U.S. Department of Veterans Affairs

Veterans Health Administration
VHA FOIA Office (105HIG)
810 Vermont Avenue NW
Washington, DC 20420

In Reply Refer To: **FOIA Request 21-07865-F**

February 15, 2022

William Marshall
Judicial Watch
425 Third Street, Suite 800
Washington, DC 20024
bmarshall@judicialwatch.org

Dear Mr. Marshall:

This letter serves as the second partial initial agency decision on your July 27, 2021 request under the Freedom of Information Act (FOIA), 5 U.S.C. § 552, submitted to the Department of Veterans Affairs (VA), FOIA Service requesting the following records:

1. All records reflecting the number, dates and types of adverse events resulting from COVID-19 vaccinations administered by VA officials, employees, contractors, hospitals, and other VA care facilities to US veterans and/or their dependents.

2. All emails sent to and from the following VA officials regarding adverse events, or potential adverse events, resulting from the administration, or planned administration, of COVID-19 vaccinations: Secretary of Veterans Affairs, Deputy Secretary of Veterans Affairs, Chief of Staff of Veterans Affairs, Under Secretary for Health, Deputy Under Secretary for Health, and the Deputy to the Deputy Under Secretary of Health.

   The time frame for the records sought is December 1, 2020 to the present.

Referral:

As indicated in their July 28, 2021 letter, the VA FOIA Service referred your request to the Veterans Health Administration (VHA) Central Office FOIA Office for further processing and direct response to you. Your FOIA request was received in my office on July 28, 2021, under FOIA tracking number 21-07865-F.

Fee Waiver:

On your July 27, 2021 request you had requested a fee waiver for search and duplication fees. 38 C.F.R. 1.561 (b)(y) indicates that News Media request is not subject to search fees or review fees. News Media requests are subject duplication fees after the first 100 pages. There are no duplication fees as this request is being sent electronically. Therefore, there are no fees assessed for this request. Please be

advised, we reserve the right to assess fees as appropriate under the FOIA on any and all future FOIA requests.

Clarification:

Per my email to you on July 29, 2021; you were advised that clarification/further information was needed for line item 2 of your request for specific search terms you would like VA and VHA to search for within the emails of the individuals within your request. On July 29, 2021, you provided the search terms of “adverse event”, “adverse events”, “adverse reaction” “adverse reactions,” “AER”, and “side effects”, each used in combination with “vaccine”, “vax” and “shot”.

Per phone conversation and via email on August 18, 2021, we discussed line item one of your request, and I informed you it would take manipulation of data to create new reports to respond to line item one of your request and VA does not create new records for FOIA requests. (See Frank v. DOJ, 941 F. Supp. 4, 5 (D.D.C. 1996) (stating that agency is not required to "dig out all the information that might exist, in whatever form or place it might be found, and to create a document that answers plaintiff's questions"); Krohn v. DOJ, 628 F.2d 195, 197-98 (D.C. Cir. 1980) (finding that agency "cannot be compelled to create the [intermediary records] necessary to produce" information sought); Schoenman v. FBI, No. 04-2202, 2009 WL 763065, at *17-18 (D.D.C. Mar. 19, 2009) (rejecting plaintiff's request for search slips, created by agency after date-of-search cut-off date, holding that "FOIA 'does not obligate agencies to create or retain documents; it only obligates them to provide access to those which it in fact has created or retained'" (quoting Schoenman v. FBI, 573 F. Supp. 2d 119, 140 (D.D.C. 2008))); Moore v. Bush, 601 F. Supp. 2d 6, 15 (D.D.C. 2009) (finding that agency properly refused to issue various statements regarding brain wave technology because FOIA does not require creation of records); West v. Spellings, 539 F. Supp. 2d 55, 61 (D.D.C. 2008) (recognizing that Department of Education had no duty to create list of uninvestigated complaints to satisfy request). However, VHA does have an updated PowerPoint presentation from August 2021 on Vaccine Adverse Events Reporting within the VA that breaks down specific symptoms and provides data on reports of adverse events along with the top 10 symptoms from COVID 19 Vaccines. You agreed this information would be beneficial as you are looking for updated information.

Per email discussions dated September 30, 2021 and December 1, 2021, we came to agreement to further narrow down the scope of the request pertaining to line item 2, to exclude media clip emails and apply the following more detailed search terms: “adverse event and vaccine”, “adverse event and vax”, “adverse event and shot”, “adverse events and vaccine”, “adverse events and shot”, “adverse events and vax”, “adverse reaction and vaccine”, “adverse reaction and vax”, “adverse reaction and shot”, “adverse reactions and vaccine”, “adverse reactions and vax”, “adverse reactions and shot”, “COVID and adverse event”, and “COVID and adverse reaction”.

Initial Agency Decisions:

On August 26, 2021, VHA released the first partial initial agency decision. This release contained one (1) PowerPoint document, totaling ten (10) slides responsive to line item 1 of your FOIA request. All information was provided in its entirety. No portions of the requested records were withheld either in whole or in part. PBM indicated the slide set contained summary data of all adverse events reported for both employees and Veterans. These reports are spontaneously reported and unvalidated so true causality of the adverse event cannot be stated.

At this time, VHA is rendering a second partial initial agency decision. Provided is six hundred thirty-six (636) pages of responsive records. These documents resulted in an online search conducted by the VA Office of Information and Technology responsive on the accounts of Richard A. Stone, date range December 1, 2020 – August 2, 2021; Steven Lieberman, date range December 1, 2020 – August 2, 2021 and Mark Upton, date range of July 17, 2021 – August 2, 2021, using the following search terms: "adverse event and vaccine", "adverse event and vax", "adverse event and shot", "adverse events and vaccine", "adverse events and shot", "adverse events and vax", "adverse reaction and vaccine", "adverse reaction and vax", "adverse reaction and shot", "adverse reactions and vaccine", "adverse reactions and vax", "adverse reactions and shot", "COVID and adverse event", and "COVID and adverse reaction". At the conclusion of the search, there were six hundred and sixty-five (665) emails totaling twenty four thousand, five hundred thirty-two (24,532) pages that were determined responsive to this request, based upon the search terms applied.

Upon my review, I have found information protected under FOIA, specifically FOIA exemption 3, 5 U.S.C. § 552(b)(3), 38 U.S.C. § 5705, FOIA exemption 5, 5 U.S.C. § 552(b)(5), and FOIA exemption 6, 5 U.S.C. § 552(b)(6).

My review of the documents revealed they contained information that falls within the disclosure protections of FOIA Exemption 3, 5 U.S.C. § 552(b)(3). FOIA Exemption 3 permits VHA to withhold VHA Patient Safety reports under FOIA Exemption 3, 5 U.S.C. § 552 (b)(3). FOIA Exemption 3 specifically exempts from disclosure all information that is specifically prohibited from disclosure by another federal statute. The applicable statute is 38 U.S.C. § 5705 which prohibits the unauthorized disclosure of designated VA medical quality assurance records. Consequently, VA denies portions of your request for this information under FOIA Exemption 3, 5 U.S.C. § 552(b)(3), citing 38 U.S.C. § 5705.

FOIA Exemption 5 permits VA to withhold a document or information contained within a document as "pre-decisional" if two requirements are met. First, if there is an identifiable deliberative process. Second, the agency generated the information or document as part of the agency decision process. Stated another way, VA may withhold information under Exemption 5 where the document or its content makes recommendations or expresses opinions about legal or policy matters during a decision-making process and the document is not the decision document or incorporated into the decision document. Additionally, as a

matter of Federal policy, the agency must state an articulable, foreseeable harm to the agency or its activities that could occur as a result of release of the document or information.

My review of the documents identified as responsive to your FOIA request reveals that they contain information that falls within the protection of Exemption 5. Specifically, drafts responses and draft policies within the attached emails are being withheld under Exemption 5. Therefore, portions of the document's status are pre-decisional as VHA's decision regarding the final response during these emails was not yet made and release of this information would cause injury to the deliberative process. The deliberative process privilege of Exemption 5 is invoked as it is determined that the release of the pre-decisional document to the public would negatively impact frank discussion on matters of policy between subordinates and supervisors. Additionally, it is my conclusion that the release would cause premature disclosure of proposed polices based on the recommendations before they are actually adopted thus creating public confusion from disclosure of reasons and rationales that were not in fact ultimately the grounds for an Agency action. Release of the documents may confuse the public, as the information contained within the report may not be consistent with the final actions of VHA. VHA seeks a full, unbiased review of these records. Protection of the decision-making process will help to ensure this result. Consequently, VA denies portions of your request for this information under FOIA Exemption 5, 5 U.S.C. § 552(b)(5).

Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information would constitute a clearly unwarranted invasion of a living individual's personal privacy. Stated another way, VA may withhold information under FOIA exemption 6 where disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government.

Specifically, the information I am withholding, as indicated on the enclosed documents, under FOIA Exemption 6 consists of names, email addresses, phone numbers of non-VA employees, as I have determined that the individuals have a personal privacy interest in their identity that is not outweighed by the public's interest. Also, withheld are the email addresses and telephone numbers of VA employees. It is noted that releasing the email address could lead to harassment and or attempted direct contact with the individual. See, Cameranesi v. DOD, 856 F.3d 626, 642 (9th Cir. 2017) "We have never held that an agency must document that harassment or mistreatment have happened in the past or will certainly happen in the future; rather, the agency must merely establish that disclosure would result in a 'potential for harassment'" quoting Forest Serv. Emps. for Envtl. Ethics v. U.S. Forest Serv., 524 F.3d 1021, 1026 9th Cir. 2008. Consequently, I have inserted (b6) to identify the FOIA Exemption applied. Individuals associated with this information have a personal privacy interest in the information that outweighs any public interest served by disclosure of the information under FOIA.

The coverage of FOIA exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the materials you provided, we have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest in this case. Consequently, redactions were made to protect information withheld under FOIA exemption 6, 5 U.S.C. § 552 (b)(6).

VHA will continue to review and provide responses on a rolling basis.

Please be advised you may appeal my determinations made within this letter to:

Office of the General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
Email: ogcfoiaappeals@va.gov

If you should choose to file an appeal, your appeal must be postmarked or electronically transmitted no later than ninety (90) calendar days from the date of this letter. Please include a copy of this letter with your written appeal and clearly state why you disagree with the determinations set forth in this response.

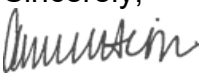
You may also seek assistance and/or dispute resolution services for any other aspect of your FOIA request, excluding the release determination, from VHA's FOIA Public Liaison and/or Office of Government Information Services (OGIS) as provided below:

VHA FOIA Public Liaison:
Email Address: vhafoia2@va.gov
Phone Number: (877) 461-5038

Office of Government Information Services (OGIS)
Email: ogis@nara.gov
Fax: (202) 741-5769
Mailing address:
Office of Government Information Services
National Archives and Records Administration
8601 Adelphi Road
College Park, MD 20740-6001

Thank you for your interest in VA. If you have any further questions, please feel free to contact me at (319) 530-7694 or via email at Amber.Heim@va.gov.

Sincerely,



Amber Heim
VHA FOIA Officer

Enclosure: Release 2 – 636 pages

From: Klein, David P. (HEFP/19HEF)
Sent: Wed, 14 Apr 2021 01:36:03 +0000
To: Lieberman, Steven
Cc: Litvin, Ed;Hewson, Rachel L (HEFP/19HEF);Cook, Jacqueline (HEFP/10NA5B)
Subject: RE: J&J Employee Vaccinations Rxns

Will do.

Respectfully,

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

Did our service meet your expectations today?
HEFP Customer Experience Survey

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 09:30 PM
To: Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Thank you! An update by tomorrow would be great.

From: Klein, David P. (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 9:29 PM
To: Lieberman, Steven (b)(6)
Cc: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Dr. Lieberman,

OIT is working to provide names, and, if possible, email addresses. Will advise when I hear more. Not sure whether that will be tonight.

Respectfully,

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)

Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

Did our service meet your expectations today?
HEFP Customer Experience Survey

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 09:10 PM
To: Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

I heard you are working with OIT. If that is true, I will wait to see what they can do to help resolve this. Otherwise, perhaps we can compared against employee lists from each VISN. THanks again

---

From: Klein, David P. (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 8:47 PM
To: Lieberman, Steven (b)(6)
Cc: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

Dr. Lieberman,

During a review of the data from the Occupational Health Record System (OHRS) 2.0, it was determined that some employees were not being correctly associated with the VISN in which the vaccine was administered. Staff from VA OIT are working with the contractor to resolve this problem. It is not clear at this time when the problem will be resolved.

Currently, we can report that a total of 1,223 female employees, age 55 or under, have received Janssen during the last 14 days. However, we cannot provide a breakdown by VISN at this time.

In addition: there are 352 records beyond that, of employees who received Janssen, are age 55 or under, and for whom the system does not provide a gender.

I apologize that we are not able to provide more comprehensive information at this time. We will forward updated information as soon as we receive it.

Respectfully,

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration

Office: (b)(6)
Cell: (b)(6)

Did our service meet your expectations today?
HEFP Customer Experience Survey

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 05:27 PM
To: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) <(b)(6)@va.gov>
Subject: RE: J&J Employee Vaccinations Rxns

Need to provide an update to the Sec VA on number of women staff 55 and under receiving vaccine in the last 14 days at 8am. I have not seen anything yet other than the HOC estimates of 2193 male and female staff fell into this cohort based upon data they have. Thanks for your help with this.

From: Litvin, Ed (b)(6)
Sent: Tuesday, April 13, 2021 4:10 PM
To: Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6) Lieberman, Steven (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: Re: J&J Employee Vaccinations Rxns

Adding in Dr. Lieberman

Thank you Rachel. Have the VISN contact lists been distributed?

Ed Litvin
Deputy AUSH for Support Services

From: Hewson, Rachel L (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 3:50:45 PM
To: Klein, David P. (HEFP/19HEF) (b)(6) Litvin, Ed (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Total: 2,809 total Females employees under age 55 received Janssen.
In addition: there are 352 records beyond that, that received Janssen, are under the age of 55 and did not provide a gender.

Rachel L. Hewson MSN, RN COHN-S

Clinical Occupational Health Program Manager for Policy Oversight (COHPM-POL)
Office of Occupational Safety and Health (19HEFB)
VHA Office of Healthcare Environment and Facilities Programs (HEFP)
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420
Office: (b)(6) X2208
Cellular: (b)(6)
(b)(6)
(b)(6)

We appreciate your feedback! Please **tell us how we're doing.**

Check out the new EOH SharePoint site.

From: Klein, David P. (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 1:32 PM
To: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Ed,

Thanks for the clarification!

Dave

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

Did our service meet your expectations today?
HEFP Customer Experience Survey

From: Litvin, Ed (b)(6)
Sent: Tuesday, April 13, 2021 02:28 PM
To: Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF)
(b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Dave, Rachel,

Thanks for working this emergency today. Dr. Lieberman just now requested that he receive a summary total by VISN of the number of employees in this category. That will save him time avoiding the math/addition work. He does not need the names/contact info for his purposes. You can send that directly to him and please copy me as well.

Thanks!

Ed

Did we in Healthcare Environment and Facilities Programs meet your needs today?
HEFP Customer Experience Survey

From: Hewson, Rachel L (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 1:43 PM
To: Litvin, Ed (b)(6) Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

The OHRS 2.0 team is working on the report(s) right now. They were able to deactivate the option in OHRS 2.0 so JJ cannot be selected until further notice. I am also in contact with the Privacy Office, I have reservations about passing a list of vaccinated employees to a group of people, only to pass that list to another group of people: privacy and confidentiality of medical health information.

As soon as I have a word on the reports, I will apprise you both. Ed, if acceptable, please send me the invite for this afternoon's meeting.

Rachel L. Hewson MSN, RN COHN-S
Clinical Occupational Health Program Manager for Policy Oversight (COHPM-POL)
Office of Occupational Safety and Health (19HEFB)
VHA Office of Healthcare Environment and Facilities Programs (HEFP)
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420
Office: (b)(6) (b)(6)
Cellular: (b)(6)
(b)(6)
(b)(6)

We appreciate your feedback! Please **tell us how we're doing.**

Check out the new EOH SharePoint site.

From: Litvin, Ed (b)(6)
Sent: Tuesday, April 13, 2021 12:31 PM
To: Klein, David P. (HEFP/19HEF) (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Any luck with this? I need to loop back to Dr. Lieberman soon. There is another national call on this at 400 pm today with the VISNs.

Ed

Did we in Healthcare Environment and Facilities Programs meet your needs today?
HEFP Customer Experience Survey

From: Klein, David P. (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 12:28 PM
To: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Ed,

The OHRS team brought up the privacy issue. If the names can be pulled, what would be done with the names? Who would have access to the names?

Thanks,

Dave

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

Did our service meet your expectations today?
HEFP Customer Experience Survey

From: Litvin, Ed (b)(6)
Sent: Tuesday, April 13, 2021 11:33 AM
To: Klein, David P. (HEFP/19HEF) (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

Dave, here's the background of the request from Dr. Lieberman. We need to pull a contact list sorted by VISN and facility so that the field can contact those staff in the female under-55 category. Please let me know what we can provide on this.

Ed

Did we in Healthcare Environment and Facilities Programs meet your needs today?
HEFP Customer Experience Survey

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 11:21 AM
To: Litvin, Ed (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

It is actually 55 and younger females we are looking for. thanks

---

From: Mimnall, Rebecca (b)(6)
Sent: Tuesday, April 13, 2021 11:15 AM
To: Lieberman, Steven (b)(6) Oshinski, Renee (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

FYI on the communications here. I will keep you updated if we need any additional pressure.

From: Mimnall, Rebecca (b)(6)
Sent: Tuesday, April 13, 2021 10:59 AM
To: Hubert, Terrence L. (b)(6) Cook, Jacqueline (HEFP/10NA5B) (b)(6) VHA EOH Program Questions (b)(6)
Cc: Czarnecki, Tammy (b)(6) VHA 15HOC Healthcare Ops Ctr Action (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Notably per the meeting today, we are going to need to get a contact list for employees who have received J&J, ideally by gender and age so that women under 55 can be targeted. Dr. Stone has requested facilities begin contacting folks today.

Can OHRS team pull that?

From: Hubert, Terrence L. (b)(6)
Sent: Tuesday, April 13, 2021 9:20 AM
To: Cook, Jacqueline (HEFP/10NA5B) (b)(6) VHA EOH Program Questions (b)(6)
Cc: Czarnecki, Tammy (b)(6) VHA 15HOC Healthcare Ops Ctr Action (b)(6)
Subject: J&J Employee Vaccinations Rxns
Importance: High

Jackie and Team,

Have we picked up any employee related adverse reactions, even if delayed a week or two, to vaccine within OHRS – specifically J&J?

Thank you,

Terry

Terrence Hubert, Ph.D.

Acting Director Monitoring and Analytics
Heathcare Operations Center (15HOC)
Veterans Health Administration
Office (b)(6)
(b)(6)

From: Litvin, Ed
Sent: Wed, 14 Apr 2021 00:36:06 +0000
To: Lieberman, Steven
Subject: RE: J&J Employee Vaccinations Rxns

Dr. Lieberman,
Our folks are working this but have discovered a data element problem that identifies the VISN. VA OIT is working on the problem and they have promised that the data will be provided tonight. Dave Klein will send it along to you this evening as soon as possible.

Ed

Did we in Healthcare Environment and Facilities Programs meet your needs today?
HEFP Customer Experience Survey

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 5:27 PM
To: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

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To: Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6) Lieberman, Steven (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: Re: J&J Employee Vaccinations Rxns

Adding in Dr. Lieberman

Thank you Rachel. Have the VISN contact lists been distributed?

Ed Litvin
Deputy AUSH for Support Services

From: Hewson, Rachel L (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 3:50:45 PM
To: Klein, David P. (HEFP/19HEF) (b)(6) Litvin, Ed (b)(6)

Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

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Rachel L. Hewson MSN, RN COHN-S
Clinical Occupational Health Program Manager for Policy Oversight (COHPM-POL)
Office of Occupational Safety and Health (19HEFB)
VHA Office of Healthcare Environment and Facilities Programs (HEFP)
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Sent: Tuesday, April 13, 2021 1:32 PM
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Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Ed,

Thanks for the clarification!

Dave

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

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Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Dave, Rachel,
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VHA Office of Healthcare Environment and Facilities Programs (HEFP)
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Sent: Tuesday, April 13, 2021 02:28 PM
To: Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Dave, Rachel,
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As soon as I have a word on the reports, I will apprise you both. Ed, if acceptable, please send me the invite for this afternoon's meeting.

Rachel L. Hewson MSN, RN COHN-S
Clinical Occupational Health Program Manager for Policy Oversight (COHPM-POL)
Office of Occupational Safety and Health (19HEFB)
VHA Office of Healthcare Environment and Facilities Programs (HEFP)
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420
Office: (b)(6) X2208
Cellular: (b)(6)
(b)(6)
(b)(6)

We appreciate your feedback! Please **tell us how we're doing.**

Check out the new EOH SharePoint site.

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Ed,

The OHRS team brought up the privacy issue. If the names can be pulled, what would be done with the names? Who would have access to the names?

Thanks,

Dave

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

Did our service meet your expectations today?
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HEFP Customer Experience Survey

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To: Litvin, Ed (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

It is actually 55 and younger females we are looking for. thanks

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Sent: Tuesday, April 13, 2021 11:15 AM
To: Lieberman, Steven (b)(6) Oshinski, Renee (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

FYI on the communications here. I will keep you updated if we need any additional pressure.

From: Mimnall, Rebecca (b)(6)
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Cc: Czarnecki, Tammy (b)(6) VHA 15HOC Healthcare Ops Ctr Action (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

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Can OHRS team pull that?

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Cc: Czarnecki, Tammy (b)(6) VHA 15HOC Healthcare Ops Ctr Action (b)(6)
Subject: J&J Employee Vaccinations Rxns
Importance: High

Jackie and Team,

Have we picked up any employee related adverse reactions, even if delayed a week or two, to vaccine within OHRS – specifically J&J?

Thank you,

Terry

Terrence Hubert, Ph.D.

Acting Director Monitoring and Analytics
Heathcare Operations Center (15HOC)
Veterans Health Administration
Office (b)(6)
(b)(6) @va.gov

From: Lieberman, Steven
Sent: Wed, 14 Apr 2021 01:08:49 +0000
To: Klein, David P. (HEFP/19HEF)
Cc: Litvin, Ed;Hewson, Rachel L (HEFP/19HEF);Cook, Jacqueline (HEFP/10NA5B)
Subject: RE: J&J Employee Vaccinations Rxns

Thanks for letting me know. Do you have the names that you can share and I can identify a way to figure this out? We need to reach out to them for their safety purposes. We cannot wait an indefinite time. I appreciate your efforts here.

From: Klein, David P. (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 8:47 PM
To: Lieberman, Steven (b)(6)
Cc: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: FW: J&J Employee Vaccinations Rxns

Dr. Lieberman,

During a review of the data from the Occupational Health Record System (OHRS) 2.0, it was determined that some employees were not being correctly associated with the VISN in which the vaccine was administered. Staff from VA OIT are working with the contractor to resolve this problem. It is not clear at this time when the problem will be resolved.

Currently, we can report that a total of 1,223 female employees, age 55 or under, have received Janssen during the last 14 days. However, we cannot provide a breakdown by VISN at this time.

In addition: there are 352 records beyond that, of employees who received Janssen, are age 55 or under, and for whom the system does not provide a gender.

I apologize that we are not able to provide more comprehensive information at this time. We will forward updated information as soon as we receive it.

Respectfully,

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
Cell: (b)(6)

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To: Litvin, Ed (b)(6) Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Need to provide an update to the Sec VA on number of women staff 55 and under receiving vaccine in the last 14 days at 8am. I have not seen anything yet other than the HOC estimates of 2193 male and female staff fell into this cohort based upon data they have. Thanks for your help with this.

From: Litvin, Ed (b)(6)
Sent: Tuesday, April 13, 2021 4:10 PM
To: Hewson, Rachel L (HEFP/19HEF) (b)(6) Klein, David P. (HEFP/19HEF) (b)(6) Lieberman, Steven (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: Re: J&J Employee Vaccinations Rxns

Adding in Dr. Lieberman

Thank you Rachel. Have the VISN contact lists been distributed?

Ed Litvin
Deputy AUSH for Support Services

From: Hewson, Rachel L (HEFP/19HEF) (b)(6)
Sent: Tuesday, April 13, 2021 3:50:45 PM
To: Klein, David P. (HEFP/19HEF) (b)(6) Litvin, Ed (b)(6)
Cc: Cook, Jacqueline (HEFP/10NA5B) (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Total: 2,809 total Females employees under age 55 received Janssen.
In addition: there are 352 records beyond that, that received Janssen, are under the age of 55 and did not provide a gender.

Rachel L. Hewson MSN, RN COHN-S
Clinical Occupational Health Program Manager for Policy Oversight (COHPM-POL)
Office of Occupational Safety and Health (19HEFB)
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Subject: RE: J&J Employee Vaccinations Rxns

Ed,

Thanks for the clarification!

Dave

David P. Klein, P.E.
Director, Office of Occupational Safety and Health
Healthcare Environment and Facilities Programs (19HEF)
Veterans Health Administration
Office: (b)(6)
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Terrence Hubert, Ph.D.

Acting Director Monitoring and Analytics
Heathcare Operations Center (15HOC)
Veterans Health Administration
Office (b)(6)
(b)(6)

From: Lieberman, Steven
Sent: Tue, 13 Apr 2021 15:33:58 +0000
To: Litvin, Ed
Subject: RE: J&J Employee Vaccinations Rxns

TY!

From: Litvin, Ed (b)(6)
Sent: Tuesday, April 13, 2021 11:34 AM
To: Lieberman, Steven (b)(6)
Subject: RE: J&J Employee Vaccinations Rxns

Thank you. I just spoke with Dave Klein, our program director, and he is now talking with Rachel Hewson our Occ Health Nurse who is covering the program in Dr. Cook's absence this week.

Will circle back to you once I hear what we can assist with.

Ed

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Acting Director Monitoring and Analytics
Heathcare Operations Center (15HOC)
Veterans Health Administration
Office (b)(6)
(b)(6)

From: Lieberman, Steven
Sent: Tue, 13 Apr 2021 23:40:39 +0000
To: Kim, Jane NCP;Elnahal, Shereef;Czarnecki, Tammy;Villatoro, Christopher E
Subject: RE: J&J Vaccine

Thank you. very helpful. I know you reported this before, but it was good to be reminded of this.

From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 7:38 PM
To: Lieberman, Steven (b)(6) Elnahal, Shereef (b)(6)
Czarnecki, Tammy (b)(6) Villatoro, Christopher E
(b)(6)
Subject: Re: J&J Vaccine

There is additional chart review and active surveillance analysis VHA conducts that is coordinated along with analyses of safety data from CDC and FDA to determine possible causality.

CDC's vaccine safety lead is scheduled to present during the ACIP meeting tomorrow probably to give a status update and plan on way forward.

Jane

Jane Kim, MD, MPH
Chief Consultant for Preventive Medicine
VA National Center for Health Promotion and Disease Prevention (NCP, 12POP4)
(b)(6)

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 6:44:24 PM
To: Kim, Jane NCP (b)(6) Elnahal, Shereef (b)(6) Czarnecki, Tammy
(b)(6) Villatoro, Christopher E (b)(6)
Subject: RE: J&J Vaccine

So many of the reported symptoms for moderna and Pfizer could have been unrelated to vaccine. After we report these adverse events, are we expected to review their records for any additional analyses? Thanks

---

From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 5:14 PM
To: Elnahal, Shereef (b)(6) Czarnecki, Tammy (b)(6)
Villatoro, Christopher E (b)(6) Lieberman, Steven
(b)(6)
Subject: RE: J&J Vaccine

Please see attached for an updated safety evaluation on VA's COVID-19 vaccine adverse events reports.

This includes mid-day numbers and CVA added to the events. Also broken down by employee vs Veteran.

No CVST reports for J&J, Moderna or Pfizer.

From: Elnahal, Shereef (b)(6)
Sent: Tuesday, April 13, 2021 9:57 AM
To: Kim, Jane NCP (b)(6) Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Subject: Re: J&J Vaccine

Thank you so much, very helpful.

Get Outlook for iOS

From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 9:55:12 AM
To: Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

There have been no VA reports of Cerebral Venous Sinus Thrombosis (CVST), the event that triggered the halt by FDA and CDC, for any COVID-19 vaccine product.

Please see attached for VA Adverse Drug Events Reporting System (ADERS) Adverse Events of Special Interest. Also summarized below. More detailed analysis with historical comparisons will be complete by this Thursday.
VA ADERS reports to FDA and CDC.

1. No reports of CVST for any agent
2. No report of Thrombotic stroke
3. 18 reports of Cerebrovascular Accident (CVA) (11 Moderna, 7 Pfizer, 0 Janssen)

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 9:34 AM
To: Kim, Jane NCP (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Awesome!

From: Kim, Jane NCP (b)(6)
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To: Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Pharmacy has data and is working it now. Will get it to you before 10.

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 9:32 AM
To: Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6) Kim, Jane NCP (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

We Are doing a dive in to the data- not sure when we will have any information.

From: Villatoro, Christopher E (b)(6)
Sent: Tuesday, April 13, 2021 9:18 AM
To: Czarnecki, Tammy (b)(6) Lieberman, Steven (b)(6) Kim, Jane NCP (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Tammy,

Thank you. Do we know of any issues with our patient population? Please let me know when able. Thank you.

Best,

Chris

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 5:46 AM
To: Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6) Kim, Jane NCP (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Confirmed- message pushed out through the Networks and Memo to be issued shortly

From: Villatoro, Christopher E (b)(6)
Sent: Tuesday, April 13, 2021 8:45 AM
To: Lieberman, Steven (b)(6) Kim, Jane NCP (b)(6) Czarnecki,

Tammy (b)(6) b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: J&J Vaccine

Good Morning Colleagues:

By now you have heard the request by the CDC and FDA to stop using the J&J vaccine throughout the country. Please provide confirmation that this action has been taken. Please let me know if you need anything from me. I will be in contact with our federal partners to ensure we have the latest information. Thank you.

Best Regards,

Chris

_____

Christopher Villatoro
COVID-19 Response Coordinator
US Department of Veteran Affairs
(b)(6)
Mobile: (b)(6)

From: Kim, Jane NCP
Sent: Tue, 13 Apr 2021 21:14:01 +0000
To: Elnahal, Shereef;Czarnecki, Tammy;Villatoro, Christopher E;Lieberman, Steven
Subject: RE: J&J Vaccine
Attachments: COVID VACCINE VA ADERS - CV-AESI 04_13_21_UpdateFinal.pptx

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Subject: RE: J&J Vaccine

We Are doing a dive in to the data- not sure when we will have any information.

From: Villatoro, Christopher E (b)(6)
Sent: Tuesday, April 13, 2021 9:18 AM
To: Czarnecki, Tammy (b)(6) Lieberman, Steven (b)(6)
Kim, Jane NCP (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Tammy,

Thank you. Do we know of any issues with our patient population? Please let me know when able. Thank you.

Best,

Chris

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 5:46 AM
To: Villatoro, Christopher E (b)(6) Lieberman, Steven
(b)(6) Kim, Jane NCP (b)(6)

Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Confirmed- message pushed out through the Networks and Memo to be issued shortly

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From: Villatoro, Christopher E (b)(6)
Sent: Tuesday, April 13, 2021 8:45 AM
To: Lieberman, Steven (b)(6) Kim, Jane NCP (b)(6) Czarnecki, Tammy (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: J&J Vaccine

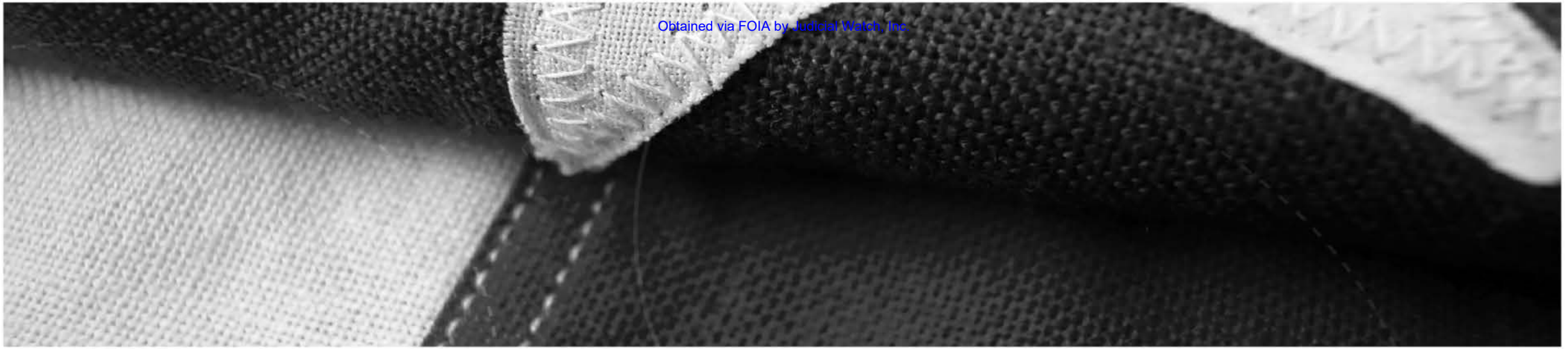
Good Morning Colleagues:

By now you have heard the request by the CDC and FDA to stop using the J&J vaccine throughout the country. Please provide confirmation that this action has been taken. Please let me know if you need anything from me. I will be in contact with our federal partners to ensure we have the latest information. Thank you.

Best Regards,

Chris

Christopher Villatoro
COVID-19 Response Coordinator
US Department of Veteran Affairs
(b)(6)
Mobile: (b)(6)



VA ADERS Summary Report

Mid-day Update 4/13/21

VA Center for Medication Safety (VAMedSAFE)

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Veterans Health Administration

VA ADERS – CV AESI Report Totals

Symptom	J&JN(/100,000)	MODERNAN(/100,000)	PFIZERN(/100,000)
CARDIAC ARREST	0	12(0.5/100,000)	5(0.23/100,000
CEREBROVASCULAR ACCIDENT	0	17(0.7/100,000)	8(0.36/100,000)
DEEP VEIN THROMBOSIS	0	4(0.16/100,000)	2(0.1/100,00)
MYOCARDIAL INFARCTION	0	6(0.24/100,000)	3(0.14/100,000)
PULMONARY EMBOLISM	0	3(0.12/100,000)	4(0.18/100,000)

VA ADERS – TIME TO EVENT (MEDIAN DAYS-RANGE)

Symptom	J&J	MODERNA	PFIZER
CARDIAC ARREST	0	3 (1-34)	1 (1-11)
CEREBROVASCULAR ACCDIENT	0	4 (0-20)	1 (0-18)
DEEP VEIN THROMBOSIS	0	8 (2-14)	15 (9-21)
MYOCARDIAL INFARCTION	0	3.5 (0-10)	0 (0-6)
PULMONARY EMBOLISM	0	6 (3-6)	6 (1-10)

VA ADERS – CV AESI Reports (Employee/Veteran Breakdown)

Symptom	J&J		MODERNA		PFIZER	
	Emp	Vet	Emp	Vet	Emp	Vet
CARDIAC ARREST	0	0	0	12	0	5
CEREBROVASCULAR ACCIDENT	0	0	5	12	0	8
DEEP VEIN THROMBOSIS	0	0	3	1	1	1
MYOCARDIAL INFARCTION	0	0	1	5	0	3
PULMONARY EMBOLISM	0	0	1	2	0	4

From: Elnahal, Shereef
Sent: Wed, 14 Apr 2021 01:57:00 +0000
To: Lieberman, Steven;Kim, Jane NCP;Czarnecki, Tammy;Villatoro, Christopher E
Subject: Re: J&J Vaccine

Thank you
Get Outlook for iOS
From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 7:40:39 PM
To: Kim, Jane NCP (b)(6) Elnahal, Shereef (b)(6) Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6)
Subject: RE: J&J Vaccine

Thank you. very helpful. I know you reported this before, but it was good to be reminded of this.

