



Veterans Health Administration

COVID-19 Response Plan

Incident-specific Annex to the VHA High
Consequence Infection (HCI) Base Plan

Version 2, August 7, 2020



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

August 7, 2020

To Whom It May Concern:

The Department of Veterans Affairs (VA) is proud to continue to serve on the frontlines of the COVID-19 pandemic. We are also working hard to keep the nation informed of our lessons learned so everyone can benefit from our experience.

The enclosed latest iteration of VA's COVID-19 Response Plan builds upon its initial release in March 2020 to offer more hard-fought insight and expertise to help the nation's healthcare system respond to this deadly enemy.

This report is the result of our continued dedication to transparency and information-sharing for the benefit of Veterans and all Americans. We will continue to publish our lessons learned at regular intervals as our response to the pandemic evolves.

I am incredibly proud of the heroic efforts of VA healthcare workers. They are working tirelessly to save lives around the country, both in VA facilities and outside our walls at the request of the nation. It is inspiring to see Americans come together to fight this disease, and we are honored to serve those who need us.

Thank you for your support of the nation during this critical time.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard A. Stone".

Richard A. Stone, M.D.
Executive in Charge

Introductory Material

Record of Changes:

Date	Description of change	Page of section	Posted by
06/03/2020			
06/03/2020	Appendix List Reorganized, now A through Q		
06/03/2020	Appendix E: Office of Information and Technology (OIT) Organization, Communications and Information – Added	51	VHACO
06/03/2020	Appendix G: Employee Wellness – Added	76	VHACO
06/03/2020	Appendix H: Mental Health and Suicide Prevention – Added	80	VHACO
06/03/2020	Appendix M: Support to Rural Health Providers and Organizations – Added	126	VHACO
06/03/2020	Appendix O: Support to State Veteran and Community Nursing Homes – Added	142	VHACO

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APPENDIX Q – FOURTH MISSION OF THE DEPARTMENT OF VETERANS AFFAIRS, NATIONAL-LEVEL ROLES AND RESPONSIBILITIES	ERROR!

Executive Summary

COVID-19 has been declared a Pandemic by the World Health Organization (WHO) and a Public Health Emergency (PHE) by the U.S. Government. A pandemic, as defined by the WHO, is a worldwide spread of a new disease, occurring over a wide geographic area and affecting an exceptionally high proportion of the population. Current evidence shows that the virus infects others at a higher rate than influenza and has higher rates of hospitalization and death when compared to influenza. U.S. citizens, including Veterans and health care personnel are at risk for COVID-19 infection.

The primary goal of the operations plan is to protect Veterans and staff from acquiring COVID-19 infection by leveraging technology, communications as well as using dedicated staff and space to care for COVID-19 patients. The Department of Veterans Affairs (VA) will create a safe environment by implementing a system where one VA facility operates as two separate “zones” (Standard and COVID-19) for inpatient care. VA will provide most outpatient care for Veterans through telehealth services as appropriate. This approach minimizes the risk of infection, supports expansion to meet an increasing need for COVID-19 services and provides Veterans in routine VA care consistent access to VA care. The plan includes strategies to address a large number of COVID-19 cases to include alternative sites of care for Veterans with COVID-19.

Purpose

This plan outlines Veterans Health Administration (VHA) response activities for COVID-19 in the United States. VHA will conduct all activities necessary to protect Veterans and staff from COVID-19 and ensure continuity of access to and delivery of health care services to Veterans as appropriate. Also, as defined in the *Pandemic Crisis Action Plan (PanCAP) Adapted U.S. Government COVID-19 Response Plan (March 13, 2020)*¹, VHA will support U.S. Department of Health and Human Services (HHS) through Emergency Support Functions (ESFs) as requested. This response will be carried out in accordance with the National Response Framework (NRF)² and in accordance with established departmental authorities and standing policies.

Situation

Background

A pneumonia of unknown cause detected in Wuhan, China was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019. The

¹ As of March 18, 2020, this plan is not available for public distribution or release. Public release of this document is pending approval.

² National Response Framework, Fourth Edition, published on October 29, 2019, and revised on February



27, 2020. <https://www.fema.gov/media-library/assets/documents/117791>

virus was later named “SARS-CoV-2” and the disease it causes named “coronavirus disease 2019” (abbreviated “COVID-19”).

On January 30, 2020, the International Health Regulations Emergency Committee of the WHO declared the outbreak a “Public Health Emergency of International Concern (PHEIC). On January 31, 2020, HHS Secretary Alex M. Azar II declared a PHE for the United States to aid the U.S. health care community in responding to COVID-19. On March 2, 2020, VA Secretary Robert Wilkie was appointed to the White House Coronavirus Task Force. On March 11, 2020 WHO publicly characterized COVID-19 as a pandemic. President Donald J. Trump declared that the severity and magnitude of the pandemic warranted an emergency determination under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the “Stafford Act”).

Pandemic

A pandemic is a global outbreak of disease. Pandemics generally happen when a new virus emerges to infect people and can spread between people sustainably. People have little to no pre-existing immunity against the new virus and it holds the potential to spread worldwide.

This is the first pandemic known to be caused by the emergence of a new coronavirus. Two other coronavirus outbreaks in the last century causes Sudden Acute Respiratory Syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS). In addition, there have been four pandemics caused by the emergence of novel influenza viruses. Existing research and guidance on both coronavirus and influenza outbreaks and pandemics provide a knowledge foundation for COVID-19. Pandemics of respiratory disease follow a certain progression outlined in a “Pandemic Intervals Framework.” Pandemics begin with an investigation phase, followed by recognition, initiation and acceleration phases³. The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses. Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.

Source and Spread of the Virus

Coronaviruses are a large family of viruses that are common in several species of animals including bats, camels, cattle and cats. Rarely, animal coronaviruses can infect people and then spread between people, as observed with Middle East Respiratory Syndrome (MERS)-CoV, Severe Acute Respiratory Syndrome (SARS)-CoV and now SARS-CoV-2 (also referred to as COVID-19).

The SARS-CoV-2 virus is a beta coronavirus and has its origin in bats like MERS-CoV and SARS-CoV. Similar sequences between patients from U.S. and initial patients in

³ <https://www.cdc.gov/flu/pandemic-resources/national-strategy/intervals-framework.html> Accessed May 28, 2020

China likely suggest a single, recent emergence of this virus from an animal reservoir.

Early on, many of the patients at the epicenter of the outbreak in Wuhan, Hubei Province, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China. The virus spread rapidly following international travel routes and locations with higher population density including cruise ships. It has also been seen at higher rates in vulnerable populations.

Illness Severity

The complete clinical picture of COVID-19 is not fully known at this time. Reported illnesses range from asymptomatic to severe including illness resulting in death. While information suggests that most COVID-19 illness is mild, reports out of multiple countries suggest serious illness occurs in approximately 20% of cases. In the U.S., 20% of persons with known COVID-19 infection and known hospitalization status have been hospitalized. Older people and people of all ages with severe underlying health conditions — like heart disease, lung disease and diabetes, for example — are at higher risk of developing serious COVID-19 illness. Recently, health care systems and researchers have found abnormalities in blood clotting that may explain the rapid decline seen in some COVID-19 cases and specific events such as strokes in young adults.

Risk Assessment

Risk depends on characteristics of the virus, including how well it spreads between people; the severity of resulting illness, the medical or other measures available to control the impact of the virus (for example, vaccines or medications that can treat the illness) and the relative success of these measures. In the absence of a vaccine or treatment medications, nonpharmaceutical interventions become the most important response strategy; these include community interventions that can reduce the impact of disease.

Risk from COVID-19 can be broken down into risk of exposure versus risk of serious illness and death:

Risk of Exposure is increased for:

- People in places of reported, ongoing community spread of the virus that causes COVID-19, with the level of risk dependent on the location
- Health care workers caring for patients with COVID-19
- First responders
- Essential workers without personal protective equipment or physical distancing
- Close contacts of persons with COVID-19
- Persons living in nursing or long-term care facilities

Risk of Severe Illness is increased for:

- Older adults, with risk increasing by age
- People who have chronic medical conditions, such as: heart disease, diabetes, lung disease, hypertension, obesity (BMI 40 or higher), liver disease, chronic kidney disease on dialysis, or immune compromise
- Disparities in social determinants of health

Planning Assumptions

The focus of VHA's preparedness model has been to maintain an "all hazards" core High Consequence Infection (HCI) response capability at all VA medical facilities. VHA is ensuring active liaisons between VA and public health authorities at all levels, and between VA Medical Centers and local health care coalitions. The following generalized assumptions specific to COVID-19 include:

- Efficient and sustained person-to-person transmission that is documented by authoritative U.S. and international scientists and that occurs anywhere in the world will indicate an imminent pandemic.
- Susceptibility to the virus may be universal.
- Rates of severe illness may be highest among the elderly (65 years of age and older).
- Some persons will become infected but may not develop clinically significant symptoms, i.e., they will not be aware that they have been infected with the COVID-19 virus for 14 days or may remain asymptomatic.
- As would symptomatic individuals, persons who have COVID-19 with little to no symptoms may be capable of transmitting infection.
- Most estimates of the incubation period for COVID-19 range from 1-14 days. Recent work reports the median incubation period to first symptoms to be approximately 5.1 days.⁴
- Children play a major role in transmission of infection as their illness rates are likely to be higher, they usually shed more virus, and they do not control their secretions as well.
- Approximately 20% of the infected population will require hospitalization, of this, approximately 5% will require ICU level care and approximately 2.3% will require ventilator support.
- Rates of serious illness, hospitalization and deaths will depend on the virulence in the U.S. and the difference between more and less severe scenarios may be tenfold.
- Risk groups for severe or fatal infection cannot be predicted with certainty but are likely to include the elderly and persons with specific chronic medical conditions.
- Limitations in early access to testing supplies for sample collection could limit the ability to conduct surveillance, rule in/out COVID-19 infection, and implement isolation and infection control practices as all symptomatic individuals are treated as persons under investigation (PUI).

- In a severe outbreak, absenteeism (the number of absent employees) may reach 40%, due to illness, the need to care for ill family members, or fear of infection during the peak weeks of a community outbreak. Lower rates of absenteeism are expected during the weeks before and after the peak.
- Lack of sensitive and specific testing for acute and convalescent COVID-19 disease along with low disease prevalence will limit the utility of testing early in the pandemic.
- There may be critical shortages of health care resources, such as Personal Protective Equipment (PPE), staffed hospital beds, mechanical ventilators, morgue capacity, temporary holding sites with refrigeration for storage of deceased and other resources. This can only be mitigated by meticulous planning.
- Antiviral treatment may not be available making the management of new and ongoing comorbidities and the host's immune response critical.
- Public health measures, such as temporarily closing schools, and quarantining household contacts of infected individuals, are likely to increase rates of absenteeism due to employees with school-aged children.
- Potentially 30% of the workforce could be non-available due to illness or caring for sick family members.
- Similar to influenza, the event could last 18 months or longer and could include multiple waves of illness.
- Multiple waves of epidemics are likely to occur across the country, lasting many months altogether. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.
- Facilities will need to plan for a surge in capacity of acute and intensive care beds, impacting hiring, supply chain, and other critical resources for Veterans with COVID-19 disease and those without requiring standard care.

⁴ Lauer SA, Grantz KH, Bi Q, et al. The Incubation Period of Coronavirus Disease 2019 (COVID-19) From Publicly Reported Confirmed Cases: Estimation and Application. *Ann Intern Med.* 2020; [Epub ahead of print 10 March 2020]. <https://doi.org/10.7326/M20-0504>

Authorities

National Authorities

Primary national authorities are listed below. For a full list of authorities, reference the Biological Incident Annex (BIA) or PanCAP Annex A: Authorities.

1. Public Health Service Act, Pub L. No. 78-410, 58 Stat. 682 (1944) (codified as amended at 42 United States Code (U.S.C.) §§ 201 et seq.; 42 U.S.C. §§ 300hh-1 and 16).
2. Public Readiness and Emergency Preparedness Act, Pub. L. No. 109-148 (codified as amended in the Public Health Service Act at 42 U.S.C. §§ 247d-6d).
3. Economy Act, Pub. L. No. 73-2 (1933) (codified as amended at 31 U.S.C. §1535).
4. Robert T. Stafford Disaster Relief and Emergency Assistance Act, Pub. L. No. 93-288 (as amended at 42 U.S.C. §§ 5121-5207).
5. Presidential Policy Directive 44 (PPD 44), Enhancing Domestic Incident Response (2016).
6. Homeland Security Presidential Directive 5 (HSPD-5), Management of Domestic Incidents (2003).

VHA Specific Authorities

1. Title 38, U.S.C., Section 8117, Emergency Preparedness (Pub L. No.107-287, as amended).
2. VA/DoD Health Resources Sharing and Emergency Operation Act, Pub L. No. 97-174, May 4, 1982.
3. Department of Veterans Affairs Emergency Preparedness Act of 2002, Pub L. No. 107-287, November 1, 2002.

Guiding Doctrine

The Biological Incident Annex (BIA) and Response and Recovery Federal Interagency Operational Plans (FIOP), approved January 2017, provides strategic guidance for the coordination of the interagency during a biological incident. The PanCAP (approved in January 2018), and the VA Pandemic Influenza Plan (March 2006) operationalize the BIA with a focus on viral pandemic pathogens. The U.S. Government and VHA COVID-19 Response Plan(s) provide adapted Federal response actions to this disease.

Mission

HHS and the Federal Emergency Management Agency (FEMA) have leadership roles
VHA COVID-19 Response Plan

in the response to COVID-19 and report to the Office of the Vice President, the task force lead for the Federal government response. HHS/FEMA will take all necessary action to leverage U.S. Government (USG) resources to prepare for, respond to, and recover from COVID-19. VHA, in conjunction with VA, will coordinate activities with HHS to:

- Limit the spread of COVID-19 infection to Veterans and staff,
- Provide care for those infected with COVID-19,
- Provide continuity of care for non-infected Veterans,
- Manage national stockpiles and coordinate supply requests for items in limited quantity, and
- Provide resources to HHS in support of ESF mission assignment tasking, as requested.

Roles and Responsibilities

National Level Roles and Responsibilities

The Federal Emergency Management Agency (FEMA) coordinates Federal support and consequence management. VHA supports Federal interagency support with HHS, as requested, to assist State, Local, Territorial and Tribal (SLTT) partners with preparedness and response activities. As defined in Annex F. Federal Roles and Responsibilities of the U.S. Government COVID-19 Response Plan (March 13, 2020), VA is responsible for the following:

- VHA will provide PPE fit-testing, medical screening and training for ESF #8⁵ and other Federal response personnel.
- Provide VHA staff as ESF #8 liaisons to FEMA the Incident Management Assistance Teams deploying to the state emergency operations center.
- Provide VHA planners currently trained to support ESF #8 teams.
- VHA provides vaccination services to VA staff and VA beneficiaries in order to minimize stress on local communities.
- VHA furnishes available VA hospital care and medical services to individuals responding to a major disaster or emergency, including active duty members of the armed forces as well as National Guard and military Reserve members activated by state or Federal authority for disaster response support.
- VHA provides ventilators, medical equipment and supplies, pharmaceuticals and acquisition and logistical support through VA National Acquisition Center.
- National Cemetery Administration (NCA) provides burial services for eligible Veterans and dependents and advises on methods for interment during national security emergencies.

⁵ Emergency Support Function #8 – Public Health and Medical Services Annex, <https://www.fema.gov/media-library/assets/documents/25512>

- VHA designates and deploys available medical, surgical, mental health and other health service support assets.
- VHA provides one representative to the National Response Coordination Center (NRCC) during the operational period on a 24/7 basis.

VA Level Roles and Responsibilities

Under Secretary for Health (USH):

- Establishes policy for VHA HCI preparedness in concert with the Secretary of VA, the HHS, Assistant Secretary for Preparedness and Response (ASPR) and Centers for Disease Control and Prevention (CDC).
- Designates VHA program offices with leadership and support responsibilities for HCI preparedness and response.
- Provides funding necessary for COVID-19 response efforts, including but not limited to equipment, supplies, pharmaceuticals, training and human resources.

Deputy Under Secretary for Health (DUSH):

- The DUSH is responsible for ensuring the support and participation of VHA program offices with the national-level HCI advisory committee.

Assistant Under Secretary for Health for Operations (AUSHO):

- The AUSHO is responsible for ensuring Veteran Integrated Service Network (VISN) and VA medical facility requirements are provided to the VHA Emergency Management Coordination Cell (EMCC).

Executive Directors of the Offices of Emergency Management (OEM) and Population Health (PH):

The Directors of OEM and PH are responsible for establishing and managing a national-level COVID-19 advisory group that is composed of subject matter experts from VHA program offices, as well as VISN and facility-level representation. The advisory group is responsible for:

- Developing policy, plans, guidance and education to support VHA's readiness for response and recovery from the COVID-19 outbreak.
- Coordinating VHA COVID-19 response plans with officials from VA, HHS Assistant Secretary for Preparedness and Response (ASPR), CDC and other Federal agencies.
- Making recommendations for the strategic management of supplies and equipment necessary to support the response to the outbreak.
- Determining requirements for the capabilities of VA health care facilities.

VISN Director

- Designating responsibility for the oversight of equipment and supplies maintained within the VISN for the COVID-19 outbreak.
- Communicate VISN response efforts to local media, the Congress, Veteran Service Organizations and Veterans.
- Maintaining active liaison with the State departments of public health for the integration of VA Medical Center (VAMC) preparedness and response activities, as appropriate.

VAMC Directors

Establishing a COVID-19 advisory workgroup. This interdisciplinary workgroup has both clinical and non-clinical expertise. Suggested composition includes representation from infectious diseases/infection prevention and control, nursing, industrial hygiene/safety, emergency management, ethics and other subject matter experts, as appropriate.

- Maintaining situational awareness and identifying sources of medical and epidemiological information.
- Establishing procedures for the identification, screening, isolation, diagnosis, and treatment of Persons Under Investigation (PUIs), including processes for cleaning/disinfecting and infectious waste removal, as appropriate.
- Maintaining and ensuring an adequate amount of medical supplies, equipment, medication and PPE is available at the point of patient care.
- Designating space to care for COVID-19 patients while minimizing the risk of contagion to non-infected patients and visitors.
- Determining and communicating a clear ethical framework for the allocation of scarce resources in coordination with the facility's Ethics Consultation Service.
- Documenting patient and employee responses to risk assessment screening questions.
- Providing education and training to those staff members who will be involved with COVID-19 patients consistent with their roles and responsibilities and risk-based job analysis at least annually.
- Conducting periodic exercises that integrate non-VA community partners.
- Coordinating VAMC COVID-19 preparedness and response activities with the VISN and with local health care coalitions, public health and emergency management authorities, as appropriate.
- Identifying any needed corrective actions through COVID-19 training, exercises, or actual incidents and include in overall improvement plans that are approved by leadership.

Execution

Concept of Operations

This plan outlines key decisions, actions and interagency coordinating structures implemented during the COVID-19 response. In addition to the core mission objective of protecting Veterans and staff from infection, providing care for those infected and maintaining continuity of care for non-infected Veterans, VHA also provides support nationally as outlined in the Pandemic and All-Hazards Preparedness Act and the NRF.

Operational Phases and Triggers

The concept of operations for this incident is based on the VHA COVID-19 Strategic Response Plan (*VHA COVID-19 Workgroup, Emergency Management Coordination Cell, version 1.0, March 3, 2020*). It aligns with the interagency triggers to the CDC intervals for each phase as well as the COVID-19 Containment and Mitigation Strategy developed by the National Security Council (NSC).

The table below provides mapping between these operational constructs:

Table 1: Mapping of Operational Constructs

Phase	Pre-Incident Phase 1C	Post-incident Operations Phase 2A	Post-incident Operations Phase 2B	Post-incident Operations Phase 2C	Recovery and Restoration Operations Phase 3
USG COVID-19 Response Plan Phase	Near Certainty of Credible Threat	Activation, Situational, Assessment and Movement	Employment of Resources	Intermediate Operations	Restoration and Long-Term Recovery
CDC Interval	Recognition	Initiation	Acceleration		Deceleration
NSC COVID-19 Containment / Mitigation Strategy	Containment	Aggressive Containment	Transition from Containment to Community Mitigation	Community Mitigation	Preparing for Future Epidemics
VHA Phases of Implementation	Phase 1 – Contingency Planning and Training	Phase 2 – Initial Response		Phase 3 - Alternate Sites of Care	Phase 4 - Extended Operations and Recovery

NOTE: Transitions between phases are informed by triggers outlined in the sections below.

National level Response Phases of Implementation

Table 2: VA Specific ESF #8 Responsibilities

Phase	1c - Near Certainty or Credible Threat	Phase 2A – Activation, Situational Assessment, and Movement	Phase: Phase 2B – Employment of Resources and Stabilization	Phase: Phase 2C – Intermediate Operations
VA Specific ESF #8 Responsibilities	- Enhance VA Facility Surveillance	- Identify and request interagency Liaison Officer (LNO) to support HHS Secretary’s Operations Center (SOC).	- Designate and deploy available medical, surgical, mental health and other health service support resources. - Provide liaisons as ESF #8 assets to Federal and state emergency coordination entities.	- Provide mortuary assistance in the interment of human remains. - Furnish available VA hospital care and medical services in a major disaster or emergency. - Provide acquisition and logistics support to public health/medical response operations.

As specified in Annex F and Annex X of the U.S. Government COVID-19 Response Plan, VHA has assigned responsibilities to HHS regarding mission assignment taskings under Emergency Support Function #8 - Public Health and Medical Services. The table below provides the details regarding the responsibilities and operational phases where these assignments may be exercised:

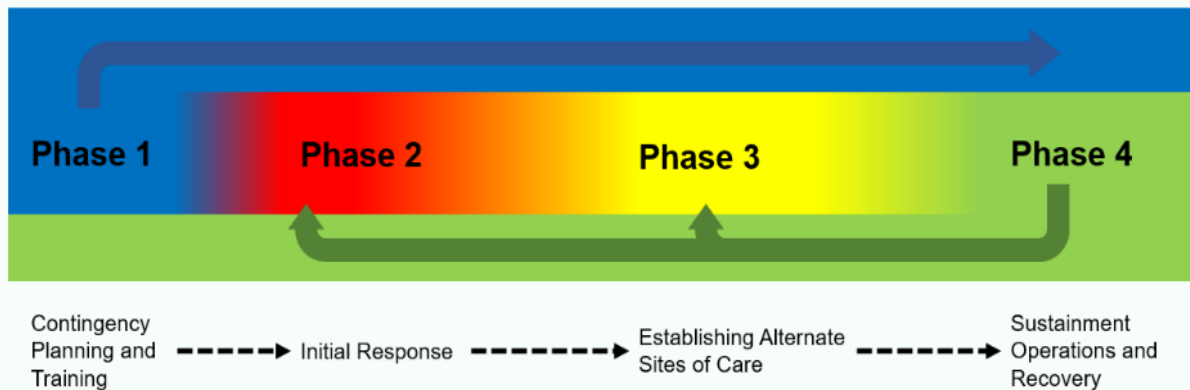
VHA Response Phases of Implementation

VHA will respond using a 4-phase approach to COVID-19:

- 1) Contingency Planning and Training;
- 2) Initial Response;
- 3) Establishing Alternate Sites of Care; and
- 4) Sustainment and Recovery.

This document provides an overview of the changes that are necessary within VHA to mitigate the impacts from the COVID-19 outbreak on Veterans, employees and health care operations.

Figure 1: VHA Concept of Operations - Phases of Operation



Phase 1 – Contingency Planning and Training

VHA’s overall strategy for mitigating the impact of COVID-19 on Veterans, employees, visitors and the VHA health care delivery system. The overarching principles guiding the strategy are:

- Protect uninfected patients and employees from acquiring COVID-19 infection.
- Shift priorities, resources, and standards of care to accommodate a large influx of infectious patients.
- Physically and functionally separate suspected or confirmed COVID-19 patients from individuals who have not been exposed to the virus.
- Use dedicated employees to care for COVID-19 patients.
- Leverage technology and communications to minimize exposure.
- Identify opportunities to deliver supportive care to large populations of patients, in coordination with community partners.

Trigger: Phase 1 is triggered during an outbreak outside of the US. This phase ends with the occurrence of an outbreak of COVID-19 in the US.

Objective: Update plans, procedures, and techniques and conduct training to protect Veterans and staff in the event of an outbreak of the COVID-19.

Table 3: Phase 1 - Strategies for Mitigating COVID-19

Strategies	Stabilization Targets
a. Develop plans, policies, and procedures to protect Veterans and staff.	Provisional plans are complete, approved and issued as guidance across the VHA enterprise.
b. Conduct training on the developed plans, policies, and procedures.	Initial training programs developed and published based on initial planning guidance with mechanisms; update/revise as necessary.
c. All VAMCs conduct a Tabletop Exercise (TTX).	100% of facilities completing a TTX, lessons learned reviewed and integrated into planning cycle.
d. Identify PPE Stockage Levels and Requirements.	Verify national stock levels, monitor/track utilization, implement proactive strategies to ensure no interruption in care.
e. Identify existing capability and “just in time capability” requirements.	Ensure plans in place and ready to accommodate rapidly developing resource needs to fulfill emerging capability gaps.
f. Develop “one voice” messaging for Veterans and staff.	Develop and communicate initial messaging. Develop processes to update, refresh and reinforce messaging.

Phase 2 – Initial Response

VAMCs must be prepared to implement a response to COVID-19 outbreaks in their areas. The strategies include:

- Ensure situational awareness reporting procedures are in place.
- Ensure transparent communications across the enterprise.
- Receive and triage Veterans with suspected or confirmed COVID-19 infection.
- Provide acute and outpatient care for Veterans with COVID-19.
- Provide a safe environment for Veterans and staff working in acute and non-acute care (e.g., Community Living Centers, Spinal Cord Injury and Disorders, Blind Rehabilitation units, rehabilitation centers) environments.
- Maintain care for Veterans without COVID-19 through telehealth services, a preferred delivery system, if possible.
- Require all Veterans, staff, and visitors to VA facilities wear a cloth mask (implemented May 7, 2020)

Trigger: Phase 2 is triggered when there is an initial outbreak of COVID-19 in the US. This phase ends when either existing capability/supply chain cannot maintain levels to meet demand or when the response capabilities can meet and sustain the response operations indefinitely.

Objective: Implement containment and mitigation actions to respond to local and/or regional outbreaks.

Table 4: Phase 2 - Strategies for Mitigating COVID-19

Strategies	Stabilization Targets
Ensure situational awareness reporting procedures are in place at all levels.	Implement procedures to capture current situation information and provide clear, accurate and timely operational information to senior management.
Transparent communication to ensure information availability and analysis is getting all levels.	Implement systems to capture, aggregate and report the latest situational information at all levels across the enterprise.
Receive and triage initial patients: <ol style="list-style-type: none"> i. Protect uninfected patients and staff from infectious patients and staff. ii. Provide acute care for COVID-19 patients. iii. Support mildly ill COVID-19 patients in home isolation –and use telehealth. iv. Support patients in voluntary home quarantine – use telehealth. v. Continue to address routine health care needs for all patients. 	<ul style="list-style-type: none"> • Initial guidance developed and published. • Physical measures implemented at the facilities to provide isolation of COVID-19 cases while ensuring continuing care operations for non-affected patients. • Implement Telehealth programs to reduce the number of cases entering medical facilities. • Provide mechanism to monitor and track patients under care in home quarantine.
Implement response plans and adjust as necessary.	Procedures to ensure management objective and operational info inform the planning cycle.

Each facility will establish workflows that create two zone types: one for outpatient and inpatient zones for suspected and confirmed COVID-19 cases and another for standard health care cases. The “two zone approach” allows every VAMC to establish separate solutions to safely care for Veterans with COVID-19 while continuing to provide care for Veterans in need of standard VA facility-based health care. Separate locations for these two populations allow for the creation of secured areas, implementation of appropriate infection control practices, and deployment of staffing models to limit risk to Veterans and staff.

Triage: VA will deploy various tools to prompt Veterans to call VA before visiting a VA facility while sick. Some of the tools will provide extensive triage capabilities (e.g., Call Centers) while other will be self-reported answers to standard questions (e.g., check-in kiosks). The table below highlights Veteran touchpoints and strategies. Virtual and in-person triage strategies are presented below.

Table 5: Phase 3 – Virtual and In-person Triage Strategies

Veteran VA Interface										
Strategy	Web	VA APP	Online Appt. Mgt.	MyHealth -eVet	Nat. Call Center	VISN/ Facility Phone	Scheduled Visit Virtual	Scheduled Visit Physical	Facility Drop in	In-house
Provide education on COVID-19	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Remind to call before going to any health care site	✓	✓	✓	✓	✓	✓				
Provide self-screening tool	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Provide education on isolation and quarantine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Link “If you have these symptoms” to actionable path	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pathway for Veteran to move within physical space	✓		✓	✓	✓	✓	✓	✓	✓	✓
Set expectations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Isolation, Quarantine and monitoring	✓	✓		✓	✓	✓	✓			

Virtual: Veterans and staff will be directed to “call first” when they have symptoms of a cold or flu before traveling into a VA facility. For Veterans, VA call centers (contract, VISN, facility) have scripted language and workflows to assess fever/symptoms and will conduct a warm handoff to trained clinical staff for additional triage over the telephone. Veterans with confirmed symptoms may be instructed to come to a VA facility for additional triage or may be asked to remain at home with VA providing virtual follow up (e.g., telehealth or telephone care). VA staff, volunteers and trainees will follow a similar process and notify their supervisor and/or occupational health before coming to work.

Patients triaged and without suspicion of COVID-19 infection who require urgent or emergency care will be directed to an area separate from the COVID evaluation area. Standard acute inpatient and ICU units will be also separate from those dedicated to COVID-19 care.

In-person: Patients who are referred to a facility by a call center or present at the facility will enter a local system designed to limit the exposure of other Veterans and VA staff to COVID-19. Veterans will be instructed by the call center or through local signage to use a limited number of designated entry points into the facility and to ask for a face mask when they enter the facility. COVID-19 triage stations are located close to these entrances and employees outfitted with appropriate PPE will screen all individuals for signs, symptoms, or epidemiological exposures that put them at high risk for COVID-19 infection. The possible outcomes of this triage are:

- Patient is sent home with or without instructions for self-care and self-quarantine or isolation as appropriate, for non-face-to-face medical evaluation, or to an alternate site of care; or
- Patient is directed to the standard urgent care or emergency department; or
- Patient is directed to the COVID emergency department.

Inpatient Care: The “two zone” plan applies to all inpatient areas and is designed to limit exposures to COVID-19 in the ICU and acute care areas, community living centers and VA rehabilitation programs. By shifting outpatient care from facility-based to virtual care for all Veterans, VA addresses potential risk through social distancing and isolation and quarantine of Veterans who have or are under investigation for COVID-19. VA facilities will be able to treat increasing numbers of Veterans with COVID-19 in a safe and high-quality environment due to these preparedness efforts.

The implementation of these principles will begin immediately through actions to address how Veterans will be triaged; to split facilities —both physically and functionally — into a “COVID-19 Hospital” encompassing COVID-19 ED/urgent care, hospitalization, and ICUs where patients suspected or confirmed to have COVID-19 would be housed and cared for, and a “Standard Hospital” for uninfected patients.

Standard Zone: The Standard Zone’s primary mission is the safe care for acute conditions in patients who do not have known COVID-19, symptoms of COVID-19, or high-risk exposure to COVID-19. All elective admissions should be cancelled to limit the risk of these Veterans entering the facility as well as to free up staff to provide care to either sicker standard patients or patients with COVID-19.

Employees should not cross-cover between COVID-19 and standard units. Traffic routes between units should be separate whenever possible. Employees and patients in the standard hospital must be screened periodically for signs or symptoms of COVID-19 infection and, if positive, immediately isolated and transferred to the COVID-19 hospital. In some instances, a standard unit (e.g., Medical/Surgical) should be converted to a COVID-19 unit based on suspected widespread exposure inside that unit (such as from an infected health care employee). Visitors should also be restricted and encouraged to use non-face-to-face methods to communicate with loved ones.

COVID-19 Zone: The COVID-19 Zone’s primary mission is the safe care of acutely ill confirmed or suspected COVID-19 patients or those with high-risk COVID-19 exposures, whether their condition relates to COVID-19 or not. The Medical Center will

dedicate complete areas for emergency/urgent care, acute care, and ICU care to COVID-19 hospitalized patients. These areas will limit COVID-19 exposure by staffing with dedicated personnel to minimize the number of individuals who become potentially exposed; restricting visitors and training activities; and minimizing patient movement. New areas capable of caring for COVID-19 patients may be found by:

- Decreasing elective admissions or procedures
- Shifting and consolidating standard patients in certain locations
- Discharging individuals not deemed at immediate need for hospitalization (such as patients in residential programs)
- Activating new (e.g., tents) or non-clinical areas

The air flow in these areas should be isolated from standard areas, and the air exhausted, or high-efficiency particulate air (HEPA)-filtered, prior to recirculation. Facilities will plan for cascading designation and activation of COVID-19 units, as necessary. The COVID-19 hospital will have dedicated ancillary services, such as radiology and phlebotomy. Employees working in the COVID-19 hospital need access to dedicated PPE, restrooms and break and call rooms. Medical care, infection control and environmental management will be done in accordance with CDC guidance. Mental health, medical and surgical specialty consultation should be conducted using non-face-to-face methods (e.g., telehealth, telephone and e-consults), when possible.

