



*Veterans Health Administration - Office
of Emergency Management*

COVID-19 Response Plan

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

Version 1.6 March 23, 2020



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

MAR 23 2020

To Whom It May Concern:

The Department of Veterans Affairs is unified with our Federal partners in leading the medical response to combat the COVID-19 pandemic.

Within days of the first confirmed COVID-19 case, Veterans Health Administration (VHA) began a comprehensive response and operations plan to protect our Veterans, their families and the workforce. The enclosed COVID-19 Response Plan is a living document and just as the pandemic evolves, the guidance will also evolve. Revisions of this document will be provided and published as more information, guidance, and best practices become available.

As the Nation's largest healthcare network, our transparency is foundational to provide the American healthcare delivery system the opportunity to leverage and contribute to how the medical community collaborates when faced with the significant challenges associated with global pandemic.

This COVID-19 Response Plan is the result of the work of dedicated VHA employees devoted to providing high-quality, compassionate care to the Nation's Veterans and more broadly when necessary. I am very appreciative of their tireless efforts. It is important for all of us to work together to protect the American people at this critical time. Thank you for your continued commitment to serve those in need.

Sincerely,

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

Richard A. Stone, MD
Executive in Charge, Veterans Health Administration

Introductory Material

Record of Changes:

Date	Description of Change	Page of section	Posted by

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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 healthcare 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 healthcare 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. healthcare community in responding to COVID-19. On March 11, 2020 WHO publicly characterized COVID-19 as a pandemic.

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. In the past century, there have been four pandemics caused by the emergence of novel influenza viruses. As a result, most research and guidance around pandemics is specific to influenza, but the same premises can be applied to the current COVID-19 pandemic. 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 phases. 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 with this new virus (named SARS-CoV-2).

The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. Similar sequences between patients from U.S. and initial patients in 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,

including in the U.S. Community spread means some people in a given area have been infected and it is not known how or where they became exposed.

Illness Severity

The complete clinical picture of COVID-19 is not fully known at this time. Reported illnesses range from very mild (including some with no reported symptoms) to severe including illness resulting in death). While information suggests that most COVID-19 illness is mild, a report out of China suggests serious illness occurs in approximately 16 percent of cases³. Older people and people of all ages with severe underlying health conditions — like heart disease, lung disease, and diabetes, for example — seem to be at higher risk of developing serious COVID-19 illness.

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
- Healthcare workers caring for patients with COVID-19
- Close contacts of persons with COVID-19
- Travelers returning from affected international locations where community spread is occurring, with level of risk dependent on where they traveled

Risk of Severe Illness is increased for:

- Older adults, with risk increasing by age
- People who have serious chronic medical conditions, such as: heart disease, diabetes, lung disease, and hypertension

³ Dr. Nancy Messonnier, Director of the National Center for Immunization and Respiratory Diseases (NCIRD) cited this in a recent telebriefing. <https://www.cdc.gov/media/releases/2020/t0303-COVID-19-update.html>

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 healthcare 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.
- Illness rates 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.
- 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 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 percent of the infected population will require hospitalization, of this, approximately 5 percent will require ICU level care and approximately 2.3 percent 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.
- In a severe outbreak, absenteeism (the number of absent employees) may reach 40 percent, 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.

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>

- There may be critical shortages of healthcare 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 is only mitigated by meticulous planning.
- 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 percent 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.

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 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 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.

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.
- 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.

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

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).

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 healthcare 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 healthcare 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 our 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:

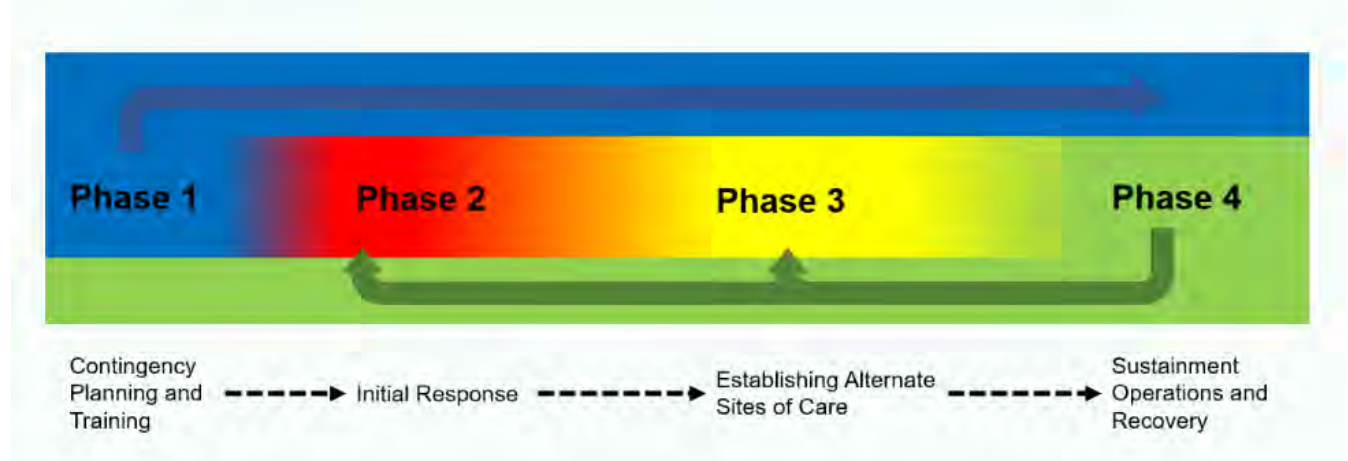
VHA Response Phases of Implementation

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 healthcare 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 healthcare delivery system. The overarching principles guiding the 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.

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 percent 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.
- 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.

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
a. 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.
b. 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.
c. 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 healthcare 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.
d. 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 healthcare 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 healthcare. 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 healthcare 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 healthcare 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. With approximately 80 percent 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.

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 our 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 healthcare 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 healthcare 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.

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

Table 7: Phase 4- Strategies for VHA Healthcare 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 healthcare 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 healthcare 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.

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.

Workgroup: Direction, control, coordination activities at the Workgroup level will occur within and under the supervision of the EMCC. The Workgroups will be formulated based on the scale and scope of the incident and the need from the VISN/field. The purpose of the Workgroup is to develop specific COVID-19 guidance and developing answers to “Frequently Asked Questions” sent from VHA Staff to the EMCC.

Information Collections, Analysis, and Dissemination

Essential Elements of Information (EEI) provide context, informs decision making, and contributes 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

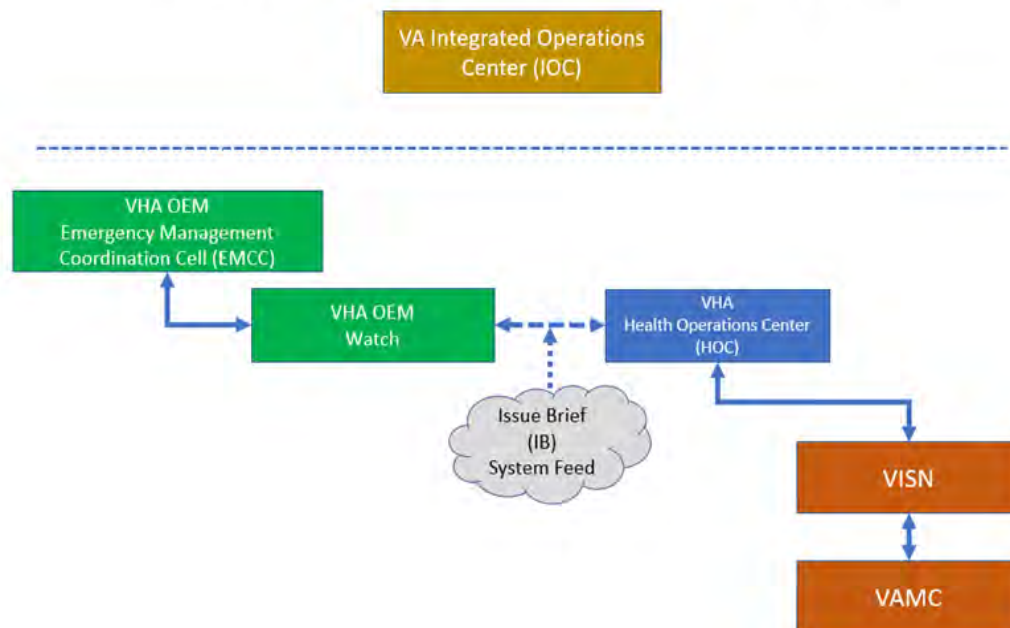
Component	Sub-Component	Essential Element of Information
Medical	Hospitals	Number of COVID-19 patients seen and number of admissions. Number of COVID-19 isolation beds available/committed
	Dialysis	Status of dialysis services. If discontinued, number of patients impacted and actions to mitigate
	Pharmacies	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

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 3: VHA Emergency Communication).

Figure 3: VHA Emergency Communication

VHA Emergency Communication Flow



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 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.

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 Workgroup).

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 Workgroup

The EMCC PIO and the Communications Workgroup, serve as the focal point for development of 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 healthcare 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.

Currently, there are three (3) points of distribution for information upon approval from Unified Command:

- HCI SharePoint: A central hub which Workgroups can make available approved informative documents, guides, AUSHO correspondence with the Field and other related COVID-19 materials for use of VA staff.
- Daily Coronavirus: VHA Leadership Coordination Call - A call setup by the EMCC Plans Section with Program offices, VISNs and facility leadership to discuss concerns, develop items for action, and track the developments of COVID-19.
- PIO/Communication Workgroup: The Communication Workgroup consists of PIOs from various VA and VHA program offices. The Communication Workgroup develops information and educational materials in a "one-voice" method to disseminate to Veterans and staff concerning COVID-19. This process can be distributed through e-mail, 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. (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 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
- 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>

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 cases. 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 from those who may be infected.

Triage and screening require either physical or virtual interaction. The triage and screening process includes both in-person and virtual and options by which patients enter a medical evaluation.

Screening should occur not only for patients, but also for staff entering all 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 necessary* 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 and triage 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
- Secure messaging e-mails
- Emergency Department
- Clinics, including primary care, mental health, geriatrics, specialty, and surgical care
- Inpatient Areas – within Standard area, recognition and transfer patients with possible COVID-19
- 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 triage, 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, 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.
- About 50 percent of those who become ill will seek care. If effective antiviral drugs become available for treatment, more people will be expected to seek medical care.
- Risk groups for severe illness or fatal infection cannot be predicted with certainty but are likely to include the elderly and persons with chronic medical conditions.
- Susceptibility to the virus may be universal in wave one. Future waves can expect some population immunity.

Additional assumptions to consider:

- 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.
- Effective response to the virus requires coordinated efforts of a wide variety of organizations.
- There may be critical shortages of healthcare 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.
- 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 COVID-19 virus.
 - As would symptomatic individuals, individuals who have COVID-19 but no or minimal symptoms may be capable of transmitting infection.
 - The typical incubation period (interval between infection and onset of symptoms) for COVID-19 is up to 14 days.
- Absenteeism:
 - In a severe outbreak, workforce absenteeism may reach 40 percent 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.
 - Public health measures of temporarily closing schools, declaring other closures, and quarantining household contacts of infected individuals are likely to increase rates of absenteeism due to employees with school-aged children.

- Staff may be capable of performing some of their duties via telework and participating in provision of virtual care.

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, but 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 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, signs, symptoms, or epidemiological exposures that put them at high risk for COVID-19 infection.



The following questions are suggestions for preliminary triage to emergency versus virtual care:

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.

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 regarding exposure should change as the course of the pandemic evolves.*

Preliminary Screening:

- Are you having fever, cough, shortness of breath, cold or flu-like symptoms?
 - If yes, mask patient and escort to COVID-19 triage area for further care.
 - 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 or travel to an area where COVID-19 is spreading in the community?
 - If yes, mask patient, escort to COVID-19 triage area for further care.
 - If no, escort to Standard area for further care.

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 the patient clinically, in order to provide appropriate medical care.

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

- Site should be geographically separate from the area in which high-risk outpatients will receive care.
- 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 regarding exposure should change as the course of the pandemic evolves.*

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, or cold symptoms? Have you had recent contact with someone with COVID-19? Have you had recent travel to an area where COVID-19 has been spreading in the community? Have you had recent travel in or outside of the U.S. (sites of travel should be noted and checked against CDC list)? 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 room with closed door for secondary clinical screening.

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 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 had recent travel to an area where COVID-19 has been spreading in the community? Have you had recent travel in or outside of the U.S. (sites of travel should be noted and checked against CDC list)? 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, e-mail or other virtual means.

Screening Questions: Have you had fever, cough, cold or flu-like symptoms? Have you had recent contact with someone with COVID-19? Have you had recent travel to an area where COVID-19 has been spreading in the community? Have you had recent

travel in or outside of the U.S. (sites of travel should be noted and checked against CDC list)? 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 e-mail 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.

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 and fever.
- **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 or fever
 - Provide Virtual Care (RN triage)
 - Arrange for initial virtual visit with provider, such as primary care, if indicated
 - Respiratory symptoms and/or fever
 - 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 Screening via primary care provider

- **Triage:** Provider will assess severity of illness and for red flags that indicate likely or potential need for hospitalization.
- **Screening:** Provider will screen for respiratory symptoms and fever.
- **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 or fever
 - Provide Virtual Care Visit (e.g., RN triage, PCP)
 - Respiratory symptoms and/or fever
 - 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 Screening via Specialty Provider

- **Triage:** Provider will assess severity of illness and for red flags that indicate likely or potential need for hospitalization.
- **Screening:** Provider will screen for respiratory symptoms and fever.
- **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 or fever
 - Provide Virtual Care
 - Arrange for initial virtual visit with provider, such as primary care, if indicated
 - Respiratory symptoms or fever
 - 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 Screening via electronic interface

- **Triage:** Automated questions and responses will assess for difficulty breathing, symptoms worrisome to the patient, or difficulty managing at home.
- **Screening:** Automated questions will assess for fever, cough, cold, flu-like symptoms.
- **Potential Outcomes:**
 - Shortness of breath, difficulty managing, or other concern
 - Call from healthcare/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 healthcare 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 healthcare 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
- E-mails

- 
- Secure messaging
 - Posters and signs
 - Mailings
 - Recorded messages when calling in

Appendix B – Infection Control

Purpose, Scope, Situations, Overview, and Assumptions

Purpose

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

First, and foremost, the 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) Share Point/ 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 healthcare personnel (HCP), and shortages of personal protective equipment such as facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), 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. 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 or airborne transmission. “Primarily” by droplets reflects that in certain circumstances, droplets can turn into aerosol particles, typically during aerosolizing procedures, such as intubation.

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 healthcare 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 healthcare facility.
- Social distancing - changing practices within healthcare facilities to provide social 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 radiology, 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 Healthcare 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 healthcare 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 well as persons under investigation (PUI). 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: The CDC also considers collection of nasopharyngeal specimens as an aerosol-generating medical procedure.

Healthcare 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 healthcare 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.

This Appendix/chapter provides IPC information which applies to all VA healthcare 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 healthcare 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:

Collection of Nasopharyngeal cultures/swabs; 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; Autopsy of lung tissue

Airborne Infection Isolation Room (AIIR) (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 and Airborne/Contact Precautions.

Close Contact for healthcare exposures is defined as follows:

- Being within approximately six feet (two meters), of a person with COVID-19 for a prolonged period (such as caring for or visiting the patient; or sitting within six feet of the patient in a healthcare 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.

Airborne Contact: Direct & Indirect Droplet. Early 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.

COVID-19 is considered to be transmitted by Airborne Contact: Direct & Indirect Droplet. PPE selection and cleaning/disinfection practices for COVID-19 are based on breaking the chain of transmission for these modes of transmission.

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.⁷

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

⁷ 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)

into the lungs. These microorganisms are relatively large and travel only short distances (up to six feet/two meters). 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.

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 healthcare 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.

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:

- **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:

- **Social 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.
- **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.

- 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.
- 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 healthcare 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. Healthcare 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. We encourage this to be shared widely.

*The following link, Guidance for the Selection and Use of PPE in Healthcare 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 under investigation (PUI) 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: All AND Contact Precautions plus Eye Protection.

Airborne Infection Isolation (All) Precautions:

- Place COVID-19 person in AIIR/negative airflow room
- PPE requirements for HCP
- Respirator

Respiratory Protection:

Respiratory protection for 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. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate).

In multi-patient rooms, more than three feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients.

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 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 Medical Procedures (AGMPs)

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 AGMPs 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, 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 AGMPs.

PPE: Gowns

Gowns are identified as the second-most-used piece of PPE, following gloves, in the healthcare 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 healthcare 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 are 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 include:

- “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 healthcare 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/home/cleaning-disinfection.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 3/12/20
2. Centers for Disease Control and Prevention (CDC). Coronavirus Disease 19 (COVID-19) <https://www.cdc.gov/coronavirus/2019-nCoV/index.html> - accessed 3/12/20
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 3/12/20
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 3/12/20

Appendix C – 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 C - 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 (xxxxxxxxxx) 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 shouldn't 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 D – Logistics

Purpose, Scope, Situations, Overview, and Assumptions

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. healthcare 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 to 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

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.
- Metrics & Analytics (M&A): 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.
- VISN and VAMC employee outbreaks will require social distancing and telework to continue operations, lengthening execution times for some tasks.
- 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)

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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)

Appendix E – Communications

Purpose, Scope, and Assumptions

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 workgroup comprises 10 members from various offices across the network. These members assist the other EMCC workgroups 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 workgroup has adopted a centralized, communications strategy that relies heavily on digital tools such as a Website and social media apps. To prepare for eventual decentralization of communications, the workgroup has developed and continues to expand a tool kit of templated materials for use by facility public affairs officers and other communicators to maintain a single voice and a coordinated, unified message.

The tool kit is being updated daily based on feedback from field communicators, VA and VHA leadership, and other stakeholders. The tool kit 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.

Additionally, a Joint Task Force has been established to formalize the clearance process and enhanced tracking ability. The Task Force comprises four communications subgroups: Veteran, Field, External, and Congressional.

Organization and Assignment of Responsibilities

Organization	Responsibilities
EMCC Communications Workgroup	<ul style="list-style-type: none"> • Monitor CDC guidance for impacts on communications. • Develop communications strategy and tools. • Attend daily EMCC coordination calls. • Brief leadership as needed on daily coronavirus update call. • Serve as liaison to other EMCC workgroups. • 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 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 e-mailed 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” e-mail 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 e-mail 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 e-mail group (vhacovidcomms@va.gov) so that best practices can be disseminated.

Guidance for Local Interviews

- Take the opportunity to highlight your facility’s successes.
- Don’t 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 don’t know the answer to a question, it’s 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. [Name of hospital] **has not encountered any patients who have tested positive for COVID-19 to date.**

- 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.

The screening consists of three questions:

1. Do you have a fever or worsening cough or shortness of breath or flu-like symptoms?
2. Have you or a close contact traveled to an area with widespread or sustained community transmission of COVID-19 within 14 days of symptom onset?
3. Have you been in close contact with someone, including healthcare workers, confirmed to have COVID-19?

Per CDC guidance and VA protocols, individuals known to be at risk for a COVID-19 infection are immediately isolated to prevent potential spread to others.

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 percent 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] stands ready support the department's "[Fourth Mission](#)" to surge capabilities into civilian healthcare systems in the event those systems encounter capacity issues. Those requests would come from the Department of Health and Human Services (HHS), so we refer you to HHS for further comment.

Information Collections, Analysis, and Dissemination

Emerging Threat Phase (pre-confirmed case within VA) – The EMCC communications workgroup monitors the CDC website regularly 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, the workgroup monitors VA social media feeds 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 workgroup and VHA Communications monitors 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). Facility operations are monitored through regular calls with the VISN and field public affairs officers and the daily coronavirus update call. 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, which is updated daily, aggregates the latest guidance and communications resources into an easy-to-use, customizable format for VA communicators.

Appendix F – Human Resources and Finance Administration

Purpose, Scope, and Assumptions

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

It is assumed that a situation exists that expands or allows the implementation of laws, rules, regulations, or policy that are not in effect during normal operations and that this expansion requires information to be communicated to leadership 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 and the Chief Officer for VHA Workforce Management and Consulting will delegate or specifically assign VHA WMC Human Resources staff to the workgroup for situational response.
- The workgroup will be responsible to field questions and inquiries and provide VHA specific guidance in reference to the specific situation.
- The workgroup 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.

Finance

The VHA Chief Financial Officer (CFO) will provide guidance to station fiscal personnel via e-mail communications, financial alert communications, and conference calls. The focus of communications will be on the appropriate costing of expenses to effectively track the amount of funds expended on the COVID-19 response for VHA. Expenses must be accompanied by receipts, invoices, etc., and can cover compensation costs for appointments of temporary personnel as well as acquisition, rental, or hire of equipment, services, materials, and supplies; for shipping, drayage, travel, and communications and for the supervision of these activities as documented in VHA Financial Alert 2020-004. (see below):

Accounting for COVID-19 Costs

1. Purpose: This Alert provides VHA stations guidance for recording and tracking expenditures related to COVID-19.
2. Background: On January 20, 2020, the VHA Executive in Charge issued a message that outlined the steps VHA is taking to closely monitor the outbreak of this respiratory illness caused by COVID-19.
3. On January 31, 2020, the Secretary of Health and Human Services declared a Public Health Emergency for the United States for the 2019 Novel Coronavirus. <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>
4. Reference: VA Financial Policy Vol. XIII Chapter 6 (Accounting During Declared Emergencies)
5. Guidance: VA will track all expenditures related to the occurrence of COVID-19. VA stations will account for costs related to COVID-19, including overhead, until such time as the Secretary or designee issues a statement indicating the occurrence or emergency has ended and normal operations can resume. Ref: VA Financial Policy Vol. XIII Chapter 6, section 060502 Paragraph A2.

VA will properly document and account for its funds expended during the occurrence of COVID-19. To the extent permitted by the scope, intensity, and duration of the occurrence of COVID-19, costs will be fully documented with timecards, receipts, invoices, etc.

VA may incur the following costs during such occurrence:

- Compensation costs for appointments of temporary personnel, as may be necessary, without regard to the provisions of Title 5 governing appointments in the competitive service.
- Obligations incurred on behalf of the United States, through contracts or otherwise, for the acquisition, rental or hire of equipment, services, materials, and supplies for shipping, drayage, travel, and communications and for the supervision and administration of such activities. Reference: VA Financial Policy Vol. XIII, Chapter 6, section 060502 Paragraphs 4a and 4b.

Appropriations: Novel Coronavirus expenses may occur within any of the following appropriations:

0140 Medical Community Care
0152 Medical Support and Compliance
0160 Medical Services
0161 Medical and Prosthetic Research
0162 Medical Facilities
0169 Federal Health Center/Lovell (VA/DoD)

- **Accounting Classification Codes (ACC):** For tracking costs associated COVID-19, VHA has established specific accounting classification codes (ACC). These ACCs should be used for costs incurred by the facilities for COVID-19 activities only. All stations seeking reimbursement from an external entity should use ACC - ND02D20F1. All other COVID-19 costs will be tracked using ACC – ND02D2001. Normal costs of operations unrelated to COVID-19 will be recorded using regular ACCs. Reference: VA Financial Policy Vol. XIII Chapter 6 Section 060502 Paragraph A).

ACC Code	Description	Usage Type
ND02D20F1	DISASTER-CORONAVIRUS FEMA	When seeking reimbursement from an external entity
ND02D2001	NAT DISASTER-CORONAVIRUS	All other novel coronavirus costs

- **Budget Object Codes (BOC):** A list of BOC codes is provided below. Please note that normal costs of operations not related to COVID-19 will be recorded using regular BOCs. Only the costs related to the declared emergency, including overhead costs, will be recorded in the restricted Declared Emergency BOCs. The

cost of disaster mitigation expenses (costs incurred to prepare for emergencies in general and not for any specific emergency) paid out of budgeted funds prior to the onset of a declared emergency will not be recorded in the Declared Emergency BOCs. Reference: *VA Financial Policy, Vol XIII Ch. 6, Appendix A, Declared Emergency Budget Object Codes.*

BOC	BOC Title	Description
1153	Declared Emergency Incremental Pay	Includes the incremental cost of personal services related to the emergency, including the additional overtime, shift differential, hazardous duty, holiday pay, etc., incurred in connection with, and directly related to, the declared emergency. It should be noted that this would also include regular pay for the duration of the declared emergency for any positions that are temporarily or permanently added to the payroll to deal with the effects of the emergency.
2160	Declared Emergency TDY	Includes all travel, meals, and lodging expenses incurred in connection with, and directly related to, dealing with the emergency itself, its clean-up, recovery, and return to normal operations. No costs related to Permanent Change of Station (PCS) are to be placed in this BOC.
2211	Declared Emergency Shipment of Bodies	Includes the shipment of the bodies of ineligible individuals as a result of or directly related to a declared emergency.
2280	Declared Emergency Shipments	Includes freight and express shipments of personal effects of deceased beneficiaries; contractual transfers of supplies and equipment; rental of trucks and vehicles from commercial sources to move goods and supplies when done in connection with, and directly related to, a declared emergency. If the shipping costs exceeds the purchase order threshold of \$250 or more, a separate purchase order must be established for the shipping cost using this BOC. If the shipping cost is less than the threshold, shipping is charged to the same BOC as the goods ordered.
2315	Declared Emergency Communications	Includes the cost of all temporary communication set up fees, hardware, service fees, etc., incurred to deal with the immediate effects and aftermath of a declared emergency.
2508	Declared Emergency Automated Data Processing (ADP) Support and Backup	Includes the cost of all systems support provided by private contractors and the rental or purchase of hardware/software, including its installation, necessary to augment/replace ADP capabilities direct.
2527	Declared Emergency Interior Repair and Refurbishment	Includes the cost to clean up/refurbish clinical and office space owned, rented, or leased by the Department and restore it to operational status. Costs to repair structural damage should be recorded in BOC 3253.
2536	Declared Emergency Burial of Unclaimed Bodies	Includes the cost of burial, temporary interment, cremation, etc., of ineligible individuals, as a result of or directly related to a declared emergency.

BOC	BOC Title	Description
2537	Declared Emergency Non-Clinical Contract Services	Includes the cost of all non-clinical contract services procured in connection with, and directly related to, a declared emergency and not covered by one of the other declared emergency BOCs.
2538	Declared Emergency Clinical Contract Services	Includes the cost of all temporary clinical service contracts (physician, nursing, laboratory, pharmacy, radiology, etc.) required as a result of, and directly related to, a declared emergency either to replace capacity lost as a result of the emergency or to deal with humanitarian care requirements.
2637	Declared Emergency Humanitarian Supplies	Includes the cost of all supplies (clinical, pharmacy, provisions, paper products, etc.) expended for humanitarian care of non-eligible individuals provided as a result of, and in direct connection with, a declared emergency.
3152	Declared Emergency Equipment – Non-Capitalized	Includes the purchase, rental or lease of all equipment (both clinical and non-clinical) required to replace comparable equipment lost or damaged as a result of a declared emergency or new equipment necessary to cope with increased humanitarian workloads resulting from such an emergency (See BOC 3153 for Capitalized Declared Emergency Equipment).
3153	Declared Emergency Equipment – Capitalized	Includes the purchase, rental, or lease of all equipment (both clinical and non-clinical) required to replace comparable equipment lost or damaged as a result of a declared emergency or new equipment necessary to cope with increased humanitarian workloads resulting from such an emergency (See BOC 3152 for Non-Capitalized Declared Emergency Equipment).
3157	Declared Emergency Cleanup and Repair of Personal Property	Includes the cost of cleanup and repair/refurbishment of personal property damaged as a result of and directly related to a declared emergency.
3252	Declared Emergency Cleanup and Repair/Refurbishment of Land, Buildings and Structures – Non-Capitalized	Includes the cost of cleanup and repair/refurbishment of real property as a result of and directly related to a declared emergency, except that the cost of interior cleanup and refurbishment of non-structurally damaged clinical and office space will be recorded in BOC 2527. (See BOC 3253 for capitalized Declared Emergency cleanup and repair/refurbishment of land, buildings or structures.)
3253	Declared Emergency Cleanup and Repair/Refurbishment of Land, Buildings and Structures – Capitalized	Includes the cost of cleanup and repair/refurbishment of real property as a result of and directly related to a declared emergency, except that the cost of interior cleanup and refurbishment of non-structurally damaged clinical and office space will be recorded in BOC 2527. (See BOC 3252 for non-capitalized declared emergency cleanup and repair/refurbishment of land, buildings and structures.)

Appendix G – 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 healthcare 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 healthcare for Veterans. Appendix L provides a full list of the guidelines grouped under the following categories:

- Administration
- Diagnostics and Testing
- Disinfection and Cleaning
- Emergency Management
- Human Resources
- Infection Control, Isolation and Quarantine
- Law Enforcement
- Personal Protective Equipment
- Safety of Healthcare Staff
- Screening and Triage
- Telemedicine and Virtual Care
- Treatment

Appendix H – Emergency Pharmacy Service

Purpose, Scope, Situations, Overview, and Assumptions

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

Requested 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 Director, Emergency Pharmacy Service requesting deploy 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/e-mail 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 I – Points of Distribution

Purpose, Scope, Situations, Overview, and Assumptions

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 Operations

Activities may be initiated in response to a variety of threats. These threats include, but are not limited to, a disease outbreak or a release of chemical or biological agents. Additionally, threats can occur naturally or be manmade. The threat may be initially present in a locality or detected in another country only to travel and emerge within the United States.



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

Depending on the incident, 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.
- Healthcare 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 en route; 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 materiel, 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 J – 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, 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.

