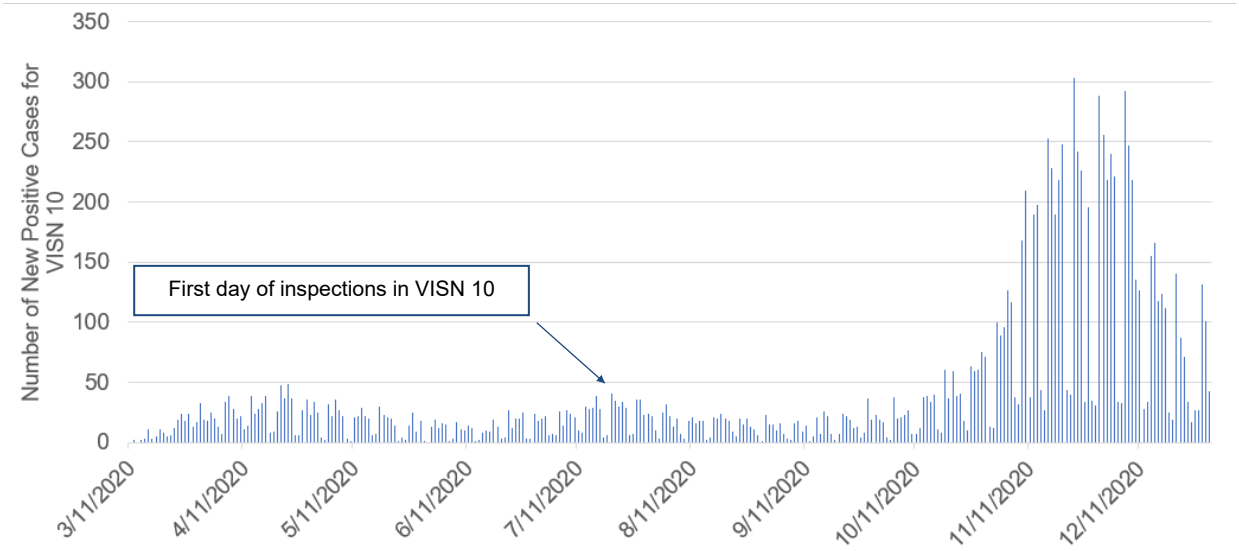

Figure 7. *Number of new positive VISN 10 cases per day (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. The definition of new positive cases is included below figure 3.

This figure demonstrates the mounting strain on VISN 10. While the highest number of new cases per day experienced through July occurred in April with close to 50 new positive cases (see figure 4), by November the surge of positive cases reached over 300. The timing of the surge aligns with the overall increases in cases across VA.

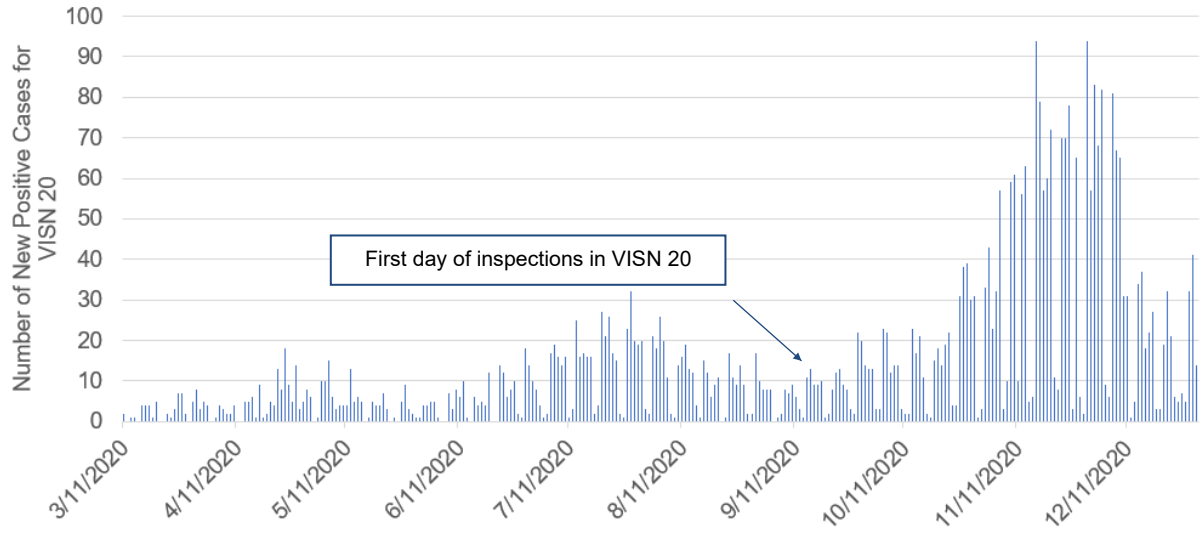

Figure 8. *Number of new positive VISN 20 cases per day (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19, VA Cases (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. The definition of new positive cases is included below figure 3.

Figure 8 shows some consistent findings with VA nationwide and VISN 10, in that considerable surges were experienced in November 2020. At the time of the site visits in September 2020, the highest number of new cases had been experienced in July 2020 with more than 30 new cases per day. The demands on VISN 20 increased significantly with almost triple that number by November 2020.

It is important to note that although facility leaders reported varying degrees of strain created by the number of COVID-19-positive patients at the time of the OIG inspections, those assessments must be evaluated in context since the VA system had yet to experience a third surge in cases that would eclipse the previous surges. Despite some leaders reporting minimal burden on their systems, this was likely not their experience at the end of 2020.

Among the many demands related to the pandemic was testing for COVID-19 and then triaging the positive cases. Table 1 examines the total testing conducted VA-wide and by VISN.

Table 1. Testing and Results
(March 11 through December 30, 2020)

Surveillance Element	VHA	VISN 10	VISN 20
Total Cases	1,133,100	73,272	41,352
• Positive Cases*	152,309	11,923	4,115
• Negative Cases	915,111	57,437	34,418
• Pending Cases	65,680	3,912	2,819

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020). 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 VISNs 10 and 20 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 through December 30, 2020)

Surveillance Element	VHA	VISN 10	VISN 20
Active*	10,916	839	194
Convalescent	134,786	10,565	3,764
Known Death‡	6,607	519	157
• Inpatient	2,561	183	33
• Other	4,046	336	124

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020). 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 VISNs 10 and 20 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 "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. Types of Patients with Positive Cases (March 11 through December 30, 2020)

Surveillance Element	VHA	VISN 10	VISN 20
Veteran	133,056	10,536	3,628
Employee	14,114	1,218	439
Veteran-Employee	573	50	26
All Other*	4,566	119	22

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020). 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 VISNs 10 and 20 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."*

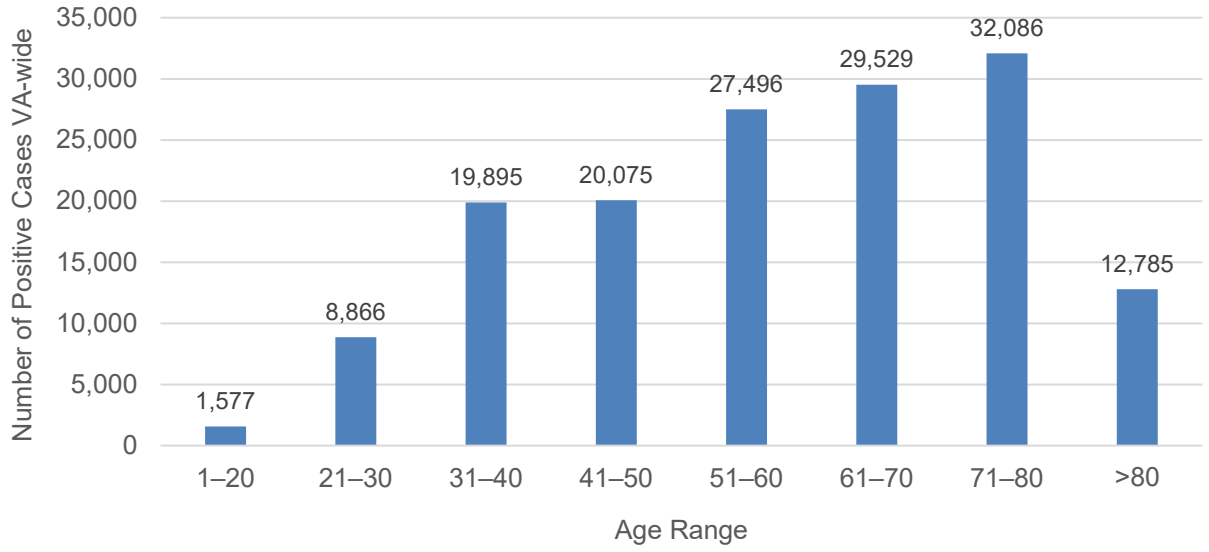

Figure 9. *Age range of VA positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