From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 7:38 PM
To: Lieberman, Steven (b)(6) Elnahal, Shereef (b)(6) Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6)
Subject: Re: J&J Vaccine

There is additional chart review and active surveillance analysis VHA conducts that is coordinated along with analyses of safety data from CDC and FDA to determine possible causality.

CDC's vaccine safety lead is scheduled to present during the ACIP meeting tomorrow probably to give a status update and plan on way forward.

Jane

Jane Kim, MD, MPH
Chief Consultant for Preventive Medicine
VA National Center for Health Promotion and Disease Prevention (NCP, 12POP4)
(b)(6)

From: Lieberman, Steven (b)(6)
Sent: Tuesday, April 13, 2021 6:44:24 PM
To: Kim, Jane NCP (b)(6) Elnahal, Shereef (b)(6) Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6)
Subject: RE: J&J Vaccine

So many of the reported symptoms for moderna and Pfizer could have been unrelated to vaccine. After we report these adverse events, are we expected to review their records for any additional analyses? Thanks

From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 5:14 PM
To: Elnahal, Shereef (b)(6) Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Subject: RE: J&J Vaccine

Please see attached for an updated safety evaluation on VA's COVID-19 vaccine adverse events reports. This includes mid-day numbers and CVA added to the events. Also broken down by employee vs Veteran.

No CVST reports for J&J, Moderna or Pfizer.

From: Elnahal, Shereef (b)(6)
Sent: Tuesday, April 13, 2021 9:57 AM
To: Kim, Jane NCP (b)(6) Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Subject: Re: J&J Vaccine

Thank you so much, very helpful.

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From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 9:55:12 AM
To: Czarnecki, Tammy (b)(6) Villatoro, Christopher E (b)(6) Lieberman, Steven (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

There have been no VA reports of Cerebral Venous Sinus Thrombosis (CVST), the event that triggered the halt by FDA and CDC, for any COVID-19 vaccine product.

Please see attached for VA Adverse Drug Events Reporting System (ADERS) Adverse Events of Special Interest. Also summarized below. More detailed analysis with historical comparisons will be complete by this Thursday.
VA ADERS reports to FDA and CDC.

1. No reports of CVST for any agent
2. No report of Thrombotic stroke
3. 18 reports of Cerebrovascular Accident (CVA) (11 Moderna, 7 Pfizer, 0 Janssen)

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 9:34 AM

To: Kim, Jane NCP (b)(6) Villatoro, Christopher E (b)(6)
Lieberman, Steven (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Awesome!

From: Kim, Jane NCP (b)(6)
Sent: Tuesday, April 13, 2021 9:34 AM
To: Czarnecki, Tammy (b)(6) Villatoro, Christopher E
(b)(6) Lieberman, Steven (b)(6)
Cc: Elnahal, Shereef (b)(6)
Subject: RE: J&J Vaccine

Pharmacy has data and is working it now. Will get it to you before 10.

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 9:32 AM
To: Villatoro, Christopher E (b)(6) Lieberman, Steven
(b)(6) Kim, Jane NCP (b)(6)
Cc: Elnahal, Shereef (b)(6)
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COVID-19 Response Coordinator
US Department of Veteran Affairs
(b)(6)
Mobile: (b)(6)

From: Lieberman, Steven
Sent: Sat, 24 Apr 2021 17:15:16 +0000
To: Upton, Mark T.
Subject: RE: J&J Vaccine
Attachments: DRAFT AUSHO Resuming use of Janssen COVID-19 Vaccine 042321 v3 (003).docx, Janssen FDA EUA amendment 4.23.pdf

thanks for reaching out about this. Am in the last stages of getting approval for our resuming our program- already have approval from Rich and Shereef. Approval still needs to include OPIA and the WH. Hope to have it by later today and then send the attached memo to the field that will also include the attached Janssen document. I can let you know when I have official approval.

From: Upton, Mark T. (b)(6)
Sent: Saturday, April 24, 2021 1:08 PM
To: Lieberman, Steven (b)(6)
Subject: Re: J&J Vaccine

Hey Steve, sorry for the weekend email. Just wanted to get your thoughts on this. I saw the message that came out earlier today saying VA is still evaluating the data on our end.

(b)(5)
(b)(5)
(b)(5)

Happy to talk with Larry or anyone coordinating this on our end if you think that'd be helpful

Appreciate it!

Mark

Get Outlook for iOS

From: (b)(6) (b)(6)
Sent: Saturday, April 24, 2021 7:45:01 AM
To: Upton, Mark T. (b)(6)
Subject: [EXTERNAL] J&J Vaccine

Morning Mark, sorry for the weekend send, but wanted to check in on the resumption of the J&J Vaccine. Is VA following national guidance or should we be prepared for a different policy? Want to get ahead of this if possible, sounds like some sites could resume using the vaccine as early as today.

Best,
(b)(6)

(b)(6)

Community Care Services

3160 Fairview Park Dr.
Falls Church, VA 22042
M : (b)(6)
(b)(6) @optum.com

optum.com

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information

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(b)(5)

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Page 069 of 636

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(b)(5)

of the Freedom of Information

From: Lilly, Ryan S.
Sent: Mon, 11 Jan 2021 12:45:04 +0000
To: Lieberman, Steven;Scher, Deborah L.;Jensen, Jon M.;Matthews, Kameron;Taylor, Beth A;Oshinski, Renee;Mole, Larry A.;Kim, Jane NCP;Kramer, Deborah E.;Law, Cassandra M.;Czarnecki, Tammy;Barry, Ashleigh;Stone, Richard A., MD
Subject: RE: Key Learnings From the State of NH Vaccine Distribution Launch

Steve: Correct. VA Maine is doing drive through, with on-site Togus Fire Department monitoring people in their cars.

The NH experience below is partly what motivated us to start talking to the Guard in other states. (b)(5) (b)(5)

Ryan

From: Lieberman, Steven (b)(6)
Sent: Sunday, January 10, 2021 9:40 PM
To: Scher, Deborah L. (b)(6) Jensen, Jon M. (b)(6) Matthews, Kameron (b)(6) Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Lilly, Ryan S. (b)(6) Kramer, Deborah E. (b)(6) Law, Cassandra M. (b)(6) Czarnecki, Tammy (b)(6) Barry, Ashleigh (b)(6) Stone, Richard A., MD (b)(6)
Subject: RE: Key Learnings From the State of NH Vaccine Distribution Launch

Very helpful information. (b)(5) (b)(5)

The drive through is a great idea. I heard that Togus VA is doing that. They also have patients wait in their cars and they beep their horns if they are having any medical issues after receiving the vaccine.

Thanks Deborah

From: Scher, Deborah L. (b)(6)
Sent: Sunday, January 10, 2021 7:57 PM
To: Lieberman, Steven (b)(6) Jensen, Jon M. (b)(6) Matthews, Kameron (b)(6) Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Lilly, Ryan S. (b)(6) Kramer, Deborah E. (b)(6) Law, Cassandra M. (b)(6) Czarnecki, Tammy (b)(6) Barry, Ashleigh (b)(6) Stone, Richard A., MD (b)(6)
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6. **Using technology to expedite the process –** Similar to Optum, the State of NH has completely automated the appointment scheduling process. They also have a call center for those who are not comfortable using the automated system.

The State has offered to share their vaccine PSAs, online vaccine administration training program and to help transport vaccines within NH, if that would be helpful to VHA. I would be happy to arrange follow-up calls on any of these topics if that may be of interest.

Thank you,
Deborah

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Subject: RE: Key Learnings From the State of NH Vaccine Distribution Launch

Very helpful information. (b)(5)
(b)(5)

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From: Stone, Richard A., MD
Sent: Mon, 11 Jan 2021 03:36:54 +0000
To: Lieberman, Steven;Scher, Deborah L.;Jensen, Jon M.;Matthews, Kameron;Taylor, Beth A;Oshinski, Renee;Mole, Larry A.;Kim, Jane NCP;Lilly, Ryan S.;Kramer, Deborah E.;Law, Cassandra M.;Czarnecki, Tammy;Barry, Ashleigh
Subject: Re: Key Learnings From the State of NH Vaccine Distribution Launch

(b)(5)

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Sent: Mon, 11 Jan 2021 12:45:04 +0000
To: Lieberman, Steven;Scher, Deborah L.;Jensen, Jon M.;Matthews, Kameron;Taylor, Beth A;Oshinski, Renee;Mole, Larry A.;Kim, Jane NCP;Kramer, Deborah E.;Law, Cassandra M.;Czarnecki, Tammy;Barry, Ashleigh;Stone, Richard A., MD
Subject: RE: Key Learnings From the State of NH Vaccine Distribution Launch

Steve: Correct. VA Maine is doing drive through, with on-site Togus Fire Department monitoring people in their cars.

The NH experience below is partly what motivated us to start talking to the Guard in other states. I (b)(5)

Ryan

From: Lieberman, Steven (b)(6)
Sent: Sunday, January 10, 2021 9:40 PM
To: Scher, Deborah L. (b)(6) Jensen, Jon M. (b)(6) Matthews, Kameron (b)(6) Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Lilly, Ryan S. (b)(6) Kramer, Deborah E. (b)(6) Law, Cassandra M. (b)(6) Czarnecki, Tammy (b)(6) Barry, Ashleigh (b)(6) Stone, Richard A., MD (b)(6)
Subject: RE: Key Learnings From the State of NH Vaccine Distribution Launch

Very helpful information. (b)(5)
(b)(5)

The drive through is a great idea. I heard that Togus VA is doing that. They also have patients wait in their cars and they beep their horns if they are having any medical issues after receiving the vaccine.

Thanks Deborah

From: Scher, Deborah L. (b)(6)
Sent: Sunday, January 10, 2021 7:57 PM
To: Lieberman, Steven (b)(6) Jensen, Jon M. (b)(6) Matthews, Kameron (b)(6) Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Lilly, Ryan S. (b)(6) Kramer, Deborah E. (b)(6) Law, Cassandra M. (b)(6) Czarnecki, Tammy (b)(6) Barry, Ashleigh (b)(6) Stone, Richard A., MD (b)(6)
Subject: Key Learnings From the State of NH Vaccine Distribution Launch

Good Evening:

On a call this weekend, the vaccine program director for the State of NH shared some key learnings from their early experience administering the vaccine. For easy reference, I will use the same topics we used to categorize feedback from Optum, and let you know where findings are similar or different.

1. **Staffing**- The State of NH has set up 13 fixed, drive thru sites throughout the State that are being run entirely by the National Guard, administering approximately 3,000 vaccines per day. The State created a short online training program for medics, retired nurses and others to learn how to administer the vaccine. They are using non-clinical staff to run the site, direct traffic, provide security etc.
2. **Addressing resistance to the vaccine**- Similar to Optum, about 30% of their health care workers showed initial resistance to the vaccine. The State of NH developed several PSAs to address this issue which they would be happy to share with us. The first PSAs will be delivered by leading medical experts. The second set of PSAs will feature their governor and other leaders.
3. **Choosing locations**- Given NH weather concerns and the need for social distancing, NH decided to structure these sites as drive thru locations. Patients check in from their cars, wait in the car lanes for their turn, roll down the window and then receive their vaccine. State personnel are driving doses of the vaccine stored in coolers to rural communities. There is a process in place to check the temperature of the cooler contents periodically and to note the readings in a data log.
4. **Extra vaccine doses**- The Pfizer package is expected to provide 5 doses of the vaccine and the Moderna package to provide 10. They are finding that frequently, the Pfizer package contains 6 and sometimes even 7 doses, the Moderna vial frequently contains 11 doses. While this is good news in terms of vaccinating more patients, the CDC supply provisions match the number of expected doses, so the State of NH is providing additional ancillary equipment to healthcare staff, beyond what is provided by the CDC, so they can administer the additional doses. It also means staff may be able to vaccinate people who were not on the original scheduling log. A potential issue is that the CDC is "saving a second dose " for each person vaccinated based on the number of expected doses per vial. This is a topic under discussion with them.
5. **Adverse event reporting and monitoring** – The State designated a portion of the parking lot where patients wait for 15 minutes in their cars to make sure there are no adverse events. A guard patrols the parking lot, checking on people to make sure they are OK and letting them know when they can leave.
6. **Using technology to expedite the process –** Similar to Optum, the State of NH has completely automated the appointment scheduling process. They also have a call center for those who are not comfortable using the automated system.

The State has offered to share their vaccine PSAs, online vaccine administration training program and to help transport vaccines within NH, if that would be helpful to VHA. I would be happy to arrange follow-up calls on any of these topics if that may be of interest.

Thank you,
Deborah

Sent: Mon, 11 Jan 2021 01:46:23 +0000
To: Scher, Deborah L.;Jensen, Jon M.;Matthews, Kameron;Taylor, Beth A;Oshinski, Renee;Mole, Larry A.;Kim, Jane NCP;Lilly, Ryan S.;Kramer, Deborah E.;Law, Cassandra M.;Czarnecki, Tammy;Barry, Ashleigh;Stone, Richard A., MD
Subject: RE: Key Learnings From the State of NH Vaccine Distribution Launch

Very helpful information. Think the PSA would be helpful to review.

The drive through is a great idea. I heard that one

From: Scher, Deborah L. (b)(6)
Sent: Sunday, January 10, 2021 7:57 PM
To: Lieberman, Steven (b)(6) Jensen, Jon M. (b)(6) Matthews, Kameron (b)(6) Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Lilly, Ryan S. (b)(6) Kramer, Deborah E. (b)(6) Law, Cassandra M. (b)(6) Czarnecki, Tammy (b)(6) Barry, Ashleigh (b)(6) Stone, Richard A., MD (b)(6)
Subject: Key Learnings From the State of NH Vaccine Distribution Launch

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so they can administer the additional doses. It also means staff may be able to vaccinate people who were not on the original scheduling log. A potential issue is that the CDC is "saving a second dose " for each person vaccinated based on the number of expected doses per vial. This is a topic under discussion with them.

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The State has offered to share their vaccine PSAs, online vaccine administration training program and to help transport vaccines within NH, if that would be helpful to VHA. I would be happy to arrange follow-up calls on any of these topics if that may be of interest.

Thank you,
Deborah

From: Pape, Lisa M.
Sent: Thu, 13 May 2021 22:05:15 +0000
To: Lieberman, Steven
Cc: Kelley, Kimberly
Subject: RE: Letters for Pt. Vaccine Hesitancy Update
Attachments: SecVA Mass Mailing Vax Letter_051221_v3.docx, Brochure_HiRisk_SLA and Janssen resumption_051021 UPDATED AND FINAL.pdf

Steve,

I wanted to provide you with a status update:

1. **Letter**: Attached is **a first draft** of a letter (b)(5) (b)(5) (b)(5) As mentioned, this is just a first draft. The team thought adding a brochure may be a helpful idea, so it is also included here. (POC: (b)(6) (b)(6)
   - (b)(5)
2. **List of Veterans no Vaccinated:** (POC: (b)(6)
   a. (b)(5)
   b. (b)(5)
   - (b)(5)
3. **Funding:** Finance has confirmed that CARES Act funding (medical service dollars) can be used for this effort as long as it is completed by September 2021. They need to know what Fund Control Point to transfer the funds to. (POC (b)(6)
4. **Mass Mailing:** The Government Printing Office can be used to do a mass mailing. The cost will be anywhere from .40 - .60 cents per letter which includes Cover letter, brochure and envelope.

A 2269/1358s have to be completed and fiscal can assist in getting the right forms completed and submitted to reimburse the GPO. (POC (b)(6)

5. **Digital outreach:** (b)(5)
(b)(5)
(b)(5) (POC: (b)(6)

6. **OGC:** (b)(5)
(b)(5) (POC (b)(6)

Happily available to discuss further.

Thanks Lisa.

From: Pape, Lisa M.
Sent: Friday, May 7, 2021 4:47 PM
To: Lieberman, Steven (b)(6)
Cc: Kelley, Kimberly (b)(6)
Subject: Letters for Pt. Vaccine Hesitancy Update

Steve,

I wanted to give a few updates so far:

HEC: They have a contracting vehicle to send letters out. It cost .60 cents a one page letter. (b)(5)
(b)(5)

Fiscal: (b)(5)
(b)(5) – They will get back to me on Monday.

HOC/VSSC: Working with the HOC to see if they can get numbers of Veterans not vaccinated and a drilled down list of those numbers by name. (No response yet)

More to come, but wanted you to have some visibility for your Monday morning meeting with SEVA.

If anything comes across this weekend that's pertinent, I will definitely let you know.

Lisa M. Pape, LISW

Senior Advisor, Office of the Deputy Under Secretary for Health
Veterans Health Administration
810 Vermont Avenue N.W.
Washington, DC 20420
Phone: (b)(6)
Cell: (b)(6)

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of the Freedom of Information

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of the Freedom of Information

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Withheld pursuant to exemption

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of the Freedom of Information

From: Pape, Lisa M.
Sent: Wed, 19 May 2021 20:31:39 +0000
To: Lieberman, Steven
Cc: Kelley, Kimberly
Subject: RE: Letters for Pt. Vaccine Hesitancy Update
Attachments: SecVA SecDef Letter to Veterans v4 LP edits.docx, Brochure_HiRisk_SLA and Janssen resumption_051021 UPDATED AND FINAL.pdf

Steve, this letter is lovely. I made some edits and comments. (b)(5)
(b)(5)
I am adding the brochure for easy access.

Two things:

1. (b)(5)
2.
3.

Available to assist as needed

Lisa

Lisa M. Pape, LISW

Senior Advisor, Office of the Deputy Under Secretary for Health
Veterans Health Administration
810 Vermont Avenue N.W.
Washington, DC 20420
Phone: (b)(6)
Cell: (b)(6)

From: Lieberman, Steven (b)(6)
Sent: Saturday, May 15, 2021 11:15 AM
To: Pape, Lisa M. (b)(6)
Cc: Kelley, Kimberly (b)(6)
Subject: RE: Letters for Pt. Vaccine Hesitancy Update

Great job with all of this Lisa. I cannot thank you enough. I am sorry that we had two teams working on the draft letter at the same time. That being said, I took what I thought was the best of both of them and combined into the 1 attached latter. See what you think. Still have to figure out whom will sign off on them.

A press release might be great idea (b)(5)

(b)(5) (b)(5)

(b)(5)

(b)(5)

(b)(5)

Let me know if you think the letter needs any changes.

Thanks again.

From: Pape, Lisa M. (b)(6)
Sent: Thursday, May 13, 2021 6:05 PM
To: Lieberman, Steven (b)(6)
Cc: Kelley, Kimberly (b)(6)
Subject: RE: Letters for Pt. Vaccine Hesitancy Update

Steve,

I wanted to provide you with a status update:

1. **Letter**: Attached is **a first draft** of a letter (b)(5)
   (b)(5)
   (b)(5) As mentioned, this is just a first draft. The team thought adding a brochure may be a helpful idea, so it is also included here. (POC: (b)(6)
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   - (b)(5)
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   a. (b)(5)
   b. (b)(5)

(b)(5)

- (b)(5)

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4. **Mass Mailing:** The Government Printing Office can be used to do a mass mailing. The cost will be anywhere from .40 - .60 cents per letter which includes Cover letter, brochure and envelope. A 2269/1358s have to be completed and fiscal can assist in getting the right forms completed and submitted to reimburse the GPO. (POC (b)(6)

5. **Digital outreach:** There are options available to email the letters as well. (b)(5)
(b)(5)
(b)(5) (POC (b)(6)

6. **OGC:** (b)(5)
(b)(5) (POC (b)(6)

Happily available to discuss further.

Thanks Lisa.

From: Pape, Lisa M.
Sent: Friday, May 7, 2021 4:47 PM
To: Lieberman, Steven (b)(6)
Cc: Kelley, Kimberly (b)(6)
Subject: Letters for Pt. Vaccine Hesitancy Update

Steve,

I wanted to give a few updates so far:

HEC: They have a contracting vehicle to send letters out. It cost .60 cents a one page letter. (b)(5)
(b)(5)

Fiscal: (b)(5)
(b)(5)

HOC/VSSC: Working with the HOC to see if they can get numbers of Veterans not vaccinated and a drilled down list of those numbers by name. (No response yet)

More to come, but wanted you to have some visibility for your Monday morning meeting with SEVA.

If anything comes across this weekend that's pertinent, I will definitely let you know.

Lisa M. Pape, LISW

Senior Advisor, Office of the Deputy Under Secretary for Health
Veterans Health Administration
810 Vermont Avenue N.W.
Washington, DC 20420
Phone: (b)(6)
Cell: (b)(6)

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From: Kim, Jane NCP
Sent: Mon, 11 Jan 2021 18:44:02 +0000
To: Maenle, Nathan;Kramer, Deborah E.;Jensen, Jon M.;Law, Cassandra M.;Fisher, Michael (10RCS);Valentino, Michael (VACO);Litvin, Ed;Cokl, Jodi VHACIN;Zacher, Jennifer L. (PBM);Warner, Debra L.;Kim, Paul D., MD;Gilbride, Nicole S.;Simpson, Todd G.;Michaud, Gerald (Jerry);Lieberman, Steven
Cc: Toles, Krystal M.;DuFon, Jack;Cogar, Dana (ATLAS);Czarnecki, Tammy;Oshinski, Renee;Scher, Deborah L.;Barry, Ashleigh;Califano, Sophia G;Diamond, Sue OHT;Varone, Jessica;Wallace, Patricia;Mole, Larry A.;Raffa, Susan, NCP;Catano, Maura;Scanlon, Aimee B.;Faherty, P Shawn;Askey, Jennifer;dcogar;Rizzo, Vincent (HEFP/10NA5E);Waters, Cherri;Jensen, Jacob A.;Emily Hawthorne;Miller, Garth G. FACHE (SES)
Subject: RE: Logistics Team First Look RE: Mass Vaccination Update
Attachments: Moderna Frozen Redistribution Plan 12.28.2020 .pdf, Pfizer Ultra-Cold Redistribution Plan 12.28.2020 .pdf, Community wide (mass) vaccination for VHA v1.5 (002).docx

Attached are clinical considerations for mass vaccination (Word document), and Pfizer and Moderna vaccine-specific redistribution plans (PDFs).

From: Maenle, Nathan (b)(6)
Sent: Monday, January 11, 2021 1:10 PM
To: Kramer, Deborah E. (b)(6) Jensen, Jon M. (b)(6) Law, Cassandra M. (b)(6) Fisher, Michael (10RCS) (b)(6) Valentino, Michael (VACO) (b)(6) Kim, Jane NCP (b)(6) Litvin, Ed (b)(6) Cokl, Jodi VHACIN (b)(6) Zacher, Jennifer L. (PBM) (b)(6) Warner, Debra L. (b)(6) Kim, Paul D., MD (b)(6) Gilbride, Nicole S. (b)(6) Simpson, Todd G. (b)(6) Michaud, Gerald (Jerry) (b)(6) Lieberman, Steven (b)(6)
Cc: Toles, Krystal M. (b)(6) DuFon, Jack (b)(6) Cogar, Dana (ATLAS) (b)(6) Czarnecki, Tammy (b)(6) Oshinski, Renee (b)(6) Scher, Deborah L. (b)(6) Barry, Ashleigh (b)(6) Califano, Sophia G (b)(6) Diamond, Sue OHT (b)(6) Varone, Jessica (b)(6) Wallace, Patricia (b)(6) Mole, Larry A. (b)(6) Raffa, Susan, NCP (b)(6) Catano, Maura (b)(6) Scanlon, Aimee B. (b)(6) Faherty, P Shawn (b)(6) Askey, Jennifer (b)(6) dcogar (b)(6) Rizzo, Vincent (HEFP/10NA5E) (b)(6) Waters, Cherri (b)(6) Jensen, Jacob A. (b)(6) Emily Hawthorne (b)(6) Miller, Garth G. FACHE (SES) (b)(6)
Subject: RE: Logistics Team First Look RE: Mass Vaccination Update

Attached is a first stab at IT and Contact Center

Nathan

From: Kramer, Deborah E. (b)(6)
Sent: Sunday, January 10, 2021 5:29 PM
To: Jensen, Jon M. (b)(6) Law, Cassandra M. (b)(6) Fisher, Michael (10RCS) (b)(6) Valentino, Michael (VACO) (b)(6) Kim, Jane NCP (b)(6) Litvin, Ed (b)(6) Cokl, Jodi VHACIN (b)(6) Zacher, Jennifer L. (PBM) (b)(6) Warner, Debra L. (b)(6) Kim, Paul D., MD (b)(6) Gilbride, Nicole S. (b)(6) Simpson, Todd G. (b)(6) Michaud, Gerald (Jerry) (b)(6) Lieberman, Steven (b)(6)
Cc: Toles, Krystal M. (b)(6) DuFon, Jack (b)(6) va.gov>; Cogar, Dana (ATLAS) (b)(6) Czarnecki, Tammy (b)(6) Oshinski, Renee (b)(6) Maenle, Nathan (b)(6) Scher, Deborah L. (b)(6) Barry, Ashleigh (b)(6) Califano, Sophia G (b)(6) Diamond, Sue OHT (b)(6) Varone, Jessica (b)(6) Wallace, Patricia (b)(6) Mole, Larry A. (b)(6) Raffa, Susan, NCP (b)(6) Catano, Maura (b)(6) Scanlon, Aimee B. (b)(6) Faherty, P Shawn (b)(6) Askey, Jennifer (b)(6) dcogar (b)(6) Rizzo, Vincent (HEFP/10NA5E) (b)(6) Waters, Cherri (b)(6) Jensen, Jacob A. (b)(6) Emily Hawthorne (b)(6)
Subject: Logistics Team First Look RE: Mass Vaccination Update

Hi Teammates,

For your consideration and discussion at Monday's meeting, attached is the Logistics Team's first stab at the logistics support for 4th Mission mass vaccination.

V/R

Deb

Deborah E. Kramer
Acting AUSH for Support, VHA
O: (b)(6) // C: (b)(6) // E: (b)(6)

Scheduling: Mr. Malcolm ("Mac") Flanders, (b)(6) or (b)(6)

"The best way to thank a Healthcare Worker is to be an American worth fighting for."

-----Original Appointment-----
From: Jensen, Jon M. (b)(6)
Sent: Tuesday, January 5, 2021 10:33
To: Jensen, Jon M.; Law, Cassandra M.; Fisher, Michael (10RCS); Valentino, Michael (VACO); Kim, Jane NCP; Kramer, Deborah E.; Litvin, Ed; Cokl, Jodi VHACIN; Zacher, Jennifer L. (PBM); Warner, Debra L.; Kim, Paul D., MD; Gilbride, Nicole S.; Simpson, Todd G.; Michaud, Gerald (Jerry);

Lieberman, Steven
Cc: Toles, Krystal M.; DuFon, Jack; Cogar, Dana (ATLAS); Czarnecki, Tammy; Oshinski, Renee; Maenle, Nathan; Scher, Deborah L.; Barry, Ashleigh; Califano, Sophia G; Diamond, Sue OHT; Varone, Jessica; Wallace, Patricia; Mole, Larry A.; Raffa, Susan, NCP; Catano, Maura; Scanlon, Aimee B.; Faherty, P Shawn; Askey, Jennifer; dcogar; Rizzo, Vincent (HEFP/10NA5E); Waters, Cherri; Jensen, Jacob A.; Emily Hawthorne
Subject: Mass Vaccination Update
When: Monday, January 11, 2021 14:30-15:00 (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

Microsoft Teams meeting

Join on your computer or mobile app
Click here to join the meeting

Or call in (audio only)
(b)(6) United States, Chicago
Phone Conference ID (b)(6)
Find a local number | Reset PIN

Learn More | Meeting options

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of the Freedom of Information

From: Lieberman, Steven
Sent: Wed, 14 Apr 2021 01:24:00 +0000
To: Kim, Paul D., MD;Mole, Larry A.;Kim, Jane NCP;Czarnecki, Tammy;Brannigan, Paul
Subject: RE: Message from Chief Medical Officer on Johnson & Johnson COVID-19 Vaccine

Thanks Paul. Hadn't seen this.

From: Kim, Paul D., MD (b)(6)
Sent: Tuesday, April 13, 2021 7:26 PM
To: Lieberman, Steven (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Czarnecki, Tammy (b)(6) Brannigan, Paul (b)(6)
Subject: Fwd: Message from Chief Medical Officer on Johnson & Johnson COVID-19 Vaccine

From DHS

Paul

From: Chief Medical Officer (b)(6)
Sent: Tuesday, April 13, 2021 7:18 PM
Subject: [EXTERNAL] Message from Chief Medical Officer on Johnson & Johnson COVID-19 Vaccine

April 13, 2021

Message from Chief Medical Officer on Johnson & Johnson COVID-19 Vaccine

Dear Colleagues,

Earlier today, the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) issued a joint statement that they are reviewing data involving a rare and severe blood clot that has been reported in six U.S adults after receiving the Johnson & Johnson (J&J) vaccine.

Out of an abundance of caution, CDC and FDA are recommending a pause of the J&J vaccine while they analyze and investigate reports of these rare and severe blood clots in patients. Operation Vaccinate Our Workforce, in close partnership with the Veterans Health Administration (VHA), is implementing this recommendation immediately and pausing the use of the J&J vaccine for all Veterans and DHS employees.

These **six cases of rare blood clots, all in adult women under age 50, occurred between 6 to 13 days after the women received the J&J vaccine.** To date, 6.8 million J&J doses have been administered in the United States. The adverse events that did occur were in the first two weeks after receiving the J&J vaccine so employees who received the vaccine more than two weeks ago would be considered even less likely to experience an adverse event.

The type of blood clot that occurred is called Cerebral Venous Sinus Thrombosis (or CVST). It happens when a blood clot forms in a blood vessel in the brain. This can cause symptoms including headache, vision changes, or symptoms of a stroke. The people who have had this type of blood clot also had low platelet counts.

Symptoms that occur in those that developed this type of blood clot include:

- A headache that occurs 6 days or more after vaccination
- A headache that is different from other headaches you have had
- Confusion or trouble thinking clearly
- Visual changes, such as blurry vision
- Weakness, numbness or trouble moving one or more parts of your body, trouble speaking or seizures
- Tiny spots under the skin away from the area where you had the injection (this is a sign of low platelets)

If you are a female DHS employee, under the age of 55, who has received the J&J vaccine in the last 14 days from VHA – VHA clinical staff will be reaching out to you directly. If you received the vaccine in the last 14 days and develop the symptoms we have mentioned, **please contact your primary care provider**. **If your symptoms are severe, or if you are experiencing shortness of breath, chest pain, leg swelling or persistent abdominal pain – call 9-1-1**.

CVST has not been observed in the other vaccines in use in the United States, namely the Pfizer-BioNTech and Moderna COVID-19 vaccines. Both of those vaccines are mRNA vaccines, which is a different type of vaccine than the J&J COVID-19 vaccine.

We continue to work closely with our VHA colleagues to ensure the safety of our 1A and 1B employees who opted-in to receive a vaccine through our DHS-VHA partnership. The VHA follows CDC guidelines for reporting adverse events related to the COVID-19 vaccinations.

Regardless of where you were vaccinated, your primary care provider is best equipped to provide you with any follow-up medical care. Please consider enrolling in the CDC's V-Safe for tracking post-vaccination side effects that you may experience. This is an online tool that helps you track your post-vaccination health and helps keep COVID-19 vaccines safe for everyone.

Rest assured our team of DHS medical experts will do our best to communicate any updates and news about COVID-19 vaccines. Keeping our employees safe and healthy is of crucial importance to us during this time.

Sincerely,

Dr. Pritesh Gandhi
Chief Medical Officer

Sent: Tue, 13 Apr 2021 00:03:35 +0000
To: Czarnecki, Tammy;Lieberman, Steven
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hi Tammy and Steve – In anticipation of a potential large # of staff reaching out to local VAMCs as follow up to this memo, I asked for a listing today of locations where OCC has >

Below is the list of sites with the greatest concentrations of our staff:
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-West CPAC, Las Vegas, NV

In many location (such as Denver), I learned that there has already been outreach/vaccinations provided to staff from VAMCs well prior to this memo.

If there are any concerns from these local VAMCs or special instructions I should give to my staff, just let me know.

Mark

From: US Department of Veterans Affairs (b)(6)
Sent: Friday, April 9, 2021 4:46 PM
To: VA All Mailboxes (b)(6)
Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

MESSAGE FROM THE ACTING DEPUTY SECRETARY

Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Fromm, Scott C.
Sent: Mon, 12 Apr 2021 13:46:39 +0000
To: Upton, Mark T.;VHA 13 Community Care ELC
Cc: VHA 13 Community Care Support Staff
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

We had two employee clinics in Denver March 27th and April 3rd. Over 400 employees received their first vaccine. I received many messages from other employees that they had already got their vaccine elsewhere. I continue to work with the medical center and believe we are covered out here.

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 7:14 AM
To: VHA 13 Community Care ELC (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
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Carolyn M. Clancy, M.D.

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From: Czarnecki, Tammy
Sent: Tue, 13 Apr 2021 11:42:38 +0000
To: Upton, Mark T.;Lieberman, Steven
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thank you Mark

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 8:34 PM
To: Czarnecki, Tammy (b)(6) Lieberman, Steven (b)(6)
Cc: Oshinski, Renee (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

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From: Lieberman, Steven
Sent: Tue, 13 Apr 2021 13:25:47 +0000
To: Czarnecki, Tammy;Upton, Mark T.
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

I do not think the way that you are describing it that the numbers should overwhelm any particular facility. Thanks

---

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 7:43 AM
To: Upton, Mark T. (b)(6) Lieberman, Steven (b)(6)
Cc: Oshinski, Renee (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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From: Hunt, Jennifer L.
Sent: Mon, 12 Apr 2021 23:08:29 +0000
To: Upton, Mark T.
Cc: VHA 13 Community Care Support Staff;Hunt, Jennifer L.
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

The list of sites with more than 100 employees is:

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Jennifer Hunt
Management Analyst | Office of Community Care
Email: (b)(6)

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 9:14 AM
To: VHA 13 Community Care ELC (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

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From: Reed, Susan A.
Sent: Mon, 12 Apr 2021 15:42:38 +0000
To: Upton, Mark T.;Pearson, Janet
Cc: VHA 13 Community Care Support Staff
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Yes, CPACs have been offered vaccines through VAMC employee health. Each facility has done it a little different. We can potentially run a report through the payroll to see how many individuals have been granted that type of leave if that is what is needed.

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 10:38 AM
To: Pearson, Janet (b)(6)
Cc: Reed, Susan A. (b)(6) VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks Janet. Do we know if any of these VAMCs have already reached to CPAC staff and have been offering vaccines? DO shared that there was a vaccine clinic offered to Denver staff via the local VAMC at the end of last month. That would be helpful for us to capture if possible

---

From: Pearson, Janet (b)(6)
Sent: Monday, April 12, 2021 11:23 AM
To: Hunt, Jennifer L. (b)(6) VHA 13 Community Care ELC (b)(6)
Cc: Barton, Vonda (b)(6) Reed, Susan A. (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

See below for Revenue Operations. CPAC employees have the ability to receive vaccines at the supporting VAMC

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From: Hunt, Jennifer L. (b)(6)
Sent: Monday, April 12, 2021 9:53 AM
To: Upton, Mark T. (b)(6) VHA 13 Community Care ELC (b)(6)

Cc: VHA 13 Community Care Support Staff (b)(6) Hunt, Jennifer L. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Good Morning ELC Members,

Please send me a list of sites with 100+ employees by COB today.

Jennifer Hunt
Management Analyst | Office of Community Care
Email: (b)(6)

From: Upton, Mark T. (b)(6)
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To: VHA 13 Community Care ELC (b)(6)
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From: Fromm, Scott C.
Sent: Mon, 12 Apr 2021 13:58:14 +0000
To: Upton, Mark T.
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Yes. Working with them closely. Also sent four nurses TDY to Colorado Springs to help out with their clinic down there (VAMC paid for TDY).