Policy

RCS will ensure continuity of access to and delivery of readjustment counseling, outreach, and care coordination to Veterans, Service members and their families, first responders and the public, as appropriate, to the COVID-19 outbreak.

Situation

On March 2, 2020, the Office of Emergency Management (OEM) engaged RCS Leadership to develop a forward moving plan in the event of further outbreak and exposure of COVID-19 to RCS clients and staff.

Risk Assessment

The population RCS serve includes eligible individuals of all ages, gender, military experience, and time of service. Additional cohort concerns include:

- Aging Veteran population with co-morbidity diagnosis to include respiratory concerns, heart disease, diabetes, etc.

- Issues stemming from military service such as respiratory issues from potential exposure to chemical or environmental factors (burn pits, etc.).
- In addition, respiratory concerns have been identified as a concern related to COVID-19.

RCS is a complex organization within VHA due to the geographical spread of small, out-patient, store front locations. Local Vet teams range from 3 to 12 staff members, exclusive of volunteers.

Virtual care options (telehealth) has not been implemented at all Vet Centers. Eligible individuals may be reluctant to engage in this mode of delivery. RCS Vet Center staff are not currently authorized to telework.


Much is unknown about COVID-19, resulting in misinformation and a lack of education. Vet Centers are external and function independent from their local VAMC. Consequently, Vet Centers are not currently included on the disbursement of preventative resources (hand sanitation and facial masks).

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 percent 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.
- There may be critical shortages of health-care resources, such as Personal Protective Equipment (PPE) to include masks and hand-sanitation stations.
- 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.

Many 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.
2. Client is directed to urgent care, an emergency department- or a local health department.

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.

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 / 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 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 healthcare services; increasing awareness of preventative 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, and clinical operations are beginning to stabilize. 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.

Healthcare 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, and 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, healthcare 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 Workgroup, 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).

KEY REFERENCES AND INFORMATION SOURCES

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Appendix K – 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 percent.

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.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance.
- 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, HCI 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 Holy Communion kits for use on isolated units and with COVID-19 positive patients.
- 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 percent to 80 percent.*

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.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance.
- 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.

Phase 3 – Critical Phase

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

Potential impact:

- National Chaplain Service Director is available to VACO Senior Leadership for spiritual support and spiritual guidance as a Nation.

- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance.
- 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.

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.
- VA Chaplains nationwide are available to Medical Center Leadership and Incident Command Teams for spiritual support and spiritual guidance.
- 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.

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 L – 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 healthcare 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 healthcare 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.

Appendix M – Additional Reference Materials

Below is VHA specific guidance (DUSHOM) memos and other applicable reference materials.

Infection Control/Isolation/Quarantine	
3/6/20	Postponement of Long-Term Care Surveys
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 (access control)
3/16/20	Guidance for Geriatrics and Extended Care Home and Community Based Services Programs
3/17/20	Guidance for Community Living Centers – Revised
Disinfection/Cleaning	
1/31/20	Cleaning Guidance for Re-Usable Medical Equipment and Patient Rooms
Personal Protective Equipment	
3/15/20	Personal Protective Equipment Use
Screening/Triage	
3/2/20	Surveillance and Virtual Resource Utilization Planning (Guidance on ways to reduce face to face contact when screening patients)
Diagnostics/Testing	
2/11/20	Standardization of Laboratory Reporting
3/17/20	Revised Standardization of Laboratory Testing
Treatment	
3/15/20	Ensuring Continuity in Suicide Prevention
3/15/20	Guidance for Elective Procedures
3/16/20	Implementation of an Episodic Special Patient Icon in Bed Management Solution
3/16/20	Managing Operations of Mental Health Unit While Managing COVID-19
3/19/20	REVISED MEMORANDUM -COVID 19 Guidance for Dialysis
Telemedicine/Virtual Care	
5/20/18	Use of Telemedicine while providing Medication Assisted Treatment (DEA)
Administration	
3/7/20	Mission Critical Travel
3/16/20	Waiver of Bi-Weekly Pay Cap (VA)
Human Resources	
2/12/20	Authority to Approve Weather and Safety Leave for Employees Affected by COVID-19
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
3/15/20	HR Facts, Version 3
3/16/20	Supplemental HR Facts

Law Enforcement	
3/7/20	VA Police Quarantine Authority
Emergency Management	
1/30/20	Request for DEMPS Personnel to Assist HHS Response Effort
1/31/20	COVID-19 Response Program Responsibilities
2/5/20	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
Safety of Healthcare Staff	
3/2/20	COVID Protection (list of actions to protect staff and Veterans)
3/15/20	Guidance for Work Recommendations for Asymptomatic Healthcare Personnel After Exposure to a COVID-19 Patient
Logistics	
2/14/20	Personal Protective Equipment (national data call/Inventory)
Communications	
3/5/20	Communications Plan for VISN and VAMC Leadership
3/5/20	MESSAGE FROM THE EXECUTIVE IN CHARGE Novel Coronavirus (COVID-19) Disease UPDATE
3/6/20	COVID-19 Communications Toolkit (VHA)

**Department of
Veterans Affairs**

Memorandum

Date: **MAR - 6 2020**
From: Deputy Under Secretary for Health for Operations and Management (10N)
Subj: Postponement of Long-Term Care Surveys
To: Network Directors (10N1-23)
Medical Center Directors
Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)

1. The Office of Geriatrics and Extended Care (GEC) held conversations March 5, 2020 with the two national contracted vendors Long Term Care Institute and Ascellon Corporation to discuss the domestic travel implications with the current COVID-19 virus and CDC recommendations. Options were discussed if it could be safe to the vendors, VA staff, Veterans and the general public to continue surveys in the VA Community Living Centers (CLC) and the State Veterans Homes (SVH).
2. GEC is recommending pausing all external review surveys in both the VA CLC and the SVH program for 30 days. This would postpone surveys from March 9, 2020 until April 6, 2020. The postponement dates would be re-evaluated prior to April 6, 2020 to evaluate the outbreak situation and determine if this pause will need to be extended.
3. Although surveys are essential for continued oversight and monitoring, a temporary pause is felt to be in the best interest of Veterans, staff and contract staff to help mitigate potential spread to our most vulnerable population.
4. Both national vendors will be notified of the decision.
5. Please contact Ms. Lisa Minor, Director, Facility Based Programs, Office of Geriatrics and Extended Care at (202) 632-8320 or via e-mail at Lisa.Minor3@va.gov with any questions.


Renee Oshinski

Date: **MAR 10 2020**

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: COVID-19 Guidance for the VA Spinal Cord Injuries and Disorders (SCI/D) Centers

To: Network Directors (10N1-23)

Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)
ADPS

1. The priority goal in the VA response to COVID-19 is the protection of Veterans and staff. The SCI/D Hub and Spokes system provides care to high risk populations for COVID-19 including Veterans requiring acute, sustaining, outpatient, home care, long stay, short stay or hospice services. Various strategies to mitigate exposure to and transmission of COVID-19 to these populations is critical. This document provides guidance to facilities providing these services.
2. Admissions to SCI/D units should include only those Veterans that absolutely need to be admitted, such as an acute injury or illness. All elective admissions including annual evaluations should be postponed until a later date.
3. Avoid any situation that might result in introduction or spread of COVID-19, including any group settings (e.g., in therapy gym, meals, sponsored events). Avoid sharing of equipment if possible.
4. Use virtual health and communication (e.g., telephone, telehealth) whenever possible, including all non-urgent interactions with Veterans with SCI/D including in the ambulatory care and home care settings.
5. Avoid all visitors if possible. Exceptions might include end-of-life care, a family member of a newly injured Veteran or Active Duty Servicemember (ADSM) during the first week and training a caregiver for discharge. However, consider telehealth whenever possible, including visits from commanding officers for ADSM.
6. Consider limiting vendors access for equipment-related purposes unless absolutely necessary.
7. Limit exposure from others coming into the SCI/D unit and minimize patients leaving the unit for diagnostic testing unless absolutely necessary.
8. Active screening of anyone entering the unit must continue per established guidance.

Page 2. COVID-19 Guidance for the VA Spinal Cord Injuries and Disorders (SCI/D) Centers

9. Staffing should be assessed to limit the number of staff entering the SCI/D Center and dedicated SCI/D staff should be maintained on the unit.
10. Please refer questions related to this guidance to the SCI/D National Program Office, at VHA10NC9Action@va.gov.


Renee Oshinski

Department of
Veterans Affairs

Memorandum

Date: MAR 11 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Homeless Program Office (HPO) Coronavirus Disease 2019 (COVID-19) Response Suggestions

To: Network Directors (10N1-23)

Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC) *JWB*

1. Attached is Veterans Health Administration (VHA) recommended suggested COVID-19 response. Populations experiencing homelessness are more at risk than the general population to emerging infectious diseases. Coronaviruses is a large family of viruses that cause illness ranging from the common cold to more severe diseases, such as Severe Acute Respiratory Syndrome (SARS). The first cases of Coronavirus 2019 (COVID-19) were detected in December 2019.
2. Once homeless specific COVID-19 response guidance is disseminated by such agencies as the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO), they will replace and/or supplement this Homeless Program Office COVID-19 Response Suggestions. The attached suggestions were compiled from multiple resources including VHA, CDC, and WHO. Please continue to coordinate with your local VA Medical Center (VAMC) and public health departments as the situation evolves across the United States.
3. Please refer to *VHA COVID-19 Strategic Response Plan* by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020 for VHA department wide COVID-19 planning, including modifying response based on the phase of the COVID-19 outbreak.
4. Further questions regarding the HPO recommended responses should be directed to Jillian J. Weber PhD, RN, CNL (Homeless-PACT National Program Manager) via email at Jillian.Weber@va.gov or Dina Hooshyar, MD, MPH via email at Dina.Hooshyar@va.gov (Director, National Center on Homelessness among Veterans).

Renee Oshinski
Renee Oshinski

Attachment

Attachment

Proactive planning: An essential component to COVID-19 Response is proactive planning prior to your community experiencing a COVID-19 outbreak. This planning will have the best success if a wide array of stakeholders are involved in the process, including but not limited to the local health department, Veterans Affairs (VA) and non-VA medical facilities, community emergency response system, community and faith-based organizations who support homeless programs, and city council.

- One way to participate in community-wide planning is to determine if your local government has a private-public emergency planning group that meets regularly.
- Know your local health department's reporting process for potential COVID-19 cases.
- Include your colleagues within your VA Medical Center (VAMC) in your planning, communications, and activities. For example, homeless program managers are encouraged to inform their VAMC infection control program, emergency management, and occupational health about the care delivery processes within homeless programs.
- Know your VAMC process regarding when Veterans present with COVID-19 symptoms to your VAMC Emergency Departments (ED) and/or outpatient clinic locations.
- Inform your VAMC leadership and the disaster management team about the known number of Veterans who are living on the streets and in shelters even if none of them currently have symptoms of COVID-19.
- Proactively address stigma and discrimination given homeless populations might be labeled more as spreaders of disease rather than being at greater risk of acquiring disease.
- As recommended by *Veterans Health Administration (VHA) COVID-19 Strategic Response Plan*, establish alternate sites of care should the healthcare system not be able to meet demands on care. Consider including in these discussions housing for homeless Veteran population. Specifically, consider discussing the plan if existing transitional and emergency housing are unable to meet the demands of sheltering Veterans ill from suspected COVID-19 who do not require hospitalization.
- Start to give consideration now about when to stop providing in-person group sessions. Follow your local VAMC recommendations regarding potential absolute stop date; however, homeless program associated groups might need to be cancelled prior to the local VAMC potential stop date depending on the prevalence of COVID-19 in local homeless population and location of these groups. If groups are stopped, considered alternative forms of care.

Cultivating these strong alliances is critical for better outcomes if a COVID-19 outbreak were to happen in your community.

Infection Prevention Methods: The best method to combat any infectious disease is to have preventive measures in place prior to an outbreak that mitigates the transmission and spread of the disease. This includes:

- Frequent handwashing with soap and water for minimum of 20 seconds
- Frequent use of 60% or greater alcohol-based sanitizers
- Avoid shaking people's hands when in situations where access to soap/water or sanitizers is not available (inform people the reason for not shaking their hands).

- Avoid touching your face.
- Increase cleaning of surfaces (e.g., workstations) and communal areas (e.g., waiting rooms). After every clinical encounter in the office, wipe down flat surfaces with your local VAMC infection control recommended wipes.
- Avoid public places and areas where large groups of people will congregate (e.g., concerts, sporting events).
- When resources are available, homeless program staff are encouraged to call Veterans on their caseload (who have access to phones) to inform them about COVID-19 infection prevention methods, especially Veterans who are at higher risk of acquiring COVID-19. Risk factors include being 65 years of age or older, underlying lung problems, weakened immune system, and tobacco user. Encourage tobacco cessation.

Further information about everyday preventive actions can be accessed at:
<https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html>

Homeless Veteran Stand Downs: Given that an essential component to COVID-19 Response is proactive planning prior to your community experiencing a COVID-19 outbreak, it is the VA's recommendation that all Stand Down events be postponed until further notice. The National Homeless Program Office's Health Care for Homeless Veterans Office will update the VAMC homeless program staff when it is felt that it is safe to resume these large community events.

Outreach: Educate Veterans on infection control measures and rationale for not engaging in close contact such as shaking hands and maintaining 6 feet distance from people even if they are not exhibiting any COVID-19 symptoms. Ask Veterans to wear a surgical mask if they have symptoms (i.e., cough, fever, or shortness of breath) and offer a mask if available.

Telework: Homeless Program Office (HPO) supports use of telework. Please follow VHA guidance on telework.

Home Visits: Staff are encouraged to utilize the same infection prevention methods that their VAMC recommends be used for community-based visits.

- Consider calling Veterans in advance of conducting home visits, when possible. If either the Veteran or the individuals in their household report symptoms suggestive of COVID-19 infection (i.e., cough, fever, or shortness of breath), then consider using telehealth to conduct the visit. VA Video Connect is preferable, when available, over a telephone encounter.
- When Veterans have been directed to self-quarantine or self-isolate, home visits should not be completed. Alternative contacts should be utilized per local resources. During these alternative contact encounters, Housing and Urban Development-VA Supportive Housing staff's discussions with these Veterans should address issues related to food security and other subsistence issues.
- Staff should use hand sanitizer before and after home visits.
- Contacts need to be maintained as much as possible to be in line with Veterans' phase of case management and the minimum number of contacts required. Potential exists that not all required face-to-face contacts may be able to be completed when Veterans are experiencing symptoms suggestive of COVID-19. Alternatives, such as VA Video Connect or telephone encounter, should be used.

- When Veterans report symptoms suggestive of COVID-19 infection, staff should be available to assist them, during the staff's normal tour hours, with connecting Veterans to their primary care provider for guidance on next steps. Veterans also have access to VHA Clinical Contact Centers (a call center staffed by registered nurses) as an alternate resource source.
- When Veterans cannot be contacted and staff have concerns for their safety, then local standard operating procedures should be completed, which may include a welfare check.

Congregate settings, such as shelters and transitional residences:

- Risk of COVID-19 transmission can be decreased by avoiding close contact with others. In general sleeping areas, Centers for Disease Control and Prevention (CDC) encourages but does not consider as an absolute requirement to situate beds/mats at least 6 feet apart. Residents should also sleep head-to-toe and use temporary barriers between beds, when possible.
- Discuss with grantees their current infection prevention process when clients have influenza or tuberculosis. Such practices may include non-medical staff asking clients about whether they have a fever, new or worsening cough or shortness of breath, or flu-like symptoms. If these symptoms are mild, then admit them to an area of the congregate setting that is restricted for residents with similar symptoms and request that the person wear a surgical mask if available. If individual isolation rooms are not available, consider using large, well-ventilated rooms. If possible, there should be designated bathroom for clients with suspected COVID-19.
- Medical care should be considered for individuals with more severe symptoms, such as difficulty breathing or shortness of breath, pain or pressure in chest or abdomen, sudden dizziness, confusion, severe or persistent vomiting, or flu-like symptoms improve but then return with fever and worse cough. Begin proactive discussions regarding local resources that may be able to assist congregate settings without medical staff in determining if Veterans need medical care. If the decision is that a Veteran needs to obtain medical care, plan now on how this process would occur: (1) know the point of contact (POC) of the medical care facility (often ED charge nurse or nurse manager); (2) call this POC to give them advance warning that a patient who has symptoms suggestive of COVID-19 will be arriving to their facility; (3) have discussions now about how this patient will be transported to the facility.

Transportation with minimal exposure to others, such as via ambulance, is suggested.

- If Veterans with COVID-19 symptoms are denied admission to shelters solely based on having COVID-19 symptoms, this should signify the need for higher level of medical care and provisions to obtain this higher level should be done.
- If Veterans develop fever, new or worsening cough or shortness of breath, or flu-like symptoms after admission, use aforementioned steps utilized during admission process to determine next steps.
- VA staff should follow the guidelines of their site's partner. Do not visit Veterans in quarantine.
- Environmental cleaning of common areas: <https://www.cdc.gov/coronavirus/2019-ncov/community/home/cleaning-disinfection.html>

Community Resource and Referral Centers: Follow your VAMC guidelines that out-patient clinics are utilizing regarding asking Veterans screening questions for COVID-19. If possible, designate an area for Veterans who are exhibiting COVID-19 symptoms and do not require

higher level of care. Request and offer them surgical masks to wear if available. Try to have a minimum number of staff to interact with these Veterans.

Coordinated entry system: Examine your community's coordinated entry system. Will knowing the COVID-19 symptom status of Veterans help to house those with and without symptoms separately? As known COVID-19 cases increase, some communities might experience predominance of their general population having COVID-19 symptoms. At this point, knowing if clients are exhibiting COVID-19 symptoms will not help facilitate housing those with and without symptoms separately.

Grantees and Contract Providers (Health Care for Homeless Veterans, Grant and Per Diem (GPD), Supportive Services for Veteran Families): Grantees and Contract Providers are encouraged to start planning now with their local health departments about local health resources and guidance for Veterans experiencing homelessness who are not eligible for VA healthcare and are exhibiting symptoms suggestive of COVID-19.

GPD Hospital-to-Housing (H2H): During the process where H2H is considering accepting a COVID-19 positive patient from local VAMC, the GPD liaison should be an active participant in these discussions with the local VAMC medical staff, local VAMC COVID-19 Response team, and GPD site. These conversations should include commitment from local VAMC COVID-19 Response team to serve as resource for GPD liaison during the time when patient will be residing at GPD site. GPD liaisons should work with grantees to ensure appropriate cohorting, education of staff, and medical supports will be provided if a COVID-19 positive patient is referred to a GPD site.

Homeless Patient Aligned Care Team (H-PACT): As having both medical and social services components, H-PACT can support not only Veterans experiencing homelessness but also other hospital and clinical teams as being the experts on health issues.

- Assist in tailoring this HPO and other COVID-19 guidance to local VAMC level's resources and needs as typical hospital-based programming does not cover all homeless care services.
- Be a technical advisor on homeless issues for local VAMC COVID-19 Response team.
- Support the non-VA medical community COVID-19 response. Examples include H-PACT medical directors being in close communication with the medical directors of their community's shelter systems, indigent primary care clinics, Federally Qualified Health Centers, and public health departments.

Staff protection: People who are 65 years old or older, have underlying lung problems, have weakened immune system, and are tobacco users are at greater risk of acquiring COVID-19. Would consider assigning tasks based also on COVID-19 acquisition risk factors of the employee until a COVID-19 vaccine is available. Also, if staff is experiencing symptoms suggestive of COVID-19, they should stay home and contact their supervisor. Guidance on leave consideration can be found through local VAMC HR guidance, on VA HR/Emergency Resource Center <https://vaww.va.gov/OHRM/Worklife/Pandemic/>, and HCI Preparedness Program SharePoint.

VHA Clinical Contact Centers: Provider of virtual urgent care by nurses to Veterans enrolled in VA Health Care. To access: Call (844) 698-2311. Press 3. Enter your zip code. System will auto-dial to the local VAMC. At additional prompts, select "talk with a nurse" or "operator."

Influenza: Currently, flu is more prevalent in the United States than COVID-19. Strongly encourage staff and Veterans to get the influenza vaccination if they have not done so already and if they do not have any contraindications to obtaining one.

Additional Resources:

- Leung CS. Homelessness and the Response to Emerging Infectious Disease Outbreaks: Lessons from SARS. *Journal of Urban Health* 2008; 85(3): 402-410.
- **CDC:** <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- **Department Housing and Urban Development:**
<https://files.hudexchange.info/resources/documents/Infectious-Disease-Toolkit-for-CoCs-Preventing-and-Managing-the-Spread-of-Infectious-Disease-within-Encampments.pdf>
- **VHA:** https://www.blogs.va.gov/VAntage/72072/coronavirus-be-informed-and-call-your-provider-if-symptoms-develop/#_blank
<https://www.publichealth.va.gov/n-coronavirus/index.asp>
<https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>
[x](#)

COVID-19 Screen: Screening questions will change as our understanding of COVID-19 changes. Follow your VAMC policy regarding management of positive screens.

Access copy at

<https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>

**Department of
Veterans Affairs**

Memorandum

Date:

From: Deputy Under Secretary for Health for Operations and Management (10N)

Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)

Subj: COVID-19 Guidance for Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)
Veterans Integrated Service Network (VISN) Directors (10N1-23)

To: VISN Mental Health Liaisons (10N1-23)

1. This memorandum provides guidance to facilities operating Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) otherwise known as Domiciliary programs and includes the Compensated Work Therapy/Transitional Residence program. In continuation with national COVID-19 prevention efforts, admissions of Veterans who require long-distance or interstate travel by plane, bus or train are to be curtailed until the VA travel ban is lifted. In the interim, arrangements must be made for continued care either in the Veteran's locality of residence, without long-distance travel, or through virtual means.
2. In addition, when a local facility curtails admission to an MH RRTP for reasons other than the travel restriction, the facility must submit an Issue Brief (IB) to 10N. The IB should outline the timeline for delayed admissions and the plan for the provision of continued care while Veteran waits for admission.
3. Questions about guidance on MH RRTP units should be directed to Mr. Ploppert, National Mental Health Director, Residential Rehabilitation and Treatment Program by email at Jamie.Ploppert2@va.gov.


Renee Oshinski

COVID-19 Action Plan for Blind Rehabilitation Centers

Purpose: To provide clear communication to the 13 VHA Inpatient Blind Rehabilitation Centers (BRC) regarding current and pending admissions.

Action: Effective immediately and until further notice, all VA BRCs will suspend and postpone admitting patients in order limit COVID-19 exposure risk for Veterans being treated in and traveling to / from these facilities. Veterans who are currently inpatients in a BRC will be evaluated and managed for proper discharge planning.

Areas of Consideration:

- Consistent message through BRC, VHA Blind Rehabilitation Continuum of Care, and Blinded Veterans Association to minimize alarm and ensure accurate communication.
- Individualized Case Management:
 - Determine the most appropriate disposition for each Veteran currently admitted to a BRC.
 - Develop appropriate timeline for discharge. Current inpatients should be discharged as soon as viable, and stagger discharges as necessary.
 - Patients should be made discharged to home ideally, although accommodations may be made to retain inpatients if they are at greater risk for exposure if discharged.
 - Ensure each discharged Veteran is provided with resources as appropriate for their plan of care.
- Determine and provide necessary follow-up care, as appropriate, at home by their Visual Impairment Service Team, or through Telehealth, or other means.
- Expectations for BRC staff members:
 - Do not report to work if sick.
 - Determine plans for how time and services will be reallocated during absence of inpatients.
- Follow local VAMC guidance with regards to:
 - Infection control measures and maintaining clean environment in BRCs and patient rehabilitation areas.
 - Operating and maintaining Outpatient programs (Visual Impairment Service Teams (VIST), Blind Rehabilitation Outpatient Specialists (BROS), HOPTEL and VISOR BRS continuum of care clinics).
 - Maintaining utilization of currently scheduled non-VA community care services for blind rehabilitation services.

Risk Communication: Manage messaging by crafting targeted correspondence to address:

- Currently admitted BRC inpatient Veterans and their families.
- Notifying Veterans and postponing pending BRC admissions.
- Staff education for BRC staff, VIST Coordinators, and BROS with regards to communication and case management for continuity of care.

**Department of
Veterans Affairs**

Memorandum

Date: March 16, 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: COVID-19 Guidance for Department of Veterans Affairs (VA) Health Care Systems

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)

1. Veterans Health Administrations (VHA) is focused on protecting our Veterans and staff as VA responds to COVID-19. The purpose of this memorandum is to provide guidance in an effort to reduce the transmission of COVID-19. All Networks are requested to limit facility access and implement screening procedures prior to entrance into the facility to mitigate exposure and transmission of COVID-19 to our patient population.

2. Facility Access: Access to the Medical Centers should be limited and able to accommodate screening of visitors and staff. Appropriate signage should be in place to direct visitors to the access point. Visitor access to our facilities will be limited.

3. Screen procedures: VHA staff will screen all visitors each time they enter the Medical Center. Screening criteria may change as information about COVID-19 evolves. All visitors will be screened for COVID-19 as described below:

As of the effective date, screening should include the following information:

- Fever (100.4F or 38C)
- Cough
- Shortness of breath

The goal is to approve access to individuals with no fever and no symptoms. Visitors who screen positive, will not be granted access to the Medical Centers.

4. Visitors returning from international travel must be in the United States, symptom free, for 14 days. Visitors with additional questions about their symptoms should be referred to their medical professional. VHA is taking these proactive precautions to protect our Veterans, employees, and the communities we serve.

5. VHA is sensitive to the separation this restriction causes our patients and their loved ones, but VHA believes this measure of protection is essential at this time to keep people safe. Only one visitor per Veteran is allowed for Veterans who require assistance to get to and from an appointment, providing support to in-patient Veterans in palliative or hospice care, and Veterans who are having major procedures.

6. Access will be determined on a case-by-case decision where the visitor is critical to the care of the Veteran. Only visitors without symptoms will be permitted to enter the Medical Center as dictated by the current situation. No visitors under the age of 18 are permitted, including infants. No Visitors will be allowed to wait in common areas

Page 2

Subj: COVID-19 Guidance for Department of Veterans Affairs (VA) Health Care Systems

(canteen areas, waiting rooms, vending areas, etc.). These restrictions apply to all care locations, including health care facilities, ambulatory care centers, urgent care centers, and emergency rooms.

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Renee Oshinski

FAQs

Q: I need to have someone bring me to my appointment. Can they wait in the lobby or another designated waiting area?

A: To help protect our Veterans, staff and visitors, VHA is implementing an enhanced patient safety policy which permits only one visitor in the building per patient.

Q: I need to have someone bring me to visit a patient. Can they wait in the lobby or another designated waiting area?

To help protect our patients, staff and visitors, VHA is implementing an enhanced patient safety policy which permits only one visitor in the building per patient. This means while you are visiting your loved one, your other family member(s) or friend(s) must remain outside of the building.

Q: A Veteran is having a complex surgery and other family members want to be present in the waiting room. What arrangements can we make?

A: Due to the COVID-19 outbreak, groups of individuals are not permitted to wait in the designated waiting spaces. Please ask one family member or friend to remain at the hospital and provide updates to the rest of the family. We suggest communicating by phone or social media as needed.

Q: The Veteran is currently a Patient Under Investigation (PUI) and we are awaiting confirmation to see if he/she has COVID-19. Can we still visit?

A: No. VHA encourages you to use telecommunication devices – phones, laptops, tablets, etc. Few exceptions will be made on a case-by-case basis. If allowed to enter the room, you will be required to wear protective equipment like gloves, gowns and a mask. You will also be educated on proper hand hygiene techniques. The visitor should not have any signs or symptoms of illness.