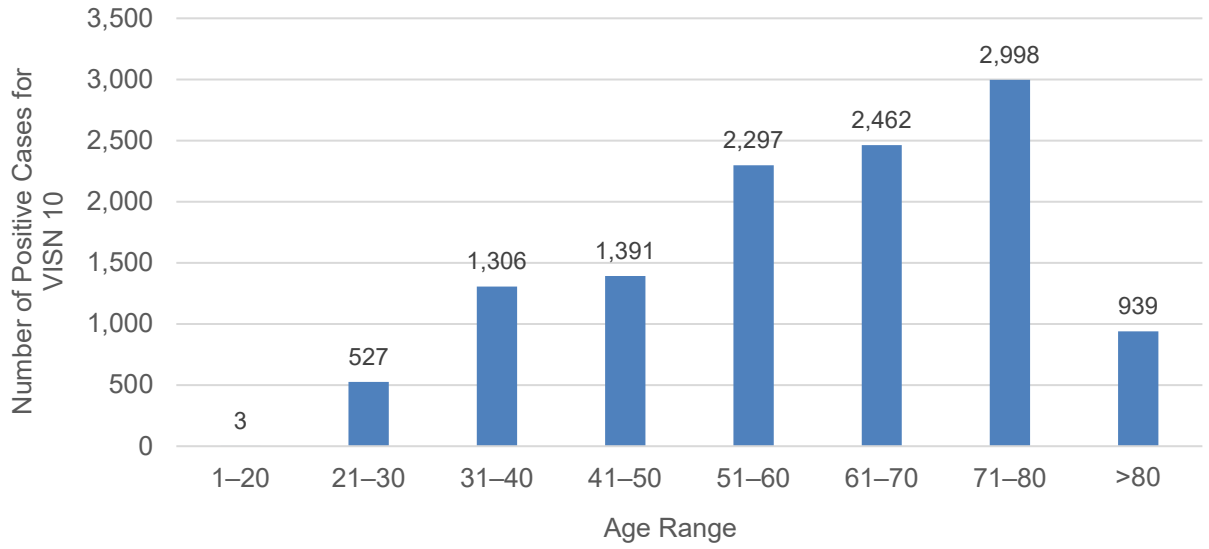

Figure 10. *Age range of VISN 10 positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

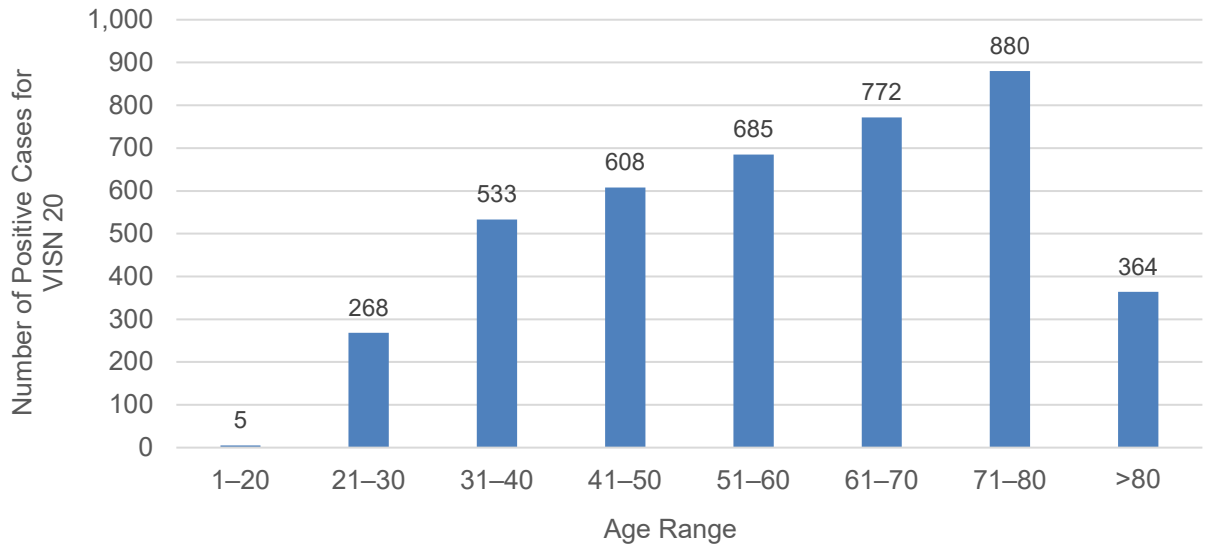

Figure 11. *Age range of VISN 20 positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

Facility-specific data for VISNs 10 and 20 from March 11 through December 30, 2020, are presented in appendixes B and C. Typically, most positive cases were among patients 71–80 years of age.

The following section details the OIG's findings for each of the five issue areas examined for all VISN comprehensive healthcare inspections related to pandemic readiness and response:

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care
- CLC patient care and operations

Emergency Preparedness

During interviews with OIG staff, leaders from two VISN 20 facilities expressed feeling only prepared to a certain extent for the pandemic given the novel nature of the virus and the country's general lack of readiness. Other VISN 10 and VISN 20 facility leaders reported feeling generally prepared for the pandemic. Additionally, all leaders reported having an emergency operations plan prior to March 2020 and activating the plan during the pandemic.

Leaders also cited various communication elements as being key to preparations, with several recognizing the efforts of the VA Central Office and VISN 10 and 20 in providing needed information and up-to-date guidance. Dayton VAMC leaders described VHA program offices' communication through VISN incident command centers, rather than directly to facility leaders, as a "game changer" because the process allowed for consistent messaging to all facility incident command centers. Dayton VAMC staff also acknowledged the importance of leaders' daily "Fireside Chats" for staying abreast of potential challenges.[11]

VA Puget Sound HCS leaders described an opportunity for improvement with emergency supply cache PPE approaching expiration. The PPE was scheduled to be rotated, but the pandemic affected the availability of replacement stock. VISN 20 leaders identified the vulnerability of placing sole responsibility for emergency supply cache management on the VISN emergency manager. VISN 20 leaders also subsequently made the management of individual caches a responsibility within each facility's supply chain process.

Supplies, Equipment, and Infrastructure

Facility leaders indicated few issues with the adequacy of supplies and equipment to support the treatment of patients with COVID-19. However, some of the leaders reported implementing changes to address infrastructure inadequacies and expand inpatient capacity.

Ann Arbor VAMC managers reported assigning trained healthcare personnel with demonstrated competencies to decontaminate protective equipment such as goggles, face shields, and powered air-purifying respirators when their use was required in high-risk areas such as the intensive care unit. Facility leaders noted borrowing 10 ventilators from the University of Michigan during the early weeks of the pandemic and acquiring additional ventilators in preparation for future waves.

Chillicothe VAMC leaders indicated no issues with supplies, equipment, or infrastructure at the time of the review but needed assistance from VISN 10, the hub for supply requests, to acquire PPE and sanitation products such as gowns, gloves, masks, hand sanitizer, and soap.

Cincinnati VAMC operating room and critical care staff noted that video laryngoscopes and additional filtration for anesthesia machines (which would be used if a COVID-19-positive patient needed surgery) had been on back order.[12] Medical center leaders worked with VISN 10 to create a PPE forecasting tool to help predict future supply needs. Leaders also assigned a clinical staff member to the Logistics Service to help better manage supply levels.

[11] The Dayton VAMC daily "Fireside Chats" with staff included a review of key issues and process updates or changes, while also allowing staff to ask questions of leaders.

[12] A laryngoscope allows the visualization of the structures of the throat. Video laryngoscope is a laryngoscope with a built-in video camera. The term "video laryngoscopy" describes the act of watching the video screen to pass a breathing tube into the trachea.

Also within VISN 10, VA Northern Indiana HCS leaders expressed difficulty procuring extra-small gloves, which were not stocked in large volume due to their limited use prior to the pandemic, but noted this did not compromise staff or patient safety. Leaders also reported supporting and loaning four ventilators to the John D. Dingell VAMC in Detroit, Michigan.

Medical center leaders at the Aleda E. Lutz VAMC, a VISN 10 low-complexity facility providing CLC and outpatient care, indicated no issues with the adequacy of supplies, equipment, or medications but had transferred CLC patients with acute care needs to other facilities due to a lack of bed capacity, negative pressure rooms, and quarantine space.[13] However, medical center leaders reported subsequently obtaining additional beds from another VA medical center to expand CLC capacity, adding additional negative pressure rooms, and modifying hallways to create isolation areas for COVID-19 patients.

Within VISN 20, Boise VAMC leaders indicated there was a shortage of hand sanitizer until the medical center's Pharmacy Service started producing its own in accordance with Food and Drug Administration instruction. The Chief of Staff also reported that, early in the pandemic, the facility acquired the necessary solution for COVID-19 testing and that this was important because community hospitals had often relied on the Boise facility to process laboratory tests for their patients. Additionally, the facility's Critical Care/Emergency Services Committee created a pandemic "code blue" training video on how to minimize exposure and decrease the need for additional PPE. Further, certified registered nurse anesthetists were also identified as the care providers who would perform intubation; crash carts were kept outside of the patient rooms; and the number of staff needed to respond to a code blue were minimized.[14]

VISN 20's VA Portland HCS was one of the sites inspected as part of the OIG's previous healthcare review resulting in the report *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*. In that report, published on March 26, 2020, leaders described a shortage of supplies, specifically flu swabs for testing, small-sized N95 masks, and general masks.[15] At the time of the OIG's September 2020 virtual comprehensive healthcare inspection, system leaders reported no issues with the adequacy of supplies, equipment, or infrastructure.

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[13] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing, accessed January 21, 2020, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. A low complexity facility is defined as having "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

[14] "Endotracheal intubation," MedlinePlus, accessed January 26, 2021, https://medlineplus.gov/ency/article/003449.htm. "Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth or nose. In most emergency situations, it is placed through the mouth."

[15] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, *March 19–24, 2020,* Report No. 20-02221-120, March 26, 2020. N95 masks are close-fitting facial respirators that filter out 95 percent of airborne particles.

Finally, leaders and staff at VA Puget Sound HCS described how they realized they had three missing ventilators, which they reported to the OIG's Office of Investigations. The resulting investigation led to the arrest of a staff member who had stolen and attempted to sell the devices.

Staffing

Facility leaders and CLC staff generally reported no systemic staffing issues or concerns related to ongoing pandemic response efforts within VISN 10. Critical care staff largely reported sufficient support for the respiratory care of COVID-19 patients but noted that the Ann Arbor VAMC had experienced a shortage in respiratory therapists during the initial patient surge and was able to hire additional staff.

Battle Creek VAMC leaders reported a staffing shortage in the inpatient mental health units due to an outbreak of COVID-19 among nurses and nursing assistants. In response, staff from other areas were cross-trained to work in the mental health unit and provided coverage for approximately 60 days during the outbreak. Reportedly, staff who tested positive for COVID-19 recovered and returned to duty, and no patients were affected by the outbreak.