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 7:51 AM
To: Fromm, Scott C. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks Scott, you/your team and Susan's were top of mind when this request came in. Glad to hear this. How did this clinic get coordinated? Was it through the VAMC?

From: Fromm, Scott C. (b)(6)
Sent: Monday, April 12, 2021 9:47 AM
To: Upton, Mark T. (b)(6) VHA 13 Community Care ELC (b)(6)
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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Upton, Mark T.
Sent: Tue, 13 Apr 2021 00:33:41 +0000
To: Czarnecki, Tammy;Lieberman, Steven
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hi Tammy and Steve – In anticipation of a potential large # of OCC staff reaching out to local VAMCs as follow up to this memo, I asked for a listing today of locations where we have >100 staff in a given area

Below is the list of sites with the greatest concentrations of our staff:
-Denver Colorado
-Mid-Atlantic CPAC, Asheville, NC
-Mid-South CPAC, Tennessee Valley HCS, TN
-North Central CPAC, Madison, WI
-Florida Caribbean CPAC, Orlando, FL
-North East CPAC, Lebanon, PA
-Central Plains CPAC, Leavenworth, KS
-West CPAC, Las Vegas, NV

Based on what I learned through additional follow up today, employees at many locations (such as Denver) have already received outreach and have had vaccinations provided through local VAMCs prior to this memo. My suspicion is that the majority of these areas will likely not see a huge influx of requests from our staff.

If there are any concerns from local VAMCs or special instructions I should give to my team as this moves forward, just let me know.

Thanks,

Mark

From: US Department of Veterans Affairs (b)(6)
Sent: Friday, April 9, 2021 4:46 PM
To: VA All Mailboxes (b)(6)
Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

MESSAGE FROM THE ACTING DEPUTY SECRETARY

Coronavirus Disease (COVID-19) Vaccine Information

Effective April 19, 2021, the COVID-19 vaccine will be offered to all Department of Veterans Affairs (VA) employees on a voluntary basis. VA employees may choose to and are encouraged to receive the COVID-19 vaccine at their first available opportunity.

The vaccine can help protect you and the people around you and reduce rates of infection, and it is an important tool to get ahead of the virus and its variants.

To find out how and where to obtain a vaccination through VA, contact your COVID-19 Vaccine Coordinator at the nearest VA Medical Center and identify yourself as a VA employee who would like a COVID-19 vaccination. For a listing of VA Medical Center Vaccine Coordinators, visit: Veterans Health Administration (VHA) COVID-19 Vaccine - VHA COVID Vaccine Coordinators - VHA COVID-19 Coordinators Contact List (sharepoint.com).

Employees who receive the COVID-19 vaccine through VA are not required to use their own leave while doing so. When an employee is authorized to participate in a VA immunization program, the employee is on official duty status for the time it takes to participate in the vaccination process.

Employees who receive the vaccine and subsequently experience an adverse reaction and are unable to work may be granted up to 2 days of authorized absence (timekeeping code "LN – Administrative" with the special note "Taking Examinations") with supervisory approval.

Employee vaccination records are being maintained in the employee medical folder, and a vaccination card is given to each employee who receives the vaccine from VA. VA employees who are enrolled to receive health care from VA may be vaccinated at VHA facilities; these individuals' vaccination records are part of their patient medical record.

Should you have any questions regarding the COVID-19 vaccination program, please review the information available about COVID-19 vaccines at VA or direct questions to your human resources office.

Please remember, although COVID-19 vaccines are being administered, it is important to continue to wear a mask, wash your hands and practice social distancing.

Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Upton, Mark T.
Sent: Mon, 12 Apr 2021 23:57:18 +0000
To: Hunt, Jennifer L.
Cc: VHA 13 Community Care Support Staff
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thank you!

From: Hunt, Jennifer L. (b)(6)
Sent: Monday, April 12, 2021 7:08 PM
To: Upton, Mark T. (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6) Hunt, Jennifer L. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

The list of sites with more than 100 employees is:

Denver Colorado
Mid-Atlantic CPAC, Asheville, NC
Mid-South CPAC, Tennessee Valley HCS, TN
North Central CPAC, Madison, WI
Florida Caribbean CPAC, Orlando, FL
North East CPAC, Lebanon, PA
Central Plains CPAC, Leavenworth, KS
West CPAC, Las Vegas, NV

Jennifer Hunt
Management Analyst | Office of Community Care
Email: (b)(6)

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 9:14 AM
To: VHA 13 Community Care ELC (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hope all of you had a great weekend. I know that OCC employees in many parts of the country have been interested in knowing when VA will offer vaccines to them. Many of you may have seen the message below on Friday (this is great news).

I spoke with VHA leadership this morning and they would like us to share with them the locations where we have the highest concentrations of employees (such as Denver, CPAC sites, etc.) in order to ensure that the local VAMCs are prepared for the volume of potential requests that come in.

13 Support – Can you work with our ELC to gather this information? I would suggest we list any location with >100 OCC employees in the local area.

I will send a message out to our OCC employees later this week to follow up on the email below and make sure they are aware of how to obtain a vaccination through VA as part of this effort.

Please reach out if you have any questions,

Mark

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Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Upton, Mark T.
Sent: Mon, 12 Apr 2021 16:00:03 +0000
To: Reed, Susan A.;Pearson, Janet
Cc: VHA 13 Community Care Support Staff
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks Susan – no worries. I'll just mention it as a general statement and if VHA needs more details, then we can ask you to do the additional work. Appreciate it

---

From: Reed, Susan A. (b)(6)
Sent: Monday, April 12, 2021 11:43 AM
To: Upton, Mark T. (b)(6) Pearson, Janet (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Yes, CPACs have been offered vaccines through VAMC employee health. Each facility has done it a little different. We can potentially run a report through the payroll to see how many individuals have been granted that type of leave if that is what is needed.

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 10:38 AM
To: Pearson, Janet (b)(6)
Cc: Reed, Susan A. (b)(6) VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks Janet. Do we know if any of these VAMCs have already reached to CPAC staff and have been offering vaccines? DO shared that there was a vaccine clinic offered to Denver staff via the local VAMC at the end of last month. That would be helpful for us to capture if possible

---

From: Pearson, Janet (b)(6)
Sent: Monday, April 12, 2021 11:23 AM
To: Hunt, Jennifer L. (b)(6) VHA 13 Community Care ELC (b)(6)
Cc: Barton, Vonda (b)(6) Reed, Susan A. (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

See below for Revenue Operations. CPAC employees have the ability to receive vaccines at the supporting VAMC

Mid-Atlantic CPAC, Asheville, NC
Mid-South CPAC, Tennessee Valley HCS, TN

North Central CPAC, Madison, WI
Florida Caribbean CPAC, Orlando, FL
North East CPAC, Lebanon, PA
Central Plains CPAC, Leavenworth, KS
West CPAC, Las Vegas, NV

From: Hunt, Jennifer L. (b)(6)
Sent: Monday, April 12, 2021 9:53 AM
To: Upton, Mark T. (b)(6) VHA 13 Community Care ELC (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6) Hunt, Jennifer L. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Good Morning ELC Members,

Please send me a list of sites with 100+ employees by COB today.

Jennifer Hunt
Management Analyst | Office of Community Care
Email: (b)(6)

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 9:14 AM
To: VHA 13 Community Care ELC (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hope all of you had a great weekend. I know that OCC employees in many parts of the country have been interested in knowing when VA will offer vaccines to them. Many of you may have seen the message below on Friday (this is great news).

I spoke with VHA leadership this morning and they would like us to share with them the locations where we have the highest concentrations of employees (such as Denver, CPAC sites, etc.) in order to ensure that the local VAMCs are prepared for the volume of potential requests that come in.

13 Support – Can you work with our ELC to gather this information? I would suggest we list any location with >100 OCC employees in the local area.

I will send a message out to our OCC employees later this week to follow up on the email below and make sure they are aware of how to obtain a vaccination through VA as part of this effort.

Please reach out if you have any questions,

Mark

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Sent: Friday, April 9, 2021 4:46 PM
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Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Upton, Mark T.
Sent: Mon, 12 Apr 2021 13:50:36 +0000
To: Fromm, Scott C.
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks Scott, you/your team and Susan's were top of mind when this request came in. Glad to hear this. How did this clinic get coordinated? Was it through the VAMC?

From: Fromm, Scott C. (b)(6)
Sent: Monday, April 12, 2021 9:47 AM
To: Upton, Mark T. (b)(6) VHA 13 Community Care ELC
(b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

We had two employee clinics in Denver March 27th and April 3rd. Over 400 employees received their first vaccine. I received many messages from other employees that they had already got their vaccine elsewhere. I continue to work with the medical center and believe we are covered out here.

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 7:14 AM
To: VHA 13 Community Care ELC (b)(6)
Cc: VHA 13 Community Care Support Staff (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hope all of you had a great weekend. I know that OCC employees in many parts of the country have been interested in knowing when VA will offer vaccines to them. Many of you may have seen the message below on Friday (this is great news).

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To: VA All Mailboxes (b)(6)
Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Jensen, Jon M.
Sent: Mon, 12 Apr 2021 16:16:11 +0000
To: Law, Cassandra M.;Lieberman, Steven
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Looks great to me!

Jon M. Jensen
Chief of Staff
Veterans Health Administration
W: (b)(6)
C: (b)(6)

A Legacy of Service. The Future of Care.

VHA 75th Anniversary

From: Law, Cassandra M. (b)(6)
Sent: Monday, April 12, 2021 12:11 PM
To: Jensen, Jon M. (b)(6) Lieberman, Steven (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Below is my suggested language to go out to all VACO employees on top of Carolyn's original email below. Please share any edits or thoughts. I will ask David Perry to edit the (b)(5)
(b)(5)

Thank you, Cassie

Addendum for all VA Central Office Employees:

(b)(5)

(b)(5)

https://dvagov.sharepoint.com/sites/SECvhawmcHROOProgramOffice/VACOCOVID/SitePages/Home.aspx

From: US Department of Veterans Affairs (b)(6)
Sent: Friday, April 9, 2021 4:46 PM
To: VA All Mailboxes (b)(6)
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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Boehm, Denise
Sent: Mon, 12 Apr 2021 13:32:18 +0000
To: Lieberman, Steven
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

That's a great plan

From: Lieberman, Steven (b)(6)
Sent: Monday, April 12, 2021 9:28 AM
To: Boehm, Denise (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks. I haven't signed up yet and it appears they already have more vaccinators than needed, so think we should be all set.

(b)(5)

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 9:27 AM
To: Lieberman, Steven (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thank you!!!
Let me know if you need help vaccinating!

From: Lieberman, Steven (b)(6)
Sent: Monday, April 12, 2021 9:26 AM
To: Boehm, Denise (b)(6) Czarnecki, Tammy (b)(6)
Cc: Law, Cassandra M. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

We will be doing the vaccines here for everyone. We need to get the word out.

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 9:25 AM
To: Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6)
Cc: Law, Cassandra M. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

I am not sure if this is helpful but many who are calling are indicating they can come to the DC VAMC as of the 19th of this month for vaccination.
(b)(5)

From: Lieberman, Steven (b)(6)
Sent: Monday, April 12, 2021 9:22 AM
To: Boehm, Denise (b)(6) Czarnecki, Tammy (b)(6)
Cc: Law, Cassandra M. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Cassie,
(b)(5) Thank you

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 8:58 AM
To: Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Good morning.
Since Dr. Clancy's message regarding process for scheduling a vaccination appointment, the DC VA has received many calls from VACO staff. Our coordinator came in this morning to over 40 voice mail messages. (b)(5)
(b)(5) Is that the plan? Any information would be great.

From: Kim, Jane NCP (b)(6)
Sent: Monday, April 12, 2021 8:55 AM
To: Boehm, Denise (b)(6) Califano, Sophia G (b)(6) Varone, Jessica (b)(6) Wallace, Patricia (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

I think you can ask Steve Lieberman and Tammy Czarnecki (b)(5)
(b)(5)
(b)(5)

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 8:51 AM
To: Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Varone, Jessica (b)(6) Wallace, Patricia (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Good morning everyone.

(b)(5)

From: US Department of Veterans Affairs (b)(6) @va.gov>
Sent: Friday, April 9, 2021 4:46:12 PM
To: VA All Mailboxes (b)(6)
Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Czarnecki, Tammy
Sent: Tue, 13 Apr 2021 11:42:38 +0000
To: Upton, Mark T.;Lieberman, Steven
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thank you Mark

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 8:34 PM
To: Czarnecki, Tammy (b)(6) Lieberman, Steven (b)(6)
Cc: Oshinski, Renee (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hi Tammy and Steve – In anticipation of a potential large # of OCC staff reaching out to local VAMCs as follow up to this memo, I asked for a listing today of locations where we have >100 staff in a given area

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Thanks,

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MESSAGE FROM THE ACTING DEPUTY SECRETARY

Coronavirus Disease (COVID-19) Vaccine Information

Effective April 19, 2021, the COVID-19 vaccine will be offered to all Department of Veterans Affairs (VA) employees on a voluntary basis. VA employees may choose to and are encouraged to receive the COVID-19 vaccine at their first available opportunity. The vaccine can help protect you and the people around you and reduce rates of infection, and it is an important tool to get ahead of the virus and its variants.

To find out how and where to obtain a vaccination through VA, contact your COVID-19 Vaccine Coordinator at the nearest VA Medical Center and identify yourself as a VA employee who would like a COVID-19 vaccination. For a listing of VA Medical Center Vaccine Coordinators, visit: Veterans Health Administration (VHA) COVID-19 Vaccine - VHA COVID Vaccine Coordinators - VHA COVID-19 Coordinators Contact List (sharepoint.com).

Employees who receive the COVID-19 vaccine through VA are not required to use their own leave while doing so. When an employee is authorized to participate in a VA immunization program, the employee is on official duty status for the time it takes to participate in the vaccination process.

Employees who receive the vaccine and subsequently experience an adverse reaction and are unable to work may be granted up to 2 days of authorized absence (timekeeping code "LN – Administrative" with the special note "Taking Examinations") with supervisory approval.

Employee vaccination records are being maintained in the employee medical folder, and a vaccination card is given to each employee who receives the vaccine from VA. VA employees who are enrolled to receive health care from VA may be vaccinated at VHA facilities; these individuals' vaccination records are part of their patient medical record.

Should you have any questions regarding the COVID-19 vaccination program, please review the information available about COVID-19 vaccines at VA or direct questions to your human resources office.

Please remember, although COVID-19 vaccines are being administered, it is important to continue to wear a mask, wash your hands and practice social distancing.

Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Lieberman, Steven
Sent: Tue, 13 Apr 2021 13:25:47 +0000
To: Czarnecki, Tammy;Upton, Mark T.
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

I do not think the way that you are describing it that the numbers should overwhelm any particular facility. Thanks

---

From: Czarnecki, Tammy (b)(6)
Sent: Tuesday, April 13, 2021 7:43 AM
To: Upton, Mark T. (b)(6) Lieberman, Steven (b)(6)
Cc: Oshinski, Renee (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thank you Mark

From: Upton, Mark T. (b)(6)
Sent: Monday, April 12, 2021 8:34 PM
To: Czarnecki, Tammy (b)(6) Lieberman, Steven (b)(6)
Cc: Oshinski, Renee (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hi Tammy and Steve – In anticipation of a potential large # of OCC staff reaching out to local VAMCs as follow up to this memo, I asked for a listing today of locations where we have >100 staff in a given area

Below is the list of sites with the greatest concentrations of our staff:
-Denver Colorado
-Mid-Atlantic CPAC, Asheville, NC
-Mid-South CPAC, Tennessee Valley HCS, TN
-North Central CPAC, Madison, WI
-Florida Caribbean CPAC, Orlando, FL
-North East CPAC, Lebanon, PA
-Central Plains CPAC, Leavenworth, KS
-West CPAC, Las Vegas, NV

Based on what I learned through additional follow up today, employees at many locations (such as Denver) have already received outreach and have had vaccinations provided through local VAMCs prior to this memo. My suspicion is that the majority of these areas will likely not see a huge influx of requests from our staff.

If there are any concerns from local VAMCs or special instructions I should give to my team as this moves forward, just let me know.

Thanks,

Mark

From: US Department of Veterans Affairs (b)(6)
Sent: Friday, April 9, 2021 4:46 PM
To: VA All Mailboxes (b)(6)
Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

MESSAGE FROM THE ACTING DEPUTY SECRETARY

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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Lieberman, Steven
Sent: Mon, 12 Apr 2021 16:43:02 +0000
To: Jensen, Jon M.;Law, Cassandra M.
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

ditto

From: Jensen, Jon M. (b)(6)
Sent: Monday, April 12, 2021 12:16 PM
To: Law, Cassandra M. (b)(6) Lieberman, Steven (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Looks great to me!

Jon M. Jensen
Chief of Staff
Veterans Health Administration
W: (b)(6)
C: (b)(6)

A Legacy of Service. The Future of Care.

VHA 75th Anniversary

From: Law, Cassandra M. (b)(6)
Sent: Monday, April 12, 2021 12:11 PM
To: Jensen, Jon M. (b)(6) Lieberman, Steven (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Below is my suggested language to go out to all VACO employees on top of Carolyn's original email below. Please share any edits or thoughts. I will ask David Perry to edit the (b)(5)
(b)(5)

Thank you, Cassie

(b)(5)

https://dvagov.sharepoint.com/sites/SECvhawmcHROOProgramOffice/VACOCOVID/SitePages/Home.aspx

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From: US Department of Veterans Affairs (b)(6)
Sent: Friday, April 9, 2021 4:46 PM
To: VA All Mailboxes (b)(6)
Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Please remember, although COVID-19 vaccines are being administered, it is important to continue to wear a mask, wash your hands and practice social distancing.

Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Lieberman, Steven
Sent: Mon, 12 Apr 2021 13:28:12 +0000
To: Boehm, Denise
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thanks. I haven't signed up yet and it appears they already have more vaccinators than needed, so think we should be all set.

Hoping to do all 3000+ over a 5 day period down in our basement area. Going to have scribes as part of the plan

---

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 9:27 AM
To: Lieberman, Steven (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Thank you!!!
Let me know if you need help vaccinating!

From: Lieberman, Steven (b)(6)
Sent: Monday, April 12, 2021 9:26 AM
To: Boehm, Denise (b)(6) Czarnecki, Tammy (b)(6)
Cc: Law, Cassandra M. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

We will be doing the vaccines here for everyone. We need to get the word out.

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 9:25 AM
To: Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6)
Cc: Law, Cassandra M. (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

I am not sure if this is helpful but many who are calling are indicating they can come to the DC VAMC as of the 19th of this month for vaccination.
(b)(5)

From: Lieberman, Steven (b)(6)
Sent: Monday, April 12, 2021 9:22 AM
To: Boehm, Denise (b)(6) Czarnecki, Tammy (b)(6)
Cc: Law, Cassandra M. (b)(6)

Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Cassie,
(b)(5) Thank you

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 8:58 AM
To: Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Good morning.
Since Dr. Clancy's message regarding process for scheduling a vaccination appointment, the DC VA has received many calls from VACO staff. Our coordinator came in this morning to over 40 voice mail messages. (b)(5)
(b)(5)

From: Kim, Jane NCP (b)(6)
Sent: Monday, April 12, 2021 8:55 AM
To: Boehm, Denise (b)(6) Califano, Sophia G (b)(6) Varone, Jessica (b)(6) Wallace, Patricia (b)(6)
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

I think you can ask Steve Lieberman and Tammy Czarnecki. (b)(5)
(b)(5)

From: Boehm, Denise (b)(6)
Sent: Monday, April 12, 2021 8:51 AM
To: Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Varone, Jessica (b)(6) Wallace, Patricia (b)(6)
Subject: FW: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Good morning everyone.
(b)(5)

From: US Department of Veterans Affairs (b)(6)
Sent: Friday, April 9, 2021 4:46:12 PM
To: VA All Mailboxes (b)(6)

Subject: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

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Carolyn M. Clancy, M.D.

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From: Upton, Mark T.
Sent: Tue, 13 Apr 2021 00:33:41 +0000
To: Czarnecki, Tammy;Lieberman, Steven
Cc: Oshinski, Renee
Subject: RE: MESSAGE FROM THE ACTING DEPUTY SECRETARY: Coronavirus Disease (COVID-19) Vaccine Information

Hi Tammy and Steve – In anticipation of a potential large # of OCC staff reaching out to local VAMCs as follow up to this memo, I asked for a listing today of locations where we have >100 staff in a given area

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Based on what I learned through additional follow up today, employees at many locations (such as Denver) have already received outreach and have had vaccinations provided through local VAMCs prior to this memo. My suspicion is that the majority of these areas will likely not see a huge influx of requests from our staff.

If there are any concerns from local VAMCs or special instructions I should give to my team as this moves forward, just let me know.

Thanks,

Mark

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Carolyn M. Clancy, M.D.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

From: Upton, Mark T.
Sent: Thu, 31 Dec 2020 15:56:49 +0000
To: Cunningham, Kristin;Greenstone, Clinton;Brill, Elizabeth L. MD, MBA, FACOG
Cc: Triebenbacher, Pauline;Bernard, Edward B.
Subject: RE: message that went out last night
Attachments: FW: Additional Guidance for Prioritizing COVID-19 Vaccine

Thanks for tracking this down Kristin. Adding Pauline/Ed so that we can make sure the new project team is aware on Monday. Appreciate it

---

From: Cunningham, Kristin (b)(6)
Sent: Thursday, December 31, 2020 10:50 AM
To: Greenstone, Clinton (b)(6) Upton, Mark T. (b)(6) Brill, Elizabeth L. MD, MBA, FACOG (b)(6)
Subject: FW: message that went out last night

Message mentioned on HOC today that went out last night about vaccine distribution.

Kristin J. Cunningham, PMP
Executive Officer to the Assistant Under Secretary
for Health for Community Care
Office of Community Care
P – (b)(6)
C – (b)(6)
Email: (b)(6)

From: Petersen, Gabrielle (b)(6)
Sent: Thursday, December 31, 2020 10:38 AM
To: Cunningham, Kristin (b)(6)
Subject: RE: message that went out last night

Correct, we only sent it to the VISN directors. It's attached. Let me know if you have any questions. Thanks!

From: Cunningham, Kristin (b)(6)
Sent: Thursday, December 31, 2020 10:22 AM
To: Petersen, Gabrielle (b)(6)
Subject: message that went out last night

Hi Gabby – Happy New Year – can you share the message about the vaccine distribution with 13? I don't believe we received it.

Thanks!

Kristin J. Cunningham, PMP
Executive Officer to the Assistant Under Secretary

for Health for Community Care
Office of Community Care
P – (b)(6)
C – (b)(6)
Email: (b)(6)

From: Stone, Richard A., MD
Sent: Wed, 30 Dec 2020 21:44:06 +0000
To: VHA VISN Directors;Oshinski, Renee;Kim, Jane NCP
Cc: Jensen, Jon M.;Law, Cassandra M.;Matthews, Kameron;Taylor, Beth A;MacDonald, Jennifer E. (Physician)
Subject: FW: Additional Guidance for Prioritizing COVID-19 Vaccine
Attachments: 12232020 -- UPDATED Department of Veterans Affairs (VA) Guidance on COVID 19 Vaccine.pdf, Attachment A. Risk Stratification for COVID-19 Vaccination 122320.docx

VISN Directors:

COVID-19 vaccination in VHA must balance site-specific resources, needs, vaccine availability, hesitancy, and status of the pandemic locally; as well as strict storage, handling, and transportation parameters of available vaccines. Facilities should follow VHA's prioritization framework for patients and staff (attached), but local flexibility is encouraged and will be critical to maximize access and efficiency, and limit potential waste of vaccine.

If vaccine supply is sufficient, facilities are authorized to progress to lower-risk phases simultaneous with administering to higher-risk Veterans and staff to optimize and quicken the administration of vaccine supply. It is expected that there may be situations where vaccine will be offered to Veterans and staff across multiple risk strata or intended phases.

Network Directors are authorized to employ flexibility in how they offer the vaccine including in what risk order. The risk stratification serves as a guideline, but will require agility and flexibility to confront the daily threats posed by the COVID-19 pandemic.

Richard A. Stone, MD
Executive in Charge

From: Office of the AUSHO Communications (b)(6)
Sent: Wednesday, December 23, 2020 11:58 AM
To: VHA VISN Directors (b)(6) VHA VISN Chief Medical Officers (b)(6) VHA VISN Chief Nursing Officers (b)(6) VHA 15 Operations MCD (b)(6)
Cc: Michaud, Gerald (Jerry) (b)(6) Mole, Larry A. (b)(6) Raftery, Meghan (b)(6) Roos, Joel A. (b)(6) Streich, Lynn T. (b)(6) VHA 106A WMC HR COVID-19 (b)(6) VHA 10BRAP Regulations Appeals and Policy (b)(6) VHA 10BVA-DoD Heatlh Affairs Action (b)(6) VHA 10E ACTION (b)(6) VHA 11 Clinical Services Action (b)(6) VHA 11 Clinical Services Admin Council (b)(6) VHA 11 Clinical Services Program Office Directors (b)(6) VHA 12NUR Nursing Action (b)(6) VHA 13 Community Care Action (b)(6) VHA 15 Operations SS (b)(6) VHA

15HOC Healthcare Ops Ctr Action (b)(6) VHA 17API Action (b)(6) VHA COVID All VISN Action (b)(6) VHA COVID Comms (b)(6) VHA COVID V16 Action (b)(6) VHA COVID V2 Action (b)(6) VHA HR (b)(6) VHA OEM EMCC Command Staff (b)(6) VHA VISN QMOs (b)(6) Kim, Jane NCP (b)(6) Varone, Jessica (b)(6) VHA COVID RR (b)(6) VHA 15 Operations SS (b)(6)

Subject: Memorandum: Updated: Department of Veterans Affairs (VA) Guidance on COVID-19 Vaccine

Good Morning Network Directors,

Please find memorandum titled, Updated: Department of Veterans Affairs (VA) Guidance on COVID-19 Vaccine. The Office of the Assistant Under Secretary for Health for Operations would like to rescind **the original memorandum dated December 16, 2020.** The updated memorandum includes revisions made to **paragraph 4 Reporting**. Differences between CDC and VHA guidance was added to the Attachment A as Appendix C .

1. The purpose of this memorandum is to provide guidance on the U.S. Food and Drug Administration (FDA) authorized use of COVID-19 vaccines under an Emergency Use Authorization (EUA) for the prevention of SARS-CoV-2 infection and COVID-19 disease, and the Centers for Disease Control and Prevention (CDC) published recommendations for use. The guidance in this memorandum will provide information on the storage, handling, distribution, reporting, administration and training for each vaccine. In some cases, this information will be the same regardless of the vaccine (e.g. risk stratification, reporting), and in others, updated logistics, clinical protocols, trainings, and other guidance will be provided through the SharePoint sites below as vaccines are approved.

2. **National Distribution**:

    a. VA will be allocated a specific number of doses of each authorized vaccine. Given that these amounts are not anticipated to be sufficient to vaccinate all patients and staff initially, VA will follow the risk stratification framework included in Attachment A. Phase 1a is approved and final. Phases 1b and 1c are draft and will be finalized after CDC issues recommendations. The VA risk stratification framework can be also be accessed on the VA COVID-19 vaccine SharePoint at: https://dvagov.sharepoint.com/sites/vhacovidvaccine/SitePages/Vaccine-Policies-and-Clinical-Guidance.aspx. As the supply of vaccine increases, this framework will be implemented in the stages indicated. It is expected that VHA should have sufficient supply to offer vaccine to all who are interested in COVID-19 vaccination over the coming months.

    b. Distribution of vaccine to sites that have previously identified capacity to receive, store and administer the COVID-19 vaccine will be coordinated by

VHA Pharmacy Benefits Management (PBM). Site distribution will be based on total allocation for VA, the number of employees and patients in the risk categories and orders previously placed and coordinated by PBM. Each site eligible for vaccine delivery will be given an individual site allocation, and orders may only be placed at quantities at or below that allocation level. Orders from the field can be placed at the following link [https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx].

c. Both first and second doses of vaccine must be from the **same** manufacturer product and should be received in the **same** clinic location.

3. **Logistics and Scheduling:**

a. Logistics of vaccine delivery, storage, and dosing requirements for each authorized vaccine will be posted on the PBM SharePoint: https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx

b. Appointments for second dose vaccination will be made at time of administration of the 1st dose. An immunization card must be provided with date, make and lot # of vaccine given and when 2nd dose is due, and will be provided in the ancillary supply kits supplied with each vaccine.

4. **Reporting:**

a. Administration data for COVID-19 vaccines must be reported electronically to CDC within twenty-four hours of administration. ***The reporting of required data elements will occur via national data extraction and transmission***. This will **require** that all facilities use the national COVID-19 vaccine clinical reminder dialog or dialog group for documentation of vaccines administered to Veteran patients and use the Occupational Health Recordkeeping System (OHRS) 2.0 for documentation of vaccines administered to VA employees.

i. Patients: The national clinical reminder dialog or dialog group for COVID-19 vaccines **must** be completed for **all** Veteran vaccinations (both outpatients and inpatients). Information on the National COVID-19 Clinical Reminder is posted here: COVID-19 Immunization Reminder page

ii. Staff: OHRS 2.0 for documentation of vaccines administered to VA employees. OHRS 2.0 will send the employee a reminder through Outlook mail for those requiring a second dose, but will not schedule the employee for a follow-up visit. Sites must develop a process for this per the guidance in the Assistant Under Secretary for Health for

Operations (AUSHO) Memorandum: *Scheduling COVID-19 Employee Vaccination*, released on December 11, 2020. More information on OHRS 2.0 is available through the AUSHO Memorandum *Coronavirus Disease 2019 (COVID-19) Vaccine Documentation Requirement for Veterans Health Administration (VHA) Employees and Health Care Personnel in the Occupational Health Recordkeeping System 2.0*, released on November 16, 2020 and information is posted on the OHRS 2.0 Training Home Page.

1. *NOTE: All COVID-19 vaccine Memos are posted here: https://dvagov.sharepoint.com/sites/vhacovidvaccine/SitePages/Vaccine-Policies-and-Clinical-Guidance.aspx*

iii. Supply and wastage must be reported to CDC daily. Documentation of vaccine supply, wastage spillage, and safety information will occur through PBM. More information is available here: https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx

iv. COVID-19 vaccine safety surveillance and enhanced Vaccine Adverse Event Reporting System (VAERS) reporting using the National Healthcare Safety Network (NHSN) sites will continue to be coordinated through PBM. More information is available here: https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx

5. **Administration:**

a. Please refer to AUSHO Memorandum: *VA COVID-19 Vaccine Administration for Vaccinators*, released on December 11, 2020, for specific guidance and procedures for eligible healthcare professionals (RNs, APRNs, PAs, LPN/LVNs, MDs, DOs, Pharmacists, and any already authorized Unlicensed Assistive Personnel, or UAPs) who may vaccinate adults for COVID-19.

i. NOTE: All COVID-19 vaccine Memos are posted here: https://dvagov.sharepoint.com/sites/vhacovidvaccine/SitePages/Vaccine-Policies-and-Clinical-Guidance.aspx

b. For sites currently using standing orders for vaccine administration, the sites may proceed with standing orders for vaccination by eligible staff.

c. Please refer to AUSHO Memo: *Updated COVID-19 Vaccination Documentation for Vaccinators* released on December 23, 2020 for specific guidance on documentation of vaccine administration in order to maintain

throughput and preserve personal protective equipment. An acceptable alternative would be for a second person to document vaccination at the point of care, as long as the following requirements are met:

i. The system supports a process with scribes and/or addendums. OHRS 2.0 does not currently have that functionality, but CPRS and CERNER do allow this.

ii. The person documenting vaccination is trained in proper documentation in the appropriate system (CPRS/CERNER) and is able to consistently meet all documentation needs as required by CDC.

iii. The person administering the vaccine is the responsible party for documentation and must review and sign the documentation before the end of the vaccinator's shift.

6. **Training and Education Materials:**

a. Information regarding the mandatory training requirements for staff handling and administering the vaccine is located here: Training Link

b. The COVID-19 Vaccine SharePoint Site provides a host of resources, including operational toolkits for planning, education and training materials, and scientific research. This site includes a Communications Toolkit providing products including frequently asked questions (FAQ) that have been approved for use to communicate and educate both internal and external audiences. Please check back regularly as the content is likely to change frequently as new information emerges.

7. Questions can be submitted to the COVID-19 Resource Room or send an email to (b)(6) @va.gov.

Renee Oshinski

Attachment

Department of Veterans Affairs

Memorandum

Date: December 23, 2020

From: Assistant Under Secretary for Health for Operations (15)

Subj: Updated: Department of Veterans Affairs (VA) Guidance on COVID-19 Vaccine

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)
VISN Chief Medical Officers
VISN Chief Nurse Officers
Medical Center Directors (00)

1. The purpose of this memorandum is to provide guidance on the U.S. Food and Drug Administration (FDA) authorized use of COVID-19 vaccines under an Emergency Use Authorization (EUA) for the prevention of SARS-CoV-2 infection and COVID-19 disease, and the Centers for Disease Control and Prevention (CDC) published recommendations for use. The guidance in this memorandum will provide information on the storage, handling, distribution, reporting, administration and training for each vaccine. In some cases, this information will be the same regardless of the vaccine (e.g. risk stratification, reporting), and in others, updated logistics, clinical protocols, trainings, and other guidance will be provided through the SharePoint sites below as vaccines are approved.

2. **National Distribution**:

   a. VA will be allocated a specific number of doses of each authorized vaccine. Given that these amounts are not anticipated to be sufficient to vaccinate all patients and staff initially, VA will follow the risk stratification framework included in Attachment A. Phase 1a is approved and final. Phases 1b and 1c are draft and will be finalized after CDC issues recommendations. The VA risk stratification framework can be also be accessed on the VA COVID-19 vaccine sharepoint at: https://dvagov.sharepoint.com/sites/vhacovidvaccine/SitePages/Vaccine-Policies-and-Clinical-Guidance.aspx. As the supply of vaccine increases, this framework will be implemented in the stages indicated. It is expected that VHA should have sufficient supply to offer vaccine to all who are interested in COVID-19 vaccination over the coming months.

   b. Distribution of vaccine to sites that have previously identified capacity to receive, store and administer the COVID-19 vaccine will be coordinated by VHA Pharmacy Benefits Management (PBM). Site distribution will be based on total allocation for VA, the number of employees and patients in the risk categories and orders previously placed and coordinated by PBM. Each site eligible for vaccine delivery will be given an individual site

allocation, and orders may only be placed at quantities at or below that allocation level. Orders from the field can be placed at the following link [https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx].

c. Both first and second doses of vaccine must be from the **same** manufacturer product and should be received in the **same** clinic location.

3. **Logistics and Scheduling:**

a. Logistics of vaccine delivery, storage, and dosing requirements for each authorized vaccine will be posted on the PBM Sharepoint: https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx

b. Appointments for second dose vaccination will be made at time of administration of the 1st dose. An immunization card must be provided with date, make and lot # of vaccine given and when 2nd dose is due, and will be provided in the ancillary supply kits supplied with each vaccine.

4. **Reporting:**

a. Administration data for COVID-19 vaccines must be reported electronically to CDC within twenty-four hours of administration. ***The reporting of required data elements will occur via national data extraction and transmission***. This will **require** that all facilities use the national COVID-19 vaccine clinical reminder dialog or dialog group for documentation of vaccines administered to Veteran patients and use the Occupational Health Recordkeeping System (OHRS) 2.0 for documentation of vaccines administered to VA employees.

i. Patients: The national clinical reminder dialog or dialog group for COVID-19 vaccines **must** be completed for **all** Veteran vaccinations (both outpatients and inpatients). Information on the National COVID-19 Clinical Reminder is posted here: COVID-19 Immunization Reminder page

ii. Staff: OHRS 2.0 for documentation of vaccines administered to VA employees. OHRS 2.0 will send the employee a reminder through Outlook mail for those requiring a second dose, but will not schedule the employee for a follow-up visit. Sites must develop a process for this per the guidance in the Assistant Under Secretary for Health for Operations (AUSHO) Memorandum: *Scheduling COVID-19 Employee Vaccination*, released on December 11, 2020. More

information on OHRS 2.0 is available through the AUSHO Memorandum *Coronavirus Disease 2019 (COVID-19) Vaccine Documentation Requirement for Veterans Health Administration (VHA) Employees and Health Care Personnel in the Occupational Health Recordkeeping System 2.0*, released on November 16, 2020 and information is posted on the OHRS 2.0 Training Home Page.