**Department of
Veterans Affairs**

Memorandum

Date: **MAR 16 2020**

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: COVID-19 Guidance for Geriatrics and Extended Care Home and Community Based Services Programs

To: Network Directors (10N1-23)
Medical Center Directors (00)

1. Effective immediately, all Department of Veteran Affairs (VA) Geriatric and Extended Care Home and Community and Purchased Care programs will implement new safeguards aimed to limit the COVID-19 exposure risk for Veterans being served by these programs. This memo provides guidance for the following programs: Home Based Primary Care ([HBPC](#)), Medical Foster Home ([MFH](#)), Community Residential Care ([CRC](#)), VA Adult Day Health Care, Community Adult Day Health Care ([CADHC](#)), and Community Nursing Home ([CNH](#)).
2. The priority goal in the VA response to COVID-19 is the protection of Veterans and staff. Guidance is necessary given the high risk, vulnerable populations in these programs, and the potential for VA staff to become exposed to COVID-19. To minimize risk of exposure to this vulnerable population of Veterans, effective March 16, 2020 and until further notice, the above stated programs will take the following actions:
 3. Home Based Primary Care (HBPC)
 - a. In-person home visits should be limited to only those deemed essential to be performed in-person. New admission assessments may be considered essential.
 - b. Whenever feasible, visits should be performed virtually via VA Video Connect, Video on Demand, or by telephone
 - c. All non-essential visits should be deferred if virtual options are not available.
 - d. Initiate screening of Veteran and all household members prior to conducting any home visits. All staff must also be screened prior to any home visit and should not visit if screened positive or if staff is sick. [VHA HCI Screening and DX](#).
 - e. If an in-person visit is deemed essential (and there are persons with positive screen), ensure proper personal protective equipment (PPE) for staff for Standard, Contact, and Droplet Precautions, including the use of eye protection. Recommended PPE includes:
 - i. A single pair of disposable patient examination gloves. Change gloves if they become torn or visibly soiled,

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- ii. Disposable isolation gown,
 - iii. Respiratory protection (i.e., surgical mask, if aerosol generating procedure/ collecting nasopharyngeal swab for COVID-19 culture wear N-95 or higher-level respirator), and
 - iv. Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face).
 - v. Provide a disposable surgical mask to the person with symptoms
- f. Don PPE outside the home and removing after exiting the home, leaving disposed PPE in a garbage bag at the home.
 - g. Provide just in time education for all Veterans in HBPC, including explaining of changes in mode of HBPC visits during COVID-19 period, how to reach HBPC providers, instructions on when to seek medical attention, respiratory hygiene, and self- isolation
 - h. Assure all Veterans on HBPC program has access to necessary food and supplies.
 - i. For questions regarding VA Home Based Primary Care guidance for COVID-19, please contact Dayna Cooper, Director VA Home and Community Care at Dayna.Cooper3@va.gov
4. Medical Foster Home (MFH)
- a. MFH clinical visits should follow the guidance for Home Based Primary Care.
 - b. Monthly unannounced visits by the MFH Coordinator should be completed via phone or telehealth.
 - c. All scheduled inspections of current or new MFHs will be suspended. The MFH Coordinator will work closely to establish a plan to reschedule Inspections with all homes in a timely manner once permitted.
 - d. If a face to face visit is deemed necessary, MFH Coordinator will initiate screening for ALL persons residing in the home prior to conducting any home visit. [VHA HCl Screening and DX](#).
 - e. If anyone in home screens positive for COVID-19, ensure proper PPE is secured and follow guidance for Home Based Primary Care for home visits.
 - f. MFH Coordinators should advise MFH Caregivers to limit in-home visitors.
 - g. For questions regarding VA Medical Foster Home guidance for COVID-19, please contact Dayna Cooper, Director VA Home and Community Care at Dayna.Cooper3@va.gov
5. Community Residential Care (CRC)
- a. All in person visits to CRC facilities will be suspended.
 - b. While in-person visits are paused, establish a plan of communication to maintain oversight of Veterans placed in a CRC. Methods used may include telephone or video telehealth.

- c. In addition, recurring review of the Veteran's electronic medical records should continue.
 - d. It is also recommended that the CRC Coordinator speak to the Residential facility leadership to ask them their plan for COVID-19. Questions should include the following:
 - i. What are their plans for maintaining operations at their facility?
 - ii. Is the home accepting new admissions?
 - iii. Is the home allowing/restricting visitors?
 - e. All scheduled inspections of current or new CRCs will be suspended. The CRC Coordinator will work closely to establish a plan to reschedule inspections with all homes in a timely manner once permitted.
 - f. For questions regarding VA CRC guidance for COVID-19, please contact Dayna Cooper, Director VA Home and Community Care at Dayna.Cooper3@va.gov.
6. VA Adult Day Health Care (VA-ADHC)
- a. All programs will immediately suspend operations.
 - b. All Veterans and identified Caregivers will be contacted to identify any home care services that may be needed during this period of suspension. If services are identified, work with the appropriate program to implement the needed service (i.e., homemaker/ Home Health Aide, skilled nursing, etc.)
 - c. Establish a follow up plan of care for each Veteran to contact via phone, or via video telehealth, during this period of suspension to ensure their status and that needs do not change.
 - d. If status of Veteran changes during this time, assist with any resources that may be needed.
 - e. For questions regarding VA Adult Day Health Care guidance for COVID-19, please contact Dayna Cooper, Director VA Home and Community Care at Dayna.Cooper3@va.gov
7. Community Nursing Home (CNH)/ Community Adult Day Health Care (CADHC)
- a. All in-person visits to CNH and CADHC facilities will be suspended.
 - b. While in-person Veteran visits are paused, a combination of telephone or virtual care by video telehealth may be used to maintain oversight of Veterans placed in CNH or CADHC facilities, maintaining the 30-day frequency for CNH Veterans and quarterly for CADHC Veterans.
 - c. A combination of telephone or video telehealth may be used to communicate with Veteran or family members directly without visiting the facilities.
 - d. Recurring review of Veterans' electronic medical records should continue as best practice.
 - e. It is recommended that CNH or CADHC coordinators also speak to CNH or CADHC facility leadership to ask them the following questions regarding the ongoing spread of COVID-19:
 - i. What are their plans for maintaining operations at their facility?

- ii. Is the provider still accepting new admissions?
- iii. Is the provider allowing visitors?
- f. The Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group has released revised guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes on March 9, 2020 for your reference. The guidance includes the topic of visiting nursing homes, and can be found here: <https://www.cms.gov/files/document/gso-20-14-nh-revised.pdf>.
- g. For questions regarding CADHC or CNH guidance for COVID-19, please contact Daniel Schoeps, Director, Purchased Long Term Services and Supports at Daniel.Schoeps@va.gov.



Renee Oshinski

Date: **MAR 17 2020**

From: Deputy Under Secretary for Health for Operations and Management (10N)

sub: Coronavirus (COVID-19) Community Living Centers – Revised 03/17/2020

to: Network Directors (10N1-23)

1. Veterans Health Administration (VHA) is providing updated guidance for its Community Living Centers (CLC).
2. Effective immediately, Department of Veterans Affairs (VA) CLCs will only admit Veterans already in a VA facility. No admissions are permitted from the community.
3. Veterans requiring admission to acute care for an emergency can be transferred to the CLC after completing 14 days of observation in the acute care facility. If bed space in acute care is an issue, then these Veterans can be transferred to a CLC if appropriate housing is available (e.g., negative air room preferred, but at a minimum a private room). The days spent in acute care count toward the 14 days of observation. Observation can be discontinued after 14 days and if the Veteran has a negative screen for COVID-19.
 - a. Observation consists of resident staying in their bedroom and daily screening for symptoms of COVID-19 including: 1) temperature greater than 100.4, 2) presence of a cough, 3) shortness of breath or 4) sore throat. This screening must be documented in the electronic health record. If the resident must come out of their room, then they should wear a mask.
4. Staffing, procedures and delivery models should limit the number of staff entering CLC space. Dedicated CLC staff should be used. Facility staff should not have duties that require them to enter a COVID-19 area at the facility and CLC. To minimize access to the CLC, facilities should address what duties can be performed by CLC staff (e.g., phlebotomy) and how to limit deliveries (e.g., pharmacy, supplies, linens, meals).
5. Telehealth modalities should be used to complete consults and replace clinic visits outside of the CLC. Additional guidance will be coming for accessing rehabilitation services for short stay residents.
6. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and follow local guidance.

Subj: Coronavirus (COVID-19) Community Living Centers – Revised 03/17/2020

7. Institute daily screening of residents for fever and symptoms of COVID-19 including: 1) temperature greater than 100.4, 2) presence of a cough, 3) shortness of breath or 4) sore throat. The information collected should be entered in the electronic health record. Any resident that screens positive should be assessed for possible infection. Existing protocols that rule out other viral disease (e.g. influenza) should be performed prior to any COVID-19 testing.
8. CLCs are to restrict all visitors, except for certain compassionate care situations, such as an actively dying Veteran (e.g., life expectancy of hours to days), and that visit will be limited to that room only. Decisions about visitation during a compassionate care situation should be made on a case by case basis, which should include careful screening of the visitor for fever or respiratory symptoms. Visitors may be asked to wear PPE to protect the CLC residents. Those visitors with symptoms should not be permitted to enter the facility at any time (even in end-of-life situations). They should also be reminded to frequently perform hand hygiene. Visitors with additional questions about their symptoms should be referred to their medical professional.
9. The facility should have a plan to isolate any resident that is suspected of having COVID-19. Facilities with negative airflow rooms in the CLC should use that location. Facilities with multiple suspected or confirmed cases should have plans to isolate residents to one area (neighborhood) in the CLC or at another location at the medical center if space does not allow to isolate in the CLC. If the need to isolate in a neighborhood setting is required, consistent staff should be assigned to those residents and not be assigned to go between COVID-19 positive and negative residents to provide care.
10. Facilities should immediately initiate procedures to cancel communal dining and all group activities, such as internal and external group activities. Residents may eat in the dining room with social distancing (there should be only one resident at a table and at least six feet between tables) Field trips and other activities that take residents outside the CLC will be cancelled until further notice.
11. Guidance for Behavioral Recovery Outreach (BRO) Teams:
 - a. Day of Discharge and Community Follow-Up Visits
 - i. **ALL community activities are to be completed via phone or VA Video Connect (VVC).**
 - ii. Please work with your community partners to see if they have capacity to use VVC (e.g. already have tablets), as well as with your local telehealth programs to determine what equipment may be available for community partners to use at this time.
 - b. Behavioral Re-admissions
 - i. Please follow your local policies and procedures for BRO Veteran re-admissions.

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Subj: Coronavirus (COVID-19) Community Living Centers – Revised 03/17/2020

12. State Veterans Homes (SVH) provide three levels of care - nursing home, domiciliary and adult day health care. SVHs are owned and operated by the states. If a SVH has a confirmed case or outbreak of COVID-19, they should immediately involve the state's public health department and follow any guidance from them to mitigate the spread. SVHs should report any confirmed cases of COVID-19 to their VAMC of jurisdiction.
13. For questions regarding the CLC guidance, please contact Lisa Minor, RN, National Director, Facility Based Care by sending an email to Lisa.Minor3@va.gov



Renee Oshinski

**Department of
Veterans Affairs**

Memorandum

Date: JAN 31 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Coronavirus Patient Room Cleaning Guidance

To: Network Directors (10N1-23)

1. The purpose of the memorandum is to provide updated guidance on ensuring all non-critical Reusable Medical Equipment (RME), and rooms used to treat suspected and confirmed cases, are cleaned and disinfected properly and adhere to the guidelines established by the Centers for Disease Control.
2. Subject matter experts from throughout the Veterans Health Administration (VHA) reviewed the guidance in detail and have concurred with the information provided in the attachment.
3. Please direct any questions you may have to the VHA Emergency Management Coordination Cell at OEMEMCCCcmdStaff@va.gov.



Renee Oshinski

Attachment

Attachment

nCoV2019 Cleaning Guidelines

The National Program Office for Sterile Processing (NPOSP/10NC6) follows the Centers for Disease Control (CDC) guidelines for cleaning of non-critical reusable medical equipment (RME). For critical and semi-critical RME, VA facilities are to refer to the manufacturer's instructions for use when reprocessing these items.

CDC Coronavirus (nCoV2019) Website for Infection Control:
<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>

1. Patient Care Equipment/Supplies

- a. Equipment (e.g., stethoscope, blood pressure cuff, thermometers) must be single-use or dedicated to use of the patient to avoid sharing with other patients whenever possible.
 - i. A **two-step cleaning and disinfection process** must be stringently adhered to during this process. If there is any question about whether hospital-approved disinfectant, suggest that facility chief of environmental services and infection prevention and control consult with manufacturer supplying disinfectant agents for these details.
- b. Reusable patient care equipment must be disinfected with an EPA-registered, hospital-approved disinfectant (with EPA registered claims for enveloped emerging viruses) before use for another patient and prior to any maintenance; manufacturer's instructions for use are to be followed, including adherence to kill-claim times for disinfectant used regarding the emerging virus claim.
- c. Supplies in the room of a patient are to be kept to a minimum. Disposable items must be used whenever possible.
- d. Hand hygiene practices must be observed upon entry and exit from the room.

The VHA Environmental Programs Services adheres to the CDC recommendations below. All VHA BPA disinfectant cleaning chemicals on the formulary have coronavirus claims consistent with CDC guidance, *"This product has demonstrated to be effective against viruses similar to 2019-nCoV on hard, non-porous surfaces."*

2. Room Turnover Time, Discharge Cleaning, and Daily Cleaning and Maintenance while occupied.
 - a. Daily/Regular Cleaning and Room Maintenance
 - i. Cleaning staff must wear respiratory protection (e.g., NIOSH-Approved N-95 respirator or PAPR) and other PPE required for Contact Precautions Isolation (gowns and gloves), and eye protection (goggles or face shields) when cleaning for all times when the room is occupied by the patient.

nCoV2019 Cleaning Guidelines

- ii. If maintenance is to be performed on equipment in the room or room fixtures while occupied by the patient, the equipment or area to be serviced must be cleaned and disinfected using a **two-step process**. Any maintenance staff are to follow appropriate PPE for respirator/airborne infection isolation, contact precautions and eye protection (including NIOSH-approved N-95 respirator or PAPR, gowns and gloves, and goggles or face shield).
 - iii. Hand hygiene practices must be observed upon entry and exit from the room.
- b. Discharge/Terminal Cleaning and Room Maintenance
- i. After a patient with confirmed case (or PUI-suspect-not yet ruled-out) vacates room or is discharged, the room must remain in negative pressure with the door closed for **30-60 minutes**, based on the number of air changes per hour (ACH) for the room, before staff enters the room without respiratory PPE or another patient is admitted to the room. Other PPE for contact precautions and use of face-shields must occur upon entrance to the room by any persons until room has been certified as cleaned and disinfected by environmental services staff.
 - ii. Cleaning staff must wear respiratory protection and other PPE required for Contact Precautions Isolation, including eye protection (goggles or face shields, along with gowns and gloves) when cleaning during this airing time after discharge and for all times when the room is occupied by the patient. If cleaning is performed after the required airing time, respiratory protection is not required but gown, gloves and face shields/eye-protection are required.
 - iii. Hand hygiene practices must be observed upon entry and exit from the room.
- c. A **two-step cleaning and disinfection process** must be stringently adhered to during this process of cleaning and disinfection of any room (whether daily cleaning and disinfection or terminal cleaning and disinfection).
- d. See **Airborne Infection Isolation Room List** for documentation of Airborne Infection Isolation Room (All) air changes per hour (ACH). See your local airborne infection isolation policy and consult your local infection prevention and control and engineering staff for directions on length of "airing" before respiratory protection (e.g., NIOSH-approved N-95 mask or PAPR) does not need to be observed. A general rule of thumb for airing time is noted.
- i. Rooms with ≥ 6 air changes per hour (ACH) = 60minutes.
 - ii. Rooms with ≥ 12 ACH = 30 minutes.

**Department of
Veterans Affairs**

Memorandum

Date: March 15, 2020
From: Deputy Under Secretary for Health for Operations and Management (10N)
Subj: Coronavirus (COVID-19) Personal Protective Equipment (PPE) Use
To: Network Directors (10N1-23)

1. Recent updates to PPE recommendations from the CDC for situations where supplies cannot meet demand recommend that respirators (e.g., N95, PAPR) be prioritized for high risk procedures that are likely to generate respiratory aerosols such as nasal/pharyngeal sample collection, nebulizer treatment, intubation and care for intubated patients. The CDC information can be found 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.
2. Network Directors should plan for redistribution of supplies to meet individual facility demand. The Deputy Under Secretary for Health for Operations and Management will oversee redistribution supplies between VISN and prioritize replenishment as necessary. Emergency Management Coordination Cell (EMCC) coordinates supplemental bulk purchases and distribution to facilities with critical PPE supply levels.
3. For further questions about PPE guidance, contact your VISN industrial hygienist or Craig Brown, Senior Industrial Hygienist for VHA at Craig.Brown@va.gov

Renee Oshinski
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Oshinski 174682
Date: 2020.03.19
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Renee Oshinski

Date: **MAR 02 2020**

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Surveillance and Virtual Resource Utilization Planning for Coronavirus Disease 2019 (COVID-19)

To: Network Directors (10N1-23)

1. The purpose of this memorandum is to establish a baseline standard of care across Veterans Health Administration (VHA) during the current public health emergency to enable robust surveillance and virtual care resource readiness. Transmission of the rapidly spreading COVID-19 is likely through contact and respiratory droplets. The actions outlined in this Memorandum are needed to decrease the risk of COVID-19 transmission, promote patient safety and protect our workforce. Implementation resources are located on the [High Consequence Infection \(HCI\) SharePoint site](#).
2. Minimize exposures to respiratory pathogens including COVID-19 by screening for signs of respiratory illness and exposure to COVID-19 at all points of entry to VHA care and following the escalation pathways for positive screening. This includes using standardized screening questions / scripting in all administrative call centers, Clinical Contact Centers (CCC), appointment check-in kiosks, and initial clinical screening questions used in the ED, Urgent Care and outpatient clinics. Acknowledging the scripting questions and processes may change as updates to travel advisories occur, refer to the [HCI SharePoint](#) for current standardized scripts, escalation pathway flow maps, and additional resources.
3. Prioritize telephone care resourcing and process improvements to provide a first line of defense using virtual screening for symptoms or exposure to COVID-19 and follow-up care when appropriate. Baseline standards of care include:
 - Use of standardized scripting for screening, defined escalation triggers and hand-off processes in all call centers, including administrative/scheduling and CCCs.
 - Licensed Independent Practitioner (LIP) access to timely consultations with infection control / infectious disease subject matter experts (telephone/eConsult). This may include experts from VA or the State Board of Public Health. Home quarantine may be appropriate in some circumstances, including while waiting for expert opinion.
 - 24/7 availability of at least one VA Video Connect (VVC) capable FTE LIP, assigned to each CCC to enable warm hand-off to provider when needed to optimize care into the home by telephone or VVC (1.0 FTE may be an LIP assigned to the CCC or comprised of portions of FTE from multiple LIPs from

Subj: Surveillance and Virtual Resource Utilization Planning for Coronavirus Disease 2019 (COVID-19)

different areas, e.g. part-time LIP in CCC, ED, Same Day provider from PC, CRH).

- MSAs capable of scheduling through Virtual Care Manager:
 - Minimum of two trained Schedulers on duty in all front-line clinics who can schedule VVC appointments
 - One trained Scheduler, and one back up in the administrative call center and CCC that can schedule VVC appointments.
 - Minimize the need for in-person screening and follow-up care, but when necessary notify the receiving facility to allow for preparation to minimize exposure.
 - Identified sources of trained contingency staffing for administrative and clinical call centers when surges in demand are experienced.
 - Employ strategies to minimize increases in speed to answer and abandonment rates in administrative call centers and CCCs due to longer call handle times.
4. Establish telework capability for identified high priority staff to provide workforce continuity using virtual care in the event of a community outbreak causing a severe reduction in workforce. Act now to supply all necessary telework components, such as telework agreements, equipment, connectivity, and training as outlined in Telework guidance located on the [HCI SharePoint Site](#).
5. Provide Veterans with written guidance such as found on the [VHA Public Health COVID-19 Website](#) on how to utilize their virtual care options during a community outbreak to minimize exposures to respiratory pathogens, where to find credible information to protect themselves, precautions to take and actions to take if symptoms develop or worsen. Where home monitoring is desired by healthcare professionals for patients with clinical symptoms of concern for COVID or respiratory illness who do not have personal equipment/peripherals (e.g. blood pressure cuff, pulse oximeter, etc.) may be requested through the Tablet Consult or the [Home Telehealth](#) program.
6. Implement quality monitoring to evaluate effectiveness and efficiency of process changes with the increased use of virtual care, considering the virtual modality, technology, and the use of telework. Refer to resources and guidance specific to quality monitoring, telework, and virtual care for more information.
7. The information in this memorandum is supplementary to instructions Issued for implementing telework, telehealth, and contingency and disaster planning affecting specific clinical areas including, but not limited to memorandums, "Standardization of Laboratory Reporting of Novel Coronavirus 2019 Tests," dated 2/11/2020; and "Inclusion of Virtual Care in Outpatient Care Contingency Planning for Disasters", dated 2/14/2020.

Page 3.

Subj: Surveillance and Virtual Resource Utilization Planning for Coronavirus Disease 2019 (COVID-19)

8. For questions not addressed by guidance and training resources on the [High Consequence Infection \(HCI\) SharePoint site](#), please email VHAHCIGeneral@va.gov.


Renee Oshinski

Attachment

Clinical Contact Center (CCC) Coronavirus Disease 2019 (COVID-19) Screening: Instructions, Actions, and Scripting*

**This is an emerging, rapidly evolving situation. VA EMCC will provide updated information as it becomes available, in addition to updated guidance.*

General Instructions: All Veterans are to be screened for the Coronavirus Disease 2019 (COVID-19) using the CCC COVID-19 screen and follow established VAMC/VISN escalation pathways. Screening is to be completed by the CCC staff first taking call/contact. A positive screen is defined as a "Yes" response to screening question #1 and (questions #2 and/or #3). **All positive screens are to be escalated to a CCC RN or CCC Licensed Independent Practitioner (LIP-physician, nurse practitioner) for additional evaluation following established processes.**

Initial Greeting:

Script: Good morning/afternoon/evening/night! This is the **name of department/unit**. My name is **name, title**. How may I assist you? (pause to allow Veteran to respond). Before I assist you with your request, I would like to ask you a few quick questions.

Action: Veteran agrees to screening. CCC staff initiates screen starting with question #1.

Action: Veteran declines screening. CCC staff documents in EHR that Veteran declines screening and follows VAMC/VISN pathways for Veteran assistance.

Information: General information regarding the Coronavirus Disease 2019 can be found in Appendix: General Information COVID-19.

Screening Questions:

Question #1:

Instruction: Ask question #1 of CCC COVID-19 screening template.

Script:

- a. Do you have a fever*?
- b. Do you have a new or worsening cough or shortness of breath?
- c. Do you have flu-like symptoms?

Instruction: Document response in template and proceed to question #2 of CCC COVID-19 screening template.

Action: "Yes" and "No" responses are to be documented in EHR; clarifying comments can be documented as needed for "Yes" responses.

Question #2:

Instruction: Ask question #2 of CCC COVID-19 screening template.

Script: Has Veteran or a close contact traveled to an area with widespread or sustained community transmission of the Coronavirus Disease 2019 (COVID-19) within 14 days of symptom onset?

Instruction: Refer to CDC for the most current information on "criteria to guide evaluation" and "geographic areas with sustained transmission." <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>

Instruction: Document response in template and proceed to question #3 of CCC COVID-19 screening template.

Action: "Yes", "No" and "Unable to Answer" responses are to be documented in EHR; clarifying reason can be documented as needed for "Unable to answer" response.

Question #3:

Instruction: Ask question #3 of CCC COVID-19 screening template.

Script: Have you been in close contact with someone, including health care workers, confirmed to have the Coronavirus Disease 2019 (COVID-19)?

Instruction: Document response in template and proceed to item #4 of CCC COVID-19 screening template.

Action: "Yes" and "No" responses are to be documented in EHR; clarifying comments can be documented as needed for "Yes" responses.

Screening Result (Item #4 on COVID-19 screen):

Action: If caller responds "Yes" to question #1 AND ("YES" to question #2 and/or #3) select **POSITIVE SCREEN**; initiate VAMC/VISN COVID-19 escalation pathways for evaluation by a CCC RN or CCC LIP (transfer/handoff to CCC RN/LIP may need to occur if screening is initiated by a CCC MSA).

NOTE: Any Veteran with a **POSITIVE** COVID-19 screen is to be assessed by a CCC RN or LIP through established CCC processes.

Action: If symptom assessment/triage indicate emergent disposition, Veteran is to be instructed to call 911 or present to the nearest Emergency Department as clinically indicated; every reasonable attempt to provide a warm handoff to the receiving emergency medical personnel or Emergency Department is to be made.

If symptom assessment/triage indicates non-emergent disposition, the CCC RN or LIP should follow VAMC/VISN processes.

Action: RN or LIP offers virtual care. If LIP believes video visit is needed, **Veteran is offered a video appointment:**

"For your video visit, you can stay home to meet over video with a VA Provider using secure, encrypted technology on your internet-connected smartphone, tablet or computer."

Clinical Contact Center Coronavirus Disease 2019 (COVID-19) Screen Instructions, Actions, and Scripting
v 3.0 01MAR2020

[Veterans agreeing to video to home may lack a device, connectivity or the literacy to use technology. A note requesting assessment for a VA loaned tablet can be sent to their Primary Care team).

Note: VAMC/VISN process and pathways are to be based on VHA and CDC/Public Health guidance for risk stratification and identification of Person Under Investigation (PUI) and indicated testing.

Action: If caller answers “No” or “Unable to Answer” to question #2 **And** question #3, select Negative Screen.

Action: Document Negative Screen per VAMC/VISN.

Action: Assist Veteran per established VAMC/VISN processes.

*For the purposes of this document, fever can be a subjective or measured fever.

Note: This document is subject to change due to the rapidly evolving situation. Original v 1.0 released 10Feb2020.

References:

VHA High Consequence Infection (HCI) Preparedness Program:

<https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>

CDC Information for Healthcare Professionals: <https://www.cdc.gov/COVID-19/COVID-19/hcp/index.html>

Interim US Guidance for Risk Assessment and Public Health Management: <https://www.cdc.gov/COVID-19/COVID-19/php/risk-assessment.html>

Appendix: General COVID-19 Information

1. What is a novel coronavirus?

Script: A novel coronavirus is a new coronavirus that has not been previously identified. The virus causing Coronavirus Disease 2019 (COVID-19), is not the same as the coronavirus that commonly circulate among humans and cause mild illness, like the common cold. Patients with COVID-19 will be evaluated and cared for differently than patients with common coronavirus diagnosis.

2. How can I help protect myself?

Script, CCC MSA/AMSA: To better answer your questions I would like to transfer you to a registered nurse after you answer a few quick questions about the Coronavirus Disease 2019.

Action: If Veteran agrees, proceed with screening and transfer per VAMC/VISN processes. Document actions in EHR per VAMC/VISN.

Script, CCC RN: There is currently no vaccine to prevent Coronavirus Disease 2019 (COVID-19). The best way to prevent illness is to avoid being exposed to this virus. However, as a reminder, CDC always recommends everyday preventive actions to help prevent the spread of respiratory diseases, including:

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Follow CDC's recommendations for using a facemask.
- CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory diseases, including COVID-19.
- Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for [health workers](#) and [people who are taking care of someone in close settings](#) (at home or in a health care facility).
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.

- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

For information about handwashing, see [CDC's Handwashing](#) website

For information specific to healthcare, see [CDC's Hand Hygiene in Healthcare Settings](#)

These are everyday habits that can help prevent the spread of several viruses. CDC does have [specific guidance for travelers](#).

3. Does CDC recommend the use of facemask in the community to prevent COVID-19?

Script: CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory illnesses, including COVID-19. You should only wear a mask if a healthcare professional recommends it. A facemask should be used by people who have COVID-19 and are showing symptoms. This is to protect others from the risk of getting infected. The use of facemasks also is crucial for [health workers](#) and other [people who are taking care of someone infected with COVID-19 in close settings](#) (at home or in a health care facility).

4. What are the symptoms and complications that COVID-19 can cause?

Script: Current symptoms reported for patients with COVID-19 have included mild to severe respiratory illness with fever, cough, and difficulty breathing.

5. Where can I get more information about the Coronavirus Disease 2019 (COVID-19)?

Script: You can contact your local VAMC. Another excellent site for updates is VA.gov.

Date: FEB 11 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Standardization of Laboratory Reporting of *Novel Coronavirus 2019* Tests

To: Network Directors (10N1-23)

1. *Novel Coronavirus 2019* (synonyms 2019 Novel Coronavirus, *Novel Coronavirus 2019*, 2019-nCoV, and unofficially Wuhan Coronavirus with variants) is a rapidly spreading infectious disease likely primarily transmitted through contact and respiratory droplets, as is the case with other coronaviruses. Increased surveillance efforts are needed to determine *Novel Coronavirus 2019* incidence, prevalence, and need for future resources in the Department of Veterans Affairs (VA).
2. The primary laboratory test for *Novel Coronavirus 2019* is a real time reverse transcription-polymerase chain reaction (rRT-PCR) test. There are two mechanisms available for VAMCs to conduct *Novel Coronavirus 2019* testing:
 - a. The Public Health Reference Laboratory (PHRL) at the VA Palo Alto Health Care System provides *Novel Coronavirus 2019* testing for all Veteran patients in care at every medical facility.
 - b. State and local health departments may also conduct *Novel Coronavirus 2019* testing.
3. Although VA medical facilities have a choice to send samples to PHRL or state or local health departments, *Novel Coronavirus 2019* virus disease is a nationally notifiable condition. Healthcare providers are encouraged to report suspected cases to their state or local health departments, regardless of where the test is performed.
4. To improve surveillance efforts in VA, VA medical facilities shall implement the following nomenclature for *Novel Coronavirus 2019* test names and *Novel Coronavirus 2019* test results: CH-subscribed test – “Novel Coronavirus 2019.” This standardization allows for national collection of data on *Novel Coronavirus 2019* testing and results whether they are conducted in the PHRL or state or local health departments. In addition, please submit an Issue Brief (IB) in the IB Tracker.
5. The attached **Standardization - Laboratory Reporting of Novel Coronavirus 2019 Test** provides instructions on coding *Novel Coronavirus 2019* orders and results in the VistA Lab package, for standardized data collection to be possible through CDW. The instructions are required for VHA providers to order the correct test, ensure appropriate sample collection and routing to the reference lab, and for entering standardized results in VistA. Additional information will be provided when an in-house version of the test is available through PHRL.

Page 2.

Standardization of Laboratory Reporting of *Novel Coronavirus 2019* Tests

6. Please create a new test entry for this PCR. Do not repurpose existing coronavirus or related respiratory virus PCR panels to the new *Novel Coronavirus 2019* rRT PCR test.
7. This test for *Novel Coronavirus 2019* should be performed in conjunction with testing for other acute respiratory infections as the standard of care.
8. When the *Novel Coronavirus 2019* rRT PCR test comes in through an outside laboratory, please use *Novel Coronavirus 2019* when reporting results in VistA. Results should not be scanned into VistA imaging only, as properly coordinated response becomes more difficult and sites will be held accountable for inhibiting national surveillance.
9. If you have any questions related to VistA laboratory file changes addressed in the attachment, please direct them to David Vo at David.Vo2@va.gov. For questions related to data capture after the VistA laboratory file is altered, please contact Richard Pham at Richard.Pham@va.gov.