Outpatient Care: Ambulatory care areas include in-hospital primary care, mental health, specialty clinics, and Community Based Outpatient Clinics (CBOCs). The strategies for these areas are:

- Postpone routine and ‘non-urgent’ care of patients who do not have known COVID-19, symptoms of COVID-19, or high-risk exposure to COVID-19 or shift to Telehealth.
- Telehealth follow-up of Influenza-Like-Illness (ILI)/COVID-19 patients at home.
- Triage of patients with ILI for home isolation versus emergency evaluation for possible hospitalization.

Larger CBOCs will maintain point of entry triage for those patients that physically present at the facility. Facilities will need to determine how smaller CBOCs will function, including whether suspected COVID-19 patients will be seen at these locations. Clinics may also be closed, and staff directed to work from home or assist at other facility locations. Clinics should attempt to shift to an “all telehealth” mode, with phone, video and/or electronic communication to meet the immediate needs of ambulatory patients, with the exception of some “standard” urgent care (including primary and mental health). Patient Aligned Care Teams (PACT) and specialty clinics should use non-face-to-face methods to communicate with all their scheduled patients, and to respond to any urgent needs.

COVID-19 Outpatient Care: Veterans who are being tested for, and those who have been confirmed to have, COVID-19 infection should be assessed for at home quarantine or isolation⁶. The majority of persons with COVID-19 having asymptomatic disease or mild symptoms, limited inpatient resources should be reserved for those with severe disease or significant contraindications to at-home quarantine or isolation. At-home Veterans will be managed through telehealth with the potential use of mobile services, such as the Annie App – a VA service that sends automated text messages to Veterans to help them stay focused on their self-care and assist with follow up. Documenting recovery from COVID-19, including a series of negative laboratory tests, continues to evolve and will require adjustments to specimen collection routines. At-home patients requiring face-to-face visits should first be considered for Home Based Primary Care-type solutions or follow guidance above for triage and inpatient care.

Residential Populations: Special consideration is needed for residential populations at the medical center: nursing homes/hospice, mental health, rehabilitation, mental health rehabilitation treatment programs, spinal cord, and blind rehabilitation. Strategies to be considered include discharging some of these patients, temporarily closing some programs, or safely sequestering these patient populations, especially particularly vulnerable populations like nursing home residents. Facilities should provide an extra layer of entry restriction, infection control precautions and supply chain scrutiny. These areas should have limited or no visitors and careful monitoring of employees, both for symptoms and history of sick close contacts. Social distancing on the ward may be required to limit viral transmission within a care unit.

Phase 3 - Alternate Sites of Care

Phase 3 includes activities that focus on how VHA organizes with community partners to address overwhelming numbers of patients who need hospitalization. For COVID-19, this work included 4th Mission Assignments to assist states with decompressing hospitals and VHA staff and resources providing guidance, training and support to State Veteran homes and community nursing homes.

Trigger: This phase only occurs if VHA cannot meet the demands of the incident. This phase occurs when demand outpaces capability and alternate capabilities are needed. Phase 3 ends when capabilities are stabilized and can meet and maintain demand requirements.

Objective: Ensure VHA's ability to meet all Veterans' needs when demand outpaces capabilities and continue to protect Veterans and staff while responding to an outbreak of the COVID-19.

⁶ Isolation is used to separate ill persons who have a communicable disease from those who are healthy. Isolation restricts the movement of ill persons to help stop the spread of certain diseases. Quarantine is used to separate and restrict the movement of well persons who may have been exposed to a communicable disease to see if they become ill.

Table 6: Phase 3 - Strategies for Coordination with Community Partners

Strategies	Stabilization Targets
a. Activate identified alternate sites of care to meet demand	Alternate physical care site plans developed and ready to implement for VA medical centers. This includes alternate buildings as well as mobile field hospital capacities.
b. Implement activities and procedures to meet limited capabilities to include facilities, staff and supplies	Plans implemented to reduce or stop all routine care at a VA medical facility and provide for continuation of care of non-infected patients at other locations or through other mechanisms.
c. Be prepared to support local communities as possible	Plans developed and ready to implement regarding contingencies to support care of non-Veteran patients if required.
d. Be prepared to implement contingency planning for worst case scenario	Plans developed and ready to support alternate care standards of care for facilities operating with greatly reduced resources.

VHA will establish alternate sites of care should the health care system not be able to meet demands on care. The goal will be to ensure VHA maintains the capability to meet the Veterans' needs when demand outpaces capabilities. The strategies are:

- Activate identified alternate sites of care in accordance with the facility Emergency Operations Plan to meet surge demand (e.g., outlying ward or building, field hospital, site off VA campus).
- Implement activities and procedures to meet limited activities to include facilities, staff and supplies.
- Be prepared to support local communities under agreement to provide care.
- Be prepared to implement contingency planning for worst case scenario.
- Be prepared to move non-critical patients to alternative sites.

Activities should focus on expanding space within the COVID-19 hospital; identifying opportunities within each VISN for housing large numbers of Veterans; and/or, integrating with local, state and Federal partners to address overwhelming numbers of patients who need hospitalization. Some solutions require legal authority to purchase services or to provide services to non-Veterans.

Phase 4 - Extended Operations and Recovery

This phase begins when the public health authorities recognize that the outbreak is beginning to wane, and clinical operations are beginning to stabilize. It also includes activities designed to sustain the VHA health care system during extended periods of active virus transmission and intervals during which transmission slows. A couple of the top priorities to consider would be to prepare for a second wave, reinstate curtailed services during the surge phase, monitor the health and well-being of staff and rehabilitate (clean, service and renew) all rooms, equipment and resources utilized in VHA COVID-19 Response Plan

the response phase. On May 8, 2020, VHA released *Moving Forward Plan: Safe Care is our Mission*. This plan lays out the principles and steps to expanding non-COVID-19 services in a COVID-19 world. The steps align with the gating criteria established in the *White House Guidelines for Opening Up America Again*.⁷

Trigger: This phase begins with the ability to meet and maintain the long-term response capabilities needed to combat the COVID-19 outbreak. The phase may end with a return to usual job functions and scopes of practice or a new model of health care is required to support ongoing activities secondary to the HCI.

Objective: Maintain the highest standards of care for all Veterans, continue to protect Veterans and staff and return to normal/new normal operations.

Table 7: Phase 4- Strategies for VHA Health Care System Sustainment

Strategies	Stabilization Targets
a. Conduct sustained operations	Plans to measure and monitor availability of routine care at all VA medical facilities and mechanisms to deliver and source care for non-affected Veterans at alternate facilities.
b. Recover facilities, staff and equipment and return to normal operations	Plans implemented to support additional resource needs: <ul style="list-style-type: none"> • Staff augmentation plans to provide rest and recovery • Restock medical equipment • Mental health care for Veterans, employees and families • Communication strategies on returning of normal operations

The overall goal of Phase 4 is to maintain the highest standards of care for all Veterans, continue to protect Veterans and staff and return to normal operations. It is also to identify facility recovery needs and develop priority recovery processes to support a return to pre-incident operations or a new standard of normalcy for the provision of health care delivery. The organization will use its emergency operations plan to define its response to emergencies and recovery after the emergency has passed. Various aspects of a recovery effort could take place during an event or after an event.

Recovery strategies and actions are designed to help restore the systems that are critical to providing care, treatment and services in the most expeditious manner possible. Emergency operations plans are designed to provide optimum flexibility to restore critical services as soon as possible to meet community needs. Recovery strategies maintain a focus on continuity of operations.

The potential for a second wave is addressed in the *Moving Forward Plan* and does not fall under emergency preparedness. Importantly, the timing of a second wave could coincide with the US hurricane or influenza season. Preparations are underway to address those seasonal events led by the Office of Emergency Preparedness and the

⁷ <https://www.whitehouse.gov/openingamerica/>

National Center for Health Promotion and Disease Prevention, respectively.

Direction, Control and Coordination

The EMCC serves as the Multi Agency Coordination System (MACS) for VHA and coordinates with:

- All VA Administrations
- Federal, state and local agencies and offices
- Private sector partners and stakeholders
- Non-governmental organizations

VISN Level: Direction, control, and coordination activities at the VISN level will occur in the VISN Emergency Operations Center (EOC). The VISN will provide coordination as a regional level MACS and direction and control as an EOC for the VA facilities within its catchment area.

VAMC Level: Direction, control and coordination activities at the facility level will occur in the Hospital Command Center. The facility will assume tactical and operational control of all deployed response resources in response to an incident. Administrative control of resources will remain with the originating facility.

Program Offices: Direction, control and coordination activities at the VHA Program level will occur congruently with the EMCC. The Program Offices may have certain tactical and operational responsibilities, specific to their programs controlling, tracking, and deploying program specific resources to a VISN or facility in response to an incident. Administrative control of resources will remain with the originative Program conjunction with the requesting VISN/facilities.

Workgroups (Clinical Coordination Cells): Direction, control, coordination activities at the Clinical Coordination Cell (CCC) level will occur in concert with the EMCC. The CCCs represent an expansion of prior advisory Workgroups and will be formulated based on the scale and scope of the incident and the need from the VISN/field. The purpose of the CCCs is to develop specific COVID-19 guidance and focus on needs in four areas: Outpatient, Inpatient, Training and Telehealth.

Information Collections, Analysis and Dissemination

Essential Elements of Information (EEI) provide context, inform decision making and contribute to analysis. The baseline EEI's for the COVID-19 incident include, but are not limited to the following:

Table 8: Essential Elements of Information

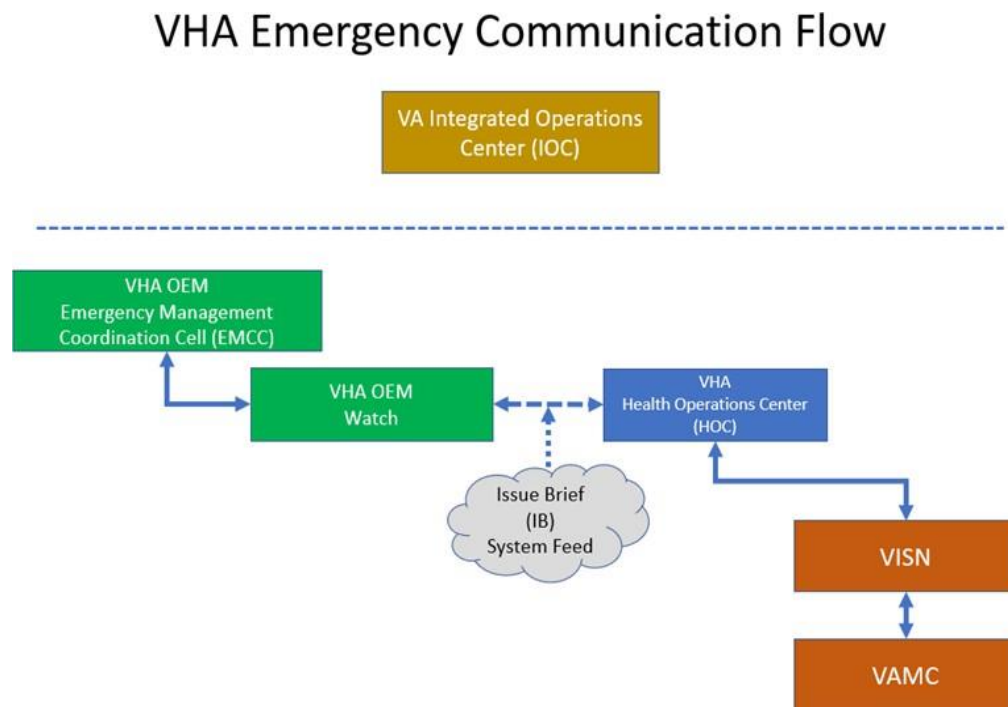
Component	Sub-Component	Essential Element of Information
Medical*	Hospitals	Number of COVID-19 patients seen and number of admissions. Number of COVID-19 isolation beds available/committed
	Dialysis	Status of dialysis services. If discontinued, number of patients impacted and actions to mitigate
	Pharmacies	When available, status of vaccination program – vaccinations available, given and shortfalls
	Home Care	Number of COVID-19 patients under home monitoring
	Community Based Outpatient Clinics (CBOC)	Operational Status of CBOC facilities, Veterans impacted if shut down, and continuation of service plan
	Readjustment Counseling Services (RCS)	Operational Status of RCS facility. Veterans impacted if shut down, and continuation of service plan including community outreach via mobile vet center deployments
	Long Term Care Facilities	Operational status of facility, number of COVID-19 admitted and facility shortfalls
	Telehealth	Number of COVID-19 calls and limitations in availability
Patient Movement	Emergency Medical Services	Status of facility emergency services department, and limitations/shortfalls
	Transportation	Patient transportation needs, availability of resources, shortfalls/unmet needs and special transportation needs
Epidemiological Surveillance	Laboratory	Availability of COVID-19 testing, number of cases tested and shortfalls in testing resources
Facility Management	Security	Status of security operations, limitations and special needs
	Human Capital	Status of personnel resources, shortfalls and unmet needs
	Mortuary	Number of COVID-19 fatalities and resource shortfalls
Medical Supply Chain	Personal Protective Equipment	Status of PPE (masks, isolation gowns, etc.), resource shortfalls and unmet needs
	Veterans Canteen Services	Status of VCS services, resource shortfalls, unmet needs and special considerations

Medical applies to the provision of sub-component activities at VA facilities or through Community Care contracts and arrangement.

The VHA OEM Watch (Watch) will be responsible for collecting, analyzing, and disseminating information regarding the disease outbreak. Information shall be formatted and shared in a manner most easily used by stakeholders and customers.

Information flow will travel from the facility Hospital Command Center (HCC) to the VISN EOC and finally through the National Healthcare Operations Center (HOC). The Watch will continuously monitor the inbound information sent to the HOC, and coordinate with the HOC to monitor and ensure all incident specific information is communicated to the EMCC Planning Section Situational Unit through the Issue Brief (IB) process (see Figure 2: VHA Emergency Communication).

Figure 2: VHA Emergency Communication



Issue Briefs

Issue Briefs (IBs) are short summary briefs of knowledge on topics specified by critical information requirements. The knowledge base of an IB consists of Essential Elements of Information (EEIs) surrounding the specifics of the event or incident. The typical EEIs of an HCI event disease outbreak are listed on the page above. IBs are created and transmitted via the Issue Brief Tracker Web Application (The Tracker). This System is owned by the VHA Healthcare Operations Center (HOC) and monitored by the VHA Watch. Typically, IBs are produced at the facility or VISN level, although a VHA Program Office could also create an IB. The Essential Elements of information (EEI) written on the IB are tracked, monitored and briefed to VHA leadership and the IOC. The IB reporting requirement may need to be modified during the HCI event to improve

granularity, standardize reporting, and decrease burden of reporting. For example, with COVID-19, the initial process was to file an IB for each new positive case of COVID-19 disease. This level of reporting became overburdensome when the local rate of infection required 10 or more IBs per day.

Situational Reports

A Situation Report (SitRep) provides a brief update on an event to make certain that VHA leadership is informed of the details of an HCI event. The SitRep gives details containing facts and verified information to give a Common Operating Picture (COP) of the “who, what, when, where, why and how” regarding the current HCI event.

Information is captured at the facility level, usually by the Emergency Manager and the HCC, and then reported to the VISN, with a courtesy copy often sent to the Office of Emergency Management. At the VISN level, the Incident Management Team, and its Emergency Program Coordinator (EPC) will collect, collate, review and combine (if a multiple facility event) SitReps and report up to the EMCC.

Additionally, the EMCC maintains situational awareness in the field through the Area Emergency Managers (AEMs) in the affected areas. When the AEM is not deployed for the HCI event and is embedded within the VISN EOC Incident Management Team, the AEM can capture information at the VISN level and coordinate reporting through the Regional Emergency Manager (REM) to the EMCC Planning Section.

Communications

Communication protocols and coordination during a disease outbreak will follow established procedures, with exceptions put into place to implement social distancing and minimize face-to-face contact. Communications at the VHA, VISN and VAMC levels will integrate into the appropriate governmental level Joint Information System (JIS).

There are two functional areas within the EMCC which focus on communications: 1) the VHA OEM Watch and 2) the EMCC Public Affairs Officer (in conjunction with the Communications Subject Matter Experts).

VHA OEM Watch

The Watch serves as the lead entity in the EMCC for risk and situational awareness communications by creating storyboards each evening. A storyboard is a sequence PowerPoint(s) representing the current COVID-19 situation as it is laid out in a pre-illustrative manner. Storyboards are briefed by the Watch to VHA leadership during the HOC morning coordination call.

The EMCC will coordinate two-way communication with program offices, VISNs and VAMCs, and other partnering agencies via conference calls and video conferences throughout the duration of COVID-19. The Watch is available 24 hours per day, 7 days a week.

The EMCC Public Information Officer (PIO) & Communications Subject Matter Experts

The EMCC PIO and the Communications Subject Matter Experts develop messaging and the distribution of communications and public education material regarding the COVID-19 incident to VHA Program Offices, VISNs and facilities. The EMCC PIO will coordinate with other interagency and program office's PIOs to ensure the consistency of communications and education messaging regarding COVID-19.

Health and medical Veteran information messaging will be coordinated among VHA health care partners through a Joint Information System.

Communication Approval and Dissemination

Unified Command serves as the lead approving entity within VHA for COVID-19 risk messaging to staff and Veteran messaging to VHA Veteran constituents. The Unified Command for VHA's COVID-19 response consist of two lead agencies, Population Health and Office of Emergency Management. The directors comprise the Unified Command and are appointed to approve and/or disapprove of all outbound messaging relating to COVID-19. Communications staff are embedded in each clinical team to maintain "on-voice" in all products and to ensure that a COMMs plan is in place when new guidance is released to the field.

Currently, there are several points of distribution for information upon approval from Unified Command, which include:

- **HCI SharePoint:** A central hub which EMCC and Clinical Coordination Cells can make available approved informative documents, guides, AUSHO correspondence with the Field and other related COVID-19 materials for use of VA staff.
- **PIO/Communication Subject Matter Experts:** The Communication Subject Matter Experts develop information and educational materials in a "one-voice" method to disseminate to Veterans and staff concerning COVID-19. This process can be distributed through email, video or telephone conferences.

Administration, Finance and Logistics

Administration, Finance and Logistics support requirements will be accomplished through the appropriate level of coordination or command center (EMCC, VISN EOC, VAMC HCC). Multi-agency agreements will generally be coordinated and executed at the EMCC or VISN EOC levels. In addition, there are specific requirements for tracking expenditures for 4th Mission Assignments. (Additional details are contained in the finance and logistics appendixes of this plan)

Plans Development and Maintenance

This plan is an incident-specific annex to the VHA HCI Base Plan. This annex and associated appendices plan shall be reviewed and revised on the same periodic schedule as the HCI Base Plan.

Key Information Sources and References

Information Sources:

- VHA nCoV Web Site: <https://www.publichealth.va.gov/n-coronavirus/index.asp>
- VHA Directive 0320.02, Veterans Health Administration Health Care Continuity Program. Available upon request.
- CDC Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States: https://www.cdc.gov/flu/pandemic-resources/pdf/community_mitigation-sm.pdf
- CDC Community Mitigation Guidelines to Prevent Pandemic Influenza - United States: <https://www.cdc.gov/media/dpk/cdc-24-7/preventing-pandemic-influenza/community-mitigation-guidelines-for-preventing-pandemic-flu.html>
- NETEC 2019 nCoV Repository: <https://repository.netecweb.org/>
- ASPR TRACIE, Infectious Disease Topic Collection: <https://asprtracie.hhs.gov/infectious-disease>
- VHA Directive 1047: All-Hazards Emergency Cache. Available upon request

References:

- Executive Order, Advancing the Global Health Security Agenda to Achieve a World Safe and Secure from Infectious Disease Threats, November 2016
- Institute of Medicine, Crisis Standards of Care, A System's Framework for Catastrophic Disaster Response, 2012. Available at: <https://www.nap.edu/catalog/13351/crisis-standards-of-care-a-systems-framework-for-catastrophic-disaster>
- Presidential Policy Directive-2 (PPD-2) Implementing National Strategy for Countering Biological Threats, November 2009.

Federal Emergency Management Agency, Biological Incident Annex, January 2017.
VHA National Center for Ethics in Health Care, "Meeting the Challenge of Pandemic Influenza: Ethical Guidance for Leaders & Health Care Professionals in the Veterans Health Administration," July 2010; Ethical Issues in Ebola Virus Disease Preparedness and Response, November 2014. Available at: <https://www.ethics.va.gov/policy.asp>.



Appendix A – Patient Screening and Treatment

Purpose

The purpose of this document is to outline best practices for screening and triage of suspected COVID-19 patients or Persons Under Investigation (PUIs). The overarching goal is quick recognition of possible COVID-19 cases in order to:

- Appropriately triage and care for patients with COVID-19.
- Appropriately triage and care for patients who are not infected with COVID-19.
- Minimize interactions between infected and uninfected persons.

Scope

Triage: Entails the entire process of clinical screening and efficient and appropriate determination as to whether a patient requires hospitalization or can be cared for at home with monitoring.

Screening: Includes assessment for clinical signs, symptoms and exposure history concerning for COVID-19 infection. Focus of screening should be on quick recognition and isolation of potential cases, with appropriate use of Personal Protective Equipment and Infection Control practices and protection of uninfected patients, staff and others from those who may be infected.

Triage and screening require either physical or virtual interaction. The triage and screening process include both in-person and virtual options.

Screening should occur not only for patients, but also for staff, contractors and all others entering VA facilities. Non-essential visitors should not be permitted in VA facilities. Non-essential visitors are persons whose physical presence is not necessary for provision of medical care.

Visitors whose presence *is deemed necessary by hospital staff* for provision of care should also undergo screening.

Virtual screening and virtual care will be utilized as first line care whenever possible to minimize exposure of Veterans, visitors and staff to respiratory pathogens including COVID-19.

Within VA: Physical Entry into VA facilities should be limited, controlled and monitored. Screening, triage and evaluation of Veterans and staff will take place in multiple sites across VA:

- Virtual triage, including:
 - Clinical Contact Call Centers

- Telephone care appointments
- VA video connect telehealth care or other virtual modalities
- Secure messaging
- Emergency Department
- Clinics, including primary care, mental health, geriatrics, specialty and surgical care
- Inpatient Areas
- Home Based Primary Care
- Other VA care sites that are separate from medical centers

Outside of VA: Non-VA Partners should be encouraged to call VA to assist in further triage and evaluation of Veterans, as many patients will be appropriate for virtual care rather than emergency or in-person care. Screening and triage of Veterans and staff will also take place in sites outside of VA:

- Local public health authority
- Residential facilities, such as nursing homes and inpatient substance abuse programs.
- Non-VA clinics
- Non-VA hospitals
- Non-VA dialysis centers
- Other sites providing Non-VA care

If a Veteran is transferred from a non-VA site to a VA site of care, whether in-person or virtual, triage and screening should be repeated.

Planning Assumptions

Clinical Operations other than emergency and inpatient services will have shifted to primarily virtual/telehealth modalities. Clinics may still be operating on a limited basis for face-to-face needs, so will need ability to triage patients appropriately to determine whether they have respiratory illness potentially concerning for COVID-19, and whether they require emergency vs home care.

At some sites, essential outpatient clinical operations, such as hemodialysis, infusions and chemotherapy, will need to continue.

Key Assumptions:

- Efficient and sustained person-to-person global transmission is documented by authoritative U.S. and international scientists signaling a pandemic that will affect VA and trigger utilization of this strategy.
- Susceptibility to the virus may be universal in wave one. Future waves can expect some population immunity.

Concept of Operations

In-Person Triage and Screening

In-Person Triage and Screening – Physical Entry Points

All staff and patients who physically present to the Medical Center will be admitted through limited triage stations set up at designated entry point(s). Best practices, locations and number of triage points will vary based on capacity, size, layout and other individual facility needs and constraints, but all entry into facilities should be monitored.

- Where possible, these should include separate entrances for patients requiring emergency evaluation, staff members and patients presenting for nonemergent (scheduled) face-to-face outpatient needs.
- In facilities where provision of chemotherapy, infusion of immunosuppressive agents, or dialysis occurs, consider separate entry points for these patients away from entry for emergency patients. Triage and standardized questions should still take place prior to entry.
- All entry points should be manned, and there should be no entry into the hospital outside of these checkpoints. Nonessential visitors should not be allowed.
- The emergency triage checkpoint should be located as close as possible to the Emergency Department (ED) and to parking to minimize crossing of infected patients through hospital common areas. If the ED and parking are distant from one another, a dedicated hallway or path should be used to get from parking to ED, and this should not be used for patients presenting for scheduled outpatient needs.
- Individual sites should consider best practices based on facility needs or constraints. Sites are encouraged to share best practices with the EMCC.
- Should consider rotating staff manning screening sites on and off screening assignments to avoid fatigue and burn-out.

In-Person Preliminary Triage and Screening: Emergency Care Entry

At the pre-emergency triage checkpoint, staff (outfitted with appropriate PPE for COVID19 per CDC guidance: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>) should screen all individuals to determine whether virtual care may be appropriate, or if there is need for emergency, in-person, evaluation. If there is need for emergency care, individuals should be screened for signs, symptoms, or epidemiological exposures that put them at high risk for COVID-19 infection to determine whether they should receive emergency evaluation in the COVID-19 or Standard zone.

The following questions are **suggestions** for preliminary triage to emergency versus virtual care. It is recommended that questions be updated as knowledge of the virus changes, and based on local patterns of disease spread:

Preliminary Triage: Checkpoint staff ascertains whether Veteran needs acute or in-person care. **Potential questions include:**

- Do you need emergency care?
- Do you need to be seen by a medical provider?
- Are you able to care for yourself at home?
- Are you having difficulty breathing?
- Are you having chest pain or pressure, weakness, or other symptoms that worry you?
- If well, patient is offered option for virtual care and is provided access instructions. If not well or requesting an in-person evaluation, proceed with preliminary screening.
 - Per CDC, consider adding physical temp check.
 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

CDC “Screen everyone (patients, HCP, visitors) entering the healthcare facility for [symptoms](#) consistent with COVID-19 or exposure to others with SARS-CoV-2 infection and ensure they are practicing source control.

- Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature $\geq 100.0^{\circ}\text{F}$ or subjective fever.
- Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection.”

The following questions are **suggestions** for preliminary screening to determine whether a patient needing emergency services should be evaluated in the COVID-19 or Standard area. **Questions should change as the course of the pandemic evolves, based on knowledge of the virus and patterns of spread:**

Preliminary Screening:

- Are you having fever, cough, shortness of breath, cold or flu-like symptoms, new nausea, vomiting, or diarrhea, or loss of taste or smell?
 - If yes, mask patient and escort to COVID-19 triage area for further care. Patients, visitors and staff should be masked per policy regardless of symptoms.
 - Consider use of a sticker or other marker to designate area of triage.
 - If no, do you have a recent close contact with someone with COVID-19, travel to, or residence in, an area where COVID-19 is spreading in the community?
 - If positive screen, mask patient and escort to COVID-19 triage area for further care.
 - If no, escort to Standard area for further care.
 - *Note: exposure questions, and action based on response, may vary based on local prevalence. Positive screen actions should be reviewed and determined locally.*

- *Note: Screening should follow CDC Guidelines*
<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

In-Person Clinical Triage and Screening: Emergency Care Areas

Clinical triage and screening occur after the preliminary triage and screening at the emergency entry checkpoint. The purpose of the preliminary triage and screening is to determine whether the patient may be appropriate for virtual care and, if not, whether they should be evaluated in the COVID-19 or Standard area. The purpose of clinical triage and screening is to assess patients who need in-person care clinically, in order to provide appropriate medical care.

This evaluation should be per the clinical team and per CDC guidance. Personal protective equipment requirements for staff conducting the screening and those performing sample collection should follow CDC guidance.

- Veterans with respiratory symptoms and/or fever are clinically evaluated and cared for in the COVID-19 Emergency area.
 - If decision is made to admit, consider re-screening to determine admission to COVID-19 versus Standard area.
- Veterans without respiratory symptoms and/or fever are clinically evaluated and cared for in the Standard Emergency area.
 - If decision is made to admit, a careful exposure history should be obtained to ensure that the Veteran is at low risk for subclinical or asymptomatic infection with COVID-19.

In-Person Initial Triage and Screening: High-Risk Outpatient Care Entry

High risk outpatient care entry sites should be the intake point for ongoing outpatient needs of patients at high risk for complications of COVID-19, particularly those requiring hemodialysis, chemotherapy, or immunomodulating infusions.

- When possible, site should be geographically separate from the area in which outpatients with COVID-19 infection will receive care.
- When possible, site should have one or more rooms with a closed door proximate to the entry point for second tier triage and screening of persons with concerning symptoms or exposure.

The following questions are **suggestions** for preliminary triage in areas serving patients at high risk of complications from COVID-19 infection. ***Questions should change as the course of the pandemic evolves, based on knowledge of the virus and patterns of spread:***

Preliminary Triage:

- Questions: Are you feeling sick or unwell? Are you able to take care of yourself right now? Are you having trouble breathing? Do you have other symptoms that worry you or that you need evaluated or looked at?

Preliminary Screening:

- Questions: Have you had fever, cough, cold or flu symptoms, new onset nausea, vomiting, or diarrhea, or new loss of taste or smell?
<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>
- Have you had recent contact with someone with COVID-19? Have you recently traveled to, or do you reside in, an area where COVID-19 has been spreading in the community?
Is anyone in your home sick?
- Physical: Assess temperature. Is the patient coughing, sweaty, appearing ill?
 - If any positives on triage and screening, bring to separate area, ideally a room with closed door, for secondary clinical screening.
 - *Note: exposure questions, and action based on response, may vary based on local prevalence.*

In-Person Initial Triage and Screening: Staff

Consider a designated entry for staff. Staff do not need medical triage but should be asked screening questions and temperature should be checked daily. Alternative options for completing the screening, such as two-way-texting, or a written set of questions to be filled out by staff prior to each shift, can be considered for screening of staff prior to physical arrival; but all staff should be screened daily prior to entry to the facility. Employees should be encouraged and reminded regularly to stay home if they have any symptoms of illness. **The following are suggested processes. Questions and processes should change as the course of the pandemic evolves, based on knowledge of the virus and patterns of spread:**

The following are best practices that some facilities are utilizing, but are not required:

- Consider a sticker or marker to indicate persons that have passed through appropriate screening.
- Consider virtual or pre-arrival options for answering pre-determined questions for staff.
- Consider staggering usual tour times to minimize bottlenecks and consider starting work and clinical duties 30 minutes after start of tour to allow for screening and entry time.

Screening Questions: Have you had fever, cough, shortness of breath, cold or flu-like symptoms? Have you had recent contact with someone with COVID-19? Have you recently traveled to, or do you reside in, an area where COVID-19 has been spreading in the community? (Note: The CDC is the source for screening questions. Questions will be updated to reflect changes published by the CDC. Current information can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>)

Is anyone in your home sick?

Physical: Assess temperature.

In-Person Initial Triage and Screening: Visitors

In general, visitors should not be allowed unless their in-person presence is necessary for care of a patient. If their presence is necessary, they do not require medical triage, but do require screening questions prior to entry. Again, consider use of a sticker or marker to indicate persons who have passed through appropriate screening. Encourage visitors who are not necessary for care for a patient to contact the patient via phone, email or other virtual means. **The following are suggested processes. Questions and processes should change as the course of the pandemic evolves, based on knowledge of the virus and patterns of spread:**

Screening Questions: Have you had fever, cough, cold or flu-like symptoms? Have you had recent contact with someone with COVID-19? Have you recently travelled to, or do you reside in, an area where COVID-19 has been spreading in the community? Is anyone in your home sick?

Physical: Assess temperature. Is the visitor coughing, sweaty, appearing ill?

Virtual Triage and Screening

Virtual Triage and screening will be via phone, telehealth, secure email messaging, texting or other non-face-to-face communication. The goal is to determine whether the patient needs emergency care and, if not, to provide a plan for provision of virtual care.