VISN 20 facility leaders and CLC staff similarly did not express widespread staffing issues or concerns. The Mann-Grandstaff VAMC critical care team also reported respiratory therapist shortages that were addressed by acquiring additional staff through VHA's Disaster Emergency Medical Personnel System and the local community.[16]

The VA Portland HCS Director cited challenges with insufficient housekeeping personnel in Environmental Management Service due to low pay and the high cost of living. In response, Sterile Processing Services employees who previously worked in the Environmental Management Service were detailed to supplement existing staff. In addition, Environmental Management Service staff assigned to closed areas (such as the operating room, post-anesthesia care unit, dental area, and other procedural sites) were reassigned to the emergency department and intensive care unit.

Roseburg VA HCS leaders reported no significant staffing issues or concerns beyond the long-standing difficulties with recruiting in rural areas. However, the OIG noted that VISN 20 had closed the residential rehabilitation treatment program at the Roseburg HCS and consolidated the program's services under a sister facility, the VA Southern Oregon Rehabilitation Center in White City. Residential rehabilitation treatment program staff were then reassigned to support the inpatient mental health unit. The OIG also noted that 113 Roseburg VA HCS staff were reportedly deployed through the Disaster Emergency Medical Personnel System to support the Indian Health Service and other hospitals in Arizona, Florida, and New York. Facility leaders

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

also created an employee support group to help staff identify community resources. For example, the support group assisted parents and guardians to identify local day care facilities and place 256 children.

Access to Care

The COVID-19 pandemic has been disruptive to many VHA operations but 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 use and…free up resources to address the increasing number of veterans under evaluation and diagnosed with COVID-19."[17] 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.[18]

Interviewed leaders reported adhering to the VISN and VHA guidance and cancelling elective procedures. At the time of the inspections, all facilities had resumed performing elective surgeries at varying capacities, except Mann-Grandstaff VAMC, which was addressing a backlog of semi-urgent surgeries prior to resuming elective procedures.

Executive leaders universally reported expanding telemedicine (virtual care) to reduce the number of cancelled outpatient appointments. Some leaders acknowledged encountering barriers during the initial expansion of virtual care that included limited software capability to handle national demand, staff and patients' lack of familiarity with virtual care, and scheduling challenges using multiple virtual modalities. The Ann Arbor VAMC implemented several corrective actions, including the use of other video modalities approved by VHA, completion of pre-appointment calls to educate patients, assistance by licensed practical nurses to patients for the log-on process to optimize clinical time, and the provision of ongoing staff training. VA Puget Sound HCS leaders planned to modify organizational goals to encourage increased telemedicine use for up to 50 percent of primary care visits and as a preferred method for mental health appointments.

Despite these efforts, significant numbers of cancelled appointments still required follow-up as of December 30, 2020 (see tables 4–7 below and appendixes B and C).[19] The OIG previously

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

[18] 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.

[19] 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), defines non-count as workload that "does not meet the definition of an encounter or an occasion of service."

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.[20]

Table 4. VISN 10 Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)

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	493,196	88,148	464,415	28,781	6%
Mental Health	326,092	41,992	313,218	12,874	4%
Specialty Care and All Other	1,012,214	282,344	908,453	103,761	10%
Total	**1,831,502**	**412,484**	**1,686,086**	**145,416**	**8%**

Source: VHA Support Service Center (accessed December 31, 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 VISNs 10 and 20 can be found in appendix A.

**"Total Cancellations" are the "the 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 that although only 8 percent of cancelled appointments within the three clinic groups required follow-up, this represented over 145,000 appointments requiring action in VISN 10.

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

Table 5. VISN 10 Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	354,613	79,050	334,605	20,008	6%
Optometry	148,660	64,654	131,788	16,872	11%
Mental Health Individual Clinic	133,417	24,307	129,036	4,381	3%
Telephone Primary Care	123,481	6,489	115,817	7,664	6%
Podiatry	88,211	34,432	78,261	9,950	11%

Source: VHA Support Service Center (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. Additional details about the types of care provided within VISNs 10 and 20 can be found in appendix A.

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

This table shows the top five clinics in VISN 10 with the highest number of cancellations across the three clinic groups (see table 4). For example, the highest number of cancellations is seen for the primary care/medicine clinics, which falls within the primary care clinic group, and had over 20,000 clinic appointments requiring follow-up. The optometry clinic, under the specialty care and all other clinic group, had the next highest number of cancellations with 11 percent or almost 17,000 clinic appointments requiring follow-up.

Table 6. VISN 20 Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Specialty Care and All Other	364,649	131,234	319,955	44,694	12%
Primary Care	208,194	38,679	199,085	9,109	4%
Mental Health	215,417	33,498	208,853	6,564	3%
Total	**788,260**	**203,411**	**727,893**	**60,367**	**8%**

Source: VHA Support Service Center (accessed December 31, 2020).

Note: The OIG did not assess VA's data for accuracy or completeness. Additional details about the types of care provided within VISNs 10 and 20 can be found in appendix A.

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

Similar to VISN 10, 8 percent of VISN 20 cancelled appointments within the three clinic groups required follow-up; however, this represented less than half the number of VISN 10 appointments requiring action (see tables 4 and 6).

Table 7. VISN 20 Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	124,193	34,984	119,503	4,690	4%
Mental Health Individual Clinic	64,797	17,147	62,721	2,076	3%
Telephone/ Psych	41,699	4,756	39,499	2,200	5%
Dental	37,080	28,060	27,199	9,881	27%
Optometry	35,464	18,057	31,305	4,159	12%

Source: VHA Support Service Center (accessed December 31, 2020).

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 4.*

Table 7 shows the top five clinics in VISN 20 with the highest number of cancellations across the three clinic groups. For those clinics, 3–27 percent of appointments required follow-up, representing 2,076–9,881 cancelled appointments.

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.[21] 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 daily. The OIG noted the considerable efforts described to ensure the safety of vulnerable CLC residents, including the reported closure of the Ann Arbor CLC on March 27, 2020, and the transfer of 13 residents to the Aleda E. Lutz VA Medical Center in Saginaw, Michigan (approximately 86 miles away from the medical center), which allowed the temporary conversion of the CLC into a medical/surgical ward.

Some leaders described CLC residents' frustration and stress due to visitation restrictions, and some described efforts to support the residents' need for social interaction with loved ones by using communication technology. Others described difficulty with maintaining residents' social distancing while dining, keeping residents active and engaged, and maintaining a "home-like" environment.

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

Facility Staff Feedback

There were 3,399 respondents to the OIG's COVID-19 survey of employees at the VISN 10 medical facilities inspected. Of those, 1,836 (54 percent) identified themselves as clinical staff, 1,368 (40 percent) identified themselves as nonclinical staff, and 195 respondents (6 percent) made no selection. The overall response rate by location was approximately 13–32 percent.[22]

When asked whether leaders and immediate supervisors communicated how to ensure the safety of patients and staff during the pandemic, 56–79 percent of respondents answered affirmatively (see appendix D 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 teamwork,
- Need for preparation, and
- Importance of communication.

Of the 3,093 VISN 20 respondents, 1,669 (54 percent) identified themselves as clinical staff, 1,347 (44 percent) identified themselves as nonclinical staff, and 77 (2 percent) made no selection. The overall response rate by location was 16–43 percent.[23] Sixty-nine to 90 percent of respondents felt as though leaders and immediate supervisors communicated how to ensure the safety of staff and patients during the pandemic (see appendix E). Similarly, 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

- Flexibility and adaptability,
- Communication, and
- Preparation.

Although leaders indicated few issues with the adequacy of supplies, 20–40 percent of VISN 10 and 10–25 percent of VISN 20 respondents reported not having access to appropriate PPE necessary to ensure their own safety at work during the COVID-19 pandemic (see appendixes D and E, tables D.2 and E.2). During follow-up discussions, some facility leaders shared their thoughts on employee perceptions with the OIG inspection team. For example, John D. Dingell

[22] 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 Paid Accounting Integrated Data (PAID) cube, accessed December 29, 2020, https://vaww.vssc.med.va.gov. (This is an internal VA website not publicly accessible.) Although the lowest VISN 10 facility response rate was approximately 13 percent, this represented 318 respondents from Dayton VAMC.

[23] The lowest VISN 20 facility response rate was approximately 16 percent, which represented 782 respondents from the VA Portland HCS.

VAMC leaders stated that although the facility had sufficient PPE, administrative staff wanted N95 masks, which the facility dedicated to clinical staff. Roseburg VA HCS leaders reported that all staff were required to wear face masks in accordance with VA expectations; however, some staff did not want or reported not being able to wear a mask. Logistics staff identified alternatives so that staff reporting an inability to wear a mask had options to support their needs and meet VA expectations. VA Puget Sound HCS leaders adjusted processes to include a sign-out procedure to ensure staff had access to and used appropriate supplies based on Centers for Disease Control and Prevention and VHA guidance, and explained that this change may have resulted in staff feeling there was insufficient PPE.

Conclusion

The OIG examined medical facilities' pandemic readiness and response within VISNs 10 and 20 based on healthcare inspections performed July 1 through September 30, 2020. Leaders at the medical facilities described limited issues and concerns at the time of the OIG's inspections. Data from the beginning of the pandemic through those inspections demonstrate, however, that VHA and facilities within those VISNs had not yet been hit with the magnitude of positive cases experienced through the end of 2020. 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 and VHA, as the nation's largest integrated healthcare system, will need to be at the forefront of that transformation armed with as much information as possible for continuous readiness.

Appendix A: VHA and VISN Profiles

The table below provides general background information for VHA and VISNs 10 and 20.