1. *NOTE: All COVID-19 vaccine Memos are posted here: https://dvagov.sharepoint.com/sites/vhacovidvaccine/SitePages/Vaccine-Policies-and-Clinical-Guidance.aspx*

iii. Supply and wastage must be reported to CDC daily. Documentation of vaccine supply, wastage spillage, and safety information will occur through PBM. More information is available here: https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx

iv. COVID-19 vaccine safety surveillance and enhanced Vaccine Adverse Event Reporting System (VAERS) reporting using the National Healthcare Safety Network (NHSN) sites will continue to be coordinated through PBM. More information is available here: https://dvagov.sharepoint.com/sites/VHAPBM/VA_MedSAFE/App/SitePages/COVID-Vaccine.aspx

5. **Administration:**

a. Please refer to AUSHO Memorandum: *VA COVID-19 Vaccine Administration for Vaccinators*, released on December 11, 2020, for specific guidance and procedures for eligible healthcare professionals (RNs, APRNs, PAs, LPN/LVNs, MDs, DOs, Pharmacists, and any already authorized Unlicensed Assistive Personnel, or UAPs) who may vaccinate adults for COVID-19.

i. NOTE: All COVID-19 vaccine Memos are posted here: https://dvagov.sharepoint.com/sites/vhacovidvaccine/SitePages/Vaccine-Policies-and-Clinical-Guidance.aspx

b. For sites currently using standing orders for vaccine administration, the sites may proceed with standing orders for vaccination by eligible staff.

c. Please refer to AUSHO Memo: *Updated COVID-19 Vaccination Documentation for Vaccinators* released on December 23, 2020 for specific guidance on documentation of vaccine administration in order to maintain

throughput and preserve personal protective equipment. An acceptable alternative would be for a second person to document vaccination at the point of care, as long as the following requirements are met:

i. The system supports a process with scribes and/or addendums. OHRS 2.0 does not currently have that functionality, but CPRS and CERNER do allow this.

ii. The person documenting vaccination is trained in proper documentation in the appropriate system (CPRS/CERNER) and is able to consistently meet all documentation needs as required by CDC.

iii. The person administering the vaccine is the responsible party for documentation and must review and sign the documentation before the end of the vaccinator's shift.

6. **Training and Education Materials:**

   a. Information regarding the mandatory training requirements for staff handling and administering the vaccine is located here: Training Link

   b. The COVID-19 Vaccine SharePoint Site provides a host of resources, including operational toolkits for planning, education and training materials, and scientific research. This site includes a Communications Toolkit providing products including frequently asked questions (FAQ) that have been approved for use to communicate and educate both internal and external audiences. Please check back regularly as the content is likely to change frequently as new information emerges.

7. Questions can be submitted to the COVID-19 Resource Room or send an email to (b)(6)

(b)(6)

Renee Oshinski

Attachment

Interim Guidance on Risk-Stratification for COVID-19 Vaccination in VHA

Version 1.1

Interim Risk-Stratification for COVID-19 Vaccination in VHA

VHA's recommendations on risk stratification, also called prioritization, are based on guidance from the independent Advisory Committee on Immunization Practices (ACIP), the Center for Disease Control and Prevention (CDC). This guidance is intended to maximize benefits of COVID-19 vaccine to Veterans and staff when initial supply is limited and help guide outreach and scheduling when supply is robust and larger scale vaccination becomes possible.

It is expected that VA sites will follow this general framework rather than creating separate guidance for each site, with the understanding that it will need customization to reflect local conditions and staff roles, and that flexibility may be needed initially when utilizing vaccines with time-sensitive storage and handling constraints.

CDC guidance comprises broad categories to maximize feasibility across all state and federal jurisdictions. The first groups to be offered vaccine COVID-19 (CDC phase 1a) include healthcare personnel and persons residing and working in long term care facilities, For healthcare personnel, this is based on risk of SARS-CoV-2 infection, risk of transmitting SARS-CoV-2 infection to patients, and public health and infrastructure risk if they are unable to work. Residents in long term care facilities are also among the first to be offered COVID-19 vaccine because they are at heightened risk of morbidity and mortality during the COVID-19 pandemic.

Following Phase 1a vaccination, ACIP voted on December 20, 2020 to offer vaccine to persons 75 years and older and persons who are essential frontline workers as Phase 1b. For Phase 1c, ACIP recommended including persons who are 65 and older, persons with high risk conditions as defined by CDC, and other essential workers. These recommendations were published as official CDC guidance on December 21, 2020 at:
https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x

While the population of enrolled Veterans who are essential workers is not known, more than half of our Veterans are aged 65 and older, and a large proportion of our Veterans have at least one high-risk condition. Because the number of Veterans expected to be offered COVID-19 vaccine during Phase 1 is so high, this group was further stratified by risk categories, to aid sites across VA in an ethical and equitable approach to offering COVID-19 vaccine. With our team of subject matter experts, including ethics, health equity, infectious diseases, infection prevention and control, preventive medicine, occupational health, pharmacy, public health, metrics and measurement, we reviewed risks to specific groups of staff and Veterans associated with COVID-19, and existing evidence and recommendations, to determine which groups should be offered COVID-19 vaccine first within broader categories, in order to maximize benefits to staff and Veterans.
Based on frameworks from the National Academies of Science, Engineering and Medicine (NASEM) (https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus) and discussions of the Advisory Committee on Immunization Practices (ACIP) for CDC (https://www.cdc.gov/vaccines/acip/meetings/index.html) we considered multiple contributors to overall risk, including:

- Risk of acquiring SARS-CoV-2 infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact (risk of harm to society if that person is unable to work)
- Risk of transmitting SARS-CoV-2 infection to others

Note, these risk criteria are not listed in order of weight or importance.

Interim Risk Stratification Table Version 1.1

<table>
<tr><th>CDC-VA</th><th>Staff</th><th colspan="3">Veterans</th><th>Comments</th></tr>
<tr><td>A- 1a</td><td>CLC/SCID unit staff</td><td colspan="3">Veterans residing in VA CLC/SCID</td><td rowspan="19">Staff members not listed, including those who travel between units, should be offered COVID-19 vaccine with the group or unit most resembling their risk profile

For COVID-19 vaccines where rate of anticipated systemic side effects is high according to the applicable EUA fact sheet and/or CDC guidance, it is recommended that COVID-19 vaccination is staggered, so that the number of personnel in each unit receiving vaccine at a given time is low. This will limit absences related to response to the COVID-19 vaccine. Under this scenario, offering COVID-19 vaccine to any HCP would be appropriate, rather than offering sequentially by risk.

*this should comprise the smallest number of staff needed to continue operations, rather than all persons who hold a particular job or role, with intent of keeping the health care system functioning to care for Veterans and keep staff safe.</td></tr>
<tr><td>A- 1b</td><td>Emergency Department, EMT</td><td colspan="3" rowspan="3"></td></tr>
<tr><td>A- 1c</td><td>COVID-19 ICU staff</td></tr>
<tr><td>A- 1d</td><td>COVID-19 non-ICU inpatient staff</td></tr>
<tr><td>A- 1e</td><td>Other staff providing face-to-face care and services for COVID-19 patients</td><td colspan="3"></td></tr>
<tr><td>A- 1f</td><td>Staff in other congregate living settings</td><td colspan="3">Veterans residing in other long term/congregate settings without access to COVID-19 vaccine.</td></tr>
<tr><td>A- 2a</td><td>Core staff critical to function of the hospital and the COVID-19 response (e.g., logistics, facilities operations, police, food services, occupational health, infection control, environmental engineering, limited executive or leadership roles) *</td><td colspan="3" rowspan="11">ACIP (CDC) Phases
1a = Blue
(HCP, LTCF)
1b = Green
(Essential Workers, 75 and older)
1c = Brown
(65-74; high-risk conditions)</td></tr>
<tr><td>A- 2b</td><td>Inpatient staff, non-COVID-19 units</td></tr>
<tr><td>A- 2c</td><td>Staff performing high risk procedures (non-COVID-19, pre-screened)</td></tr>
<tr><td>A- 3a</td><td>Hemodialysis staff</td></tr>
<tr><td>A- 3b</td><td>Oncology/chemotherapy unit staff</td></tr>
<tr><td>A- 4a</td><td>Homeless Outreach staff</td></tr>
<tr><td>A- 4b</td><td>Staff with frequent contact with Veterans who have not been pre-screened for COVID-19 symptoms (screeners, drivers, etc.)</td></tr>
<tr><td>A- 4c</td><td>Outpatient direct care/contact (pre-screened, non-COVID-19)</td></tr>
<tr><td>A- 4d</td><td>Other health care personnel and staff</td></tr>
<tr><td>B- 1a</td><td></td><td>Veterans age 75+</td><td>Homeless Veterans, Hemodialysis patients, Solid Organ Transplant patients or patients who are listed for transplant, and Chemotherapy patients (receiving chemotherapy in a clinic/hospital setting)</td><td>Frontline Essential Workers as defined by CDC</td></tr>
<tr><td>C- 1a</td><td rowspan="3">Other VA services, non-health care</td><td colspan="2">Veterans age 65-74</td><td rowspan="2">Other Essential Workers, as defined by CDC</td></tr>
<tr><td>C- 1b</td><td colspan="2">Veterans younger than 65 with high-risk conditions as defined by CDC</td></tr>
<tr><td>C- 1c</td><td colspan="3">Veterans younger than 65</td></tr>
</table>

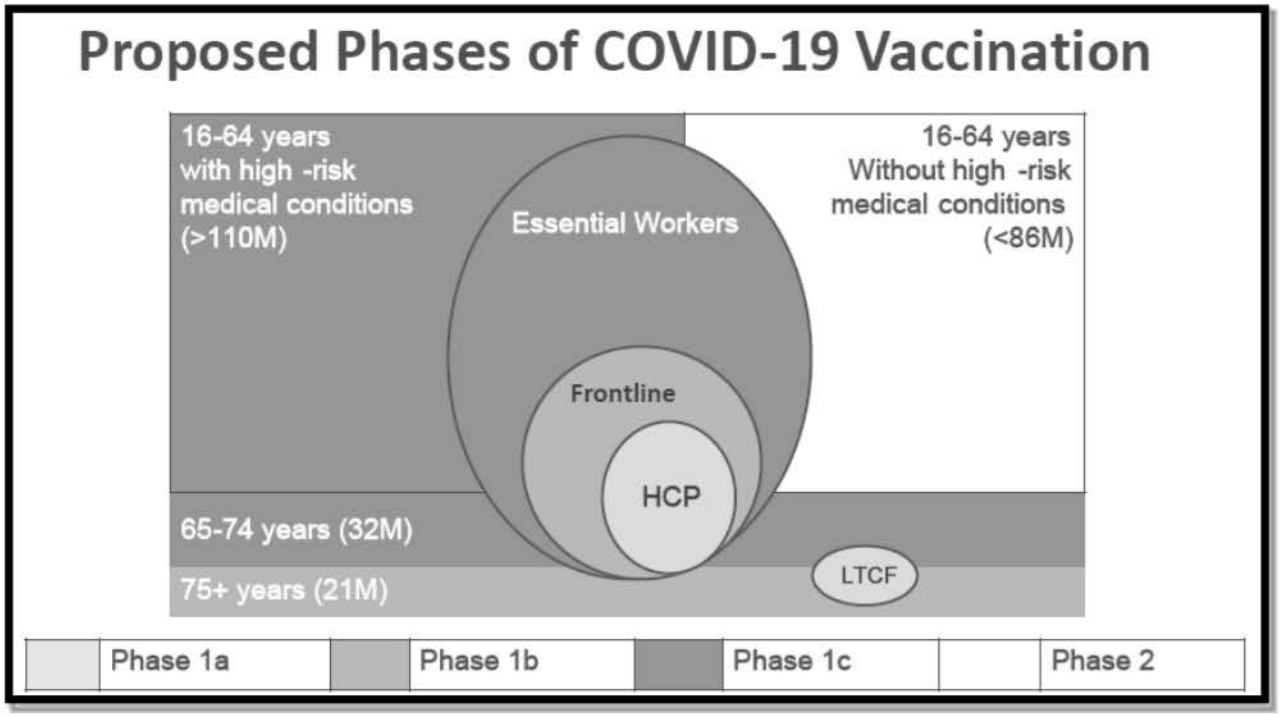
Appendix A: Population Enumeration

Note: this list does NOT contain all conditions that may be on the list of high-risk conditions as defined by CDC. This is because that list is being continually updated. This list may help guide planning, but should not be considered a recommendation for which groups to invite for vaccination. The high-risk conditions as defined by CDC should be used to guide invitation for vaccination.

Category	Estimated Population Size	%
Employees		
Department of Veterans Affairs (Total)	418,688	
Veterans Health Administration (Total)	373,435	
HCP	247,239	
Essential	41,259	
Others	84,937	
Volunteers	61,420	
Trainees	124,190	
Veterans		
Enrolled Veterans (total)	10,075,834	
Age 85 and older	832,973	8%
Age 75-84	1,483,666	15%
Age 65-74	2,675,315	27%
≥65	4,991,954	50%
Veterans Receiving Care	5,821,113	-
≥65	3,063,682	52.6%
High Risk Medical Conditions Please use the CDC high-risk conditions list for vaccination decisions.		
Cancer	544,149	9.3%
Chronic Kidney Disease	339,435	5.8%
COPD	439,287	7.5%
Obesity (BMI of 30 or greater)	2,278,608	39.1%
Cardiovascular disease	2,709,759	46.6%
Sickle cell disease	2,998	0.1%
Type 2 diabetes mellitus	1,556,431	26.7%
Homeless	242,297	
Nursing Home	9998	0.1%
Other congregate settings	2279	0.04%
Rural	1,992,232	34.2%
Veterans with disability (100%)	847,580	14.5%
Veterans with significant disabilities	291,348	5.0%
Home based primary care	144,447	2.5%

Appendix B: ACIP/CDC Phases of Vaccination

This graphic is from the 12/20/20 meeting of the independent Advisory Committee on Immunization Practice (ACIP).



CDC recommends offering vaccine in phases when supply of vaccine is limited initially.

Phase 1a includes healthcare personnel and residents in long term care facilities, was approved by ACIP 12/1/2020, and is now official CDC guidance. ACIP voted on Phases 1b and 1c on 12/20/2020. Phase 1b includes adults 75 and older and frontline essential workers, and Phase 1c includes adults 65-74 and adults 16-64 with high-risk medical conditions. Phases 1b and 1c were published as official CDC guidance on December 22, 2020, available at: **https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x**

Frontline Essential Workers:

ACIP classified the following non–health care essential workers as frontline workers:

- first responders (e.g., firefighters and police officers)
- corrections officers
- food and agricultural workers
- U.S. Postal Service workers
- manufacturing workers
- grocery store workers, public transit workers
- those who work in the education sector (teachers and support staff members)
- childcare workers

Other Essential Workers: Essential worker sectors recommended for vaccination in Phase 1c include those in transportation and logistics, water and wastewater, food service, shelter and

housing (e.g., construction), finance (e.g., bank tellers), information technology and communications, energy, legal, media, public safety (e.g., engineers), and public health workers

https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x

https://www.cdc.gov/mmwr/volumes/69/wr/mm6949e1.htm?s_cid=mm6949e1_w

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-20/02-COVID-Dooling.pdf

CDC uses Cybersecurity & Infrastructure Security Agency definitions for essential workers and noted that this comprises about 87 million persons in the United States.

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-20/02-COVID-Dooling.pdf

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations-process.html

Appendix C: Differences between CDC and VHA guidance

VHA guidance closely follows guidance from CDC with a few branch points that are in keeping with the general CDC framework.

- CDC guidance states: "State and local health authorities will need to take local COVID-19 epidemiology and demand for vaccine into account when deciding to proceed to the next phase or to sub prioritize within an allocation phase if necessary." https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x

1. The first exception is that VHA includes a small subgroup of Veterans that may be younger than age 75 in Phase 1b, because they fall into several categories of risk.
    - This includes Veterans who are homeless, Veterans with Solid Organ Transplant, with particular emphasis on the peri-transplant period, and Veterans who are treated with hemodialysis or chemotherapy in a hospital or clinic setting.
    - These groups are not only at elevated risk for morbidity or mortality from COVID-19 disease, but also have an additional exposure/transmission risk, which is of particular importance during surges of SARS-CoV-2 infection.
        - For homeless Veterans, there is increased risk of needing to be in congregate living settings/shelters, particularly during the upcoming winter months.
        - For Veterans receiving in-facility chemotherapy or hemodialysis, they will be present in a hospital or clinic setting, generally shared with other high risk Veterans, on a regular basis, which means increased risk of exposure to infection or of passing it to others who are also at high risk.
        - For Veterans in the peri-transplant period for solid organ transplant, there is not only a very high morbidity and mortality associated with COVID-19 disease, but there is also a planned period of profound immunosuppression and hospitalization in the post-transplant period. Ideally, this group would be offered COVID-19 in the pre-transplant period, when immune response to vaccine might be greatest, and prior to planned hospitalization, surgery, and intensive care unit stay.
2. The second branch-point is a sub-stratification in CDC Phase 1c.
    - CDC Phase 1c includes persons who are 65 and older, and persons with high-risk conditions. VHA sub-stratifies this into persons 65 and older, followed by younger persons with a high-risk condition.
        - Note that in
        - Evidence specific to our Veteran population suggests that age has a greater influence on COVID-19-related mortality than even presence of multiple high-risk conditions
        - A very large proportion of the Veterans served in VA have high-risk conditions and/or are aged 65 or older, making CDC Phase 1c a very large population

CDC guidance is available here:

https://www.cdc.gov/mmwr/volumes/69/wr/mm6949e1.htm?s_cid=mm6949e1_w

https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x

Appendix D: Using the risk-stratification (prioritization) table

Using the risk-stratification framework: Groups of staff not specified

Note: risk stratification assumes sites are following infection control guidance on personal protective equipment and screening measures.

This table includes only categories of staff and units with predictable exposure risks across VA; others, such as food service workers, environmental management, IT, radiology and engineering, are not specifically assigned because exposure and risk patterns varies significantly from site to site.

It is expected that all staff will be accounted for in your local COVID-19 vaccine plan. Because of variation in assignments and movement patterns from site to site, local determination must be made based on local patterns of movement and exposure.

For each subset of staff that are not directly mentioned in this framework, the three major risk-based criteria that form the basis for prioritizing healthcare personnel vaccination should be compared to those of the units listed (risk of acquiring SARS-CoV-2 infection, risk of transmitting SARS-CoV-2 infection to others, and societal/hospital impact if unable to work). Staff members should be offered vaccine along with the group or unit most resembling their risk profile. For example, Home Based Primary Care providers who care for COVID-19 patients may fall under "Other staff providing face-to-face care for COVID-19 patients"; those who perform high risk procedures in the home but do not care for COVID-19 patients may fall under "Staff performing high risk procedures"; and those who perform general outpatient care of patients without COVID would fall under "Outpatient direct care". Similarly, food service workers may be offered vaccine along with the COVID+ units if they spend significant time interacting with patients in that setting. See additional examples at the end of this section.

Staff who do not interact with patients at all may be considered essential personnel depending on their role. Some staff may also be considered to be "core staff critical to the function of the hospital and the COVID-19 response" even if their role is virtual, but caution must be taken to ensure that front line staff at highest risk for exposure to COVID-19 are at the forefront, and this exception should be used judiciously. See additional examples at end of this section.

Using the priority framework: Progressing through phases

The intent of the framework is to collaborate in the public health response to the COVID-19 pandemic and follow the national COVID-19 vaccine framework per CDC guidance to maximize benefit when vaccine quantities are limited. It is important to note that CDC recommends local flexibility in determining when to progress from one phase to the next: "State and local health authorities will need to take local COVID-19 epidemiology and demand for vaccine into account when deciding to proceed to the next phase or to sub prioritize within an allocation phase if necessary."
https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x
It is expected that there will be some overlap between phases as vaccine is offered.

Using the priority framework: Age stratification and Risk stratification

The relative effects of comorbid 'high-risk' conditions on overall COVID-19 risk are attenuated in older age groups (because of the high level of risk associated with increasing age). The role of high-risk conditions as defined by CDC and membership in certain high-risk racial or ethnic

minority groups becomes increasingly important in younger age groups, as overall risk decreases. The expectation is that VA will have ample availability of COVID-19 vaccine within Phase 1c, and it is for this reason that risk groups are addressed as a priority for outreach but are not tightly stratified.

If vaccine supply remains limited during phase 1c, use of the Veteran Outreach Tool allows sub-stratification by number of high-risk conditions as defined by CDC. Veterans may be further stratified based on presence of 5+ high-risk conditions, 4+ high-risk conditions.

Outreach and education to ensure that we communicate with and promote access for Veterans in high-risk racial and ethnic minority groups and Veterans with high-risk medical conditions must be a focus of COVID-19 vaccination planning at all sites.

Using the risk-stratification framework: Flexibility of the framework

- **Flexibility for Staff**
  As above, it is expected that this framework will be followed to ensure that benefits to staff and Veterans are maximized during periods of limited vaccine supply and that vaccine is offered in a way that is ethical and equitable. However, local flexibility is needed in assigning staff not specifically mentioned, as noted under “Groups of staff not specified”. Additionally, significant flexibility may be needed for feasibility of use with vaccine products requiring ultra-cold storage methods. While it is expected that general principles of this framework will be followed, it is possible that additional staff or Veterans who are not in the highest risk groups may need to be included in several scenarios, including if: interest in initial vaccine is low (i.e., vaccine hesitancy); there are cancellations among scheduled staff or Veterans and a waitlist must be utilized to avoid wasting vaccine; or significant side effects from vaccine are expected (e.g., it may be preferable not to vaccinate entire units of staff simultaneously if potentially work-curtailing side effect from vaccination are common, as this would jeopardize ability to work, and potentially affect safety of other staff and Veterans).

- **Flexibility for Veterans**
  It is expected that this framework will be followed when offering COVID-19 vaccine to Veterans to ensure equitable vaccination across VA. While it is expected that general principles of this framework will be followed, it is possible that additional staff or Veterans who are not in the highest risk groups may need to be included in several scenarios, including if: interest in initial vaccine is low (i.e., vaccine hesitancy); there are cancellations among scheduled staff or Veterans and a waitlist must be utilized to avoid wasting vaccine; or significant side effects from vaccine are expected (e.g., it may be preferable not to vaccinate entire units of staff simultaneously if potentially work-curtailing side effect from vaccination are common, as this would jeopardize ability to work, and potentially affect safety of other staff and Veterans).
  For the first dose in the vaccine series, it is not expected that COVID-19 vaccines be held if there is delay among Veterans in the highest risk groups in returning calls and mailings for scheduling, and it is reasonable to continue on to next priority groups as long as reasonable attempts have been made to reach and schedule Veterans in the higher risk group.

Using the priority framework: sub-stratification
If vaccine supply does not cover the size of a population group in the risk stratification table, consider further stratifying by age, as risk rises significantly with increased age. For example, could start with persons 85 and older if there is insufficient vaccine for all persons 75 and older. Can further stratify by high risk conditions, as defined by CDC, by using the Veterans Outreach tool, which will allow sorting by number of high-risk conditions.

Using the priority framework: staff and Veterans who opt out for the first vaccine
For staff and Veterans who opt out of receiving the first COVID-19 vaccine but are in a priority group to vaccinate early, they should still be eligible to receive COVID-19 vaccine later even if unwilling or unable to receive COVID-19 vaccine initially, unless they have changed jobs/roles and no longer meet criteria for prioritization. These staff and/or Veterans should be considered and scheduled along with whichever priority group is prioritized for COVID-19 vaccine at the time they 'opt in' but should not be allowed to take the place of another Veteran that has already been scheduled for COVID-19 vaccination. There is possibility of delays in scheduling due to high demand or limited quantity of COVID-19 vaccine.

Using the priority framework: COVID-19 vaccine requirements.
Being in a high priority group for COVID-19 vaccination means that COVID-19 vaccine should be offered. ***However, COVID-19 vaccination will not be required while a vaccine is available under an Emergency Use Authorization.*** Many healthcare personnel are at risk for SARS-CoV-2 infection, and may also transmit SARS-CoV-2 to others, including patients who may be at high-risk for severe COVID-19 disease if they become infected. For this reason, healthcare personnel will be encouraged to get vaccinated to lower risks to themselves, colleagues, and their patients.

Assignments and Personal Protective Equipment: Decision to accept or refuse COVID-19 vaccine

Veterans and staff should continue to follow infection control recommendations regardless of COVID-19 vaccination status, including masking for source control and distancing. Staff should not be assigned differently based on their decision to accept or decline vaccine, as this may create incentives to either receive or decline vaccination.

Additional Examples:

There is some degree of risk associated with any in-person work during the COVID-19 pandemic and the goal is to eventually offer COVID-19 vaccine to all staff. While supply of COVID-19 vaccine is limited, it must first be offered to those with highest risk of exposure to COVID-19 in the workplace, those caring for the most vulnerable patients, and those critical to continued ability to maintain operations, care for Veterans, and keep staff safe. This list is not inclusive of all occupations and is meant to provide examples to guide decision making at the facility level.

CLC – to start with a unit listed, it is expected that all staff performing roles on this unit where they will be interacting closely with Veterans and other unit staff will be offered vaccination with

the unit. This may include, for example, nurses, physicians, technicians drawing blood, other unit-based personnel.

Food Services –personnel should be prioritized based on with whom they interact, which determines their risk of COVID exposure in the workplace. If frequent close contact* with COVID-positive patients is expected, it may be most appropriate to offer those staff vaccine along with staff in those units. If they do not enter rooms on those units, it may be more appropriate to offer vaccine with non-COVID inpatient or outpatient staff, depending on pattern of service.

Environmental Management Services –should be considered similarly to food services, based on units in which service is provided.

Nursing staff who work in multiple units – nursing staff working across multiple units should be offered vaccine with the highest risk unit in which they are assigned.

Scheduling staff – when to offer vaccine to scheduling staff will depend on the environment in which they work. If they have direct contact with Veterans, they should be assigned according to whether that includes close contact with COVID positive, unscreened, or pre-screened Veterans.

Van Drivers – van drivers interacting with Veterans who have been pre-screened as with hospital entry may be considered at similar risk to outpatient non-COVID clinics, provided they have the same personal protective equipment (PPE). If Veterans have not been pre-screened, it would be most reasonable to consider them along with persons who interact with Veterans who have not been pre-screened.

Entry Screeners – entry screeners for hospitals and clinics may have close contact with persons who have not been pre-screened for COVID signs and symptoms.

Vaccination Providers – risk should be considered based on screening processes and likelihood of close contact with persons who are COVID positive, in comparison to units listed.

Anesthesiology – risk should be considered based on whether services are performed on COVID-positive patients (similar risk to COVID ICU personnel), pre-screened patients only (risk similar to those performing high-risk procedures) or include roles such as functioning on a cross-cutting code team (risk similar to the staff in the highest-risk unit that the code team serves).

Gastroenterology – this is an example of a specialty where some may be performing high risk procedures, some on COVID-positive patients (similar risk to COVID unit personnel), some on pre-screened patients (similar risk to those performing high risk procedures) while others may provide virtual care only (offered vaccine after it has been offered to staff providing in-person care). Risk stratification should align with services provided.

Home Based Primary Care – risk will depend on whether care is provided for COVID-positive patients, whether high-risk procedures are performed, and on symptom screening processes.

Support staff on site, no patient contact –staff will need to be considered based on risk. Limited personnel may be considered as critical to operations, while most would be offered vaccine after all Veteran/patient-facing staff have been offered.

VA Central Office Employees – these staff are expected to be offered vaccine after healthcare personnel, with limited exceptions for those persons critical to maintain operations or critical to the COVID response.

Staff working virtually – these staff would be considered after staff providing in-person care. There may be limited exceptions to keep a minimum core of staff for ongoing care of Veterans.

* definition of close contact should follow CDC definitions.

Appendix E: Ethical Justifications for COVID-19 Vaccine Allocation in a Situation of Scarcity

VHA's National Center for Ethics in Health Care

When allocating a scarce health care resource, such as a vaccine, VA health care leaders and experts must develop an ethically justifiable plan or framework for how to allocate the resource. When vaccines against SARS-Cov-2, the virus that causes COVID-19, first become available, there will be a limited supply of doses, requiring a fair plan to determine who will receive the vaccine first. If we only have 100 doses of a vaccine, and 1000 people need to be vaccinated, selecting who should receive the vaccine will depend on several factors. Are the individuals being considered for COVID-19 vaccination similar to those on whom safety and efficacy of the vaccine has been demonstrated? Will targeting the COVID-19 vaccine to these individuals or groups better stop the spread of the virus? What are practical methods for vaccine administration? Unfortunately, there are many unknowns related to COVID-19 that challenge the ability to unequivocally predict which vaccine allocation framework will provide the most benefit and avoid the most harm to individuals and society. However, VA has developed an ethically defensible approach to vaccine allocation that has been informed by a wide range of subject matter experts.

In the very early phase of vaccine availability, the goal will be to select only individuals meeting certain scientific and ethical criteria to vaccinate so that benefit to Veterans and VA staff is maximized, and everyone is treated with equal respect. As more vaccine becomes available, the goal will be to expand outreach so that the greatest number of Veterans and VA staff will be vaccinated to achieve community immunity (also referred to as "herd immunity") from COVID-19. Below, we expand on the ethical justifications for the VA's proposed allocation plan. This includes maximizing benefit to Veterans, treating people with equal concern (meaning attributing the same worth to all individuals regardless of their vaccine allocation priority), and addressing health inequities as they relate to vaccination.

Maximizing benefit

The ethical principle of utility involves seeking the greatest good for the greatest number of people—that is, maximizing benefit to society. Assuming that an FDA authorized or licensed vaccine mounts a sufficient immune response against the SARS-CoV-2 virus, three categories of benefit may be achieved: (1) sparing infection, illness, and death from COVID-19 in vaccinated individuals; (2) not spreading the virus; and (3) allowing vaccinated individuals to continue serving as essential workers. In the early phase of COVID-19 vaccine deployment, when there is more demand than supply, benefit is maximized by vaccinating individuals for whom all three categories of benefit can be achieved. Because COVID-19 spreads fastest in areas where there are people in close quarters and harms are greatest for those who are vulnerable to becoming seriously ill (e.g., elderly people with multiple medical conditions), prioritizing health care workers who care for such individuals will mitigate the spread of the virus to the patients in their care. COVID-19 vaccination would thus begin with the staff of community living centers (CLCs) and spinal cord injury and disorder (SCID) facilities, followed by vaccinating patients in these facilities. This is justified because the patients there are at higher risk of contracting COVID-19 and suffering severe or fatal outcomes. In a modeling study from

CDC, vaccinating staff first was likely to more effectively halt viral contagion in such facilities. This is because staff interact with a greater number of individuals and can more easily spread the virus, especially when infected with SARS-CoV-2 but showing no symptoms of COVID-19. Also, staff (being generally younger and healthier) may more effectively mount an immune response as a result of receiving the COVID-19 vaccine.

The categories of persons allocated to receive the vaccine next represent evaluations, in decreasing order of priority, of which VA staff and Veterans are most likely to transmit SARS-CoV-2to others, be removed from critical professional functions, and/or are most at risk of contracting SARS-CoV-2 and suffering serious or fatal illness. The latter (individuals at highest risk of suffering serious or fatal illness) are those with advancing age and presence of comorbid conditions such as asthma, kidney disease, diabetes, high blood pressure, and obesity. As more becomes known about COVID-19, adjustments may be made to these allocation phases to achieve maximum benefit to the most people from the vaccine allocation framework.

It is important that Veterans and VA staff maintain trust in VA's plan for COVID-19 vaccine allocation. Allocation decisions should be based on the principles outlined here and not on arbitrary factors or individual favoritism or perceived social worth. For example, if COVID-19 vaccine is dispatched to a CLC facility and all CLC staff with direct patient contact are eligible to be vaccinated, all such staff should have an equal opportunity to be selected for vaccination, rather than using an ad hoc process. Effectively informing COVID-19 vaccine-eligible individuals of the risks and benefits of the candidate vaccine and establishing a fair and transparent process for selecting which individuals to vaccinate is essential. All communication should be truthful and respectful to earn, secure, and maintain trust in the COVID-19 vaccination program.

Independent of the COVID-19 vaccine allocation protocol, vaccine acceptance will be critical for any vaccine program because to achieve community immunity, most VA Veterans and staff will need to be vaccinated against COVID-19. A recommended approach is to provide tailored education to individuals on both the benefits (both to them individually and to society) and burdens of and concerns with accepting the vaccine and to appeal to altruism and solidarity in achieving vaccine acceptance. Special efforts are necessary to minimize the number of vaccine non-adopters, a term encompassing individual hesitant to accept vaccine (due to lack of information, misinformation, or emotional ambivalence) as well as individuals refusing vaccine (Su et al., 2020). Wilson and Wiysonge (2020) demonstrated a correlation between misinformation spread through false news outlets and social media and vaccine non-adoption. This underscores the importance of effective messaging and education.

There are limits to what is justifiable in the interest of maximizing societal benefit. For example, quarantine of individuals who test positive for COVID-19 has been voluntary to date. However, as stated in VHA's *Ethics Guidance for Pandemics,* 2020, "individual liberties may be limited to prevent harm to others; public health measures are established on this basis." Because individual liberty is highly valued, the notion of using the least restrictive means is critical in promoting COVID-19 vaccine acceptance among Veterans and VA staff. Mandating vaccination either when COVID-19 vaccines are first released or later is a matter for discussion; no decision has been made thus far. A COVID-19 vaccine mandate might be justified if a proven safe and effective vaccine is the least restrictive means to prevent serious harm to others and no alternative is available. This evokes the concept of proportionality, which involves weighing risks, benefits, and alternatives.

Criteria to mandate COVID-19 vaccine will not likely be met in the early vaccination program, since COVID-19 vaccines will initially only be available under emergency use authorization (EUA). An EUA is a mechanism through which the U.S. Food and Drug Administration (FDA) may facilitate the availability and use of certain unapproved medical countermeasures, including vaccines, during public health emergencies. Under an EUA, FDA may allow the use of an unapproved medical product, or unapproved uses of approved medical products, in an emergency when certain statutory criteria have been met. FDA has stated that, for a COVID-19 vaccine for which there is adequate manufacturing information, FDA may issue an EUA if FDA determines that the vaccine's benefits outweigh its risks based on data from at least one well-designed Phase 3 clinical trial that demonstrates the vaccine's safety and efficacy in a clear and compelling manner. EUA criteria include that the product may be effective in diagnosing, treating, or preventing a serious or life-threatening disease or condition, that the known and potential benefits of the vaccine outweigh its known and potential risks, and there are no adequate, approved, and available alternatives (FDA, 2017).

Treating people with equal concern

Fairness does not require treating everyone exactly alike. For example, an elderly individual residing in a CLC rightly warrants getting vaccinated earlier than a younger, healthy person living at home because the elderly individual's risk of serious illness and death is greater. This does not mean that the elderly individual is considered more valuable, rather, he or she has greater need to be protected from the virus. Fairness in this context involves giving opportunity of access based on need. Every individual, however, is equally valued and thus should be treated with equal concern. Discharging this ethical duty involves providing consistent, respectful, and accurate communication to earn, secure, and maintain Veterans' and VA staff's trust in the COVID-19 vaccination program.