Minimize the need for in-person screening by screening for signs of respiratory illness and exposure to COVID-19 using standardized screening questions / scripting in all administrative call centers and Clinical Contact Centers (CCC). Administrative call center screening scripting includes defined escalation triggers and hand-off processes for positive screens. **The following are suggested processes. Questions and processes should change as the course of the pandemic evolves, based on knowledge of the virus and patterns of spread:**

Virtual Triage and Screening via RN

- **Triage:** Nurse will assess severity of illness and for red flags that indicate likely or potential need for hospitalization.
- **Screening:** Nurse will screen for respiratory symptoms, fever, or other symptoms of COVID-19.
- **Potential Outcomes:**
 - Patient has severe illness or red flags
 - Triage to Emergency Care **and call ahead**
 - Patient can manage at home, has no red flags and:
 - No respiratory, cold, flu-like symptoms, fever, or other symptoms of COVID-19
 - Provide Virtual Care (RN triage)

- Arrange for initial virtual visit with provider, such as primary care, if indicated
 - Respiratory symptoms, fever, or other symptoms suggesting COVID-19
- Provide Virtual Care (RN triage)
- Advise on home isolation and provide instructions including:
 - How to protect self and household members
 - When to call if symptoms worsen
- Arrange for initial virtual visit with provider, such as primary care, if indicated

Consider home isolation self-monitoring protocols, such as “Annie”, home telehealth COVID-19 protocol. Consider whether a VA loaned tablet is needed. Consider use of tools similar to the CDC CARE (Check and Report Every Day) booklet to assist patients in monitoring symptoms (please note this is designed for persons on quarantine, rather than isolation):

https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19_CAREKit_ENG.pdf
- Arrange for ongoing virtual follow up to extend through expected course of illness, and in particular, to assess symptoms in the second week, when illness may be severe.

Virtual Triage and Assessment via primary care provider

- **Triage:** Provider will assess severity of illness and for red flags that indicate likely or potential need for hospitalization.
- **Assessment:** Provider will screen for respiratory symptoms, fever, or other symptoms of COVID-19.
- **Potential Outcomes:**
 - Patient has severe illness or red flags
 - Refer to Emergency Care **and call ahead**
 - Patient can manage at home, has no red flags and:
 - No respiratory, cold, flu-like symptoms, fever, or other symptoms of COVID-19
 - Provide Virtual Care Visit (e.g., RN triage, PCP)
 - Respiratory symptoms, fever, or other symptoms suggesting COVID-19
 - Provide Virtual Care Visit (e.g., RN triage, PCP)
 - Assess for possibility of influenza, consider test or treat
 - Assess for possibility of COVID-19, consider test
 - Advise on home isolation, provide instructions including
 - How to protect self and household members
 - When to call if symptoms worsen

- Consider home isolation self-monitoring protocols, such as “Annie”, home telehealth COVID-19 protocol. Consider whether a VA loaned tablet is needed. Consider use of tools similar to the CDC CARE (Check and Report Every Day) booklet to assist patients in monitoring symptoms (please note this is designed for persons on quarantine, rather than isolation):
https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19_CAREKit_ENG.pdf
- Arrange for ongoing virtual follow up to extend through expected course of illness, and in particular to assess symptoms in the second week, when illness may be severe.

Virtual Triage and Assessment via Specialty Provider

- **Triage:** Provider will assess severity of illness and for red flags that indicate likely or potential need for hospitalization.
- **Assessment:** Provider will screen for respiratory symptoms and fever, or other symptoms of COVID-19.
- **Potential Outcomes:**
 - Patient has severe illness or red flags
 - Triage to Emergency Care **and call ahead**
 - Patient can manage at home, *has no red flags* and:
 - No respiratory symptoms, fever, or other symptoms of COVID-19.
 - Provide Virtual Care
 - Arrange for initial virtual visit with provider, such as primary care, if indicated
 - Respiratory symptoms, fever, or other symptoms suggesting COVID-19
 - Provide Virtual Care (e.g., Registered Nurse [RN] triage, Primary Care Physician [PCP])
 - Assess for possibility of influenza, consider test or treat
 - Assess for possibility of COVID-19, consider test
 - Advise on home isolation, provide instructions including:
 - How to protect self and household members
 - When to call if symptoms worsen
 - Arrange for initial virtual visit with provider, such as primary care, if

indicated

Virtual Triage and Assessment via electronic interface

- **Triage:** Automated questions and responses will assess for difficulty breathing, symptoms worrisome to the patient, or difficulty managing at home.
- **Assessment:** Automated questions will assess for fever, cough, cold, flu-like symptoms, or other symptoms of COVID-19.
- **Potential Outcomes:**
 - Shortness of breath, difficulty managing, or other concern
 - Call from health care/virtual care provider
 - No concern
 - Continued automated virtual monitoring

Environmental Services

Triage areas will need regular cleaning per CDC guidance. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in health care settings, including those patient-care areas in which aerosol-generating procedures are performed.


<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>)

If a person screens positive for respiratory symptoms or COVID-19 exposure in the entry for high-risk patients (dialysis, infusion, chemotherapy), that area should undergo additional cleaning before additional patients are screened.

Organization and Assignment of Responsibilities

Planning for patient screening and treatment requires a multidisciplinary team to address the continuum of patient assistance and care surrounding a medical visit. Small rapid response teams were assembled with program office staff and facility-based SMEs to quickly address patient triage and health care system workflows. These teams developed recommendations to VHA senior leadership for decision. Approved recommendations were then implemented across the enterprise through policy update and broad communications. Below is a list of rapid response teams for the initial phases of the response:

- Communications
- Diagnostics
- HR and Finance
- Infection control

- 
- Interagency and States
 - Isolation, Quarantine and Treatment
 - Surveillance
 - Veteran and Employee Triage

Communications

Veterans, staff and potential visitors will need communication on this plan. This should be done via all available channels including, but not limited to:

- Automated phone and text messaging
- Emails
- Secure messaging
- Posters and signs
- Mailings
- Recorded messages when calling in

Appendix B – Logistics

Purpose

To outline how Veterans Health Administration (VHA) Procurement & Logistics Office (P&LO) 10NA2 will support the directive of the President of the United States to the Secretary of Veterans Affairs (VA) to “do everything imaginable, as aggressively as possible, to help protect the 9.5 million Veterans who are part of the Department of Veterans Affairs.”

Scope

The P&LO Emergency Response Team (ERT) will conceive, develop and provide operational directives, tactical oversight, strategic plans and communications on behalf of the P&LO Executive Director to the Emergency Management Coordination Cell (EMCC) and VISN Chief Supply Chain Officers (CSCO) undertaking medical supply, equipment and procurement actions during the Coronavirus 2019 (COVID-19) National Emergency. All related organization, management, monitoring and reporting activities will be provided by the P&LO ERT to the P&LO Executive Director for approval and processing throughout the enterprise’s 18 Emergency Operations Centers established across the country over the past month.

Situation Overview

To ensure the planning environment remains organized, information provided must be unquestionable and properly analyzed. Efforts to expand unity of effort and Subject Matter Expertise (SME) related to supply, equipment, and procurement emergency preparedness and contingency medical assemblage management during this time of uncertainty is underway. An Emergency Operations Plan and Response Team is critical in order to keep control of the Personal Protective Equipment (PPE) and prophylactic materiel management performed to date; and as importantly, the anticipated and imminent requirements associated with Laboratory, Pathology, Mortuary, Transportation, Patient Flow and Holding reserves.

Planning Assumptions

- VHA human resource susceptibility and exposure will degrade the timelines and efficiency of response efforts.
- The COVID-19 pandemic will last 18 months or longer and could include multiple waves of illness, which will require an adaptable response.
- The spread and severity of COVID-19 will be especially difficult to forecast and characterize for an at-risk Veteran population over the age of 65.
- Increasing COVID-19 suspected or confirmed cases among VHA beneficiaries will result in increased hospitalizations, straining VA Medical Centers.
- States will request VHA assistance as the largest U.S. health care system when requirements exceed state, local, tribal and territorial (SLTT) capabilities to respond to COVID-19.
- Supply, equipment, procurement, and transportation impacts due to ongoing COVID-

19 outbreak will likely result in significant shortages for VHA, as well as other government, private sector and individual U.S. consumers.

- As the Federal response to COVID-19 evolves beyond a VHA medical response, Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) will be required to respond to the outbreak and secondary impacts, thereby increasing the need for VHA P&LO coordination to ensure a unified, complete and synchronized Agency response.

Concept of Operations (CONOP)

This P&LO CONOP identifies the VA Emergency Management Coordination Cell (EMCC) as the center of gravity for coordination to lead the VHA health response for the COVID-19 National Emergency. The Office of Operations, Plans, and Readiness (OPR) will execute P&LO responsibilities and provide additional support to the EMCC on request.

The P&LO COVID-19 response plan triggers will be adapted from the EMCC and harmonized with the phases of overall VHA, VA and U.S. Government Response to the 2019 Novel Coronavirus, dated February 11, 2020.

Tasks performed by position and organization:

- Office of Procurement: Administer the full range of emergency procurement services through the effective and innovative use of procurement policies, procedures, and processes to provide the best possible care to Veterans.
- Office of Logistics: Provide a full range of consumable supply, equipment, and contingency assemblage management services in support of VISN and VAMC operations.
- Regional Procurement Offices (RPO): RPO East, RPO Central, and RPO West, will ensure ready access, expert assistance and local knowledge throughout the COVID-19 National Emergency.

Direction, Control and Coordination

The framework for all direction, control, and coordination activities rests with the Office of OPR on behalf of the P&LO Executive Director. Tactical and operational control of response assets rests with the EMCC. Additionally, Direction, Control and Coordination is in coordination with Standard Operating Procedures.

Organization and Assignment of Responsibilities

VHA P&LO is organized into two functional business lines to address both the Procurement actions and activities and the Logistics activities to support emergency operations: 1) Procurement and 2) Logistics/Supply Chain.

Procurement

VHA Executive Director of Procurement: Provides oversight and high-level coordination of all VHA Contracting assets to address urgent and compelling procurement priorities.

- 3 VHA Regional Procurement Offices: Provide oversight and coordination between

the VHA's 18 Network Contracting Offices.

- Procurement Contracting Activity Central (PCAC): Procurement cell supports many national VHA requirements associated with COVID-19 in addition to routine customer support.
- Consolidated Mail Outpatient Pharmacy (CMOP) Contracting Office: Provides routine and emergency contract support to CMOPs and activities.

Logistics/Supply Chain

- Logistics Operations, Plans, & Readiness (Log OPR): Provides direct operational and readiness support to the EMCC.
- Medical Supply Program Office (MSPO): Commodities and Medical / Surgical Prime Vendor.
- Equipment Lifecycle Management (ELCM): Medical Equipment and Equipment Systems planning and management.
- Supply Chain Systems: Ensures continuity of logistics and supply chain system enablers.

Information Collections, Analysis and Dissemination

- COVID-19 updates, outbreaks, or pandemic response require short-notice VHA and are critical information requirements for P&LO.
- Responses must involve vertical and horizontal integration between VHACO, VISNs and VAMCs as well as interagency partners, Federal Emergency Management Agency (FEMA) officials and the private sector.
- Different VISNs are in different operational response phases depending upon the COVID-19 spread and illness severity in impacted communities.
- Critical supply, equipment and procurement resources need to be prioritized and directed to meet evolving demands and to maximize mission effectiveness.
- P&LO management should include prioritization and redirection of essential critical resources to meet evolving demands and to facilitate VHA mission effectiveness, Veteran health and safety.
- Clear and coordinated P&LO messages to key audiences are important to avoid confusion, prompt customizable support measures, minimize adverse impact to critical organization structure and continuity of operations and limit misinformation.

Communications

Communication protocols and coordination procedures used between P&LO ERT and EMCC are the single authoritative source and flow of information and activity. The framework for delivering communications support and how the jurisdiction's communications integrate is in accordance with EMCC Standard Operating Procedures.

Administration, Finance and Logistics

All in accordance with Standard Operating Procedures and Emergency Operations.

Authorities and References

1. Public Health Service Act, Pub L. No. 78-410, 58 Stat. 682 (1944)
(codified as amended at 42 U.S.C. et seq.; 42 U.S.C. §300hh-1 and 16)
2. Public Readiness and Emergency Preparedness Act, Pub. L. No. 109-148
(codified as amended in the Public Health Service Act at 42 U.S.C.-6d)
3. Economy Act, Pub. L. No. 73- 2 (1933) (codified as amended at 31 U.S.C. §1535)
4. Robert T. Stafford Disaster Relief and Emergency Assistance Act, Pub. L. No. 93 288 (as amended at 42 U.S.C. § § 5121-5207)
5. Presidential Policy Directive 44 (PPD 44), Enhancing Domestic Incident Response (2016)
6. Homeland Security Presidential Directive 5 (HSPD-5), Management of Domestic Incidents (2003)
7. Emergency Operations Standard Operating Procedures

Appendix C – Communications

Purpose

The purpose of this Annex of the EOP is to establish communication processes, procedures, materials and points of contact for field Public Affairs Officers (PAOs) or those acting in the capacity of field communications specialists regarding communications about the ongoing Coronavirus Disease 2019 (COVID-19) outbreak with staff, patients, volunteers and visitors at VHA care facilities and community stakeholders. These will guide field communications specialists as to the approved messaging, audiences and materials for communicating means of preventing infection, limiting disease spread and protecting the health of all persons passing through VHA-run locations, as well as to provide a clear chain of command and approval process for any unique communications needs that arise, inquiries from media, lawmakers, community partners, or other stakeholders and to maintain available information in an up-to-date and accessible form throughout these very fluid circumstances.

Scope

The scope of this plan includes all communications to staff, patients, volunteers, visitors and the general public. These communications are intended to inform, educate and reassure stakeholders of VA's readiness to respond during the outbreak.

Planning Assumptions

For purposes of this plan, it is assumed:

- Information about the ongoing COVID-19 outbreak will remain highly fluid;
- Conditions and instructions under which VHA staff will be operating may change often, with little notice and with significant operational and public health implications;
- Demand for, nature, and content of informational materials will be somewhat similar from location to location, allowing for standardized tools and procedures to provide manageable, consistent, coordinated and compliant communications (and obviating the need for each site to prepare their own materials);
- All communications that could reasonably be assumed to represent the organizational authority of VHA should be approved, coordinated and up to date to reflect the most recent available information and instructions, and as necessary messaging and materials may require review and modification by other Federal Government entities;
- Routinizing those communications functions that can be anticipated will allow personnel more resources to respond to unforeseen communications needs;
- Comprehensive, timely and accurate information can alleviate anxiety and protect public health.

Concept of Operations

The Emergency Management Coordination Cell (EMCC) communications subject matter experts (SMEs) assist the EMCC and CCCs to identify the disparate communications needs of Veterans and staff, help to monitor and explain CDC guidance for lay audiences, and develop communications resources for customization and distribution to field public affairs officers and leadership.

The communications strategy utilizes digital tools such as a Website and social media apps. To prepare for eventual decentralization of communications, a tool kit of templated materials was developed for use by facility public affairs officers and other communicators to maintain a single voice and a coordinated, unified message.

The tool kit is updated based on feedback from field communicators, VA and VHA leadership and other stakeholders. It contains guidance to the field, communications contacts, key messages, and both templated and sample communications tools, including press statements, signage, social media posts and blog posts.

A Joint Task Force was established to formalize the clearance process and enhanced tracking ability.

Organization and Assignment of Responsibilities

Organization	Responsibilities
EMCC Communications Subject Matter Experts	<ul style="list-style-type: none">• Monitor CDC guidance for impacts on communications.• Develop communications strategy and tools.• Discuss updates and needs with the EMCC and CCCs.• Clear responses to media queries.
Joint Task Force	<ul style="list-style-type: none">• Define strategic direction of communications.• Develop content for Veteran-, field-, external- and Congressional-facing communications.• Review and approve communications products.
VHA Communications	<ul style="list-style-type: none">• Coordinate and update calls with facility communicators as needed.• Communicate top-down guidance to workgroup and field communicators.• Assist in response to questions from the field, which help drive development of the tool kit.• Review and comment on field generated products and offer determinations of what constitutes operational communications.• Clear responses to media queries.
Patient Care Services Communications	<ul style="list-style-type: none">• Create and update web content.• Draft blogs and social media messaging.• Assist in response to questions from the field, which help drive development of the tool kit.

VA Office of Public and Intergovernmental Affairs (OPIA)	<ul style="list-style-type: none"> • Interface with the White House Coronavirus Task Force and obtain necessary approvals. • Monitor CDC press conferences and scope of the outbreak. • Communicate top-down guidance to workgroup and field communicators. • Interface with the media. • Review and approve communications products.
VISN and Field Public Affairs Officers	<ul style="list-style-type: none"> • Attend update calls as needed. • Work with facility leadership to respond to local communications needs. • Align communications with national messaging and obtain required approvals.

Direction, Control and Coordination

1. National media queries must be emailed to VHA Media Relations (VHACO10B2BMedia@va.gov) for coordination with and/or approval by VA OPIA. This guidance does not apply to national media outlets.
2. Facility directors are authorized to provide interviews with local media outlets regarding their COVID-19 response. All media interviews should be cleared by the Office of Public and Intergovernmental Affairs (OPIA) and interview participants should conduct media preparation with their local OPIA representative before conducting interviews.
3. Any Congressional queries must be coordinated with the Office of Congressional and Legislative Affairs (OCLA). The queries are being managed through the established "VHA COVID Comms" email group.
4. Any operational messages (patient and employee health and safety communications, facility instructions, signage, etc.) do not require VA or VHA approval. Help to determine operational communications is available through the VHA COVID Comms email group (vhacovidcomms@va.gov).
5. Operational examples include but are not limited to screening, Personal Protective Equipment (PPE), or any cancellations of activities due to COVID-19. Previously approved materials are approved for use unless they are updated or withdrawn.
6. All communications activities must comply with all standard operating procedures and official VA and VHA Policies to protect all Veterans' and patients' personal information, especially Protected Health Information (PHI), Protected Personal Information (PII) and any other confidential information as provided by law.
7. Offices that produce local communications (using pre-approved messaging and graphics) or devise useful communications techniques are encouraged to share these with the VHA COVID Comms email group (vhacovidcomms@va.gov) so that best practices can be disseminated.

Guidance for Local Interviews

- Take the opportunity to highlight your facility's successes.
- Do not speculate or discuss hypotheticals. Speak factually about topics that facility leadership can discuss with confidence.
- Focus on your facility's operations and your local situation.
 - Avoid debating or critiquing policies that are outside of your control.
 - Avoid political matters.
- If you do not know the answer to a question, it is OK to say so.

Recommended Talking Points (for localization)

- [Name of hospital] offers comprehensive COVID-19 screening and treatment services. When it comes to testing, we are taking samples on-site and getting them processed [insert name of lab].
- The facility is equipped with essential items and supplies to handle an influx of coronavirus cases and is following CDC and [local/state] Department of Health guidelines for testing and reporting.
- To minimize risk for employees and Veterans, everyone who enters the [Name of hospital] campus will be pre-screened. This may lengthen entry times, so patients are advised to allow for that when arriving for their appointments.

Veterans and staff are encouraged to take everyday preventive actions to avoid being exposed to the virus:

- Wash your hands often with soap and water for at least 20 seconds.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Stay home if you are sick or becoming sick.
- Use an alcohol-based hand sanitizer that contains at least 60% alcohol.
- If you have symptoms or have been exposed to someone with symptoms, call the VA before going to the facility.

More information for Veterans is here: <https://www.va.gov/coronavirus>

For more information about the Coronavirus, please visit: [CDC.gov](https://www.cdc.gov)

For Questions about VA's "Fourth Mission"

[Facility name] supports the Department's "[Fourth Mission](#)" to extend surge capabilities in civilian care when civilian health care systems encounter capacity issues.



Information Collections, Analysis and Dissemination

Emerging Threat Phase (pre-confirmed case within VA)

The EMCC communications Subject Matter Experts monitor the CDC website for updates about the scope and extent of the outbreak, guidance on communicating about the outbreak and the availability of public-facing communications tools. Additionally, VA social media feeds are monitored for public sentiments about the outbreak. This information informs the goals and objectives of the communications strategy and the tool kit tactics.

Realized Threat Phase (post-confirmed cases within VA)

The EMCC and VHA Communications monitor public sentiment about the outbreak, facility operations and readiness, CDC updates and operational changes.

Public sentiment is monitored through public comments and levels of engagement through social media (e.g., questions asked, comments on blogs). The CDC Website continues to be mined for changes in guidance with implications for communications and patient-facing resources that can be shared with VA communicators. The communications tool kit aggregates the latest guidance and communications resources into an easy-to-use, customizable format for VA communicators.

Appendix D – Points of Distribution

Purpose

The purpose of this section is to explain processes to dispense a medical countermeasure (MCM) cache via a point of dispensing (POD) at a VA facility. Although the goal of this is to provide prophylactic medication(s), the processes could also be employed to distribute supplies (e.g., Personal Protective Equipment [PPE]) to VA personnel, support staff, Federal partners and persons under the care and custody of VHA.

Scope

This appendix supports the High Consequence Infection (HCI) Base Plan along with the associated annexes and applies to all VHA Departments and stakeholders. It outlines details associated with the planning, preparedness and activation of a VHA POD in response to an HCI event.

Planning Assumptions

The following assumptions cover a wide range of potential medical situations:

- VHA Office of Emergency Management (OEM) Emergency Management Coordination Cell (EMCC) will assist in the activation of the POD planning and coordination efforts across the enterprise.
- The POD will be activated based on the medical emergency.
- Emergencies may require cooperation/coordination of internal and external departments, organizations and agencies.
- Normal suppliers may not be able to deliver goods depending on the situation.
- VHA facilities with identified PODs capability are trained and ready to respond to emergent situation(s).
- HHS will be the lead agency for all HCI events needing a POD activation and requests will funnel through HHS Secretary's Operation Center (SOC).

Concept of Operation

When a threat to public health is detected, VHA leadership meets and determines the need for activating POD operations. If activation is required, a command structure will be implemented to meet the unique needs of the incident through the EMCC.

For the COVID-19 response, medical countermeasures, supplies and equipment will be distributed and managed in one or more of the following ways:

- Directly distributed from Federal sources to their ultimate destination,
- From to a single location in the state and then distributed to their ultimate destination, and/or
- From a single location in the state, redistributed to regional or local distribution sites or staging areas, and then distributed to their ultimate destination.

A redistribution process will be utilized to ensure that materiel is appropriately disbursed when no longer needed at the original location.

VAMC local sites will be activated to dispense MCM; those local sites may use one or more following models:

- **Point of Dispensing (POD):** A temporary facility to provide MCM to many people in a short period of time.
- **Mass Clinics:** A temporary facility to provide MCM to large numbers of people over a longer period.
- **Health Care Facility:** Existing facilities that can provide MCM to their usual clientele.
- **Open POD:** Sites staffed and managed by organizations and agencies (both public and private) to dispense MCMs only to their own populations while continuing operations during a public health emergency.
- **Closed POD:** A private location where MCM are dispensed to a pre-identified population.
- **Drive-through POD:** Designated sites where MCM is provided to persons in their vehicles.
- Other models depending on circumstances.

Each of the above models may vary in configuration and resource needs. VAMC activities will be coordinated with or co-managed by the VHA Area Emergency Manager or the Regional Emergency Manager.

Hour	Milestone
0	A decision is made to implement response activity and SNS is requested.
2	If not already activated, the EMCC and other coordinating entities are activated.
4	POD sites are selected; SNS assets are enroute; POD staff are activated.
10	POD setup initiated; and a detailed Distribution Plan completed.
12	SNS medical assets arrive in state.
13	In-state transportation of assets initiated.
14	MCM dispensing campaign initiated.
17	Transportation of assets initiated.
48	Initial MCM distribution completed and sustainment begins.

Organization and Assignment of Responsibilities

VHA

- Provide medical material, technical support, financial support, situational information, priorities and guidance.

VHA EMCC

- Implements and enforces emergency directives.
- Processes VHA internal resource requests and requests for assistance from other states, agencies and jurisdictions.
- Establishes a Joint Information System (JIS) and a Joint Information Center (JIC).

VISN

- Activate and staff VISN's Emergency Operations Center (EOC) or other coordination center (Situation/Scale dependent).
- Represents the VISN in Local Emergency Operation Centers (LEOCs), if requested. Assumes responsibility for MCM operations or provides technical assistance for local POD operations.
- Carries out the objectives for MCM operations as outlined in an Incident Action Plan (IAP) developed by the VISN EOC.
- Coordinates and communicates with local, tribal and regional entities regarding operational issues.
- Assists in volunteer staffing management.
- Collects, consolidates and distributes information to maintain a common operating picture.
- Participates in JIS and a JIC.

VAMC

- Coordinates with local Incident Command Posts (ICPs) and/or the VISN EOC, VHA OEM EMCC, or State EOC for operational support.
- Supports POD operations.
Activates and manages local distribution sites or staging areas for VAMC MCM distribution (Facility specific).

Direction, Control and Coordination

The EMCC is the center of gravity for overarching communications and will make efforts to fit into existing VISN and VAMC command structures. The organizational model for the EMCC is the National Incident Management System (NIMS) along with the Incident Management System (ICS). NIMS/ICS is a model that can be adopted and adapted enterprise-wide to provide efficient and productive responses to the VISN and VHA facilities.

Information Collections, Analysis and Dissemination

Essential Elements of Information (EEI) provide context, inform decision making and contribute to analysis. The baseline EEI's for the POD activations include, but are not limited to, the following:

Component	Sub-Component	Essential Element of Information
Medical	Hospitals	Number of POD patients seen
	Pharmacies	When available, status of vaccination program - vaccinations available, given and shortfalls
Facility Management	Security	Status of security operations, limitations and special needs
	Human Capital	Status of personnel resources, shortfalls and unmet needs
Medical Supply Chain	Personal Protective Equipment	Status of PPE (masks, isolation gowns, etc.), resource shortfalls and unmet needs

The HOC, in conjunction with the VHA OEM Watch, will be responsible for collecting, analyzing and disseminating information regarding the process of dispensing.

Information shall be formatted and shared in a manner most easily used by stakeholders and customers.

Appendix E – Office of Information and Technology (OIT) Organization, Communications and Information

1. Situation

The primary goal of OIT's support to VHA COVID-19 response plan is to protect Veterans and staff from acquiring COVID-19 infection by leveraging technology and communications as well as using dedicated staff and space to care for COVID-19 patients. The Department of Veterans Affairs (VA) will create a safe environment by implementing a system where one VA facility operates as two separate "zones" (Standard and COVID-19) for inpatient care. VA will provide most outpatient care for Veterans through telework, telehealth and other remote services as appropriate. OIT will provide the equipment and services to enable these services to minimize the risk of infection, support expansion to meet an increasing need for COVID-19 services and provide Veterans consistent access to VA care. OIT's plan includes strategies to support alternative sites of care for Veterans with COVID-19.

1.a Threats, Vulnerabilities, Shortfalls, Limitations

- Specific types of equipment needed to support the changing business needs of VHA may be limited, especially in areas with significant outbreaks and demand. OIT has plans to mitigate these limitations, through expansion of available devices and utilization of alternative devices where possible.
- Installation of connectivity circuits to alternate locations of care identified by VHA has a lead time per existing contracts, even when requests are expedited. Alternative methods of connectivity can be established to mitigate this concern (Satellite, Cellular LTE, etc.). These alternatives may be deployed to support enhanced connectivity and/or continuity of support in a lesser capacity while longer-term, permanent telecommunications implementation methods are deployed.
- Increases in telework and other virtual technologies may result in additional demand on infrastructure and bandwidth available. Limitations could occur in these services. OIT has already expanded this capability and will further increase the expansion.
- Absenteeism due to illness of the employee or family member, similar to VHA's expectations, may limit the number of available staff to support the critical needs of VHA. Rosters of available staff have been developed in the local area to supplement existing staff should staff shortages occur and OIT will exploit special hiring authorities to hire additional resources (both FTEE and contractors) as required.
- OIT will onboard additional support personnel to process COVID-19 surge procurement and hiring requirements. No capability limitations for OIT Strategic Sourcing have been identified that will affect support to VHA. VA is leveraging the Federal community in support of VA's requirements to minimize any sourcing challenges, including Inter-Agency Agreements (IAA), General Services Administration rated order authority and/order-established strategic contracting vehicles.

1.b OIT Organization

For the purposes of responding to the requirements of COVID-19, OIT has task

organized along the following workstreams and lines of operation:

1.b.1 Telehealth: Expands the capacity of the VA Video Connect through addition of on-premise and Cloud capacity, removes single points of failure by adding redundant capabilities, increases the level of performance monitoring to allow for pro-active prevention of incidents, assesses and permits use of alternate video systems, implements screen lock software to allow use of video on locked systems, increases the flexibility of tablet use for telehealth, allows single provider access to multiple record systems (via WebVRAM) and expands the use of Tele-ICU carts through site wireless upgrades and additional cart deliveries.

1.b.2 Remote Access: Tests all Internet Access Gateways remote access capabilities and capacity and enhances readiness, augments equipment, routing, and security across the Enterprise to support an increase in bandwidth requirements and number of telework users. Provisions additional equipment to increase support and capabilities to a greater number of remote users.

1.b.3 Call Centers: Provides Tier 3 Support to Unified Communications Systems that include: Automated Call Distributor (ACD) support, Voice Mail services and Unified Contact Center Express (UCCX) and Contact Center Enterprise (UCCE) deployments across the VA Enterprise. Provides Enterprise-level real-time reporting on all Contact Centers supported on UCCX/UCCE for caller wait times, call drop rate and other calling metrics Facilitates PIV exemptions to allow access to VA's network when access to a PIV card is unavailable.

1.b.4 Information Technology Equipment: Provisions hardware and provides hands-on support across the enterprise, both at VA locations and at locations in the community where VA is establishing locations to provide care.

1.b.5 Information Security: Ensures the resiliency of VA's networks during COVID-19 to include proactive monitoring, vigilant protection against Advanced Persistent Threats, and advise on compliance with Federal requirements. Performs application vulnerability and risk assessments as requested and required for systems, applications, infrastructure and technologies supporting COVID-19. Provides increased visibility and protections against threats posed by new requirements. Supports improvements on the ability to report anomalies such as phishing. Responds to reports of known or suspected data breaches.

1.b.6 Strategic Sourcing: Provides the following capabilities: agency compliance of Federal Information Technology Acquisition Reform Act (FITARA) as it relates to VA procurement of IT and IT-related products; conducts vendor engagements for IT services and goods to include vendor ecosystems, contract auditing for IT procurements, and contracting officer representative training for OIT; serves as IT Acquisition Category Management (ACM) owners for OIT; refines requirements, develops acquisition packages for execution, assists in budget operating plan build and multi-year planning; identifies spending trends, execution reporting, coordinates unfunded requests, identifies IT strategic vehicles/options for VA; and assessment of internal supply chain for IT. POCs: ACMVAOSS005GCategoryManagement@va.gov; FITARA askstrategicsourcing@va.gov; Vendor Management ITVMO@va.gov.

1.b.7 Information Technology Resources: Gathers cost and capability requirements for OIT systems and VA programs supported by OIT to develop budgets; develops cost estimates for pay dollars to enable OIT surge hiring via term appointments for via contract capabilities; provides spend rate and obligations financial reports; and establishes IT financial tracking mechanisms for the system of record, Budget Tracking Tool. Provides executive agency-level interface with OMB and Congress to justify IT expenditures and costs. Drafts legislative proposals in concurrence with OMB for increased funding requests. Provides expanded financial authorities to increase purchasing thresholds for government purchase card. OIT Human Capital Management (HCM) provides expedited hiring and personnel services for OIT employees.

1.b.8 Software Management: Provides oversight, planning, development and deployment of software capabilities in direct and in-direct support of COVID-19 activities. Software Management manages OIT products/applications critical in supporting patient health, patient management, other aspects of patient care and VA operations in support of COVID-19 including collaboration across OIT and the Business Lines.

1.b.9 Customer Experience: Manages the Veteran-facing Content working group that supports VHA and VEO efforts and reports up to the COVID-19 Communications Joint Task Force. All Veteran-facing content related to COVID-19 goes through this approval chain and the Veteran Facing Content group developed and regularly updates the VA.gov COVID-19 FAQ page. This group also determines if/when to use the VEText messaging platform.

1.b.10 Leadership: Consists of key leadership: the Assistant Secretary of Information and Technology, the Executive-in-Charge of the OIT COVID-19 Response, the OIT COVID-19 Scrum Master, and OIT Pillar Leadership; OIT liaison functions: the OIT representative to the Integrated Operations Center (IOC), the OIT Account Management Office, and the End User Operations Area Managers; and the IT Strategic Communications division.

1.c Facts and Assumptions

1.c.1 Facts. OIT will:

- Fulfill its obligations as stated in the VA Essential Supporting Activities
- Support the safety and health of employees.
- Provide support for VHA alternate or field locations outside of established VA facilities (e.g. Plum Cases, VSAT, etc.).
- Increase bandwidth to meet increased demand across VA.
- Support increased telework requirements.
- Support increased telemedicine.
- Support increased demands for Video Teleconferencing.

- Provide specialized IT support (equipment, services and guidance) to meet customer requirements.
- Surge Service Desk Support to meet increased demand.
- Support increased provisioning for fixed and mobile IT equipment.
- Prioritize IT acquisitions to support COVID response.
- Support increased call center activity.
- Triage increased security and privacy risk associated when the relaxation of standard FISMA security and operating requirements is deemed acceptable for this pandemic.
- Continue to provide secure communications and protect the information security of the VA IT enterprise.
- Identify critical systems supporting VHA's COVID Response, ensure stability and availability and enhance when possible to meet the unique COVID requirements.
- Allocate staffing in alignment with VHA operational priorities.