Renee Oshinski

Attachment

Attachment A:

Standardization - Laboratory Reporting of *Novel Coronavirus 2019* Test

Instructions:

1. Each VA facility is to implement the following test names and laboratory reporting for *Novel Coronavirus 2019* tests. This standardization allows for national collection of data on *Novel Coronavirus 2019* Virus testing results. VHA Laboratory Services must record results of *Novel Coronavirus 2019* Tests performed within a VA laboratory or Public Health Reference Lab using the following methodology:

CH-subscribed tests will be used for *Novel Coronavirus 2019* 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).

2. Implementation Notes

a. CH-Subscribed Tests:

(1) *Novel Coronavirus 2019* rRT PCR will be reported using CH-subscript.

(2) The following Test Names and Logical Observation Identifiers Names & Codes (LOINC) will be used:

(a) ***Novel Coronavirus 2019* rRT PCR**. SITE/SPECIMEN could be "serum," "plasma," "nasopharyngeal wash," "oropharyngeal wash," "nasopharyngeal swab AND oropharyngeal swab," "bronchoalveolar lavage," "tracheal aspirate," or "sputum"; no other SITE/SPECIMEN can be used with this test name

***NOTE:** *There is not an existing LOINC code available at this time for Novel Coronavirus 2019 rRT PCR, leave the test un-mapped.*

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

(a) 94983.xxxx for *Novel Coronavirus 2019* rRT PCR

(4) For integrated or co-located sites that need to offer site/division specific tests, the test name has to start with "*Novel Coronavirus 2019*" (or any other standard test name listed above).

(5) 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

Not Detected is to Not Detected

A1

Invalid is to Invalid Inhibitors.

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

a. Enter the data type of **Novel Coronavirus 2019 rRT PCR**: (N)umeric, (S)et of Codes, or (F)ree text ? **S**

(i) INTERNALLY-STORED CODE://Not Detected WILL STAND FOR:// Not Detected

(ii) INTERNALLY-STORED CODE://DETECTED WILL STAND FOR:// DETECTED

(6) The results must be documented under a specifically created *Novel Coronavirus 2019* 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.

(a) Vista GUI Cumulative View will need to be set-up for Horizontal Format reporting to ensure that test results will be easily accessible.

(b) 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.

(c) Sample Major Header: CORONAVIRUS TESTING

(d) Sample Minor Header: 2019 NOVEL CORONAVIRUS 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.).

b. 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 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 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 (DETECTED) and the Delta check (DETECTED) should match if this specific coding is utilized.

NAME: TEXT ALERT DETECTED *H

XECUTABLE CODE: Q:\$D(LRGVP) | X["DETECTED" S LRFLG="H**

c. Laboratory Management Index Program (LMIP): *Novel Coronavirus 2019* testing is countable (billable) for the LMIP program. The National Laboratory Test (NLT) code chosen is based on the methodology used to perform the test at the site and must be

A2

marked billable in File 64 for workload recording purposes. Since method specific NLT codes are not available in File 64 for *Novel Coronavirus 2019*, 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 for *Novel Coronavirus 2019* are as follows:

(1) Human Coronavirus RNA QI PCR 94983.8640 for CH-subscribed "PCR" tests send to PHRL at VA Palo Alto HCS.

(2) Human Coronavirus RNA QI PCR 94983.8051 for CH-subscribed "PCR" tests send to State lab.

***NOTE:** *The NLT code 94983.8640 suggested above indicates in LMIP statistics that the Novel Coronavirus 2019 test is a send-out test performed by PHRL at VA Palo Alto HCS. The NLT code 94983.8051 suggested above indicates in LMIP statistics that the Novel Coronavirus 2019 test is a send-out test performed by State Health Lab.*

d. Current Procedural Terminology (CPT): At this point in time, *Novel Coronavirus 2019* tests are not usually billable to a third-party payer for reimbursement therefore, these *Novel Coronavirus 2019* 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.

3. Additional Notes for Sites:

a. 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. So, there is an issue that it would be good to have National codes assigned to tests BUT the lab shouldn't 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. So, sites may need to address this issue at some point for LEDI issues and HDR issues.

b. LOINC and LEDI TOPOGRAPHY FILE 61 set-up issue:

As per directions from VA Palo Alto PHRL.

Date: March 17, 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Revised Standardization of Laboratory Reporting of *COVID-19* Tests

To: Network Directors (10N1-23)
Medical Center Directors (00)
Pathology and Laboratory Medicine Services Chiefs
VHA Lab Information Managers

1. *COVID-19* (synonyms 2019 Novel Coronavirus, Novel Coronavirus 2019, 2019-nCoV, and unofficially Wuhan Coronavirus with variants) is a rapidly spreading infectious disease likely primarily transmitted through contact and respiratory droplets, as is the case with other coronaviruses. Increased surveillance efforts are needed in Department of Veterans Affairs (VA) to determine *COVID-19* incidence, prevalence, and need for future resources in VA.
2. The primary laboratory test for *COVID-19* is a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test. There are several mechanisms available for VA medical facilities to conduct *COVID-19* Testing:
 - a) The Public Health Reference Laboratory (PHRL) at the VA Palo Alto Health Care System provides *COVID-19* testing for all Veteran patients in care at every medical facility.
 - b) State and local health departments may also conduct *COVID-19* testing.
 - c) Commercial labs testing.
 - d) In-house testing.
3. VA medical facilities may send samples to PHRL, state or local health departments, commercial labs, or in-house testing. As *COVID-19* virus disease is a nationally notifiable condition, healthcare providers should report suspected cases to their state or local health departments, regardless of where the test is performed.
4. To improve surveillance efforts in VA, VA medical facilities are required to implement the following nomenclature for *COVID-19* test names and *COVID-19* test results: CH-subscripted test – "*COVID-19 PANEL*". This standardization allows for national collection of data on *COVID-19* testing and results whether they are conducted in the PHRL, state or local health departments, commercial labs, or performed in-house.
5. The attached Standardization - Laboratory Reporting of *COVID-19* Tests provides guidance on *COVID-19* orders, results and coding in the VistA Lab package for standardized data collection to be possible through the Cooperate Data Warehouse.

6. Do not repurpose existing coronavirus or related respiratory virus PCR panels to the new *COVID-19* rRT PCR test. Create new test entries for the PCR and Confirmatory tests.
7. Do not neglect to work up and test for other acute respiratory infections as you would normally.
8. When the *COVID-19* rRT PCR test comes in through an outside laboratory, use *COVID-19* when reporting results. Results should not be scanned into VistA imaging only, as proper coordinated response becomes more difficult and sites will be held accountable for inhibiting national surveillance.
9. For the original test setup from the testing standardization, which was distributed to the field, rename the test to one of the scenarios below and include it to the panel for this revised testing. Work with your CACs staff to update any existing quick order set which was setup to reflect the change.
10. At this time, there is no LOINC code available to use in VistA.
11. If you have any questions related to VistA laboratory file changes addressed in the attachment, direct them to David Vo at David.Vo2@va.gov. For questions related to data capture after the VistA laboratory file is altered, please contact Richard Pham at Richard.Pham@va.gov.


Renee Oshinski
Attachment

Attachment A

Standardization - Laboratory Reporting of COVID-19 Test Instructions

- I. 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).

II. Implementation Notes

a. **Panel CH-Subscribed Tests:**

- i. The orderable panel test name must be "COVID-19 PANEL". The test subscript must be CHEM, HEM, TOX, SER, RIA, ETC..
- ii. 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)

a. **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.

b. **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.

c. 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)

a. 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.

b. 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.

c. 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

a. 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.

b. 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.

c. 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

a. COVID-19 (xxxxxxxx) 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.

b. 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.

c. 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

iii. 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).

iv. 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.**

- a. Enter the data type of **COVID-19**: (N)umeric, (S)et of Codes, or (F)ree text ? **S**
 1. INTERNALLY-STORED CODE://DETECTED WILL STAND FOR://
DETECTED
 2. INTERNALLY-STORED CODE://Not Detected WILL STAND FOR://
Not Detected

3. INTERNALLY-STORED CODE://Inconclusive WILL STAND FOR:// Inconclusive
 4. INTERNALLY-STORED CODE://Invalid WILL STAND FOR:// Invalid
- b. Enter the data type of **COVID-19 CONFIRMATION**: (N)umeric, (S)et of Codes, or (F)ree text ? **S**
1. INTERNALLY-STORED CODE://CONFIRMED WILL STAND FOR:// CONFIRMED
 2. INTERNALLY-STORED CODE://Not Detected WILL STAND FOR:// Not Detected
 3. INTERNALLY-STORED CODE://Inconclusive WILL STAND FOR:// Inconclusive
 4. INTERNALLY-STORED CODE://Invalid WILL STAND FOR:// Invalid

- v. 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.
- a. VistA GUI Cumulative View will need to be set-up for Horizontal Format reporting to ensure that test results will be easily accessible.
 - b. 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.
 - c. Sample Major Header: CORONAVIRUS TESTING
 - d. 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.).

- b. **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) I X="DETECTED" S LRFLG="H"

For COVID-19(Confirmatory) test delta check:

NAME: TEXT ALERT CONFIRMED *H

XECUTABLE CODE: Q:\$D(LRGVP) I 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 ADPAC to contact David.Vo2@va.gov for mapping determination.

- c. **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:


- i. Human Coronavirus RNA QI PCR 94983.8640 for CH-subscribed "PCR" tests sent to PHRL at VA Palo Alto HCS.
- ii. 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.
- iii. Human Coronavirus RNA QI PCR 94983.8xxx for CH-subscribed "PCR" tests sent to a commercial reference lab.
- iv. Human Coronavirus RNA QI PCR 94983.xxxx for CH-subscribed "PCR" tests performed in-house.
- v. Corona Virus 87408.8035 for specimens sent to CDC for *COVID-19* confirmation.

- d. **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.

III. Additional Notes for Sites:

- a. **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. So, there is an issue that it would be good to have National codes assigned to tests BUT the lab shouldn't 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. So, sites may need to address this issue at some point for LEDI issues and HDR issues.

- b. This revised testing standardization setup information is targeted to the Lab Information Managers, Lab ADPACs, and/ or Lab Managers.
- c. **LOINC and/ or LEDI TOPOGRAPHY FILE 61 set-up issue:**
As per directions from PERFORMING LABS.

**Department of
Veterans Affairs**

Memorandum

Date: March 15, 2020
From: Deputy Under Secretary for Health for Operations and Management (10N)
Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)
Subj: Ensuring Continuity in Suicide Prevention While Managing COVID-19
Veterans Integrated Service Network (VISN) Directors (10N1-23)
To: VISN Mental Health Liaison (10N1-23)

1. Our commitment to the lifelong health, well-being, and resilience of Veterans requires us to remain focused on our overarching mission. As we fortify facility operations with screening, limit in-person contacts, curtail travel, and utilize more virtual care, we must provide robust support for those who may be at risk of suicide or otherwise are vulnerable in their mental health. Social isolation is an appropriate infection control procedure, but it can have unintended negative effects on mental well-being and runs contrary to what we communicate with respect to suicide prevention. As you ensure safety, continuity of operations, and mitigate infection risks, please also ensure continuity in suicide prevention protocols and in supporting the mental health of Veterans, many of whom may now have added challenges related to COVID-19 and may be alone.
2. Please consult with your local mental health leadership to identify virtual care options for Veterans to manage mental health concerns during this period which may include telemental health or telephonic care. For example, group therapies can continue virtually even if no longer possible in a face-to-face modality. As treatment modalities shift and as staff work more virtually, communications among team members and Veterans require careful attention.
3. In particular, local protocols must address the following situations and needs.
 - Veterans with high risk flags and REACH-VET identified Veterans
 - Continuity of safety plans with added consideration of the impact of COVID-19 isolation protocols and related stress
 - Continued attention to Safety Planning in Emergency Departments
4. Should you have questions related to this memorandum, please contact Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention at VHA10NC5Action@va.gov.

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Renee Oshinski

VA FORM 2105
MAR 1989

**Department of
Veterans Affairs**

Memorandum

Date: March 15, 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Coronavirus (COVID-19) – Guidance for Elective Procedures.

To: Network Directors (10N1-23)

1. In Veterans Health Administration, the safety of our Veterans and employees is our highest priority. Effective immediately, VHA facilities will plan to cease non-urgent elective procedures no later than Wednesday, March 18, 2020. This action will reduce unnecessary hospitalizations and ICU use and will free up resources to address the increasing number of Veterans under evaluation and diagnosed with COVID-19.

2. Facility leadership will determine how this is implemented, including appropriate communication with impacted Veterans. It is important that urgent and emergent cases continue during this period.

3. National Program offices may offer guidance on prioritizing procedures in high risk populations. Additional information can be obtained from National Program office directors:

- Mark Wilson, National Director of Surgery at Mark.Wilson5@va.gov
- W.C. Yarbrough, National Director Pulmonary/Critical Care/Sleep Medicine at WC.Yarbrough@va.gov
- Patricia E. Arola, Asst. Under Secretary for Health for Dentistry at Patricia.Arola@va.gov
- Jason Dominitz, National Director of Gastroenterology at Jason.Dominitz@va.gov

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Renee Oshinski

**Department of
Veterans Affairs**

Memorandum

Date: March 16, 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Implementation of an Episodic Special Patient Icon in Bed Management Solution

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)

Thru: Assistant Deputy Under Secretary for Health for Clinical Operations(10NC)

1. The purpose of this memorandum is to notify all VISNs and their medical centers of the creation of a new special patient episodic Bed Management Solution (BMS) icon that is being deployed. The new patient specific Episodic Icon can be easily added or deleted as needed to a patient within the BMS application.
2. All icons are located on the BMS whiteboard and can be displayed on large kiosks/displays on each unit or viewed electronically from any secured location. The large kiosks are within the public view so many icons are made so that they cannot be easily identified by the public. Therefore, an exact symbol will not be used for COVID-19 for this reason.
3. The new special patient Episodic Icon will be used to assist in the identification of a patient under investigation (PUI) or presumptive / confirmed positive cases during epidemics or other situations where it may be necessary to track incidence in the future. The difference between the two new BMS icons is the difference between the color of the two icons. PUI icons will be black and presumptive / confirmed will be red in color. The background of the icons is blue, to indicate it is a patient icon.
4. All special patient Episodic icons are required to be used in conjunction with the opt out functionality in BMS so that patient names are not displayed on public facing whiteboards. The opt out feature allows XXXXX to show in place of the Veteran's name.
5. The Negative Pressure Room Icon must also be used to indicate all negative pressure rooms, regardless if the room is in or out of service. Room icons remain in place, unless manually deleted. Using this icon will allow identification of available negative pressure beds to support emergency management response. Facilities need to maintain the accuracy of negative pressure room icons. This provides increased transparency for accurate and real-time bed capacity across the enterprise.
6. Enhanced BMS reports are available at the link below to easily locate negative pressure rooms including their availability. The accuracy of BMS occupancy, bed availability, patient, and room icon reporting, is dependent on Medical Center full implementation of BMS including real time updates to all patient and bed information.
7. Please reference the below links for access to the BMS system and associated resources:
[BMS Login](#) (BMS access is required)
[BMS Leadership Reports](#)

Implementation of an Episodic Special Patient Icon in Bed Management Solution

[BMS SharePoint](#)
[VHA BMS Directive 1002](#)

8. The National BMS Team will host a virtual training meeting to assist in implementation on Wednesday, March 18, 2020 from 1:00-2:00 noon ET [Join Skype Meeting](#) 844-825-8490, 844-352-6288, or 844-355-6288, access code: 947337595. Each VISN is required per Directive 1002 to have a VISN staff member assigned as a BMS and Patient Flow Coordinator. Additional medical center ADPACs or interested stakeholders may also attend the virtual training. This meeting will review the use of these icons, the opt out feature and access to applicable BMS reports that will be helpful for needed VISN and medical center planning.
9. For questions or additional information, please contact Mr. Reginal "Scott" Saunders, BMS Application Manager, VHA Office of Systems Redesign and Improvement, via email at Reginal.Saunders@va.gov, Katherine Herold, Clinical Applications Coordinator, VHA Office of Health Systems Innovation at Katherine.Herold@va.gov or Diane Campeau, Associate Director, Patient Flow Optimization, National Patient Flow Coordinator/BMS Business Owner Designee, VHA Office of Systems Redesign and Improvement at Diane.Campeau@va.gov.

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Renee Oshinski

Page 2

Implementation of an Episodic Special Patient Icon in Bed Management Solution

Attachments: The new patient specific Episodic Icons

Bed Management Solution Episodic New Patient Icons



Patient Under Investigation (PUI)



Presumptive / Confirmed Positive

**Department of
Veterans Affairs**

Memorandum

Date: MAR 16 2020


From: Deputy Under Secretary for Health for Operations and Management (10N)

Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC) *JTB*

Subj: Managing Operations of Mental Health Unit While Managing COVID-19

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)
VISN Mental Health Liaison (10N1-23)

1. While elective procedures and admissions in general may be curtailed at this time, admissions to inpatient mental health units and Mental Health Residential Rehabilitation Treatment Programs (MHR RTP) are often based upon emergent or urgent need to address an immediate life-threatening crisis or other situation of high risk. Similarly, it is critical to maintain continuity in opioid treatment care. Please utilize the attached guidance documents to guide local decision-making regarding admissions to and operations of inpatient mental health units and MHR RTPs.
2. Questions should be directed to Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention at VHA10NC5Action@va.gov.


Renee Oshinski

Attachments

- Attachment A – Guidance for VA Inpatient Mental Health Programs
- Attachment B – Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)
- Attachment C – Guidance for Managing Positive Hospitalized Suicidal Patients
- Attachment D – Guidance for VA Opioid Treatment Programs

VA FORM 2105
MAR 1989

Attachment A

**Department of Veterans Affairs
Veterans Health Administration
Guidance for VA Inpatient Mental Health Programs**

Purpose: This document provides guidance to facilities operating Inpatient Mental Health Programs located at VA medical centers. **This guidance is intended to inform the development of local facility policy and procedures for prevention, screening and surveillance of the Coronavirus (COVID-19) on Inpatient Mental Health Programs.** Please refer to *VHA COVID-19 Strategic Response Plan* by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020 for VHA department wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak.

Synopsis: The priority goal in the VA response to COVID-19 is the protection of Veterans and staff. Inpatient Mental Health Programs provide an inpatient level of care to Veterans that may be at risk for COVID-19 because of their current mental and medical health conditions and for some, a recent history of homelessness. Inpatient Mental Health Programs are open to visitors from the community therefore exposure to the community is possibly recurring during their length of stay. Various strategies to mitigate exposure to and transmission of COVID-19 to Inpatient Mental Health Veterans and staff are critical.

Prevention: The best method to combat any infectious disease on an Inpatient Mental Health Program is to have preventive measures in place, prior to an outbreak, that mitigate the transmission and spread of the disease. This includes:

- Pre-screening all referrals and requiring a current temperature. If a Veteran has a positive screen, they will need triage following local established protocols.
- Re-screening all admissions once they arrive on inpatient unit.
- Re-screening all visitors before they enter the unit (even though screened at main entrance). This may change to eliminating visitors at some point.
- All patients will receive BID vital signs at a minimum with reports of all temps over 99.0 to a licensed provider and Nurse Manager
- All Veterans receive daily huddle regarding hand hygiene and reminders prior to meals. Instructing to ask nursing staff for hand sanitizer as desired
- Laminated hand hygiene signage placed in bathrooms and bulletin boards
- Hand sanitizer dispensers placed at door to nursing station
- All staff given individual hand sanitizers to keep on person
- All high touch areas should be cleaned at least twice per day or prior to each shift
- Stocking necessary PPE on the unit for contingency purposes

VA Response to COVID-19

Guidance for VA Inpatient Mental Health Programs

- Frequent handwashing with soap and water for minimum of 20 seconds
- Veterans are not permitted to possess or use alcohol-based hand sanitizers unless under the direct supervision of a staff member
- Avoid shaking hands when in situations where access to soap/water or sanitizers is not available (inform people why you are not shaking hands)
- Avoid touching your face
- Avoid public places and areas where large groups of people will congregate
- Staff and patients will be provided a copy of the attached Poster: "Stop the Spread of Germs New CoVID-19 Poster"

Further information about everyday preventive actions:

<https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html>

Follow your VAMC policy regarding management of positive screens. Access copy at <https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>

Staffing: Staffing, procedures and delivery models should be assessed to limit the number of non-Inpatient Mental Health Program staff and contractors entering Inpatient Mental Health program space. Deliveries (e.g., pharmacy, supplies, linens) should be limited, when possible. Inpatient Mental Health Program staff should not have duties that require them to enter a COVID-19 area at the facility. Staff will not be floated between these units from other areas when possible.

Inpatient Mental Health Program Access: All Inpatient Mental Health staff and patients must follow local facility policy and procedures for accessing the . The Inpatient Mental Health patients and staff must be trained in the locally developed Inpatient Mental Health Program procedures for the prevention, screening and surveillance of COVID 19. Access to the Inpatient Mental Health Program should be limited and able to accommodate screening of all patients, visitors, contractors and potentially staff. Appropriate signage should be in place to direct visitors to the access point. Screening criteria may change as information about COVID-19 evolves. As of the effective date, screening should include the following information:

1. Do you have any of the following?
 - Fever (100.4F or 38C)
 - New or worsening cough
 - Shortness of breath
 - Flu-like symptomsYes No

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2. Have you or a close contact traveled to an area with widespread or sustained community transmission of Coronavirus Disease 2019 (COVID-19) within 14 days of symptom onset?
Yes No

3. Have you been in close contact with a person, including a health care worker, with confirmed (COVID-19)?
Yes No

A **positive** screen is “Yes” to any part of question #1 AND “Yes” to question #2 and/or #3. Inpatient Mental Health Programs will follow protocols as indicated for providing a mask to the patient and anyone with the patient; moving the patient to the nearest room to isolate the person from the rest of the patients on the unit (as best you can) while awaiting acute care bed transfer. Once transferred to an acute care medical bed, medical team evaluates and performs necessary diagnostic testing and treats as indicated.

Veterans who are currently admitted and who leave the building for an on-station outpatient clinic appointment will be screened using the questions in #1 upon return to the unit. There is no requirement to complete questions #2 and #3. Veterans who are currently admitted and leave the unit for an off-station appointment will be screened using questions #1, #2 and #3 when they return to the unit.

Surveillance: Patients observed or reported to be ill will be required to report to Nursing and/or 24/7 staff for evaluation or referral for evaluation for possible infection. Inpatient Mental Health Programs will follow protocols as indicated for providing a mask to the patient and anyone with the patient; moving the patient to the nearest room to isolate the that person from the rest of the patients on the unit; call a code “ICE” (Infection Control Emergency) on VOCERA (or other communication device); transport the patient to the Emergency Department or other medical setting as indicated. Existing protocols that rule out other viral disease (e.g. influenza) should be performed prior to any COVID-19 testing. The information collected should be entered in CPRS. Any patient that screens positive should be assessed for COVID-19 testing.

Isolation Plan: The Inpatient Mental Health Program should have a plan to isolate any patient that is suspected of having COVID-19. Inpatient Mental Health Programs do not have negative airflow rooms and should identify an area, such as a vacant room or office, on the unit which can be used to confine patients, away from the other patients, until transported to the Emergency Department or other medical setting as indicated for further evaluation or consultation with Infection Control for further guidance. Facilities with multiple suspected or confirmed cases should have plans to isolate patients to one pod or floor in the Inpatient Mental Health Program or at another location at the medical

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center if space does not allow to isolate in the Inpatient Mental Health Program. Patients currently being treated in the Inpatient Mental Health Program will not be relocated to other locations in the facility unless medically indicated.

Visitors: The goal is to approve access to individuals with no fever and no symptoms. Visitor access will be greatly limited to include limited visiting hours. All visitors will be screened for COVID-19 as described above. Visitors who screen positive, will not be granted access to the Inpatient Mental Health Program. Visitors without symptoms will be permitted to enter the Inpatient Mental Health Program as dictated by the current policy. Visitors with additional questions about their symptoms should be referred to their medical professional and follow established facility guidelines.

Social Distancing: Inpatient Mental Health Programs should initiate procedures to limit social activities that bring together groups of patients. Group size should be limited to five patients, if possible. Since Veterans eat in a designated dining area, Veterans should be reminded to practice infection prevention methods that include frequent handwashing with soap and water for 20 seconds minimum, avoid touching face, avoid close contact (within 6 feet) of anyone who is sick; not going to the dining hall or other public places if sick.

Restrictions: Veterans who have a fever, cough, shortness of breath or flu-like symptoms must be restricted to the Inpatient Mental Health Program or other designated unit at the medical center during this period for closer monitoring by staff thus minimizing interactions with other patients and staff. Veterans must be limited to their rooms and tray service provided. If necessary, a patient may be moved to a single room or a double room without a roommate, if there are no contraindications. Monitoring will consist of Veterans being screened at least twice per 24-hour period for fever and symptoms. The restriction period will last for a total of 14 days including the time already spent in the hospital for Veterans admitted from a ward at the facility.

VA Response to COVID-19

Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

Attachment B

**Department of Veterans Affairs
Veterans Health Administration**

**Guidance for VA Mental Health Residential Rehabilitation Treatment Programs
(MH RRTP)**

Effective Date:

Purpose: This document provides guidance to facilities operating Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) located on medical center grounds and in the community. **This guidance is intended to inform the development of local facility policy and procedures for prevention, screening and surveillance of the Coronavirus (COVID-19) on MH RRTP units.** Please refer to *VHA COVID-19 Strategic Response Plan* by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020 for VHA department wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak.

Synopsis: The priority goal in the VA response to COVID-19 is the protection of Veterans and staff. Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) otherwise known as Domiciliary Care Programs include facilities that may be located on VA grounds in the main medical center building, in a separate building on the medical center campus or in a separate community-based location. MH RRTPs provide a residential level of care to Veterans who may be at risk for COVID-19 because of their current medical and mental health conditions and for many, a recent history of homelessness. MH RRTPs are open residential units and Veterans may leave the facility for work, appointments or on pass; therefore, exposure to the community is possibly recurring during their length of stay. Various strategies to mitigate exposure to and transmission of COVID-19 to MH RRTP residents and staff are critical. MH RRTP program and nurse managers should be part of local VAMC COVID19 Response teams to make local VAMC leaders aware of their particular care delivery process.

Prevention: The best method to combat any infectious disease on a MH RRTP unit is to have preventive measures in place, prior to an outbreak, that mitigate the transmission and spread of the disease. This includes:

- frequent handwashing with soap and water for minimum of 20 seconds
- frequent use of 60% or greater alcohol-based sanitizers (individualized care for Veterans with an Alcohol Use Disorder must be considered to minimize the risk of abuse of alcohol-based sanitizers)
- avoid shaking hands when in situations where access to soap/water or sanitizers is not available (inform people why you are not shaking hands)
- avoid touching your face

VA Response to COVID-19

Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

- increase cleaning of unit surfaces that are repeatedly touched by staff and residents
- avoid public places and areas where large groups of people will congregate including facility specific plans for social distancing in dining halls, group rooms, lounges, etc.
- facilities should provide staff and residents a copy of the attached Poster: "Stop the Spread of Germs New CoVID-19 Poster"

Further information about everyday preventive actions:

<https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html>

Follow your VAMC policy regarding management of positive screens. Access copy at <https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>

Admissions: Curtailing admissions to MH RRTPs is not currently recommended, however, since this is an evolving situation, this may change. Curtailing MH RRTP admissions will be based on the local facility evaluation of risk to staff and Veterans. Facilities must submit an Issue Brief if admission to the MH RRTP is curtailed and provide alternative services to all Veteran whose admission is delayed or cancelled. Veterans, who are screened and accepted for admission and are placed on the wait list, will be followed in accordance with current MH RRTP policy for waiting Veterans. When a Veteran presents for admission, the Veteran will follow the local facility policy and procedures for accessing the campus and for screening using the Call Center/Clinical Contact Center (CCC) Coronavirus Disease 2019 (COVID-19) Screen.

Staffing: Staffing, procedures and delivery models should be assessed to limit the number of non-MH RRTP staff and contractors entering MH RRTP space. Deliveries (e.g., pharmacy, supplies, linens) should be limited, when possible. MH RRTP staff should not have duties that require them to enter a COVID-19 area at the facility. MH RRTP staff must be provided the appropriate personal protective equipment for responding to a positive screen for COVID-19.

MH RRTP Unit Access: All MH RRTP staff and residents must follow local facility policy and procedures for accessing the campus. The MH RRTP residents and staff must be trained in the locally developed MH RRTP unit procedures for the prevention, screening and surveillance of COVID 19. Access to the MH RRTP unit should be limited to one entrance and able to accommodate screening of all residents, visitors and potentially staff. Screening criteria may change as information about COVID-19 evolves. As of the effective date, screening should include the following information:

1. Do you have any of the following?
 - Fever (100.4F or 38C)
 - New or worsening cough
 - Shortness of breath
 - Flu-like symptoms

VA Response to COVID-19

Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

Yes No

2. Have you or a close contact traveled to an area with widespread or sustained community transmission of Coronavirus Disease 2019 (COVID-19) within 14 days of symptom on-set?