Table A.1. Profiles for VHA and VISNs 10 and 20 (October 1, 2019, through September 30, 2020)

Profile Element	VHA	VISN 10	VISN 20
Total medical care budget	$81,870,319,580	$5,850,847,097	$4,163,776,007
Number of:			
• Unique patients	6,447,210	503,738	333,731
• Outpatient visits	81,305,962	6,274,399	3,323,674
Type and number of operating beds:			
• Blind rehabilitation	243	15	9
• Community living center	13,053	1,085	313
• Domiciliary	7,219	686	455
• Intermediate	152	7	–
• Medicine	6,885	470	229
• Mental Health	3,434	289	65
• Neurology	99	11	–
• Rehabilitation medicine	439	26	12
• Residential rehabilitation	548	34	43
• Spinal cord injury	1,222	58	38
• Surgery	2,661	205	111
Average daily census:			
• Blind rehabilitation	75	6	2
• Community living center	7,622	634	202
• Domiciliary	3,320	304	199
• Intermediate	37	1	n/a
• Medicine	4,518	298	148
• Mental Health	1,830	143	37
• Neurology	40	5	2
• Rehabilitation medicine	184	9	7
• Residential rehabilitation	268	17	17
• Spinal cord injury	596	38	19

Profile Element	VHA	VISN 10	VISN 20
• Surgery	860	64	32

Source: VHA Support Service Center.

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

n/a = not applicable

Appendix B: VISN 10 Facility-Specific Data

Table B.1. VISN 10 Testing and Results
(March 11 through December 30, 2020)

Surveillance Element	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
Total Cases	8,431	2,440	2,294	6,907	6,654	5,498	4,450	1,273
• Positive Cases*	1,149	686	342	1,111	1,102	641	859	443
• Negative Cases	7,051	1,618	1,938	5,539	5,349	4,605	3,125	800
• Pending Cases	231	136	14	257	203	252	466	30

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020). 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."*

Table B.2. Status of VISN 10 Positive Cases (March 11 through December 30, 2020)

Surveillance Element	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
Active*	75	13	39	107	75	23	35	6
Convalescent	1,029	631	298	978	993	556	788	410
Known Death‡	45	42	5	26	34	62	36	27
• Inpatient	30	2	2	6	17	36	15	3
• Other	15	40	3	20	17	26	21	24

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020). 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 "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 10 Positive Cases (March 11 through December 30, 2020)

Surveillance Element	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
Veteran	984	618	290	980	947	582	812	383
Employee	130	65	47	127	139	37	42	49
Veteran-Employee	1	1	3	1	4	0	3	9
All Other*	34	2	2	3	12	22	2	2

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020). 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."*

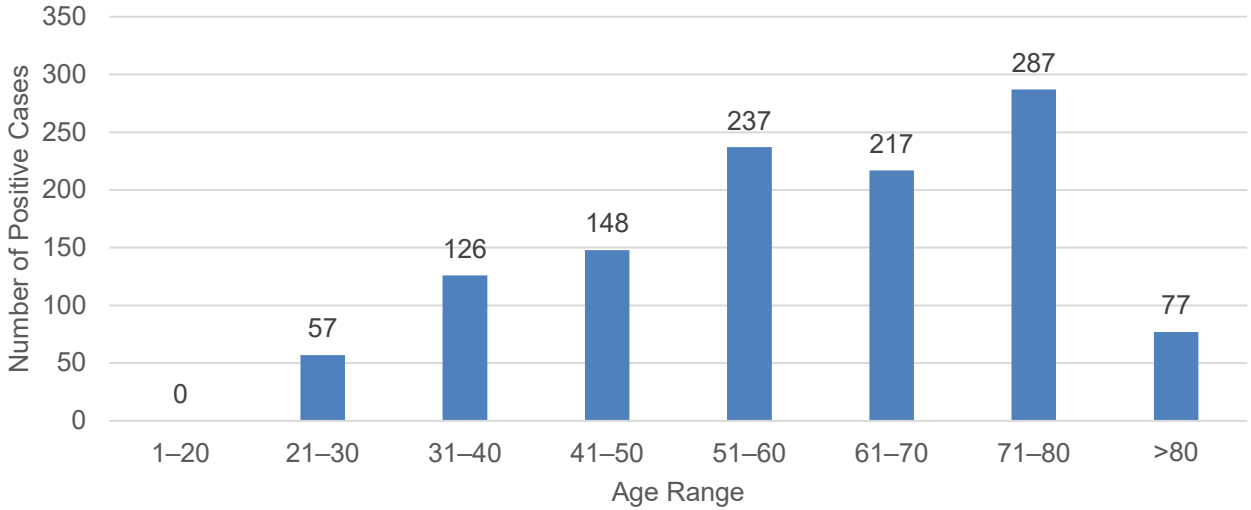

Figure B.1. *Age range of Ann Arbor VA Medical Center positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

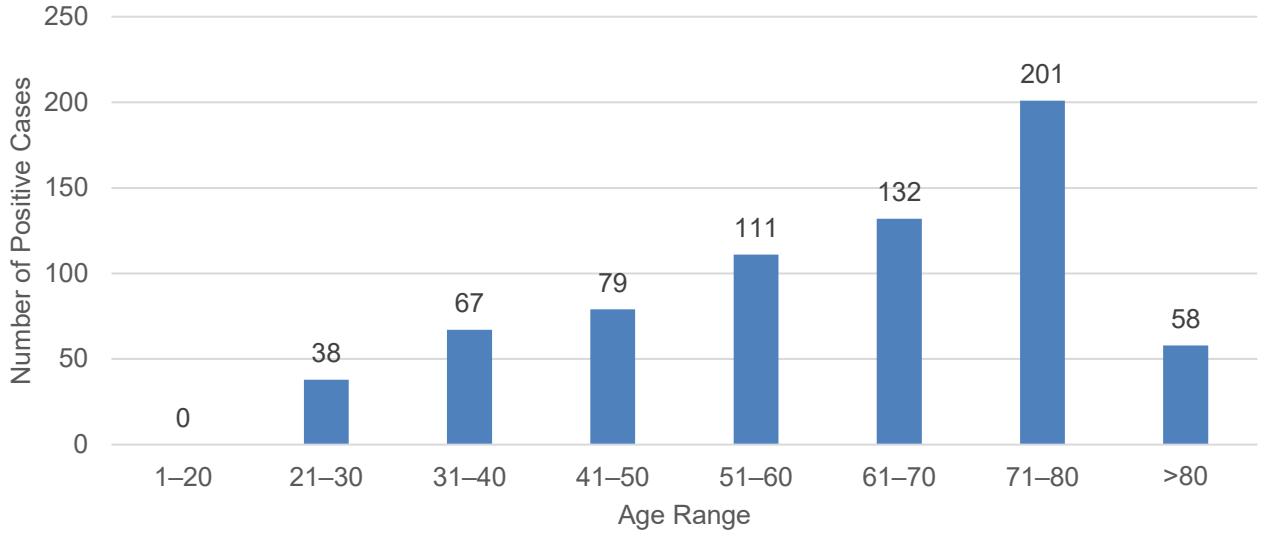

Figure B.2. *Age range of Battle Creek VA Medical Center positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

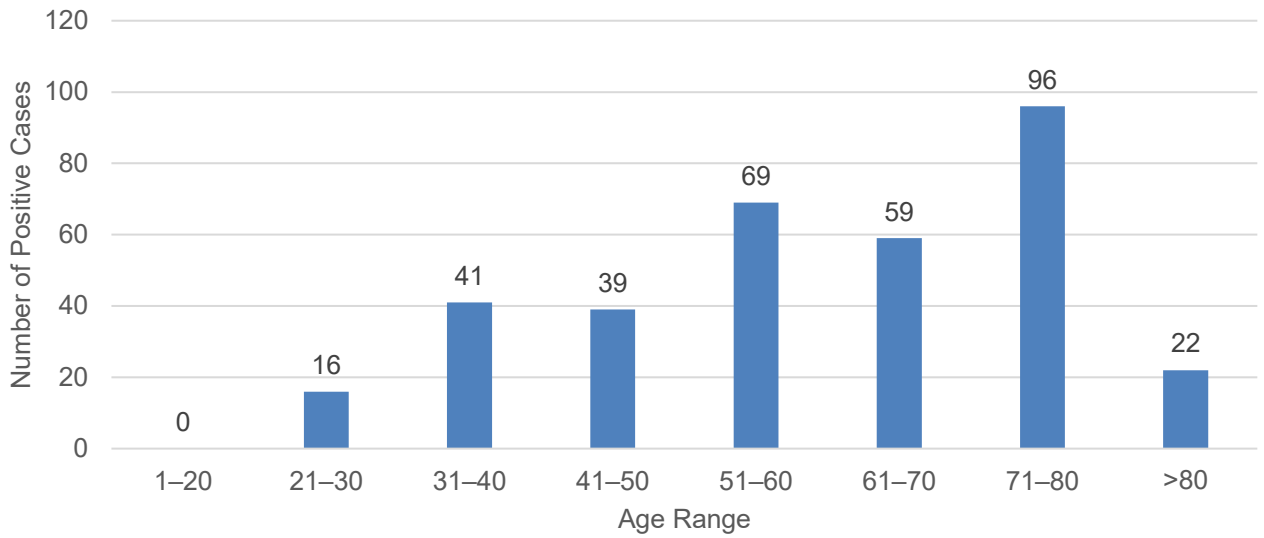

Figure B.3. *Age range of Chillicothe VA Medical Center positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