1.c.2 Assumptions

- OIT will be a full member of VHA planning and operational efforts to ensure proactive and timely IT support.
- Certain OIT personnel will require Personal Protective Equipment to operate in high-risk environments.
- Expanded remote work by users unfamiliar with remotely accessing the VA network will require increased Enterprise Service Desk staffing and services.
- VA will require a sharp increase in fixed and mobile IT equipment and implementation of secure baseline configuration imaging.
- VA and the Federal Government will prioritize IT acquisitions to support COVID response.
- COVID-19 will create increased call center activity.
- Triage increased security and privacy risk associated when the relaxation of standard FISMA security and operating requirements is deemed acceptable for this pandemic.
- Additional hiring flexibilities will be available to support the COVID response
- Supplemental budget will be made available by Congress and the President to fund the requirements created by the COVID-19 circumstances.
- Potentially approximately 30% of the workforce could be unavailable due to illness or caring for sick family members.
- The event could last 18 months or longer and could include multiple waves of illness.
- Restrict patching of VistA to COVID-19, emergent or patient safety related items.
- Different phases may occur in different regions of the country or within the same

regions at the same time

- Definition of normal operations may change as the situation evolves.
- Resources required to mitigate identified risk may be scarce.
- Driving factors to reopen state functions may not align with Federal “gating criteria” to increase physical presence in Federal facilities.
- Geographically separated Federal entities’ implementation of “gating criteria” will vary due to local environmental considerations and associated risks.
- Active engagement with key stakeholders, including the unions, will occur throughout planning efforts at the national and local levels.
- There may be a “second wave” or seasonal outbreak of COVID-19 resulting in increased telework and telehealth requirements.

1.d Resource Availability/Limitations

If requests are made that exceed the supply of available IT resources, OIT will work through the OIT Office of Strategic Sourcing, Office of Procurement, Acquisition and Logistics to obtain needed resources. This process will utilize available logistics and supply chains and will be performed in close collaboration with the local VHA logistics team to ensure seamless, rapid delivery of required products. Refer to paragraph 1.B for specific contact information for additional requests. OIT is utilizing special hiring authorities and volunteer programs to surge IT support at critical areas requiring additional IT support.

1.e Planning Factors

1.e.1 Higher Level Mission

HHS is the Lead Federal Agency (LFA) and reports to the Office of the Vice President, the task force lead for the whole government response. HHS will take all necessary action to leverage U.S. Government (USG) resources to prepare for, respond to, and recover from COVID-19. VHA, in conjunction with VA, will coordinate activities with HHS to:

- Limit the spread of COVID-19 infection to Veterans and staff,
- Provide care for those infected with COVID-19,
- Provide continuity of care for non-infected Veterans and
- Provide resources to HHS in support of ESF mission assignment tasking, as requested.

1.e.2 VHA Mission

VHA will conduct all activities necessary to protect Veterans and staff from COVID-19 and ensure continuity of access to and delivery of health care services to Veterans as appropriate. Also, as defined in the Pandemic Crisis Action Plan (PanCAP) Adapted U.S. Government COVID-19 Response Plan (March 13, 2020), VHA will support U.S. Department of Health and Human Services (HHS) through Emergency Support Functions (ESFs) as requested. This response will be carried

out in accordance with the National Response Framework (NRF).

2. Mission

The Office of Information and Technology (OIT) provides Information Technology (IT) equipment, operations, services, Information Security (INFOSEC), policy guidance and specialized IT support to the Veterans Health Administration (VHA) in accordance with the COVID-19 Response Plan at locations prioritized by VHA for the duration of the pandemic while supporting the requirements of the other Administrations and Offices across VA.

3. Execution

3.a Operational Concept

OIT will integrate with VHA at all organizational levels to provide the necessary IT equipment, capabilities, operations and services to provide uninterrupted support to and meet the needs of VHA in COVID-19 response where and when required through all four phases of the VHA COVID-19 Response Plan. For the purposes of responding to the needs of COVID-19 response, OIT has tasked organized its COVID-19 responsibilities in the following functional teams:

- Telehealth (TH)
- Remote Access (RA)
- Call Centers (CC)
- Information Technology Equipment (E)
- Information Security (IS)
- Strategic Sourcing (SS)
- Information Technology Resources (R)
- Software Management (SM)
- Customer Experience (CX)
- Leadership (C4)

Refer to paragraph 3.B for specific tasks

Phase 1- Contingency Planning and Training

OIT must be prepared to support VHA's overall strategy for mitigating the impact of COVID-19 on Veterans, employees, visitors and the VHA health care delivery system. The overarching principles guiding VHA's strategy are:

- Protect patients not infected and employees from acquiring COVID-19 infection.
- Shift priorities, resources and standards of care to accommodate a large influx of infectious patients.
- Physically and functionally separate suspected or confirmed COVID-19 patients from individuals who have not been exposed to the virus.
- Use dedicated employees to care for COVID-19 patients.
- Leverage technology and communications to minimize exposure.
- Identify opportunities to deliver supportive care to large populations of patients, in coordination with community partners.

Trigger: Phase 1 is triggered during an outbreak outside of the US. This phase ends with the occurrence of an outbreak of COVID-19 in the US.

VHA Objective: Update plans, procedures, and techniques and conduct training to protect Veterans and staff in the event of an outbreak of the COVID-19.

OIT Objective: OIT will provide the necessary equipment, capabilities, operations, and services to provide uninterrupted support and meet the needs of VHA in COVID-19 response where and when required.

Phase 2- Initial Response

OIT must be prepared to support VHA's plan to mitigate COVID-19 outbreaks and provide continuous patient care in their areas. VHA's strategies include:

- Ensure situational awareness reporting procedures are in place.
- Ensure transparent communications across the enterprise.
- Receive and triage Veterans with suspected or confirmed COVID-19 infection.
- Provide acute and outpatient care for Veterans with COVID-19.
- Maintain care for Veterans without COVID-19 through telehealth services, a preferred delivery system, if possible.

Trigger: Phase 2 is triggered when there is an initial outbreak of COVID-19 in the US. This phase ends when either existing capability/supply chain cannot maintain levels to meet demand or when the response capabilities can meet and sustain the response operations indefinitely.

VHA Objective: Implement containment and mitigation actions to respond to local and/or regional outbreaks.

OIT Objective: OIT will provide the necessary equipment, capabilities, operations, and services to meet the needs of VHA in containing and mitigating the outbreak and providing uninterrupted patient care where and when required.

Phase 3- Alternate Sites of Care

Phase 3 includes activities that focus on how VHA organizes with community partners to address overwhelming numbers of patients who need hospitalization.

Trigger: This phase only occurs when/if VHA cannot meet the demands of the incident. This phase occurs when demand outpaces capability and alternate capabilities are needed. Phase 3 ends when capabilities are stabilized and can meet and maintain demand requirements.

VHA Objective: Ensure VHA's ability to meet all Veterans' needs when demand outpaces capabilities and continue to protect Veterans and staff while responding to an outbreak of the COVID-19.

OIT Objective: OIT will surge IT operations, equipment, capabilities, services and VHA COVID-19 Response Plan

support to the priority locations and areas identified by VHA as required.

VHA will establish alternate sites of care should the health care system not be able to meet demands on care. The goal will be to ensure VHA maintains the capability to meet the Veterans' need when demand outpaces capabilities. The strategies are:

- Activate identified alternate sites of care in accordance with the facility Emergency Operations Plan to meet surge demand (e.g., outlying ward or building, field hospital, site off VA campus).
- Implement activities and procedures to meet limited activities to include facilities, staff and supplies.
- Be prepared to support local communities under agreement to provide care.
- Be prepared to implement contingency planning for worst case scenario.
- Be prepared to move non-critical patients to alternative sites.

Activities should focus on expanding space within the COVID-19 hospital; identifying opportunities within each VISN for housing large numbers of Veterans; and/or, integrating with local, state and Federal partners to address overwhelming numbers of patients who need hospitalization. Some solutions require legal authority to purchase services or to provide services to non-Veterans.

Phase 4- Extended Operations and Recovery

This phase begins when the public health authorities recognize that the outbreak is beginning to wane, and clinical operations are beginning to stabilize. It also includes activities designed to sustain the VHA health care system during extended periods of active virus transmission and intervals during which transmission slows. A couple of the top priorities to consider would be to prepare for a second wave, reinstate curtailed services during the surge phase, monitor the health and well-being of staff and rehabilitate (clean, service and renew) all rooms, equipment and resources utilized in the response phase.

Trigger: This phase begins with the ability to meet and maintain the long-term response capabilities needed to combat the COVID-19 outbreak. The phase ends with a return to usual job functions and scopes of practice.

VA Guidance: VA's return to normal, pre-COVID-19 public-facing operations will be controllable and steady, by aligning Department operations through the "Gating Period" and 3-Phase framework outlined in the National guidelines. Before proceeding through any of the phases, VA will incorporate state and county gating criteria into its business-line specific assessments, along with weighing the criticality of currently suspended face-to-face Veteran services. The timeline for moving through the 3-Phase process will be dependent upon the ability to minimize and control exposure and infection levels and to maintain a constant decrease over time. VA is committed to following a Federally supported, state-managed, and locally executed model that incorporates VA mission-specific factors. The SECVA, or designee(s), will determine when regions initiate and transition through the phases using a combination of the parameters, criteria and risk assessments identified in the VA Maintaining Continuous Services to Veterans and Resuming Normal, Pre-

COVID-19 Operations Framework.

VHA Objective: Maintain the highest standards of care for all Veterans, continue to protect Veterans and staff and return to normal operations.

OIT Objective: OIT will provide uninterrupted, sustained IT operations, capabilities, services, equipment and support to VHA and the Administrations for the duration of the COVID pandemic response and will coordinate with VHA and the Administrations to facilitate an orderly recovery as VA and VHA scale back their operations in phases at the close of this emergency. OIT will use its emergency operations plan to define its response to emergencies and recovery after the emergency has passed. Various aspects of a recovery effort could take place during an event or after an event. Recovery strategies and actions are designed to help restore the systems that are critical to providing care, treatment and services in the most expeditious manner possible. Emergency operations plans are designed to provide optimum flexibility to restore critical services as soon as possible to meet community needs. Recovery strategies will maintain a focus on continuity of operations.

Tasks

Phase 1- Contingency Planning and Training

VHA Objective	OIT Supporting Efforts
a. Develop plans, policies and procedures to protect Veterans and staff.	<p>E: Participate with local facility leadership to collaborate with planning and execution.</p> <p>IS: Develop a process to prioritize resources in order to expedite authority to operate (ATO) review for new systems on the VA network.</p> <p>CC: Plan Call Center Capacity upgrades to support increased demand in support of VHA priorities.</p> <p>TH: Implement additional telehealth capacity required to support VHA's strategy and expansion timelines.</p> <p>TH: Implement new telehealth product evaluation and activation.</p> <p>TH: Issue evaluation and exception memorandum to use commercial products to support telehealth activities.</p> <p>TH: Expand the use of WebVRAM to allow remote access to VistA applications.</p> <p>TH: Expand the use cases for iPad use to increase availability of telehealth capability.</p> <p>TH: Increase monitoring of telehealth systems to</p>

	<p>increase availability to users/decrease downtime.</p> <p>TH: Expand tele-ICU capabilities at priority surge sites and then more sites to achieve a 1:10 tele-ICU cart to ICU bed ratio.</p>
b. Conduct training on the developed plans, policies and procedures.	<p>E: Participate in facility training to ensure OIT staff are positioned to support VHA needs.</p> <p>SM: OIT will conduct tabletop exercises (TTX) for major incident response on all IT systems critical to COVID-19 response.</p>
c. All VAMCs conduct a Tabletop Exercise (TTX).	E: OIT will participate in VHA TTXs to identify required capabilities at each location.
d. Identify PPE Stockage Levels and Requirements.	<p>E: OIT will work with facility to ensure that the local OIT staff requirements for PPE are addressed.</p> <p>SM: Track Ventilators and N95 Masks on the NST dashboard using VISTA AEMS/MERS (Engineering), GIP and MAXIMO.</p>
e. Identify existing capability and “just in time capability” requirements.	<p>RA: Plan Call Center Capacity upgrades to support increased demand in support of VHA priorities.</p> <p>CC: Plan the expansion of the Enterprise Contact Centers.</p> <p>E: OIT will coordinate with local facilities to identify required and potential surge capabilities at each location.</p> <p>TH: Plan Telehealth capacity expansion to Cloud environment for rapid scaling.</p>
f. Develop “one voice” messaging for Veterans and staff.	C4: OIT will integrate with VHA leadership at all levels to ensure consistent VA messaging.

Phase 2- Initial Response

VHA Objective	OIT Supporting Effort
<p>a. Ensure situational awareness reporting procedures are in place at all levels.</p>	<p>C4: OIT will maintain a 24x7 presence in the Integrated Operations Center (IOC) to exchange key information with VA leadership.</p> <p>C4: OIT will maintain VA-wide Emergency and Accountability Alert System readiness notification to ensure updates to employee profiles.</p> <p>TH: Initiate daily reports VHA Telehealth Organization on video conferencing utilization and capacity.</p> <p>CC: Provide Call Center Metric Dashboard for real-time monitoring to support VHA decision making.</p> <p>SS: Execution reporting against acquisition packages for strategic procurements to support COVID-19 surge procurements.</p> <p>SM: Field VA National Surveillance Tool: COVID-19/Dashboard.</p> <p>IS: Utilize real time phishing and malicious email reporting for user community and boundary protection.</p>
<p>b. Transparent communication to ensure information availability and analysis is getting all levels.</p>	<p>TH: Provide Telehealth Performance Reporting by Ops Dashboard.</p> <p>CX: Support the call center content coordination effort and coordinate alternate messaging and call management capabilities through text messaging and automated call triage systems; VEText; and Chat Bot initiatives.</p> <p>TH: Execute end user training for all new Telehealth functionality and expansion of services.</p> <p>TH: Expand Telehealth Capability to accommodate increasing video demands as the total number of patients continues to rise including standing up Care2 cloud environment</p> <p>SS: Track IT COVID-19 procurements for FITARA compliance.</p> <p>RA: Expand Video Teleconferencing through increased Real Time Monitoring and Alternate Video Conferencing Systems.</p> <p>SS: OIT will respond to the surge in supply chain</p>

	<p>demand for equipment and remote access capacity to support telework and telehealth requirements of our customers.</p> <p>C4/E: OIT will expand Enterprise Service Desk capacity to seven days a week to meet the demand of new VHA staff and increase capability to deliver new accounts within one day.</p> <p>IS: Provide daily updates pertaining to COVID-19 cybersecurity threats and compliance reporting.</p>
<p>c. Receive and triage initial patients:</p> <ul style="list-style-type: none"> i. Protect uninfected patients and staff from infectious patients and staff. ii. Provide acute care for COVID-19 patients. iii. Support mildly ill COVID-19 patients in home isolation –and use telehealth. iv. Support patients in voluntary home quarantine – use telehealth. v. Continue to address routine health care needs for all patients. 	<p>CX: Initiatives: Telehealth expansion; Clinical chat pilot expansion; Secure Messaging / MHV performance improvements; Annie app expansion; Chatbot; VA.gov FAQ; and Mental health content.</p> <p>E/RA: Support technology and bandwidth needs as utilization of virtual technologies increases, including facilitating equipment placement and relocation in VHA facilities; procure, issue and support equipment to meet VHA’s rapidly expanding telework /telehealth needs.</p> <p>RA: Expanded employee remote access through Citrix Access Gateway (CAG) and RESCUE capabilities to ensure remote work capability.</p> <p>RA: Expanded Bandwidth enabling Clinicians to provide telecare to Veterans on mobile and other devices.</p> <p>R: COVID-19 hiring surge triaging recruitments to support temporary/term hiring to support need Activating HCM Talent Acquisition Team for resume mining, virtual interviews, etc.</p>
<p>d. Implement response plans and adjust as necessary.</p>	<p>E: Integrate with local facility leadership and Emergency Management/Incident Command Operations teams to provide support for technology needs.</p> <p>E: Expand Enterprise Service Desk capacity to meet the demand of new VHA staff.</p> <p>RA: Continue expanding CAG/RESCUE and remote access capabilities to provide scalability as needed.</p> <p>R: Enable quick/surge IT hiring utilizing COVID-19 hiring flexibilities.</p> <p>R: Forward IT funds to cover immediate costs while waiting for appropriation to follow; ensure thorough documentation of forward funding.</p>
<p>e. Additional OIT initiatives</p>	<p>RA/E: Expand Video Teleconferencing and increase Real Time Monitoring to rapidly resolve issues.</p>

	<p>IS: Allow access to Alternate Video Conferencing Systems, expand Single provider access to VISTA/CPRS Systems.</p> <p>E: Expand distribution of Tele ICU equipment to 1:10 cart to ICU beds.</p> <p>E: Provide Solution for Bring Your Own Device (BYOD) for VA Telehealth and increase flexibility of mobile devices.</p> <p>CC: Execute re-routing of calls to under-utilized call centers based on VHA direction.</p> <p>RA: Implement Call Center expansion based on VHA direction: Increase Voice Circuit capacity at VHA facilities to support increased demands.</p> <p>S: Expedite Software as a Service (SaaS) Authority to Operate (ATO) risk capturing process to ensure that COVID-19 system can be deployed as quickly as possible.</p> <p>SS: Utilization of DPAS ratings on critical requirements.</p> <p>E: Expand capabilities at the Enterprise Service Desk with greater self-service options such as Chat bot and self-service PIV exemptions and certificate extensions.</p> <p>IS: Provide daily updates pertaining to COVID-19 cybersecurity threats and compliance reporting.</p>
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Phase 3- Alternate Sites of Care

VHA Objective	OIT Supporting Efforts
a. Activate identified alternate sites of care to meet demand	<p>E: Procure, install and support required technology solutions to establish alternative sites of care.</p> <p>RA: Provide additional IT technical support to maintain access to VA Networks for VA Mobile Hospitals, Medical Mobile Units (MMU) and Mobile Pharmacies are deployed.</p>
b. Implement activities and procedures to meet limited capabilities to include facilities, staff, and supplies	<p>CX: expand telehealth capabilities; updated facility locator.</p> <p>E: Provide hands-on technology support to meet VHA's needs in rapidly changing, flexible environments.</p> <p>RA: Enhance remote access capabilities to enable</p>

	<p>medical staff to treat patients via telehealth, providing continuous medical treatment and oversight and uninterrupted ordering and delivery of supplies to facilities.</p> <p>R: Remote/Virtual Verification of Employment Eligibility Verification (Form I-9) and Oath of Office Due to COVID-19. Temporary postponement of pre-employment applicant drug testing for testing designated positions (TDP).</p> <p>SS: Adding temp hires to support requirements of developing acquisition packages to support surge in procurements and IT operations.</p>
c. Be prepared to support local communities as possible	<p>E: Provide flexible technology solutions to support connectivity and computing needs as VHA expands care to the community.</p> <p>RA: integrate OIT personnel/capabilities into VHA Disaster Emergency Medical Personnel System (DEMPS) for onsite support.</p>
d. Be prepared to implement contingency planning for worst case scenario	<p>RA: provide increased IT technical support to VA Networks as VA Mobile Hospitals, Medical Mobile Units (MMU), and Mobile Pharmacies are deployed.</p> <p>E: Prepared to surge IT equipment/capabilities at VHA identified hotspots.</p> <p>E: Expand Enterprise Service Desk capacity to meet the demand of new VHA staff.</p> <p>SS: Plans developed and ready to support alternate care standards of care for facilities operating with greatly reduced resources. Mandatory telework in place where feasible.</p>
e. Additional OIT Initiatives	<p>RA: Integration of the use of Non-GFE equipment into the Contact Center strategy based on VHA priorities.</p> <p>SM: Bed Management System (BMS) updates; Access CPRS</p> <p>E: Procurement of additional technology and support resources to be able to quickly flex in response to changing needs of VHA.</p>

Phase 4- Extended Operations and Recovery

VHA Objective	OIT Supporting Efforts
a. Conduct sustained operations	<p>C4: OIT will continue to maintain information technology (IT) capacity ahead of demand to assure access to and security of VA's information and information systems to ensure the continuity of access to and delivery of health care services and benefits to Veterans as appropriate.</p> <p>TH: Implement end-to-end monitoring for Telehealth with system performance and health scores to allow system reliability improvements.</p> <p>RA: Maintain uninterrupted support to established and alternate sites of care through resilient networks.</p> <p>R: Data analysis - Leverage dashboard to have visibility of potential OIT skills gaps or deficits.</p>
b. Recover facilities, staff and equipment and return to normal operations	<p>TH: Build capacity for Telehealth in a Cloud environment to allow for rapid scaling and descaling.</p> <p>IS: Rescind, if warranted the memorandum to use commercial products to support telehealth activities.</p> <p>TH: De-commission the Care2 Cloud environment upon return to normal demand for Telehealth if warranted.</p>
c. Additional OIT Initiatives	<p>RA: Support transition needs of VHA as operations transition into a recovery pattern and care needs change across the facilities.</p> <p>E: Recover equipment determined by the Administrations to be no longer required to return to a "ready state" and ensure availability for future emergency needs.*</p> <p>IS: Ensure all existing and newly deployed COVID-19 systems are covered by continuous monitoring and that plans of action and milestones are created and maintained for each to mitigate all outstanding tasks and associated risks.</p> <p>R: Apportion supplemental funds for ongoing operations.</p> <p>*OIT will coordinate with the Administrations prior to recovering any IT equipment to ensure there is no interruption of IT service or support.</p>

3.c Special Measures

3.c.1 Listing of all special authorities, exceptions to policy and new policies in effect for the duration of the COVID-19 National Emergency.

Title	Granting Authority	Type
Use of Video Communication Technology Under COVID-19	OIT Policy	CIO Memo
Federal employee leave provisions under the Families First Coronavirus Response Act	H.R. 6201, Public Law 116-127	OCHCO Bulletin
Waiver of the Exclusion of Temporary Appointments to Receive Recruitment, Relocation and Retention Incentives During the COVID-19 Pandemic	OCHCO	OCHCO Bulletin
On-Boarding Processes for New Employees During the COVID-19 Emergency	OPM	OPM Memo
Delegated Authority to Waive Salary Offset Guidance - COVID-19 National Emergency	CHCO references OPM Memo	OCHCO Memo
Delegation of Authority for Response to COVID-19	OIT Policy	CIO Memo
Recording COVID-19 Ad-Hoc Telework and Weather and Safety Leave	OCHCO	OCHCO Bulletin
Updated Preliminary Guidance during Coronavirus Disease 2019 (COVID-19)	OCHCO	OCHCO Bulletin
COVID-19 Schedule A Hiring Authority for New Appointments	OCHCO, OPM 5 CFR 213.3102(i)(3)	OCHCO Bulletin
Temporary Procedures for Personnel Security Vetting and Appointment of New Employees and Alternative Personal Identity Verification Credentials for Eligible Users During COVID-19	Asst Sec for HRA/OSP and Asst Sec for IT references M 20-16 (below)	Asst Sec for HRA/OSP and Asst Sec for IT Memo
Federal Agency Operational Alignment to Slow the Spread of Coronavirus COVID-19	OMB Mem0 20-16	OMB Memo
Updated Guidance for the National Capital Region on Telework Flexibilities in Response to Coronavirus	OMB Memo 20-15	OMB Memo
COVID-19 Schedule A Hiring Authority for Temporary Appointments	OPM	OPM Memo
Approved Direct Hire Authority (DHA)	OPM	OPM Memo
Peace Corps Hiring	OPM	OPM Memo
Dual Compensation Waiver (Re-Employed Annuitants)	OPM	OPM Memo

DevSecOps Bulletin: COVID-19 Freeze Change Control Management	OIT	OIT DevSecOps Bulletin
Presidential Management Fellows (PMF) Hiring	OPM	OPM Memo

3.c.2 Critical Systems

For risk mitigation purposes, OIT continues to review:

- **Contract Actions:** For contract transitions (period of performance, etc.), OIT is taking action to stabilize around current vendor, contract, etc.
- **Configuration Management:** OIT is prioritizing risk mitigation with updates to critical systems, while keeping pace with the normal cadence of security and functionality upgrades that the user community needs and expects without creating a large backlog.

3.c.3 Information Security, Privacy, Policy and Data Breach

OIT will maintain all Federal requirements in terms of proper Privacy and HIPAA related transmission, storage, and processing. All incidents, where VA Sensitive data is breached, are tracked within the associated system incident response plan, that is tested annually, to ensure proper preparation, detection, analysis, containment, eradication, recovery and post-incident activity.

4. Administration and Logistics

4.a Administration

OIT will continue to comply with all provisions of the Federal Records Act and will adhere to approved retention schedules, disposition actions and protection of all VA/OIT records produced during this pandemic timeframe in support of joint OIT-VHA operations. This guidance will remain in effect unless officially modified or otherwise updated by the National Archives and Records Administration (NARA).

4.b Logistics

Requests for standard IT services, support and equipment at the local level should be directed to the OIT Area Manager servicing the requesting location and by completing a ServiceNow ticket using the self-service feature on the *YourIT* link on each employee desktop, or by contacting the Enterprise Service Desk by phone.

Local or VISN VHA leadership should coordinate with the local OIT Area Manager or OIT district leadership to prioritize bulk requests for equipment as part of their COVID-19 response efforts. Local Area Managers will coordinate delivery schedules with the requesting local organization.

OIT will utilize the Integrated Operations Center (IOC) as a centralized control mechanism to receive IT service, equipment, operations requests that exceed local IT capabilities and assist with handling any emergency needs that may arise. The

IOC is available 24x7 by calling 202-632-3817 or by sending an email to VA IOC OIT Liaison Team (vaoitliaison@va.gov). In addition to the IOC support, additional IT support is also available 24x7 through the Enterprise Service Desk by calling 855-673-4357 (TTY: 844-224-6186).

Requests received by OIT will be addressed in close collaboration with VHA to ensure prioritization of the most emergent needs. The IOC will provide daily situation reports to identify resources allocated across the organization, urgent requests in process and will provide additional situational awareness and an enterprise level view.

If requests are made that exceed the supply of available resources, OIT will work through the Office of Strategic Sourcing, Office of Procurement, Acquisition and Logistics to obtain needed resources. This process will utilize available logistics and supply chains and will be performed in close collaboration with the local VHA logistics team to ensure seamless, rapid delivery of required products.

OIT's Office of Strategic Sourcing (OSS) will support IT acquisition package development and execution in support of the COVID-19 Response Plan in collaboration with VHA and the contracting agency (TAC). OIT/OSS maintains contacts with VHA to support VHA facilities, sites and networks to contract standards/agreements for IT operations and sustainment. OIT/OSS contracts IT vendor support remotely and on-site and ensures that support is in accordance with the contract agreements however, alternate methods may be approved due to the current COVID-19 environment will be made by contracting officer and requirements owner as required. OSS provides Acquisition Requirements Module (ARM) training for all OIT and VHA ARM users to ensure all procurement requirements are processed efficiently and in accordance with the FITARA guidance and CIO visibility.

5. Command and Signal

5.a Command Relationships

- HHS is the Lead Federal Agency (LFA) and reports to the Office of the Vice President, the task force lead for the Federal Government response.
- VHA is the supported organization
- OIT is the supporting organization
- OIT COVID-19 Response Chain of Command:
 - Assistant Secretary for Information and Technology and Chief Information Officer
 - OIT COVID-19 Response Executive-in-Charge
 - OIT COVID-19 Response Scrum Master
 - OIT Pillar Leadership

5.b Coordination

5.b.1 Organizational Representation/Liaison

- VACO representation with the Assistant Secretary for Information and Technology and Chief Information Officer (CIO)
- Integrated Operations Center (IOC) representation 24x7
VAOITCOVID19@va.gov
- Representation with VHA and the Administrations through the IT Account Management Office (AMO) and IT Account Managers
- Representation at the VISNs and Regional Offices through the OIT End User Operations District Directors and Directors of Operations
- Representation at the VAMCs through the OIT End User Operations Area Managers and their support teams

5.b.2 Meetings

- OIT Daily COVID-19 Scrum (0830)
- Recurring OIT-VHA Meeting(s) Daily COVID-19 Joint Operations Center Call with VHA (1530), Participation in VHA planning cells to support Staffing and End User Priorities, Forward Strategy Development (As scheduled by VHA)
- Recurring daily VA Crisis Action Team Meeting at 1430

5.c. OIT Dashboards

- **VA National Surveillance Tool:** COVID-19 <https://va-atc-dev.azurewebsites.us/Healthcare/NationalSurveillance>
- **E-comm Portal:** <https://vawww.oit.va.gov/oit/e-comm/>

References

National:

- (U) Public Health Service Act, Pub L. No. 78-410, 58 Stat. 682 (1944) (codified as amended at 42 United States Code (U.S.C.) §§ 201 et seq.; 42 U.S.C. §§ 300hh-1 and 16).
- (U) Public Readiness and Emergency Preparedness Act, Pub. L. No. 109-148 (codified as amended in the Public Health Service Act at 42 U.S.C. §§ 247d-6d).
- (U) Economy Act, Pub. L. No. 73-2 (1933) (codified as amended at 31 U.S.C. §1535).
- (U) Robert T. Stafford Disaster Relief and Emergency Assistance Act, Pub. L. No. 93-288 (as amended at 42 U.S.C. §§ 5121-5207).
- (U) Presidential Policy Directive 44 (PPD 44), Enhancing Domestic Incident Response (2016).
- (U) Homeland Security Presidential Directive 5 (HSPD-5), Management of Domestic Incidents (2003).
- (U) Title 38, U.S.C., Section 8117, Emergency Preparedness (Pub L. No.107-287, as amended).

- (U) CARES Act §3548 This Act may be cited as the “Coronavirus Aid, Relief, and Economic Security Act” or the “CARES Act”. (U) The Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207 (the Stafford Act).
- (U) The Federal Information Technology Acquisition Reform Act (FITARA) H.R.1232 - 113th Congress Federal Information Technology Acquisition Reform Act.
- (U) The Chief Financial Officers (CFO) Act H.R.5687 - Chief Financial Officers Act of 1990.
- (U) The Clinger-Cohen Act of 1996 encompasses the (1) Information Technology Management Reform Act (ITMRA) (Division E) and the (2) Federal Acquisition Reform Act (FARA) (Division D) which were signed into law as part of the National Defense Authorization Act for Fiscal Year 1996.
- (U) Evidence-Based Policy Making Act, H.R.4174 - Foundations for Evidence-Based Policymaking Act of 2018.
- (U) VA/DoD Health Resources Sharing and Emergency Operation Act, Pub L. No. 97-174, May 4, 1982.

Department of Veterans Affairs:

- (U) Veterans Health Administration - COVID-19 Response Plan.
- (U) Department of Veterans Affairs Emergency Preparedness Act of 2002, Pub L. No. 107-287, November 1, 2002.
- (U) Department of Veterans Affairs Directive 6008, Acquisition and Management of VA Information Technology Resources.
- (U) Department of Veterans Affairs Handbook 6500, Risk Management Framework for VA Information Systems - Tier 3: VA Information Security Program.
- (U) Department of Veterans Affairs Handbook 6500.2, Management of Breaches Involving Sensitive Personal Information.
- (U) Department of Veterans Affairs Handbook 6500.8, Information System Contingency Planning.

Appendix F – Human Resources and Finance Administration

HUMAN RESOURCES

Purpose

To provide overall and situational human resources guidance to aid in the decision making at the Veterans Health Administration (VHA) Central Office, Network and Facility levels by providing proactive and reactive communication, information, legislative interpretation and policy guidance in all human resources areas including Leave, Hours of Duty, Compensation, and Employee and Labor Management Relations.

Scope

Human Resources guidance will be applicable to the VHA Central Office and the Networks and Facilities under the purview of the VHA.

Planning Assumptions

For purposes of this plan, it is assumed:

- Information about the ongoing COVID-19 outbreak will remain highly fluid;
- Conditions and instructions under which VHA staff will be operating may change often, with little notice and with significant operational and public health implications;
- The implementation and/or changes of laws, rules, regulations, or policy that are not in effect during normal operations will become necessary to respond to issues globally, as well as locally, with agility and flexibility and;
- That this expansion requires information to be communicated to leadership clearly and consistently in order to facilitate operations at all levels.

Concept of Operations

VHA leadership, upon recognition of a situation that requires a higher-level response than normal operations, will select human resources points of contact for areas that are likely to be utilized for the issue. As the situation changes, additional members will be added to the human resources team to provide subject matter expertise and guidance. The following sections will have a subject matter expert from VHA Workforce Management and Consulting (WMC) Office appointed to the team as needed:

- Employee/Labor Relations
- Compensation
- Staffing/Recruitment

Organization and Assignment of Responsibilities

- The Office of the Chief Human Capital Officer (OCHCO) will provide guidance for all of VA in consultation with the Office of Personnel Management and other entities.
- The Chief Human Capital Officer, VHA Chief, Human Capital, Management, and the Chief Officer for VHA Workforce Management and Consulting will delegate or

specifically assign VHA WMC Human Resources staff for situational response, field inquiries and specific guidance.