This duty to show equal concern and respect for all persons likewise disallows deprioritizing older adults for COVID-19 vaccine allocation on a utilitarian basis. For example, some have reasoned that because the mortality rate from COVID-19 is five times higher for individuals 80 years of age and older and that such individuals have limited remaining life years left, this would justify allocating resources to younger individuals with better prognoses and more years of life to enjoy. However, Veterans are older on average than the general population (over 50% of Veterans in VA care are 65 years and older) and denying older Veterans priority access to a potentially lifesaving or disease-sparing vaccine is inconsistent with VA values. Instead, VA's COVID-19 vaccine allocation plan *prioritizes* older Veterans because of their vulnerability to the disease. This is based on an assessment of their need (i.e., sparing disease and contagion) and equal regard for their worth.

Addressing health inequities

National U.S. data show that COVID-19 has disproportionately affected persons of color (Kopel et al. 2020). This is attributed to social injustices that create a higher disease burden and shorter lifespan in this population (Ajilore & Thames 2020). Geronimus (1992) attributed this partly to the concept of "weathering," that lifelong exposure to the stresses of racial disparity and injustice manifests in greater physical and psychological disease burden and less ready access to quality health care and health-related resources. In addition, persons of color are more likely to work and live in settings with higher exposure to SARS-CoV-2. That is, merely being Black or Hispanic or Native American does not cause one to more easily contract SARS-CoV-2. Rather,

the lifetime social disadvantages experienced by persons of color make them more likely to have health problems that predispose them to contract SARS-CoV-2and more often suffer serious or fatal outcomes. Thus, these individuals, along with others who are at risk for suffering serious or fatal illness due to the presence of comorbidities, will be prioritized for COVID-19 vaccine per the allocation plan as a consequence of risk factors.

There is widespread consensus that more must be done to rectify health disparities upstream through improved access to quality education, preventive health care, economic and job opportunities, safe housing and healthy food, reduced exposure to crime and violence, and public safety (CDC, n.d.). The VA plays a role here in its provision of high-quality health care to Veterans. Another way to address health disparities is to reach out effectively to communities of color and others who have been socially disadvantaged to engage them in the vaccination process. Active efforts must be made to address concerns about vaccine safety and fairness in the allocation process. Outreach efforts should engage community champions to ensure that communications are culturally congruent and transparent and remove access obstacles that might thwart individuals who are eligible for vaccine from getting it.

Other duties to address health inequities include ensuring that individuals with disabilities have unimpeded access to vaccine when they are eligible as per the allocation plan. This involves anticipating and removing access barriers by accommodating persons who are blind or have low vision, deaf, or hard of hearing, and cognitively or physically impaired, in communications and logistics for vaccine administration. For example, messaging should be available in plain language and in multiple formats, such as audio, large print, and captioning, and websites or health alerts should provide accessible information.

SUMMARY

Ensuring trust in vaccine allocation decisions requires using objective criteria to justify these decisions with a clear explanation of their ethical basis and applying criteria equally across settings. These ethical criteria are described above. The procedural principles undergirding VA's COVID-19 vaccine allocation framework include fairness, transparency, and reliance on best-available scientific evidence. This requires communication that is tailored to specific groups, consistent, respectful, and accurate to earn, secure, and maintain the trust of VA staff and Veterans under their care.

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Wilson, S.L. & Wiysonge, C. (2020). Social media and vaccine hesitancy. *BMJ Glob Health, 5*(10), e004206.

Appendix F: Evidence Review and Rationale

Healthcare Personnel

Healthcare Personnel are prioritized for vaccination based on risk of acquiring infection, risk of passing infection to others, and risk of harm to society and hospital operations if unable to work.

Among those with status available, healthcare personnel status represented 6% of infections documented in COVID-NET from March 1–May 31, 2020 (Kambhampati). Seroprevalence studies among healthcare personnel have shown high rates, comparable to areas that have had a high burden of SARS-CoV-2 infection.

Kambhampati, A et al. COVID-19–Associated Hospitalizations Among Health Care Personnel — COVID-NET, 13 States, March 1–May 31, 2020. Morbidity and Mortality Weekly.30 October 2020. Accessed 9 Nov 2020 at https://www.cdc.gov/mmwr/volumes/69/wr/mm6943e3.htm?s_cid=mm6943e3_x

Nguyen et al. Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. Lancet. 1 September 2020. Accessed 9 Nov 2020 at https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30164-X/fulltext

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Moscola J, Sembajwe G, Jarrett M, et al. Prevalence of SARS-CoV-2 Antibodies in Health Care Personnel in the New York City Area. *JAMA*. 2020;324(9):893–895. doi:10.1001/jama.2020.14765. Accessed 9 Nov 2020 at https://jamanetwork.com/journals/jama/article-abstract/2769322

Persons residing in nursing facilities

Persons residing in nursing care, including CLC and SCI within VA, have borne a profoundly disproportionate burden of infections, morbidity, and mortality throughout the pandemic. As of November 9, 2020, CMS reported 281,110 confirmed nursing home cases and 63,617 confirmed deaths (CMS). In the US, 9,913,553 cases were reported as of the same date, and 237,037 deaths (CDC). This represents at least 2.8% of infections and 26.8% of deaths in the United States, even though <1% of the United States population resides in nursing care (see note).

In modeling studies presented by the data, analytics, and Modeling task for the Advisory Committee on Immunization Practices for CDC on August 26 2020, a model of vaccinating nursing home healthcare personnel versus nursing home residents showed greater reductions in both infections and deaths when personnel received vaccine (Slayton), which offers support to vaccinating staff in nursing homes first.

Note: In 2016, there were an estimated 286,300 current participants enrolled in adult day services centers, 1,347,600 current residents in nursing homes, (National Center for health statistics) At the end of December 2016, the US population was 324,310,011 (United States Census Bureau).

Centers for Medicare and Medicaid Services. COVID-19 Nursing Home Data. Accessed 9 Nov 2020 at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

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United states Census Bureau. Census Bureau Projects U.S. and World Populations on New Year's Day. 28 December 2016. Accessed 9 Nov 2020 at https://www.census.gov/newsroom/press-releases/2016/cb16-tps158.html

Slayton, Rachel B. Modeling Allocation Strategies for the Initial SARS-CoV-2 Vaccine Supply. Presented for the Advisory committee on Immunization practices 26 August 2020. https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-08/COVID-06-Slayton.pdf

Essential Workers

According to CDC, "workers in essential and critical industries are considered part of America's critical infrastructure, as defined by the Cybersecurity & Infrastructure Security Agency. Current data show that many of these workers are at increased risk for getting SARS-CoV-2 (the virus causing COVID-19). Early vaccine access is critical not only to protect them but also to maintain the essential services they provide U.S. communities." In the November 2020 meeting of the Advisory Committee on Immunization Practices, a proposal was made that offering vaccine to this group is supported by the balance of science, ethics, and ability to implement.

Ethical Principle	Essential Workers (non-healthcare) (~87 million)	Adults with high-risk medical conditions (>100 Million)	Adults age ≥65 years (53 Million)
Maximize benefits and minimize harms	Preserves services essential to the COVID-19 response and overall functioning of society "Multiplier effect"	Reduces morbidity and mortality in persons with high burden of COVID-19 disease and death	Reduces morbidity and mortality in persons with highest burden of COVID-19 hospitalization and death
Promote justice	-Workers unable to work from home (↑exposure risk) -Promotes access to vaccine and may reduce barriers for workers with low vaccine uptake	Will require focused outreach to those with limited or no access to healthcare	Will require focused outreach to those who experience barriers to access healthcare
Mitigate Health inequities	-Racial and ethnic minority groups disproportionately represented in many essential industries -~1/4 of essential workers live in low-income families	Increased prevalence of some medical conditions in race/ethnic minority groups & persons in rural areas -Diagnosis of medical conditions requires access to healthcare	-Highest incidence and mortality in congregate living --Racial and ethnic minority groups under-represented among adults ≥65

McCiung N, Chamberland M, Kinlaw K, et al. The Advisory Committee on Immunization Practices' Ethical Principles for Allocation of Initial Supplies of COVID-19 Vaccine — United States, 2020. MMWR Morb Mortal Wkly Rep. ePub: 23 November 2020. DOI: http://dx.doi.org/10.15585/mmwr.mm6947e3external icon

On December 20, 2020, ACIP separated essential workers into “frontline” and “other”, with “frontline essential workers” falling into Phase 1b, and others falling into Phase 1b.

Frontline Essential Workers:

ACIP classified the following non–health care essential workers as frontline workers:

- first responders (e.g., firefighters and police officers)
- corrections officers
- food and agricultural workers
- U.S. Postal Service workers
- manufacturing workers
- grocery store workers, public transit workers
- those who work in the education sector (teachers and support staff members)
- childcare workers

Other Essential Workers: Essential worker sectors recommended for vaccination in Phase 1c include those in transportation and logistics, water and wastewater, food service, shelter and housing (e.g., construction), finance (e.g., bank tellers), information technology and communications, energy, legal, media, public safety (e.g., engineers), and public health workers

https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x

Work Group assessment: Ethics

Ethical Principle	Essential Workers (non-healthcare) (~87 million)	Adults with high -risk medical conditions (>100 Million)	Adults age ⩾65 years (53 Million)
Maximize benefits & minimize harms	+++	++	+++
Promote justice	+++	++	++
Mitigate health inequities	+++	+	+

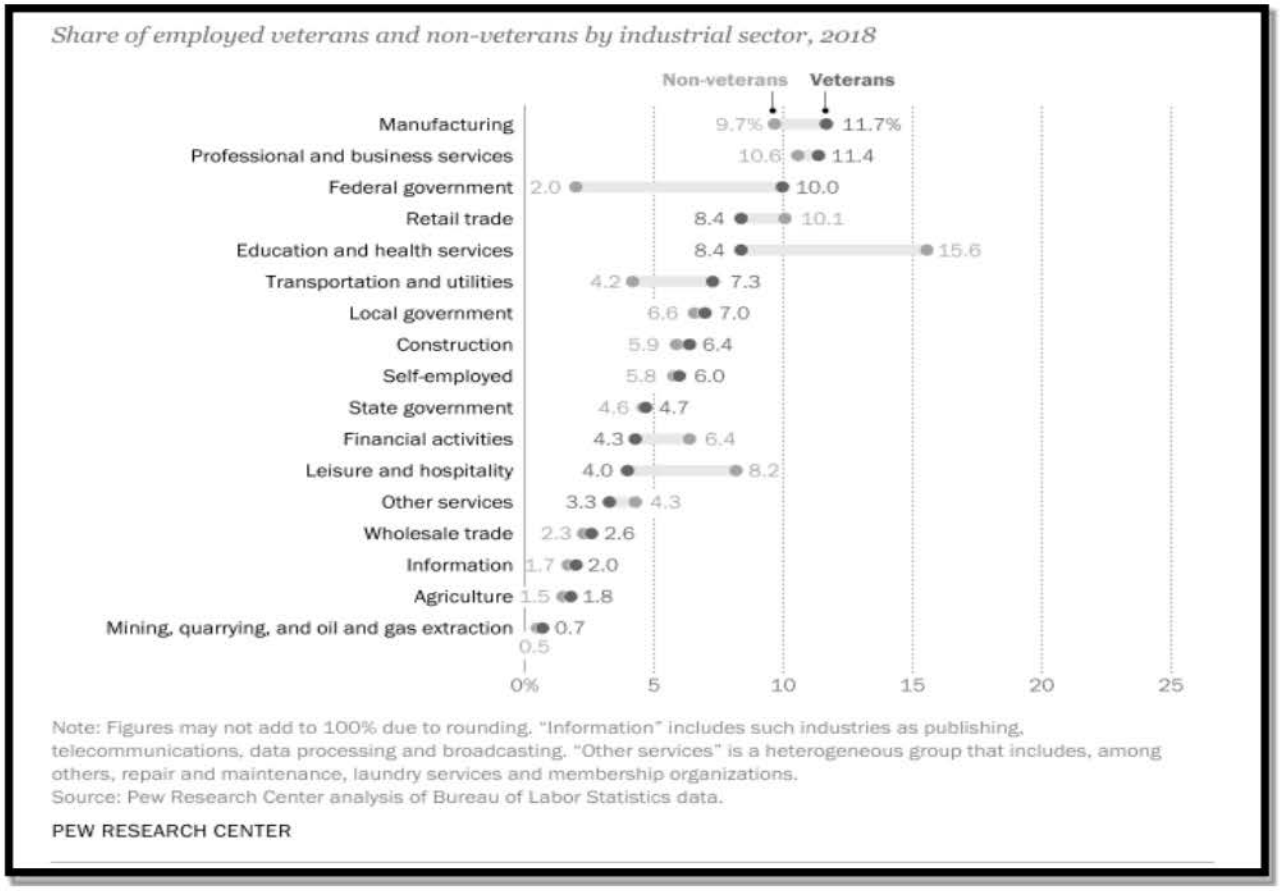
Work Group assessment: Overall

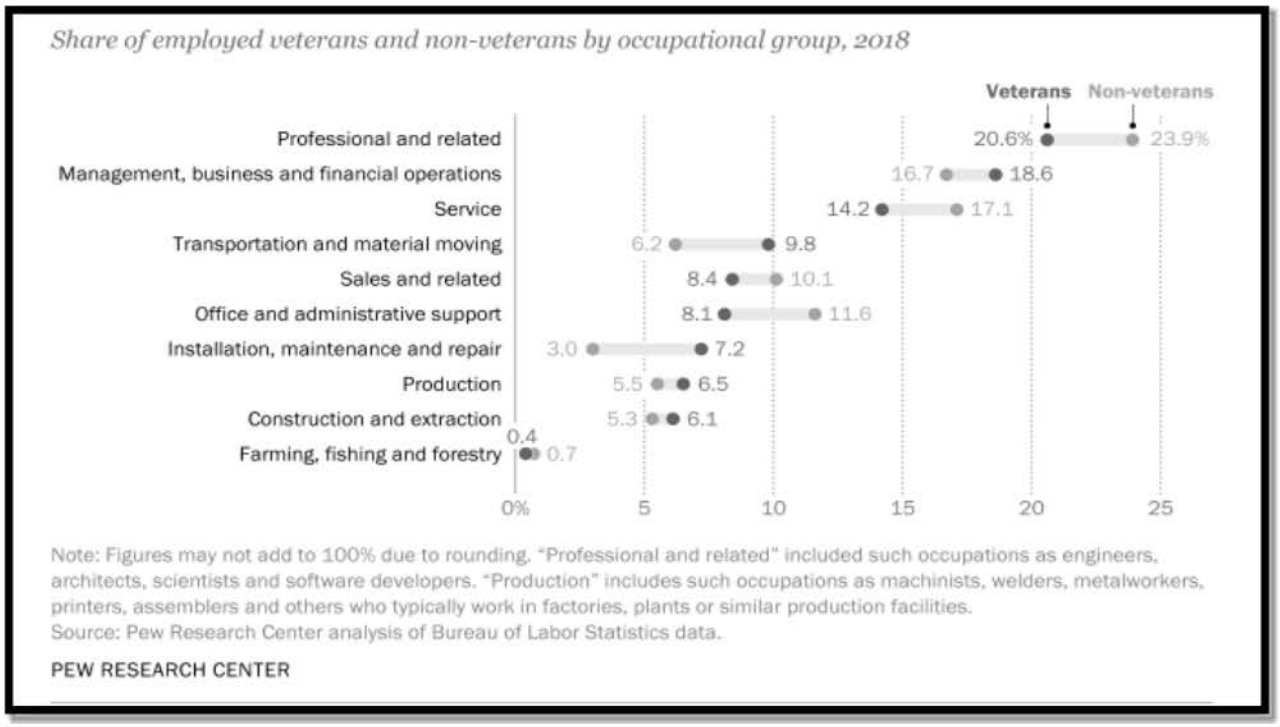
	Essential Workers (non-healthcare) (~87 million)	Adults with high -risk medical conditions (>100 Million)	Adults age ⩾65 years (53 Million)
Science	+++	+++	+++
Implementation	++	++	+++
Ethics	+++	+	+

Dooling, K. Phased Allocation of COVID-19 Vaccines. Advisory Committee on Immunization Practices COVID 19 Vaccine Work Group. ACIP Meeting 23 November 2020. Accessed 27 Nov 2020 at https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-11/COVID-04-Dooling.pdf

Centers for Disease Control and Prevention. How CDC Is Making COVID-19 Vaccine Recommendations. Accessed 27 Nov 2020 at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations-process.html

While the exact numbers of enrolled Veterans who are essential workers is not known, there is some data on employment among Veterans in the United States. Noting that this includes data on Veterans not enrolled in VA care, a 2019 Pew Research Center report noted that, among Veterans, 8.4% were in education and health services, 7.3% in transportation and utilities, 1.8% in agriculture, 4.3% in financial activities, 2.0% in information, and 6.4% in construction.





DeSilver, Drew. How Veterans and non-Veterans fare in the U.S. job market. Pew Research Center. 17 September 2019. https://www.pewresearch.org/fact-tank/2019/09/17/how-veterans-and-non-veterans-fare-in-the-u-s-job-market/

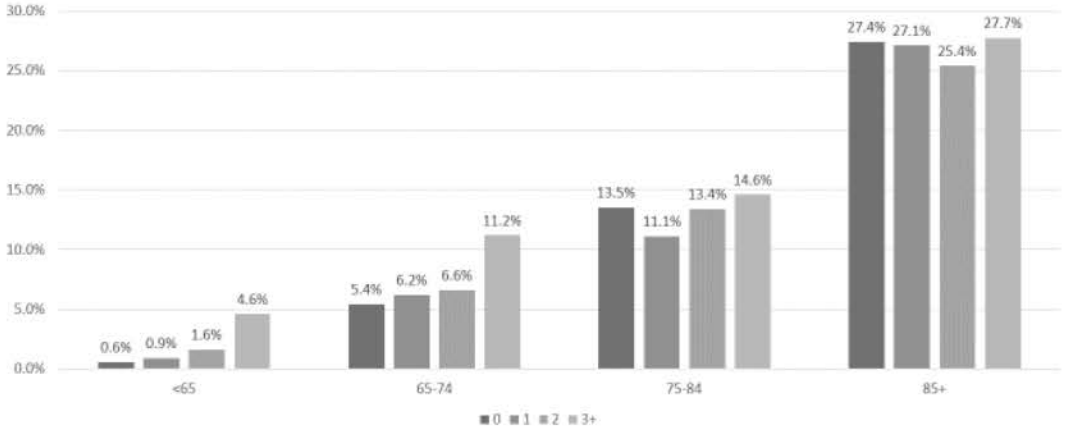
Age

Age has a profound effect on morbidity and mortality related to COVID-19. The Centers for Disease Control and Prevention report that, when compared to persons aged 18-29, hospitalizations are 5 times higher and mortality is 90 times higher in persons aged 65-74; 8 times higher and 220 times higher, respectively, in persons aged 75-84; and 13 times higher and 360 times higher, respectively, in persons aged 85 and older.

On review of COVID-19-associated mortality among Veterans in VHA, age was found to have a stronger association with excess mortality than other high-risk conditions or combination of multiple conditions (see figure below). Among Veterans, increasing age appears to be a much more significant risk factor even than having several high-risk conditions. Additionally, among persons aged 75 and older, having one or several high-risk conditions did not appear to significantly alter that risk.

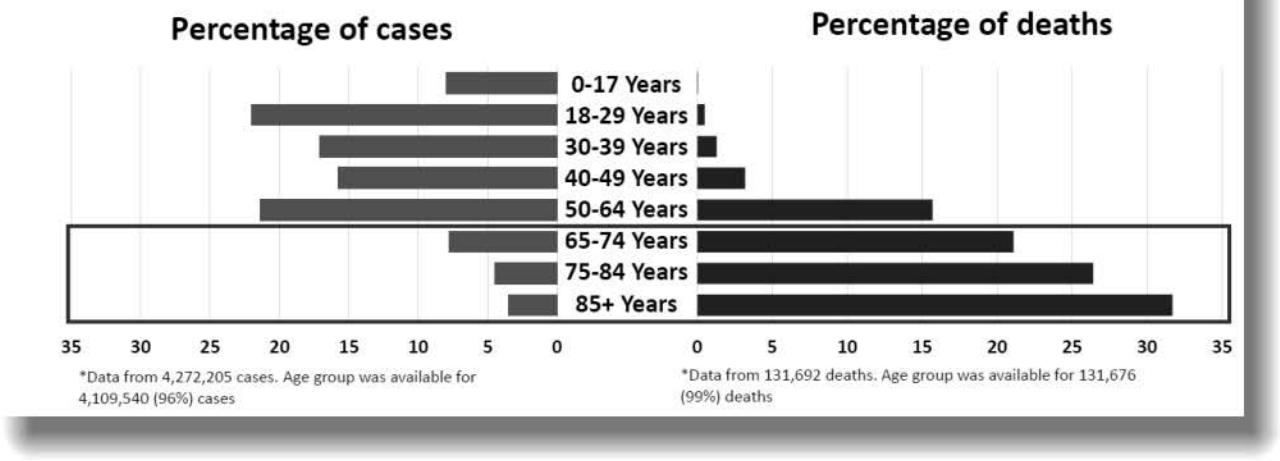
If vaccine supply does not cover the size of a population group in the stratification table, consider further stratifying by age, as risk increases significantly with increased age. For example, could start with persons 85 and older if there is insufficient vaccine for all persons 75 and older.

Mortality Rate among COVID Veteran Cases by Age and # of Comorbidities through 8/27/20

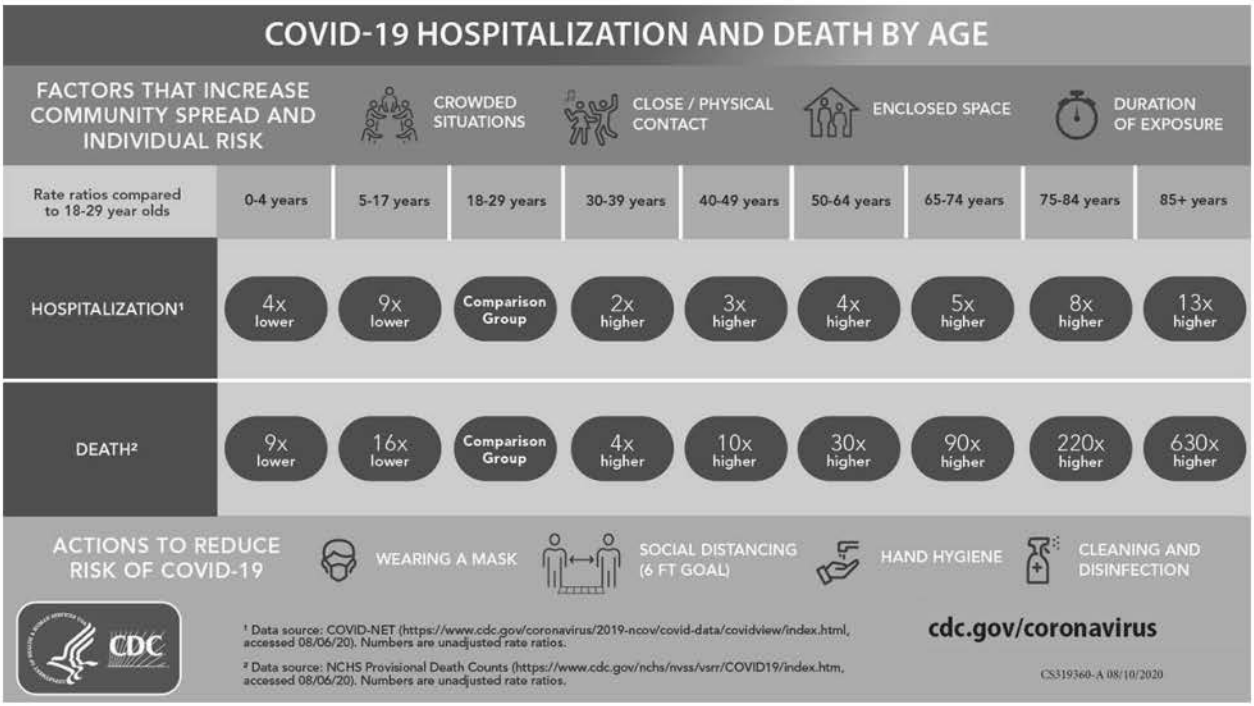


Comorbidities: BMI>=30, asthma, diabetes, CKD, IHD, stroke, COPD

In the United States, adults aged 65 years or older represent 16% of COVID-19 cases, but nearly 80% of COVID-19 deaths



Source: ACIP 8/26 Meeting, McClung



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Veterans on Hemodialysis

Chronic kidney disease is considered a high-risk condition for severe disease from COVID-19 by the Centers for Disease Control and Prevention with similar magnitude of risk to other high-risk conditions. There is less data specific to hemodialysis. However, data from small studies reveals that mortality rates from COVID-19 may be as high as 14.9-30% among hemodialysis patients.

In addition to high risk of severe disease, morbidity and mortality, persons receiving hemodialysis in a facility or center need to be physically present in a healthcare setting several times per week, which means they are at increased risk of acquiring and passing on infection to others who are also at high risk from COVID-19.

It is because of this “triple-risk” that Veterans requiring in-person hemodialysis are stratified among Veterans who should be offered vaccine early: risk of severe disease, morbidity and mortality from COVID-19; risk of acquiring infection; and risk of transmitting infection.

Shimada N, Shimada H, Itaya Y, Tomino Y. Novel coronavirus disease in patients with end-stage kidney disease. Ther Apher Dial. 2020 Oct 11. doi: 10.1111/1744-9987.13599. Epub ahead of print. Accessed 9 November 2020 at. https://onlinelibrary.wiley.com/doi/10.1111/1744-9987.13599

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Ma Y, et al. 2019. novel coronavirus disease in hemodialysis (HD) patients: report from one HD center in Wuhan, China. medRxiv 2020; Accessed 9 November 2020 at https://www.medrxiv.org/content/10.1101/2020.02.24.20027201v3

Veterans with a Solid Organ Transplant or who are listed for transplant

Although it is likely that risk differs by timing relevant to transplant (i.e., likely highest closer to time of transplant), and also differs based on type of transplant, data on solid organ transplantation overall shows increased mortality related to COVID-19 when compared to the general population. In a July review in Transplant Infectious Disease, Moosayi et al found that "excluding studies, in which their data about expired patients were not clear in detail, the mortality rate was 18/79 (22.8%), 3/21 (14.3%), 2/10 (20.0%), and 1/6 (16.7%) among patients with kidney, liver, heart, and lung transplantations, respectively".

In addition to having a high-risk condition, the peri-transplant populations is likely to undergo hospitalization and have frequent medical visits including planned surgery and intensive care unit stay during a period of immune suppression, which increases risk.

When considering magnitude of risk, it is likely highest for those nearer to transplant and those with frequent contact with the healthcare system (i.e. in the peri-transplant period). Because immunologic response to vaccine may be attenuated post-transplant because of immune-suppression, patients listed for transplant are also included, as the ideal timing for offering vaccine would be in the pre-transplant period.

Outreach to this group should emphasize those in the peri-transplant period.

Moosavi, S et al. "COVID-19 clinical manifestations and treatment strategies among solid-organ recipients: a systematic review of cases." *Transplant infectious disease : an official journal of the Transplantation Society*, e13427. 24 Jul. 2020, doi:10.1111/tid.13427 Accessed 18 November 2020 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7404594/pdf/TID-9999-e13427.pdf
Ketcham, S.W., et al., Coronavirus Disease-2019 in Heart Transplant Recipients in Southeastern Michigan: A Case Series. Journal of Cardiac Failure, 2020.

Akalin, E., et al., Covid-19 and Kidney Transplantation. New England Journal of Medicine, 2020. Accessed 10 November 2020 at https://www.nejm.org/doi/full/10.1056/NEJMc2011117

Latif, F., et al., Characteristics and Outcomes of Recipients of Heart Transplant With Coronavirus Disease 2019. JAMA Cardiology, 2020. Accessed 10 November 2020 at https://jamanetwork.com/journals/jamacardiology/fullarticle/2766123

Fernández-Ruiz, M., et al., COVID-19 in solid organ transplant recipients: A single-center case series from Spain. American Journal of Transplantation, 2020. 20(7): p. 1849-1858. Accessed 10 November 2020 at https://onlinelibrary.wiley.com/doi/full/10.1111/ajt.15929

Travi, G., et al., Clinical outcome in solid organ transplant recipients with COVID-19: A single-center experience. American Journal of Transplantation, 2020. Accessed 10 November 2020 at https://onlinelibrary.wiley.com/doi/10.1111/ajt.16069

Tschopp, J., et al., First experience of SARS-CoV-2 infections in solid organ transplant recipients in the Swiss Transplant Cohort Study. American Journal of Transplantation, 2020. Accessed 10 November 2020 at https://pubmed.ncbi.nlm.nih.gov/32412159/

Veterans on Chemotherapy (in person, facility-based)

According to the Centers for Disease Control and Prevention, having current cancer increases risk of severe illness from COVID-19, but it is not known at this time whether a history of cancer increases that risk.

The data on cancer and COVID-19 risk are mixed and limited by heterogeneity of cancer types and prognoses.

It is not clear what role immunosuppression plays in COVID-19 risk. Rather, the rationale for placing Veterans receiving in-person, facility-based chemotherapy is that, in addition to having cancer, they must be physically present in a healthcare setting on a regular basis, generally for prolonged periods of time and often in a communal setting. This means that this group is not only at elevated risk for morbidity and mortality from COVID-19, but also for acquiring and passing on infection.

It is because of this “triple-risk” that Veterans requiring in-person chemotherapy are stratified among Veterans who should be offered vaccine early: risk of severe disease, morbidity and mortality from COVID-19; risk of acquiring infection; and risk of transmitting infection.

Centers for Disease control and prevention. People with Certain Medical Conditions. Accessed 9 Nov 2020 at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html#cancer

Centers for Disease control and prevention. Evidence used to update the list of underlying medical conditions that increase a person’s risk of severe illness from COVID-19. Accessed 9 Nov 2020 at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/evidence-table.html

Fung M, Babik JM. COVID-19 in Immunocompromised Hosts: What We Know So Far. 27 June 2020. Clin Infect Dis. 2020; Accessed 9 Nov 2020 at https://pubmed.ncbi.nlm.nih.gov/32592461/

Liang W, et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. Lancet Oncol. Accessed 9 Nov 2020 https://pubmed.ncbi.nlm.nih.gov/32066541/

Robilotti, EV, et al. Determinants of COVID-19 disease severity in patients with cancer. Nature Medicine. 2020. 26(8): p. 1218-1223. Accessed 9 Nov 2020 https://pubmed.ncbi.nlm.nih.gov/32581323/

Zhang H et al. Outcomes of novel coronavirus disease 2019 (COVID-19) infection in 107 patients with cancer from Wuhan, China. Cancer. https://pubmed.ncbi.nlm.nih.gov/32573776/

Veterans Experiencing Homelessness

There is very limited data available on the impacts of the COVID-19 pandemic on homeless persons, and demographic data including homelessness and housing is not always available for hospitalized patients. However, homeless persons are more likely to have underlying high-risk conditions and fall into older age groups. Additionally, and particularly during the winter months, persons experiencing homelessness are at high risk of needing housing in congregate living settings.

This group was included among Veterans who should be offered vaccine early because of the likelihood of being in a congregate setting, in addition to likely elevated risk of morbidity and mortality from COVID-19.

Veterans who are currently in, or are likely to be in, congregate living such as a shelter, should be prioritized for outreach.

Centers for Disease Control and Prevention. People Experiencing Homelessness. Accessed 4 December 2020 at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/homelessness.html

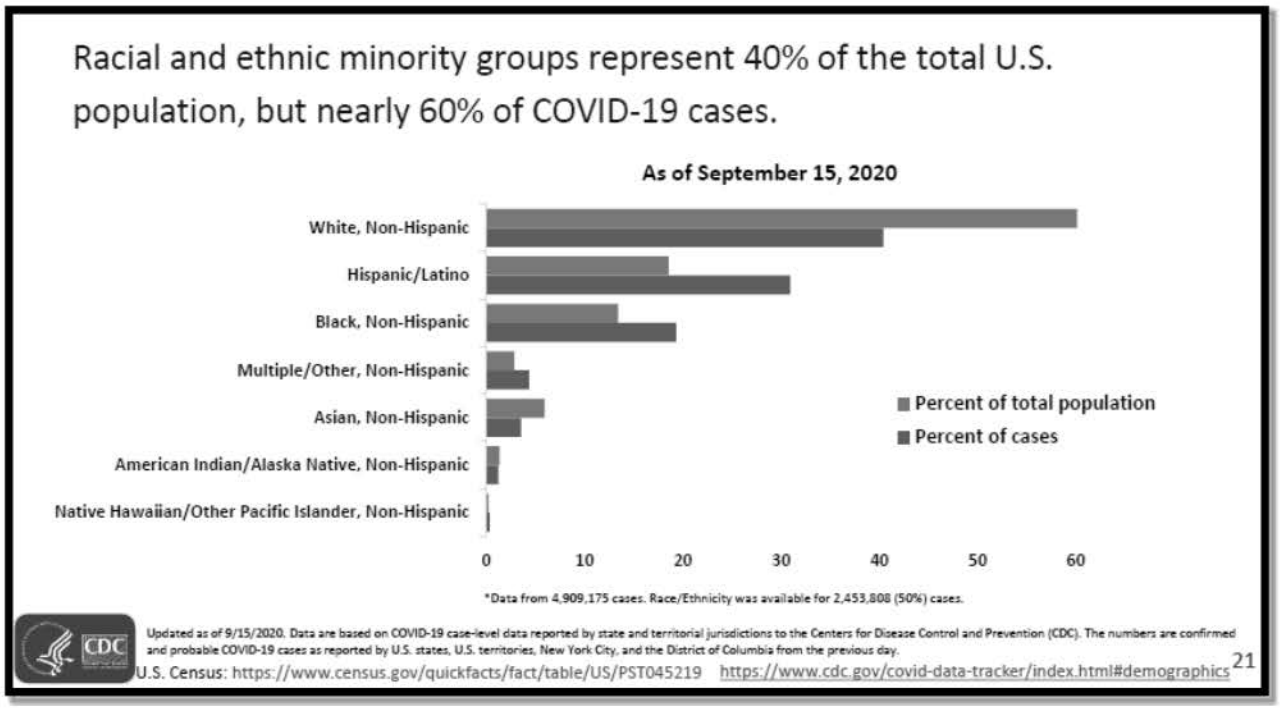
Perri, M et al. COVID-19 and people experiencing homelessness: challenges and mitigation strategies. Canadian Medical Association Journal. 29 June 2020. Accessed 9 Nov 2020 at https://www.cmaj.ca/content/192/26/E716

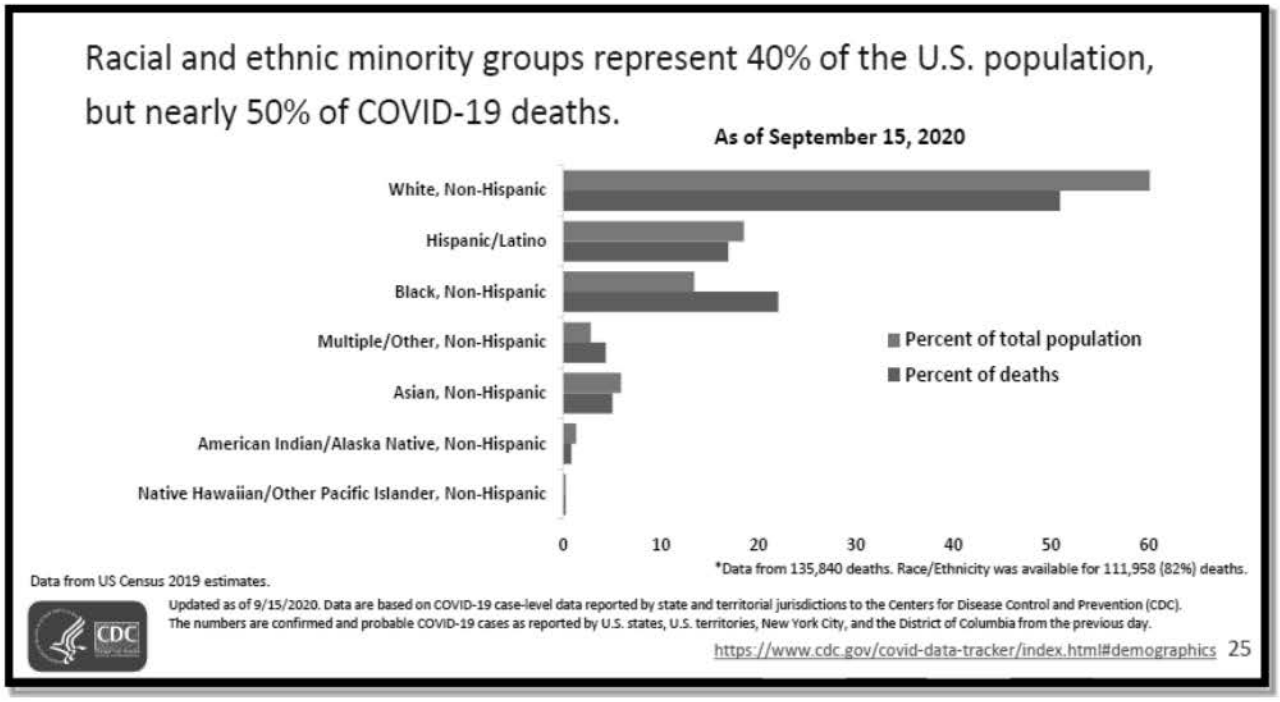
Race and Ethnicity

Certain racial and ethnic minorities are at higher risk for acquiring SARS-CoV-2 infection and for severe outcomes from COVID-19. The disproportionate burden of COVID-19 on racial and ethnic minorities has been well described and is thought to be multifactorial.