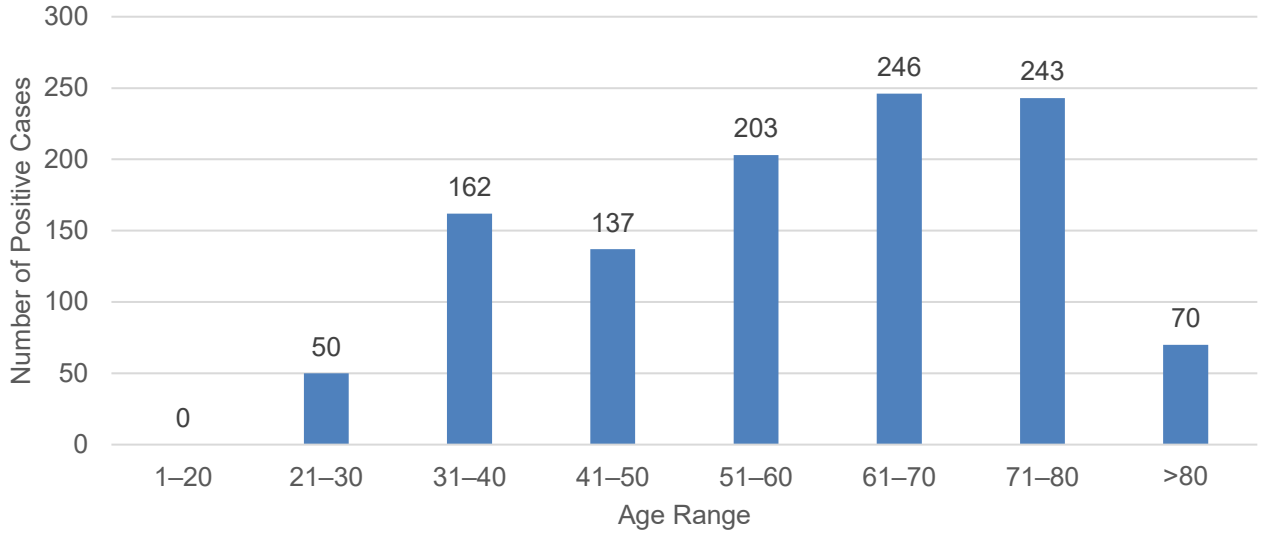

Figure B.4. *Age range of Cincinnati VA Medical Center positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

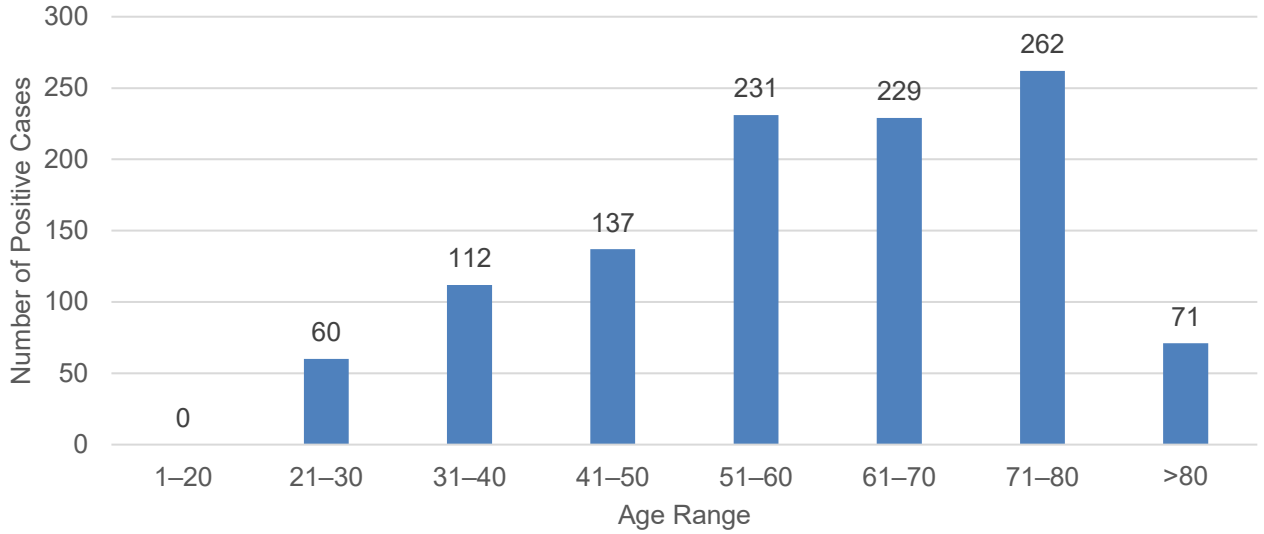

Figure B.5. *Age range of Dayton VA Medical Center positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

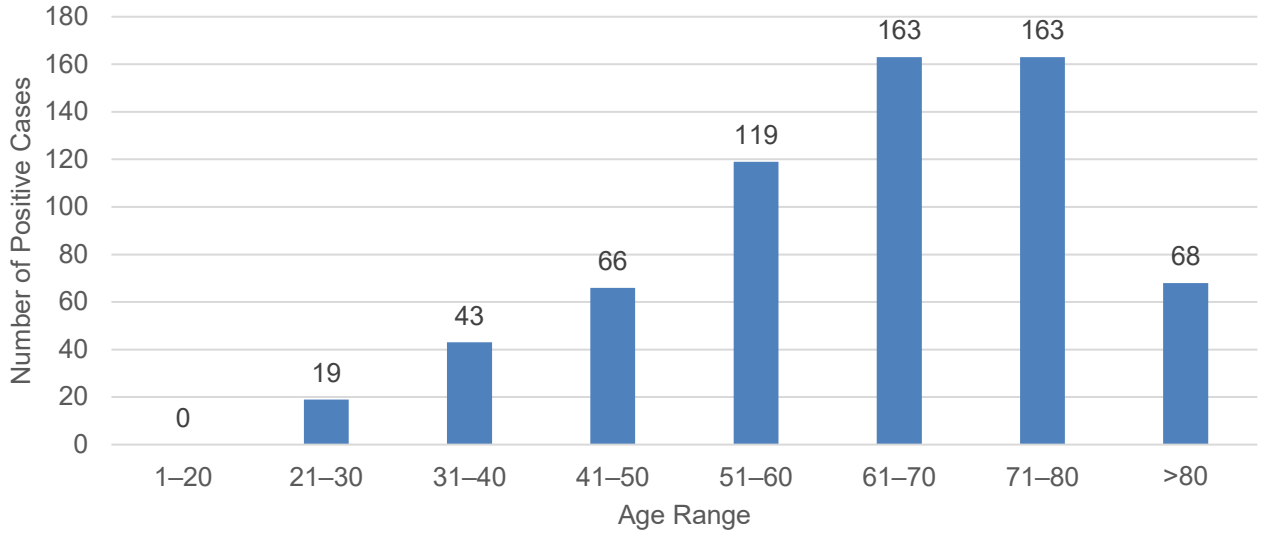

Figure B.6. *Age range of John D. Dingell VA Medical Center (Detroit, MI) positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

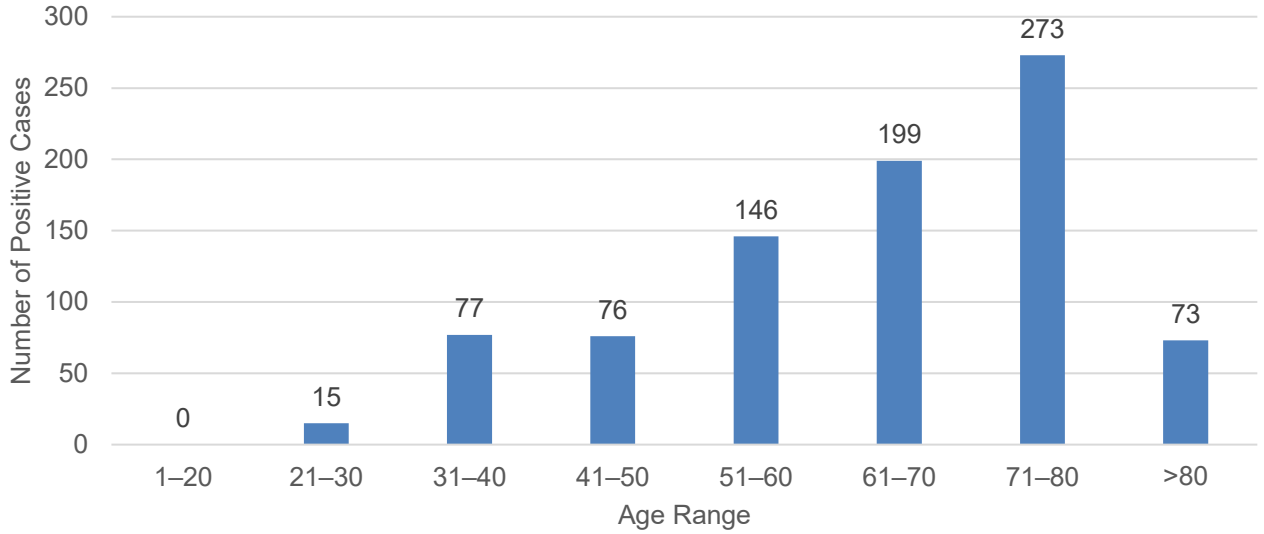

Figure B.7. *Age range of VA Northern Indiana Health Care System (Marion, IN) positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