- Staff will be responsible to field questions and inquiries and provide VHA specific guidance in reference to the specific situation.
- Staff will be responsible for researching, preparing, routing, and disseminating additional approvals, documents, memorandums, etc. needed to properly address the specific situation within the guidelines of law, regulation and policy.
- Staff will be responsible for identifying legislative and/or policy changes necessary to address operational issues and provide leadership with appropriate documentation to facilitate the change request

Direction, Control and Coordination

- All requests for VHA operational changes will be tracked and maintained by WMC Human Resources Centers of Expertise (HRCoE) for reporting and communications.
- WMC HRCoE will provide scheduled briefings to Network Human Resources Officers to ensure timely, accurate, and consistent communication of information.

FINANCE

Purpose

To oversee the allocation, distribution, tracking and reporting of funds for execution by program offices and facilities in Veterans Integrated Service Networks (VISNs) and to provide guidance in the areas of resource management, accounting operations, policy and managerial cost accounting.

Scope

Financial management guidance will be applicable to the VHA Central Office and the Networks and Facilities under the purview of the VHA.

Planning Assumptions

It is assumed that resources will be utilized consistent with the intent of legislative language in the Coronavirus Aid, Relief, and Economic Security Act or the "CARES Act." For facilities that have accepted Mission Assignments from the Federal Emergency Management Agency (FEMA) it is assumed that services will be provided consistent with the signed agreement and that VA will be reimbursed by FEMA in a timely manner.

Concept of Operations

VHA leadership, upon recognition of a situation that requires a higher-level response than normal operations, will engage the VHA Office of Finance as the key point of contact for the allocation and execution of resources. The VHA Chief Financial Officer will designate an emergency response team lead by the Deputy Chief Financial Officer to provide subject matter expertise and guidance. The following VHA Office of Finance sections will have a subject matter expert appointed to the team as needed:

- Financial Management and Accounting Systems Oversight

- Financial Operations and Support
- Managerial Cost Accounting
- Resource Management

Organization and Assignment of Responsibilities

- The Office of Finance will provide guidance for VHA financial operations in consultation with the VHA Governing Board, the VA Office of Management and external entities, including but not limited to the Office of Management and Budget.
- The VHA Chief Financial Officer and the Deputy Financial Officer will delegate or specifically assign staff for providing status of funds reports, situational responses, congressional inquiries, field inquiries and other specific guidance.
 - Staff will be responsible for providing VHA specific guidance in accordance with the CARES Act.
 - Staff will issue guidance in written form, utilizing financial alerts, conference call minutes and questions and answers documents available on the Office of Finance Intranet and designated SharePoint site.
 - Staff will analyze financial information and activities at the national and facility levels in support of financial statement reporting and the annual financial statement audit.

Staff will be responsible for researching, preparing, routing, and disseminating additional approvals, documents, memorandums, etc., needed to properly address specific situations within the guidelines of law, regulation and policy.

Appendix G – Employee Wellness

Purpose

To make holistic support available to frontline employees and leaders as they deal with the personal and professional stresses of the pandemic. To organize this support in a way that makes it more user-friendly and accessible.

Scope

Support will be available to employees and leaders throughout VHA.

Planning Assumptions

The support plan is based on the following assumptions:

- An important provider of support to employees is the immediate supervisor and executive leadership at the site.
- Access to supportive resources needs to be possible inside and outside the VA firewall.
- A “one size fits all” approach at a national level would not be effective. Support needs to be customizable to fit the culture and context at the local level.
- Leaders need access to highly responsive, tailored support that is available to them on an as needed basis, not as a mandatory offering.
- Due to the length of time that the pandemic is likely to endure, leaders will need to support their employees as operations open back up in a phased approach over time.

Concept of Operations

It was noted early on that pre-COVID availability of mental health support for leaders and employees would not be sufficient to meet the unique needs and stresses likely to arise during the pandemic. In response to this identified gap, the following approaches were developed:

For Leaders

- The Rapid Response Consultation Service
 - The VHA National Center for Organization Development (NCOD) re-deployed 18 psychologists to provide highly responsive coaching support to leaders at all levels (frontline supervisors through SES) across VA.
 - Any leader can request coaching related to an area of concern for them – response times to requests are typically less than an hour
 - Typical consultation themes include:
 - Managing emotions, stress, and bereavement
 - Decision-making around shifting priorities
 - Developing a leadership team strategy to manage disruptions
 - Leading and managing in a virtual environment
- Rapid Response Self-Help Resources

For leaders that prefer to utilize self-help resources or want these as a complement to coaching, NCOD put together a repository of printable tools, useful references and real-world scenarios.

- These resources are readily available to all leaders as a link on NCOD's webpage as well as through the electronic request link for Rapid Response Consultation described above.

Resources are organized by similar consultation themes as described above.

- Recovery Effort (under development)
 - Leaders will need support/solutions to help get their workforces back on track – NCOD is working on an organized approach to help them mitigate negative employee outcomes related to the pandemic.
 - This will include helping leaders understand the human side of crisis/recovery, assess their org/team, and support individual employees reacting to and recovering from crisis (i.e. finding/accepting a 'new normal').
 - Services/resources will be designed to reach leaders with what they need when they need it (i.e., reflect the rolling impact of covid-19 and their phase in the response-recovery process).

For Employees

- Self-Help Resources for Employee Whole Health
 - The VHA Organizational Health Council (OHC) brought together relevant VHA Central Office program offices to develop a repository of resources that employees can access for emotional, spiritual, and physical support as well as support for morale.
 - The resources are housed on a va.gov site that is accessible inside or outside the VA firewall.
 - The resources are organized into the following folders and contain short videos, tip sheets, and links to other useful sites:
 - Relaxation Practices/Mindfulness
 - Spiritual Health/Spirit & Soul
 - Staying VA Strong/Resilience
 - You Owned the Moment (morale-building, uplifting stories)
 - Moving the Body
 - The landing page of this site also promotes the Disaster Distress Helpline (operated by SAMHSA), the National Physician Support Hotline (newly stood up specifically for the pandemic) and the National Suicide Prevention Helpline.
 - All resources designed specifically for COVID-19 response are vetted through the VHA COVID Communications workgroup before uploading to the site.
- The Employee Support Toolkit
 - The OHC along with the same relevant program offices developed a national toolkit to provide a framework for the implementation of local support services for employees utilizing available local mental health, social work and chaplain staff.
 - This toolkit spreads best practices making it easier and quicker for sites to support staff without having to re-invent the wheel.
 - The toolkit shares ideas in the following areas as well as providing linked resources in each to help with implementation:
 - Executive Sponsorship
 - Establishing the Team
 - Support the Team

- Rounding Support for Employees
- Live Support for Employees
- Email support for Employees
- Virtual Resources for Employees
- Care Carts
- Employee Assistance Program (EAP) Roadmap
- The landing page of the toolkit also promotes the Disaster Distress Helpline (operated by SAMHSA), the National Physician Support Hotline (newly stood up specifically for the pandemic) and the National Suicide Prevention Helpline.

Organization and Assignment of Responsibilities

The VHA NCOD will provide all consultation and resource support for leaders as described above and is responsible for ongoing maintenance of them. The VHA OHC is responsible for overseeing the ongoing maintenance of the employee resources described above and will continue to work in collaboration with the relevant program offices. These program offices include NCOD, the Office of Patient-Centered Care/Cultural Transformation, the Office of Mental Health & Suicide Prevention and its sub-office the National Center for PTSD, the Patient Experience Directorate of the Veterans Experience Office, the Office of Social Work and the Office of Chaplain Service.

VHA Communications Office approves all employee support resources designed specifically for COVID-19 support prior to uploading to the dedicated va.gov website.

Communications

Communications about the employee and leader resources has gone out in a variety of formats and multiple times over the past several weeks to relevant audiences to ensure broad dissemination.

Links to VA Employee Wellness Resources:

[NCOD Rapid Response Consultation](#) – for leaders at all levels

[Rapid Response Self-Help Resources](#) – for leaders at all levels

[Employee Support Resources](#) – for all employees

[Employee Support Toolkit](#) – to implement local support for employee wellness during pandemic

Sample of References:

<https://hbr.org/2020/03/are-you-leading-through-the-crisis-or-managing-the-response>
[Team Resiliency Handout](#)

<https://www.gsb.stanford.edu/insights/crisis-leadership-playbook>

[Managing Stress Associated with the COVID-19 Outbreak - National Center for](#)

VHA COVID-19 Response Plan



PTSD

<https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4894.pdf>

[That Discomfort You're Feeling is Grief - HBR Article](#)

https://www.ptsd.va.gov/covid/COVID_leaders_support_staff.asp

Appendix H – Mental Health Care and Suicide Prevention Services

Purpose, Scope and Assumptions

Purpose

To ensure access and continuity of mental health care and suicide prevention services throughout the pandemic allowing for flexibility at the local level regarding the modality in which those services continue to be made available.

Scope

The rising suicide rate in the US population, the recent increase in gun and alcohol sales and domestic violence, as well as rising concerns about the effects of isolation are stark reminders of the need for both early intervention and sustained treatment for both acute and persistent mental health disorders. Regardless of the course of the current pandemic, the economic consequences are expected to be devastating to all, further exacerbating risk factors for mental health related morbidity and mortality for Veterans, family members and their communities.

Planning Assumptions

The support plan is based on the following assumptions:

- Mental health/SUD care and suicide prevention services are not elective.
- The COVID crisis is a stressor for vulnerable Veterans with mental health issues that could worsen their overall health and put them at higher risk for suicide and other adverse outcomes.
- Failure to attend to mental health care and suicide prevention now will create additional burden on Veterans and on health care systems and facilities.
- Social distancing, including stay at home orders and maintaining physical distance in public, and expectations to quarantine will place Veterans with any MH condition at increased risk of relapse. As an example, patients with SUD are at increased risk for emergent symptoms of withdrawal due to inability to secure alcohol or other substances or adverse outcomes associated with an overdose due to lack of bystanders available to respond.
- Addressing the most basic mental health care needs and suicide prevention services is not the same as maintaining business as usual or simply moving in-person care to virtual care.
- This is the time to employ the entire continuum of mental health care including integrated providers within PACT, geriatrics and other program areas.
- The best solution is to improve efficiency of care and services rather than to eliminate services and to prioritize care for the most vulnerable populations.
- It is anticipated that facilities will experience a second surge as stay at home orders are relaxed and in-person services resume, with increased demand for mental health and SUD services.

- Expect that the impact of COVID-19 on the population will be ongoing at least until the population has developed a reasonable amount of herd immunity via exposure and vaccination, likely by January 2022, if not sooner. Many public health experts expect the long-term psychological effects to last many more years, including projections of deaths of despair that may be similar to the number of deaths caused directly by the virus.

Concept of Operations

The following are recommendations to guide local decision-making to ensure that opportunities for Veterans to connect for care, crisis intervention, and support remain intact and easily available even if other modalities of care and connection (e.g., VA Video Connect, and telephone) are utilized.

1. Ensure continued treatment of high priority patients and prepare for next wave when subacute patients become increasingly acute. This includes consideration of the following:
 - a. Care for Veterans with Serious Mental Illness (SMI)
 - i. Follow any available Food and Drug Administration (FDA) relaxed guidelines for prescribing antipsychotic medications including Clozapine
 - ii. Shift care to telephone and VA Video Connect (VVC), including for community-based Mental Health Intensive Case Management programs
 - b. Substance Use Disorders
 - i. Follow any available FDA and Substance Abuse and Mental Health Services Administration relaxed guidelines for opiate use disorders
 - ii. Increase use of VVC, telephone, secure messaging and other technologies
 - c. Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH-VET) and Veterans with high risk for suicide flags.
 - i. Emphasize virtual technologies to maintain connection to this group of Veterans until in-person care is safe.
 - d. Employees, especially those who are working on the front lines with the sickest patients
 - i. Emphasize self-help resources available from the Office of Patient Centered Care, the National Center for Posttraumatic Stress Disorder, and other sources.
 - ii. Encourage employees to take time away from work, including breaks during the workday as well as annual leave.
 - e. Homeless
 - i. Shift as much care as possible from in-person to virtual

- f. Mental Health Residential Rehabilitation Treatment Programs (MHR RTP), ensuring continued contacts with and the provision of alternate care to those awaiting or declined admission.
 - g. Inpatients
 - i. Maintain availability of care for those who cannot be safe at home
 - h. Use dashboards provided by 10NC5 (e.g., SPRITTE) to identify other Veterans potentially at risk - e.g. Vets who cancel appointments.
 - i. As MHR RTP admissions are reduced, leverage available staff to provide outpatient services via telehealth for those Veterans that are awaiting admission.
2. Maintain services for those currently in care and maintain access for new patients by increasing efficiency and adopting a continuum of care for mental health.
- a. Discharge or shift stable patients to a less intensive level of service, consistent with the continuum of care guidelines, using “FLOW” criteria.
 - b. Incentivize secure messaging and other technologies. Increase use of self-care apps, including use of clinician support.
 - c. Expand virtual group offerings.
 - d. Implement stepped care approach to care to assure the appropriate intensity of care is being provided.
 - e. Shift or expand duties of staff in community-based programs to other programs. First consideration should be to use them to serve the populations with whom they are most familiar.
 - f. Relaxing policy guidance where appropriate, such as suspend administrative duties for some positions and change to clinical. Examples include Local Recovery Coordinators, Evidence Based Psychotherapy Coordinators and other positions occupied by mental health professionals with clinical privileges.
 - g. Incentivize longer work hours up to 20%.
 - h. Reduce frequency and length of appointments. Several phone contacts can be made during the time typically used for a regular appointment.
 - i. Identify all qualified providers with Drug Enforcement Agency (DEA) x-waiver to provide sufficient back-up coverage to ensure continued access to medication for opioid use disorder (OUD). Emergency exceptions provided by DEA allow for use of telehealth including telephone care to initiate buprenorphine. Leverage national SMEs to provide emergency coverage if needed.
 - j. Adopt the collaborative care model (CoCM) for management of patients in Behavioral Health Interdisciplinary Program (BHIP) team care. The CoCM is typically used in Primary Care Mental Health Integration (PCMHI) care but can be used for ongoing follow-up in BHIP as well. Provision of this service by PCMHI care managers may require additional staffing.

- k. Use the Behavioral Health Lab software for initial triaging of new patients and use PCMHI as first step in care. Emphasize the role of PCMHI in assessing need for mental health care for the Patient Aligned Care Team (PACT) population as described in the PACT Primary Care Continuation of care throughout COVID-19 field guide.
 - l. If not already part of existing PCMHI, consider providing psychiatry and other specialty MH services within PCMHI to manage patients who may have previously been referred to specialty care. For those whose needs cannot be met by PCMHI staff, consider using referral management protocols to improve the likelihood of engagement in specialty care.
 - m. Increase use of services offered by VA partners, e.g. Vets Prevail.
 - n. Work collaboratively with Veterans Readjustment Counseling Centers to develop increased support for Veterans and family members.
 - o. Substitute newer brief approaches to care developed for PCMHI, such as Problem-Solving Training- Primary Care, Brief Cognitive Behavioral Therapy- Primary Care and Prolonged Exposure Treatment for Primary Care for PTSD (where trained providers can be made available and when clinically appropriate based on symptomatology, Veteran preference and clinical judgement).
3. System changes to support increased use of virtual technologies and low relative value unit services:
- a. Suspend current performance measures but continue to monitor.
 - b. Suspend current workload requirements. (see statement on the Office of Productivity, Efficiency and Staffing page:
<http://opes.vssc.med.va.gov/Pages/Default.aspx>)
 - c. Utilize all pandemic related resources on the Office of Mental Health and Suicide Prevention web pages:
<https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NC/10NC5/Lists/COVID19%20Response%20Team/AllItems.aspx>
4. Anticipate and prepare for care after COVID-19 surge:
- a. Rapidly return MHR RTP programs, particularly those for Substance Use Disorder (SUD) care, back to full capacity ensuring sufficient staff to rapidly admit Veterans to meet anticipated demand for care. Consider shorter lengths of stay with transition to outpatient continuing care that can be provided via telehealth.
 - b. Consistent with a stepped-care model, leverage consultative role of specialty care services locally and national consultation resources to support provision of treatment outside of specialty care. Encourage brief interventions and ambulatory services when possible to minimize demand for more intensive mental health and SUD resources.
 - c. Maintain efficiency steps outlined in part 2, above.

Organization and Assignment of Responsibilities

The Office of Mental Health and Suicide Prevention (OMHSP or 10NC5) will work in collaboration with the other program offices in Clinical Operations to coordinate field support, guidance and technical assistance working closely with the VISN Chief Mental Health Officers to ensure rapid communication.

Communications

The OMHSP COVID Response Team (MARVEL Team) is leading the communication efforts within OMHSP. Resources of various types are noted in the links below. In addition, the MARVEL team will be reviewing, identifying, and presenting various strong practices developed in the field to adapt to COVID.

References

Tracker: <https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NC/10NC5/Lists/COVID19%20Response%20Team/AllItems.aspx>

Resources Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/COVID-19/SitePages/Home.aspx>

Sharing site link: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/COVID-19/SitePages/OMHSP-Sharing-Site.aspx>

Appendix I – Infection Control

Purpose

The purpose of this Annex is to provide guidance concerning the infection prevention and control (IPC) aspects in VA health care during the pandemic environment due to COVID-19. This document provides guidance and information on IPC procedures for staff working in VA health care settings for all pandemic phases. The goal is to provide information for all health care workers (HCWs) to know how to protect themselves and protect others.

Basic infection prevention and control principles applied during this pandemic are not new. How they are applied is based on what is known about the mode of transmission (see definitions) for the infectious disease (COVID-19) causing this pandemic. Guidance from the Centers for Disease Control and Prevention (CDC) and this document may evolve as information on this pandemic virus emerges. The most current CDC COVID-19 guidance is to be followed. Refer to the VA Emergency Management Coordination Cell (EMCC) High Consequence Infection (HCI) SharePoint/ intranet site for the most current version of this document, which may be updated as new information arises.

This guidance has been based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in health care personnel (HCP) and shortages of personal protective equipment such as facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), eye protection, gloves, and gowns. ***Certain precautions may be feasible only in the early pandemic periods, as they may not be achievable or practical as the pandemic spreads and resources (equipment, supplies and human resources) become scarce.***

Please refer to CDC and VA guidance for conservation of PPE:

CDC “Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings”
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

A comprehensive local infection prevention and control program forms the basis of a successful pandemic plan. Adherence to IPC policies and procedures and basic IPC principles is imperative to minimize the transmission of COVID-19, regardless of the availability of vaccine and/or antiviral medications.

These guidelines are to be incorporated with other ongoing IPC principles, guidelines and recommendations put forth by the CDC “Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)”
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

IPC resources may need to be prioritized. Critically evaluate situations in which Personal Protective Equipment (PPE) is indicated, following CDC guidance:

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

Infection prevention and control measures are to be followed by all employees. The facility Infection Prevention and Control Professional, Hospital Epidemiologist and Infectious Diseases physician are key persons and subject matter experts (SMEs) especially during times of pandemic. It is likely that one or more of them may serve as Medical Technical Specialists to the Incident Command structure during a pandemic. They should be consulted for any practice/process changes and/or issues identified related to infection prevention and control. During times of pandemic, the responsibilities and demands on these SMEs may become stretched. It is advisable to designate a key person in each department to act as the liaison for infection prevention and control. The department level person can assist with keeping abreast of updates related to infection prevention and control, fielding questions to clarify with the SMEs, coordinate educational offerings and monitoring adherence to infection control practices in the department.

Scope

VA is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China in December 2019 and is now responsible for a global pandemic as of March 11, 2020. The virus has been named “SARS-CoV-2” and the disease it causes has been named “coronavirus disease 2019” (abbreviated “COVID-19”).

Mode of Transmission of SARS-CoV-2 Virus - The SARS-CoV-2 virus is transmitted primarily by respiratory droplets. Primarily” by droplets reflects that in certain circumstances, droplets can turn into aerosol particles which might be theoretically able to spread by the airborne transmission route, typically during aerosolizing procedures, such as intubation; however, most data to-date indicate that the predominant mode of transmission is via droplet spread.

Direct & Indirect Droplet. Reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity (within three to six feet). The contribution of small respirable particles, sometimes called “aerosols” or “droplet nuclei”, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.

The main difference between the two types of transmission is: droplets drop, and airborne particles float. Droplets are larger and generally easier to control than the smaller airborne particles. Additionally, SARS-CoV-2 may be transmitted by direct or indirect contact.

Routine IPC practice, Non-Pharmacological Interventions (NPI), and additional measures to limit/ prevent transmission of infection are important. The primary NPIs for health care systems involve surveillance/screening, patient cohorting, staff cohorting,

visitor restriction, hand hygiene, respiratory etiquette, isolation and PPE use.

Additional NPIs include, but are not limited to:

- Education of staff, patients/residents and visitors regarding the transmission and prevention of COVID-19, stressing individual responsibility and measures to be implemented. This information must be understandable and reinforced. Additional controls, such as the segregation of patients/residents with COVID-19 from those with other medical conditions within the health care facility.
- Physical distancing of 6 feet or more - changing practices within health care facilities to provide /physical distancing (e.g., closure of dining rooms, limiting or stopping outside visitors, pre- arranged traffic flow patterns in the facility which separate COVID-19 patients from non-COVID-19 patients, restricting communal/group activities [e.g. recreational facilities/activities, dedicated space in physical therapy/occupational therapy for COVID-19 patients or care provided in the patient's room, etc.]).
- Dedicating specific areas for treatment/care of COVID-19 patients (e.g., specific rooms in diagnostic or procedural areas, operating rooms, use of portable x-rays at the point of care when feasible, etc.). A shift in paradigm concerning modalities for care delivery for COVID-19 patients or the converse (e.g., drive-through pick-up of medications, screening for COVID-19, virtual visits).
- Alternate sites for provision of care may be employed (e.g. home care, telemedicine, temporary sites set up specifically for the care of COVID-19 persons which is spatially separate from the site where persons seeking non-COVID related medical care are seen, etc.). Limit movement of patients to medically essential purposes.

IPC resources may need to be prioritized. Situations must be critically evaluated to determine situations in which Personal Protective Equipment (PPE) is indicated, based on CDC guidance. Prior to any patient interaction, all health care professionals (HCPs)/staff have a responsibility to assess the infectious risk posed to themselves, other patients, visitors and co-workers by a patient, situation, or procedure. The risk assessment is based on professional judgment about the clinical situation and up-to-date information on how the specific health care organization has designed and implemented engineering and administrative controls, along with the availability and use of PPE. All HCPs are responsible to wear the recommended PPE and to properly don and doff PPE. Transmission of virus can occur from contaminated surfaces on PPE, if not removed properly.

Current recommendations from CDC for Transmission Based precautions for COVID-19 are to be followed. These can be located at:

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

In addition to standard precautions, droplet or airborne infection isolation and contact precautions should be followed for patients with known or suspected COVID-19 as long as appropriate PPE is available. Refer to the CDC Guidance "Interim Infection

Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings” for current information.

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

Standard Precautions include strict adherence to hand hygiene and selection of appropriate PPE, such as gloves, gowns, masks, face and eye protection. During aerosol-generating medical procedures (e.g., endotracheal intubation or bronchoscopy), a N95 respirator, eye and face protection, a gown and gloves are to be worn.

NOTE: While CDC does not designate collection of nasopharyngeal specimens as an aerosol-generating medical procedure, PPE recommendations are stringent for this procedure. CDC has recommended use of gown, gloves, eye protection and preference for N95 respirator for PPE used during specimen collection. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.

Health care personnel are at high risk of exposure and illness during an infectious disease outbreak/epidemic/pandemic due to their close contact with contagious patients. The infection prevention aspect of this emergency management plan includes provisions to protect health care personnel during an infectious disease outbreak/epidemic/pandemic.

These provisions include, but are not limited to:

- Encouraging and monitoring compliance with IPC practices, including PPE selection and appropriate donning and doffing of PPE.
- Having adequate PPE for staff. Having a fit-testing program for designated HCP for respirators.
- Having a culture supporting employees to not report to work while ill.
- Encouraging employees to develop personal/family disaster plans that enable them to work.
- Providing telework options for employees when the work can be accomplished via telework.
- Explicitly state the scope of emergency and disaster response and the entities (e.g., departments, agencies, private sector and citizens) and geographic areas to which the plan applies
- Consider having testing available for symptomatic employees, using contact tracing principles to identify and mitigate potential spread within the facility.

This Appendix/chapter provides IPC information which applies to all VA health care settings so all sites can use and adapt it for their areas.

Planning Assumptions

Infection Prevention and Control Guidance in this Annex (Infection Prevention and Control) is based on the guidance provided by Centers for Disease Control and Epidemiology (CDC) for COVID-19 and evidence-based outcome data.

Concept of Operations

This Annex will provide specific guidance to VHA employees concerning Infection Prevention and Control principles and measures to be followed for COVID-19. This information will guide practices to mitigate and prevent transmission of COVID-19 in VA health care facilities. Specific guidance follows key definitions:

Definitions

Aerosol-Generating Medical Procedures (AGMPs): Any procedure carried out on a patient that can induce the production of aerosols of various sizes, including droplet nuclei. Examples include, but are not limited to: non-invasive positive pressure ventilation (BIPAP); Continuous Positive Airway Pressure (CPAP); endotracheal intubation; respiratory/airway suctioning; high-frequency oscillatory ventilation; tracheostomy care; chest physiotherapy; aerosolized or nebulized medication administration; diagnostic sputum induction; bronchoscopy procedure; and autopsy of lung tissue.

Airborne Infection Isolation Room (AIIR) as defined by the CDC (previously referred to as Negative Pressure Isolation Room): A room with air pressure differential between two adjacent airspaces such that air flow is directed into the room relative to the corridor ventilation, e.g., room air is prevented from flowing out of the room and into adjacent areas. These rooms are used for patients requiring Airborne Transmission-based Isolation Precautions

Close Contact for health care exposures is defined as follows:

- Being within approximately six feet (two meters), of a person with COVID-19 for a period > 15 minutes (such as caring for or visiting the patient; or sitting within six feet of the patient in a health care waiting area or room);
- Having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

Data are limited for definitions of close contact. Factors for consideration include the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the patient (e.g., coughing likely increases exposure risk) and whether the patient was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment), PPE used by personnel and whether aerosol-generating procedures were performed.

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Mode of Transmission: The manner in which an infectious disease is transferred to a person. Breaking the chain of mode of transmission is one of the most important ways to interrupt the spread of infection. This is where infection prevention strategies can be most effective. Microorganisms can be transmitted by three main routes: 1) airborne

mode of transmission; 2) contact mode of transmission; and 3) droplet mode of transmission.

PPE selection and cleaning/disinfection practices for COVID-19 are based on breaking the chain of transmission for the modes of transmission.

Droplet Mode of Transmission: Transmission occurs when droplets containing microorganisms generated during coughing, sneezing and talking are propelled through the air. These microorganisms may land on another person, entering their body through contact with the eye conjunctivae, nasal mucosa or mouth. These can then be breathed into the lungs. These microorganisms are relatively large and travel only short distances (up to six feet/two meters). They do not remain in the air for long periods of time. These infected droplets may remain on surfaces for long periods of time, so these surfaces (within the range of the coughing/sneezing person) are to be considered contaminated and require cleaning and disinfecting. For this reason, there may be both Droplet and Contact Precautions required at the same time.

Airborne Mode of Transmission: Airborne transmission of infectious agents can occur by airborne droplet nuclei (small particles of five mm or smaller in size) or dust particles containing infectious agents.

Microorganisms carried in this manner remain suspended in the air for long periods of time (float) and can be dispersed widely by air currents. There is risk that all the air in a room may be contaminated.

Some examples of other microorganisms that are transmitted by the airborne route are: M. tuberculosis (TB), rubeola, varicella and hantaviruses.

Contact Mode of Transmission: Can be divided into two types: direct and indirect.

- **Direct:** Involves direct body surface contact and physical transfer of microorganisms between an infected or colonized person to another by touch.
- **Indirect:** Involves contact between a person and a contaminated object. This frequently involves unclean hands contaminating an object or surface in the environment. The microorganism remains on the surface to be picked up by the next person who touches it. The length of time COVID-19 stays viable on surfaces is unknown at this time. Studies of similar coronaviruses indicate viability on environmental surfaces for up to nine days.⁸

Standard Precautions

Infection prevention measures that are used for all patient care. They are based on a risk assessment and make use of common-sense practices and personal protective equipment (PPE) use that protect health care providers from infection and prevent the spread of infection from patient to patient. These precautions include, but are not limited to the selection and use of PPE whenever there is an expectation of potential exposure to infectious material, proper use of hand hygiene, respiratory hygiene/cough etiquette principles, and proper handling, cleaning and disinfection of patient care equipment and proper patient placement according to infection transmission risk. Room placement decisions are made balancing risks to other patients.

⁸ Kampf, G. et al. Journal of Hospital Infection, Volume 104, Issue 3, 246 – 251.
[https://www.journalofhospitalinfection.com/article/S0195-6701\(20\)30046-3/fulltext](https://www.journalofhospitalinfection.com/article/S0195-6701(20)30046-3/fulltext)

Non-Pharmaceutical Interventions (NPIs)

Actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic influenza (flu). NPIs are also known as community mitigation strategies. When a virus spreads among people, causing illness worldwide, it is called pandemic virus. The human population has little or no immunity against this novel virus. This allows the virus to spread quickly from person to person worldwide. NPIs are among the best ways of controlling pandemics when vaccines are not yet available.

There are 3 basic types of NPIs:

1. Community NPIs: Policies and strategies that organizations and communities put into place to help slow the spread of illness during an infectious disease outbreak, such as a pandemic.

Two of the most commonly used community NPIs include:

- **Physical distancing:** Creating ways to increase distance between people in settings where people commonly come into close contact with one another. Specific priority settings include schools, workplaces, events, meetings and other places where people gather.
- **Closures:** Temporarily closing child-care centers, schools, places of worship, sporting events, concerts, festivals, conferences and other settings where people gather.

2. Environmental NPIs Examples: Routine surface cleaning that helps to eliminate the virus from frequently touched surfaces and objects, such as kiosks, keyboards, cell phones, desks and doorknobs in homes, childcare facilities, schools, workplaces and other settings where people regularly gather.

3. Personal NPIs Examples: Staying home when you are sick, covering coughs and sneezes and hand hygiene.

- Examples of NPIs during a pandemic: Staying home if you have been exposed to a family or household member who is sick, staying in a separate section of your home from others you live with if you are sick or have been exposed to someone who is ill, in case you are incubating the infectious diseases.

Transmission-Based Precautions

Transmission-Based Precautions are the second tier of basic infection control measures. These are used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to break the chain of transmission. These are the types of transmission-based precautions:

- **Airborne Infection Isolation (AII):** Patients known or suspected to be infected with pathogens transmitted by the airborne route.
- **Interventions for Source Control:** Put a mask on the patient. Ensure appropriate patient placement in an airborne infection isolation room (AIIR) constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient

and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned home.

- **HCPs:** Use PPE appropriately, including a fit-tested NIOSH-approved N95 or higher-level respirator for health care personnel. Limit transport and movement of patients outside of the room to medically necessary purposes. If transport or movement outside an AIIR is necessary, instruct patients to wear a surgical mask, if possible and observe Respiratory Hygiene/Cough Etiquette. Health care personnel transporting patients who are on Airborne Precautions do not need to wear a mask or respirator during transport if the patient is wearing a mask.

Contact Precautions

For patients with known or suspected infections that represent an increased risk for contact transmission with direct or indirect contact.

Patient placement: Ensure appropriate patient placement in a single patient space or room if available in acute care hospitals. Cohorting may be required depending on space availability. In long-term and other residential settings, make room placement decisions balancing risks to other patients. In ambulatory settings, place patients requiring contact precautions in an exam room or cubicle as soon as possible. Use PPE appropriately, including gloves and gown. For COVID-19, eye protection with goggles or facemask with eye protection is recommended. Refer to the CDC website for the most current guidance: <https://www.cdc.gov/coronavirus/2019-nCoV/index.html>. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens and prevent unintentional contamination. Limit transport and movement of COVID-19 patients outside of the room to medically necessary purposes. When transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport location. Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient. Prioritize cleaning and disinfection of the rooms of patients on contact precautions ensuring rooms are frequently cleaned and disinfected (e.g., at least daily or prior to use by another patient if outpatient setting), focusing on frequently touched surfaces and equipment in the immediate vicinity of the patient.

Droplet Precautions

For patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking.

Source Control: Put a mask on the patient. Ensure appropriate patient placement in a single room if possible. In acute care hospitals, if single rooms are not available, utilize the recommendations for alternative patient placement considerations in the CDC

Guideline for Isolation Precautions. In Community Living Centers / long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives. In ambulatory settings, place patients who require Droplet Precautions in an exam room or cubicle as soon as possible and instruct patients to follow Respiratory Hygiene/Cough Etiquette recommendations.