Racial and ethnic minorities make up 40% of the population but about 50% of the COVID-19 deaths. In the United States, there are about 25% more COVID-19 deaths in racial and ethnic minorities than there should be based on population size, and the mortality differences indicates that the burden of COVID-19 on these communities cannot be adequately explained by overdiagnosis bias. For some groups, risks associated with COVID-19 are comparable to risks for persons with a high-risk condition, so it is important that this be a focus of outreach and education.

The consideration of race and ethnicity and of health equity was cross-cutting in the deliberations of the Advisory Committee on Immunization Practices and in the deliberations in VHA, where our team included representation from the National Center for Ethics in Health Care and the Office of Health Equity. It is thought that much of the elevated risk relates to factors such as medical conditions and presence in the essential workforce. Over-representation of racial and ethnic minorities and persons of lower socioeconomic status among essential workers was one factor in the prioritization of essential workers by ACIP. In VHA the decision was made additionally to hold listening sessions and include focused communications to promote equitable access to COVID-19 vaccine.





Centers for Disease Control and Prevention. Health Equity Considerations and Racial and Ethnic Minority Groups. Accessed 9 Nov 2020 at https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#anchor_1595551025605

Price-Haygood EG, Burton J, Fort D, Seoane L. Hospitalization and Mortality among Black Patients and White Patients with Covid-19. N Engl J Med 2020. Accessed 9 Nov 2020 at https://doi.org/10.1056/nejmsa2011686.

Millet GA, Jones AT, Benkeser D, et al. Assessing Differential Impacts of COVID-19 on Black Communities. Ann Epidemiol. 2020;47:37-44. Accessed 9 Nov 2020 at https://doi.org/10.1016/j.annepidem.2020.05.003.

Killerby ME, Link-Gelles R, Haight SC, et al. Characteristics Associated with Hospitalization Among Patients with COVID-19 — Metropolitan Atlanta, Georgia, March–April 2020. MMWR Morb Mortal Wkly Rep. ePub: 17 June 2020. Accessed 9 Nov 2020 at http://dx.doi.org/10.15585/mmwr.mm6925e1 .

Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:759–765. Accessed 9 Nov 2020 at http://dx.doi.org/10.15585/mmwr.mm6924e2.

Gold JA, Wong KK, Szablewski CM, et al. Characteristics and Clinical Outcomes of Adult Patients Hospitalized with COVID-19 — Georgia, March 2020. MMWR Morb Mortal Wkly Rep 2020;69:545–550. Accessed 9 Nov 2020 at http://dx.doi.org/10.15585/mmwr.mm6918e1.

Veterans younger than age 75

While the relative effects of comorbid 'high-risk' conditions on overall COVID-19 risk are attenuated in older age groups and other very high risk populations, the role of CDC high-risk conditions and membership in certain high-risk racial or ethnic minority groups becomes increasingly important in younger age groups, as overall risk decreases. It is predicted that VA will have ample availability of vaccine by Phase 1c, and it is for this reason that risk groups are addressed as a priority for outreach but are not tightly stratified.

Outreach and education to ensure that we are reaching Veterans in high-risk racial and ethnic minority groups and Veterans with high-risk medical conditions must be a focus of COVID-19 vaccination planning at all sites. While these groups are categorized together based on similar risks of morbidity and mortality due to COVID-19, the needs of each group are distinct and targeted communications are vital.

Appendix G: Workgroup Members

Lisa Backus, MD, PhD
Acting Chief Consultant Health Solutions
Deputy Chief Consultant, Measurement and Reporting
VHA Population Health Services

Gio Baracco, MD
VISN 8 Infectious Disease Lead
Chief, Infectious Disease Section
Hospital Epidemiologist and Medical Director, Infection Prevention and Control
Miami VA Healthcare System

Pamela Belperio, BCPS, AAHIVP
National Public Health Clinical Pharmacy Specialist
VHA Population Health Services

Sophia Califano, MD, MPH
Deputy Chief Consultant, Preventive Medicine
VHA National Center for Health Promotion and Disease Prevention

Marla Clifton, MSN, RN, CIC
Clinical Programs Coordinator
VHA National Infectious Diseases Service

Jacqueline Cook, MD
Medical Advisor
VHA Office of OSH and GEMS Programs

Kathleen DeRoos, APRN, MSN
Healthcare Associated Infection (HAI) Clinical Program Coordinator
Infection Prevention & Control
VHA National Infectious Diseases Service

Ajay Dhawan, MD
National Director of Medicine
VHA Specialty Care Services

Kelly Echevarria, PharmD
National Clinical Pharmacy Program Manager
VHA Pharmacy Benefits Management

Jane Kim, MD, MPH
Chief Consultant, Preventive Medicine
VHA National Center for Health Promotion and Disease Prevention

Steven Kralovic, MD
Deputy Director
VHA National Infectious Diseases Service

Ernest Moy MD, MPH
Executive Director
VHA Office of Health Equity

Leonard Pogach, MD, MBA
National Program Director
VHA Office of Diabetes and Endocrinology

Gary Roselle, MD
Director
VHA National Infectious Diseases Service

Anita Tarzian, PhD, RN
Deputy Executive Director
VHA National Center for Ethics in Health Care

Patricia Wallace, MSN, RN
Senior Clinical Advisor
VHA Office of Healthcare Transformation

Jennifer Zacher, PharmD
Deputy Chief Consultant
VHA Pharmacy Benefits Management

From: Kim, Jane NCP
Sent: Wed, 10 Mar 2021 20:03:15 +0000
To: Czarnecki, Tammy
Cc: Lieberman, Steven
Subject: RE: NARA
Attachments: Vaccination Program MOA-Fed Agencies_VHA_final 11-9-2020_NM.pdf

Tammy, please see attached.

From: Czarnecki, Tammy (b)(6)
Sent: Wednesday, March 10, 2021 2:59 PM
To: Kim, Jane NCP (b)(6)
Cc: Lieberman, Steven (b)(6)
Subject: NARA

NARA is requesting a copy of the CDC MOU we have since it is referenced in the IAA

Tammy Czarnecki MSOL, MSN, RN
Deputy, AUSH for Operations
iPhone: (b)(6)
Office: (b)(6)

AGREEMENT

Between

Veterans Health Administration

AND

Centers for Disease Control and Prevention

CDC Coronavirus Disease 2019 (COVID-19) Federal Agency Vaccination Program

This Memorandum of Agreement (MOA) sets forth the terms and understanding **Veterans Health Administration** (hereafter referred to as the Agency) and the Centers for Disease Control and Prevention (CDC) (collectively, the Parties), to receive and administer one or more of the publicly funded COVID-19 vaccines (COVID-19 Vaccine), constituent products, and ancillary supplies at no cost. The Agency agrees that it will adhere to the following requirements as a vaccination provider in the CDC COVID-19 Federal Agency Vaccination Program.

BACKGROUND

CDC greatly appreciates the participation of the Agency in the COVID-19 vaccination effort. Participation is a vital service that will protect individuals against SARS-CoV-2, the virus that causes COVID-19. The United States Government (USG) has purchased COVID-19 Vaccine and is making this publicly funded vaccine available to certain Federal Agencies that have critical workforces and serve populations at higher risk for COVID-19. In addition to these responsibilities, Federal Agencies are not always able to be integrated into the usual processes that allow organizations to receive and distribute an allocation of vaccine from the state, territorial, or local jurisdiction (jurisdiction).

Therefore, Federal Agencies may elect to receive COVID-19 Vaccine outside of the standard jurisdictional process. This program is designed to complement jurisdiction-managed immunization programs. The Agency will have an independent, but collaborative, program to provide COVID-19 Vaccine to the Federal civilian workforce in Federal occupational settings and to persons under its care in parallel with jurisdictional immunization programs.

PURPOSE

This MOA will ensure appropriate vaccine distribution, management, and monitoring of the Agency's plans for COVID-19 vaccination. The goal of the USG is to have enough COVID-19 Vaccine for all people in the United States who wish to be vaccinated. In the early stages of availability, there may be a limited supply of COVID-19 Vaccine. Therefore, vaccination efforts may focus on those critical to the response, providing direct medical care, or maintaining essential societal functions, as well as those at highest risk for developing severe illness from COVID-19.

This MOA between CDC and the Agency specifies the conditions for receiving COVID-19 Vaccine from CDC.

ROLES AND RESPONSIBILITIES

The Parties agree as follows:

The Agency will[1]:

1. Administer COVID-19 Vaccine consistent with all requirements, recommendations, and guidance of CDC and CDC's Advisory Committee on Immunization Practices (ACIP).[2]

2. Within 24 hours after administering a dose of COVID-19 Vaccine, record to the extent not already recorded in the vaccine recipient's record, the agreed upon field definitions and specifications for each data population requirement (Appendix A) and report the required Vaccine Administration Data to the CDC.

3. The Agency will submit Vaccine Administration Data for public health purposes through a system as agreed to by the Parties. Data sent from VHA and parsed into the database by CDC will contain only the minimum necessary set of PII and PHI.

4. The Agency will preserve the vaccine recipient's record for at least three years following vaccination or longer in accordance with medical record retention requirements of the Agency. Agency will make such records available, upon request, to any federal, state, local, or territorial public health department to the extent authorized by law.

5. The Agency will not sell or seek reimbursement for COVID-19 Vaccine or any adjuvant, syringes, or needles, or any other constituent products or ancillary supplies that the USG provides at no cost to the Agency. The Agency will not sell and will not seek reimbursement for COVID-19 Vaccine doses administered to the individual.

6. To the extent permitted by law, the Agency will administer COVID-19 Vaccine regardless of the vaccine recipient's ability to pay COVID-19 Vaccine administration fees or coverage status. The Agency may seek reimbursement, to the extent authorized, from a program or plan that covers COVID-19 Vaccine administration fees for the vaccine recipient. Agency may not seek any reimbursement, including through balance billing, from the vaccine recipient.

7. Before administering COVID-19 Vaccine, the Agency will provide an approved Emergency Use Authorization (EUA) fact sheet or vaccine information statement (VIS), as applicable, to each vaccine recipient, the adult caregiver accompanying the recipient (as applicable), or other legal representative (as applicable). If the EUA fact sheet or VIS is available electronically, Agency may provide it in electronic form to the recipient, adult caregiver accompanying the recipient (if applicable), or other legal representative (if applicable), if such person agrees to accept it electronically in the file format offered by the Agency.

8. The Agency will take steps to minimize the potential for transmission of SARS-CoV-2 to vaccine recipients, staff, and others. The Agency's COVID-19 vaccination services must be provided in compliance with CDC's Guidance for Immunization Services During the COVID-19 Pandemic for safe

[1] This MOA expressly incorporates all recommendations, requirements, and other guidance that this MOA specifically identifies though footnoted weblinks. The Agency will monitor such identified guidance for updates and comply with such updates.

[2] https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

delivery of vaccines.[3]

9. The Agency will comply with CDC requirements for vaccine management. Those requirements include the following:

    a. The Agency will store and handle COVID-19 Vaccine under proper conditions, including maintaining cold-chain conditions and chain of custody at all times in accordance with the manufacturer's package insert and CDC guidance in CDC's Vaccine Storage and Handling Toolkit,[4] which will be updated to include specific information related to COVID-19 Vaccine(s);
    b. The Agency will monitor vaccine storage unit temperatures 24 hours a day using equipment and practices that comply with guidance located in CDC's Vaccine Storage and Handling Toolkit[5];
    c. The Agency will comply with CDC-provided guidance for dealing with temperature excursions[5];
    d. The Agency will monitor and comply with vaccine expiration dates; and
    e. The Agency will preserve all records related to COVID-19 Vaccine management for a minimum of three years, or longer if required under the Agency's retention requirements.

10. The Agency will report the number of doses of COVID-19 Vaccine and adjuvants that were unused, spoiled, expired, or wasted, as required by CDC or the relevant jurisdiction. CDC will provide further instructions on how to report.

11. The Agency will comply with all federal instructions and timelines for disposing of COVID-19 Vaccine and adjuvant, including unused doses.[6]

12. The Agency will report the following adverse events (AEs) after vaccination, and other AEs if later revised by CDC, to the Vaccine Adverse Event Reporting System (VAERS)[7] to the extent authorized by law. The Agency will also report any additional select AEs and/or any revised safety reporting requirements per FDA's conditions of authorized use of vaccine(s) throughout the duration of the EUA.

    a. Vaccination administration errors, whether or not associated with an AE
    b. Severe COVID-19 illness (e.g., resulting in hospitalization)
    c. Serious AEs regardless of causality. Serious AEs are defined as:
        i. Death
        ii. A life-threatening AE
        iii. Inpatient hospitalization or prolongation of existing hospitalization
        iv. Persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions
        v. A congenital anomaly/birth defect

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[3] https://www.cdc.gov/vaccines/pandemic-guidance/index.html
[4] https://www.cdc.gov/vaccines/hcp/admin/storage-handling.html
[5] CDC will provide temperature excursion guidance
[6] The disposal process for remaining unused COVID-19 Vaccine and adjuvant may be different from the process for other vaccines; unused (but still viable – *e.g.*, unexpired and properly maintained) vaccines must remain under storage and handling conditions noted in Paragraph 9 until CDC provides disposal instructions; website URL will be made available.
[7] https://vaers.hhs.gov/reportevent.html

vi. Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered serious when, based upon appropriate medical judgment, they may jeopardize the patient and may require medical or surgical intervention to prevent one of the outcomes listed above.

The Agency will also report any additional select AEs and/or any revised safety reporting requirements per FDA's conditions of authorized use of vaccine(s) throughout the duration of any COVID-19 Vaccine being authorized under EUA.

13. The Agency will provide a completed COVID-19 vaccination record card to every COVID-19 Vaccine recipient, the adult caregiver accompanying the recipient (if applicable), or other legal representative (if applicable). Each COVID-19 Vaccine shipment will include COVID-19 vaccination record cards.

14. The Agency will comply with all applicable requirements as set forth by the U.S. Food and Drug Administration, including but not limited to requirements in any EUA that covers COVID-19 Vaccine.

15. The Agency will administer COVID-19 Vaccine in compliance with all relevant federal, state, local, territorial, or tribal vaccination laws to the extent that the Agency incorporates such compliance into their standard medical practices.

16. The Agency will comply with applicable patient assent or consent laws for administration of COVID-19 Vaccine.

17. The Agency will order COVID-19 Vaccine through the CDC vaccine order and tracking system (VTrckS).

18. The Agency will submit to CDC, on a daily basis through methods designated by CDC, the number of doses of COVID-19 Vaccine that the Agency:

    a. has ordered on hand to distribute to its facilities;
    b. has distributed to each Agency location; and
    c. has administered to individuals.

    The Agency will report supply levels using the online web platform VaccineFinder, or other method determined by CDC. Supply quantities will not be made publicly available through this platform. Making information reported into VaccineFinder public will be at the discretion of the Agency.

19. The Agency will ensure secondary locations receiving redistributed COVID-19 Vaccine, constituent products, or ancillary supplies also comply with all conditions in this MOA.

    The Agency will document and make available to CDC any redistribution records of COVID-19 Vaccine sent to secondary facilities or ship-to sites, including dates and times of redistribution, sending and receiving locations, lot numbers, expiration dates, and numbers of doses.

20. Before receiving COVID-19 Vaccine, the Agency will propose, in writing, its minimum capacity for vaccine implementation, including:

    a. Population estimates used for vaccine allocation and potential prioritization

b. The process for ordering through VTrckS, receipt, distribution, and management of COVID-19 Vaccine supply
c. The process for meeting required daily reporting on inventory
d. Confirmation of the system used for reporting required Vaccine Administration Data elements
e. The number of Agency facilities that will administer COVID-19 Vaccine
f. The location of each of those facilities and estimated cold chain capacity within the facility for refrigerated (2°C to 8°C) and frozen (-15° to -25°C) storage conditions
g. The number of COVID-19 Vaccine doses that each facility will be able to administer within defined time periods

CDC will not distribute COVID-19 Vaccine to the Agency unless and until CDC accepts the proposal for vaccine implementation. CDC will notify the Agency of acceptance within 10 days of receipt of the Agency's proposal. Once accepted, the Agency will notify CDC within 24 hours, in writing, of any proposed changes in the vaccine implementation plan. If any of those proposed changes are unacceptable to CDC, CDC may decline to provide further COVID-19 Vaccine.

21. Failure to comply with any of the provisions under this Agreement shall be grounds for immediate dismissal of the Agency in whole or in part from the COVID-19 Vaccination Program.

22. The Agency will work collaboratively with CDC to minimize vaccine wastage to the greatest extent possible.

CDC will:

1. Provide technical assistance to the Agency as it develops end-to-end COVID-19 Vaccine implementation plans.

2. Ship COVID-19 Vaccine to the Agency based on available doses of COVID-19 Vaccine and populations served by the Agency. The allocations will be based on a three-phased approach: Phase 1. - potentially limited supply of COVID-19 Vaccine doses available; Phase 2. - increased number of COVID-19 Vaccine doses available; and Phase 3. - sufficient supply of COVID-19 Vaccine doses for entire population (surplus of doses).

3. Ship COVID-19 Vaccine ordered directly to the Agency's designated facilities or ship-to sites.

4. Work collaboratively with the Agency to minimize vaccine wastage to the greatest extent possible.

DATA REPORTING AND USE

1. **Confidentiality:** Where Data provided pursuant to this Agreement are identifiable or potentially identifiable, Recipient agrees to maintain the confidentiality of the Data to the fullest extent required by applicable law. CDC further agrees to not disclose such Data, including but not limited to names and other identifying information of persons who are the subject of such Data, either during the term of this Agreement or longer, except as consistent with this Agreement or as may be allowed or required by applicable law.

   CDC will protect the privacy and confidentiality of the Data consistent, where applicable, with the

following federal laws: the Privacy Act of 1974; and, to the extent applicable, standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Where other more specific federal laws apply to the Data, CDC will comply with those laws, as well. CDC will seek to assert relevant exemptions to disclosure available under federal law, most critically, where applicable, for personal and/or private information, the disclosure of which would constitute an invasion of privacy; trade secret and commercial or financial information that is private and confidential; or information exempted from release by federal statute.

2. **Security:** CDC will use all reasonable administrative, technical, and physical measures to safeguard Data once transmitted, and to protect Data from unauthorized access, disclosure, use, or modification. This includes setting permissions to access or edit data commensurate with the level of sensitivity of the data. Should there be a data breach and unauthorized disclosure of Data, consistent with applicable legal requirements, CDC will notify appropriate response teams and Agency of the incident and take appropriate measures consistent with applicable laws.

3. **Transfer:** Where Data provided pursuant to this Agreement are identifiable or potentially identifiable or are privileged, sensitive, or confidential, transmission of the Data from the Agency to CDC shall be done in accordance with applicable standards as provided by the National Institute of Standards and Technology (NIST) for ensuring the protection, confidentiality, and integrity of the contents. CDC and Agency may coordinate to implement methods to achieve these outcomes consistent with procedures already in place for similar data exchanges.

4. **Storage:** Data will be maintained and stored in compliance with CDC's security policies and procedures and consistent with applicable law.

5. **Access**: Where Data provided pursuant to this Agreement are identifiable or potentially identifiable or are privileged, sensitive, or confidential, CDC and its authorized users shall access Data on secured devices only.

POINTS OF CONTACT

The following CDC employee is the point of contact under this Agreement:

[Name] (b)(6) MD, MS
[Title] CDR, United States Public Health Service
Centers for Disease Control and Prevention
1600 Clifton Road, N.E.
Atlanta, Georgia 30333
[e-mail address] (b)(6)
[phone number] (b)(6)

The following Agency employee is the point of contact under this Agreement:

Jane Kim, MD, MPH
VHA Chief Consultant for Preventive Medicine
VHA National Center for Health Promotion and Disease Prevention (10P4N, NCP)
Office of Patient Care Services

3022 Croasdaile Dr. Suite 200
Durham, NC 27705
(b)(6)

LEGAL AUTHORITY

This MOA is authorized under sections 301 and 319 of the Public Health Service Act (42 U.S.C. §§ 241 and 247d).

FUNDING

CDC is providing COVID-19 Vaccine as described above. Any activities under this MOA that contemplate future funding by the Parties will be carried out under a separate agreement under which the obligation of funds is appropriate. In general, each Party is expected to bear the costs of its participation in this vaccination program. Nothing in this MOA shall obligate the Parties to any current or future expenditure of resources in advance of the availability of appropriations from Congress.

ENTIRETY

This MOA represents the entire agreement of the Parties with respect to the subject matter hereof and supersedes all prior and/or contemporaneous agreements or understandings, written or oral, with respect to the subject matter of this MOA.

ENTRY INTO FORCE, MODIFICATION, AND TERMINATION

1. This Agreement shall enter into force upon signature by the respective Parties. This Agreement expires 1 year from the effective date (with the option of extension by mutual written agreement of the Parties).

2. The Agency may cease its participation in the COVID-19 vaccination program by providing written notice to CDC no later than two weeks before Agency wishes to end its participation. During that period, Agency will continue to comply with the Agreement.

3. In addition to CDC dismissal of the Agency from the COVID-19 vaccination program in whole or in part as provided in paragraph 21, *supra*, CDC may also terminate this Agreement at any time with two weeks' written notice.

4. The Parties may amend or modify this Agreement at any time through written mutual consent.

IN WITNESS WHEREOF, the undersigned, being duly authorized by the respective Parties, have signed this Agreement.

Done on the _____ of Nov _____, 2020.

FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION:

(b)(6) MD
Director, National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention

(b)(6)

Digitally signed by (b)(6)
Date: 2020.11.17 14:14:40 -05'00'

Title

FOR VETERANS HEALTH ADMINISTRATION:

Steven Lieberman, MD, MBA, FACHE
Acting Deputy Under Secretary for Health
Veterans Health Administration

(b)(6)

Title

From: Law, Cassandra M.
Sent: Thu, 10 Jun 2021 13:50:58 +0000
To: Lieberman, Steven;Oshinski, Renee
Cc: Jensen, Jon M.
Subject: RE: New Leave Program Associated with COVID

With negotiations underway (b)(5) you should connect with LMR.

Cassie

From: Lieberman, Steven (b)(6)
Sent: Thursday, June 10, 2021 9:43 AM
To: Law, Cassandra M. (b)(6) Oshinski, Renee (b)(6)
Cc: Jensen, Jon M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

Not yet. National conversations with the unions are underway

From: Law, Cassandra M. (b)(6)
Sent: Thursday, June 10, 2021 9:42 AM
To: Lieberman, Steven (b)(6) Oshinski, Renee (b)(6)
Cc: Jensen, Jon M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

Was this the formal Department guidance? I don't recall seeing it.

Cassie

From: Lieberman, Steven (b)(6)
Sent: Thursday, June 10, 2021 9:35 AM
To: Oshinski, Renee (b)(6) Law, Cassandra M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

(b)(5)
(b)(5)

(b)(5)

Thanks

From: Oshinski, Renee (b)(6)
Sent: Thursday, June 10, 2021 8:26 AM
To: Lieberman, Steven (b)(6) Law, Cassandra M. (b)(6)
Subject: Fwd: New Leave Program Associated with COVID

Get Outlook for iOS

From: Lapuz, Miguel H. (b)(6)
Sent: Thursday, June 10, 2021 8:25:02 AM
To: Oshinski, Renee (b)(6)
Subject: FW: New Leave Program Associated with COVID

Please see below. Thanks,

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Sent: Thursday, June 10, 2021 8:04 AM
To: Lapuz, Miguel H. (b)(6) Twinn, Kimberly (b)(6) VHATAM Nursing NAM Expanded Group (b)(6) VHATAM ALL RN Staff (b)(6)
Cc: Battle, Joe D.(VHATAM) (b)(6) Sutton, Andrew C. (b)(6)
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Thank you in advance,

Dennis Mclain

NNU Tampa Director

(submitted on break)

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Employees who are unable to be vaccinated for medical or religious reasons will also be granted four hours of administrative leave upon their agreement to participate in an alternate activity that provides similar health and safety protections, such as wearing a mask or observing social distancing guidelines per VA and Center for Disease Control (CDC) protocols.

Employees who do not accrue leave are encouraged to receive the vaccine and provide confirmation to the agency but are not eligible for four hours of administrative leave.

Proof of Vaccination: To qualify for this voluntary program, employees must provide designated agency officials with proof of vaccination, which will be kept in the appropriate Privacy Act system of records, and will be submitted as outlined below:

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Method 3: Employees unable to receive the COVID-19 vaccine due to medical or religious reasons are not required to disclose the reason for medical contraindication or religious exemption to the designated agency official. However, the employee may elect to share this information on a voluntary basis with the designated agency official to qualify for an exception to receive four hours of administrative leave. In addition, employees must provide a signed, written statement with the following information:

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- Special Note: Parades, Ceremonies and Civic Activities
- Submitter Remarks: OCHCO 06092021

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From: Mayo, Jeffrey
Sent: Thu, 10 Jun 2021 14:15:39 +0000
To: Lieberman, Steven
Cc: Therit, Tracey
Subject: RE: New Leave Program Associated with COVID

Thanks Steve, agree. I will get LMR to contact as we have just made union notification and are not implementing yet.

Jeff

Jeffrey R. Mayo
Acting Assistant Secretary for Human Resources and Administration / Operations, Security, and Preparedness
Department of Veterans Affairs

Office Phone (b)(6)
Cell Phone (b)(6)
(b)(6)

From: Lieberman, Steven (b)(6)
Sent: Thursday, June 10, 2021 9:56 AM
To: Mayo, Jeffrey (b)(6)
Subject: RE: New Leave Program Associated with COVID

(b)(5)

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Sent: Thursday, June 10, 2021 9:07 AM
To: Lieberman, Steven (b)(6)
Subject: RE: New Leave Program Associated with COVID

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To: Mayo, Jeffrey (b)(6)
Subject: FW: New Leave Program Associated with COVID

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(submitted on break)

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- Submitter Remarks: OCHCO 06092021

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From: Lieberman, Steven
Sent: Thu, 10 Jun 2021 13:56:05 +0000
To: Mayo, Jeffrey
Subject: RE: New Leave Program Associated with COVID

(b)(5)

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From: Lieberman, Steven
Sent: Thu, 10 Jun 2021 13:56:48 +0000
To: Law, Cassandra M.;Oshinski, Renee
Cc: Jensen, Jon M.
Subject: RE: New Leave Program Associated with COVID

Thanks. I just asked Jeff to have LMR reach out to ensure this official stands down on effort with Miguel unless there is an official agreement in place.

From: Law, Cassandra M. (b)(6)
Sent: Thursday, June 10, 2021 9:51 AM
To: Lieberman, Steven (b)(6) Oshinski, Renee (b)(6)
Cc: Jensen, Jon M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

With negotiations underway (b)(5) you should connect with LMR.

Cassie

From: Lieberman, Steven (b)(6)
Sent: Thursday, June 10, 2021 9:43 AM
To: Law, Cassandra M. (b)(6) Oshinski, Renee (b)(6)
Cc: Jensen, Jon M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

Not yet. National conversations with the unions are underway

From: Law, Cassandra M. (b)(6) va.gov>
Sent: Thursday, June 10, 2021 9:42 AM
To: Lieberman, Steven (b)(6) Oshinski, Renee (b)(6)
Cc: Jensen, Jon M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

Was this the formal Department guidance? I don't recall seeing it.

Cassie

From: Lieberman, Steven (b)(6)
Sent: Thursday, June 10, 2021 9:35 AM
To: Oshinski, Renee (b)(6) Law, Cassandra M. (b)(6)
Subject: RE: New Leave Program Associated with COVID

(b)(5)

(b)(5)

Also, do you think I should ask LMR to tell the Florida NNU to stand down with their request?

Thanks

From: Oshinski, Renee (b)(6)
Sent: Thursday, June 10, 2021 8:26 AM
To: Lieberman, Steven (b)(6) Law, Cassandra M. (b)(6)
Subject: Fwd: New Leave Program Associated with COVID

Get Outlook for iOS

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Note: By requesting this administrative leave, employees voluntary elect to provide the agency with proof of their COVID-19 vaccination status. This information may be used by management officials as a tool to make informed workplace planning decisions.

Other flexibilities: Employees who are vaccinated after August 31, 2021, or do not otherwise meet the eligibility requirements for administrative leave may qualify for other leave flexibilities available for COVID-19 vaccinations.

- Administrative Leave to Receive the COVID-19 Vaccine: Employees are eligible for administrative leave for the time necessary to be vaccinated by VA or through a non-VA provider. See: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210205-01.pdf
- Administrative Leave for Adverse Reactions to the COVID-19 Vaccine: Employees are eligible to receive up to two days of additional administrative leave per dose when experiencing an adverse reaction and unable to work due the vaccine side effects. See OCHCO Bulletin:

https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210205-01.pdf

- Emergency Paid Leave: VA also provides up to 600 hours of emergency paid leave for employees to obtain a vaccination related to COVID-19, or to recover from any injury, disability, illness, or condition related to such immunization. See OCHCO Bulletin: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210527-01.pdf

From: Mayo, Jeffrey
Sent: Thu, 10 Jun 2021 13:07:14 +0000
To: Lieberman, Steven
Subject: RE: New Leave Program Associated with COVID
Attachments: Union Notification: Four Hours of Administration Leave to Recognize VA Employees Who Voluntarily Provide Proof of COVID-19 Vaccination -- NNU, OCHCO Bulletin - Authorized Absence for Individuals who Receive the COVID-19 Vaccine.pdf

Steve

I attached what was sent to the NNU as well as other unions yesterday at 1045. Please let me know if I can help or if you would like for LMR to contact the Tampa official.

Jeff

Jeffrey R. Mayo
Acting Assistant Secretary for Human Resources and Administration / Operations, Security, and Preparedness
Department of Veterans Affairs

Office Phone (b)(6)
Cell Phone (b)(6)
(b)(6)

From: Lieberman, Steven (b)(6)
Sent: Thursday, June 10, 2021 8:29 AM
To: Mayo, Jeffrey (b)(6)
Subject: FW: New Leave Program Associated with COVID

Look what got sent to the ND in Florida.

From: McLain, Dennis (b)(6)
Sent: Thursday, June 10, 2021 8:04 AM
To: Lapuz, Miguel H. (b)(6) Twinn, Kimberly (b)(6) VHATAM Nursing NAM Expanded Group (b)(6) VHATAM ALL RN Staff (b)(6)
Cc: Battle, Joe D.(VHATAM) (b)(6) Sutton, Andrew C. (b)(6)
Subject: New Leave Program Associated with COVID

Dr. Lapuz,

Could you confirm whether you have approved the leave program listed below for James A Haley VA and Clinic employees? This Administrative Leave related to COVID vaccination has from our understanding been approved at other VA Hospitals. If you have approved the leave could you provide the date when requests for the 4 hours of Administrative Leave can be submitted, specifics as to which VISN 8 employee will be approving the leave requests and contact information for any employees that may have questions. The only contact information that I have currently is (b)(6) or (b)(6) (b)(6)

If you have approved the leave for JAHVA employees could you provide notification to our employees through traditional means such as Haley Broadcast or any other means of communication that would disseminate the information. Alternatively, if you have decided not to approve the leave could you provide the NNU with rationale for your decision.

Thank you in advance,

Dennis Mclain

NNU Tampa Director

(submitted on break)

The Office of Labor Management Relations is providing this email as notification that the Department will be providing four hours of administrative leave to recognize VA employees who voluntarily provide proof of COVID-19 vaccination.

Purpose: The Department will authorize four hours of administrative leave to recognize VA employees who voluntarily provide proof they have been fully vaccinated against COVID-19. VA employees who receive the COVID-19 vaccination reduce the risk of acquiring COVID-19 and transmitting the virus to Veterans, customers, and co-workers. Further, accounting for the individual number of VA employees who are vaccinated will allow greater efficiency in the performance of the agency's mission. VA employees who receive the COVID-19 vaccination reduce the risk of acquiring COVID-19 and transmitting the virus to Veterans, customers, and co-workers.

Eligibility: Current VA employees who accrue leave will be eligible to receive four hours of administrative leave for receiving the COVID-19 vaccine (i.e., after the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or after a single-dose vaccine (Johnson and Johnson (J&J)/Janssen)) on or before August 31, 2021.

Employees who are unable to be vaccinated for medical or religious reasons will also be granted four hours of administrative leave upon their agreement to participate in an alternate activity that provides similar health and safety protections, such as wearing a mask or observing social distancing guidelines per VA and Center for Disease Control (CDC) protocols.

Employees who do not accrue leave are encouraged to receive the vaccine and provide confirmation to the agency but are not eligible for four hours of administrative leave.

Proof of Vaccination: To qualify for this voluntary program, employees must provide designated agency officials with proof of vaccination, which will be kept in the appropriate Privacy Act system of records, and will be submitted as outlined below:

Method 1: Employees who were fully vaccinated at VA will show the designated agency official the CDC COVID-19 Vaccination Record Card they received as proof of vaccination to receive administrative leave under this program.

Method 2: Employees who were fully vaccinated outside VA may:

A. Provide local Employee Occupational Health (EOH) Service* with their CDC COVID-19 Vaccination Card or other medical documentation of COVID-19 vaccination* so it can be entered in the employee medical folder; and

B. Show the designated agency official the CDC Vaccination Record card or other appropriate medical documentation as proof of vaccination to receive administrative leave under this program.

*If an employee does not have an occupational health service (ex: remote worker or an employee that does not live within commuting distance of the occupational health unit) the vaccine documentation should be provided to the designated agency official using an encrypted email. The designated agency official will share the information with the local occupational health service for documenting the employee health record.

*Other acceptable proof of vaccination includes a pharmacy administration record or administration record from the provider.

Method 3: Employees unable to receive the COVID-19 vaccine due to medical or religious reasons are not required to disclose the reason for medical contraindication or religious exemption to the designated agency official. However, the employee may elect to share this information on a voluntary basis with the designated agency official to qualify for an exception to receive four hours of administrative leave. In addition, employees must provide a signed, written statement with the following information:

A. Employees unable to receive the vaccine due to a medical reason will provide a signed statement confirming that they have an underlying medical condition which prevents the employee from receiving the vaccine. The employee must also agree in writing to wear a face mask and follow social distancing guidelines per VA and CDC protocols, and any other infection control measures VA establishes for their work location.