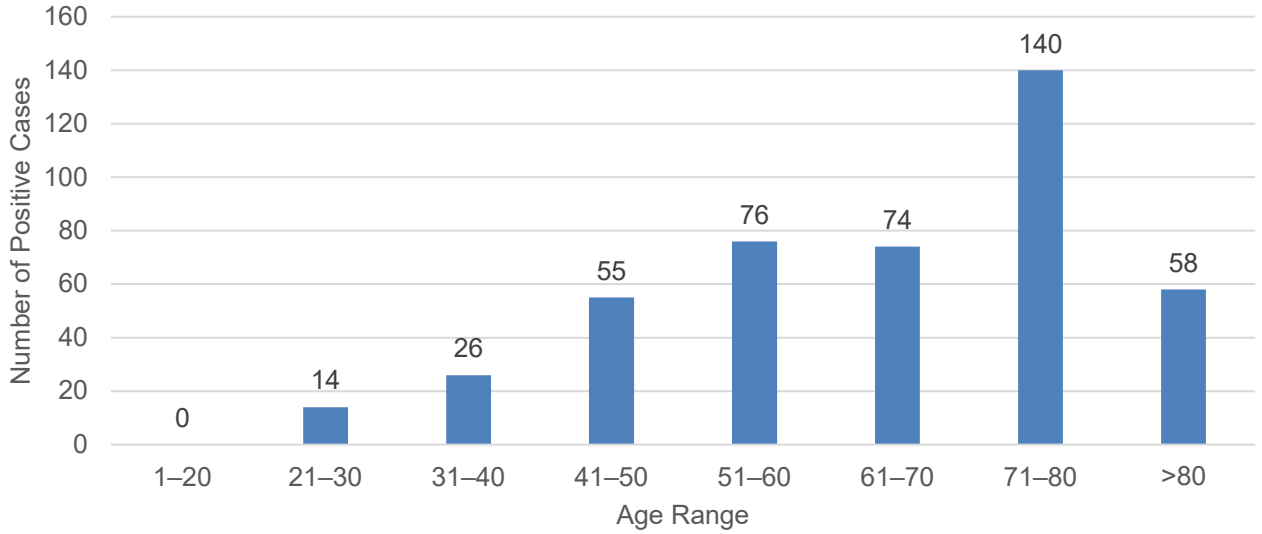

Figure B.8. *Age range of Aleda E. Lutz VA Medical Center (Saginaw, MI) positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

Table B.4. Ann Arbor VA Medical Center Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)

Clinic Group	Total Cancellations*	Cancellations Due to COVID-19	Follow-Up Found‡	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up§
Mental Health	48,237	9,204	46,761	1,476	3%
Primary Care	58,905	12,541	56,306	2,599	4%
Specialty Care and All Other	99,189	23,928	91,597	7,592	8%
Total	**206,331**	**45,673**	**194,664**	**11,667**	**6%**

Source: VHA Support Service Center (accessed December 31, 2020). COVID-19 Cancellations Definitions (accessed January 11, 2021).

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

**"Total Cancellations" are the "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. Ann Arbor VA Medical Center Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	35,752	9,686	34,585	1,167	3%
Telephone Primary Care	22,390	2,633	20,989	1,401	6%
Mental Health Individual Clinic	16,225	2,753	15,748	477	3%
Physical Therapy	9,153	1,023	8,762	391	4%
Dental	6,501	2,845	6,091	410	6%

Source: VHA Support Service Center (accessed December 31, 2020).

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. Battle Creek VA Medical Center Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	23,273	1,310	22,367	906	4%
Primary Care	37,131	6,839	35,292	1,839	5%
Specialty Care and All Other	53,731	21,694	50,307	3,424	6%
Total	**114,135**	**29,843**	**107,966**	**6,169**	**5%**

Source: VHA Support Service Center (accessed December 31, 2020).

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. Battle Creek VA Medical Center Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	29,884	6,590	28,431	1,453	5%
Mental Health Individual Clinic	14,541	977	13,982	559	4%
Podiatry	9,827	5,646	9,185	642	7%
Dental	8019	4,296	7,557	462	6%
Optometry	7168	3,798	6,727	441	6%

Source: VHA Support Service Center (accessed December 31, 2020).

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. Chillicothe VA Medical Center Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	14,199	1,825	13,541	658	5%
Primary Care	19,942	5,210	18,975	967	5%
Specialty Care and All Other	40,156	15,666	35,685	4,471	11%
Total	**74,297**	**22,701**	**68,201**	**6,096**	**8%**

Source: VHA Support Service Center (accessed December 31, 2020).

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. Chillicothe VA Medical Center Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	15,931	5,109	15,159	772	5%
Optometry	10,211	6,033	9,003	1,208	12%
Mental Health Individual Clinic	6,388	1,421	6,087	301	5%
Podiatry	4,308	2,316	3,842	466	11%
Weight Management and MOVE! Program Group Clinic	2,636	702	1,796	840	32%

Source: VHA Support Service Center (accessed December 31, 2020).

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. Cincinnati VA Medical Center Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	25,834	2,224	25,014	820	3%
Primary Care	39,227	11,910	35,184	4,043	10%
Specialty Care and All Other	94,891	32,333	83,076	11,815	12%
Total	**159,952**	**46,467**	**143,274**	**16,678**	**10%**

Source: VHA Support Service Center (accessed December 31, 2020).

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. Cincinnati VA Medical Center Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	30,772	10,999	27,411	3,361	11%
Optometry	13,608	7,072	12,334	1,274	9%
Podiatry	7,696	2,897	5,530	2,166	28%
Mental Health Individual Clinic	7,667	863	7,399	268	3%
Urology	5,228	2,112	4,656	572	11%

Source: VHA Support Service Center (accessed December 31, 2020).

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. Dayton VA Medical Center Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	24,929	8,220	24,338	591	2%
Primary Care	33,709	4,433	31,747	1,962	6%
Specialty Care and All Other	83,069	28,237	76,080	6,989	8%
Total	**141,707**	**40,890**	**132,165**	**9,542**	**7%**

Source: VHA Support Service Center (accessed December 31, 2020).

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.13. Dayton VA Medical Center Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	27,255	4,036	25,684	1,571	6%
Mental Health Individual Clinic	14,766	6,723	14,561	205	1%
Optometry	8,345	3,444	7,622	723	9%
Dental	5,412	2,234	5,115	297	5%
Podiatry	5,142	1,834	4,709	433	8%

Source: VHA Support Service Center (accessed December 31, 2020).

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.14. John D. Dingell VA Medical Center (Detroit, MI) Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	20,284	3,712	19,113	1,171	6%
Primary Care	48,680	14,926	45,158	3,522	7%
Specialty Care and All Other	97,776	27,502	83,820	13,956	14%
Total	**166,740**	**46,140**	**148,091**	**18,649**	**11%**

Source: VHA Support Service Center (accessed December 31, 2020).

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.15. John D. Dingell VA Medical Center (Detroit, MI) Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	32,075	13,526	29,949	2,126	7%
Telephone Primary Care	14,785	849	13,586	1,199	8%
Optometry	14,770	7,531	13,391	1,379	9%
Telephone Mental Health	8,193	771	7,471	722	9%
Dental	6,945	699	5,945	1,000	14%

Source: VHA Support Service Center (accessed December 31, 2020).

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.16. VA Northern Indiana Health Care System Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	23,887	3,314	22,944	943	4%
Primary Care	42,132	8,755	39,976	2,156	5%
Specialty Care and All Other	69,512	27,091	63,545	5,967	9%
Total	**135,531**	**39,160**	**126,465**	**9,066**	**7%**

Source: VHA Support Service Center (accessed December 31, 2020).

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.17. VA Northern Indiana Health Care System Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	35,312	8,317	33,570	1,742	5%
Optometry	14,879	9,684	13,176	1,703	11%
Mental Health Individual Clinic	10,187	1,728	9,809	378	4%
Podiatry	8,159	2,802	7,408	751	9%
Physical Therapy	5,746	1,415	5,456	290	5%

Source: VHA Support Service Center (accessed December 31, 2020).

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.18. Aleda E. Lutz VA Medical Center (Saginaw, MI) Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	23,708	6,275	22,863	845	4%
Primary Care	27,804	7,809	26,844	960	3%
Specialty Care and All Other	50,188	21,528	44,932	5,256	10%
Total	**101,700**	**35,612**	**94,639**	**7,061**	**7%**

Source: VHA Support Service Center (accessed December 31, 2020).

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.19. Aleda E. Lutz VA Medical Center (Saginaw, MI) Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	22,376	7,579	21,699	677	3%
Mental Health Individual Clinic	14,200	4,963	13,863	337	2%
Physical Therapy	8,651	2,590	7,615	1,036	12%
Optometry	7,963	4,996	7,414	549	7%
Dental	6,020	3,801	5,724	296	5%

Source: VHA Support Service Center (accessed December 31, 2020).

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.*

Appendix C: VISN 20 Facility-Specific Data

Table C.1. VISN 20 Testing and Results
(March 11 through December 30, 2020)

Surveillance Element	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
Total Cases	6,510	10,818	2,181	15,437	2,510
• Positive Cases*	1,157	767	142	939	246
• Negative Cases	5,222	9,325	1,868	13,332	2,003
• Pending Cases	131	726	171	1,166	261

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

**The definition for positive cases is provided in notes for table B.1.*

Table C.2. Status of VISN 20 Positive Cases (March 11 through December 30, 2020)*

Surveillance Element	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
Active	53	56	3	53	0
Convalescent	1,067	682	134	848	226
Known Death	37	29	5	38	20
• Inpatient	13	8	0	7	5
• Other	24	21	5	31	15

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

**The surveillance element definitions are provided in notes for table B.2.*

Table C.3. Patient Types of VISN 20 Positive Cases (March 11 through December 30, 2020)

Surveillance Element	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
Veteran	999	679	127	789	237
Employee	152	76	14	132	5
Veteran-Employee	4	7	0	12	0
All Other*	2	5	1	6	4