PPE: Don mask upon entry into the patient room or patient space. Limit transport and movement of patients outside of the room to medically necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene and Cough Etiquette.

Personal Protective Equipment (PPE)

It is very important to don and doff PPE in the correct order to prevent contamination.

The CDC presentation (below)* provides guidance concerning PPE, including doffing and donning. This guidance should be shared widely.

*The following link, Guidance for the Selection and Use of PPE in health care settings may be helpful for staff review for PPE: <https://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf>

PPE for care of persons suspected to have or diagnosed with COVID-19. Follow CDC Guidelines for Transmission Based Precautions as outlined in “Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)”: <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

Specific to COVID-19, follow CDC guidance:

“Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings”:

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

In addition to Standard Precautions, the following Transmission-Based precautions are recommended for care of COVID-19 persons: Droplet AND Contact Precautions plus Eye Protection.

Airborne Precautions AND Contact Precautions plus Eye Protection are to be followed with Aerosol Generating Procedures (AGPs).

If admitted, place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room with the door closed. The patient should have a dedicated bathroom. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients who will be undergoing aerosol generating procedures.

Respiratory Protection:

Respiratory protection for AGPs/ CDC-defined high risk exposures

(<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>)

that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator or Purified Air Purifying Respirator (PAPR). These respirators offer a higher level of protection and are used to prevent inhalation of small particles that may contain infectious agents transmitted via the airborne route.

The respirator is to be donned before entry into the patient room or care area. Fit testing of an N95 or higher-level mask is required. Special attention to proper technique for donning and doffing masks is required to prevent transmission of microorganisms. The surface of the mask can become contaminated from droplet nuclei that land on the mask surface.

In the event there is a shortage of N95 level respirator masks during the pandemic, there may be a need to allocate according to risk stratification. If this occurs, there may be a need to reserve use of available N95 respirators (or respirators that offer a higher level of protection) for performing or when present for an aerosol-generating procedure (per CDC guidance). As per CDC, a regular facemask may be used when the supply of N95 level respirators is limited, in the milieu of the pandemic.

Eye Protection:

Goggles or disposable face shield that protects the membranes/conjunctivae of the eyes and covers the front and sides of the face. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.

Contact Precautions:

A single-patient room is preferred for patients who require contact precautions.

PPE: HCPs wear gowns and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.

Don PPE upon room entry and discard before exiting the patient room. *"Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings"

Located at:

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

If unable to provide All due to lack of AIIR or shortage of N95 masks, Droplet Precautions are to be followed, in addition to Contact Precautions and Eye Protection.

In the event there is a shortage of AIIRs - negative airflow rooms - alternate settings may need to be used (e.g., single patient room with the door closed).

At any given time, a shortage of PPE supplies could occur. Per CDC*: Based on local and regional situational analysis of PPE supplies, regular facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this VHA COVID-19 Response Plan

time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to HCP.

- Facemasks protect the wearer from splashes and sprays
- Respirators, which filter inspired air, offer respiratory protection

When the supply chain is restored, facilities should return to use of respirators for patients with known or suspected COVID-19.

Droplet Precautions:

Patient placed in private room with door closed. PPE: Masks and Eye Protection.

Masks may be used in combination with goggles to protect the mouth, nose and eyes, or a face shield may be used instead of a mask and goggles, to provide more complete protection for the face. Masks should not be confused with particulate respirators that are used to prevent inhalation of small particles that may contain infectious agents transmitted via the airborne route. Masks are effective as a barrier for larger droplets.

PPE & ICP Considerations: Aerosol Generating Procedures (AGPs)

Perform a risk assessment based on professional judgement about the procedure and current information to determine the appropriate administrative controls, environment controls and PPE. Whenever possible, ensure AGPs are conducted in a controlled setting. Early recognition of patients who may require high-risk interventions is required (e.g., intubation, bronchoscopy) in order to avoid emergency situations. Perform these procedures in an AIIR, if feasible and/or whenever possible. The availability of these rooms may be limited. If this is not possible, perform the procedures in a single room. If a single room is not available, a minimum of six feet (two meters) separation with privacy curtains should be used. Limit personnel in the room. All personnel in the room must wear PPE (e.g. gowns, gloves, N95 respirators or equivalent and eye protection). Do not delay urgent procedures waiting for an AIIR. Refer to the definitions in this Annex (B) for a list of AGPs.

PPE: Gowns

Gowns are identified as the second-most-used piece of PPE, following gloves, in the health care setting. Isolation gowns are defined by Association for the Advancement of Medical Instrumentation (AAMI) as the protective apparel used to protect HCWs and patients from the transfer of microorganisms and body fluids in patient isolation situations.

The Food and Drug Administration (FDA) also defines isolation gowns similarly: “a gown intended to protect health care patients and personnel from the transfer of microorganisms, body fluids and particulate material”. Standard isolation gowns are to be worn.

Standard isolation gowns are typically Level 2 or 3 gowns, based on the Levels of gowns as determined by standards of the American National Standards Institute (ANSI) and the Association of the AAMI: ANSI/AAMI PB70:2003 & the FDA.

Check with the manufacturer of the gown to determine what level of protection the gown is designated and/or provides. Sterile gowns, surgical gowns and chemo gowns are not indicated as PPE of persons suspected/known to have COVID-19. Isolation gowns are

not the same as surgical gowns. It may be helpful to monitor gown use to assure appropriate use, based on this guidance and in the event of shortages, conduct a risk assessment for allocating gowns for highest risk procedures (e.g., contact with body fluids, splashes, etc.)

According to the CDC's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting 2007, pg. 52 II.E.2., Isolation gowns are used, as specified by Standard and Transmission-Based Precautions, to protect the HCP's arms and exposed body areas and prevent contamination of clothing with blood, body fluids and other potentially infectious material.

The need for and type of isolation gown selected is based on the nature of the patient interaction, including the anticipated degree of contact with infectious material and potential for blood and body fluid penetration of the barrier. The wearing of isolation gowns and other protective apparel is mandated by the Occupational Safety & Health Administration (OSHA) Bloodborne Pathogens Standard 739. Clinical and laboratory coats or jackets worn over personal clothing for comfort and/or purposes of identity are not considered PPE.

Here is the link to the CDC Guideline for Isolation Precautions:

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/>

The CDC published guidance for PPE for the previous outbreak of SARS-CoV. This document indicates the following:

“Gown and gloves - Wear a standard isolation gown and pair of nonsterile patient-care gloves for all patient contacts. The gown should fully cover the front torso and arms and should tie in the back. Gloves should cover the cuffs of the gown.”

Here are links to the CDC SARS guidance documents concerning PPE/gowns:

<https://www.cdc.gov/sars/guidance/i-infection/healthcare.html>

<https://www.cdc.gov/sars/guidance/i-infection/app2.html>

PPE Recommendations for Mortuary Services

Follow CDC guidance: “Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020”

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html>

Strategies for PPE Conservation During COVID-19

- PPE & VHA MDRO Prevention Program: With increasing cases of Coronavirus as well as PUI shortages across the country, there were concerns about the availability of gowns, gloves, masks and other PPE at any given time, at local facilities. The VA National Methicillin Resistant Staphylococcus Aureus (MSRA)/Multi-Drug Resistant Organism (MDRO) Task Force members made “temporary” changes to the Contact Precautions and Enhanced Barrier Precautions policy for the MDRO/MRSA Prevention Program during the COVID-19 pandemic.

Check the most current version of the clarification document posted on the VHA High Consequence Infection (HCI) Preparedness Program Share Point: MDRO Initiative “MRSA” website: <http://vaww.mrsa.va.gov/MRSA.asp>

- PPE- N95 Masks Conservation: Refer to CDC Guidance for “Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response”:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirator-supply-strategies.html

CDC Guidance Documents:

- “Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response”:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html>
- “Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response”:
<https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html>

Environmental Cleaning and Disinfection

Equipment should be cleaned and disinfected according to manufacturer’s instructions and facility policies. The same guidance applies to medical equipment for patient care/use and IT equipment, such as kiosks and keyboards. Consider use of wipeable covers for electronics. Check with your local IT department for further guidance.

Surface Disinfectants: Products with EPA-approved “emerging viral pathogens” claims are recommended for use against COVID-19, based on data for harder to kill viruses. Follow the manufacturer’s instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).

Verify with the manufacturer’s instructions that the EPA-approved “emerging viral pathogen” product is compatible for the surface being cleaned and disinfected.

These products can be identified by the following claim:

“[Product name] has demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces. Therefore, this product can be used against COVID-19 when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces.”

This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, “1-800” consumer information services, social media sites and company websites (non-label related). Specific claims for “COVID-19” will not appear on the product or master label. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.

<https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>

References

1. APIC Text of Infection Control and Epidemiology. Chapter 121- “Infectious Disease Disasters: Bioterrorism, Emerging Infections, and Pandemics. Published 10/3/14-

Revised 3/5/20 <https://text.apic.org/toc/community-based-infection-prevention-practices/infectious-disease-disasters-bioterrorism-emerging-infections-and-pandemics#embed-17236> - accessed 6/29/20

2. Centers for Disease Control and Prevention (CDC). Coronavirus Disease 19 (COVID-19) <https://www.cdc.gov/coronavirus/2019-nCoV/index.html> - accessed 6/29/20
3. Department of Veterans Affairs. National Infectious Diseases Service (NIDS) "VHA Suggested Strategies for PPE During COVID-19"- 3/11/20 The document can be found on the MDRO Initiative "MRSA" website: <http://vaww.mrsa.va.gov/MRSA.asp>
4. Kampf, G., Todt, D, Pfaender, S., and Steinmann, E. "Persistence of coronaviruses on inanimate surfaces and their inactivation with biocidal agents" Journal of Hospital Infection Volume 104, Issue 3, March 2020, Pages 246-251_ <https://www.sciencedirect.com/science/article/pii/S0195670120300463?via%3Dihub> - accessed 6/29/20
5. U.S. Department of Health and Human Services Pandemic Influenza Plan 2017 UPDATE: <https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>- accessed 6/29/20

Appendix J – Clinical Practice Guidelines

The following Appendix supports the Clinical Practice Guidelines.

VHA develops national policy from laws and regulations that establish the roles and responsibilities for all aspects of health care delivery, management and oversight through national directives and memorandums. For COVID-19, VHA has released a series of guidance memorandums to all VHA facilities that together address the provision of safe and quality health care for Veterans. A full list of the guidelines grouped under the following categories can be found at the following webpage:

<https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/Administration/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVACOVHAPublicHealth%2FHCI%2FAdministration%2FDUSHOM%20Guidance&FolderCTID=0x012000745D115C5DCC6540A5DB728FFF62BBC6&View=%7B3D72DE37%2D619D%2D41FF%2DB687%2D6B108DDB1A5F%7D>

Topic	Date	Policy
Related Directives	02/22/20	VHA Directive 0320.02, VHA Continuity Program
	4/21/20	VHA Directive 1047, All Hazards Emergency Cache Program
	4/21/20	VHA Directive 1899, Healthcare Professional Practice in VA
Infection Control/Isolation/Quarantine	3/10/20	Guidance for Spinal Cord and Disorders Centers
	3/11/20	Homeless Program Response Suggestions
	3/14/20	Guidance for Mental Health Residential Rehabilitation Treatment Programs
	3/15/20	COVID-19 Action Plan for Blind Rehabilitation Centers (VHA)
	3/16/20	Guidance for Department of Veterans Affairs (VA) Health Care Systems (also under screening/triage)

	3/16/20	Guidance for Geriatrics and Extended Care Home and Community Based Services Programs
	3/17/20	Guidance for Community Living Centers – Revised
	3/19/20	Guidance for Fisher Houses
	3/19/20	Isolation vs. Quarantine Poster
	3/24/20	Guidance for Nutrition and Food Service
	4/3/20	Guidance for Notifications Surrounding Exposures of Health Care Personnel with COVID
	4/9/20	DHS, Risk and Exposure Mitigation Best Practices for Law Enforcement
	5/15/20	Updated Guidance: Funding for Homeless Veterans Stand Downs
	7/20/20	COVID-19: Updates for Eye Protection in Department of Veterans Affairs (VA)
Disinfection/Cleaning		
	4/14/20	Cleaning Guidance for Re-Usable Medical Equipment and Patient Rooms
	5/21/20	Cleaning Matrix
Personal Protective Equipment		
	4/16/20	Update: Coronavirus (COVID-19) Return to a Contingency Strategy for Facemask and N95 Use
	3/20/20	PPE Conservation Strategies for Pharmacy Compounding
	4/7/20	FDA Guide for Respirators REVISED
	4/7/20	Facemask and N-95 Respirator Use and Attachment
	4/8/20	See Administration, Donations of PPE

VHA COVID-19 Response Plan		
	5/1/20	Update: Coronavirus (COVID-19) Mask Use in Veterans Health Administration (VHA) Facilities
	5/11/20	Personal Protective Equipment (PPE) in the Magnetic Resonance Imaging (MRI) Environment
	7/31/20 of 5/26/20	Clarification for COVID-19 Memorandum Addressing Requirements for Providing Personal Protective Equipment for Selected Home Care Services.
Screening/Triage		
	3/2/20	Surveillance and Virtual Resource Utilization Planning (Guidance on ways to reduce face to face contact when screening patients)
	3/16/20	Guidance for Department of Veterans Affairs (VA) Health Care Systems (also under infection control)
	3/20/20	Screening Process Maps
	3/26/20	VetLink Screening Scripting
	5/12/20	Updated Guidance on Screening Procedures and Facility Access for Department of Veterans Affairs (VA) Health Care Systems
	5/19/20	Coronavirus (COVID-19) Non-Clinical Screening for Entry into Health Care Facility
	5/28/20	Temperature screening considerations to identify possible cases of COVID-19
Diagnostics/Testing		
	2/11/20	Standardization of Laboratory Reporting
	3/17/20	Revised Standardization of Laboratory Testing
	4/6/20	Clinical Laboratory Improvement Amendments

	4/9/20	Prioritizing Testing to Maximize Value for Response
	6/11/20, original 4/15/20	CLC and SCI/D Unit Veteran and Staff Testing
	4/21/20	Supplemental Information to CLC and SCI/D Testing
	5/14/20	COVID-19 Updated Guidance on Testing for Veterans and Employees
	5/29/20	Discontinuation of Transmission-Based Precautions for Patients with Confirmed COVID-19 in Settings
Surveillance		
	4/17/20	National Surveillance Tool for VHA COVID Operations
	5/5/20	Network Surveillance
Treatment		
	3/15/20	Ensuring Continuity in Suicide Prevention
	3/15/20	Guidance for Elective Procedures
	3/30/20	Guidance for Emergent and Urgent Surgical Procedures
	4/20/20	Implementation of an Episodic Special Patient Icon in Bed Management Solution
	6/26/20, update of 5/26/20, 4/14/20	Continuity in Mental Health and Suicide Prevention
	3/30/20	Hardening of Mental Health Residential Rehabilitation Treatment Programs
	3/19/20	Colonoscopy Screening Guidance
	3/19/20	Radiology and Nuclear Medicine Clarification Guidance
	3/30/20	Radiology and Nuclear Medicine, Appendices A, B and C
	3/20/20	Guidance for Dialysis

	3/21/20	Interim Guidance for the Medical Management of Hospitalized COVID Patients and SOP
	3/20/20	See also Primary Care Guidance under Telemedicine/Virtual Care
	3/23/20	Guidance Limiting Hydroxychloroquine Prescriptions to 30-day Supplies
	3/24/20	Guidance on Eye Care Operations during COVID
	3/24/20	Elective Gastroenterology and Hepatology Procedures
	3/30/20	Guidance to Avoid Routine and Non-Urgent Face to Face Visits
	3/30/20	Transplantational Care Guidance
	4/6/20	Anticoagulation Therapy
	4/8/20	Crisis Standards of Care
	4/14/20	Decedent Care
	4/27/20 (4/13/20)	Use of Automated of Mechanical Chest Compression Devices to Reduce to Healthcare Provider Exposures to COVID-19
	4/17/20	Primary Care Field Guide for Managing COVID-19 Patients
	5/14/20	COVID-19 Requirements for the Caregiver Support Program: Identification of High-Risk Veterans Participating in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) (original 4/27/20)
	4/30/20	Corrected: Contingency Plans for Staffing Shortages in Mental Health and Suicide Prevention
	05/01/20	Guidance for Urgent/Emergent Operating Room Procedures for COVID-19

VHA COVID-19 Response Plan		
	5/8/20	Remdesivir Distribution for Department of Veterans Affairs (VA) patients
	5/22/20	Moving Forward: Guidance for Resumption of Procedures for Non-Urgent and Elective Indications
	7/29/20	COVID-19 Supplemental Consent for Scheduled Operative and Invasive Procedures
Telemedicine/Virtual Care		
	5/20/18	Use of Telemedicine while providing Medication Assisted Treatment (DEA)
	3/19/20	Recommendations for Pulmonary/Sleep Ambulatory Services, use of Telehealth services, Non-urgent Procedures and Screening During Community Spread of COVID-19
	3/20/20	Use of Video Communications for Patient Care during COVID-19
	3/20/20	Changes to On-line Scheduling
	3/17/20	Supporting ICU Operations with Tele-Critical Care
	3/19/20	Appendices for Expanding Telehealth Capabilities
	3/11/20	Protecting Veterans and VA by Leveraging Video TeleHealth for Clinics and Home
	3/21/20	Controlled Substance Prescribing using Telehealth and Appendices
	3/21/20	Guidance on Caregiver Support
	3/21/20	Use of Standard Care Messaging
	6/9/20, original 3/20/20	Primary Care Guidance
	3/25/20	Supporting Critical Care Demand Surge through Tele-Critical Care and Appendices

	3/28/20	VANTS Use for Patient Care
	3/30/20	Updated Guidance on Access Standards and Access COVID Toolkit
	3/30/20	Leveraging Capacity to Support Surges in Demand for COVID and Attachment
	3/30/20	Clinical Resource Hub Activation Guidance for Clinical Contact Centers
	4/14/20	Tele-critical Care Consultative Continuity
	4/21/20	Technical Recommendations for Tele-Radiology during COVID-19 and Other National Emergencies
	4/24/20	COVID-19: Telehealth to Community Living Centers and State Veterans Homes
	4/24/20	COVID-19: Increased Remote Patient Monitoring – Home Tele-health Staffing Needs for COVID-19 Patients
	4/28/20	Supporting Virtual Care in Mental Health Services and Suicide Prevention Activities During COVID-19
	4/29/20	Changes to the Department of Veterans Affairs (VA) Online Scheduling (VAOS) Mental Health Appointment requests during Coronavirus (COVID-19)
	5/1/20	Coronavirus (COVID-19): Store and Forward Telehealth in the Home
	5/18/20	National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065– COVID-19 Upgrades (see also 3/20/20 Access Standards)
	5/27/20	Implementation of COVID-19 Aid, Relief, and Economic Security (CARES) Act Telehealth Requirements in the Housing and Urban Development-Veterans Affairs Supportive Housing Program

Administration		
	5/26/20, update of 3/6/20	Postponement of Long-term Care Surveys
	7/10/20 update of 6/9/20 update of 5/5/20	Mission Critical Travel
	3/16/20	Waiver of Bi-Weekly Pay Cap (VA)
	4/9/20	Emergency Credentialing and Privileging
	3/30/20	Emergency Credentialing and Privileging, Additional Guidance
	5/27/20	Guidance on Inspections, Fire Drills and Routine Maintenance of Equipment
	3/20/20	Mandatory Implementation of Bed Management Solutions for Community Living Centers
	3/20/20	Guidance on Access Standards During COVID-19
	3/30/20	Updated Guidance on Access Standards, See Virtual Care
	See 6/5/20 HUD- VASH (below), original 3/13/20	Available Supportive Services for Veterans Families for Homeless Veterans at risk for COVID-19
	7/7/20 update of 5/18/20, original 4/1/20	Outpatient Scheduling Management Post COVID
	3/20/20	Attorney General, Federal Employee Exemption from State-imposed Shelter-in- Place Orders
	3/23/20	Essential Health Care Operations Allowed to Continue under Shelter in Place
	3/24/20	Emergency Child Care Guidance

VHA COVID-19 Response Plan		
	3/24/20	Preparedness for Mechanical Ventilation
	3/24/20	Safeguards for Military Environmental Registry Exams
	3/25/20	Personal Liability of Federal Employees
	3/26/20	Use and Disclosure of Employee PHI During COVID-19, Fact Sheet on Serious and Imminent Threat and Privacy Questions
	3/26/20	Use of Government Purchase Cards for PPE with Amazon
	3/25/20	Interim Guidance in Consideration of COVID-19 Pandemic: Environmental Validation of Engineering Controls of Legionella Growth
	3/30/20	Clarification on IPEC Legionella Reporting
	3/27/20	COVID-19 Definitions of Bed Categories
	3/27/20	Suspension of Face to Face Payment Operations
	3/30/20	Guidance in Hiring, Compensation and Utilization of Alternate Nurse and Assistive Personnel
	3/30/20	Suspension of Registered Nurse Transition to Residency Practice
	5/7/20 Q&A, 4/1/20	Authority to Pay for Lodging and Meals
	4/2/20	Bed Expansion Planning and Reporting
	4/2/20	508 Compliance for Posting Videos Related to COVID Training on VA Share Points
	4/9/20	Managing Donations of PPE
	4/2/20	Contracted Outpatient Sites of Care
	4/2/20	Changes to MOVE Weight Management Activities

	4/2/20	Changes in In-Person Identity Verification to MyHealthyVet
	4/3/20	Temporary Pause In-Person Verification for MyHealthyVet
	4/3/20	Exemptions of Clinical and Admin Staff from EHRM Activities
	4/6/20	Guidance for Tuberculosis Testing for New Employees
	4/6/20	Guidance for Veterans in Residential Settings Participation in 2020 Census
	4/6/20	Release of State Veterans Homes Per Diem FY20-21
	4/6/20	Professional Practice Evaluation Guidance
	4/6/20	Public Housing Closure, Supportive Services for Veterans Families
	4/7/20	Child Care Subsidy
	4/7/20	Guidance for Academic Detailing Services
	4/14/20	State Veterans Home Admission Issue Brief Requirements
	4/14/20	Purchased Long-Term Services and Support
	4/14/20	Temporary Moratorium on non-COVID Required Training
	4/15/20	Equipment Re-certification and Management of Surge Capacity
	4/15/20	Nursing Documentation Standard Operating Procedure for Acute Care Units
	4/15/20	Workplace Violence Prevention Reporting Extension
	4/16/20	Updated: Postponement of Long-term Care Surveys

	4/17/20	Homeless Program Office Staffing Surge
	4/17/20	Ordering iPADS for Patient and Provider Use
	4/21/20	CRNA Practice During the COVID-19 National Emergency
	4/22/20	Mandated Implementation of COVID-19 CPRS Tools
	4/20/20	Increase in Annual Hour Limitation for Part-Time/Intermittent Title 38 Registered Nurses/Advanced Practice Nurses, Certified Registered Nurse Anesthetists and Physician Assistants
	4/22/20	Hosting Blood Drives at VA Medical Centers
	4/22/20	Instructions for Admitting State Home Veterans during the COVID-19 Pandemic
	4/23/20	Suspension of VHA Collection Activities and Extension of VHA Claim and Appeal Filing Deadlines
	4/27/20	VISN Bed Expansion Planning for Post-Acute Surge
	4/28/20	Updated: Postponement of Long Term Care Surveys
	4/28/20	Bed Management Solution (BMS) Beds Out of Service for Bed Expansion
	4/27/20	Authorization to Waive Certain Limitations on Pay During the Coronavirus Disease 2019 (COVID-19) Public Health Emergency
	5/11/20	Clarification for VISN Reports of Positive and PUI Veterans
	5/14/20	COVID-19 Documentation in the Homeless Operations Management and Evaluation System (HOMES)

	6/3/20	SecVA: Department Bargaining Guidance During Coronavirus Disease (COVID-19) Pandemic
	6/5/20	Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) Admissions During COVID-19 Response
	6/9/20	VHA Transportation Guidance during Coronavirus (COVID-19)
	6/8/20	Updated Guidance, due to COVID 19 Response Operations, for Information and Instructions for Fiscal Year 2020 Reusable Medical Equipment (RME) Program Audits
	6/9/20	On-Site Volunteer Engagement at VHA Facilities
	6/16/20	Reporting Operating Room Guidance
	6/9/20 update of 4/9/20	Use YourIT Services to Expedite User Provisioning in VistA
	6/26/20	Mid-course Review of VHA's Response to COVID-19
	7/9/20	VHA 3D Printing National Database Survey
	7/16/20	Protocol for Homeless Veterans At-Risk of COVID-19 Placed in Hotels and Motels by the Supportive Services for Veteran Families Program
Human Resources		
	5/14/20	Authority to Approve Weather and Safety Leave for Employees Affected by COVID-19 (original 3/27/20)
	2/12/20	Supervisor Guidance (VA)
	3/4/20	Preliminary Guidance to Agencies (VA)
	3/12/20	HR Flexibilities (VA)
	3/14/20	Recording Ad-Hoc Telework and Weather and Safety Leave

	3/15/20	Federal Government Operating Status in the Washington DC Area
	3/16/20	Guidance for Telework, Scheduling and Duty Location
	3/20/20	UPDATED, HR Facts, Version 4
	3/16/20	Supplemental HR Facts
	3/24/20	Dual Compensation Waiver Authority (5 attachments on HCI SP, Administration, DUSHOM Guidance
	3/25/20	Waiver of Professional Standards Board
	3/25/20	Delegation of Authority – Group Recruitment and Retention for Title 38 Employees
	3/26/20	Establishment of New Hire Processing Timeline
	3/27/20	Retired Annuitants and Traveling Nurse Corps
	4/17/20	COVID-9 Emergency Supplemental Travel Nurse Staffing
	5/18/20	Delegation of Authority to Exclude an Employee from Application of the Emergency Paid Sick Leave Act, Division E of the Families First Coronavirus Response Act
	5/18/20	Veterans Health Administration (VHA) Workers' Compensation Program (WCP) Guidance for Workplace Exposure and Employee Workers' Compensation Claims During COVID-19
	7/21/20	COVID-19 Data Reporting
Law Enforcement		
	3/7/20	VA Police Quarantine Authority

	4/9/20	DHS, Risk and Exposure Mitigation Best Practices for Law Enforcement (See Infection Control)
Emergency Management		
	1/30/20	Request for DEMPS Personnel to Assist HHS Response Effort
	1/31/20	COVID-19 Response Program Responsibilities
	3/20/20	UPDATED Guidance for Managing Local Requests for Assistance
	2/12/20	HHS Request for Support (DEMPS)
	2/18/20	COVID-19 Tabletop Exercises
	3/2/20	Request for DEMPS Personnel to support Police operations at Palo Alto VAMC
	3/3/20	VHA COVID-19 Strategic Response Plan
	3/13/20	Declaration of National Emergency / Stafford Act
	3/26/20	VHA Central Office Clinical Request – DEMPS
	3/30/20	(DEMPS) Leveraging Capacity to Support Surges in Demand for COVID (see Virtual Care)
	4/9/20	Process of Providing Resources to State and Federal Requests
	4/20/20	VHA COVID Incident Operations Plan, version 2 (Annex to VHA HICI Base Plan)
	4/21/20	COVID-19 Pandemic Pre-Approved Deployable Personnel
	5/21/20	Deployed Personnel Reporting Requirements for COVID -19
	6/3/20	Disaster Response During a Pandemic

Safety, Engineering		
	3/2/20	COVID Protection (list of actions to protect staff and Veterans)
	3/20/20	UPDATED Guidance for Work Recommendations for Asymptomatic Healthcare Personnel After Exposure to a COVID-19 Patient
	4/9/20	Engineering Information for the Assessment of the Capacity of Medical Gas Systems
	4/17/20	Guidance for Return-to-Work for Recommendations for Healthcare Personnel with Confirmed or Suspected COVID-19 Illness
	5/12/20	Patient Safety Aspects of Using Infusion Pumps Outside of Patient Rooms
	7/14/20	Patient Safety considerations when using medical devices that require a powered air supply for inflation.
	7/16/20	Patient Safety guidance on the use of face coverings for patients on acute mental health units, specifically with regard to suicide risk.
Logistics		
	2/14/20	Personal Protective Equipment (national data call/Inventory)
	4/3/20	Guidance for Reporting On-hand Inventories of Drugs for COVID
	4/17/20	Reporting PPE Levels and Consumption
	4/28/20	Federal Emergency Management Agency (FEMA) Discontinuation of Procurement Support to Health and Human Services to Acquire Personal Protective Equipment
Legal		
		Federal Quarantine Authority, See Law Enforcement

VHA COVID-19 Response Plan		
		Potential Movement of VA COVID-19 Patients
	4/24/20	Authorization to Use Government Aircraft for Travel of Staff Support to NYC
Public Affairs		
	3/5/20	Communications Plan for VISN and VAMC Leadership
	3/6/20	COVID-19 Communications Toolkit (VHA)
	3/19/20	COVID-19 Fact Sheet
	3/30/20	Communications using the Internet and Social Media
	4/21/20	Capturing Bright Moments and Good News Stories
	4/22/20	Mental Health Care Media Pitch
	05/14/20	Moving Forward Together: Safer Care is Our Mission
	6/23/20	Performance Improvement Management System (PIMS) Utilization (DEMPS Recruitment)
Re-Opening Strategy		
	4/28/20	National Coronavirus Response A Road Map to Re-opening, American Enterprise Institute
	5/1/20	White House, Guidelines for Opening Up America Again
	5/7/20	VA, Charting the Course: Maintaining Continuous Services to Veterans and Resuming Normal, Pre-COVID-19 Operations, VHA Plan
	5/11/20	VHA Moving Forward Plan
	5/17/20	CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Again

	5/22/20	Moving Forward: Guidance for Resumption of Procedures for Non-Urgent and Elective Indications (See Treatment)
	6/9/20	VHA Moving Forward Guidebook
	6/19/20	VA, Chartering the Course: Maintaining Continuous Services to Veterans and Resuming Normal, Pre-COVID-19 Operations
	7/28/20	Visitation to Veterans Health Administration (VHA) Facilities During COVID-19

Appendix K – Guidance for the Safe Performance of Laboratory Testing and Mortuary Care

The following Appendix supports the VHA COVID-19 Incident-specific Annex.

Scope

The latest recommendations are available from the Centers for Disease Control and Prevention (CDC), and World Health Organization for the safe laboratory and mortuary care in cases of Coronavirus Disease 2019 (COVID-19) infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Planning Assumptions

In accordance with these recommendations, laboratories must develop facility specific policies and procedures that take into account local capabilities and regulations.

Concept of Operations

Laboratory Services

Specimens from COVID-19 patients are considered infectious and should be handled appropriately by lab workers using disposable gloves, laboratory coat/gown and eye protection. Generation of aerosols should be avoided. Any procedure expected to generate aerosol or droplets should be conducted within a Class II Biological Safety Cabinet (BSC2). Centrifugation should occur either in a BSC 2 cabinet or a sealed centrifuge, with loading /unloading occurring within a BSC2 cabinet. Any procedure occurring outside a BSC2 should be done with eye and face protection or behind a physical barrier.

Specimen Procurement and Transport to Laboratory

Use of nasopharyngeal or oropharyngeal swabs or sputum to collect diagnostic specimens are likely to produce coughing or sneezing and should be performed in a negative pressure room or at a minimum a closed room with the minimal number of persons present who are wearing appropriate Personal Protective Equipment (PPE). Specimens should be double bagged with the specimen placed in the first bag in the collection room. Specimens should be hand delivered to lab. Use of pneumatic tube systems is to be avoided.

Point of Care Testing

Point of care instrumentation should be left in the isolation room with the patient. If removed from isolation it should be decontaminated according to manufacturer's instructions.

Mortuary Care

Transfer of Human Remains to Morgue

Transfer of the recently deceased from bed to gurney may result in air being expelled from the lungs. Patients should be placed in a body bag prior to transfer and the outer surface of the body bag decontaminated using an Environmental Protection Agency (EPA)- registered hospital disinfectant.

Autopsy

Autopsy may be performed using aerosol precautions. Generally, this includes the use of full PPE and avoidance of the use of power tools such as oscillating saws. Detailed instructions including the procurement of specimens for CDC, cleaning and waste disposal are provided at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html>

Disposition of remains

Transport and disposition of may occur using standard procedures.

Organization and Assignment of Responsibilities

For Laboratory Directors

Laboratory directors are responsible for all laboratory testing (including Point of Care testing) that occurs in their facilities (outlined in the Pathology Handbook 1106.1) and as a result they will develop their own policies and procedures for the testing for COVID-19. These will vary according to the public health lab (VA/State/CDC) used for testing. A standardized test build for VistA was provided in the attached memo.

Currently there are no special precautions for blood or blood products and COVID-19. There has been no documented blood transmission of SARS-CoV-2/COVID 19, previous SARS, or Middle East Respiratory Syndrome (MERS) corona viruses. No special blood precautions are recommended at this time. Directors should be prepared to manage short term blood shortages if restriction on movement or quarantine effect the rate of blood donation.