B. Employees unable to receive the vaccine due to religious reasons must sign a written statement indicating they have a sincerely held religious belief that prevents them from receiving the COVID-19 vaccine. The employee must also agree in writing to wear a face mask and follow social distancing guidelines per VA and CDC protocols, and any other infection control measures VA establishes for their work location.

Administrative Leave Request: Employees may request to use four hours of administrative leave beginning on date the guidance is issued and until December 4, 2021.The leave request must be made at least one pay period in advance. The four hours must be used in a single four hour increment on the same date; the hours cannot be used on multiple dates or taken retroactively.

Employees will account for their request as administrative leave in the VA Time and Attendance System as follows:

- Leave Type: LN – Administrative
- Special Note: Parades, Ceremonies and Civic Activities
- Submitter Remarks: OCHCO 06092021

Leave approving officials are authorized to approve administrative leave requests not to exceed four hours beginning on date the guidance is issued and until December 4, 2021.

Note: By requesting this administrative leave, employees voluntary elect to provide the agency with proof of their COVID-19 vaccination status. This information may be used by management officials as a tool to make informed workplace planning decisions.

Other flexibilities: Employees who are vaccinated after August 31, 2021, or do not otherwise meet the eligibility requirements for administrative leave may qualify for other leave flexibilities available for COVID-19 vaccinations.

- Administrative Leave to Receive the COVID-19 Vaccine: Employees are eligible for administrative leave for the time necessary to be vaccinated by VA or through a non-VA provider. See: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210205-01.pdf
- Administrative Leave for Adverse Reactions to the COVID-19 Vaccine: Employees are eligible to receive up to two days of additional administrative leave per dose when experiencing an adverse reaction and unable to work due the vaccine side effects. See OCHCO Bulletin: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210205-01.pdf
- Emergency Paid Leave: VA also provides up to 600 hours of emergency paid leave for employees to obtain a vaccination related to COVID-19, or to recover from any injury, disability, illness, or condition related to such immunization. See OCHCO Bulletin: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210527-01.pdf

From: Michael, Cathyrine A.
Sent: Wed, 9 Jun 2021 14:43:41 +0000
To: Weitz, Jonathan;Irma Westmoreland (NNU)
Subject: Union Notification: Four Hours of Administration Leave to Recognize VA Employees Who Voluntarily Provide Proof of COVID-19 Vaccination -- NNU

Good morning Jonathan,

The Office of Labor Management Relations is providing this email as notification that the Department will be providing four hours of administrative leave to recognize VA employees who voluntarily provide proof of COVID-19 vaccination.

Purpose: The Department will authorize four hours of administrative leave to recognize VA employees who voluntarily provide proof they have been fully vaccinated against COVID-19. VA employees who receive the COVID-19 vaccination reduce the risk of acquiring COVID-19 and transmitting the virus to Veterans, customers, and co-workers. Further, accounting for the individual number of VA employees who are vaccinated will allow greater efficiency in the performance of the agency's mission. VA employees who receive the COVID-19 vaccination reduce the risk of acquiring COVID-19 and transmitting the virus to Veterans, customers, and co-workers.

Eligibility: Current VA employees who accrue leave will be eligible to receive four hours of administrative leave for receiving the COVID-19 vaccine (i.e., after the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or after a single-dose vaccine (Johnson and Johnson (J&J)/Janssen)) on or before August 31, 2021.

Employees who are unable to be vaccinated for medical or religious reasons will also be granted four hours of administrative leave upon their agreement to participate in an alternate activity that provides similar health and safety protections, such as wearing a mask or observing social distancing guidelines per VA and Center for Disease Control (CDC) protocols.

Employees who do not accrue leave are encouraged to receive the vaccine and provide confirmation to the agency but are not eligible for four hours of administrative leave.

Proof of Vaccination: To qualify for this voluntary program, employees must provide designated agency officials with proof of vaccination, which will be kept in the appropriate Privacy Act system of records, and will be submitted as outlined below:

> Method 1: Employees who were fully vaccinated at VA will show the designated agency official the CDC COVID-19 Vaccination Record Card they received as proof of vaccination to receive administrative leave under this program.
>
> Method 2: Employees who were fully vaccinated outside VA may:

A. Provide local Employee Occupational Health (EOH) Service* with their CDC COVID-19 Vaccination Card or other medical documentation of COVID-19 vaccination* so it can be entered in the employee medical folder; and

B. Show the designated agency official the CDC Vaccination Record card or other appropriate medical documentation as proof of vaccination to receive administrative leave under this program.

*If an employee does not have an occupational health service (ex: remote worker or an employee that does not live within commuting distance of the occupational health unit) the vaccine documentation should be provided to the designated agency official using an encrypted email. The designated agency official will share the information with the local occupational health service for documenting the employee health record.

*Other acceptable proof of vaccination includes a pharmacy administration record or administration record from the provider.

Method 3: Employees unable to receive the COVID-19 vaccine due to medical or religious reasons are not required to disclose the reason for medical contraindication or religious exemption to the designated agency official. However, the employee may elect to share this information on a voluntary basis with the designated agency official to qualify for an exception to receive four hours of administrative leave. In addition, employees must provide a signed, written statement with the following information:

A. Employees unable to receive the vaccine due to a medical reason will provide a signed statement confirming that they have an underlying medical condition which prevents the employee from receiving the vaccine. The employee must also agree in writing to wear a face mask and follow social distancing guidelines per VA and CDC protocols, and any other infection control measures VA establishes for their work location.

B. Employees unable to receive the vaccine due to religious reasons must sign a written statement indicating they have a sincerely held religious belief that prevents them from receiving the COVID-19 vaccine. The employee must also agree in writing to wear a face mask and follow social distancing guidelines per VA and CDC protocols, and any other infection control measures VA establishes for their work location.

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- Leave Type: LN – Administrative
- Special Note: Parades, Ceremonies and Civic Activities
- Submitter Remarks: OCHCO 06092021

Leave approving officials are authorized to approve administrative leave requests not to exceed four hours beginning on date the guidance is issued and until December 4, 2021.

Note: By requesting this administrative leave, employees voluntary elect to provide the agency with proof of their COVID-19 vaccination status. This information may be used by management officials as a tool to make informed workplace planning decisions.

Other flexibilities: Employees who are vaccinated after August 31, 2021, or do not otherwise meet the eligibility requirements for administrative leave may qualify for other leave flexibilities available for COVID-19 vaccinations.

- Administrative Leave to Receive the COVID-19 Vaccine: Employees are eligible for administrative leave for the time necessary to be vaccinated by VA or through a non-VA provider. See: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210205-01.pdf
- Administrative Leave for Adverse Reactions to the COVID-19 Vaccine: Employees are eligible to receive up to two days of additional administrative leave per dose when experiencing an adverse reaction and unable to work due the vaccine side effects. See OCHCO Bulletin: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210205-01.pdf
- Emergency Paid Leave: VA also provides up to 600 hours of emergency paid leave for employees to obtain a vaccination related to COVID-19, or to recover from any injury, disability, illness, or condition related to such immunization. See OCHCO Bulletin: https://vaww.va.gov/OHRM/HRLibrary/Bulletins/2021/ochco-bulletin-20210527-01.pdf

If you would like to have a briefing or will be submitting a demand to bargain, please let me know. If any questions, please do not hesitate to ask.

r/Cat

Cat Michael | Labor Relations Advisor
U.S. Department of Veterans Affairs | Office of Labor-Management Relations (LMR)

Tel: (b)(6) | Email: (b)(6)

FOR OFFICIAL USE ONLY

This transmission may contain information that is protected from disclosure by one or more laws. This transmission may also contain information that is internal management guidance regarding collective bargaining and protected from disclosure under 5 U.S.C. 7114(b)(4)(C). DO NOT disclose or forward this message to others without prior permission to send from the sender. If you received this message in error, please notify the sender immediately via reply email and DELETE this message.

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

VA Central Office
Washington, DC

February 5, 2021

OFFICE OF THE CHIEF HUMAN CAPITAL OFFICER (OCHCO) BULLETIN

SUBJECT: Authorized Absence for Individuals who Receive the COVID-19 Vaccine

This OCHCO Bulletin provides guidance to Human Resources (HR) offices on the use of authorized absence (AA) as an available leave option for employees who receive the COVID-19 vaccine. Specifically, this Bulletin addresses employees who 1) receive the COVID-19 vaccine and 2) experience adverse reactions to the vaccination.

Leave to Receive the COVID-19 Vaccine. Employees who receive the COVID-19 vaccine through the Department of Veterans Affairs (VA) employee occupational health (EOH) service are not required to use their own leave. When employees are authorized to participate in a VA immunization program, the employee is on official duty status for the time it takes to be vaccinated by VA EOH.

In some instances, employees may have opportunities to receive the COVID-19 vaccine as veteran patients or through a non-VA source prior to being offered the opportunity to receive the vaccine by VA as an employee. Employees who do not receive the vaccine through the VA EOH may be authorized to participate in a civic health or immunization program that is offered through a federal or state sponsored COVID-19 immunization program. Employees may be authorized to participate in a civic health or immunization program when:

- The employee receives the vaccine from the Veterans Health Administration (VHA) as a veteran patient.
- The VA EOH vaccination site is more than 50 miles from the employee's official worksite and a non-VA Occupational Health vaccination site is a shorter distance from the employee's location.
- VA EOH is unable to provide the vaccine (for example: no available appointments or no available vaccine).
- The employee is able to obtain the vaccine quicker from another non-VA source.

When an employee is authorized to participate in such civic health or immunization programs through a non-VA source, the employee shall be granted administrative leave (recorded as "LN – Administrative" with the special note "Taking Examinations") for the time required to be vaccinated (including time to travel to the vaccination site, waiting times, and other factors).

Authorization to participate in a civic health or immunization program is for the sole purpose of granting administrative leave. VA Handbook 5011 will be updated to incorporate this change.

Leave for Employees Who Experience Adverse Reactions to the COVID-19 Vaccine. Employees who receive the vaccine within or outside the VA who subsequently experience a severe, adverse reaction and are unable to work may be granted up to two days of AA with supervisory approval (timekeeping code "LN – Administrative" with the special note "Taking Examinations").

Employees must follow proper leave requesting procedures in the event that the need to request AA is required. The AA may not exceed two consecutive and scheduled tours of duty and may be approved even in the absence of medical certification. The AA may be approved immediately following each dose of the vaccine when an employee becomes ill and is unable to work.

Limitations on Use of Authorized Absence. This serves as a reminder that 5 U.S.C. § 6329a limits the amount of authorized absence an employee may use within any calendar year. Specifically, an agency may place an employee in administrative leave for a period of not more than a total of 10 workdays.

If additional time is required, the employee is not eligible for additional days of AA. The employee can request accrued sick leave, annual leave, advanced sick leave, advanced annual leave, or leave without pay. Any leave requested besides sick leave is discretionary and should only be approved after consideration of operational needs.

Avenues to File Claim for Compensable Injury or Illness. Employees suffering from an injury following receipt of the vaccine through VA may file a workers' compensation claim under the Federal Employees Compensation Act (FECA). When an individual is treated as a patient (either as a veteran or general member of the public), rather than as an employee, the available remedy may be through the Public Readiness and Emergency Preparedness (PREP) Act, 42 U.S.C. § 247d-6d, and its implementing Declarations (up through and including the 4th Amended Declaration, 85 Fed. Reg. 79, 190 (Dec. 12, 2020)), the Countermeasures Injury Compensation Program (CICP), the National Vaccine Injury Compensation Program, or the Federal Tort Claims Act. See 38 U.S.C. § 1785.

Employees with questions regarding this guidance should contact their HR office. HR offices with questions regarding the VHA COVID-19 vaccination program should review the information on the VHA COVID-19 Vaccine SharePoint and may submit questions regarding the COVID-19 vaccination to the COVID-19 Resource Room.

HR offices with questions regarding this Bulletin may contact the Worklife and Benefits Service at: (b)(6)

Issued by: VA OCHCO/Worklife and Benefits Service

From: Kelley, Kimberly
Sent: Thu, 13 May 2021 14:27:50 +0000
To: Lieberman, Steven
Subject: RE: Notes from Vaccinating Adolescents Call
Attachments: Vaccinating Adolescents- May 12, 2021.docx

Use this one to review, as I added an additional link that Sophie provided.

From: Kelley, Kimberly
Sent: Thursday, May 13, 2021 10:23 AM
To: Lieberman, Steven (b)(6)
Subject: Notes from Vaccinating Adolescents Call

Kim Kelley, MA, MSW, LCSW
Executive Assistant
Office of Deputy Under Secretary for Health (10A)
Veterans Health Administration
810 Vermont Avenue NW
Washington, DC 20420
Office (b)(6)
iPhone (b)(6)

(b)(6)

Consideration of Vaccinating Adolescents
May 12, 2021

Present on call: Dr. Lieberman, Lisa Pape, Gerald Cox, Kameron Matthews, Beth Taylor, Tom O'Toole, Marianne Chick, Renee Oshinski, Tammy Czarnecki, Larry Mole, Mike Valentino, Jennifer Martin, Sophia Califano, Susan Blauert, Jessica Bonjorni, Christina Knott, Jessica Varone, Jane Kim, Amelia Parsons, Maria Llorente, Sue Diamond, Kim Kelley

Background:

Pfizer vaccine was approved today for adolescents age 12+

VHA has been involved in White House meetings & requests for doing more 4th Missions. Secretary wants us to take a serious look at the request for vaccinating adolescents. (b)(5)

White House would like a quick response to the inquiry.

Target Population:

- Adolescents age 12 and up who are children of Veterans
- This could also include Veterans' spouses and caregivers through SAVE Lives Act
- If 4th Mission, all adolescents age 12 and up to be considered, not just children of Veterans

Discussion

OGC: Susan Blauert & Christina Knott

- OGC not aware of any legislative barriers to treating adolescents
- (b)(5)
- (b)(5)
- Through CHAMPVA, medical services are provided at medical centers
- (b)(5)
- Parental consent would be needed
- (b)(5)
- Some states have waived parental consent due to public health crisis

Credentialing & Privileging: Marianne Chick

- Reviewed the by-laws nothing from her perspective that prevents this or limits this to adults only. (b)(5)

(b)(5)

Office of Nursing: Beth Taylor & Maria Llorente

- (b)(5)
- Family NPs, board certification covers birth to death
- Adult NPs, board certification covers 14 and up
- All staff nurses complete pediatric rotations as part of their training.
- No difference in using Benadryl or ibuprofen for adolescents 12+, then adults
- (b)(5)
- (b)(5)
- (b)(5)

Human Capital Management: Jessica Bonjorni

- (b)(5)
- Labor Management needs to be engaged
- (b)(5)
- (b)(5)
-

Pharmacy: Mike Valentino

- (b)(5)
-

Preventative Medicine: Sophie Califano

- https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf
- https://www.cdc.gov/vaccines/covid-19/clinical-considerations/managing-anaphylaxis.html
- (b)(5)
-
-

Population Health: Larry Mole

- (b)(5)
-
-
-

Clinical Services: Tom O'Toole

- (b)(5)
-
-

Acting DUSH: Dr. Lieberman

- (b)(5)
- (b)(5)
-
-
- VHA employees are trained in BLS and ALS, which includes pediatrics
- (b)(5)
- We have the authority in an emergency to treat children with adverse reactions
- We have an excess of 350,000 doses of Pfizer that will expire in July.
- Look at vaccination sites at VA Medical Centers: Veteran, Spouse, Kids

Dr. Lieberman thanked everyone for their participation and feedback. Dr. Lieberman will discuss this with the Secretary and get back to the group.

From: Gunnar, William
Sent: Wed, 17 Feb 2021 16:29:48 +0000
To: (b)(6) Yackel, Edward E. (NCPS (b)(6) Brill, Elizabeth L. MD, MBA, FACOG;Upton, Mark T.;Willoughby-Brooker, Michelle;Campbell, Tamara, VHACIN;Charles, Maureen A. (NCPS);Morrish, Wendy (NCPS);Van Alstine-Megargee, Margaret (NCPS);Bunce Ozanian, Lisa A. (Guidehouse);Alayon, Dawn C. (Guidehouse);Dawn Alayon
Subject: RE: OCC/NCPS Monthly Touch Base
Attachments: FY 2020 NCPS Annual Report.pdf

I have attached the FY20 NCPS Annual Report for reference. Community Care is Chapter 7, page 47-8.

From: (b)(6) (b)(6)
Sent: Wednesday, February 17, 2021 11:26 AM
To: Yackel, Edward E. (NCPS) (b)(6) (b)(6) (6) Brill, Elizabeth L. MD, MBA, FACOG (b)(6) Upton, Mark T. (b)(6) Gunnar, William (b)(6) Willoughby-Brooker, Michelle (b)(6) (b)(6) Campbell, Tamara, VHACIN (b)(6) Charles, Maureen A. (NCPS) (b)(6) Morrish, Wendy (NCPS) (b)(6) Van Alstine-Megargee, Margaret (NCPS) (b)(6) Bunce Ozanian, Lisa A. (Guidehouse) (b)(6) Alayon, Dawn C. (Guidehouse) (b)(6) (b)(6) (b)(6)
Subject: [EXTERNAL] RE: OCC/NCPS Monthly Touch Base

Hi Ed,

You are correct! We wanted to circle back with Drs. Brill and Campbell, and Michelle, to discuss the best approach, given we (OCC PS/Q Team) take a deep dive into the community care data each quarter. We thought it may be better to provide something to respond to, but open to other suggestions, of course.

(b)(6)

From: Yackel, Edward E. (NCPS) (b)(6)
Sent: Wednesday, February 17, 2021 10:39 AM
To: (b)(6) (b)(6) Brill, Elizabeth L. MD, MBA, FACOG (b)(6) Upton, Mark T. (b)(6) Gunnar, William (b)(6) Willoughby-Brooker, Michelle (b)(6) Campbell, Tamara, VHACIN (b)(6) Charles, Maureen A. (NCPS) (b)(6) Morrish, Wendy (NCPS) (b)(6) Van Alstine-Megargee, Margaret (NCPS) (b)(6) (b)(6) Bunce Ozanian, Lisa A. (Guidehouse) (b)(6) Alayon, Dawn C. (Guidehouse) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (6)
Subject: RE: OCC/NCPS Monthly Touch Base

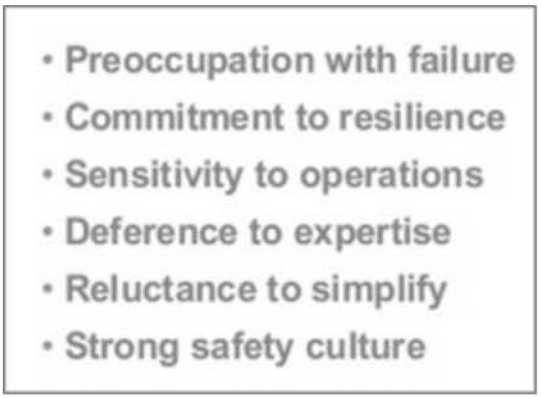
Hi team,

I thought another due out was for NCPS and OCC to meet to go over the NCPS annual report to understand the data in order to build a presentation for the QSV Council followed by a brief to the Governance Board?

Ed

Edward E. Yackel
DNP, FNP-C, FAANP
Deputy Executive Director,
VHA National Center for Patient Safety

Office Phone: (b)(6)
Work Cell: (b)(6)
Email: (b)(6)



From (b)(6) (b)(6)
Sent: Wednesday, February 17, 2021 10:35 AM
To: Brill, Elizabeth L. MD, MBA, FACOG (b)(6) Yackel, Edward E. (NCPS) (b)(6) Upton, Mark T. (b)(6) Gunnar, William (b)(6) Willoughby-Brooker, Michelle (b)(6) Campbell, Tamara, VHACIN (b)(6) Charles, Maureen A. (NCPS) (b)(6) Morrish, Wendy (NCPS) (b)(6) Van Alstine-Megargee, Margaret (NCPS) (b)(6) Bunce Ozanian, Lisa A. (Guidehouse) (b)(6) Alayon, Dawn C. (Guidehouse) (b)(6) (b)(6) (b)(6) (b)(6)
Subject: [EXTERNAL] RE: OCC/NCPS Monthly Touch Base

Hello all,

Thank you for joining this morning's call. Meeting minute are attached and action items are below. Let me know if you have any questions.

	Action item	Due date	Responsible
1	Send opioid review questions to OCC	2/23/2021	NCPS
2	Update types of care reference sheet	2/24/2021	(b)(6)
3	Meet with DHA to discuss lessons learned for DHA PSP and TRICARE contractor events	3/3/2021	Dr. Gunnar/Dr. Brill
4	OCC presents at PSO meeting	3/4/2021	Dr. Brill
5	Update JPSR Change Request	3/17/2021	Lisanne Bunce Ozanian
6	Research how to distinguish specialty data	3/17/2021	NCPS
7	Implement CC-CITN Process	3/31/2021	Dr. Gunnar/Dr. Brill
8	Share updates of the JPSR Business Rules and Guidebook to OCC for review, when available	5/19/2021	OCC/NCPS

Best,
(b)(6)

(b)(6)
Senior Consultant
Enterprise Resource Performance, Inc. (ERPi)
(b)(6) | (b)(6)
ERPi.net | News | LinkedIn | Twitter

ERPi
Collaboration. Results. Impact.

-----Original Appointment-----
From: Brill, Elizabeth L. MD, MBA, FACOG (b)(6)
Sent: Wednesday, January 27, 2021 8:12 AM
To: Brill, Elizabeth L. MD, MBA, FACOG; Yackel, Edward E. (NCPS); Upton, Mark T.; Gunnar, William; Willoughby-Brooker, Michelle; Campbell, Tamara, VHACIN; Charles, Maureen A. (NCPS); Morrish, Wendy (NCPS); Van Alstine-Megargee, Margaret (NCPS); Bunce Ozanian, Lisa A. (Guidehouse); Alayon, Dawn C. (Guidehouse); Lisanne Bunce Ozanian; Dawn Alayon; (b)(6)
Subject: OCC/NCPS Monthly Touch Base
When: Wednesday, February 17, 2021 9:00 AM-9:45 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

Microsoft Teams meeting

Join on your computer or mobile app
Click here to join the meeting

Or call in (audio only)
(b)(6) United States, Chicago
Phone Conference ID (b)(6)
Find a local number | Reset PIN

Learn More | Meeting options

VHA NATIONAL CENTER FOR PATIENT SAFETY

FY 2020 ANNUAL REPORT

U.S. Department of Veterans Affairs

Veterans Health Administration

Introduction

The Fiscal Year (FY) 2020 National Center for Patient Safety (NCPS) Annual Patient Safety Report is intended to provide an overview of Veterans Health Administration (VHA) national and Veterans Integrated Service Network (VISN) regional level patient safety outcome and related data. The information contained within this report is high-level and not intended to replace the detailed Department of Veterans Affairs (VA) Medical Center data contained within the NCPS Quarterly Report published separately. This report is expected to evolve over time as reliable and valid data becomes available and data sources are modified with the adoption of a new electronic health record.

VHA National Center for Patient Safety (17PS)

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Executive Summary

The Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) publishes the Fiscal Year (FY) 2020 NCPS Annual Patient Safety Report to provide an overview of VHA national and Veterans Integrated Service Network (VISN) regional level patient safety outcome and related data. The report also serves as a foundation for standardization across the enterprise, a reference for focused improvement areas against benchmark or other published data, and for use as an interpretation document for the NCPS Quarterly Reports, published separately. Where applicable, comparison data from the FY 2019 NCPS Annual Report is provided. Report chapters are summarized as follows with specific detail available in the report document.

Chapter 1: Patient Safety Event Reporting

NCPS collects patient safety event reports in the Joint Patient Safety Reporting (JPSR) system. JPSR classifies events as either an adverse event or close call. A close call is an event that could have resulted in an adverse event but did not, either by chance or through timely intervention. In FY 2020, JPSR registered 162,683 total events of which 114,486 (70%) were adverse events and 47,579 (29%) were close calls (618 unassigned). The national JPSR total event reporting rate was 253.1/10,000 unique patients (uniques), with rates for adverse events and close calls 178.9 and 66.0, respectively. The national ratio of adverse events to close calls was 2.4.

Serious safety events are those events that result in death, permanent bodily injury or the substantial risk thereof and potential serious safety events would have resulted in a Serious Safety Event under the worst-case scenario. VHA recorded 589 serious safety events and 10,709 potential serious safety events. The national rates for serious safety events and potential serious safety events were 0.9/10,000 uniques and 16.7/10,000 uniques, respectively.

The emergence of the worldwide COVID-19 pandemic in Quarter 2(Q2)-FY 2020 was associated with approximately a 30% decrease in JPSR overall reporting per month with an increase towards prior levels in Q4. Care Management was the predominant event type classification entered into JPRS, representing 83% of reported events. A breakdown of care management event reports identified the following subtypes: falls (33%), clinical administration (30%), and medication/biological/nutritional error (23%). The mean time to finalize a JPSR event report improved to 13.3 days (target 14 days) and the mean time to complete a Root Cause Analysis (RCA) remained essentially unchanged at 45.9 days (target 45 days).

VHA policy establishes an annual requirement for VA medical centers to perform a minimum of eight patient safety analyses including the following: RCA, Aggregate Review, Wild Card Aggregate Review, Proactive Risk Assessment (PRA), and Patient Safety Assessment Tool (PSAT) evaluation. Wild Card Aggregate Reviews evaluate the predominant low harm events or an emerging trend at the VA medical center. In FY 2020, VHA performed 1984 patient safety analyses, including 1023 RCAs, 132 Medication Error Aggregate Reviews, 168 Wild Card Aggregate Reviews, 140 Falls PSAT, 128 Fall/Winter Mental Health Environment of Care Checklist (MHEOCC) and 127 Spring/Summer MHEOCC, and 127 PRAs. More than 50% of the RCAs completed were the result of falls, delays in care, and suicide attempts and deaths. Delays in care were represented in 21% of the Wild Card Aggregate Reviews.

In accordance with VHA Directive 1068, NCPS oversees the VHA Alerts and Recalls web application to facilitate the recall of defective medical devices and medical products, including food and food products and

administers and tracks Patient Safety Alerts, Advisories, and Notices. In FY 2020, NCPS administered 592 recalls, published one Patient Safety Alert and thirteen Patient Safety Notices.

The following observations follow comparison of Patient Safety Event Reporting data for FY 2019 and FY 2020:

- JPSR total event reporting per 10,000 uniques increased from 247.3 to 253.1, adverse event rates decreased from 178.9 to 178.1, close call rates increased from 66.0 to 74.0, and the national adverse event to close call ratio decreased from 2.7 to 2.4, led by twelve VISNs recording an increase in close call counts;
- Serious Safety Events decreased 7.5% (637 to 589) and the Serious Safety Event rate per 10,000 uniques decreased from 1.0 to 0.9,
- Potential Serious Safety Events decreased 27.6% and the Potential Serious Safety Events rate per 10,000 uniques decreased from 22.4 to 16.7;
- Care management continues to be >80% of JPSR Events of which sub-type classification of Falls, Delays in Care and medication error continue to comprise >80%;
- Falls, delays in care and suicide events continue to comprise >50% of RCAs performed;
- Delays in care continues to be a leading interest in wild card aggregate reviews; and
- Timeliness to finalize JPSR events substantially improved while mean RCA timeliness to completion remained just above the target of 45 days.

Chapter 2: Inpatient Hospital

In FY 2020, the VHA recorded 24,785 falls of which 7,791 (31.4%) were falls with injury and 399 (1.6%) were falls with a major injury, 310 pressure ulcers (represents two years of data), 179 catheter associated urinary tract infections, and 253 central line associated blood stream infections. The 138 VHA Surgery Programs performed 299,518 procedures and reported 14 Wrong Site Surgery (WSS) procedures and 16 procedures associated with a Retained Surgical Item (RSI). VHA national rates for these events were consistent with or lower than published reference data.

Peer Review for Quality Management Level 3 designations identify systems issues that do not meet an expected standard of care. The total number of Peer Reviews for Quality Management performed was 9847 with 1571 (16%) assigned as a Peer Review Level 3 designation.

The following observations follow comparison of Inpatient Hospital data for FY 2019 and FY 2020:

- The overall number of falls reported decreased 22% however the fall rate per 1,000 bed days of care increased from 4.18 to 4.46 most likely associated with a decrease in inpatient care including Community Living Centers (CLCs) associated with the COVID-19 pandemic. VHA fall rates are consistent with published rates;
- The number of pressure ulcers decreased 4% however the observed rate per 1,000 Bed Days of Care increased from 0.62 to 0.66;

- The COVID-19 pandemic impacted the reporting of Catheter Associated Urinary Tract Infection (CAUTI) infections and Central Line Associated Bloodstream infection (CLABSI) rates. The number of reported urinary catheter days decreased 54% and the number of CAUTI infections decreased by 45% however the CAUTI rate increased from 0.79 to 0.96. The number of central line days decreased by 17% yet the number of CLABSI infections increased (247 to 253) and the CLABSI rate increased from 0.73 to 0.91;
- The absolute number of WSS events decreased from 20 to 14 and the number of RSI events decreased from 24 to 16. The rates for WSS and RSI per 10,000 surgical procedures however remained unchanged due to a 29% decrease in operating room surgical procedures to 299,518 (WSS 0.47/10,000 procedures, RSI .53/10,000 procedures); and
- The total number of Peer Reviews for Quality Management decreased 17% associated with a decrease in the Peer Review Level 3 rate per 10,000 uniques from 2.86 to 2.44.

Chapter 3: Mental Health

In FY 2020, across all campuses, VHA experienced 303 on-campus suicide attempts and 19 on-campus suicide deaths, including three suicide deaths on an inpatient non-mental health unit, and 16 suicide deaths on the campus grounds and clinics. VHA recorded 61,452 Mental Health Unit admissions at 114 VA medical facilities with at least one mental health unit. No suicide deaths occurred on a VHA mental health unit. As of Q2-FY 2020, the VHA requires the instillation of over-the-door alarms on all Mental Health Units to mitigate the risk of suicide by hanging.

In comparison to FY 2019, the total number of on-campus suicide deaths, including suicide deaths in the hospital, outpatient clinics, parking lots, and grounds decreased from 26 to 19. While the number of deaths within 3 days of a hospital discharge increased from 16 to 23 and 7 days from a Mental Health Unit discharge decreased from 30 to 27. For the past 5 years, VHA's suicide death rate on Mental Health Units was 0.83/100,000 admissions and below published rates.

Chapter 4: Dental Adverse Events

In FY 2020, NCPS added dental adverse events reporting. A total of 20 Aspirations or Ingestion of a Foreign Body and 16 wrong site procedures were identified. VHA performed 2,921,797 dental procedures for 462,823 Veterans resulting in a dental adverse reporting rate of 0.12/10,000 procedures. The overall reported incident rate for dental adverse events is below published rates.

Chapter 5: Health Information Technology (HIT)

In FY 2020, 13,195 total HIT events were reported of which 6.604 (50%) were adverse events and 6,563 (50%) were close calls. Eighty-two percent of HIT reports were attributable to medication events (41%), clinical administration including delays in care (27%) and product/device (14%). NCPS and the Office of Informatics Patient Safety within the Office of Health Informatics (105) actively collaborate to improve HIT patient safety event reporting as well as the evaluation of patient safety events associated with the electronic health record and the storage and retrieval of digital information. Comparing FY 2019 to FY 2020, the number of HIT patient safety events in JPSR increased from 1,473 to 13,195

Chapter 6: Medication Safety

Medication safety events are most often not associated with harm but represent the potential for significant harm. JPSR recorded 3,867 medication safety events of which 47% were close calls. Administering the incorrect medication or administering a medication to the wrong patient represented over 90% of the reported events.

VHA tracks the number of patients receiving anticoagulation therapy with warfarin (Coumadin) and their test values for International Normalized Ratio (INR). Time in therapeutic range (TTR) has been shown to be strongly predictive of both bleeding and thromboembolic events while an INR > 6 is known to be associated with bleeding episodes and related complications. A measured TTR > 70% is considered optimal. In FY 2020, 43,548 Veterans received warfarin medication and INR testing of which 7,288 (16.7%) were identified to have triggered an INR > 6. The national mean TTR was 68.8%, representing an opportunity for improvement.

Optimizing opioid prescribing alone and in combination with benzodiazepines is an ongoing VHA initiative. In FY 2020, VHA dispensed opioid medication to 346,700 Veterans representing 8.20% of the total medications dispensed to Veterans as an outpatient. VHA dispensed opioid and benzodiazepine medication to 21,902 Veterans representing 0.52% of the total medications dispensed to Veterans as an outpatient. Variability in prescribing patterns were evident across the VISNs.

The following observations follow comparison of Medication Safety data for FY 2019 and FY 2020:

- JPSR medication events decreased 24% associated a decrease in actual and potential SAC-3 events;
- The national mean TTR decreased from 69.3% to 68.8%, the INR >6 increased from 13.94% to 16.74% which identifies an opportunity for improvement in anticoagulation therapy; and
- The percent Veterans dispensed opioid medications decreased 9.7% to 8.26% and the percent Veterans dispensed opioid and benzodiazepine medications decreased from 0.67% to 0.52%.

Chapter 7: Community Care

Community care represents the authorization of health care and services of an VHA enrolled Veteran to a community (non-VA employee) provider. VHA staff are directed to enter JPSR safety events associated with the delivery of community care when identified. In FY 2020, 7,616 community care related patient safety events were recorded, of which 5,511 (72%) were adverse events and 2,070 (27%) were close calls (35 not assigned). Of the adverse events, 60 were identified to be associated with severe harm and 442 with potential severe harm.

Delay in care, falls, and medication events were the most frequently identified reasons for JPSR entry, representing respectively 23%, 22%, 15% of the total number of community care events. NCPS and the Office of Community Care (13) actively collaborate to promote the reporting and investigation of patient safety events related to the VHA authorized care and services by community providers. Comparing FY 2019 to FY 2020, the number of Community Care patient safety events in JPSR increased from 1,707 to 7,616.

Chapter 8: Patient Safety Culture

In FY 2019, NCPS collaborated with the VHA National Center for Organization Development (10A2C) to embed a 15 question Patient Safety Culture Module in the FY 2019 All Employee Survey (AES). These questions in addition to five standard AES questions now comprise the AES-Patient Safety Culture Survey (PSCS) with 20 questions utilizing a 1-5 Likert scale in 14 dimensions. The FY 2020 AES-PSCS was administered in September 2020 to all VISN and VA medical center staff and received 227,101 respondents.

The VHA national results of the FY 2020 AES-PSCS identified the following: dimension results with a mean score >4.0 were Overall Perceptions of Patient Safety (#1), Education, Training, and Resources (#3), Job Satisfaction (#10), and Perceptions of Patient Safety at your Facility (#12); dimension results with a mean score between 3.75-4.0 were Non-Punitive Response to Error (#2), Communication and Openness (#5), and Teamwork within Hospital Units (#6); dimension results with a mean score between 3.5-3.75 were Teamwork across Hospital Units (#7), Organizational Learning and Continuous Improvement (#8), Feedback and Communication about Error (#9), Patient Safety in Comparison to Other Facilities (#11), Senior Management Awareness and Actions in Promoting Safety (#13), and Frequency of Event Reporting (#14); and dimension results with a mean score of <3.5 was Shame (#4). These results target specific patient safety culture dimensions for improvement.