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

**The surveillance element definition is provided in notes for table B.3.*

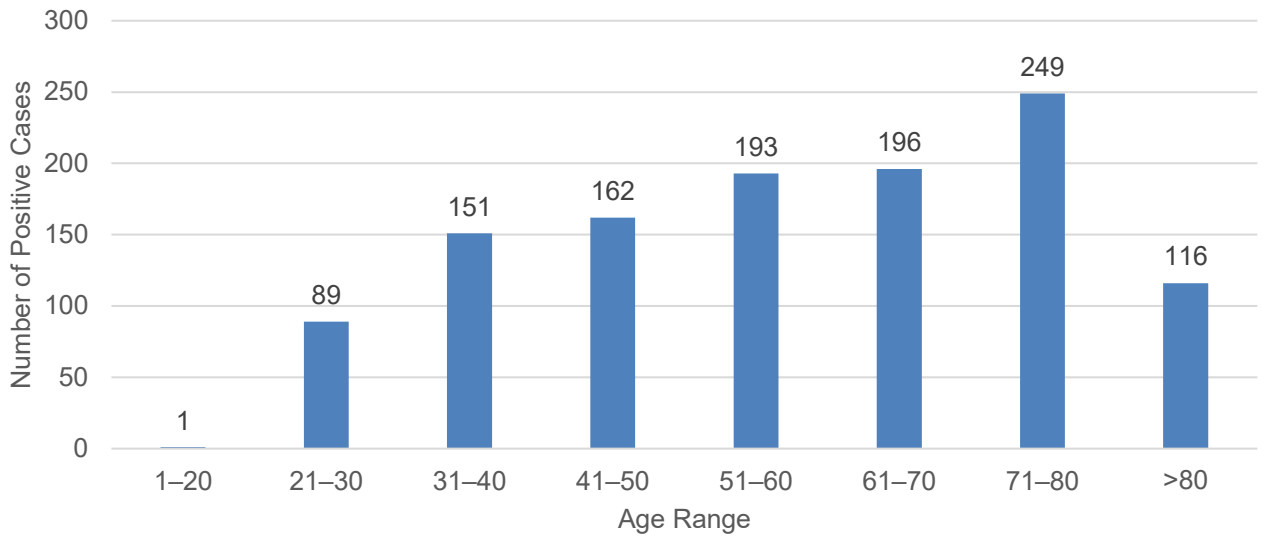

Figure C.1. *Age range of Boise VA Medical Center positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

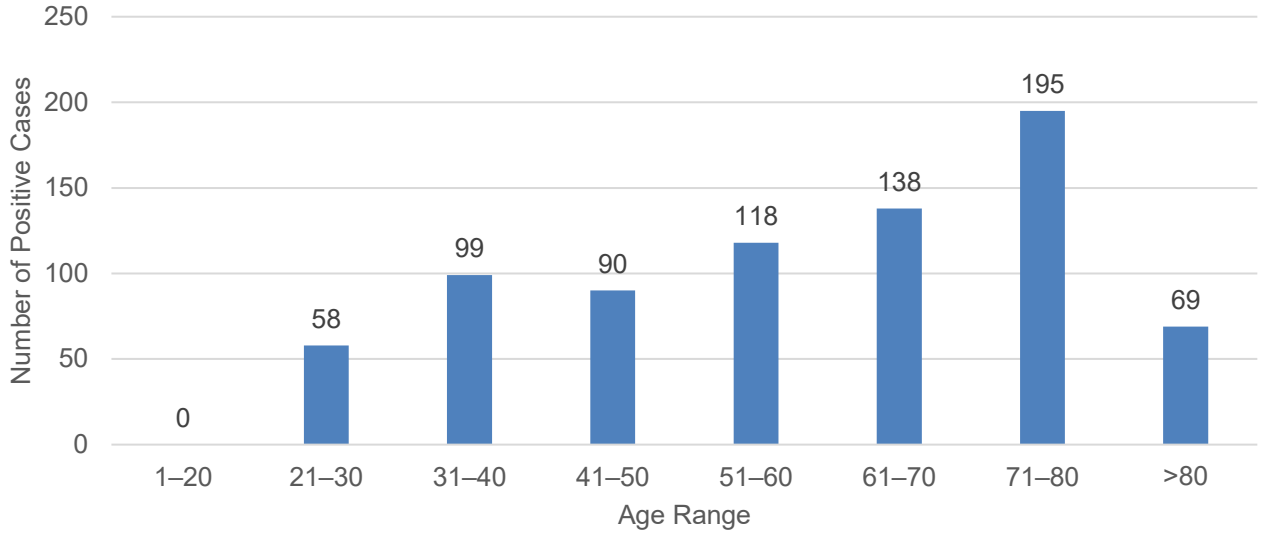

Figure C.2. *Age range of VA Portland Health Care System positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

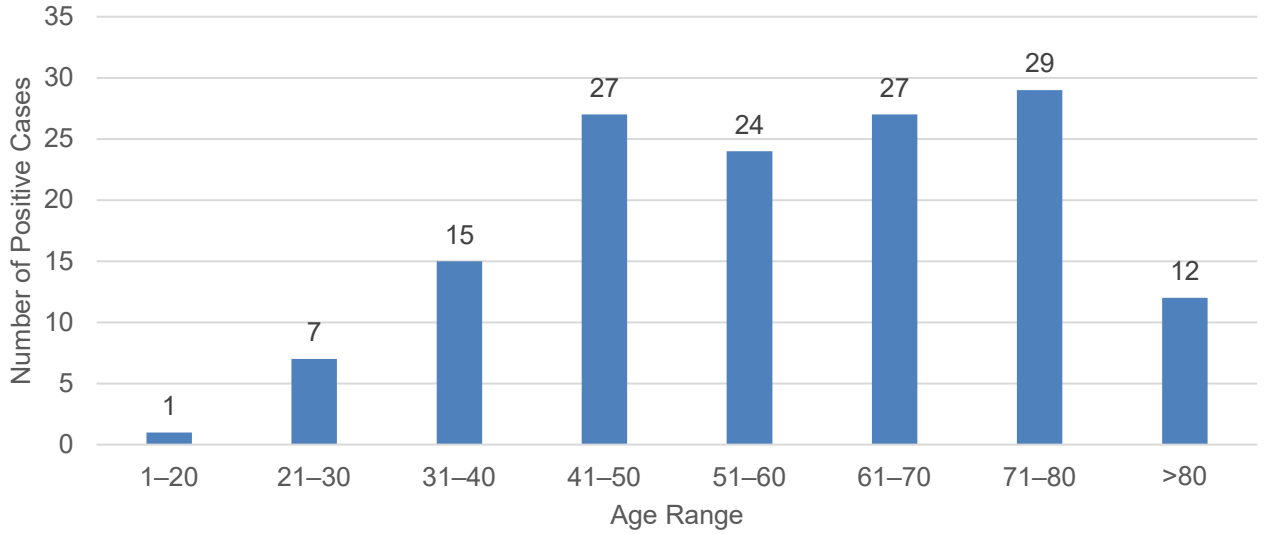

Figure C.3. *Age range of Roseburg VA Health Care System positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

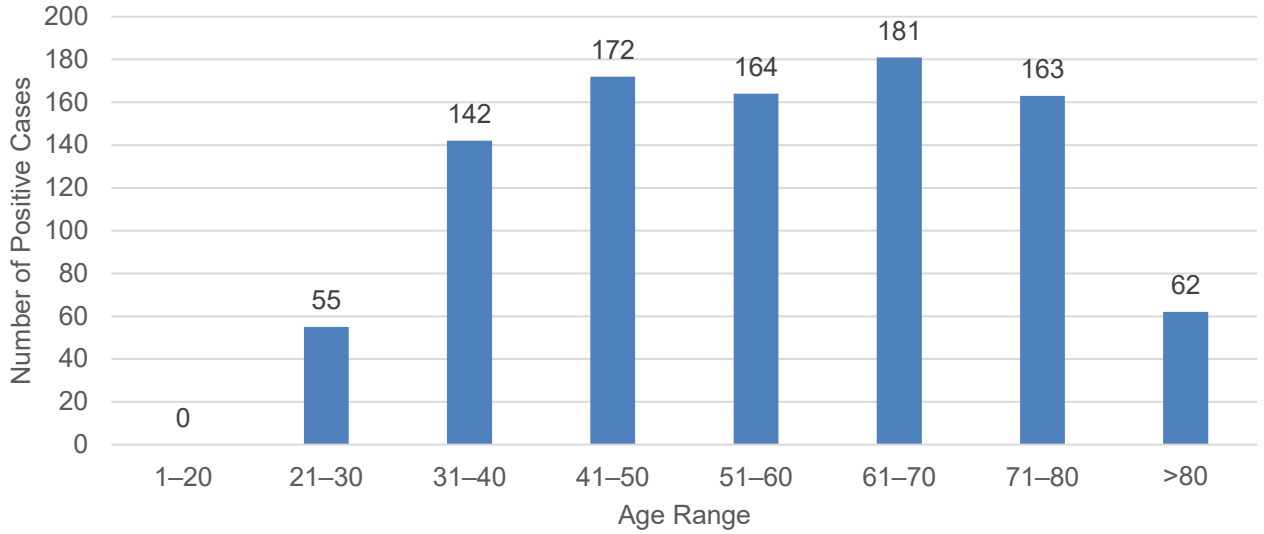

Figure C.4. *Age range of VA Puget Sound Health Care System (Seattle, WA) positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