Direction, Control and Coordination

Pathology and Laboratory Medicine Services (10P11P):

- Provide technical guidance for laboratory collection, examination and disposition of samples;
- Provide guidance on internal and external specimen collection, preparation, chain of custody and transportation to identified laboratory;
- Identify appropriate analytical laboratories for specimen analysis and guidelines for any in-house lab work; and
- Provide guidance for mortuary protocols and policies.

References

1. <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>
2. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html>
3. <https://www.cdc.gov/coronavirus/2019-nCoV/lab/lab-biosafety-guidelines.html>
4. <http://www.aabb.org/advocacy/regulatorygovernment/Documents/Impact-of-2019-Novel-Coronavirus-on-Blood-Donation.pdf>

Addendum to Appendix K - Standardization - Laboratory Reporting of COVID-19 Test Instructions

Each VA facility is to implement the following test names and laboratory reporting for COVID-19 tests. This standardization allows for national collection of data on COVID-19 Virus testing results. VHA Laboratory Services must record results of COVID-19 Tests performed within a VA laboratory, Public Health Reference Lab, Local or State Health Lab, or Commercial Reference using the following methodology.

CH-subscribed tests will be used for COVID-19 screening because they have limited defined values. The results are used to establish prevalence, or monitor and control a situation (i.e., identification of asymptomatic individuals or carriers).

Implementation Notes

Panel CH-Subscribed Tests:

- The orderable panel test name must be “COVID-19 PANEL”. The test subscript must be CHEM, HEM, TOX, SER, RIA, ETC.
- Atomic tests used within the orderable panel will be defined according to the following scenarios:

Setup for test to be sent to Public Health Reference Lab (PHRL)

COVID-19 (PHRL)

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” “PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “YES”
3. **TYPE** sets to “OUTPUT”

***NOTE:** There is not an existing LOINC code available at this time for COVID-19, leave the test un-mapped.

COVID-19 CONFIRMATORY

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” “PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “NO”

3. **TYPE** sets to “OUTPUT”

***NOTE:** There is not an existing LOINC code available at this time for COVID-19 CONFIRMATION, leave the test un-mapped.

The following National Laboratory Test (NLT) code will be:

1. 94983.8640 for Human Coronavirus RNA QI PCR~ VA PALO ALTO, CA
2. 87408.8035 for Corona Virus~ CENTERS FOR DISEASE CONTROL

Setup for test to be sent to Local/State Health Reference Lab (Local/State)

COVID-19 (State Health Lab)

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” “PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “YES”
3. **TYPE** sets to “OUTPUT”
***NOTE:** There is not an existing LOINC code available at this time for COVID-19, leave the test un-mapped.

COVID-19 CONFIRMATORY

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” “PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “NO”
3. **TYPE** sets to “OUTPUT”
***NOTE:** There is not an existing LOINC code available at this time for COVID-19 CONFIRMATION, leave the test un-mapped.

The following National Laboratory Test (NLT) code will be:

1. 94983.8051 for *Human Coronavirus RNA QI PCR~ State Health Lab*
2. 87408.8035 for Corona Virus~ CENTERS FOR DISEASE CONTROL

Setup for test to be sent to commercial labs:

COVID-19 (Reference Lab Name)

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” ”PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “YES”
3. **TYPE** sets to “OUTPUT”

***NOTE:** There is not an existing LOINC code available at this time for COVID-19, leave the test un-mapped.

COVID-19 CONFIRMATORY

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” ”PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “NO”
3. **TYPE** sets to “OUTPUT”

***NOTE:** There is not an existing LOINC code available at this time for COVID-19 CONFIRMATION, leave the test un-mapped.

The following National Laboratory Test (NLT) code will be:

1. 94983.8xxx for *Human Coronavirus RNA QI PCR~ Quest/Labcorp*
2. 87408.8035 for Corona Virus~ CENTERS FOR DISEASE CONTROL

Setup for test to be performed in house

COVID-19 (xxxxxxx) instrument name or vendor name

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” “PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “YES”
3. **TYPE** sets to “OUTPUT”
***NOTE:** There is not an existing LOINC code available at this time for COVID-19, leave the test un-mapped.

COVID-19 CONFIRMATORY

1. **SITE/SPECIMEN** could be “NASOPHARYNX,” “PHARYNX,” “NASAL FLUID,” “NASAL WASH,” “BRONCHIAL,” “TRACHEA,” “SPUTUM” or “NASOPHARYNGEAL/AROPHARYNGEAL combo”; no other SITE/SPECIMEN can be used with this test name. If these site/specimens are not existing in your file 61 then new entry needs to be created.
2. **REQUIRED TEST** sets to “NO”
3. **TYPE** sets to “OUTPUT”
***NOTE:** There is not an existing LOINC code available at this time for COVID-19 CONFIRMATION, leave the test un-mapped.

The following National Laboratory Test (NLT) code will be:

1. 94983.xxxx for *Human Coronavirus RNA QI PCR~ Instrument or vendor suffix*
2. 87408.8035 for Corona Virus~ CENTERS FOR DISEASE CONTROL

For integrated or co-located sites that need to offer site/division specific tests, the test name has to start with “COVID-19” (or any other standard test name listed above).

To standardize data entry format, when the Data name is created for each test the CH-subscript test input transform needs to be Set of Codes:

- DETECTED is to DETECTED
- CONFIRMED is to CONFIRMED
- Not Detected is to Not Detected
- Inconclusive is to Inconclusive
- Invalid is to Invalid

***NOTE: DETECTED is intentionally in uppercase for impact.**

- Enter the data type of **COVID-19**: (N)umeric, (S)et of Codes, or (F)ree text ? **S**
 - INTERNALLY-STORED CODE://DETECTED WILL STAND FOR:// DETECTED
 - INTERNALLY-STORED CODE://Not Detected WILL STAND FOR:// Not Detected
 - INTERNALLY-STORED CODE://Inconclusive WILL STAND FOR:// Inconclusive
 - INTERNALLY-STORED CODE://Invalid WILL STAND FOR:// Invalid
- Enter the data type of **COVID-19 CONFIRMATION**: (N)umeric, (S)et of Codes, or (F)ree text ?
 - INTERNALLY-STORED CODE://CONFIRMED WILL STAND FOR:// CONFIRMED
 - INTERNALLY-STORED CODE://Not Detected WILL STAND FOR:// Not Detected
 - INTERNALLY-STORED CODE://Inconclusive WILL STAND FOR:// Inconclusive
 - INTERNALLY-STORED CODE://Invalid WILL STAND FOR:// Invalid
- The results must be documented under a specifically created *COVID-19* Section of Laboratory Results display in Computerized Patient Record System (CPRS) Graphic User Interface (GUI). The report sections must be set up in the Lab Reports File (File 64.5) under the Cumulative Reports entry.
 - VistA GUI Cumulative View will need to be set-up for Horizontal Format reporting to ensure that test results will be easily accessible.
 - At least one Major Header will need to be created. Only the Minor Headers show in the CPRS Cumulative View, but they are grouped together by the Major Header.
 - Sample Major Header: CORONAVIRUS TESTING
 - Sample Minor Header: COVID-19 TESTING

***NOTE:** A new test should be created only if the original test and the new test are vastly different (i.e., methodology is different, new reference ranges that are clinically significant, etc.).

Critical View Alert: A delta check can be created to provide a mechanism to alert providers if a patient is DETECTED. When the test is resulted as DETECTED and/ or CONFIRMED it will set the flag to a CRITICAL high to generate a View Alert to the provider. The test must be set up as a Set of Codes with DETECTED stands for DETECTED or CONFIRMED stands for CONFIRMED to ensure consistency of reporting and flagging. If sites need to generate a Critical View Alert the following Delta Check can be created in File 62.1 that will then need to be added to the File 60 test set up in the Site/Specimen (field 100) multiple subfield 7, Type of Delta Check. This mechanism is case-sensitive so the Set of Codes should match the following if this specific coding is utilized.

- **For COVID-19 (xxxxx) test delta check:**
 - NAME: TEXT ALERT DETECTED *H
 - XECUTABLE CODE: Q:\$D(LRGVP) | X="DETECTED" S LRFLG="H*"
- **For COVID-19(Confirmatory) test delta check:**
 - NAME: TEXT ALERT CONFIRMED *H
 - XECUTABLE CODE: Q:\$D(LRGVP) | X="CONFIRMED" S LRFLG="H*"

NOTE*: If your referral test result does not conform with this standard then you need to have your Lab Information Manager or Lab for mapping determination.

Laboratory Management Index Program (LMIP): *COVID-19* testing is countable (billable) for the LMIP program. The suffix on the National Laboratory Test (NLT) code chosen as the Verify WKLD Code on each of the atomic tests in this panel is based on the methodology each site uses to perform the test. This suffixed NLT code must have the Billable Procedure field set to Yes in File 64 so that the Verify WKLD Code is collected for workload recording purposes. Since method specific NLT codes are not available in File 64 for *COVID-19*, the following NLT codes will need to be created by adding a method specific suffix from the WKLD Suffix codes file (File 64.2) to the WKLD Code file (File 64) NLT code. Create the suffixed workload code necessary using VistA option "Add a new WKLD code to file [LRCAP CODE ADD]". The recommended suffixed NLT codes to use as Verify WKLD Codes for *COVID-19* atomic tests are as follows:

- Human Coronavirus RNA QI PCR 94983.8640 for CH-subscribed "PCR" tests sent to PHRL at VA Palo Alto HCS.
- Human Coronavirus RNA QI PCR 94983.8051 for CH-subscribed "PCR" tests sent to a State health lab. Note: Laboratories may choose to use the State Health Dept suffix code created specifically for their state, for example, .8068 CA STATE HEALTH DEPT suffix can be used by labs in California.
- Human Coronavirus RNA QI PCR 94983.8xxx for CH-subscribed "PCR" tests sent to a commercial reference lab.
- Human Coronavirus RNA QI PCR 94983.xxxx for CH-subscribed "PCR" tests performed in-house.
- Corona Virus 87408.8035 for specimens sent to CDC for *COVID-19* confirmation.

Current Procedural Terminology (CPT): At this point in time, *COVID-19* tests are not usually billable to a third-party payer for reimbursement therefore, these *COVID-19* tests should not be passing CPT codes to the Patient Care Encounter (PCE) application.

***NOTE:** Refer to the Additional Notes section under LEDI and HDR for related information if your site sends this testing to a reference lab.


Additional Notes for Sites:

Lab Electronic Data Interchange (LEDI) and Health Data Repository (HDR): Tests require National VA Lab codes for the HDR (the CH-subscribed tests need this information) and if LEDI is used by a site and they send their testing to another lab then the tests need National VA Lab codes as Order NLT codes and Result NLT codes as Result codes. There is an issue that it would be good to have National codes assigned to tests BUT the lab should not pass CPT codes for surveillance issues. Since the National VA Lab code field is one of the mechanisms the lab uses to pass CPT coding to PCE this needs to be considered. The way to handle this is to leave the field blank if LEDI is not an issue or have a generic NLT code that doesn't carry any CPT code in it and/or remove the CPT code if one is there. This is not a critical issue at this point as long as these tests are not passing CPT codes to billing. Sites may need to address this issue at some point for LEDI issues and HDR issues.

This revised testing standardization setup information is targeted to the Lab Information Managers, Lab ADPACs and/ or Lab Managers.

LOINC and/ or LEDI TOPOGRAPHY FILE 61 set-up issue: As per directions from PERFORMING LABS.

Appendix L – Emergency Pharmacy Service

Purpose

The purpose of this Annex is to establish the processes, procedures and organizational structure of the Emergency Pharmacy Service regarding the Coronavirus 2019 (COVID-19) outbreak.

Scope

This scope of this plan includes the management and deployment of the All Hazards Emergency Cache (AHEC) and Mobile Pharmacy Units (MPU).

Planning Assumptions

- Information about the ongoing COVID-19 outbreak remains highly fluid.
- Conditions and instructions under which the emergency pharmacy service will operate may change often, with significant operational and clinical implications.
- Demand for pharmaceuticals will likely increase and drug shortages will become more frequent.

Staffing will likely be an issue as staff will be unavailable due to sickness, quarantine, family care and fear of the unknown.

Concept of Operations

Emergency Pharmacy Service (EPS) has a dual function of managing the AHEC and managing/deploying the MPU. EPS supports all the AHECs strategically located across the states as the logistical arm of the AHEC. EPS supplies and updates the AHECs with supplies and medications as required. During COVID-19, EPS would resupply activated AHECs. The activation of the AHEC is the Medical Center Directors responsibility.

The MPUs are mobile outpatient pharmacies which consist of a 40-foot straight truck and three semi-tractor trailers. MPUs can be mobilized to an area of need as directed.

Organization and Assignment of Responsibilities

EPS maintains the inventory of the AHEC. The local Medical Center Director is responsible for the activation of the AHEC. EPS deploys and maintains the MPU during activation. The MPU pharmacy is staffed by Disaster Emergency Medical Personnel (DEMP). EPS reports to the Consolidated Mail Outpatient Pharmacy under the Pharmacy Benefit Management.

Direction, Control and Coordination

Requests for Emergency Pharmacy Service are identified at the local level and routed through the VISN to VHA OEM. Once validated, VHA OEM sends mission assignment tasking to the Director, Emergency Pharmacy Service requesting the deployment of Mobile Pharmacy Unit resources to the effected region.

Information Collections, Analysis and Dissemination

- Guidance on treatment medications for COVID-19; will be shared across the system.
- On the MPU, the status of supplies and drug inventories, will be monitored by EPS and documented. Adequate inventory levels to ensure patient needs. Inventory will be adjusted daily to meet current demands.
- Status of AHEC will be reported to the AHEC Leadership Committee quarterly. The AHEC Leadership Committee will review all activations of the AHEC to determine appropriateness.

Communications

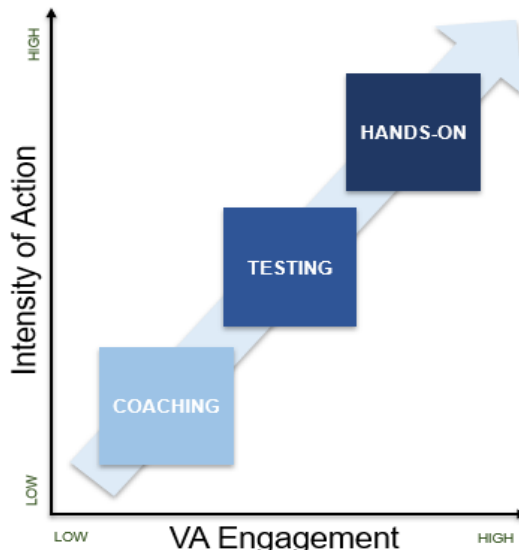
Communications concerning the AHEC is accomplished with phone/email between the medical center and EPS. EPS reports to the AHEC Leadership Committee regarding any issues originating from the medical centers. During deployment, the MPU communication is accomplished with cellular or satellite. The MPU is equipped with computers and a satellite to link into the host medical center.

Appendix M – Support to Rural Health Providers and Organizations

Background

The Department of Veterans Affairs (VA) has a fourth statutory mission to support the Department of Defense, Public Health Service and other entities such as state governments during times of national emergency. This includes local and national support to rural providers and organizations including, but not limited to, critical access hospitals (CAH), Tribal Nation (TN)/Indian Health Service (IHS) facilities and Federally Qualified Health Centers (FQHC).

Rural medical facilities often face staffing and continued financial viability challenges. This can lead to inadequate resources for meeting the local demand for health care. Rural residents often face substantial barriers for accessing care, services and amenities; including longer travel times, lack of transportation options and limited availability of services. Additionally, rural counties with higher minority populations are experiencing higher than average COVID-19 death rates.



Support the Department of Defense, Public Health Service and State Governments During Times of National Emergency

Within the Veterans Health Administration (VHA), the Office of Emergency Management has the lead responsibility for the mission of emergency management. Appendix Q, “Fourth Mission of the Department of Veterans Affairs, National-Level Roles and Responsibilities” describes the statute that details specific support that VA can provide in times of national emergencies (VA/DoD Health Resources Sharing and Emergency Operation Act (Pub. L. 97-174) and National Response Framework (Public Law 93-288)). In addition, Appendix Q describes some of the services VA can provide when requested, including participating in the National Disaster Medical System (NDMS), providing available hospital care and medical services to individuals responding to the emergency, and designating and deploying available medical, surgical, mental health, and other health service support assets, among many other essential services.

Concept of Operations

Some rural health providers and organizations with Veteran and/or non-Veteran patients may struggle to provide adequate care during the COVID-19 pandemic. Per the statute defined in Appendix L and summarized above, VA’s Fourth Mission allows VA to provide rural health providers and organizations with escalating levels of support using

predefined criteria in partnership with Federal/state/local government, nonprofit and private sector entities.

VA can engage with rural health providers and organizations at three levels of support ranging in intensity and level of engagement. These interventions scale from formal and informal coaching, to providing testing procedures and supplies, to actual hands-on support.

Coaching

Rural health providers and organization facility administrators may need practical information describing best practices that address Veteran and community health care needs during the COVID-19 pandemic. Topics for discussion can include resiliency and mental health coaching and support for staff, disease prevention and management, clinic management, med/surg and ICU bed utilization, use of telehealth and Personal Protective Equipment (PPE) and cohorting of patients. VA staff can provide guidance on space management in terms of ward re-organization, staffing assignments and quarantine/isolation requirements.

In addition, VA can ensure access to and understanding of current Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) guidelines and share lessons learned from response efforts to previous disease outbreaks. VA can provide this information remotely, via online, printed or downloaded materials, or via webinars and videos. VA staff can be available for remote technology/telephony Q&A sessions and/or Town Hall events, be on call for on-demand mentoring, or can be scheduled to provide one-on-one coaching to clinical providers, leaders and facility administrators.

VA Project ECHO is virtual/didactic and telehealth case-based training for practicing physicians to learn from specialists. It is well-suited to bring community providers up to-date on the latest protocols and techniques used in the evaluation and management of COVID-19 patients.

Testing

Rural health providers and organization facility administrators may need assistance in many activities related to testing and how to alter operations based on the results. VA can provide support through a tiered approach. First, VA could provide test kits and the rural facilities could conduct the testing, as well as manage the resulting downstream infection control and patient management requirements.

The next level of support could include providing staff to administer test kits. VA staff could be available to assist in testing coordination, including workflow management, and operating procedures for each step (phlebotomy, transport, lab services, transmission of results and patient follow up). If the facility has staff to conduct the testing activities, VA staff could still be present to provide direction to the facility staff on procedures for reliable patient and employee testing and recommendations for how to alter operations in the event of COVID-19 positive staff or residents. Additionally, as needed, VA could provide laboratory testing and results.

Finally, if members of the community test positive and do not need hospitalization but require self-isolation, VA can either provide or work with local or state authorities to find

appropriate lodging for the required 14-day isolation period. Lodging may also be required for displaced staff.

Hands-On Support

At the highest level of engagement and intensity, VAMC and VISN leaders could provide direct hands-on support, including staff/equipment/space augmentation, assistance with environment of care, patient triage, telehealth and patient transfer to a VAMC or other acute care facility with ICU capacity. VA also can deploy medical tents or trailers to augment space and bed capacity. This can include the tent or trailer alone or consultation and assistance related to the environment of care including negative pressure capacity and other required infrastructure.

Additionally, VA can provide means to enhance staffing and workforce management. This can include direct staff augmentation of rural facility staff with VA Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA), Physical Therapists (PT), Registered Dietitians (RD), and environment management and clerical staff, etc. Alternatively, VA staff can facilitate hiring of furloughed, laid off, or displaced health care workers directly to the rural facilities and collaborate with Veterans Benefits Administration (VBA) to identify Veterans seeking employment. VA can also provide virtual training and/or supervision of any new hires on behalf of the rural facility.

To enhance access to care, as an industry leader in telehealth, VA can provide e-consultation through telephony and assessment and evaluation via televideo for patient diagnosis, treatment and disposition.

Finally, if the condition of a patient or patients deteriorates to the point that a higher-level of care is needed, the VA can facilitate transportation support. This can include air or ground movement from the remote location to the closest VAMC or tertiary care center and could involve working through the Emergency Management Coordination Cell to request air assets from the National Guard.

Process for Providing Support to Rural Health Providers and Organizations During Times of National Emergency

Due to existing barriers for accessing care and facility staffing challenges, rural health providers and organizations may experience a shortage of medical resources to support operations and may need assistance to slow the spread of the disease and mitigate risks.

Many of the requests for support from rural health providers and organizations can be managed locally or regionally, but others may require a higher level of engagement from VA Central Office through the Emergency Management Coordination Cell (EMCC). VA has developed a standardized process for assisting rural health providers and organizations during the COVID-19 pandemic. Key stakeholders include:

Stakeholder	Role
Executive in Charge (EIC), VHA	Leads VA's coordinated COVID-19 response; makes decisions related to rural health providers and organizations support.
Deputy Under Secretary for Health (DUSH)	Supports VA's coordinated COVID-19 response; escalates rural health providers and organizations requests for lifesaving assistance to the Federal Emergency Management Agency (FEMA).
VHA Health Operations and Management (10N)	Provides guidance, operations, procurement and oversight of support to rural health providers and organizations.
VHA Office of Rural Health (ORH)	Assists 10N in tracking status of local rural health providers and organizations support activities; provides subject matter expertise.
VHA Emergency Management Coordination Cell (EMCC)	Coordinates multi-agency response for VHA, including FEMA requests for rural health providers and organizations support.
VHA Office of Finance (OF)	Guides fiscal tracking, costing and compensation for support to rural health providers and organizations.
VISN Director	Provides emergency assistance to rural health providers and organizations; escalates requests for assistance to EMCC and DUSH.
VAMC Director	Provides emergency assistance to rural health providers and organizations; escalates requests for assistance to the VISN.

Local/Regional Response via VAMC and/or VISN

Rural health providers and organizations should direct all requests for resource support to their local VAMC. If the local VAMC or VISN has capacity to support the request, the VAMC or VISN will provide assistance to the rural health provider or organization at the local level. The VAMC or VISN will notify the DUSH, who will make EMCC, 10N and ORH aware of the request. DUSH, EMCC, 10N and ORH will collaborate to monitor interventions and outcomes.

Once the rural health provider or organization escalates the request for assistance, the DUSH will determine if the requested resources are covered under the Coronavirus Aid, Relief and Economic Security (CARES) Act. If covered, there are no additional steps in the escalation process. If the resources are not covered, the DUSH will escalate the

request for assistance to FEMA, and FEMA will transmit a Mission Assignment (MA) to EMCC and Health and the Human Services (HHS) Secretary Operations Center (SOC). EMCC will notify the appropriate VA stakeholders (EIC, 10N, ORH, Office of General Council [OGC], VISN, etc.) of the MA. Once the assistance has been provided, the DUSH, EMCC, 10N and ORH will continue to monitor the rural health provider or organization's interventions and outcomes.

National Response via VA Central Office

If the local VAMC or VISN does not have capacity to support the request, the rural health provider or organization must escalate the request to the state and VA may provide support at the national level. The local VAMC or VISN should notify the DUSH that they cannot support the request, who will share the information with EMCC, 10N and ORH. If another VISN has the ability to support the request, the DUSH and EMCC can facilitate their assistance.

Under the state escalation process, the state submits a Resource Request Form (RRF) to FEMA. If FEMA transmits the Mission Assignment to VA for tasking, HHS and VA EMCC respond. EMCC notifies the EIC and DUSH, as well as 10N, ORH, OGC and VISN as appropriate. Assistance is provided, and the interventions and outcomes are monitored.

If the state submits a request for resources to FEMA and VA does not have the capacity to support, FEMA will task the MA to another appropriate governmental agency that can fulfill the request.

Data Tracking and Reporting

In an effort to reduce redundancies in outreach and communication between rural health providers, organizations and VA stakeholders, 10N (in collaboration with ORH, VISNs and VAMCs) provides regular data reports on trends and risks facing rural health providers and organizations, as well as resources that have been deployed during the daily HOC meeting.

Reporting to Congressional Committees

Within 60 days of the commencement of a disaster or emergency (or as soon thereafter as is practicable) in which the Secretary furnishes care and services as described above, (i.e. per the interagency RFA process), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the Secretary's allocation of facilities and personnel to furnish such care and services.

Appendix N – Readjustment Counseling Services (RCS)

Introduction

Readjustment Counseling Services (RCS) provides counseling, outreach and care coordination to eligible Veterans, active duty Service members and their families through community-based sites (Vet Centers) of care external to other VHA facilities to include VA Medical Center (VAMC). Vet Centers provide non-medical services. Complexities include variations in physical structure, store-front locations, isolated communities, proximity to nearest VAMC and lack of medical services on-site.

RCS is comprised of 300 Vet Centers, 20 Outstations and over 900 Community Access Points. RCS also operates over 83 Mobile Vet Centers (MVC), many of which can be deployed to areas of impact. RCS assets are located in all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam and American Samoa.

Purpose

This document provides the requirements and responsibilities for the RCS National Office, District Offices and local Vet Centers to ensure the necessary level of readiness for mitigation, preparedness, response and recovery of potential impacts from the COVID-19 outbreak.

Planning Assumptions

RCS services are provided in community-based location and do not have medical providers on-site. Resources may be available on a limited bases to Vet Center staff and will vary based on location and community complexity. There may be high-risk locations, separate from VAMCs, that may not be included in response planning scenarios. Due to high demand, supplies such as medical masks may not be readily available at Vet Centers.

The following are generalized assumptions specific to COVID-19:

- Risk groups for severe or fatal infection cannot be predicted with certainty but are likely to include the elderly and persons with chronic medical conditions.
- In a severe outbreak, absenteeism may reach 40% attributable to illness, the need to care for ill family members, or fear of infection during the peak weeks of a community outbreak, with lower rates of absenteeism during the weeks before and after the peak. Additional staff absenteeism may increase due to school closures and the employee need to care for their family.
- Multiple waves of epidemics are likely to occur across the country, lasting many months.

RCS is staffed with a large number of licensed mental health professionals, many may be called to engage follow-up services to support traumatic or triggering experiences related to COVID-19, preparation for epidemic waves, recovery, readjustment and bereavement services.

Most Readjustment Counselors have been trained and are equipped to provide virtual services via VA Video Connect. Additionally, Outreach Specialists can

effectively engage community partners and stakeholders in the education and awareness of COVID-19 and community partnerships, responses and developments.

Concept of Operations

Phases of operations will consist of a four-step threat indicator regarding COVID-19. The designators will be identifiable as Alpha, Bravo, Charlie and Delta. Alpha being minimal virus spread and Delta being the most severe.

Phases of Implementation

RCS overall strategy for mitigating the impact of COVID-19 on Veterans, Service members and their families and staff will be guided by principles which are implemented within the Vet Center response plan.

The overarching VHA guiding principles are:

- Protect uninfected clients and staff from acquiring COVID-19 infection.
- Shift priorities, resources and standards of care to virtual services when possible.
- Physically and functionally separate suspected or confirmed COVID-19 clients from those without it.
- Use staff to screen COVID-19 patients and leverage technology and communications to minimize exposure.
- Identify opportunities to deliver supportive care virtually.

The overarching RCS guiding principles are:

- Ensure continuity of care by continuing to provide direct counseling and care coordination.
- Outreach in local communities, establishing pathways for those we serve.
- Local approach given needs of the local environment.

The implementation of these principles will begin immediately through Client screening and referral to appropriate level of care pursuant to the results of the screening.

Screening

All clients and visitors entering Vet Centers will be screened using established screening protocols and referral pathways. The preferred screening option will be during the telephonic appointment reminder 24 hours prior to the scheduled appointment. Walk-in screening protocols have also been developed and implemented.

Clients will be referred to qualified medical staff for further evaluation. When a “positive screen” is indicated, Vet Centers will direct clients to the appropriate VA or Community Provider for further evaluation.

The possible outcomes of positive screenings are:

1. Client is referred to local VA Medical Center (VAMC) or community provider, and instructed to call before presenting for care, unless it is an emergency.

2. Client is directed to urgent care, an emergency department- or a local health department, and instructed to call before presenting for care, unless it is an emergency.

Any client unable to be seen in the Vet Center for services will be offered and scheduled for telehealth services, if available and agreeable to the patient.

RCS staff and clients to follow VHA personal protective equipment policy and guidance.

Alternates Methods of Care

RCS will establish alternate methods of care should there be an interruption in the ability to provide services or if an increase in risk occurs for staff and clients in a local community. Opportunities for alternative provisions of care can include VA Video Connect, phone visits, and 24-hour Call Center support or other identified alternatives.

RCS COVID-19 Operational Levels

Below are the four RCS COVID-19 Operational Levels. Each level is assigned an operational level based on the local environment.

Alpha: A minimal impact of COVID-19 has been reported within the community. Vet Center is open and monitors community responses to include VA and Non-VA partners.

Focus Area	In Person Services	Virtual Services
Counseling	Little to no disruption to individual, group, marriage and family counseling	Used as needed
Outreach	Little to no disruption to participation in outreach events	Not Applicable
Care Coordination	Little to no disruption	Used as needed
COVID-19 Screening	Telephonic Appointment reminder with screening questions in place 24 hours before all appointments; all walk-ins are screened as per protocol	

Bravo: A more invasive COVID-19 spread has been reported. Vet Center is open and will limit foot traffic to Vet Center.

Focus Area	In Person Services	Virtual Services
Counseling	Some disruption to individual, group, marriage and family counseling	Services are shifting to Virtual counseling (phone, telehealth)
Outreach	Participation in outreach events is limited or cancelled	Outreach is shifting to Virtual connections
Care Coordination	Some Disruption	Shifting to Virtual Means
COVID-19 Screening	Telephonic Appointment reminder with screening questions in place 24 hours before all appointment as per guidance; all walk-ins are screened per protocol to include referral services when applicable.	

Charlie: Substantial virus outbreak escalates. Vet Center is open. Staff still report for duty, however, no inbound client or visitor traffic at the Vet Center. The Vet Center becomes a telehealth hub.

Focus Area	In Person Services	Virtual Services	Other Tasks
Counseling	None	Virtual Visits Only	NA
Outreach	No Outreach	Virtual Outreach Only	NA
Care Coordination	Disrupted	Virtually Only	NA
COVID-19 Screening	Virtual Services Only. Appointment reminders continue with appropriate screening and referral. No walk-in screening.		

Delta: Virus is upgraded to the most extreme form by Government / States (Mass Casualties/ Uncontrollable Outbreak). Essential Businesses are closed. Major employers in the area are in telework status or closed until further notice. Most schools, local, state and Federal buildings are closed.

Focus Area	In Person Services	Virtual Services
Counseling	None	Virtual / Applicable Telework
Outreach	None	Virtual Outreach through telework None
Care Coordination	None	Virtually Only through telework
COVID-19 Screening	Vet Center is closed until Further Notice. Vet Center Director will be responsible for giving daily updates of their community to the District Level.	

MVC Operations:

1. MVC Request will be made through Emergency Management Coordination Cell (EMCC). EMCC will route request to RCS Central Office - Operations (OPS). OPS will route request to appropriate District to identify and activate appropriate local Vet Center/MVC. (It is recommended that a running list of MVC Drivers that are willing and qualified to respond to these requests be kept at each District Office).
2. If EMCC deems appropriate, employee will complete a physical and blood work prior to deployment EMCC will provide guidance on this process. EMCC and RCS employee will coordinate with local VAMC Occupational/ Employee Health to facilitate necessary screenings/exams.
3. MVC Driver will coordinate with MVC requestor on materials needed and where to obtain material for requested deployment.
4. MVC drivers must have training on how to decontaminate themselves and the entire MVC once leaving the affected area. EMCC will provide guidance on this process.
5. Vet Center services offered during this time will largely consist of outreach and pathway connections. Virtual counseling services may be available. RCS Central Office can delegate MVC usage for other duties in conjunction with EMCC needs.

Outreach Operations:

1. Vet Center Director will conduct weekly 30-day evaluations of local environment to decide participation in outreach events.
2. Vet Center Director will consult with Deputy Director for final decision-making approval on Limited Outreach Status based on local environment.
3. Limited Outreach Status - will be defined and adjusted between Vet Center Director, Outreach Specialists and current community concerns.
4. Vet Center Director has discretion to limit Outreach.
5. Outreach and MVC staff who are on limited Outreach Status will help with preventative measures to include placing follow up calls and making calls to clients in advance to screen Veteran population and participate in virtual outreach.
6. Outreach Specialist / MVC staff will work alongside Director to establish relationships with community health providers, specifically points of contacts at VA Medical Centers, health departments and urgent care centers for COVID-19 support and services.

The Deputy District Director is responsible for communicating guidance and plans within their respective zones and will communicate their plan to their zone. Additionally, the Deputy District Director, with support from District Director, will report and document operational statuses.

Mitigation: Mitigation includes information and referral to health care services; increasing awareness of preventive measures (hand sanitation, masks), reduced services for those clients with low risks, limited access to Vet Center, implementation of virtual sessions (VA Video Connect) and education and awareness for RCS employees nationally with emphasis on areas of increased risk.