Yes No

3. Have you been in close contact with a person, including a health care worker, with confirmed (COVID-19)?

Yes No

A **positive** screen is “Yes” to any part of question #1 AND “Yes” to question #2 and/or #3. MH RRTPs will follow protocols as indicated for providing a mask to the resident and anyone with the resident; moving the resident to the nearest designated room to isolate the person from the rest of the residential community; call a code “ICE” (Infection Control Emergency) on VOCERA (or other communication device); and communicate and coordinate transport of the resident to the Emergency Department per local facility procedures. If the resident, staff member or visitor has screened positive for COVID-19, the MH RRTP program will follow local facility policy and procedures to determine if further testing of staff and residents is necessary or if isolation is required. Veterans who screen positive and refuse to follow local facility infection control policy may be discharged from the MH RRTP after appropriate discharge planning and with appropriate and authorized communication with state and local health officials. Veterans who are currently admitted and who leave the building for an on-station outpatient clinic appointment will be screened using the questions in #1 upon return to the building. There is no requirement to complete questions #2 and #3. Veterans who are currently admitted and leave the unit for an off-station appointment, work or go on pass will be screened using questions #1, #2 and #3 when they return to the unit. All off-station passes, and recreational activities not deemed critical to the Veterans treatment may be cancelled on a weekly basis based on a local evaluation of risk.

Surveillance: Residents observed or reported to be ill with symptoms suggestive of COVID19 as per COVID19 screener will be required to report to Nursing and/or 24/7 staff for evaluation or referral for evaluation for possible infection. MH RRTPs will follow protocols as indicated for providing a surgical mask to the resident and anyone with the resident; moving the resident to the nearest room to isolate the that person from the rest of the residential community; call a code “ICE” (Infection Control Emergency) on VOCERA (or other communication device) communicate and coordinate transport of the resident to the Emergency Department (ED). Existing protocols that rule out other viral disease (e.g. influenza) should be performed prior to any COVID-19 testing when COVID-19 testing is available. The information collected should be entered in CPRS. Any resident that screens positive for COVID-19 should be assessed for COVID-19 testing.

VA Response to COVID-19

Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

Isolation Plan: The MH RRTP should have a plan to isolate any resident that is suspected of having COVID-19. MH RRTPs do not have negative airflow rooms and should identify an area, such as a designated vacant room or office, on the unit which can be used to confine residents, away from the general public, until transported to the Emergency Department for further evaluation or consultation with Infection Control for further guidance. Proactive planning should include scenarios for when multiple suspected or confirmed cases exist, such as isolating residents to one pod or floor in the MH RRTP or at another location at the medical center if space does not allow to isolate in the MH RRTP. Residents currently residing in the MH RRTP will not be relocated to other locations in the facility unless medically indicated.

Visitors: During the heightened risk for COVID-19, facilities may institute a ban on all visitors to the MH RRTP unit and to residents both on and off the unit.

Social Distancing: MH RRTPs should initiate procedures to limit social activities that bring together groups of residents. Examples include activities and games, field trips and other activities that take residents outside the MH RRTP may be paused until further notice. Since Veterans eat in a designated dining area, Veterans should be reminded to practice infection prevention methods that include frequent handwashing with soap and water for 20 seconds minimum, avoid touching face, avoid close contact (within 6 feet) of anyone who is sick; not going to the dining hall or other public places if sick.

Restrictions: Veterans who have a fever, cough, shortness of breath or flu-like symptoms must be restricted to the MH RRTP or other designated unit at the medical center during this period for closer monitoring by staff minimizing interactions with other residents and staff. Veterans must be limited to their rooms and tray service provided. If necessary, a resident may be moved to a single room or a double room without a roommate, if there are no contraindications. No day or overnight passes will be authorized during this time for identified residents. Monitoring will consist of Veterans being screened at least twice per 24-hour period for fever and symptoms. The restriction period will last for a total of 14 days including the time already spent in the hospital for Veterans admitted from a ward at the facility. Veterans who screen positive and refuse to follow local facility infection control policy may be discharged from the MH RRTP after appropriate discharge planning and with appropriate and authorized communication with state and local health officials.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) Located Off-Station

MH RRTPs that are located off-station will follow the same procedures above. MH RRTPs will follow protocols as indicated for a positive screen and provide a mask to the resident and anyone with the resident; moving the resident to the designated room to isolate the person from the rest of the residential community. The MH RRTP residents

VA Response to COVID-19

Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

and staff must be trained in the locally developed unit procedures for the prevention, screening and surveillance of COVID-19.

Local procedures will be developed to call a code "ICE" (Infection Control Emergency) and for communicating and coordinating the transport of the Veteran to the VA medical center's emergency department or a community emergency department. If the resident, staff member or visitor has tested positive for COVID-19, the MH RRTP program will follow local facility policy and procedure to determine if further testing of staff and residents is necessary or if isolation is required.

Compensated Work Therapy- Transitional Residences

Local facility policy and procedures for the screening and surveillance of COVID-19 must include procedures for Veterans in the Compensated Work Therapy/Transitional Resident (CWT/TR) programs. The Compensated Work Therapy-Transitional Residence (CWT-TR) programs are group homes designed for Veterans whose rehabilitative focus is based on employment and continuing outpatient care. CWT/TR beds are official VA operating beds and are listed on the local facilities Gains and Losses Sheet as a facility ward or unit. Most of the CWT/TR programs are VA-owned houses in the community and do not have 24/7 paid VA staff on site. A live-in House Manager generally provides this on-site supervision. House Managers may be a senior resident or patient, a graduate of the CWT-TR, or a volunteer. The House Manager and residents must be trained in the specific CWT/TR procedures for the prevention, screening and surveillance of COVID-19.

If the House Manager or residents observes or if a resident reports an illness that includes a fever, coughing or shortness of breath, the House Manager must immediately report the illness to the designated CWT/TR staff or other designated VA medical facility personnel. The resident should be given a mask and confined to the Veteran's bedroom. Local procedures will be developed to call a code "ICE" (Infection Control Emergency) and for communication and coordinating the transport of the Veteran to the VA medical center's emergency department or a community emergency department. If the resident, staff member or visitor has tested positive for COVID-19, the CWT/TR program will follow local facility policy and procedure to determine if further testing of staff and residents is necessary or if isolation is required.

For further questions about the MH RRTP guidance, contact Jamie Ploppert, National MH Director, MH RRTPs at Jamie.plopper2@va.gov

Attachment C

Guidance for Managing Hospitalized COVID-19 Positive Patients Who Are Suicidal

In the event that a Veteran test positive for COVID-19 and requires hospitalization for a medical condition or for a psychiatric condition, they should be moved to the facility's COVID-19 Zone, as described in the Veteran Health Administration COVID-19 Strategic Response Plan (3/3/20). If the Veteran voices suicidal ideation or intent, it is recommended that the following procedure be followed:

- 1) Veteran should be placed on 1:1 observation, as described in VHA Directive 1167. The Directive defines 1:1 observation as the following:

One-to-one observation is defined as the constant observation of one patient by one staff. Staff providing one-to-one observation should only be observing one patient at a time and have no other responsibilities during the assignment to one-to-one observation. While under one-to-one observation, any restroom visit requires an escort who can visually monitor the patient for suicidal behavior. Such restrictions on the Veteran's freedom must be consistent with statutory and regulatory authority, and be sensitive to privacy and dignity. Observation by cameras cannot substitute for one-to-one observation. (See table on the following pages for additional information)

- 2) The room where the Veteran is placed should have all non-essential equipment removed. All equipment that is only used temporarily should be removed when not in use.
- 3) Consult should be placed to the Mental Health Consultation- Liaison team to assess the Veteran's mental health condition, determine level of suicidality, and to suggest treatment/management options.
- 4) Traffic in and out of the Veterans room should be kept at a minimum, with only those with a need to enter be allowed to do so.
- 5) No outside visitation will be allowed.

All individuals entering the Veteran's room should be clad in appropriate Personal Protective Equipment. For all routine patient care, staff should wear a surgical mask as N95 masks or PAPRs are reserved ONLY for procedures at high risk of generating aerosols (intubation, CPR, nasopharyngeal/oropharyngeal swabbing, bronchoscopy, non-invasive ventilation like Bipap, or nebulizer treatments)

Guide to Various Safety Observation Levels

Safety Observation Status	Description of Observation	Documentation Frequency
Routine admission (15) or Intermittent (30) Patient Observations	<p>Proximity: Direct visual face-to-face interaction/observation at specific intervals or designated frequency defined by policy. Typically, all newly admitted patients are initially placed on this level of observation unless care needs require a higher level of observation. This observation level entails staff are monitoring the patient's behavior, welfare, safety, location and immediate environment at Q 15 minutes or Q 30 minutes</p>	<p>Routine observation is documented on each patient for that unit (area of care) for the ordered time intervals of observation (Q 15 minutes/Q 30 minutes). Documentation in the medical record includes: The rationale for the observation; patient's behavior; activity; safety; unit location; at Q 15 minutes or Q 30 minutes and is also included in the treatment plan.</p>
Direct Line of Sight Observation.	<p>Direct line-of-sight observation is defined as continuous observation by staff. Staff can observe multiple patients but must remain safely in the area with patients such that, if a patient needs immediate intervention, the staff member can safely intervene and call other staff to help as needed. Observation by cameras cannot substitute for direct line-of-sight observation.</p>	<p>Direct line of sight observation of the patient is continuously maintained and documented in the medical record as 'maintained' for each shift or time required along with the rationale for the observation. The treatment plan is updated to reflect the observation.</p>
Line of Sight: Medical equipment only	<p>One staff member observes 2 or more (depending on the space configuration and the sight lines) patients (who are assessed as non-suicidal)</p>	<p>Direct line of sight observation of the medical equipment is continuously maintained and documented in the medical record as 'maintained' for</p>

	with medical equipment at a time. (CPAP; oxygen tubing, power cords etc.).	each shift or time required along with the rationale for the observation. The treatment plan is updated to reflect the observation. Line of sight for medical equipment-is to be facilitated face-to-face in person and not via camera monitoring.
One-to-One Observation. (To be utilized for high risk suicidal patients in all settings)	This is an 'Arm's length' away constant observation which requires constant visualization of the patient. The staff member is always within an arm's length from the patient including when using the bathroom, shower, etc.	Constant observation is documented as 'maintained' on each patient for that unit (area of care) for each shift or time required and is documented in the medical record. Documentation includes the rationale for the observation; patient's behavior; activity; safety; and unit location. The treatment plan is updated to reflect the observation.
	One-to-one observation is defined as the constant observation of one patient by one staff. Staff providing one-to-one observation should only be observing one patient at a time and have no other responsibilities during that time. While under one-to-one observation, any restroom visit requires the staff member to escort and visually monitor the patient for safety and suicidal behavior. Such restrictions on the Veteran's freedom must be consistent with statutory	



	<p>and regulatory authority and be sensitive to privacy and dignity.</p> <p>Note: Observation by cameras cannot substitute for one-to-one observation. If the patient is agitated or has a potential for violence, the staff member should consider observation at 2-3 arm's length away and patient behaviors should be discussed with the treatment team.</p>	
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VA Response to COVID-19
Guidance for VA Opioid Treatment Programs (OTP)

Attachment D

**Department of Veterans Affairs
Veterans Health Administration
Guidance for VA Opioid Treatment Programs (OTP)**

Effective Date:

Purpose: This document provides guidance to facilities operating Opioid Treatment Programs (OTPs) located on medical center grounds and in the community. This guidance is intended to inform the development of local facility policy and procedures for prevention, screening and surveillance of the Coronavirus (COVID-19) and continuity of operations. Please refer to *VHA COVID-19 Strategic Response Plan* by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020 for VHA department wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak.

Synopsis: The priority goal in the VA response to COVID-19 is the health and safety of Veterans and staff. Ensuring the health and safety of Veterans diagnosed with opioid use disorder (OUD) includes ensuring uninterrupted access to medication for the treatment of OUD (M-OUD) provided in outpatient treatment settings and by the accredited Opioid Treatment Programs (OTPs) in VA. OTPs may be located on VA grounds in the main medical center building, in a separate building on the medical center campus or in a separate community-based location. OTP operations are regulated by the Substance Abuse and Mental Health Services Administration (SAMHSA). As such, OTPs are encouraged to review any guidance provided directly by SAMHSA. While VA OTPs are not licensed by the State and generally do not follow State specific regulations, OTP Medical Directors are encouraged to monitor guidance from their State Opioid Treatment Authority to ensure awareness of recommendations that account for local variance in prevalence of the COVID-19.

<https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/covid-19-guidance-otp>

State Opioid Treatment Authorities: <https://dpt2.samhsa.gov/regulations/smalist.aspx>

OTP Emergency Response Plan: Each Opioid Treatment Program is required to have an emergency response plan to ensure continuity of services in the event of an emergency or natural disaster. Programs are encouraged to review their emergency response plan at this time. The emergency response plan is required to include:

- Identification of an alternate accredited OTP for dosing or an alternate dosing location for use by the VA OTP. If the new dosing location is not within the same building as the current OTP, please see https://www.deadiversion.usdoj.gov/disaster_relief.htm to request DEA assistance in relocating your OTP DEA registered address to a new location.

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Guidance for VA Opioid Treatment Programs (OTP)

- Maintenance of a 24-hour telephone answering capacity to respond to facility emergencies with contingencies plans if phone service is disrupted;
- An active roster of patients and log of medication dosages that are easily accessible (programs must ensure that if not integrated directly into the VA Electronic Health Record, medications are manually entered into the VA Computerized Patient Record System (CPRS) as non-VA medications); and
- A specific plan for how information will be communicated to Veterans in advance of and following any disruption in program operations.

Prevention: The best method to combat any infectious disease is to have preventive measures in place, prior to an outbreak, that mitigate the transmission and spread of the disease. This includes:

- frequent handwashing with soap and water for minimum of 20 seconds using a paper towel to turn off faucet to prevent recontamination
- frequent use of 60% or greater alcohol-based sanitizers with placement at each dosing window (individualized care for Veterans with an Alcohol Use Disorder must be considered to minimize the risk of abuse of alcohol-based sanitizers)
- avoid shaking hands when in situations where access to soap/water or sanitizers is not available (inform people why you are not shaking hands)
- avoid touching your face
- increase cleaning of unit surfaces that are repeatedly touched by staff and residents to include areas around the dosing window
- avoid public places and areas where large groups of people will congregate including facility specific plans for social distancing in group rooms, lounges, etc.
- facilities should provide staff and residents a copy of the attached Poster: "Stop the Spread of Germs New CoVID-19 Poster"

OTPs, in collaboration with infection control subject matter experts at the facility, are encouraged to evaluate standard operating procedures for completion of breathalyzers. This critical function must be continued, but collection procedures may need to be modified to minimize the risk for spread of the disease. In addition, programs are encouraged to review dosing procedures to determine whether other mitigation strategies may be warranted (i.e., use of disposable covers, provision of pre-filled cups of water).

Further information about everyday preventive actions:

<https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html>

Follow your VAMC policy regarding management of positive screens. Access copy at <https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>

Admissions: Curtailing admissions to the OTP is not recommended. However, facilities are encouraged to consider alternate treatment modalities for newly identified Veterans requiring treatment for OUD. This should include consideration for prescribing of

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buprenorphine/naloxone in an office-based outpatient setting with appropriate psychosocial support that can be provided via VA Video Connect (VVC). Facilities must submit an Issue Brief if OTP operations are curtailed and must activate emergency response procedures to ensure continued access to M-OPUD through an alternate OTP for dosing or an alternate location for use by the VA OTP (see earlier guidance).

Staffing: OTP staff must be provided the appropriate personal protective equipment to respond to a positive screen for COVID-19. Programs are encouraged to identify additional staff with designated credentials to ensure continuity of operations (i.e., dispensing of methadone, patient orders) in the event that OTP staff are not available to provide direct patient care.

Surveillance: All OTP staff and patients must follow local facility policy and procedures for accessing the campus. OTP staff must be trained in locally developed procedures for prevention, screening, and surveillance of COVID-19. *NOTE: Current VA guidance on prevention, screening, and surveillance can be found here:* <https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>. Patients observed or reported to be ill with symptoms suggestive of COVID-19, influenza like illness (ILI), as per the COVID-19 screen should be provided a mask, assessed for self-harm or suicide and then safely moved to a room with a closed door. Appropriate PPE should be provided to staff prior to determining the next steps for provision of clinical care. The Veteran should be provided with their medication dose from staff with appropriate PPE while awaiting determination of the next steps for provision of clinical care.

Social Distancing: OTPs should initiate procedures to limit the number of Veterans congregating in the clinic. Procedures may include:

- Increasing times available for dispensing to avoid crowding;
- Reviewing current schedules for receipt of take-home medications to distribute assigned dispensing times across the week;
- Implementing procedures to provide space between patients presenting for receipt of their medication (i.e., marking spaces in line, requesting patients remain seated until called);
- Providing psychosocial services, to include groups, via VVC.

Dosing Considerations: Programs are encouraged to proactively review all patients admitted to the program to determine whether take-home medication can be implemented and/or increased consistent with current regulations. A determination to deviate from [current federal regulations](#) for take-home medication must be made at the level of the individual Veteran based on assessed patient risk. If indicated, programs should submit a request for an exception through the [SAMHSA OTP Extranet website](#). Programs are encouraged to communicate to patients the need to contact the clinic in advance if they become sick, so that approval for take-home medications can be obtained and to discuss how the patient will receive the medication, possibly through the designation of another trusted individual to pick up the medication.

The need to submit a request for an exception or receive formal approval through the SAMHSA OTP Extranet should not be a barrier to providing take-home medications when determined to be medically appropriate. SAMHSA has issued guidance providing for a 48-hour window for completion of the exception request.

Programs with active community spread of COVID-19 may elect to submit a request for a blanket exception for all patients who have tested positive for COVID-19 or who are asked to quarantine allowing for take home medications. In all cases, there should be a clinical review to determine the most appropriate course of action for the Veteran. Additional dosing considerations for Veterans known to be positive for COVID-19, experiencing ILI, or who are asked to quarantine are provided below.

Federal regulations for take-home medications can be found at:
<https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/submit-exception-request>

Programs are encouraged to consider what procedures will be implemented to allow Veterans to retain access to medications in the event they are asked to self-quarantine, report a positive test for COVID-19, or report ILI. OTPs can dose patients who present to the OTP with ILI in a separate room or unit if take home doses of methadone are not clinically appropriate. When providing services to a Veteran potentially or known to be positive for COVID-19 appropriate precautions must be taken to ensure the safety of the Veteran, other Veterans receiving care at the medical center, and OTP staff.

Access to M-OPUD must be sustained for any patient assessed as unsafe to manage take-home medications or only able to manage a limited supply of take-home medications (i.e., cognitive condition, inability to keep take home doses safe due to chaotic living situation). OTP program directors should work in collaboration with facility leadership to ensure that appropriate standards for infection control are maintained.

OTPs are encouraged to establish a plan to allow for continued receipt of take-home medication for those patients who report a positive test for COVID-19 or who report ILI. Options, consistent with guidance from the Centers for Disease Control, may include:

- Dispensing of medications in a separate location, minimizing contact with other Veterans and staff with appropriate infection control procedures in place. *NOTE: this may be the same space designated for continuation of daily dosing for patients known to be positive for COVID-19 or presenting with ILI.*
- Delivery of the medication to the Veteran. When this occurs, the Veteran should be contacted in advance to arrange the delivery. When the staff person arrives at the designated location, they should call the Veteran to let them know that they have arrived. The staff member should place the medication on the doorstep and then retreat a minimum of 9 feet to observe the Veteran or designated individual picking up the medication. Upon return to the facility, staff would document delivery of the medication in the medical record. Medications must not be left

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unobserved. If the Veteran does not present to pick up the medication, the staff member must retrieve the medication, return it to the facility, and document in the OTP record.

Access to Non-VA OTPs: In some facilities Veterans may be receiving medication from a Non-VA OTP. OTPs within the community are receiving similar guidance from the State Opioid Treatment Authorities. Mental Health Residential Rehabilitation Treatment Programs with Veterans who are leaving the facility daily for dosing in the community are encouraged to contact the non-VA OTP to discuss available options for take-home medications that can be safely stored at the MH RRTP limiting the need for the Veteran to go into the community. When the Veteran is admitted for a diagnosis other than OUD, methadone can also be continued as an inpatient medication (inpatient order). This option should be considered when available and clinically appropriate.

Continuity of Care: When an OTP implements procedures that significantly increases the number of Veterans receiving take home medications and/or reduces the availability of recurring psychosocial services, procedures must be in place to ensure regular contact with the Veteran. It is expected that counseling services will continue using available technology solutions.

A number of guidance documents have been developed that OTP program managers may find helpful to review including information on the provision of telehealth services, including groups, via VVC as well as guidance for meeting the needs of Veterans who may be homeless or at risk for homelessness.

As local conditions change, facilities are encouraged to review any updates to existing guidance provided by VA, SAMHSA, their local State Opioid Treatment Authority, and the Drug Enforcement Administration. Specific questions about this guidance can be directed to the Substance Use Disorders Program Office within OMHSP at vhacosudprogram@va.gov.

DEPARTMENT OF
VETERANS AFFAIRS

Memorandum

Date: **MAR 19 2020**
From: Deputy Under Secretary for Health for Operations and Management (10N)
Subj: **REVISED-COVID 19 Guidance for Dialysis**
To: Network Directors (10N1-23)
Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC) *JTB*

1. VHA is providing updated guidance for dialysis provided in VHA facilities. Effective immediately, VHA facilities providing dialysis (either inpatient or outpatient) will:
 - a. Review personal protective equipment (PPE) requirements with staff: surgical mask, face shield or goggles, gown and gloves.
 - b. Identify a limited COVID-19 dialysis team. In preparation of possible future need, ensure all such staff are fit tested for N95 respirators and trained in powered air purifying respirator (PAPR) use, hood and goggle disinfection (Oxivir wipes: 0.5% hydrogen peroxide), and hand washing.
 - c. Ensure Dialysis Unit providers are trained and capable of using virtual care (i.e. VA Video Connect):
 - 1) TMS training 4279741
 - 2) Contact facility telehealth coordinator to receive web camera and head set to equip workstation
 - 3) View online training resources and demonstration (<http://vaww.telehealth.va.gov/pgm/vvc/providers/index.asp>)
 - 4) Review VA Telenephrology Manual ([https://vaww.infoshare.va.gov/sites/specialtycare/kidney/Kidney%20SP/Telehealth/TeleNephrology%20Supplement%20\(tnph-spp\)%20Feb%202020%20esigned.pdf](https://vaww.infoshare.va.gov/sites/specialtycare/kidney/Kidney%20SP/Telehealth/TeleNephrology%20Supplement%20(tnph-spp)%20Feb%202020%20esigned.pdf))
 - d. Ensure all dialysis medical staff are approved for telework privileges so they can work from home if quarantined.

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- e. Ensure routine cleaning and disinfection using approved products are appropriate for COVID-19 in dialysis settings. *NOTE: Refer to List N (<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>) on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program from use against SARS-CoV-2.*
 - f. Disinfect or discard any surface, supplies, or equipment (e.g., dialysis machine) located within 6 feet of symptomatic patients.
 - g. In collaboration with logistics department, conduct an inventory of dialysis and Continuous Renal Replacement Therapy (CRRT) supplies and equipment and make the necessary adjustments/orders to procure sufficient supplies and machines to meet an anticipated surge in demand for renal support services. Dialysis program should have at a minimum four weeks supplies for hemodialysis (HD), peritoneal dialysis (PD), and CRRT.
 - h. Review facility's dialysis emergency preparedness response plan and consider actions to bolster program's dialysis capacity for:
 - 1) Surge in dialysis demand resulting from the return to VA of veterans outsourced for dialysis care for evaluation and management of COVID-19 infection
 - 2) Increased inpatient dialysis demand due to hospitalization of VA managed maintenance dialysis patients
 - 3) Dialysis staff outages due to work force restrictions
 - i. Identify potential COVID-19 zones for dialysis care in facility.
 - j. Review Dialysis Natural Disaster Planning Excel-based Tool (<https://vaww.infoshare.va.gov/sites/specialtycare/kidney/Kidney%20SP/Emergency%20Preparedness/Natural%20Disaster%20Dialysis%20Tool%20%20V6.xlsm>)
2. Effective immediately, VA facilities providing outpatient dialysis will:
- a. Instruct patients in hand hygiene (60-95% alcohol-based hand rub or hand washing with soap and water for a minimum of 20 seconds), respiratory hygiene, and cough etiquette.

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- b. Instruct patients on how to use facemasks.
- c. Provide patients with supplies for respiratory hygiene and cough etiquette.
- d. Post signs at clinic entrances that indicate that patients with fever or symptoms of respiratory infection should alert staff so appropriate precautions can be implemented.
- e. Prohibit nonessential visitors to dialysis unit or waiting area.
- f. Verbally screen patients as soon as they report to the unit and BEFORE admitting them to main unit.
- g. Mask and triage symptomatic patients to the designated facility area for testing for respiratory pathogens (which may or may not include COVID-19) before dialysis.
- h. Dialyze symptomatic patients in isolation if possible. *NOTE: Hepatitis B (HBV) room should only be used for patients with respiratory symptoms if patient is HBV surface antigen (sAg) positive or there are no other hemodialysis patients with HBV who require room.*
- i. If no isolation room:
 - 1) Masked patient should dialyze at a corner or end of row station, away from traffic.
 - 2) Maintain at least 6 feet of separation (in all directions) between masked symptomatic patients and other **patients** during treatment.
 - 3) If intolerant of mask, maintain patient at least 6 feet from nearest **station** (in all directions).
- j. Notify facility infection prevention and control when a patient with suspected or confirmed COVID-19 is dialyzed in your unit.
- k. Minimize patient loitering in waiting area: ensure rapid screen and triage.
- l. Ensure sufficient space to permit social distancing between patients (6 feet) in waiting area.

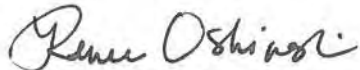
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- m. If dialyzing > 1 patient with suspected or confirmed COVID-19 in the unit, consider cohorting these patients and the health care provider caring for them. Dedicate one section of the unit and/or the last shift of the day for these patients.
 - n. If the etiology of respiratory symptoms is known, patients with different etiologies should not be cohorted (e.g. patients with influenza and COVID-19 should not be cohorted).
3. Effective immediately, VA facilities providing inpatient dialysis will:
- a. Patients with known or suspected COVID-19 should be cared for in a single-person room with the door closed and a private bathroom.
 - b. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.
4. According to CDC's risk assessment criteria, dialysis staff caring for a COVID-19 infected patient with ESRD are considered **low risk** as long as they adhere to recommended PPE and precautions.
5. Resources:
- a. VA Public Health High Consequence Infection SharePoint:
<https://dva.gov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx>
 - b. CDC Guidance:
 - 1) Staff monitoring and work restrictions:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
 - 2) Infection Prevention and control 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
 - 3) Dialysis guidance: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/dialysis.html>

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6. For questions regarding the dialysis guidance, please contact VHA Kidney Program at 202-461-7120, or by sending an email to VHANationalKidneyProgramOffice@va.gov.


Renee Oshinski



Use of Telemedicine While Providing Medication Assisted Treatment (MAT)



Under the Ryan Haight Act of 2008, where controlled substances are prescribed by means of the Internet, the general requirement is that the prescribing Practitioner must have conducted at least one in-person medical evaluation of the patient. [U.S.C. § 829\(e\)](#). However, the Act provides an exception to this requirement. 21 U.S.C. § 829 (e)(3)(A). Specifically, a DEA-registered Practitioner acting within the United States and its territories is **exempt** from the requirement of an in-person medical evaluation as a prerequisite to prescribing or otherwise dispensing controlled

substances by means of the Internet **if** the Practitioner is engaged in the practice of telemedicine and is acting in accordance with the requirements of [21 U.S.C. § 802\(54\)](#).

Under 21 U.S.C. § 802(54)(A),(B), for **most** (DEA-registered) Practitioners in the United States, **including** Qualifying Practitioners and Qualifying Other Practitioners ("Medication Assisted Treatment Providers") who are using FDA approved Schedule III-V controlled substances to treat opioid addiction, the term "practice of telemedicine" means the practice of medicine in accordance with applicable Federal and State laws, by a practitioner (other than a pharmacist) who is at a location remote from the patient, and is communicating with the patient, or health care professional who is treating the patient using a telecommunications system referred to in (42 C.F.R. § 410.78(a)(3)) which practice is being conducted:

A. while the patient is being treated by, and physically located in, a DEA-registered hospital or clinic registered under [21 U.S.C. § 823\(f\)](#) of this title; and by a practitioner

- who is acting in the usual course of professional practice;
- who is acting in accordance with applicable State law; and
- is registered under 21 U.S.C. § 823(f) with the DEA in the State in which the patient is located.

OR

B. while the patient is being treated by, and in the physical presence of, a DEA-registered practitioner

- who is acting in the usual course of professional practice;
- who is acting in accordance with applicable State law; and
- is registered under 21 U.S.C. § 823(f) with the DEA in the State in which the patient is located.

Please be advised that the remote Practitioner engaged in the practice of telemedicine must be registered with the DEA in the state where they are physically located **and** in every state where their patient(s) is (are) physically located. [21 U.S.C. § 822\(e\)\(1\)](#); [21 C.F.R. § 1301.12\(a\)](#); Notice 69478 Federal Register / Vol. 71, No. 231 / Friday, December 1, 2006.

Also be advised that all records for the prescribing of an FDA approved narcotic for the treatment of opioid addiction need to be kept in accordance with [21 C.F.R. § 1304.03\(c\)](#), 21 C.F.R. § [1304.21\(b\)](#), and with all other requirements of 21 C.F.R. Part 1300 to End.