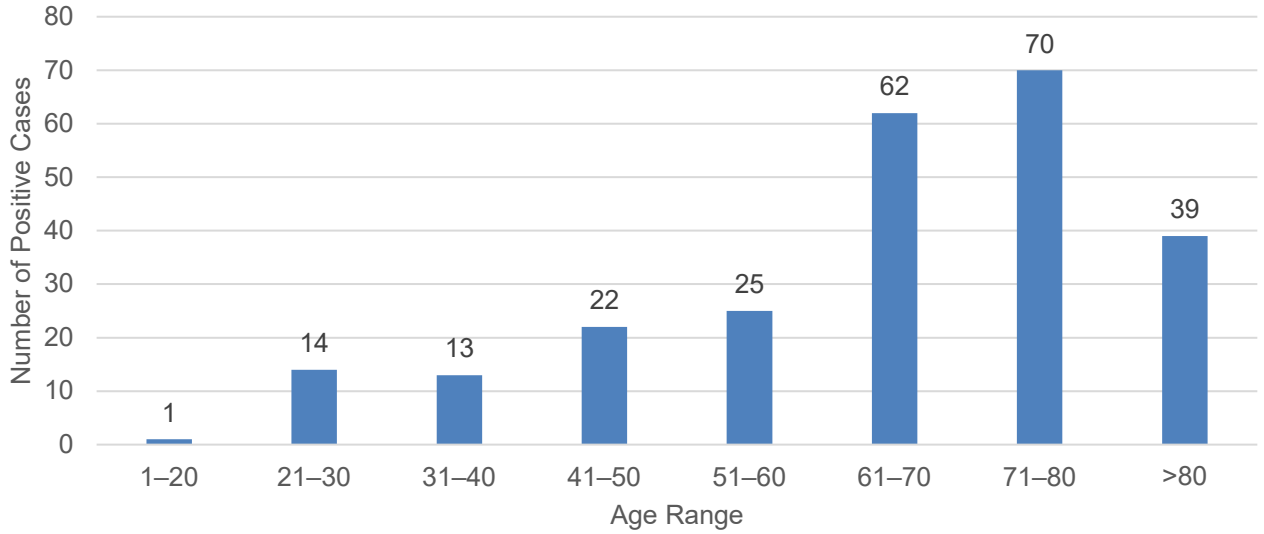

Figure C.5. *Age range of Mann-Grandstaff VAMC (Spokane, WA) positive cases (March 11 through December 30, 2020).*

Source: Department of Veterans Affairs National Surveillance Tool: COVID-19 Facility Detail (accessed December 31, 2020).

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

Table C.4. Boise VA Medical Center Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	15,143	2,249	14,510	633	4%
Primary Care	27,685	4,258	26,404	1,281	5%
Specialty Care and All Other	46,438	11,517	40,877	5,561	12%
Total	**89,266**	**18,024**	**81,791**	**7,475**	**8%**

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.5. Boise VA Medical Center Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	16,045	3,790	15,378	667	4%
Mental Health Individual Clinic	6,198	1,680	5,977	221	4%
Dental	3,483	1,823	2,347	1,136	33%
Optometry	3,457	1,116	2,747	710	21%
Physical Therapy	3,420	865	3,212	208	6%

Source: VHA Support Service Center (accessed December 31, 2020; optometry data accessed January 4, 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 C.6. VA Portland Health Care System Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	52,498	14,268	51,195	1,303	2%
Primary Care	48,209	12,324	46,651	1,558	3%
Specialty Care and All Other	112,136	44,688	98,524	13,612	12%
Total	**212,843**	**71,280**	**196,370**	**16,473**	**8%**

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.7. VA Portland Health Care System Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	33,989	11,288	33,045	944	3%
Mental Health Individual Clinic	20,190	6,650	19,717	473	2%
Telephone Mental Health	15,374	4,150	14,795	579	4%
Optometry	13,110	7,261	12,186	924	7%
Physical Therapy	9,335	2,642	8,839	496	5%

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.8. Roseburg VA Health Care System Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	11,664	1,476	11,077	587	5%
Primary Care	25,512	5,476	24,238	1,274	5%
Specialty Care and All Other	43,683	18,140	36,755	6,928	16%
Total	**80,859**	**25,092**	**72,070**	**8,789**	**11%**

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.9. Roseburg VA Health Care System Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	17,024	5,269	16,029	995	6%
Dental	10,288	8,970	8,082	2,206	21%
Telephone Primary Care	8,481	202	8,202	279	3%
Optometry	3,605	1,341	3,033	572	16%
Audiology	3,579	1,820	2,935	644	18%

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.10. VA Puget Sound Health Care System (Seattle, WA) Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	81,985	10,541	79,515	2,470	3%
Primary Care	59,147	6,871	56,282	2,865	5%
Specialty Care and All Other	99,198	32,461	90,596	8,602	9%
Total	**240,330**	**49,873**	**226,393**	**13,937**	**6%**

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.11. VA Puget Sound Health Care System (Seattle, WA) Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	27,106	5,925	26,256	850	3%
Mental Health Individual Clinic	20,376	5,554	19,749	627	3%
Optometry	7,483	3,904	7,186	297	4%
Mental Health Integrated Care Individual Clinic	6,961	1,491	6,716	245	4%
Dental	6,864	5,009	6,322	542	8%

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.12. Mann-Grandstaff VA Medical Center (Spokane, WA) Clinic Cancellations and Follow-Up (March 1 through December 30, 2020)*

Clinic Group	Total Cancellations	Cancellations Due to COVID-19	Follow-Up Found	No Follow-Up Found	Percent of Cancelled Appointments Without Follow-Up
Mental Health	10,669	737	10,021	648	6%
Primary Care	12,742	2,629	11,996	746	6%
Specialty Care and All Other	29,531	11,694	23,446	6,085	21%
Total	**52,942**	**15,060**	**45,463**	**7,479**	**14%**

Source: VHA Support Service Center (accessed December 31, 2020).

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 C.13. Mann-Grandstaff VA Medical Center (Spokane, WA) Top Five Clinic Cancellations (March 1 through December 30, 2020)*

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	8,400	2,548	7,983	417	5%
Mental Health Individual Clinic	3,932	200	3,623	309	8%
Physical Therapy	3,583	1,204	3,244	339	9%
Optometry	3,442	1,508	2,954	488	14%
Dental	3,120	2,834	1,512	1,608	52%

Source: VHA Support Service Center (accessed December 31, 2020).

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.*

Appendix D: VISN 10 OIG Survey Results

Table D.1. VISN 10 OIG Survey Respondents

Respondent Indication	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
Clinical	323	238	179	294	160	165	242	235
Nonclinical	220	201	143	182	143	117	202	160
No Selection	31	19	22	31	15	19	36	22
Total	**574**	**458**	**344**	**507**	**318**	**301**	**480**	**417**
Approximate Number of Staff at the Time of Inspection	3,034	1,750	1,552	2,652	2,499	2,177	2,002	1,313
Approximate Response Rate	**19%**	**26%**	**22%**	**19%**	**13%**	**14%**	**24%**	**32%**

Source: VA OIG.

Table D.2. VISN 10 Respondents' Assessment of Communication and Personal Protective Equipment Availability

Question	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
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?	74%	67%	66%	67%	71%	56%	59%	60%

Question	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
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?	71%	72%	79%	74%	75%	64%	72%	64%
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?	74%	67%	65%	69%	73%	58%	64%	61%
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?	70%	71%	77%	72%	76%	60%	71%	65%
PPE: Did you have access to appropriate PPE necessary to ensure your own safety at work during the COVID-19 pandemic?	80%	69%	80%	70%	80%	61%	76%	60%

Source: VA OIG.

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

Table D.3. Identified Trends Among VISN 10 Respondents' Comments on Facility Readiness and Response

Question	Ann Arbor, MI	Battle Creek, MI	Chillicothe, OH	Cincinnati, OH	Dayton, OH	Detroit, MI	Marion, IN	Saginaw, MI
What lessons were learned during the facility's pandemic response?	• Being flexible and able to adapt • Importance of teamwork • Need for preparation • Importance of communication	• How to effectively utilize virtual modalities of care • Importance of teamwork • Need for preparation • Importance of communication • Need for PPE	• Importance of teamwork • Need for preparation • Importance of communication	• How to adapt and be flexible • Importance of teamwork • Need for preparation • Importance of transparent communication • Need for PPE • How to better utilize telehealth	• n/a	• Importance of teamwork • Need for preparation • Importance of clear and concise communication • Need for PPE • Need for technology platforms to provide patient care remotely (telehealth)	• Importance of teamwork • Need for preparation • Importance of communication • Need for PPE	• How to effectively adapt during a crisis • Importance of teamwork • Need for preparation • Communication is key to success

Source: VA OIG.

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

n/a = not applicable (limited responses, no themes identified).

Appendix E: VISN 20 OIG Survey Results

Table E.1. VISN 20 OIG Survey Respondents

Respondent Indication	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
Clinical	193	410	285	506	275
Nonclinical	150	356	259	384	198
No Selection	4	16	14	32	11
Total	**347**	**782**	**558**	**922**	**484**
Approximate Number of Staff at the Time of Inspection	1,763	4,887	1,311	4,755	1,420
Approximate Response Rate	**20%**	**16%**	**43%**	**19%**	**34%**

Source: VA OIG.

Table E.2. VISN 20 Respondents' Assessment of Communication and Personal Protective Equipment Availability

Question	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
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?	90%	81%	69%	77%	82%
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?	83%	83%	84%	76%	85%
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?	89%	80%	72%	75%	84%

Question	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
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?	82%	81%	84%	74%	84%
PPE: Did you have access to appropriate PPE necessary to ensure your own safety at work during the COVID-19 pandemic?	90%	76%	77%	75%	83%

Source: VA OIG.

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

Table E.3. Identified Trends Among VISN 20 Respondents' Comments on Facility Readiness and Response

Question	Boise, ID	Portland, OR	Roseburg, OR	Seattle, WA	Spokane, WA
What lessons were learned during the facility's pandemic response?	• Ability to adapt and work as a team • Importance of communication	• Ability to be flexible and adapt • Importance of communication • Preparation is required • Telework is a viable option to social distancing	• Ability to be flexible and adapt • Importance of communication • Preparation is required • Importance of teamwork	• Ability to be flexible and adapt • Importance of communication • Preparation is required • Telework for clinical staff is a viable option	• Ability to be flexible and adapt • Importance of communication • Importance of preparation (PPE inventory) • Importance of teamwork

Source: VA OIG.

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

Appendix F: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: March 8, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in VISNs 10 and 20 (VIEWS 4654952)

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 Networks 10 and 20*.

2. VHA has reviewed the document and has no comments on the content of the draft report.

3. Comments regarding the content of this memorandum may be directed to VHA's GAO-OIG Accountability Liaison Office at [redacted].

(Original signed by:)

Richard A. Stone, M.D.

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