Extended Operations and Recovery

This phase begins when the public health authorities recognize that the outbreak is beginning to wane. District Leadership and Vet Center staff will prepare for a second wave, reinstate curtailed services during the initial threat levels and monitor the health and well-being of staff and clients.

Trigger: This phase begins with the ability to meet and maintain the long-term response capabilities needed to combat the COVID-19 outbreak. The phase ends with a return to usual job functions and scopes of practice.

Goal: Maintain the highest standards of care for all Veterans, active duty Service members and their families, continue to protect those individuals and staff and return to normal operations. Recovery strategies maintain a focus on continuity of operations.

Monitoring, Assessment and Planning

- Evaluate the effectiveness of the measures used and update response plans, guidelines, protocols and algorithms accordingly.
- Preparing debriefing materials and data including:
 - Lessons learned, including psychological sequelae.

- Uses and roles of Vet Center in local, state and national responses.
- Cooperation between counterparts at all levels.
- Determine the need for additional resources and capacities during possible future outbreak waves.
- Review telework plans and procedures, and designated staffing for necessary changes.
- Develop plan to reinstate services that were curtailed during Threat Level implementations.
- Monitor the psychological impacts of the outbreak, especially on the health workforce.
- After Action Report (AAR)
 - Conduct a thorough evaluation of all the non-pharmaceutical interventions used, including:
 - Connected Care
 - Triage (effective questions, masking, etc.)
 - Social distancing
 - Stay at Home
 - Handwashing
- Review and, if necessary, revise HCI preparedness and response plans in anticipation of possible future outbreak wave(s).
- Revise case definitions, protocols and algorithms as required.
- Evaluate crisis communications plan.
- Request funding to implement any new procedures, requirements and strategy changes.

Health Care Operations

- Ensure that health care personnel have the opportunity for rest and recuperation.
- Conduct occupational health screening, monitoring and follow-up of staff.
- Critical Incident Stress Management.
- Initiate plan to reinstate services that were curtailed in Threat Levels.
- Begin rebuilding of essential services.
- Return to usual job functions and scopes of practice.
- Resuming usual standards of care.
- Continuing to promote principles of the “Infection: Don’t Pass It On” campaign with adherence to hand washing and respiratory hygiene.
- Complete tracking of resources used.
- Complete tracking of fiscal costs.

- Completing work for financial reimbursement through national emergency plans.
- Providing death benefits to surviving family members of staff who died from exposure to COVID-19 in the course of their duties.

Communications

- Regularly update staff and clients on any changes to the status of the outbreak.
- Participate in community AARs and planning revisions.
- Share AAR with partners.
- Vet Center facilities will also conduct an internal incident reviews to identify strengths, best practices and areas for improvement.

Organization and Assignment of Responsibilities

RCS Chief Officer:

- Designating responsibility for the overall RCS COVID-19 response
- Maintaining active liaison with national partners both internal and external to the VA.
- Ensure the creation and distribution of appropriate National guidance.
- Ensure effective communication to all RCS staff.

Operations Officer:

- Coordinating COVID-19 preparedness and response activities with OEM/EMCC as appropriate.
- Identifying any needed corrective actions through COVID-19 training, exercises or actual incidents. Corrective actions are included in overall improvement plans that are approved by leadership.
- Ensure the distribution and implementation of appropriate National guidance.
- Ensure effective communication to RCS Districts.

District Director:

- Coordinating COVID-19 preparedness and response activities with the District as appropriate.
- Ensure the distribution of all guidance to RCS zones.
- Ensure effective communication with District.
- Providing education and training to those staff who will be involved with COVID-19 clients consistent with their roles and responsibilities.

Deputy District Director:

- Coordinating COVID-19 preparedness and response activities with the local VAMC, health care coalitions, public health and emergency management authorities, as appropriate.
- Ensure the distribution of all guidance to respective Vet Centers.

- Ensure effective communication with Vet Centers.
- Providing education and training to those staff who will be involved with COVID-19 clients consistent with their roles and responsibilities.

Vet Center Director:

- Providing education and training to those staff who will be involved with COVID-19 clients consistent with their roles and responsibilities.
- Engagement with local VAMC COVID-19 Advisory Workgroups, where available.
- Maintaining situational awareness and identifying sources of medical and epidemiological information.

Report accurate information to District Office in regard to community and staff concerns regarding COVID-19.

Direction, Control and Coordination

Program Office (PO) Level: National direction, guidance and control will occur through 10RCS (National Program Office).

District Office (DO) Level: The DO will provide coordination, direction and control as an EOC for the VC facilities within its catchment area.

Vet Center (VC) Level: Direction, control and coordination activities at the Vet Center level will occur in partnership with the local VAMC and District Leadership. The Vet Center will follow local facility tactical and operational approach, coordinate responsive activities and identify resources needed in response to an incident.

Information Collections, Analysis and Dissemination

Common informational requirements for a disease outbreak include, but are not limited to:

- Protective measures
- Locations providing treatment
- Restrictions
- Impacts to Vet Center operational capabilities

The Communication Officer, functioning as Public Affairs Officer, will be responsible for collecting, analyzing and disseminating information regarding the disease outbreak. Information shall be formatted and shared in a manner most easily used by stakeholders and customers.

Communications

Communication protocols and coordination during a disease outbreak will follow established procedures, with exceptions put into place to implement social distancing and minimize face-to-face contact.

Administration, Finance and Logistics

Administration, Finance and Logistics support requirements will be accomplished

through the appropriate level of coordination or command center (EMCC, VISN EOC, VAMC HCC). Multi-agency agreements will generally be coordinated and executed at the EMCC or VISN EOC levels.

Plans Development and Maintenance

The RCS plan will be an incident specific annex to the HCI Emergency Operations Plan (EOP). The plan shall be reviewed and revised by RCS Operations Team on the same periodic schedule as the HCI Operations Plan.

Authorities, Information Sources and References

Authorities

Title 38, United States Code (USC), Section 8117, Emergency Preparedness (P.L. 107-287, as amended).

Information Sources:

1. CDC 2019 Novel Coronavirus Main Page: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
2. VHA nCoV Web Site: <https://www.publichealth.va.gov/n-coronavirus/index.asp>
3. VHA Directive 0320.02, Veterans Health Administration Health Care Continuity Program has been approved for publication; it can be found by clicking on the following link: http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=8644
4. CDC Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza
5. Mitigation in the United States: https://www.cdc.gov/flu/pandemic-resources/pdf/community_mitigation-sm.pdf
6. CDC Community Mitigation Guidelines to Prevent Pandemic Influenza - United States: <https://www.cdc.gov/media/dpk/cdc-24-7/preventing-pandemic-influenza/community-mitigation-guidelines-for-preventing-pandemic-flu.html>
7. NETEC 2019 nCoV Repository: <https://repository.netecweb.org/>
8. ASPR TRACIE, Infectious Disease Topic Collection: <https://asprtracie.hhs.gov/infectious-disease>

References:

1. Executive Order, Advancing the Global Health Security Agenda to Achieve a World Safe and Secure from Infectious Disease Threats, November 2016.
2. Institute of Medicine, Crisis Standards of Care, A System's Framework for Catastrophic Disaster Response, 2012. Available at: <http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>
3. Presidential Policy Directive-2 (PPD-2) Implementing National Strategy for Countering Biological Threats, November 2009.
4. Federal Emergency Management Agency, Biological Incident Annex, January 2017.
5. VHA National Center for Ethics in Health Care, "Meeting the Challenge of Pandemic

Influenza: Ethical Guidance for Leaders & Health Care Professionals in the Veterans Health Administration,” July 2010; Ethical Issues in Ebola Virus Disease Preparedness and Response, November 2014. Available at: <https://www.ethics.va.gov/policy.asp>

6. VHA Office of Emergency Management, VHA High Consequence Infection Incident Annex, October 2017. Available at: <https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/HCI/SitePages/Home.aspx>

Appendix O – Support to State Veteran and Community Nursing Homes

Background

The Department of Veterans Affairs (VA) has a fourth statutory mission to support the Department of Defense, Public Health Service and other entities such as state governments during times of national emergency. This includes local and national support for State Veteran Homes (SVH) and Community Nursing Homes (CNH).

SVH: Although SVH are owned, operated, managed and financed by the individual states, VA assists states with the construction and renovation of SVH by providing funding up to 65% of the allowable costs of the project, with states providing 35% matching funds. There are three levels of care: nursing home care (NH); domiciliary care (DOM); and/or adult day health care (ADHC). Currently, across the 50 states and territories, there are more than 160 SVH in which VA pays per diem to states as a grant program for the care of eligible Veterans.

CNH: Veterans who require 24-hour nursing services and meet the nursing home level of care can choose to reside in one of 1,750 contracted Medicare or Medicaid-certified nursing homes. These facilities provide quality nursing home care close to the Veteran's family and community. CNH services also include inpatient hospice and respite care as well as traditional nursing home levels of support.

Support the Department of Defense, Public Health Service and State Governments During Times of National Emergency

Within the Veterans Health Administration (VHA), the Office of Emergency Management has lead responsibility for the emergency management mission. Appendix Q, "Fourth Mission of the Department of Veterans Affairs, National-Level Roles and Responsibilities" describes the statute that details the support VA can provide in times of national emergencies (VA/DoD Health Resources Sharing and Emergency Operation Act (Pub. L. 97-174) and National Response Framework (Public Law 93-288)). In addition, Appendix Q describes some of the services VA can provide when requested including participating in the National Disaster Medical System (NDMS), providing available hospital care and medical services to individuals responding to the emergency, and designating and deploying available medical, surgical, mental health and other health service support assets, among many other essential services. The Coronavirus Aid, Relief, and Economic Security (CARES) Act also stipulates that VA may provide medicines, Personal Protective Equipment (PPE,) medical supplies and any other equipment, supplies and assistance available to SVH.

Concept of Operations

Some SVH/CNH with Veteran and/or non-Veteran residents will struggle to provide adequate care during the COVID-19 pandemic. As per the statute defined in Appendix Q and summarized above, VA's Fourth Mission allows VA to provide SVH/CNH with

escalating levels of support using predefined criteria in partnership with Federal/state/local government, nonprofit and private sector entities.

VA can engage with SVH/CNH at three levels of support ranging in intensity and level of engagement. These interventions scale from formal and informal coaching, to providing testing procedures and supplies, to actual hands-on support.

Local Veterans Administration Medical Center (VAMC) and SVH leadership will engage in regular contact to ascertain the status of the SVH. Phone assessment of the SVH response to the COVID-19 pandemic consists of initial questions designed to identify potential crises. More than two negative responses to the questions below signal that coaching and additional evaluation are required:

1. Are those entering the facility assessed for COVID-19 signs and symptoms?
2. Are residents cohorted by known, suspected, or negative for COVID-19 infection?
3. Are workers assigned to resident cohorts of known, suspected, or negative for COVID-19 infection with no cross-cohort care?
4. Are symptomatic residents and workers tested for COVID-19?
5. Are hand hygiene supplies and PPE available?
6. Are workers using PPE as recommended by the Centers for Disease Control (CDC)?
7. Are there adequate numbers and appropriate types of workers present during all shifts?
8. Are procedures in place to transfer residents to a higher level of care?

CNH may also participate in regular contact with the local VAMC and may volunteer for further assessment as indicated above.

Coaching

During the COVID-19 pandemic, SVH/CNH administrators are often looking for practical real-world information describing best practices in long term care operations, patient care and employee safety, as well as guidance regarding infrastructure and space requirements. This knowledge transfer can take place through “push” information that VAMC and Veterans Integrated Service Network (VISN) leaders provide in the form of planning checklists and other written materials, webinars, videos and Frequently Asked Questions (FAQ). In addition, support can be provided through live consultation and communications such as 1:1 mentoring to SVH/CNH Administrators, Town Hall Meetings and/or live question and answer sessions. (For example, see [CDC’s Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#)).

Testing

SVH/CNH Administrators may need assistance in activities related to COVID-19 testing and how to alter operations based on the results. This assistance can include procedures on reliable resident and employee testing, actual testing supplies and equipment and recommendations for how to alter operations in the event of COVID-19 positive staff or residents. VA can provide recommendations and best practices for space management in terms of ward re-organization, staffing assignments, PPE usage and quarantine/isolation requirements.

Hands-on Support

At the highest level of engagement and intensity, VA can provide direct hands-on support, including staff/equipment/space augmentation, assistance with the environment of care, patient triage, telehealth and patient transfer. This could include the evaluation of patients for movement to higher or lower levels of care such as transfer to acute care settings and/or Community Living Centers (CLC), or to another nursing home with appropriate services.

If appropriate, VA can provide means to enhance staffing and workforce management. Examples include direct staff augmentation of SVH/CNH staff with VA Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA), Physical Therapists (PT), Registered Dietitians (RD), environment management employees, clerical staff and others. VA employees can facilitate the hiring of furloughed, laid off, or displaced health care workers directly to the SVH/CNH and collaborate with Veterans Benefit Administration (VBA) and other state or Federal entities to identify Veterans seeing employment. VA can also provide virtual training and/or supervision of new hires on behalf of the SVH/CNH.

An industry leader in telehealth, VA can provide advice for SVH/CNH staff through telephony, as well as assessment and evaluation of residents through video telehealth. If indicated, VA can facilitate installation of wireless sensor integration and assist with continuous resident monitoring from the SVH/CNH or a VA facility.

Process for Providing Support to SVH/CNH During Times of National Emergency

Due to their vulnerable population and challenges maintaining qualified staff, SVH/CNH may experience a shortage of medical resources to support operations and may need assistance to slow the spread of the disease and mitigate risks. Many of the requests for support from SVH/CNH can be managed locally or regionally, but others may require a higher level of engagement from VA Central Office through the Emergency Management Coordination Cell (EMCC). VA has developed a standardized process for assisting SVH/CNH during the COVID-19 pandemic. Key stakeholders include:

Stakeholder	Role
Executive in Charge (EIC), VHA	Leads VA's coordinated COVID-19 response; makes decisions related to SVH/CNH support
Deputy Under Secretary for Health (DUSH)	Supports VA's coordinated COVID-19 response; escalates SVH/CNH requests for lifesaving assistance to the Federal Emergency Management Agency (FEMA)
VHA Health Operations and Management (10N)	Provides guidance, operations, procurement and oversight of support to SVH/CNH

VHA Office of Geriatrics and Extended Care (GEC)	Assists 10N in tracking status of local SVH/CNH support activities; provides subject matter expertise
VHA Emergency Management Coordination Cell (EMCC)	Coordinates multi-agency response for VHA, including FEMA requests for SVH/CNH support
VHA Office of Finance (OF)	Guides fiscal tracking, costing and compensation for support to SVH/CNH
VISN Director	Provides emergency assistance to SVH/CNH; escalates requests for assistance to EMCC and DUSH
VAMC Director	Provides emergency assistance to SVH/CNH; escalates requests for assistance to the VISN
Office of Intergovernmental Affairs (IGA)	Coordinates between Federal and state governments; fosters communications with SVH

Local/Regional Response via VAMC and/or VISN

SVH/CNH should direct all requests for assistance to their local VAMC.

The VAMC Director will make the decision about whether the requested support is lifesaving or not. If it is deemed lifesaving, and the local VAMC or VISN has capacity to support the request, the VAMC or VISN will provide assistance to the SVH/CNH at the local level. The VISN will notify the DUSH, who will make EMCC, 10N and GEC aware of the request. DUSH, EMCC, 10N and GEC will collaborate to monitor interventions and outcomes. All notifications to GEC should be sent to the VHAGECFBP@va.gov email address.

Once the VISN notifies the DUSH of the SVH/CNH support, the DUSH will determine if the requested resources are covered under the CARES Act. If they are covered, there are no additional steps in the escalation process. If the resources are not covered, the DUSH will escalate the request for assistance to FEMA, and FEMA will transmit a Mission Assignment (MA) to EMCC and Health and the Human Services (HHS) Secretary Operations Center (SOC). EMCC will notify the appropriate VA stakeholders (EIC, 10N, GEC, Office of General Council [OGC], VISN, etc.) of the MA. Once the assistance has been provided, the DUSH, EMCC, 10N and GEC will continue to monitor the SVH/CNH's interventions and outcomes.

National Response via VA Central Office

If the VAMC Director deems a request to be for non-lifesaving assistance, the local

VAMC/VISN should notify the EMCC of the request. The EMCC will share the information with the DUSH, 10N and GEC. Simultaneously, the VAMC/VISN should advise the SVH/CNH to contact their state for support. The SVH/CNH can escalate their request to the state, and VA may provide support at the national level.

If the request is for lifesaving assistance, but the local VAMC/VISN does not have capacity to support the request, they should notify the EMCC that the request cannot be supported. The EMCC will share the information with the DUSH, 10N and GEC. Simultaneously, the VAMC/VISN should advise the SVH/CNH to contact their state for support. If another VISN has the capacity to assist with the request, the EMCC will coordinate action. If another VISN cannot support the request, the SVH/CNH can escalate their request to the state, and VA may provide support at the national level.

Under the state escalation process, the state may submit a Resource Request Form (RRF) to FEMA. If FEMA sends the Mission Assignment to VA for tasking, HHS and EMCC respond. EMCC notifies the EIC and DUSH, as well as 10N, GEC, OGC and VISN as appropriate. Assistance is provided, and interventions and outcomes are monitored.

If the state submits a request for resources to FEMA and VA does not have the capacity to support, FEMA will task the MA to another appropriate Federal agency that can fulfill the request.

Data Tracking and Reporting

In an effort to reduce redundancies in outreach and communication between SVH/CNH and VA stakeholders, 10N (in collaboration with GEC, EMCC, VISNs and VAMCs) provides regular data reports on trends and risks facing SVH/CNH, as well as resources that have been deployed during the daily HOC meeting.

Reporting to Congressional Committees

Within 60 days of the commencement of a disaster or emergency (or as soon thereafter as is practicable) in which the Secretary furnishes care and services as described above, (i.e. per the interagency RFA process), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the Secretary's allocation of facilities and personnel to furnish such care and services.

Appendix P – Chaplain Services

Introduction

This document provides Chaplain Service Operating Procedures for sustaining Continuity of Operations in support of the Department of Veterans Affairs (VA) Medical Centers (MC) during a National Emergency, COVID-19. Veterans Health Administration (VHA) Directive 1111(1) provides overall guidance defining Chaplain Service roles and responsibilities for rendering services across VA.

Continuity of Chaplain Services in the field will be predicated on the requirements of respective VAMC Leadership and the capabilities of Chaplain Service resources at local Medical Centers. Within the National Chaplain Service Office, continuity of operations involving field support, staff coverage, as well as coordination with Faith Group Endorsers and/or other Federal/nonfederal entities will be assessed, and action deployed as necessary.

Record of Distribution: The Director, Chaplain Service, (10P4C) is responsible for the content of this plan. Questions concerning this Plan may be directed to the National Chaplain Service Office.

Recertification: This Plan will continue to serve as national policy until it is recertified or rescinded.

Purpose

This document prescribes requirements and responsibilities of the National Chaplain Service Office to ensure the necessary level of readiness and support for mitigation, preparedness, response, and recovery of potential impacts from the COVID-19 outbreak.

Scope

Chaplain Service will provide continuity of services across the VA enterprise as appropriate and in support of VA facilities in response to COVID-19 outbreak.

Situation Overview

Chaplain Service is reacting to the COVID-19 outbreak in coordination with the VHA Office of Emergency Management's (OEM) plan to collaborate an approach to maintain and/or plan for continuity of Chaplain Service operations in conjunction with VA/VHA phase responses.

Capability Assessment: Chaplain Service will maintain self-sustaining capability deploying spiritual and emotional resources necessary to support the VA/VHA's response to COVID-19 situation.

Mitigation Overview: Chaplains will restrict their personal movement to the same degree as fellow interdisciplinary team members via direction from Facility Director. Chaplains will strictly adhere to PPE protocol as set forth via local medical center policy.

Planning Assumptions

VAMCs are conducting Tabletop Exercises in response to VHA directives involving the COVID-19 pandemic. Local Chaplain Service leadership (Chief Chaplains) are included in these discussions to prepare for planning and execution of initiatives in support of actions required of Medical Center leadership.

The National Chaplain Office will convene the Emergency Command Center to define, provide and develop communication strategies and operating procedures in support of national and local Continuity of Operations Plans.

- The National Chaplain Service Director is available to VACO Senior Leadership for spiritual support and spiritual guidance as a Nation.
- The National Chaplain Office will disseminate national guidance regarding employee communication and operational coverage at VAMCs.
- A VA Chaplain must be included on every VA Hospital Incident Command System (HICS).
- The National Chaplain Office, in conjunction with local VHA leadership, will include procedures for informing local leadership on the status of Chaplain Service operations, employee and operational readiness, or other situations about which Medical Center leadership should be aware. Likewise, Chaplain Service employees will receive information locally regarding current conditions and be included in leadership meetings, appropriate trainings and provided PPE from Medical Centers.
- VA Chaplain staffing levels, spiritual assessments and patient visits may be reduced due to social distancing, cancellation of local VA programs or community services to include schools, daycare facilities, transportation venues, etc.
- VA Chapel Worship Services at local Medical Centers will follow what is being done for other group meetings at the local Medical Centers. If other group meetings are cancelled, VA Chapel Worship Services are also cancelled. VA Chapel Worship Services which can virtual broadcast Chapel Worship Services are encouraged to proceed with virtual broadcasts.
- Face-to-Face VA Chaplain Programs, like Warrior to Soulmate and Community Clergy Trainings, will be cancelled during the COVID-19 pandemic. Developing the use of VA Video Connect for these programs can be considered if supporting critical mission of patient care and COVID-19 emergency response.
- VA Chaplain Services may be required to respond to specific or unique VA Medical needs that may require additional resources.

Concept of Operations

Phase 1 – Initial Planning Phase

Individual Chaplain Services are minimally impacted. Chaplain Service field staffing levels are normal up to 85%.

There is no major impact to the business lines or other services.

- National Chaplain Service Director is available to VACO Senior Leadership for spiritual support and spiritual guidance as a Nation. National Chaplain Service Director will provide inspirational spiritual reflections and meditations for VACO and VISN Staff.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance. Local VA Chaplains will provide inspirational spiritual reflections and meditations for local VAMC Staff.
- National Chaplain Service Office will activate Emergency Operations Center. The National Director will lead discussions and update staff on conditions and field impact.
- Immediate assessment of projected staff travel will be reviewed and curtailed to “essential travel” only.
- In conjunction with VHA guidance, National Chaplain Service Office will deploy communication plans introducing Universal Precautions to Chaplains; e.g., no touch/no contact, frequent handwashing, not allowing employees with flu symptoms to work, etc. Communications will also include CDC, HCl guidelines and DUSHOM memo guidelines.
- Chief Chaplains must identify mission essential personnel who will provide minimal services in the event Chaplain Services are significantly reduced and/or staff shortages occur.
- Local VA Chaplain Services must use effective chemical sanitizers that are effective for COVID-19 virus. Chaplain Services are to ensure routine disinfect of VA Chapels on a more frequent basis. Chief Chaplains should coordinate with local EMS representatives to ensure work environment is set to Universal Precautions.
- Addition of portable handwashing machines at entry area of Chapels.
- Remove Holy Water Founts from Chapel. Holy Water can be supplied for those who request by bringing their own bottle to obtain Holy Water from the VA Catholic Chaplain.
- Remove shared Hymnals from the Chapel for infection control. (Ensure that “give-away” Faith Based Literature is supplied for comfort/support, but not communally shared.)
- Local Chaplain Services are encouraged to purchase individually packaged Protestant Holy Communion kits for use on isolated units and with COVID-19 positive patients. Catholic Holy Communion must be given in-person with utilization of appropriate PPE.
- National Chaplain Service Office will identify VA Chaplains that may be able to deploy to another Medical Center that no longer has a VA Chaplain available to serve due to COVID-10 quarantine.

- Chaplain Services will ensure VA Chaplains are trained in telehealth to provide virtual spiritual care for Veterans via VA Video Connect.
- National Chaplain Service Office will disseminate specific communication regarding operational issues and instruction via special communication venues.
- National Chaplain Service Office will maintain close coordination with VHA OEM, PAO and PA Specialists to develop and disseminate communication to the field and other entities.

Phase 2 – Elevated Response Phase

*Individual Chaplain Service or multiple Chaplain Services are impacted and are now in an elevated response mode in support of the Medical Center response specific situations. *Note: elements identified in Phase 1 may carry over into Phase 2. Chaplain Service Staffing Level are at 40% to 80%.*

Potential adjustments to local Chaplain Service could include:

- National Chaplain Service Director is available to VACO Senior Leadership for spiritual support and spiritual guidance as a Nation. National Chaplain Service Director will provide inspirational spiritual reflections and meditations for VACO and VISN Staff.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance. Local VA Chaplains will provide inspirational spiritual reflections and meditations for local VAMC Staff.
- VA Chaplains call high-risk (suicidal) Veterans who are at higher risk of suicide with the complication of social distancing.
- Limit Face-to-Face Spiritual Assessments and Chaplain Visits.
- No Face-to-Face Chapel Worship Services (Virtual strongly encouraged).
- No Chaplain Group Sessions (Virtual strongly encouraged).
- No Clinical Pastoral Education Training Sessions.
- Utilization of PPE, as provided by the Medical Center.
- Addition of portable handwashing machines at entry area of Chapels.
- Redistribute functions to appropriate National Chaplain Office Staff to support field operations.
- Deploy VA Chaplains as needed to support coverage of Chaplain Services in need.
- National Chaplain Service Director and VAMC Chaplain Services will work with next of kin (NOK) of employees who die of COVID-19 to prepare Employee Remembrances for the Wall of Honor at VACO.

Phase 3 – Critical Phase

Chaplain Services nationwide impacted significantly. Chaplain Service Staffing Levels are 0% to 40%.

Potential impact:

- National Chaplain Service Director is available to VACO Senior Leadership for spiritual support and spiritual guidance as a Nation. National Chaplain Service Director will provide inspirational spiritual reflections and meditations for VACO and VISN Staff.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance.
- Local VA Chaplains will provide inspirational spiritual reflections and meditations for local VAMC Staff.
- VA Chaplains call high-risk (suicidal) Veterans who are at higher risk of suicide with the complication of social distancing.
- Spiritual Care by consult to most critical needs and/or deaths only.
- No Chapel Worship Services (Virtual strongly encouraged).
- No Chaplain Group Sessions (Virtual strongly encouraged).
- No Clinical Pastoral Education Training Sessions.
- If VA redirects clinics and/or consolidate patients to one location, Chaplains may be tasked to deploy Rapid Response as needed to support the VHA response.
- National Chaplain Service Director and VAMC Chaplain Services will work with NOK of employees who die of COVID-19 to prepare Employee Remembrances for the Wall of Honor at VACO.

Phase 4 – Recovery and Sustainment Phase

Individual Chaplain Services are impacted – return to regular operations.

- National Chaplain Service Director is available to VACO Senior Leadership for spiritual support and spiritual guidance as a Nation. National Chaplain Service Director will provide inspirational spiritual reflections and meditations for VACO and VISN Staff.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance. Local VA Chaplains will provide inspirational spiritual reflections and meditations for local VAMC Staff.
- Assess staffing levels.
- Re-establish Chapel Worship Services.
- Re-establish Chaplain Group Sessions.
- Re-establish Clinical Pastoral Education Training Sessions.
- Confirm special requirements with the Medical Center.

- Prepare the EOC for Post Pandemic Processes/After-action reporting.
- National Chaplain Service Director and VAMC Chaplain Services will work with NOK of employees who die of COVID-19 to prepare Employee Remembrances for the Wall of Honor at VACO.

Organization and Assignment of Responsibilities

- National Chaplain Service Director will articulate policy and procedures and coordinate contingency plans with VHA OEM and senior leadership.
- National Chaplain Service Director will manage day-to-day operations and execution of initiatives in support of the field and Medical Center leadership.
- National Chaplain Service Director will communicate and coordinate all activities with Chief Chaplains nationwide. National Chaplain Service Director will keep VACO leadership informed of all developments.
- Medical Center Chief Chaplains will be responsible for developing operating strategies to help sustain a level of service in the field. Coordinate with National Chaplain Service Director to their strategy to support local Medical Center.
- Chief Chaplains will coordinate with Medical Center leadership responding to any special requirements and communicate needs and challenges to National Chaplain Service Office.

Direction, Control and Coordination

Chaplain Service will coordinate with OEM for required missions. National Chaplain Service Director will define operational and tactical procedures in collaboration with VHA and EOM.

Information Collections, Analysis and Dissemination

National Chaplain Service Office requires information and data from local facilities and VHA EOM for operational status.

Communications

Communication is established between National Chaplain Service Director, Office of VHA Public Affairs, and Assistant Under Secretary for Health for Operations (AUSHO) to distribute information accordingly. Operational information is distributed to Network Directors and Medical Center Directors highlighting specific procedures and processes for deployment.

Appendix Q – Fourth Mission of the Department of Veterans Affairs, National-Level Roles and Responsibilities

Background

Department of Veterans Affairs (VA) has a fourth statutory mission, which is to support the Department of Defense and the Public Health Service during times of national emergency. Within the Veterans Health Administration (VHA), the Office of Emergency Management has lead responsibility for the emergency management mission.

Support the Department of Defense and the Public Health Service During Times of National Emergency

The VA/DoD Health Resources Sharing and Emergency Operation Act (Pub. L. 97-174) was enacted on May 4, 1982. This law gave VA a new mission: to serve as the principal health care backup to DoD in the event of war or national emergency that involves armed conflict. In addition to the contingency mission, this public law amended Title 38, United States Code (U.S.C.), to promote greater peacetime sharing of health care resources between VA and DoD.

Additionally, under the National Response Framework (Public Law 93-288, as amended), VA is tasked with ensuring backup medical support for military personnel in wartime, and for the general public during natural, manmade, or technological emergencies.

Concept of Operations

Under the auspices of the National Response Framework (NRF), the Department of Health and Human Services (HHS) may request interagency assistance from other departments, including VA, under their authority as the lead agency for Emergency Support Function #8 (ESF #8) - Public Health and Medical Services.

As outlined in ESF #8, subject to the availability of resources and funding and consistent with the VA mission to provide priority services to Veterans, the VA shall provide the following services when requested:

- VHA coordinates with participating National Disaster Medical System (NDMS) hospitals to provide incident related medical care to authorized NDMS beneficiaries affected by a major disaster or emergency.
- VHA furnishes available VA hospital care and medical services to individuals responding to, involved in, or otherwise affected by a major disaster or emergency, including members of the Armed Forces on active duty.
- VHA designates and deploys available medical, surgical, mental health and other health service support assets.

- VHA provides a Medical Emergency Radiological Response Team for technical consultation on the medical management of injuries and illnesses due to exposure to or contamination by ionizing radiation.
- VHA alerts VHA Federal Coordinating Center (FCCs) and provides reporting instructions to support incident relief efforts.
- VHA alerts VHA FCCs to activate NDMS patient reception plans in a phased and regional approach, and when appropriate in a national approach.
- NCA buries and memorializes eligible Veterans and advises on methods for interment of the dead during national or homeland security emergencies.

Tasking and Assignment Tasking Process

When a deficiency or gap is identified in related response activities by HHS, FEMA, the Federal inter-agencies, or the State, Local, Tribal and Territorial (SLTT) partners, a Request for Assistance (RFA) is generated. Typical examples might include lack of adequate or appropriate supplies (such as Personal Protective Equipment [PPE]); need for medications (such as anti-viral or antibiotics); or need for staffed hospital beds in an alternate care site for a medical surge (such as a Federal Medical Shelter [FMS]). Collaboration and communication among the requesting agency, HHS, and the targeted supporting Federal agency, prior to and during the formation of an RFA is recommended.

Upon receipt of the RFA from the requesting agency received at the FEMA National Resource Coordination Center (NRCC), the request is validated based on authorities, mission need, availability of resources and funding. A mission assignment is prepared and submitted to the HHS Secretary's Operation Center. HHS creates a mission assignment sub-tasking that is forwarded to VA. Upon receipt of the mission assignment, the request is reviewed by the VHA Emergency Management Coordination Cell. Recommendations are developed and submitted to VHA leadership and the appropriate internal support units/assets activated and tasked. If VA is unable to fulfill the assignment, VA/VHA leadership will inform NRCC and HHS SOC that the RFA needs to be modified or denied.

All Hazards Emergency Cache Program

The VHA maintains a stockpile of medical supplies and countermeasures to bridge the gap between the time a disaster occurs and when the Strategic National Stockpile is deployed. The cache is designed to treat Veterans, staff and other victims that may present to local VA Medical Centers (VAMC) in a local mass casualty event. The caches are intended to provide pharmaceuticals and some equipment for short-term care until resources from the Strategic National Stockpile can be made available in the immediate area and to support and augment a VA facility's involvement in the local community disaster plan.



Reporting to Congressional Committees

Within 60 days of the commencement of a disaster or emergency (or as soon thereafter as is practicable) in which the Secretary furnishes care and services as described above, (i.e. per the interagency RFA process), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the Secretary's allocation of facilities and personnel in order to furnish such care and services.