Please note that while this document reflects DEA's interpretation of the relevant provisions of the Controlled Substances Act (CSA) and DEA regulations, to the extent it goes beyond merely reiterating the text of law or regulations, it does not have the force of law and is not legally binding on registrants. Because this document is not a regulation that has the force of law, it may be rescinded or modified at DEA's discretion.

**Department of
Veterans Affairs**

Memorandum

Date: **MAR 09 2020**
From: Executive in Charge, Office of the Under Secretary for Health (10)
Subj: Mission Critical Travel (VIEWS 2541442)
To: Veterans Health Administration Employees

1. While the Centers for Disease Control (CDC) still considers COVID-19 to be a low threat to the general American public, the Department of Veterans Affairs remains focused on caring for patients, protecting employees and maintaining readiness.
2. Out of an abundance of caution, only mission critical Veterans Health Administration (VHA) travel is approved. All other VHA travel is canceled for the next 30 days as a proactive action in response to the COVID-19 outbreak. "Mission- critical" will be determined by local leadership. Keeping our workforce stationary will give us the ability to better isolate affected areas and ensure the stability of operations as we monitor, prepare for and respond to the outbreak.
3. It is important to note that we are taking this action because we want to ensure continuity of operations and not because there is an elevated risk of travel at this time. The CDC still considers the immediate health risk from COVID-19 to the American public to be low.
4. This is the right thing to do, because we place the utmost value on the health and safety of Veterans and our employees. We will keep you updated on new developments as information is made available. For COVID-19 guidance, visit the [HCI Sharepoint site](#).



Richard A. Stone, M.D.

**Department of
Veterans Affairs**

Memorandum

Date: **MAR 16 2020**

From: Assistant Secretary for Human Resources and Administration/Operations,
Security, and Preparedness (006)

Subj: Waiver of the Biweekly Pay Limitation - Coronavirus Disease (COVID-19)
(VIEWS #02561830)

To: Under Secretaries, Assistant Secretaries, and Other Key Officials

1. This memorandum provides guidance on the biweekly limitation on premium pay for agency employees performing duties in response to the Coronavirus Disease (COVID-19). These employees are eligible to receive overtime and premium pay up to the annual maximum earnings limitations in 5 CFR 550.106.
2. I am authorizing a waiver of the biweekly pay limitation in 5 CFR 550.105(a) for work performed in response to COVID-19. Employees may be paid overtime, or other premium pay, based on the annual limitation of GS-15, step 10 or the rate payable for Level V of the Executive Schedule, (\$160,100 for 2020) (VA Handbook 5007, Pay Administration, Part V, Chapter 2, Paragraph 5).
3. The waiver applies to employees as defined in 5 U.S.C 5541(2), Fair Labor Standards Act (FLSA) exempt employees. The biweekly limitation on premium pay does not include Federal Wage System employees or FLSA Non-Exempt employees. The biweekly limitation on premium pay does not apply to Title 38 employees or hybrid Title 38 employees who have been authorized to receive premium pay on the same basis as registered nurses (commonly referred to as designated hybrids).
4. The following table must be provided to the Financial Services Center by close of business on the Thursday in the second week of the pay period to ensure employees receive the proper payments for overtime and premium pay. This information must be submitted each pay period until the end of the emergency. Following these procedures is critical to ensure the biweekly limitations are waived, payments are made timely, and controls are in place to ensure the annual maximum earnings limits are not exceeded.

Employee Name	Official Position Title	Pay Plan, Series, Grade/Step	Station	SSN	Time and Leave Code (T&L)

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Subj: Waiver of the Biweekly Pay Limitation – Coronavirus Disease (COVID-19)
(VIEWS #02561830)

5. Should you have any questions or require additional information, please contact Ms. Tracey Therit, Chief Human Capital Officer at (202) 461-0235 or via email at tracey.therit@va.gov.

For *J R Mayo*

Daniel R. Sitterly
Assistant Secretary for Human Resources
and Administration/Operations,
Security, and Preparedness (006)

16 MAR 20

Date



VA Central Office
Washington, DC

March 16, 2020

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJECT: Biweekly and Annual Limitation on Premium Pay

This bulletin provides information on the biweekly and annual limitation on premium pay for General Schedule (GS) employees. Title 5 employees may receive premium pay for a bi-weekly pay period only to the extent that basic pay and premium pay for the pay period does not exceed the biweekly rate for a GS-15, step 10 or rate payable at the level V Executive Schedule (EX-V) (\$160,100 for 2020). Premium pay includes overtime, compensatory time earned, night differential, Sunday premium pay, and holiday premium pay.


The biweekly limitation on premium pay does not apply to title 38 employees or hybrid title 38 employees that have been authorized to receive premium pay on the same basis as registered nurses (commonly referred to as designated hybrids).

Authorization to waive the biweekly limitation on premium pay is delegated to the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness. This authority is redelegated to the Under Secretaries, Assistant Secretaries, and Other Key Officials.

The biweekly limitation on premium pay may be waived, and the annual limitation on premium pay will apply when the designated official determines an employee is performing work in connection to a qualifying emergency (e.g., a natural disaster) or a mission critical event.

The annual limitation on premium pay provides that in any calendar year during which an employee performs qualifying emergency or mission-critical work, the employee may receive premium pay, when combined with basic pay, does not cause the total pay to exceed the greater of the annual rate payable for:

- 1) GS-15, step 10 (including any applicable locality-based payment or special rate supplement) in effect on the last day of the calendar year; or
- 2) Level V of the Executive Schedule (EX-V) (\$160,100) in effect on the last day of the calendar year.



When the biweekly (or annual, if applicable) limitation on premium pay is reached, employees may still be ordered to perform overtime work without receiving further compensation. There is no provision to waive the annual limitation on premium pay. Additional guidance on exceptions to the biweekly limitation on premium pay for mission-critical and emergency work can be found in VA Handbook 5007, Part V, Chapter 2, Paragraph 5.

Questions regarding this Bulletin may be directed to the Compensation Specialist assigned to your geographic area, as shown on the [OCHCO Compensation website](#).

References: 5 U.S.C. § 5547(a) and 5 CFR 550.105, 5 CFR 550.106, Comptroller General Opinions: B-178117, May 1, 1973; B-229089, December 28, 1988; and B-240200, December 20, 1990.

Issued by: Compensation and Classification Service (055)

Department of
Veterans Affairs


Memorandum

Date: FEB 12 2020
From: Deputy Under Secretary for Health for Operations and Management (10N)
Subj: Authority to Approve Weather and Safety Leave for Employees Affected by
2019-nCoV, Coronavirus
To: Executive in Charge, Office of the Under Secretary for Health (10)

1. To assist Department of Veterans Affairs (VA) employees within Veterans Health Administration (VHA) whose employment may be disrupted due to 2019-nCoV, I am requesting up to 15 days of weather and safety leave for employees who are subject to quarantine or isolation in connection with 2019-nCoV.
2. Current VA policy grants field facility heads the authority to excuse employees from duty, and from reporting to duty for up to seven consecutive workdays. For any period of excused absence more than seven consecutive workdays for field facility employees, the approval must come from the Under Secretary for Health.
3. Your approval of this recommendation would constitute a delegation of the authority to local officials to approve weather and safety leave for employees under their supervision, on a case-by-case basis, up to the 15-day limit. This leave may be authorized for employees who have had known contact and direct exposure to others (e.g., recent travel to China) but are not symptomatic. If such employees are able to telework, telework is the preferred approach to use prior to authorizing any weather and safety leave.
4. If you have any questions regarding this recommendation, please contact the Office of the Assistant Deputy Under Secretary for Health, Workforce Services at VHA_10A2_Action@va.gov.


Renee Oshinski

Approved/Disapproved


Richard A. Stone, M.D.

HR Flexibilities 2019 Novel Coronavirus (2019-nCoV)

The following charts provide supervisors with actions for an employee who is ill or has been exposed during a declared public health emergency.

Two charts are provided:

1. Actions for an employee who appears symptomatic and indicating possible infection.
2. Actions for an employee who has known contact or exposure to others with the Coronavirus but is still capable of working.

Guidance for Supervisors – When an employee is sick during a declared public health emergency				
If the employee	Take following action	Does the employee request leave?	Take the following action	and
Appears symptomatic with signs of Coronavirus (See Note 1)	Express concern that the employee appears to be symptomatic of Coronavirus - encourage the employee to take leave and seek medical care.	Yes.	Approve the leave request. (See Note 2)	No further action.
		No.	Consult HR to determine if there is objective evidence of medical incapacity to perform the duties of the employee's position. Consider use of onsite employee occupational health services, if available, to assist in making this determination. (See Note 2)	If there is objective evidence and the employee still refuses to request leave, advise that you have determined the employee is incapable of working and order the employee to take sick leave and leave the premises. Directing an employee to take leave may constitute enforced leave, which is an adverse action. Consult with HR on next steps. (Note 3) . Excused absence is not an entitlement, although the appropriate authority may grant excused absence beyond 59 minutes (See VA Handbook 5011, Part III, Chapter 2, par 12 and Chapter 3 par 9.)

Note (1) Follow guidance from [Centers for Disease Control and Prevention \(CDC\)](#) on symptom and exposure criteria.

(2) Consult with your HR servicing office and follow medical advice from CDC or an employee's physician when allowing an employee to return to work after illness or Coronavirus exposure.

Last Updated: 2/5/2020

HR Flexibilities 2019 Novel Coronavirus (2019-nCoV)

(3) An employee ordered to leave the workplace has no "right" to remain on VA premises. If an employee has been ordered to leave and refuses to do so, supervisors should consult with HR and building security staff to have the employee escorted from the premises.

Guidance for Supervisors – When an employee has known contact and direct exposure during a public health emergency				
If the employee	Take following action	Does the employee request leave?	Take the following action	and
Has known contact and direct exposure to others (e.g. has recently traveled to China) but is not symptomatic and is still capable of working.	Express concern that the employee could be ill.	Yes.	The employee may be approved for sick leave, annual leave, advanced leave, credit hours, compensatory time off, compensatory time off for travel. *An employee who is not ill may use sick leave for exposure to quarantinable communicable diseases	No further action.
		No.	Allow the employee to continue to work but monitor the employee to see if the employee develops any symptoms.	If symptoms occur, see chart "Guidance for Supervisors - When an employee is sick during a declared public health emergency" and take the appropriate action. Consult HR on the next steps.
			Determine if the employee has a telework agreement in place. (Note 2) If yes, and work can be performed from home.	Send the employee home to telework.
			If the employee does not have a telework agreement, determine if the employee can telework on a periodic basis. If yes, and the employee agrees to do so, establish a telework agreement if work can be performed from home.	Send the employee home to telework.

Note (1) Follow the [Department of Labor, Occupational Safety and Health Administration](#) guidance on assessing the likelihood of an employee who has been exposed to Coronavirus.

(2) Consult with HR and follow medical advice from CDC or an employee's physician when allowing an employee to return to work after illness or Coronavirus exposure.

Last Updated: 2/5/2020



U.S. Department of Veterans Affairs
Office of the Chief Human Capital Officer

VA Central Office
Washington, DC

March 4, 2020

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJ: Preliminary Guidance during Coronavirus Disease 2019 (COVID-19)

This OCHCO Bulletin notifies Human Resources (HR) offices of the Office of Personnel Management's (OPM) [memorandum](#) providing preliminary guidance to prepare the Federal workforce for the potential impacts of COVID-19. Department of Veterans Affairs (VA) provides this guidance to address telework and mission resilience, domestic and international travel by employees, management of visitors to Federal facilities, as well as updated recommendations from the Center for Disease Control and Prevention (CDC).

Telework and Mission Resilience

To be prepared for COVID-19, VA administrations and staff offices must incorporate telework in their continuity of operations (COOP) plans. If a COOP plan is in operation, that plan "shall supersede any telework policy." Therefore, administrations and staff offices should immediately review their current COOP plans to ensure that telework has been fully incorporated and that as many employees as possible have been identified as telework employees in the plan and are telework capable (or "telework ready").

Domestic Travel

VA administrations and staff offices should only authorize essential travel as appropriate. Employees planning domestic travel should routinely check [COVID-19 Information for Travel](#) for information about COVID-19 and take into consideration the location and purpose of their travel.

International Travel

VA employees who have spent time in certain countries or specific regions designated by the [U.S. Department of State as Level 4 \(Do Not Travel\)](#) are advised to stay at home and monitor their health for 14 days after returning to the United States. VA employees should seek medical advice if they become sick with fever, cough or difficulty breathing.

This guidance does not require immediate cancellation of pre-planned, conferences or large meetings that are not located in areas with a Level 4 travel advisory.

VA employees planning to travel to other destinations overseas are advised to individually

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review up-to-date overseas [travel information for destination countries](#) and the [Emergency Alert for Coronavirus](#) page. Approval for travel to any country outside the continental United States is approved by the Chief of Mission for that country. This is usually the Ambassador or his/her designee. Travel advisories are directly available at [Department of State Travel Advisories](#).

All VA employees seeking to travel overseas for official purposes should refer to VA Financial Policy [Volume XIV Ch. 6, International Travel](#) for guidance on foreign area travel requirements.

Travelers should also consult CDC's [guidelines for the prevention of coronavirus](#) and visit the [CDC Travelers' Health Page](#) for information on specific country health conditions.

Guidance on Visitor Access to Federal Offices and Buildings

The Interagency Security Committee has established standards for day-to-day risk management of Federal facilities. State and Federal health officials are providing ongoing guidance to Federal agencies regarding control and containment of COVID-19 exposure. Based on that health guidance, the Facility Security Committee (FSC) and/or designated official (DO) in each Federal facility has the authority and discretion to set requirements for admission to Federal property. VA facilities should contact their respective FSC or DO for any further developments on visitor access, as well as for any developments related to protection of facilities.


CDC Guidance

The CDC continues to update the American public that the immediate health risk from COVID-19 is low at this time. Nevertheless, VA administrations and staff offices should review their plans and continue their preparations since this is an emerging, rapidly evolving situation. CDC will provide updated information on the [CDC website](#). Additionally, CDC and the National Institute for Occupational Safety and Health (NIOSH) have created a page to highlight resources available for the protection of U.S. workers in all settings. See [CDC/NIOSH worker resources](#).

CDC's [Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 \(COVID-19\)](#) may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings where it is unlikely that work tasks creates an increased risk of exposure. The guidance includes planning considerations for widespread, community outbreaks of COVID-19. CDC also provides [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 \(COVID-19\)](#).

A list of everyday preventive actions to help mitigate the spread of respiratory diseases is available at [CDC Prevention and Treatment Actions](#).

Employees who have symptoms of acute respiratory illness are recommended to stay home and not come to work until they are free of fever (100.4° F [37.8° C] or greater using an oral thermometer), signs of a fever and any other symptoms for at least 24 hours and without the use of fever-reducing or other symptom-altering medicines (e.g. cough suppressants). Employees should notify their supervisor and stay home if they are sick.



The CDC recommends that employees who appear to have acute respiratory illness symptoms (i.e. cough, shortness of breath) upon arrival to work or become sick during the day should be separated from other employees and be sent home immediately. Sick employees should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

Additional HR information and resources can be found on the [HR Emergency Resource Center website](#).

Employees should contact their HR office with questions. HR offices with questions regarding this bulletin may be referred to Worklife and Benefits Service at vaco058worklife@va.gov.

Issued by: VA/OCHCO/Worklife and Benefits Service



U.S. Department of Veterans Affairs
Office of the Chief Human Capital Officer

VA Central Office
Washington, DC

March 12, 2020

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJECT: COVID-19 HR Emergency Preparedness FAQs - Version 1

This OCHCO bulletin notifies employees of the Office of Personnel Management's (OPM) [memorandum](#) and [questions and answers](#) issued on March 7, 2020.

To prepare HR offices with guidance specific to VA, the HR Emergency Preparedness FAQs are attached and will be posted to the HR Emergency Resource Center website, linked below.

This guidance addresses a wide range of HR flexibilities in response to COVID-19.

- Leave and Hours of Duty
- Telework
- Staffing and Recruitment
- Employee Relations
- Labor Relations
- Compensation and Pay
- Evacuation Pay
- Hazard Pay
- Benefits
- Reasonable Accommodation

Additional information and resources can be found on the [HR Emergency Resource Center website](#).

Employees should contact their HR office with questions. HR offices with questions regarding this bulletin may be referred to Worklife and Benefits Service at vaco058worklife@va.gov.

Issued by: VA/OCHCO/Worklife and Benefits Service



U.S. Department of Veterans Affairs
Office of the Chief Human Capital Officer

VA Central Office
Washington, DC

March 14, 2020

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJECT: Recording COVID-19 Ad Hoc Telework and Weather and Safety Leave

This OCHCO Bulletin provides Human Resources (HR) offices with information for dissemination to supervisors, payroll and timekeepers regarding requirements to appropriately record Ad Hoc Telework and Weather and Safety Leave in the VA Time and Attendance System (VATAS).

ACTION REQUIRED:

Ad Hoc Telework should be indicated on the employee timesheet in VATAS.

VATAS guidance for ad hoc telework

Upon notification from the supervisor, the timekeeper will:

- 1) **If related to COVID-19, use the ad hoc telework code of "TS – Other 1 (Reserve Use for OHRM Notice)"**
 - Example 1: Employee teleworks to practice social distancing at the direction of their supervisor due to potential exposure to COVID-19
 - Example 2: Employee quarantined under the direction of public health authorities teleworks due to significant risk of exposure to COVID-19
 - Example 3: Employee teleworks due to a child's school closure due to COVID-19
 - Example 4: Employee teleworks due to a minor child/elderly relative quarantined under the direction of public health authorities due to a significant risk of exposure to COVID-19
 - Example 5: Employee teleworks due to high risk of serious complications due to COVID-19

Weather and Safety Leave requests related to COVID-19 should be requested in VATAS by the employee

VATAS guidance for Weather & Safety Leave for COVID-19 absences:

- 1) **The employee will submit a leave request for "Weather and Safety: LN – Admin Leave, PS – Weather and Safety"** or the timekeeper can submit a proxy leave request when directed by the supervisor
- 2) **The supervisor must enter "OCHCO030520" in the Approver Comments** section when approving the leave request (this is to ensure proper reporting)

Overtime/Compensatory Time related to COVID-19 coverage

- For an employee who is requested to work additional hours to cover COVID-19 absences or activities, the supervisor must indicate "OCHCO030520" in the Approver Comments section when approving the premium pay request.

For additional information regarding VATAS timekeeping instructions, refer to the VATAS SharePoint (<https://dvagov.sharepoint.com/sites/OITFSCVATASSupport/SitePages/Home.aspx>) or contact the VATAS help desk at (512) 460-5643.

Payroll processing guidance for "Telework Reporting Requirements" and "Weather and Safety" leave is located on FSC's Payroll Support Operations SharePoint under the Payroll Procedural Guidance section (<https://dvagov.sharepoint.com/sites/OITFSCFPS/PSSD/PSO/SitePages/Home.aspx>).

Questions regarding Weather and Safety Leave and Telework policies from HR offices may be referred to the Worklife and Benefits Service at: vaco058worklife@va.gov.

Questions may be referred to the VATAS Help Desk at 512-460-5643.

Issued by: VA OCHCO/Worklife and Benefits Service



U.S. Department of Veterans Affairs

Office of the Chief Human Capital Officer

VA Central Office
Washington, DC

March 15, 2020

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJECT: Federal Government Operating Status in the Washington, DC, Area Beginning March 16, 2020

This OCHCO Bulletin is issued by the Worklife and Benefits Service to provide information on the "Federal Government's Operating Status in the Washington, DC, Area" **beginning** Monday, March 16, 2020.

The Office of Personnel Management (OPM) has determined that "Federal agencies in the Washington, DC area are **OPEN WITH MAXIMUM TELEWORK FLEXIBILITIES TO ALL CURRENT TELEWORK ELIGIBLE EMPLOYEES, PURSUANT TO DIRECTION FROM AGENCY HEADS.**" Please contact your supervisor to confirm telework schedule and to receive further direction.

Emergency and telework-ready employees required to work must follow their agency's policies. Employees who are not currently telework-ready but whose position may be leveraged to telework should discuss the possibility of telework with their supervisors.

If you are not telework eligible or do not have access to telework equipment, please contact your supervisor to discuss next steps. For those employees whose position is not telework suitable, weather and safety leave may be appropriate, pending supervisory approval. Employees are subject to recall based on workload and staffing needs.

Please refer to [OMB Guidance M-20-15](#) for full details. AGENCIES remain OPEN to serve the American people and conduct mission critical functions. Operating status updates will be issued based on OPM announcements.

Required Action: Approving Officials for time and attendance must ensure that all ad hoc and situational telework is recorded in the time and attendance system for telework-ready employees who perform unscheduled telework. **Unscheduled telework performed related to COVID-19 must use the ad hoc telework code of "TS – Other 1 (Reserve Use for OHRM Notice)"**



We appreciate your dedication to our nations Veterans through this rapidly evolving situation.

Issued by: Worklife and Benefits Service

Date: **MAR 16 2020**

From: Executive in Charge, Veterans Health Administration (10)

Subj: Coronavirus (COVID-19) – Guidance for Telework, Scheduling, and Duty Location

To: VHA Senior Leaders

1. Many of you may have seen the memorandum that was published by the Office of Management and Budget (OMB) (M-20-13, "Updated Guidance on Telework Flexibilities in Response to Coronavirus", dated March 12, 2020) that encourages Federal agencies to maximize telework and leave flexibilities whenever possible during this unprecedented COVID-19 response. Veterans Health Administration (VHA) leadership has reviewed the memorandum and the following information is provided to you to better understand how VHA is responding.

2. The safety of our employees and patients is our highest priority and one that we take very seriously. Our primary mission is to provide care to our nation's Veterans. OMB communications are broad so that each organization can use the information in ways that makes sense for them. VHA is the backbone of the American healthcare system, and one of our core missions in times of national emergency is to provide healthcare resources if the community becomes overwhelmed. We need to keep our hospitals open, especially in a time of crisis.

3. It is critical that we prioritize access to the VA network for our healthcare providers so the VA can continue provide healthcare via telehealth or telework to our Veterans; therefore, telework decisions for administrative personnel and those not providing direct patient care will be critically assessed and, where appropriate, denied based on our highest priority of delivering health care to Veterans.

4. The OMB Memo M-20-13 expands the pool of those who can request to telework during COVID-19 but does not require management to approve telework if there is justification for denial. Many positions in VHA are not feasible for telework. Other factors that may be considered in evaluation of a request to telework include availability of IT equipment and scheduling concerns. Reasonable accommodation requests for telework must be evaluated on a case by case basis and undue hardship considered in whether to approve, disapprove, or propose an alternative accommodation.

5. New telework approvals should only be made for clinical staff who will be using the remote connection to provide healthcare. New telework approvals should not be approved for non-clinical staff without the approval of a second level supervisor. VHA must preserve network access for the mission critical provision of healthcare. A review of non-clinical staff currently on telework agreements may need to be conducted as information about the availability and speed of the network becomes available. All

Coronavirus (COVID-19) – Guidance for Telework, Scheduling, and Duty Location

supervisors are directed to conduct a review of telework agreements currently in place to determine if staff should temporarily shift their duty locations or modify their schedules during this emergency to ensure mission essential functions can continue uninterrupted.

6. This guidance should not be taken to diminish the role of non-clinical staff. For administrative staff who have a vital role in maintaining our operations we need them to be physically at work, to the extent feasible, to preserve our bandwidth for clinical needs. We are carefully screening our patients, visitors, and staff, prior to entering to provide the safest environment possible for staff to work. All employees, whether clinical or administrative, are critical to the work we do for Veterans.

7. We also know that widespread school closures are creating significant strain on our employees who have children in the home. In light of this, we are recommending approval of leave or telework for a limited period in order to make appropriate long-term childcare arrangements. Absent undue hardship, long term school closures may not be a reason to approve new telework agreements.

8. OMB Memo M-20-15 (“Updated Guidance for National Capitol Region on Telework Flexibilities in Response to Coronavirus”, dated March 15, 2020) recommends that “...agency heads should develop an operational plan that maximizes resources and functional areas to most safely and efficiently deliver these mission-critical functions and other Government services (including but not limited to staggered work schedules and other operational mitigation measures).” In support of these efforts, leaders are encouraged to work with their employees to explore alternative schedules, including shift work, weekend work, split shifts, expanded use of compressed work schedules, flexible start and stop times, and part-time work.

9. Please remember that alternative work schedules for Title 5 and Hybrid Title 38 employees may not be subject to the exclusions that apply to taking action in an emergency or other management rights identified in 5 U.S.C. § 7106(a)(2). Managers should consult with their local HR representatives to ensure that appropriate employee relations and labor laws and collective bargaining agreements are considered.

10. Employees who are working remotely are encouraged to take actions to reduce the strain on IT bandwidth:

- Take advantage of offline work
- Check email periodically throughout the day using mobile devices
- Log off when not actively working email, i.e., during meetings
- Eliminate unnecessary activity like using Skype for meetings (use VANTS), unnecessary email (thank you, you’re welcome, ok, etc.)
- Suspend non-mandatory TMS training

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Coronavirus (COVID-19) – Guidance for Telework, Scheduling, and Duty Location

- Employees in local commuting areas of hub offices, increase office presence when able and when permissible, as determined by managers.

11. For further questions, contact the Office of Workforce Management and Consulting at wmc@va.gov.



Richard A. Stone, M.D.

Attachment:

Workforce Management and Consulting Combined Frequently Asked Questions



U.S. Department of Veterans Affairs
Office of the Chief Human Capital Officer

VA Central Office
Washington, DC

March 15, 2020

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJECT: COVID-19 HR Emergency Preparedness FAQs - Version 3

This updated OCHCO bulletin notifies employees of the Office of Management and Budget's (OMB) [memorandum](#) issued on March 15, 2020. This memorandum provides guidance to Federal agencies in the National Capital Region regarding:

- Maximizing telework flexibilities to safeguard the health and safety of employees;
- Offering telework to additional employees, to the extent their work could be telework enabled; and,
- Utilization of weather and safety leave for employees who are not able to telework.

Education and communication are the best tools against COVID-19. To prepare Human Resource (HR) offices with Department of Veterans Affairs-specific guidance, HR Emergency Preparedness Frequently Asked Questions (FAQs) are updated on the [HR Emergency Resource Center website](#).

- Leave and Hours of Duty
- Telework
- Staffing and Recruitment
- Employee Relations
- Labor Relations
- Compensation and Pay
- Evacuation Pay
- Hazard Pay
- Benefits
- HIPPA/Privacy Act and Reasonable Accommodation

Additional information and resources can be found on the [HR Emergency Resource Center website](#).

Employees should contact their HR office with questions. HR offices with questions regarding this bulletin may be referred to Worklife and Benefits Service at vaco058worklife@va.gov.

Issued by: VA/OCHCO/Worklife and Benefits Service

Veterans Health Administration COVID-19 Supplemental HR FAQs

These answers have been reviewed by OCHCO and OGC, and represent the best interpretation of current policy, law, bulletins, or other guidance by VHA WMC HRCoE. This document is designed to supplement guidance provided by OCHCO based on specific questions posed by VHA managers.

All information contained here is intended to be broad guidance to quickly advise VHA managers during this emergency situation. Management Officials should consult with their labor relations specialist in HR to review applicable labor laws and collective bargaining agreements with questions related to bargaining unit employees and schedule changes. Supervisors are advised to consult with their human resources (HR) staff and District counsel prior to taking any action against an employee, making schedule changes, or if they have remaining questions about leave and premium pay. Supervisors should also consult the relevant collective bargaining agreements (CBA) and labor relations specialist with questions related to bargaining unit employees and applicable labor laws.

Be sure to check out the latest guidance from OCHCO here:

<https://vawww.va.gov/OHRM/Worklife/Pandemic/>.

Compensation

1. If we move admin staff to shift work, what rules apply regarding night differential and weekend premium pay?
 - Night differential – 5 U.S.C. 5545 requires that GS employees who work between 6:00 PM and 6:00 AM be entitled to pay for nightwork at their rate of basic pay plus premium pay amounting to 10 percent of that basic rate. Of note, 5 U.S.C. 5545(b)-(c) contain limited exceptions.
 - 5 U.S.C. 5343 requires that prevailing rate employees (wage) are entitled to their scheduled rate plus a night differential –
 - (1) amounting to 7½ percent of that scheduled rate for regularly scheduled non-overtime work a majority of the hours of which occur between 3 p.m. and midnight; and
 - (2) amounting to 10 percent of that scheduled rate for regularly scheduled non-overtime work a majority of the hours of which occur between 11 p.m. and 8 a.m.Night differential as described is considered a part of basic pay.
 - Weekend Premium Pay - Administrative employees have generally not received weekend premium pay; however, there is a provision for Sunday premium pay. (See VA Handbook 5007 Part V, Chapter 6)

VA Police Quarantine Authority in the Absence of a Federal Order

Guidance issued on March 2, 2020 by the Office of Security and Law Enforcement (“OSLE”) and the VHA Senior Security Officer addressed VA police authority with respect to patients under a CDC quarantine Order that receive treatment at VA medical facilities.

Absent a federal quarantine Order issued by the CDC, or other applicable federal declaration, the laws of the several states will inform VA authority to enforce a quarantine.

State Quarantine

Traditionally, protection of the health and safety of the citizens of a state is an exercise of the States’ police powers. *See Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 569, 111 S. Ct. 2456, 2462, 115 L. Ed. 2d 504 (1991) (“The traditional police power of the States is defined as the authority to provide for the public health, safety, and morals.”).

The authority to compel quarantine or isolation is historically derived from a state’s inherent “police power” to enact laws and promulgate regulations to safeguard the health, safety, and welfare of its citizens, a power reserved to the states under the Tenth Amendment of the United States Constitution. There is significant variation among states regarding isolation and quarantine laws but any authority to compel quarantine or isolation, absent specific federal authority, will be conferred by the laws of the respective states.¹

VA police derive their authority from federal law, specifically, 38 U.S.C. §§ 901 and 902, but in situations where no applicable federal quarantine order has been implemented, or other pertinent federal declaration, VA must turn to state law to implement a legal framework that will enable delivery of needed care which may or may not include compelled isolation or quarantine restrictions.

Because VA police have no inherent authority to enforce or implement a quarantine or isolation of a patient in any VA facility, compelled detention, isolation, or quarantine authority will be derived from state law generally, and each respective facility should continually monitor their respective states for issuance by the state of any applicable isolation or quarantine orders.

¹ The National Conference of State Legislatures (NCSL) compiled a list, last updated in October 2014, of state quarantine and isolation statutes, available on the NCSL web page at: <https://www.ncsl.org/research/health/state-quarantine-and-isolationstatutes.aspx>

State Issued Quarantine Orders

State and local governments have the primary authority to prevent and control the spread of communicable diseases within their own jurisdictions. The Federal government may assist in state or local efforts to curtail the spread of a communicable disease when a state expressly requests assistance.²

However, as there is no expressly vested authority contained in the Constitution that would allow for the executive branch or executive branch agencies to execute state laws, the authority for enforcement of any state-imposed quarantine order rests solely with a state, not with the federal government.

VA police authority is conferred by federal law, 38 U.S.C. §§ 901 and 902; thus, VA police lack authority to enforce state law. Further, and in keeping with Constitutional constraints, VA Handbook 0730 restricts VA police officers from being conferred state policing authority. "VA police officers will not be deputized or appointed as special police officers or otherwise empowered with law enforcement authority by state, municipal, county, or other non-VA agencies for the purpose of enforcing state laws and local ordinances on VA property."

A quarantine or isolation order issued by a state does not alter the above analysis. VA police lack authority to enforce state law on VA property and, as a quarantine order would be issued under the "police power" of an individual state or locality, similarly lack authority to enforce a state quarantine order as no greater or lesser authority is conveyed merely because a state law is designed to protect the welfare and health of citizens or to prevent the possible proliferation of a communicable disease.

Supremacy Clause

Any matter that intrudes upon Congress's power to legislate gives way under the Supremacy Clause.³ Thus, to the extent that a state were to attempt to enforce a state quarantine order on VA property, Federal supremacy would prevail, and VA could elect to not comply with the state ordered quarantine restrictions.

Limited Detention of an Individual

VA police may temporarily detain an individual attempting to violate an enforceable and operative quarantine order issued by a state or municipality, to prohibit a violation of law

² U.S. CONST. art. IV, § 4.

³ U.S. CONST. art. IV, § 2.

in an officer's or officers' presence, so long as the actions taken by VA police are communicated to the appropriate state quarantine authorities, as identified in the individual state's quarantine statutes, as soon as practicable.⁴

While the precise wording of any quarantine or isolation order will necessarily further inform VA police as to whether or not an individual is violating or attempting to violate an enforceable state quarantine order, individuals seeking medical treatment should be provided such treatment, in comport with their eligibility for treatment, as this would not be considered violative of a quarantine order generally. Individuals who attempt to avoid ordered treatment or attempt to depart a facility in contravention of an applicable state quarantine order, would be those individuals violating or attempting to violate an order and who might also be subject to detention as a result of their actions, or inaction.

Such a detention for a violation of a state law, for which VA police have no conferred authority to enforce, as referenced above, may be accomplished generally under the citizen's arrest authority of the individual states. Such authority, like quarantine laws, is specific to the individual states, and familiarization with respective state law is encouraged.⁵ Citizen's arrest authority has long been the standard by which a federal officer's actions have been measured when confronted with conflicts between federal law enforcement authority and State law prohibitions. See *generally*, *U.S. v. Atwell*, 470 F. Supp. 2d 554 (D. Md. 2007); see also, 10 U.S.C. § 1047.4.

Conclusion

VA police operate effectively and professionally everyday under these same authorities and constraints and no greater prohibitions are imposed, or greater authority created, merely because a disease may be communicable. As a practical matter, the convergence of state and federal law is an issue in which VA police are extremely well-versed. VA police should continue to employ the training and guidance that has been provided as no greater or lesser authority has been conferred upon VA police as a result of the Federal and State responses to COVID-19.

⁴ This analysis is not identical to but is consistent with VA's interpretation of state involuntary commitment laws generally. A direct corollary is not intended to be drawn between the two separate and distinct provisions of state law, but instead the commitment provisions are merely a comparative for the appropriate legal analysis that would be applied.

⁵ With respect to concerns over lack of explicit authority to engage in such policing actions, VA police officers, when assisting in the furtherance of medical treatment, would likely enjoy the immunity protections of 38 U.S.C. § 7316(f). See also, *Ingram v. Faruque*, 728 F.3d 1239 (10th Cir. 2013)

**Department of
Veterans Affairs**

Memorandum

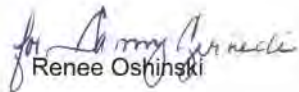
Date: JAN 30 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Request for Disaster Emergency Medical Personnel System (DEMPS) volunteers to support HHS Response to 2019-nCoV

To: Network Directors (10N1-23)

1. The purpose of the memorandum is to request DEMPS personnel in support of the Department of Health and Human Services (HHS) response to the 2019 Novel Coronavirus (2019-nCoV). The Veterans Health Administration has been asked to support screening missions to assist Centers for Disease Control (CDC) and HHS teams; the actual locations are to be determined.
2. All DEMPS deployed personnel will receive training on the screening process, fit testing for personnel protective equipment, and safety training, and will be part of the CDC/HHS teams.
3. VISNs are requested to review their capability for the time period of February 316, 2020. VISNs that have fully-qualified DEMPS personnel in the DEMPS Management System (DMS) registration application will receive an automated request generated by the DMS. A list of needed occupations is attached.
4. The VA Financial Services Center (FSC) Travel office will coordinate all travel and lodging arrangements and the FSC VA Time and Attendance System office will complete the timekeeping process.
5. Local transportation will be arranged through VHA's Office of Emergency Management (OEM). All other staff needs while deployed will be coordinated through OEM. The DEMPS rotation will be for two weeks in duration: one day for outbound travel, 12 work days and one day for return travel.
6. DEMPS VISN Points of Contact will utilize the DMS processes and procedures to fill the assigned requirements at: <https://vhapims.orau.org>.
7. Questions regarding this request can be addressed to your VISN DEMPS POC, Facility DEMPS Coordinator or the National Deployment Operations Program Officer, Karen Newell MSN, RN, at 202-400-5668, or Karen.Newell@va.gov.


Renee Oshinski

Attachment



Attachment

DEMPS REQUEST

# Requested	Profession	Specialty	Special Requirement/ Competency
12	Health Technicians and/or Nursing Assistants		none

DEPARTMENT OF
VETERANS AFFAIRS

Memorandum

Date: **JAN 31 2020**

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

Subj: Veterans Health Administration Central Office (VHACO) Program Responsibilities for Novel Coronavirus in China (VIEWS 02370776)

To: VHACO Senior Leaders, Network Directors (10N1-23), and Medical Center Directors

1. Novel coronavirus, first identified on December 1, 2019, in Wuhan City, China, has infected 2,794 people in 15 countries and resulted in 80 deaths. Five confirmed cases in the United States all had recent travel to Wuhan City. The Centers for Disease Control and Prevention along with State Public Health departments are tracking close contacts to these individuals and others who had traveled to Wuhan City for the development of symptoms associated with this new viral infection in humans. The Veteran status of these individuals is unknown.

2. The Department of Veterans Affairs has a pandemic influenza plan that has been used to develop national, Veterans Integrated Service Network (VISN), and facility level preparedness plans. I have asked the Offices of Emergency Management (Dr. Paul Kim) and Population Health (Dr. Larry Mole) to co-lead the adaptation of this plan for the new coronavirus. VHACO Program Offices should be prepared to support the development of plans and policy to prepare facilities, Veterans, and employees/volunteers/trainees for the potential of a coronavirus pandemic. Draft plans and policy will be vetted by VISN and facility leadership in an expedited manner.

3. The most current information for health care providers, infection control, and laboratory testing for this coronavirus can be found at:
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

4. Thank you for your leadership in development, and if needed, implementation of a plan to address an emerging threat to Veterans and employees/volunteer/trainees' health. If you have any questions, please contact the offices co-leading this initiative at VHAHCIWorkgroup@va.gov.



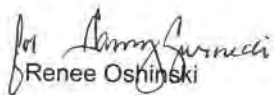
Richard A. Stone, M.D.

Department of
Veterans Affairs

Memorandum

Date: FEB - 5 2020
From: Deputy Under Secretary for Health for Operation and Management (10N)
Subj: Managing Local Requests for Assistance related to Coronavirus (nCoV2019)
To: Veterans Integrated Service Network (VISN) Directors (10N1-23)

1. The primary mission of the Veterans Health Administration (VHA) is to deliver care to enrolled Veterans. VHA normally supports requests for assistance (RFA) when local, tribal, State and other Federal assets are not available, when a capability unique to VHA is required, or when mutual aid agreements are already in place.
2. The Department is a full partner in the federal response to domestic incidents, and VA's response is fully coordinated with our interagency partners in accordance with the National Response Framework and the Pandemic and All-Hazards Preparedness Act. VHA support is typically provided on a reimbursable basis, as required by the appropriate statutory authorities.
3. VHA resources are committed after approval by the Secretary of Veterans Affairs or at the direction of the President. In some instances, these assets may be made available to support local, regional and/or national routine and catastrophic incidents such as public health emergencies declared by the Secretary of Health and Human Services.
4. If a VISN or VA health care facility receives a healthcare-related request for assistance from a non-VA entity under a declared Public Health Emergency, please forward the RFA to the VHA Emergency Management Coordination Center. Questions concerning this memorandum may be directed to the VHA Office of Emergency Management at (304) 264-4800 or email at OEMEMCCCmdStaff@va.gov.


Renee Oshinski

Department of
Veterans Affairs

Memorandum

Date: February 12, 2020

From: Deputy Assistant Secretary Office of Emergency Management and Resilience (007)

Subj: Department of Health and Human Services Request for Support to Novel Coronavirus Outbreak Task Order 5.7 - RELOAD (VIEWS# 2436754)

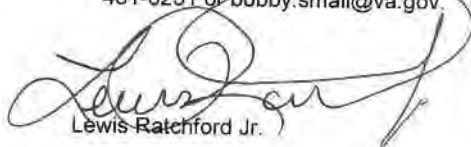
To: Deputy Under Secretary for Health for Operations and Management (10N)

1. The Department of Health and Human Services (HHS), as the lead for Emergency Support Function 8 (Public Health and Medical Services) has vetted and requested support from the Department of Veterans Affairs (attached), six (6) Veterans Health Administrations Medical Technicians for Medical Screening Mission in response to the Novel Coronavirus.
2. If this request is supportable, direct coordination with HHS is authorized. Names of participating personnel will be submitted to the HHS point of contact as soon as identified. Please include the VA Integrated Operations Center (VAIOC) on all correspondence and advise of any requests for additional VA resources outside the scope of this request.
 - a. Requested Capability: Six (6) Veterans Health Administrations Medical Technicians for Medical Screening Mission in response to the Novel Coronavirus.
 - i. Deployment Location: Travis AFB, California
 - ii. Deployment Dates: February 14, 2020 – February 24, 2020
 - iii. Command and Control: Upon arrival at the deployment location, the Veterans Health Administrations Medical Technicians will operate at the direction of HHS. Once released, operational control returns to VA
 - iv. Transportation: Provided by HHS
 - v. Funding: HHS
 - vi. Requesting Agency Point of Contact: Joe Newcomer, Resource Coordinator Branch (HHS/ASPR/RCB), 202-445-0158
3. If this request is supportable, advise VA Integrated Operations Center via email (vaioc@va.gov) no later than (NLT) 1700, February 13, 2020.
4. Direct coordination with the requesting agency is authorized. Names of participating personnel should be submitted to the HHS point of contact as soon as identified. Please include the VA Integrated Operations Center (VAIOC) on all correspondence and advise of any requests for additional VA resources outside the scope of this request.

Page 2.

Subj: Department of Health and Human Services Request for Support to Novel Coronavirus
Outbreak Task Order 5.7 - RELOAD (VIEWS# 2436754)

5. Thank you in advance for consideration of this interagency request. The OSP point of contact is Mr. Bobby J. Small Jr., Director of Operations. He may be reached at (202) 461-0251 or bobby.small@va.gov.



Lewis Ratchford Jr.

Attachment



United States Department of Health & Human Services
Office of the Assistant Secretary for Preparedness and Response (ASPR)

Public Health, Medical, and Human Services
2020 Novel Coronavirus
Task Order 5.7 **Reload 2/11/20**

1. Assigned To: LOG, A&F, RAMS, VA	Funding Source: Per A&F decision
2. Effective DTG: 2/1/2020 2/14/2020	Completion: 2/15/2020 2/24/2020
4. Summary of Changes: RFR 0131-3567	
5. Assistance Requested: TRAVIS AFB	
6. Statement of Work: VA to send 14 Medical Technicians (as defined by Lamana) to provide support for the Medical Screening Mission EDIT: Please update TO 5.7 and source to VA for staffing. Andrew McBrearty	
7. Administrative Responsibility: IMT	
8. Operational Responsibility: IMT	
9. Special Instructions: Please have the roster built in RMS and positions staffed. Do NOT generate orders or travel until authorized by IMT Washington DC. We are requesting that all personnel have been mask fit tested within the past 12 months.	
10. Authorized Personnel: 14 VA Medical Technicians 6 (six) VA-Medical Technicians	
11. Authorized Equipment:	
12. Authorized Vehicles: Enough Vehicles to transport 14 PAX Rentals for 6	
13. Authorized Facilities: Lodging	
14. Authorization: At direction of ASPR Approved By: Resource Coordination Branch	
(RCB) Time/Date: 1350 1/31/2020 1730 2/11/20	<i>Joe Newcomer</i> Resource Coordination Desk

Department of
Veterans Affairs

Memorandum

Date: FEB 18 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Coronavirus (COVID-19) Table-Top Exercise(TTX) (VIEWS# 02449593)

To: Veterans Integrated Service Network Directors (10N1-23)

1. The Office of Emergency Management (OEM) has developed a COVID-19 TTX for Veterans Health Administration (VHA) medical facilities, Community Based Outpatient Clinics, and staff offices. The COVID-19 TTX was developed in conjunction with subject matter experts from VHA clinical specialists and facility emergency managers.

2. The purpose of each TTX is to assist all VHA entities and affiliates in identifying strengths, weaknesses, and gaps associated with response capabilities and resource availability when responding to the COVID-19. Also, TTX provides insight into the medical facilities and staff offices' response to a public health emergency, including communicating and coordinating with other agencies, departments, and/or organizations. The exercises can be modified to meet any specific requirements deemed appropriate by each facility or staff office.

3. The exercises can be found in the VHA Performance Improvement Management System at the following link: <https://vhapims.orau.org>, under the Primary Organization "OEM-HQ" (See attachments).

4. To ensure all VHA facilities and staff offices are preparing for a potential COVID-19 outbreak in the United States, I am directing all VHA medical facilities to conduct a COVID-19 specific TTX **no later than March 6, 2020**. I am encouraging all staff offices and program offices to contact the local VAMC Emergency Manager for the date and time of their exercise and participate as appropriate. Facilities are not required to use the TTX prepared by OEM, however, the exercises should address the modules identified in the OEM TTX. If a facility has already accomplished a COVID-19 related exercise, it has met the intended requirements for TTX. Reporting exercise completion can be found in the attached instructions.

5. Questions regarding the TTX can be emailed to VHAEMCCStaff@va.gov.


Renée Oshinski

Date: MAR 02 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Request for Disaster Emergency Medical Personnel System (DEMPS) volunteers to support COVID-19

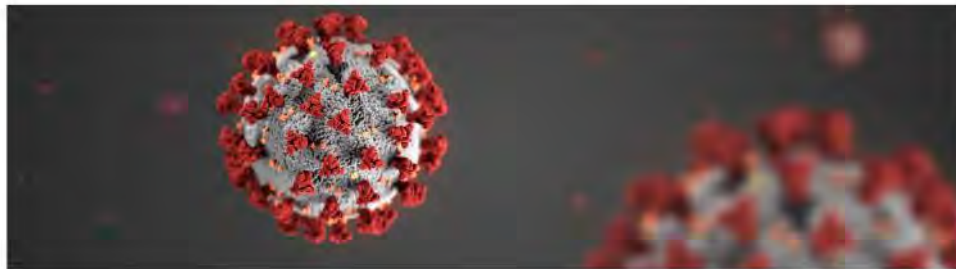
To: Network Directors (10N1-23)

1. The purpose of this memorandum is to request DEMPS personnel to provide 4 Police Officers to augment law enforcement at the VA Palo Alto Healthcare System.
2. VISNs are requested to review their capability for the time period of March 3 – 16, 2020. VISNs that have fully-qualified personnel in the DEMPS Management System (DMS) registration application will receive an automated request generated by the DMS.
3. The VA Financial Services Center (FSC) Travel office will coordinate all travel and lodging arrangements and the FSC VA Time and Attendance System office will complete the timekeeping process.
4. Local transportation will be arranged through VHA's Office of Emergency Management (OEM). All other staff needs while deployed will be coordinated through OEM. The DEMPS rotation will be for 14 days in duration: one day for outbound travel, 12 work days and one day for return travel.
5. DEMPS VISN Points of Contact will utilize the DMS processes and procedures to fill the assigned requirements at: <https://vhapims.orau.org>.
6. Questions regarding this request can be addressed to your VISN DEMPS POC, Facility DEMPS Coordinator or the National Deployment Operations Program Officer, Karen Newell MSN, RN, at 202-400-5668, or Karen.Newell@va.gov.


Renee Oshinski

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**Veterans Health Administration
COVID-19 Strategic Response Plan**



*If you are sick, stay home.
If someone in your household is
ill, stay home
Reduce close contacts in the
community and at work*

March 3, 2020

VHA COVID-19 Workgroup
Emergency Management Coordination Cell
Version 1.0

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Overview

COVID-19, a novel coronavirus infecting humans, has been declared a Public Health Emergency of International Concern by the World Health Organization and a Public Health Emergency by the U.S. Government. Current evidence shows that the COVID-19 virus when compared to influenza has a slightly higher transmission rate, similar rates of hospitalization and a higher overall death rate. Studies from China show higher death rates in men, those aged 70 and older, and those with cardiovascular disease, diabetes, chronic obstructive pulmonary disease, hypertension, and cancer.

The primary goal of the response plan is to protect uninfected Veterans and staff from acquiring COVID-19 infection by leveraging technology and communications and by using dedicated staff and space to care for COVID-19 patients. 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 and provides most outpatient care for Veterans through telehealth services. 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 an overwhelming number of COVID-19 cases to include alternative sites of care for Veterans with COVID-19.

VHA will respond using a 4-phase approach to COVID-19: Contingency Planning and Training; Initial Response; Establishing Alternate Sites of Care; and Sustainment and Recovery. This document provides an overview of the changes that are necessary within the Veterans Health Administration (VHA) healthcare system to mitigate the impacts from the COVID-19 outbreak on Veterans, employees and health care operations.

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 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

VA facilities have prepared for previous infectious disease events including H1N1 influenza, Ebola, and Zika. These plans are foundational to response plan development for COVID-19

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and should be exercised in tabletop exercises designed for COVID-19 in administrative and clinical areas. The strategies for planning and training COVID-19 are:

- Develop and conduct training on plans, policy and procedures to protect Veterans and staff
- Conduct tabletop exercises
- Identify personal protective equipment requirements and stock levels
- Identify existing capability and "just in time" requirements
- Develop "one voice" messaging for Veterans and staff

Phase 2 – Initial Response

VA facilities 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
- Maintain care for Veterans without COVID-19 through telehealth services

Each facility will establish workflows that create outpatient and inpatient zones for suspected and confirmed COVID-19 cases and standard zones. The "two zone approach" allows every VA medical center to establish separate solutions to safely care for Veterans with COVID-19 while continuing to provide care for Veterans in need of VA facility-based 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., Kiosks). The table below highlights Veteran touchpoints and strategies. Virtual and in-person triage strategies are presented below.

Strategy	Veteran VA Interface									
	Web	VA APP	Online Appointment Mgt	MyHealth-eVet	National 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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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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, follow up, including 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 and symptoms and will conduct a warm handoff to trained clinical staff for additional triage through 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. 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 Personal Protective Equipment (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 go 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.

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Inpatient Care: The "two zone" plan applies to all inpatient areas and is designed to limit exposures to COVID-19 in the intensive and acute care areas, community living centers, and VA rehabilitation programs. By shifting outpatient care from facility-based to virtual 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 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 Intensive Care Unit (ICU) units where patients suspected or confirmed to have COVID-19 would be housed and cared for, and a "Standard Hospital" for uninfected patients.



Standard Zone: This 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.

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 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 Hospital 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

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- 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 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 (telehealth, 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:

- Continue routine and 'urgent' care of patients who do not have known COVID-19, symptoms of COVID-19, or high-risk exposure to COVID-19
- 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 isolation. With 80% 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 (e.g., Annie) to 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

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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.

Phase 3 – Establishing Alternate Sites of Care

VHA will establish alternate sites of care should the healthcare 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

Activities would 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 will require legal authority to purchase services or to provide services to non-Veterans.

Phase 4 – Sustainment and Recovery

The objective 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 when able. This phase addresses staff augmentation, rest and recovery, mental health care, and protocols for returning the facility to normal operations. VA facilities may transition from this phase back to phase 3 and then 2 activities or an asynchronous manner as a function of the prevalence of COVID-19 in the local community, local facility caseload and severity of disease.

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. Listed below is a list of recovery considerations under phase 4. While not an exhaustive list, it is intended to guide planning, operational and communication efforts:

- 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
- Inventory and Restock medications and supplies
- Clean, Service and Renew essential medical equipment and AIR rooms
- Initiate plan to reinstate services that were curtailed in Phase 2/3
- If activated, closing alternative health care sites

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- Return to usual job functions and scopes of practice
- Resuming usual standards of 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.

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THE WHITE HOUSE

WASHINGTON

March 13, 2020

The Honorable Chad F. Wolf
Acting Secretary
Department of Homeland Security
Washington, D.C. 20032

The Honorable Steven T. Mnuchin
Secretary
Department of Treasury
Washington, D.C. 20220

The Honorable Alex M. Azar II
Secretary
Department of Health and Human Services
Washington, D.C. 20201

The Honorable Pete T. Gaynor
Administrator
Federal Emergency Management Agency
Washington, D.C. 20472

Dear Secretary Wolf, Secretary Mnuchin, Secretary Azar, and Administrator Gaynor:

I have determined that the ongoing Coronavirus Disease 2019 (COVID-19) pandemic is of sufficient severity and magnitude to warrant 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").

My decision to make this determination pursuant to section 501(b) of the Stafford Act is based on the fact that our entire country is now facing a significant public health emergency. The World Health Organization has officially declared that we are in the midst of a global pandemic. As of the date of this declaration, 32 states, 3 territories, 4 tribes, and 1 tribal nation, spread geographically across our country, have declared a state of emergency as a result of the virus. Only the Federal Government can provide the necessary coordination to address a pandemic of this national size and scope caused by a pathogen introduced into our country. It is the preeminent responsibility of the Federal Government to take action to stem a nationwide pandemic that has its origins abroad, which implicates its authority to regulate matters related to interstate matters and foreign commerce and to conduct the foreign relations of the United States. For example, the Federal Government, through the Department of Health and Human Services (HHS) and its component, the Centers for Disease Control and Prevention (CDC), has authority

to take the necessary steps “to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession,” 42 U.S.C. § 264(a), in close coordination with State, local, and tribal officials. In addition, the Federal Government has responsibility for securing our borders and overseeing entry of foreign nationals into our country in the interest of the United States.

This pandemic has the potential to cause severe consequences for our country’s national and economic security. Based on the advice of public health officials, I have already taken stringent measures to restrict travel to the United States of foreign nationals who have been recently physically present in certain countries that pose a threat of intensifying the spread of COVID-19 within our country. And HHS and CDC have taken effective action to address the public health threat posed by COVID-19. While these actions have been in the best interest of the health of our people, COVID-19 has the potential to impose a temporary financial hardship on all Americans. It is therefore critical that we deploy all powers and authorities available to the Federal Government to provide needed relief.

Therefore, as an initial step, I hereby determine, under section 501(b) of the Stafford Act, that an emergency exists nationwide.

In accordance with this determination, the Federal Emergency Management Agency may provide, as appropriate, assistance pursuant to section 502 and 503 of the Stafford Act for emergency protective measures not authorized under other Federal statutes. Administrator Gaynor shall coordinate and direct other Federal agencies in providing needed assistance under the Stafford Act, subject to the Department of Health and Human Services’ role as the lead Federal agency for the Federal Government’s response to COVID-19.

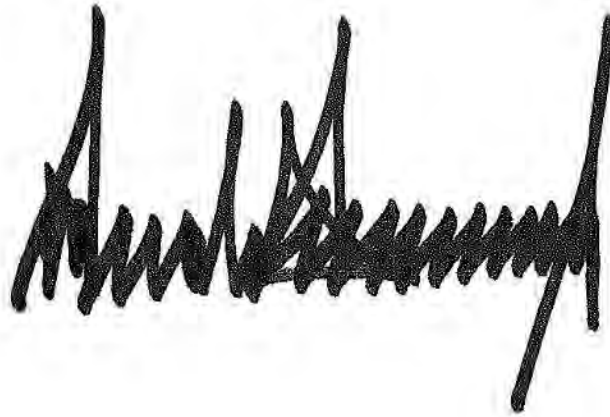
In order to meet the challenges caused by this emergency pandemic, I have encouraged all State and local governments to activate their Emergency Operations Centers and to review their emergency preparedness plans. In the meantime, I expect FEMA to continue to review all ways in which it can provide assistance to States consistent with the authorities provided to it by this letter and by statute.

I am also instructing Secretary Mnuchin to provide relief from tax deadlines to Americans who have been adversely affected by the COVID-19 emergency, as appropriate, pursuant to 26 U.S.C. 7508A(a).

In addition, after careful consideration, I believe that the disaster is of such severity and magnitude nationwide that requests for a declaration of a major disaster as set forth in section 401(a) of the Stafford Act may be appropriate.

I encourage all governors and tribal leaders to consider requesting Federal assistance under this provision of the Stafford Act, pursuant to the statutory criteria. I stand ready to expeditiously consider any such request.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Cuomo". The signature is written in a cursive, somewhat stylized font with a long, sweeping tail on the final letter.

Date: MAR 02 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Coronavirus (COVID-19) Protection

To: Network Directors (10N1-23)

1. New COVID-19 cases have been confirmed in the United States where individuals had not traveled to high-risk countries nor had close contact with someone with COVID-19. Veterans Health Administration (VHA) facilities may see similar cases and experience an influx of concerned Veterans with flu-like symptoms. The VHA Office of Emergency Management (OEM) COVID-19 tabletop exercise addresses several scenarios, and this memorandum lists a series of steps each VHA location should implement to protect Veterans and staff from COVID-19 infection.

- a. Advise and encourage all Veterans and staff members to call ahead, prior to presenting at a VHA facility, when they have flu-like symptoms.
- b. Implement procedures for Veterans with flu-like symptoms to safely maneuver the facility and campus to their designated appointments or areas.
- c. Educate VHA staff, volunteers, and trainees on COVID-19 procedures for each of your care locations.
- d. Masks should ONLY be provided to Veterans and staff who are exhibiting flu like symptoms. This guidance is to protect other Veterans and staff from the ill patient. Masks should not be provided to Veterans or staff for home isolation or quarantine.
- e. Implement a strategy throughout the facility to conserve, track and account for all Personal Protective Equipment (PPE). These procedures and processes must be in place to ensure we have the appropriate amount of PPE to sustain our ability to work safely for an extended period.
- f. Implement plans to identify, approve and support Ad Hoc Telework in the event staff require quarantine/isolation at home.

2. Thank you for all your efforts every day and particularly during this Public Health Emergency. If you have additional questions, please contact Paul D. Kim, MD or Larry Mole, PharmD by sending an email to OEMEMCCCcmdStaff@va.gov


Renee Oshinski

Date: March 15, 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Coronavirus (COVID-19) – Guidance for Work Recommendations for Asymptomatic Healthcare Personnel after Exposure to a COVID-19 Patient

To: Network Directors (10N1-23)

1. VHA facilities have initiated mitigation strategies to decrease employee exposures to COVID-19 at work through active screening outside the facility, restricted patient flow through the facility, and by limiting the number of staff that work with COVID-19 patients. However, employees remain at risk of exposure when performing procedures on known COVID-19 patients and from asymptomatic COVID-19 infected patients.

2. The Centers for Disease Control and Prevention (CDC) has updated recommendations on public health management of health care personnel (HCP) with potential exposure in a healthcare setting to patients with COVID-19. The updated guidance allows for asymptomatic healthcare personnel who have an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program or designee. Information on this topic from the CDC can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

3. VHA facilities will have a process in place for staff to self-refer or supervisors to refer employees with an exposure to a patient with COVID-19 infection to occupational health or designee for consultation. The consultation with the occupational health program or designee will include:

- The provision of face masks (not N95) to wear while working at a VA facility during the 14 days following exposure to a patient with COVID-19 infection.
- A tracking system for the 14 days following exposure to a patient with COVID-19 infection that includes:
 - Daily reports on symptoms and fever prior to starting work,
 - Location where employee will work that day (e.g., office, hospital, clinic)
- Staff education:
 - Guidance to remain at home if they develop any symptoms prior to work.
 - Health checks for fever and respiratory symptoms while at work.
 - Process to immediately report to occupational health if they become symptomatic.

4. If health care personnel exposed to a patient with COVID-19 infection develop even mild symptoms consistent with COVID-19, they will immediately cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or

occupational health services prior to leaving work. Healthcare facilities should have a low threshold for evaluating symptoms and testing symptomatic HCP.

5. For further questions, contact Jacqueline M. Cook, MD, MPH, Medical Advisor, Office of Occupational Safety and Health at Jacqueline.cook@va.gov.

Renee Oshinski
174682

Digitally signed by Renee
Oshinski 174682
Date: 2020.03.15
09:38:50 -0400

Renee Oshinski

Date: FEB 14 2020

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Personal Protective Equipment

To: Network Directors (10N1-23)

1. The purpose of this memorandum is to ensure all Veterans Health Administration (VHA) facilities have adequate supplies of the appropriate personal protective equipment (PPE). VHA will monitor usage and respond to any shortages as quickly as possible.
2. In the event you have either a suspected case or a confirmed case of COVID-19 and require the use of PPE to treat and/or care for the Veteran(s) please provide to the Emergency Management Coordination Cell (EMCC) the following information daily:
 - The quantity of each item used, to include the description, the manufacturer, and manufacturer number
 - Current stock of each item
 - Any immediate needs to replenish items used
 - Any additional shortfalls in supplies.
3. To help ensure your consumption of PPE does not exceed any demand, please provide PPE to only those who will be caring directly for any suspected/confirmed cases.
4. It is highly recommended that all fit testing be done in a qualitative manner with a challenge agent as opposed to quantitative so that the same mask can be used multiple times.
5. The EMCC will track all information and address any unmet needs as quickly as possible.
6. If you have any questions regarding this memorandum, please contact the EMCC at OEMEMCCCmdStaff@va.gov.


Renee Ostrowski

Coronavirus Communication Plan
For VISN Directors and Medical Center Leadership

3-5-2020

Background:

The COVID-19 (Coronavirus) is a new virus that originated in China in December 2019. Cases have been identified in the [United States](#) and other [international](#) locations.

All Employee Message

Goal: Provide employee update timely notifications of presumptive and confirmed cases

Key messages:

- VA is committed to protecting our staff and uninfected patients, limiting the spread of COVID-19 transmission
- Employees are all bound by HIPAA regulations (Health Insurance Portability and Accountability Act) and must respect patient privacy
- Quarantine is for people who could have been exposed and are waiting to see if they become sick; Isolation is for someone who is already sick
- Each facility has processes/procedures in place to screen for signs of respiratory illness and to ensure inventory of personal protective equipment (PPE)
- Staff who feel sick with fever or cold/flu symptoms should call in sick and contact their provider; If at work, staff should put on a mask and arrange with their supervisor to go home and call their provider
- Continue to practice good baseline hand hygiene and use PPE as indicated.

Sample Employee Messages:



COVID Preparedness Guide for Internal & External Stakeholders

Goal: Provide Veteran & staff with easily comprehensible information regarding Coronavirus Prevention

Approved message

A Veteran inpatient has tested positive for Coronavirus (COVID-19) here at the _____ Healthcare System. The risk of transmission to other patients and staff remains low, as the Veteran is being cared for in isolation by staff who are specially trained on the latest Centers for Disease Control treatment guidelines and utilizing personal protective equipment and infection control techniques.

The risk of transmission to other patients and staff remains low, as the Veteran is being cared for in isolation by staff who are specially trained on the latest Centers for Disease Control treatment guidelines and utilizing personal protective equipment and infection control techniques.

VA is screening Veterans and staff who present with symptoms of fever, cough, and shortness of breath who meet the CDC criteria for evaluation of COVID-19 infection. Per CDC guidance and VA protocols, individuals known to be at risk for a COVID-19 infection are immediately isolated to prevent potential spread to others.

Veterans and staff are encouraged to take every day preventative 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.

For more information about the Coronavirus, please visit:

<https://www.cdc.gov/coronavirus/2019-ncov/index.html>

Approved Congressional sample message

VA and VISN 6 are paying special attention to Veteran Health due to the COVID-19 (Coronavirus) outbreak and escalation. This effort is coordinated at the VA, VHA, and VISN levels to effect operations in all our facilities. VA is working closely with the CDC and other federal agencies, as you are already aware, to address the outbreak. Our staff is taking precautions to safeguard everyone in VA facilities.

This morning VHA's Executive in Charge, Dr. Richard Stone directed VA facilities to conduct a screening process, with restricted access, to mitigate the risk of COVID-19 (Novel Coronavirus). Leadership at our medical centers and clinics are assuring that staff minimize entry to the least necessary entryways, and staff them for controlled access, based on a screening process.

The screening consists of three questions:

1. Do you have a fever? Do you have a worsening cough or flu-like symptoms?
2. Have you traveled to China, Japan, Italy, Iran or South Korea in the last 14 days?
3. Have you been in close contact with someone, including health care workers, confirmed to have the coronavirus disease?

Patients and staff are being advised of proper protocols addressing the virus through signage, electronic messaging in facilities, on the web and through social media. Staff have been provided scripts for screening visitors, and handling patients who answer screening questions affirmatively.

A process is in place to report and track Veterans and staff who screen positively. Those individuals will also be taken through a complete protocol that helps them and protects staff and others. Staff have been advised of the risks and the steps to take if they find themselves feeling affected.

We will continue to provide updates as the situation changes and we adjust to conditions as they occur.

Internal Signage (Posters, Kiosk Message) (Disseminate Wednesday, March 4, 2020)

Goal: Inform internal audience of extra safety precautions to mitigate spreading of Coronavirus



NOTICE Limited Visitation 3-4-2020.docx

Limited Visitation Poster



Coronavirus Alert Poster 2-28-2020 Ve

Front Desk Signage



Coronavirus Alert Poster 2-25-2020a.p

Govdelivery Message to Veterans:

Goal: Inform Veterans of extra safety precautions to mitigate spreading of Coronavirus



Adobe Acrobat PDFXML Document

Media Response(s) to Query Only



Adobe Acrobat PDFXML Document



COVID-19
Communications
Toolkit

VA



U.S. Department of Veterans Affairs
Veterans Health Administration

Revision 1
Date Revised: 03/06/2020



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Purpose

VHA Communications intends to assist you in communicating to your staff and patients through this evolving toolkit. As we move from focusing on containment to mitigation of this coronavirus outbreak, the information keeps evolving. This is designed to be a blueprint, not a bible.

However, there are commandments to remember (less than 10):

- 1. All media queries must be forwarded to [VHA Communications](#) and OPIA.**
- 2. Any Congressional queries must be forwarded to OCLA and OPIA.**
- 3. Any messages (internal or external) addressing possible positive cases of COVID-19 should be coordinated and approved through [VHA Communications](#) and OPIA.**
4. Any operational messages (patient and employee health and safety communications, facility instructions, signage, etc.) **do not require approval**. We are glad to review them and offer another set of eyes, but you have a hospital to run. If you have a question about whether a message might go beyond "operational," contact [VHA Communications](#).
5. In all communications, please make sure that you protect all Veterans' and patients' personal information, especially health information. [\[VA Policy\]](#)

This document will be continually updated, corrected, revised and generally messed with, so please make sure you have the latest revision. We will provide samples, best practices and examples of COVID-19 communications that could be helpful.

Note, many of these documents are on various SharePoint sites.

Please [forward](#) what you create locally, so we can continue to replace "the best" with "even better" to share throughout the network in future revisions.

Contacts:

Jerry Michaud, Executive Director, VHA Communications
gerald.michaud@va.gov | Office: 202.461.4801 | Cell: 202.210.1224

Alan Greilsamer, Director, VHA Media Relations
Alan.greilsamer@va.gov | Office: 202.379-8217

Important Links

Frequently Asked Questions

[COVID-19 Frequently Asked Questions – VA](#)

[COVID-19 Frequently Asked Questions -- CDC](#)

Key Reference Websites

[VHA Public Health COVID-19 Information](#)

[CDC COVID-19 Information](#)

[VHA High Consequence Infection \(COVID-19\) SharePoint](#)

Situation Summary

[CDC Situation Summary](#)

Prevention & Treatment Guidance

[CDC Prevention & Treatment](#)

Travel Information

[CDC Travel Information](#)

Long Term Care Facilities

[CDC Long-Term Care Strategies](#)

Latest EIC Message to All Employees

MESSAGE FROM THE EXECUTIVE IN CHARGE

March 05, 2020

Novel Coronavirus (COVID-19) Disease UPDATE

We continue to work closely with the Centers for Disease Control and Prevention (CDC) and other Federal agencies to monitor and respond to the current outbreak of Novel Coronavirus (COVID-19) in the United States.

VA has received its first confirmed case of a COVID-19 positive Veteran at the Palo Alto VA Medical Center. First, I want to allay fears. VA has a comprehensive plan in place to protect the health of everyone who visits or works at one of our facilities. And while we must be prepared as a health care organization, the CDC still considers COVID-19 to be a low threat to the general American public. For people in communities where the ongoing community spread of COVID-19 has been reported, the risk of exposure is elevated but still relatively low.

That said, preparation is a team approach, and everybody needs to be involved. It is imperative that all VHA employees understand and adhere to the Standard, Contact, and Airborne Precautions, which include the use of Personal Protective Equipment (PPE). Healthcare personnel evaluating or treating a patient suspected or confirmed to have a COVID-19 infection should use these precautions. In addition, it is critical that all facilities and VISNs communicate COVID-19 outbreak-related information to the Emergency Management Coordination Cell (EMCC) at OEMEMCCCmdStaff@va.gov so we can maintain accurate, up-to-date information to respond to this rapidly changing situation.

All VA medical facilities are implementing screening measures for signs of respiratory illness and exposure to COVID-19. Via telehealth services, we will provide a first line of defense using virtual screening for symptoms or exposure. Onsite, we will use standardized screening questions at appointment check in and during initial clinical screening. The [High Consequence Infection \(HCI\) SharePoint](#) site has screening scripts and resources.

Prevention is the best medicine. To protect yourselves and others, wash your hands often for 20 seconds or the length of two happy birthday songs, avoid touching your face, cover coughs and sneezes, get a flu shot if you haven't already, avoid other people who are sick, and importantly, stay home if you are sick. If you notice that a fellow employee has come to work sick, encourage them to take leave. Our goal is to prevent COVID-19 infections from spreading within VA while maintaining our usual high level of care for all Veterans.

Follow CDC Guidance

People who show symptoms of COVID-19, including fever, cough, shortness of breath, or have had exposure to a confirmed case of COVID-19 should wear a facemask and isolate themselves from others.

Currently, the CDC does not recommend that people who are well wear PPE (e.g., facemasks) to protect themselves from COVID-19 and other respiratory diseases in the community.

Please know that PPE does not fully protect a healthy person from becoming infected. Instead it is for use by people with symptoms to attempt to prevent the spread of infection.

Stay Informed

COVID-19 specific guidance developed by VA's Emergency Management Coordination Cell (EMCC) is available on the [HCI SharePoint](#) site. The site includes information on prevention, screening/diagnosis/treatment, Infection Control, Communications, Administration, and a series of frequently asked questions (FAQs).

Links to the CDC Website and resources are also on the SharePoint site. You can also visit [VA's Public Health Website](#) for general updates to the public.

It is important for us all to work together to protect ourselves from infection, keep our facilities clean, follow CDC guidelines to evaluate and care for Veterans with potential exposure and symptoms of respiratory illness, and maintain our focus on doing our jobs to the best of our abilities.

Richard A. Stone, MD
Executive In Charge, VHA

Travel Message from VA Secretary

A MESSAGE FROM THE SECRETARY

Important Information Regarding the Novel Coronavirus (COVID-19)

As the expanding global outbreak of COVID-19 continues, your health and safety as members of the Department of Veterans Affairs (VA) workforce remains a top priority.

Although the risk of contracting COVID-19 remains low, employees should be proactive in reducing the spread of disease by taking preventative actions, including:

- Cover your mouth and nose with a tissue when you cough or sneeze.
- Wash your hands often with soapy water for at least 20 seconds.
- Use alcohol-based hand sanitizer (at least 60% alcohol) if soap and water are not available.
- Clean and disinfect frequently touched objects and surfaces.
- Do not touch your eyes, nose, or mouth with unwashed hands.
- Stay home when you are sick.

Information about COVID-19 is available on the VHA High Consequence Infection [SharePoint](#) site. The site includes information on prevention, screening/diagnosis/ treatment, infection control, communications, administration, and a series of frequently asked questions. You can also visit [VA's Public Health Website](#) for general updates to the public. The Centers for Disease Control and Prevention (CDC) continues to provide [updates](#) and insight from medical professionals about how to protect you and your loved ones from COVID-19.

The VA Office of the Chief Human Capital Officer, in collaboration with Office of Personnel Management, has issued several Bulletins on HR topics that can be found on the [HR Emergency Resource Center website](#). If you have questions regarding leave or telework flexibilities available in dealing with COVID-19, please speak with your supervisor or human resources office to discuss your specific concerns.

VA is monitoring the situation and will share updates as the situation evolves. We remain deeply appreciative of your continued service to our Veterans, the Department, and the Nation.

Robert L. Wilkie

Congressional Messages

Veterans Health Administration Novel Coronavirus (COVID-19) Congressional One-Pager Current as of March 4, 2020

The Veterans Health Administration (VHA) is working closely with the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS) and other Federal agencies to monitor and respond to the current outbreak of Novel Coronavirus (COVID-19) in the United States. VHA is operating in accordance with CDC guidance and actively participating in response efforts in local communities to address the outbreak.

VHA Actions

VHA has a comprehensive plan in place to protect the health of everyone who visits or works at one of our facilities. The Emergency Management Coordination Cell (EMCC) has been activated and is working diligently to respond to this rapidly changing situation. Supply chain measures are in place, negative airflow beds are available across VHA facilities, and testing kits have been made available.

VHA is reinforcing adherence to the Standard, Contact, and Airborne Precautions, which include the use of Personal Protective Equipment (PPE). Healthcare personnel evaluating or treating a patient suspected or confirmed to have a COVID-19 infection have been directed to use these precautions.

VHA is conducting frequent, repeated communications with employees on the importance of common sense behaviors for reducing the spread of illness, including washing hands for at least 20 seconds, avoiding touching their faces, covering coughs and sneezes, getting vaccinated against the flu, avoiding other people who are sick, and encouraging employees to stay home if they are sick.

In addition, VHA is heavily encouraging Veterans to call their local medical center before visiting the facility and telling them to consider using [VA's telehealth and virtual care options](#) like VA Video Connect. VA's telehealth providers can evaluate their symptoms and provide a diagnosis and comprehensive care.

Screening at VHA Facilities

All VA medical facilities are in the initial stages of implementing screening measures for signs of respiratory illness and exposure to COVID-19. Via telehealth services, VHA will provide a first line of defense using virtual screening for symptoms or exposure. Standardized screening questions are in place for all administrative call centers and Clinical Contact Centers (CCC). Onsite at medical facilities, VHA is instituting

screening at all points of entry and following escalation pathways for positive screening. Facilities will use standardized screening questions at appointment check in and during initial clinical screening. In addition, facilities will use a two-tiered system with an “active” COVID-19 zone and a “passive” zone for standard care unrelated to COVID-19.

Patient Privacy

As a reminder, VHA cannot release Personally Identifying Information (PII) about patients, in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Visit [VA's Public Health Website](#) for the latest updates.

Further Detail on Screening (March 5 DUSHOM Message)

The Department of Veterans Affairs (VA) and Veterans Integrated Service Network (VISN) _____ are paying special attention to Veteran health due to the COVID-19 (Novel Coronavirus) outbreak and escalation. This effort is coordinated at the VA, Veterans Health Administration, and VISN levels to impact operations in all our facilities. VA is working closely with the Centers for Disease Control and other federal agencies, as you are already aware, to address the outbreak. Our staff is taking precautions to safeguard everyone in VA facilities.

This morning, VHA's Executive in Charge, Dr. Richard Stone, directed VHA facilities to conduct a screening process, with restricted access, to mitigate the risk of COVID-19. Leadership at our medical centers and clinics are assuring that staff minimize entry to as few entryways as necessary, and staff them for controlled access, based on a screening process.

The screening consists of three questions:

1. Do you have a fever? Do you have a worsening cough or flu-like symptoms?
2. Have you traveled to China, Japan, Italy, Iran or South Korea in the last 14 days?
3. Have you been in close contact with someone, including health care workers, confirmed to have the coronavirus disease?

Patients and staff are being advised of proper protocols to address the virus through signage, electronic messaging in facilities, on the web and through social media. Staff have been provided scripts for screening visitors and for handling patients who answer screening questions affirmatively.

A process is in place to report and track Veterans and staff who screen positively for COVID-19. Those individuals will also be taken through a complete protocol that helps them and protects staff and others. Staff have been advised of the risks and the steps to take if they find themselves feeling affected.

Messaging about COVID-19 Positive Patients/Employees

These are template messaging that will need to be adjusted per situation and **approved through VHA Communications and OPIA.**

Positive

Puget Sound

On March 5, 2020, VA Puget Sound Health Care System evaluated and tested a Veteran for Coronavirus (COVID-19). VA Puget Sound was able to discharge the Veteran home based on clinical status with instructions for home isolation and self-care according to Centers for Disease Control and Prevention guidelines. After receiving the presumptive positive COVID-19 test results, VA Puget Sound is collaborating with the local health jurisdiction for monitoring.

The risk of transmission to other patients and staff remains low, as the Veteran is in isolation at home and VA continues to follow Centers for Disease Control guidelines in treating the patient.

VA is screening Veterans and staff who present with symptoms of fever, cough, and shortness of breath who meet the CDC criteria for evaluation of COVID-19 infection. Per CDC guidance and VA protocols, individuals known to be at risk for a COVID-19 infection are immediately isolated to prevent potential spread to others.

Veterans and staff are encouraged to take every day preventative 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.

For more information about the Coronavirus, please visit:

<https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

Palo Alto

A Veteran who has tested positive for Coronavirus (COVID-19) was transferred to VA Palo Alto Health Care System (VAPAHCS) for treatment Monday, March 2, 2020. This is the first confirmed case to be treated at a VA health care facility.

Presumptively Test Positive

Persons with a positive test performed locally without CDC lab confirmation
<https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html>

Southern Nevada

A Veteran inpatient presumptively tested positive for Coronavirus (COVID-19) March 4 at the VA Southern Nevada Healthcare System. The facility is awaiting confirmatory results from the Centers for Disease Control.

The risk of transmission to other patients and staff remains low, as the Veteran is being cared for in isolation by staff who are specially trained on the latest Centers for Disease Control treatment guidelines and utilizing personal protective equipment and infection control techniques.

VA is screening Veterans and staff who present with symptoms of fever, cough, and shortness of breath who meet the CDC criteria for evaluation of COVID-19 infection. Per CDC guidance and VA protocols, individuals known to be at risk for a COVID-19 infection are immediately isolated to prevent potential spread to others.

Veterans and staff are encouraged to take every day preventative 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.

For more information about the Coronavirus, please visit:
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

Not Confirmed or Presumed

We only send releases for presumptive positive or positive COVID-19 infection results. We don't send releases for suspected cases or "persons under investigation."

All Employee Messaging

Goal: Provide employee update timely notifications of presumptive and confirmed cases

Key messages:

- VA is committed to protecting our staff and uninfected patients, limiting the spread of COVID-19 transmission
- Employees are all bound by HIPAA regulations (Health Insurance Portability and Accountability Act) and must respect patient privacy
- Quarantine is for people who could have been exposed and are waiting to see if they become sick; Isolation is for someone who is already sick
- Each facility has processes/procedures in place to screen for signs of respiratory illness and to ensure inventory of personal protective equipment (PPE)
- Staff who feel sick with fever or cold/flu symptoms should call in sick and contact their provider; If at work, staff should put on a mask and arrange with their supervisor to go home and call their provider
- Continue to practice good baseline hand hygiene and use PPE as indicated.

Samples:

 All Employee Message Template_M	 All Employee Message Template 2.	 All Employee Message Template 3.	 Adobe Acrobat Document	 COVID-19 Employee Education_update.ppt
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Signage

Goal: Inform internal audience of extra safety precautions to mitigate spreading of coronavirus

Samples:

 ~WRO1510.doc	 Coronavirus Alert Poster 2-28-2020 Ve	 Coronavirus Alert Poster 2-25-2020a.p	 Coronavirus Alert Poster 2-29-2020 Ve	
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Messages to Veterans

Goal: Inform Veterans of extra safety precautions to mitigate spreading of coronavirus through GovDelivery or other medium

Samples:

 Adobe Acrobat PDFXML Document				
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VETResources Messages:

02/05/2020: <https://content.govdelivery.com/accounts/USVA/bulletins/279037e>

02/26/2020: <https://content.govdelivery.com/accounts/USVA/bulletins/27c83fd>

Social Media

Blog:

VA is ready for coronavirus—and working to protect you

Planning to visit a VA health care facility? Here's what to expect

By now, you've heard about the coronavirus disease, known as COVID-19, that's causing respiratory illness around the world.

Fortunately, VA is ready. We have plans in place to protect everyone who gets care, visits or works at one of our facilities.

For Veterans, families and visitors, that means your VA visit will be different for a while. If you're a Veteran seeking medical care, call before visiting—even if you already have an appointment. Or you can sign in to MyHealthVet and send a secure message. You may be able to get diagnosed and receive care through VA telehealth without having to come in at all.

If you do visit a VA hospital, clinic, community living center or other health care facility, you'll be met at the entrance by a VA staff. They will greet you and ask three screening questions:

1. Do you have a fever? Do you have a worsening cough or flu-like symptoms?
2. Have you traveled to China, Japan, Italy, Iran or South Korea in the last 14 days?
3. Have you been in close contact with someone, including health care workers, confirmed to have the coronavirus disease?

Depending on your answers, a VA health care professional will assist you on the next steps of your visit.

If you're a Veteran coming in for an appointment, plan to leave home a little earlier than usual to allow time for the screening.

We're doing all we can to make sure everyone in every VA facility—patients, families, visitors, staff and anyone else—stays as safe as possible during this situation. For the latest VA updates on the coronavirus and common-sense tips on preventing the spread of disease, visit www.publichealth.va.gov.

VANTAGE Blog published on January 31 and continually updated since:

<https://www.blogs.va.gov/VAntage/70999/cdc-coronavirus-information-and-resources/>

Facebook

Veterans: VA is ready for coronavirus—which means in order to protect you, your family and every Veteran, your VA visit will be different from what you're used to. If you're coming in for a health care visit, stop and call first, or send a secure message through MyHealthVet—even if you have an appointment. You may be able to get diagnosed and receive care through VA telehealth without having to leave home. If you do visit, plan to get there earlier than usual to answer three simple screening questions. It's for everyone's safety! Find out more: (blog URL)

Twitter

#Veterans: #VA is ready for coronavirus, w/ changes that affect you. Before your appointment, call first or message your care team—you might not have to leave home. If you do need to visit a VA facility, we're doing things to protect you & your family. Find out more: (blog URL)

Both Facebook and Twitter

1. Stay informed about coronavirus. VA is prepared to protect the health and safety of staff and Veterans in our care, and is taking steps to curb the spread of respiratory illness in our facilities. <https://www.blogs.va.gov/VAntage/72072/coronavirus-be-informed-and-call-your-provider-if-symptoms-develop/>
2. Protect yourself and your loved ones against respiratory illness: Get a flu shot. Cover your coughs and sneezes. Wash hands often with soap for 20 seconds. Avoid touching your eyes, nose and mouth. Stay home if you're sick, and avoid others who are sick. <https://www.publichealth.va.gov/n-coronavirus/index.asp>
3. Your best defense against coronavirus: keep doing what you're doing to stay healthy. That means avoiding the flu. <https://www.myhealth.va.gov/mhv-portal-web/ss20200211-coronavirus>



Photos:

If you need high resolution photographs, contact [VHA Digital Media](#):



Appendix N – Acronyms

Acronym	Definition
AAMI	Advancement of Medical Instrumentation
AAR	After Action Report
ACC	Accounting Classification Codes
AEM	Area Emergency Manager
AGMP	Aerosol-Generating Medical Procedures
AHEC	All Hazards Emergency Cache
All	Airborne Infection Isolation
AIIR	Airborne Infection Isolation Room
ANSI	American National Standards Institute
ASPR	Assistant Secretary for Preparedness and Response (HHS)
AUSHO	Assistant Under Secretary for Health and Operations
BIA	Biological Incident Annex
CBOC	Community Based Outpatient Clinics
CCC	Clinical Contact Center
CDC	Centers for Disease Control and Prevention
CFO	VHA Chief Financial Officer
CMO	Chief Medical Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COP	Common Operating Picture
COVID-19	Coronavirus Disease 2019
CSCO	VISN Chief Supply Chain Officers
DA	Dispense Asset
DEMP	Disaster Emergency Medical Personnel
DHHS	United States Department Health and Human Services
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DO	District Office
DOD	Department of Defense
DPA	Defense Production Act
DUSHOM	Deputy Under Secretary for Health for Operations Management
ED	Emergency Department
EEI	Essential Element(s) of Information
ELCM	Equipment Lifecycle Management
EMAC	Emergency Management Assistance Compact
EMCC	Emergency Management Coordination Cell
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	HCI Emergency Operations Plan
EPA	Environmental Protection Agency
EPC	Emergency Program Coordinator
EPS	Emergency Pharmacy Service
ERT	P&LO Emergency Response Team
ESF	Emergency Support Functions
FCC	Federal Coordinating Center

Acronym	Definition
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Administration
FFR	Filtering facepiece respirators
FIOP	Federal Interagency Operational Plan
FMS	Federal Medical Center
HCC	Hospital Command Center
HCI	High Consequence Infection
HCP	Healthcare Personnel
HCW	Healthcare Workers
HEPA	High-Efficiency Particulate Air
HHS	Health and Human Services (Federal)
HIPAA	Health Insurance Portability and Accountability Act of 1996
HOC	Healthcare Operations Center
HSEEP	Homeland Security Exercise Evaluation Program
HSPD	Homeland Security Presidential Directive
IAP	Incident Action Plan
IB	Issue Brief
ILI	Influenza-Like-Illness
ICP	Incident Command Post
ICS	Incident Command System
ICU	Intensive Care Unit
IOC	Integrated Operations Center
IPC	Infection Prevention and Control
JIC	Joint Information Center
JIS	Joint Information System
LEOC	Local Emergency Operations Center
LFA	Lead Federal Agency
LNO	Liaison Officer
Log OPR	Logistics Operations, Plans, & Readiness
MACS	Multi Agency Coordination System
MC	Medical Centers
MCM	Medical Countermeasure
MCV	Mobile Vet Centers
MERS	Middle East Respiratory Syndrome
MPU	Mobile Pharmacy Units
MRC	Medical Reserve Corps
MSPO	Medical Supply Program Office
M&A	Metrics & Analytics
NCA	National Cemetery Administration
NDMS	National Disaster Medical Services
NIMS	National Incident Management System
NPI	Non-Pharmaceutical Interventions
NRCC	National Response Coordination Center
NRF	National Response Framework
NSC	National Security Council
OCHCO	Office of the Chief Human Capital Officer
OCLA	Office of Congressional and Legislative Affairs

Acronym	Definition
OEM	Office of Emergency Management
OPIA	Office of Public and Intergovernmental Affairs
OPM	Office of Personnel Management
OPR	Office of Operations, Plans, and Readiness
PACT	Patient Aligned Care Teams
PanCAP	Pandemic Crisis Action Plan
PAO	Public Affairs Officers
PCP	Primary Care Provider
PDUSH	Principal Deputy Under Secretary for Health
PH	Population Health
PHE	Public Health Emergency
PHEIC	Public Health Emergency of International Concern
PHERA	Public Health Emergency Response Act
PIO	Public Information Officer
PO	Program Office
POD	Point of Dispensing
PPE	Personal Protective Equipment
PUI	Person Under Investigation
P&LO	Procurement & Logistics Office
RCS	Readjustment Counseling Services
RDS	Regional Dispensing Site
REM	Regional Emergency Manager
RFA	Request for Assistance
RHO	Regional Health Officer
RN	Registered Nurse
ROC	Regional Operations Center
RPO	Regional Procurement Offices
RSS	Receipt, Staging and Storing
SARS	Severe Acute Respiratory Syndrome
SEOC	State Emergency Operations Center
SitRep	Situational Reports
SLTT	State, Local, Tribal, and Territorial
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOC	HHS Secretary's Operation Center
TB	Tuberculosis
The Tracker	Issue Brief Tracker Web Application Tracker
TTX	Tabletop Exercise
U.S.	United States
U.S.C.	United States Code
USG	United States Government
USH	Under Secretary for Health
VA	Veterans Affairs
VAMC	Veteran Affairs Medical Center
VBA	Veterans Benefits Administration
VC	Vet Center
VCS	Veterans Canteen Services



Acronym	Definition
VHA	Veterans Health Administration
VISN	Veteran Integrated Service Network
Watch	VHA OEM Watch
WMC	VHA Workforce Management and Consulting
WHO	World Health Organization