The following observations follow comparison of Patient Safety Culture Survey data for FY 2019 and FY 2020:

- The number of respondents to at least one AES-PSCS question increased from 205,051 to 227,101 (11%) associated with a corresponding increase in the number of respondents to any single AES-PSCS question;
- The distribution of AES-PSCS national mean scores by dimension were unchanged, for example the dimensions with a mean score >4.0 remained Overall Perceptions of Patient Safety (#1), Education, Training, and Resources (#3), Job Satisfaction (#10), and Perceptions of Patient Safety at your Facility (#12);
- The national mean AES-PSCS score increased in the following domains related to communication, teamwork, continuous improvement, and job satisfaction: Communication and Openness (#5), Teamwork within Hospital Units (#6), Teamwork across Hospital Units (#7), Organizational Learning and Continuous Improvement (#8), Feedback and Communication About Error (#9), Job Satisfaction (#10), and Frequency of Event Reporting (#14);
- The national mean AES-PSCS score decreased in the following domains related to perceptions of patient safety, just culture, and education: Overall Perception of Patient Safety (#1), Non-Punitive Response to Error (#2), Education, Training, and Resources (#3), Shame (#4); Patient Safety in Comparison to Other Facilities (#11), and Perceptions of Patient Safety at your Facility (#12); and
- The national mean AES-PSCS score was unchanged in Senior Management Awareness and Actions in Promoting Safety (#13).

Chapters 9 & 10: Publications

In FY 2020, NCPS published nineteen articles related to quality improvement and safe patient care in peer reviewed journals. The ten Patient Safety Centers of Inquiry (PSCI), funded with NCPS oversight and Veterans Equitable Resource Allocation (VERA) specific purpose funds, published sixty-eight articles in peer reviewed journals in the following areas of interest: hospital acquired infections; transitions in care for complex Veterans and geriatric safety; transitions of care between VHA and Community Care; suicide prevention; diagnostic errors and delays; and falls prevention and mobility.

Chapter 11: NCPS Guidance

In FY 2020, NCPS updated the following guidance documents:

1. Healthcare Failure Modes and Affects Analysis HFMEA Guidebook, HFMEA Guidebook
2. Joint Patient Safety Reporting (JPSR) system Business Rules and Guidebook, JPSR Guidebook
3. Guide to Performing a Root Cause Analysis (RCA), RCA Guidebook

Chapter 1: Patient Safety Event Reporting

Patient safety event reports are entered into the Joint Patient Safety Reporting (JPSR) system and investigated under the direction of the facility Patient Safety Manager (PSM). The JPSR system tracks the date the event is entered, the date the PSM opens the event report, the harm score assigned to the event by the PSM following investigation, and the date the JPSR event was finalized and closed.

JPSR classifies events as either adverse events or close calls. Close calls are events or situations that could have resulted in an adverse event but did not, either by chance or through timely intervention. In FY 2020, JPSR registered 162,683 total events of which 114,486 were adverse events and 47,579 were close calls with (618 unassigned; Table 1.1). Reporting of close calls is considered a bellwether for transparency and psychological safety in patient safety event reporting. The VHA national adverse event/close call ratio is 2.4 with VISNs ranging from 1.2 to 4.5.

To compare reporting rates between VISNs, the total event reporting rate per 10,000 unique Veterans served for each VISN is identified in Table 1.2. The national JPSR event total/10,000 uniques is 253.1 with rates for adverse events and close calls 178.1 and 74.0, respectively. VISN total events reported/10,000 uniques ranged from 159.1 to 347.0, of which adverse events ranged from 110.1 to 277.4 and close calls ranged from 39.1 to 157.0. This information is graphically displayed in Figure 1.1.

Comparing data for FY 2019 to FY 2020 showed an increase in JPSR total event reporting per 10,000 uniques (247.3 to 253.1), a decrease in adverse event rates (178.9 to 178.1), an increase in close call rates (66.0 to 74.0), and a decrease in adverse events to close call ratio (2.7 to 2.4). Twelve VISNs recorded an increase in close call counts (Figure 1.2)

Table 1.1: JPSR Total Events, Adverse Events, and Close Calls

VISN	Total Events	Adverse Events	Close Calls	Ratio of Adverse Events to Close Calls
V 1	6,443	4,470	1,902	2.4
V 2	10,187	8,145	2,028	4.0
V 4	7,088	5,159	1,927	2.7
V 5	7,299	5,956	1,312	4.5
V 6	7,579	5,092	2,465	2.1
V 7	8,699	5,260	3,421	1.5
V 8	11,650	9,104	2,512	3.6
V 9	8,365	5,588	2,749	2.0
V 10	13,098	8,914	4,163	2.1
V 12	10,141	6,338	3,728	1.7
V 15	8,970	4,873	4,089	1.2
V 16	8,124	6,081	1,986	3.1
V 17	7,114	5,349	1,747	3.1
V 19	9,636	7,476	2,067	3.6
V 20	6,030	3,971	2,048	1.9
V 21	9,428	6,702	2,642	2.5
V 22	12,677	9,096	3,559	2.6
V 23	10,155	6,912	3,234	2.1
National	162,683	114,486	47,579	2.4

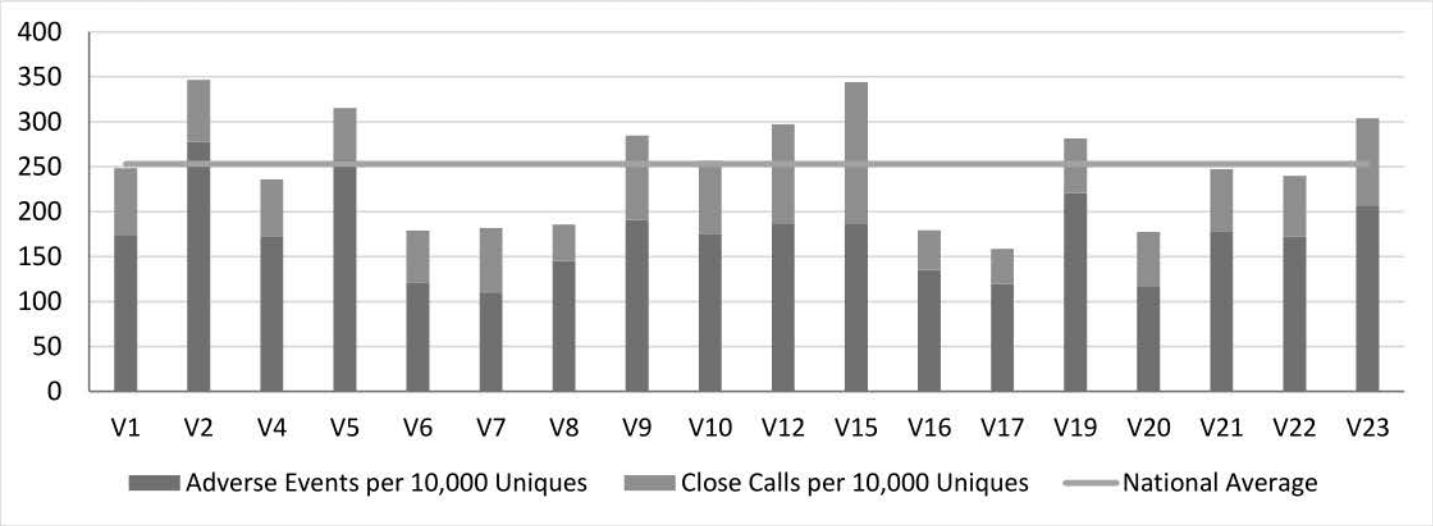
Notes: Data pulled on 11/12/2020 by Closed Date with finalized events.
Source: Joint Patient Safety Reporting (JPSR) System

Table 1.2: JPSR Report Total Events, Adverse Events, and Close Calls per 10,000 Uniques

VISN	Uniques	Total Events per 10,000 Uniques	Adverse Events per 10,000 Uniques	Close Calls per 10,000 Uniques	Ratio of Adverse Events per 10,000 Uniques to Close Calls per 10,000 Uniques
V 1	256,676	251.0	174.1	74.1	2.4
V 2	293,613	347.0	277.4	69.1	4.0
V 4	300,251	236.1	171.8	64.2	2.7
V 5	230,636	316.5	258.2	56.9	4.5
V 6	422,526	179.4	120.5	58.3	2.1
V 7	477,565	182.2	110.1	71.6	1.5
V 8	626,067	186.1	145.4	40.1	3.6
V 9	292,754	285.7	190.9	93.9	2.0
V 10	510,097	256.8	174.8	81.6	2.1
V 12	338,981	299.2	187.0	110.0	1.7
V 15	260,461	344.4	187.1	157.0	1.2
V 16	449,710	180.6	135.2	44.2	3.1
V 17	447,169	159.1	119.6	39.1	3.1
V 19	339,066	284.2	220.5	61.0	3.6
V 20	339,079	177.8	117.1	60.4	1.9
V 21	377,874	249.5	177.4	69.9	2.5
V 22	528,060	240.1	172.3	67.4	2.6
V 23	334,047	304.0	206.9	96.8	2.1
National	6,427,081	253.1	178.1	74.0	2.4

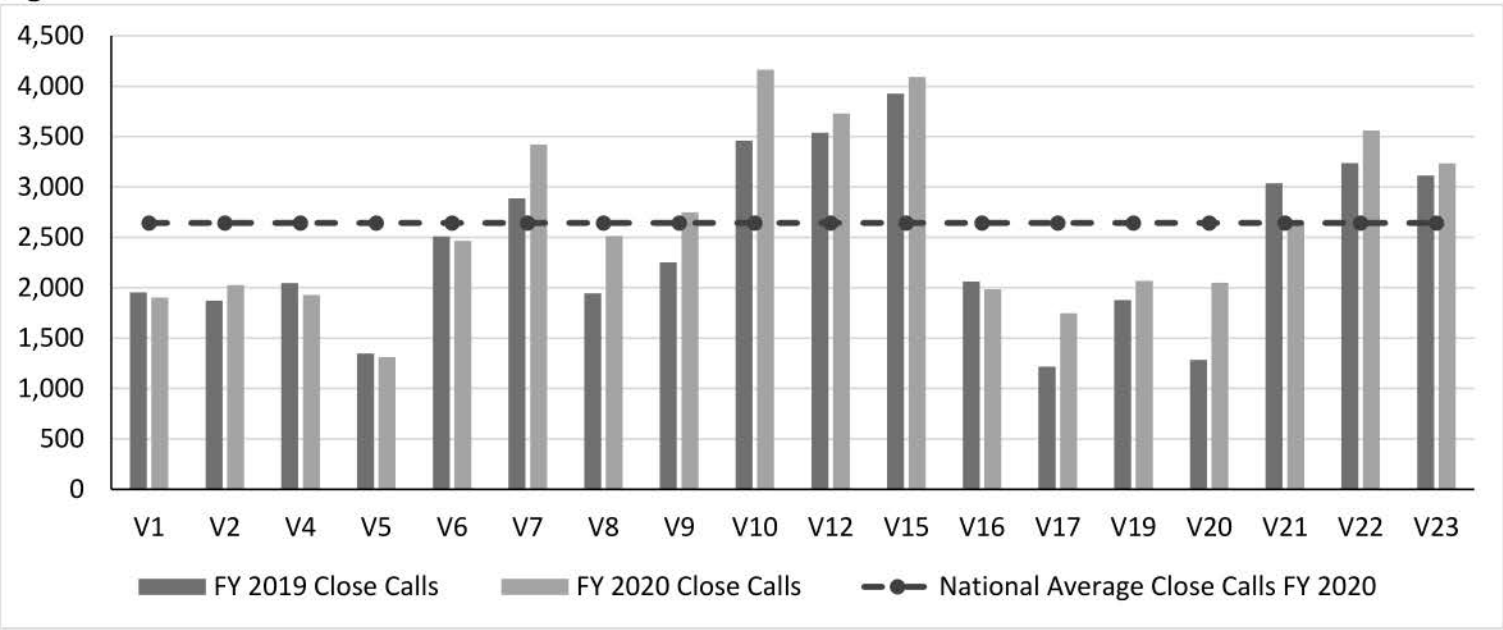
Notes: Data pulled on 11/12/2020 by Closed Date with FY20 uniques and finalized events.
Source: Joint Patient Safety Reporting (JPSR) System

Figure 1.1: Adverse Events and Close Calls per 10,000 Uniques



Notes: Data pulled on 11/12/2020 by Closed Date with FY 2020 uniques and finalized events.
Source: Joint Patient Safety Reporting (JPSR) System

Figure 1.2: Close Calls from FY 2019 to FY 2020



Notes: Data pulled on 11/12/2020 by Closed Date with finalized events.
Source: Joint Patient Safety Reporting (JPSR) System

Serious Safety Events are those events that result in death, permanent bodily injury or the substantial risk thereof and are assigned by the PSM in JPSR a Safety Assessment Code (SAC) score of 3[1]. Potential Serious Safety Events would have resulted in a Serious Safety Event under the worst-case scenario and recorded as Potential SAC-3 events. Table 1.3 identifies that the national total number of Serious Safety Events was 589, with VISNs reporting between 5 to 55. The national total of Potential Serious Safety Events was 10,709, with VISNs reporting between 35 to 1,991. The national rate of Serious Safety Events per 10,000 uniques was 0.9, VISNs ranging from 0.1 to 1.9 and the national rate of Potential Serious Safety Events per 10,000 uniques was 16.7, VISNs ranging from 0.9 to 58.7. In comparison to FY 2019, FY 2020 Serious Safety Events decreased 7.5% (637 to 589), the Serious Safety Event rate decreased from 1.0 to 0.9, Potential Serious Safety Events decreased 27.6%, and the Potential Serious Safety Events rate decreased from 22.4 to 16.7.

Table 1.3: JPSR Serious Safety Event and Potential Serious Safety Event Totals

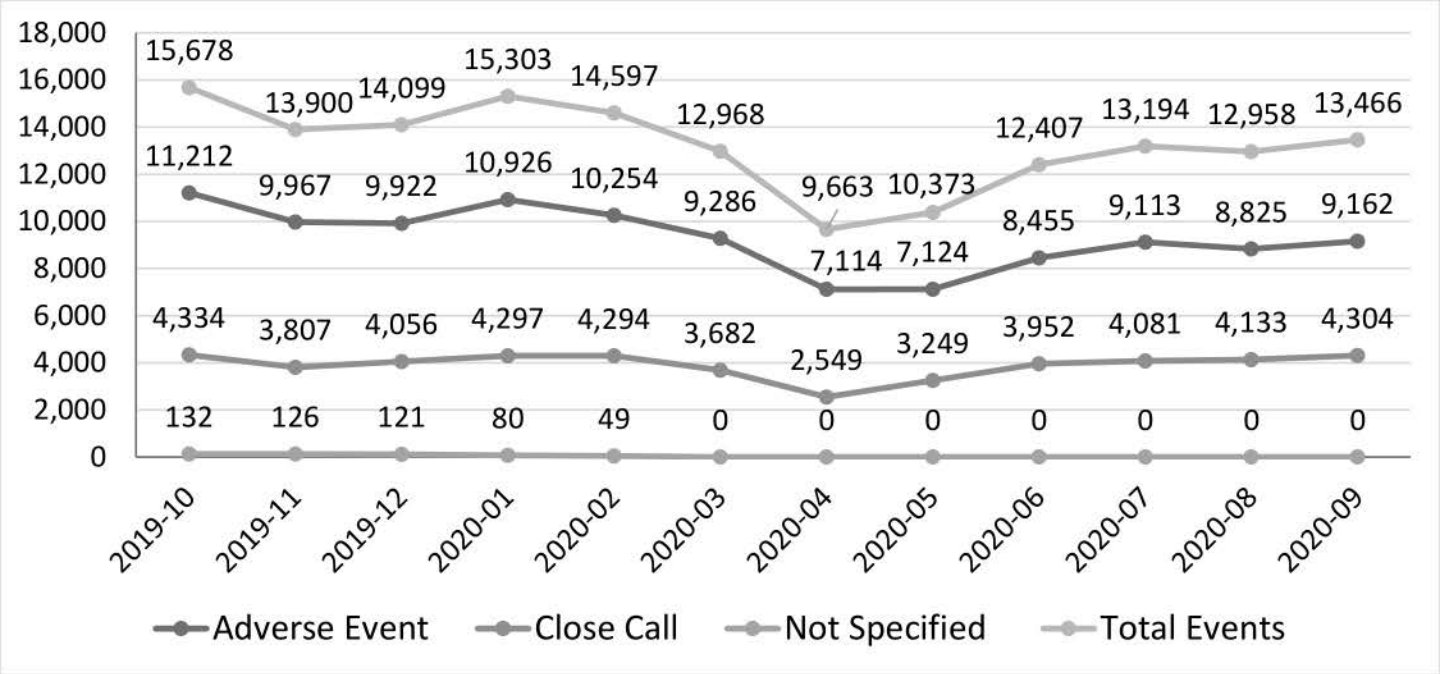
VISN	Uniques	Serious Safety Events	Serious Safety Events per 10,000 Uniques	Potential Serious Safety Events	Potential Serious Safety Events per 10,000 Uniques
V 1	256,676	35	1.4	595	23.2
V 2	293,613	55	1.9	1,479	50.4
V 4	300,251	50	1.7	216	7.2
V 5	230,636	30	1.3	344	14.9
V 6	422,526	11	0.3	77	1.8
V 7	477,565	31	0.6	216	4.5
V 8	626,067	32	0.5	157	2.5
V 9	292,754	11	0.4	187	6.4
V 10	510,097	50	1.0	1,809	35.5
V 12	338,981	21	0.6	1,991	58.7
V 15	260,461	20	0.8	421	16.2
V 16	449,710	52	1.2	804	17.9
V 17	447,169	21	0.5	157	3.5
V 19	339,066	40	1.2	491	14.5
V 20	339,079	48	1.4	423	12.5
V 21	377,874	5	0.1	35	0.9
V 22	528,060	55	1.0	635	12.0
V 23	334,047	22	0.7	672	20.1
National	6,427,081	589	0.9	10,709	16.7

Notes: Data pulled on 11/12/2020 by Closed Date on finalized events. Serious Safety Event are reports with Safety Assessment Code (SAC) assignment of Actual SAC-3. Potential Serious Safety Events are reports with Safety Assessment Code (SAC) assignment of Potential SAC-3.
Source: Joint Patient Safety Reporting (JPSR) System.

[1] Additional information regarding SAC scores can be found in VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook.

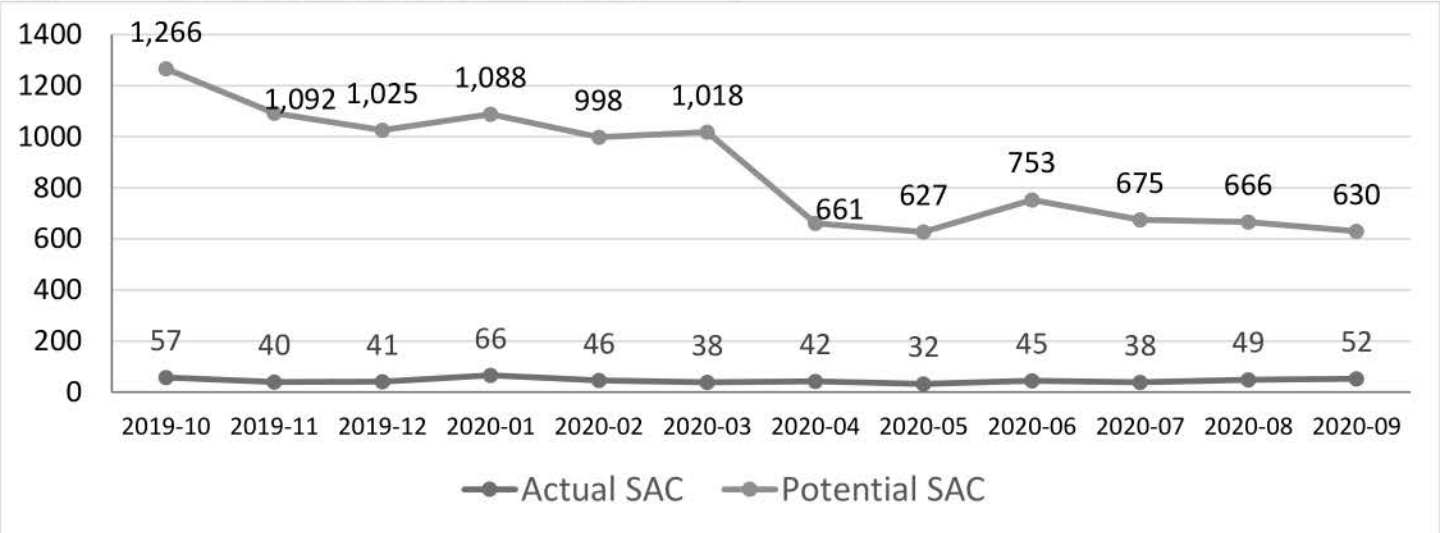
In Quarter 3 (Q3)-FY 2020, the monthly JPSR total events, adverse events, and close calls decreased in association with the emergence of the worldwide COVID-19 pandemic and recovered toward pre-pandemic monthly reporting rates in Q4 (Figure 1.3). Monthly totals for JPSR Serious Safety Events did not change during the year however there was a decline in Potential Serious Safety events beginning Q3-FY 2020 which persisted through Q4 (Figure 1.4). Care Management represented 83% of JPSR Event types (Figure 1.5). Figure 1.6 provides a breakdown of Care Management and shows the following predominant subtypes: falls (33%), clinical administration (30%), and Medication/biological/nutritional error (23%). In comparison to FY 2019, Care Management continues to be >80% of JPSR Events of which sub-type classification of Falls, Delays in Care and medication error continue to comprise >80%.

Figure 1.3: Adverse Events and Close Calls from JPSR



Notes: Data pulled on 1/20/2021 by Closed Date with finalized events.
Source: Joint Patient Safety Reporting (JPSR) System.

Figure 1.4: JPSR Actual and Potential SAC 3 Events



Notes: Data pulled on 1/20/2021 by Closed Date with finalized events.
Source: Joint Patient Safety Reporting (JPSR) System.

Figure 1.5: Events Types in JPSR

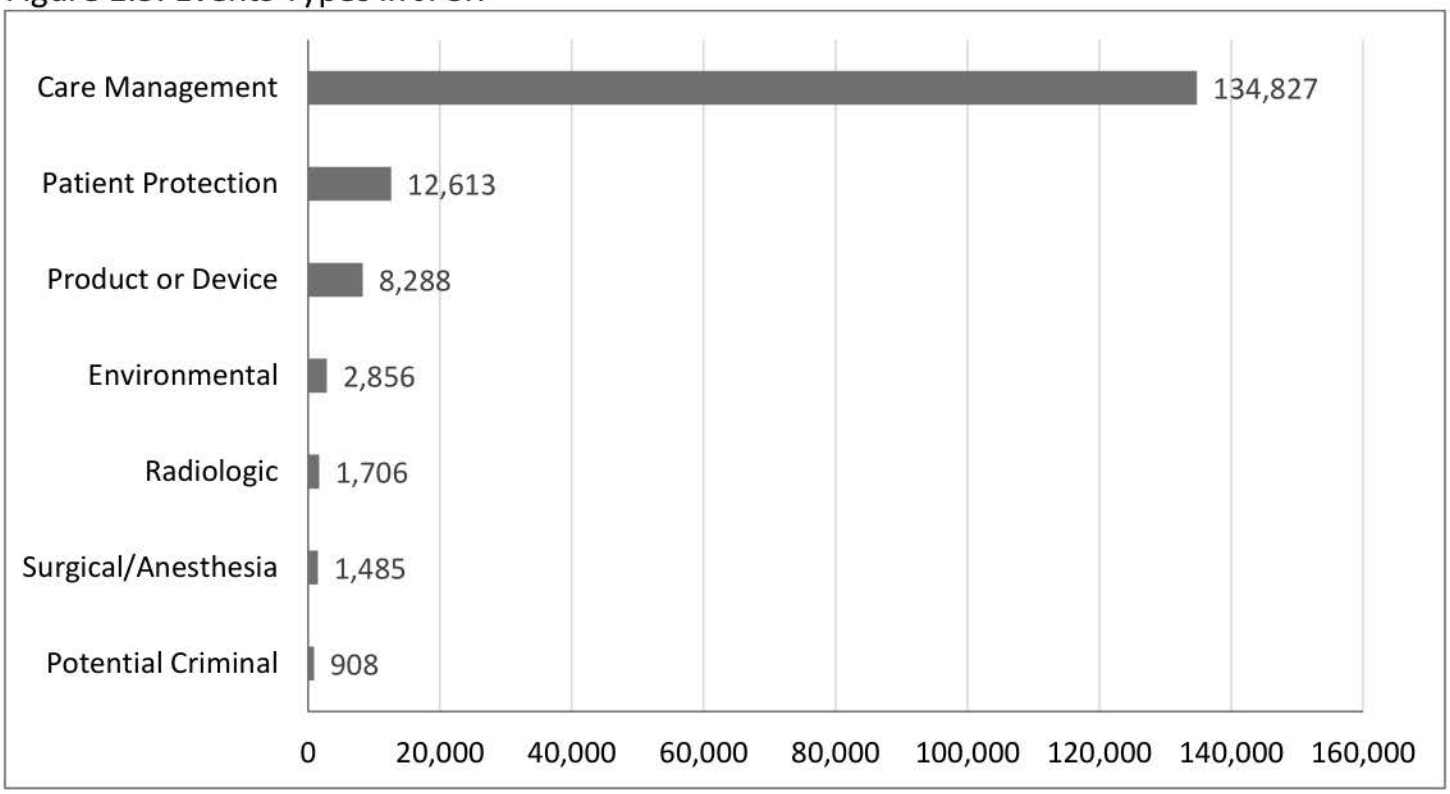
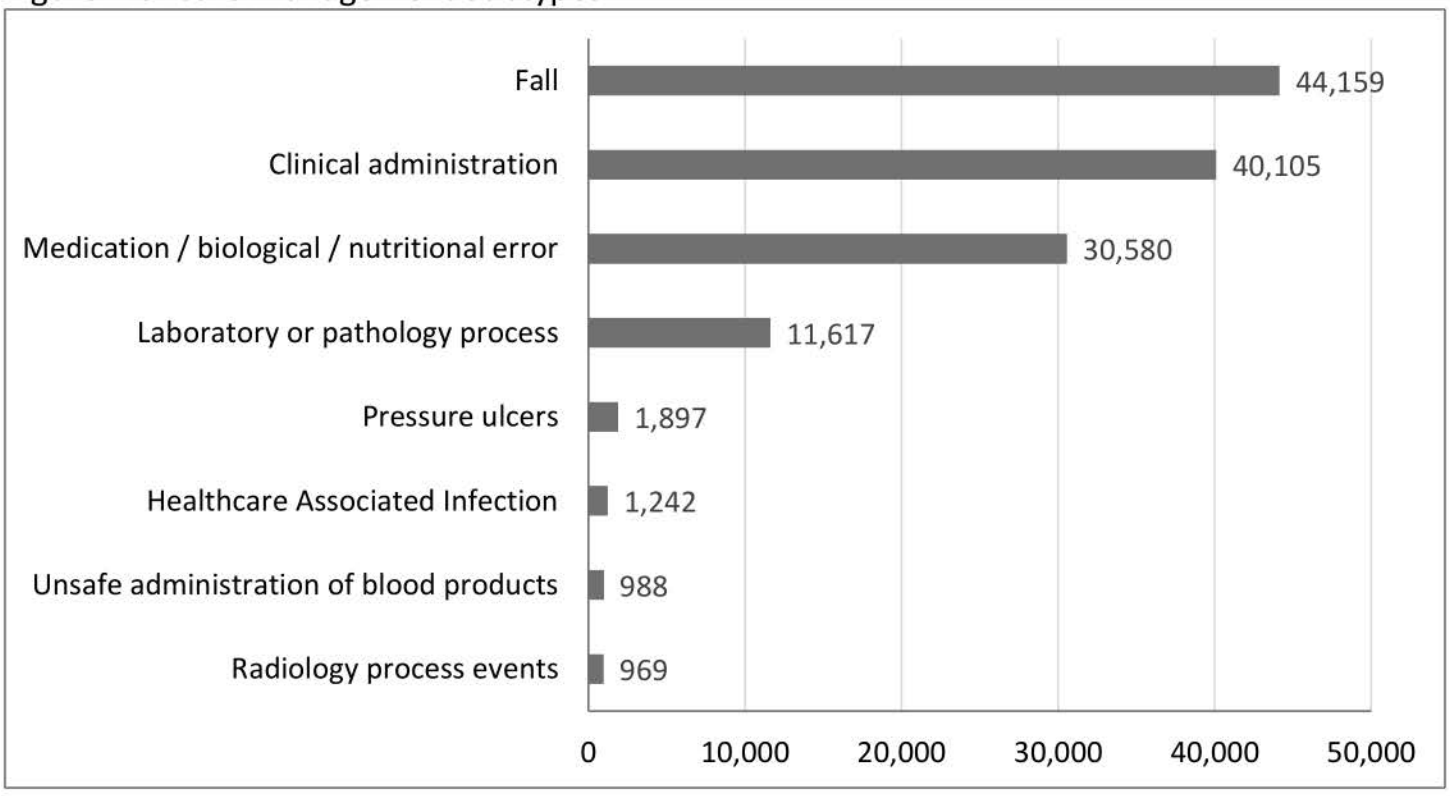


Figure 1.6: Care Management Subtypes



Notes: Figure 1.5 and 1.6 data pulled on 1/11/2021 by Closed Date.
Source: Joint Patient Safety Reporting (JPSR) System.

VHA policy establishes an annual requirement for VA medical centers to perform a minimum of eight patient safety analyses including the following: Root Cause Analysis (RCA), Aggregate Review, Wild Card Aggregate Review, Proactive Risk Assessment (PRA), and Patient Safety Assessment Tool (PSAT) evaluation.[2] Wild Card Aggregate Reviews evaluate the predominant low harm (SAC 1 and 2) events or an emerging trend at the VA medical center. In FY 2020, the VA medical centers performed 1,984 patient safety analyses, including 1,023 RCAs, 132 Medication Error Aggregate Review, 168 Wild Card Aggregate Reviews, 140 Falls PSAT, 128 Fall/Winter Mental Health Environment of Care Checklist (MHEOCC) and 127 Spring/Summer MHEOCC, and 127 PRAs (Table 1.4). Monthly RCA submissions ranged from a low of 64 to a high of 127 (Figure 1.7). Falls, Delays in Care, and Suicide attempts and deaths represent 48% of the RCAs submitted; representing serious or potential serious harm events Figure 1.8). Twenty-one percent of Wild Card Aggregate Reviews were performed to examine Delays in Care (Figure 1.9). In comparison to FY 2019, falls, delays in care and suicide events continue to comprise >50% of RCAs performed and delays in care continues to be a leading interest in wild card aggregate reviews.

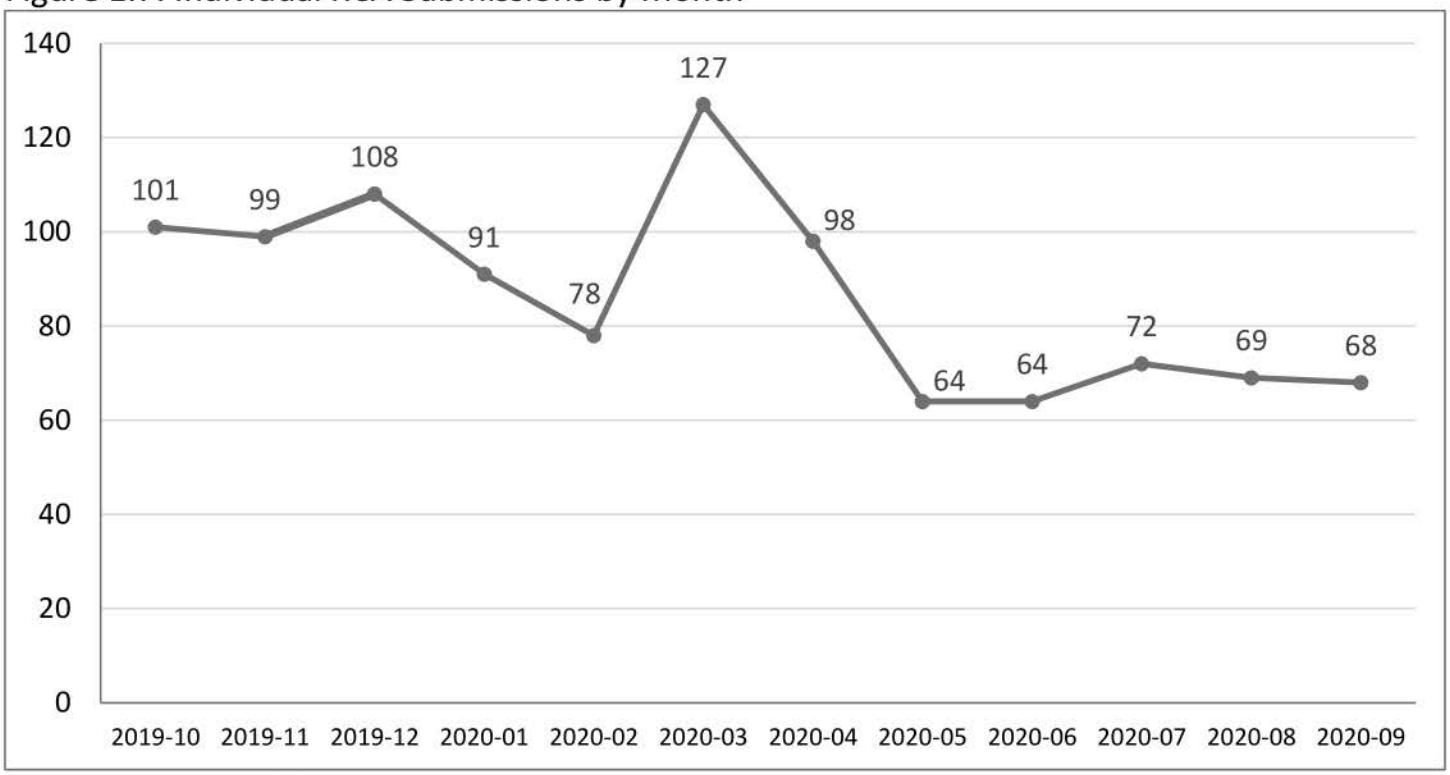
Table 1.4: Required Patient Safety Element Submission, Last 12 Months

VISN	RCA	Med Aggregate Review	Wild Card Aggregate Review	Falls PSAT Jan'20	MHEOCC Jan'20	MHEOCC July'20	AWM PSAT July'20	Proactive Risk Assessment	Total
V 1	56	9	13	8	8	8	8	5	115
V 2	104	8	11	10	9	9	10	6	167
V 4	72	9	10	9	7	7	9	17	140
V 5	58	6	8	6	4	4	6	12	104
V 6	46	7	6	7	7	7	7	6	93
V 7	61	7	18	8	8	8	8	1	119
V 8	51	7	9	7	7	7	7	5	100
V 9	34	4	5	5	5	5	5	5	68
V 10	71	11	15	11	11	11	10	15	155
V 12	37	8	8	8	8	8	8	9	94
V 15	41	7	9	7	7	7	6	6	90
V 16	71	6	11	8	8	8	8	4	124
V 17	41	6	7	7	3	3	7	4	78
V 19	63	9	5	8	8	8	8	7	116
V 20	63	8	11	8	6	5	8	8	117
V 21	34	6	5	7	7	7	7	3	76
V 22	70	6	9	8	7	7	9	8	124
V 23	50	8	8	8	8	8	8	6	104
National	1,023	132	168	140	128	127	139	127	1,984

Notes: Data pulled 11/12/2020 for the period October 1, 2019 through September 30, 2020. Includes RCAs, medication, and any other aggregated reviews (falls, missing patient, wild card), PSATs, proactive risk assessment (including HFMEA).
Source: SPOT, PSAT

[2] VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, Memoranda dated 12/20/2016, 6/6/2017, 4/3/2019, and 3/17/2020 (available at http://vaww.ncps.med.va.gov/).

Figure 1.7: Individual RCA Submissions by Month



Notes: Data pulled on 1/11/2021
Source: SPOT

Figure 1.8: Top Reported Events for RCAs

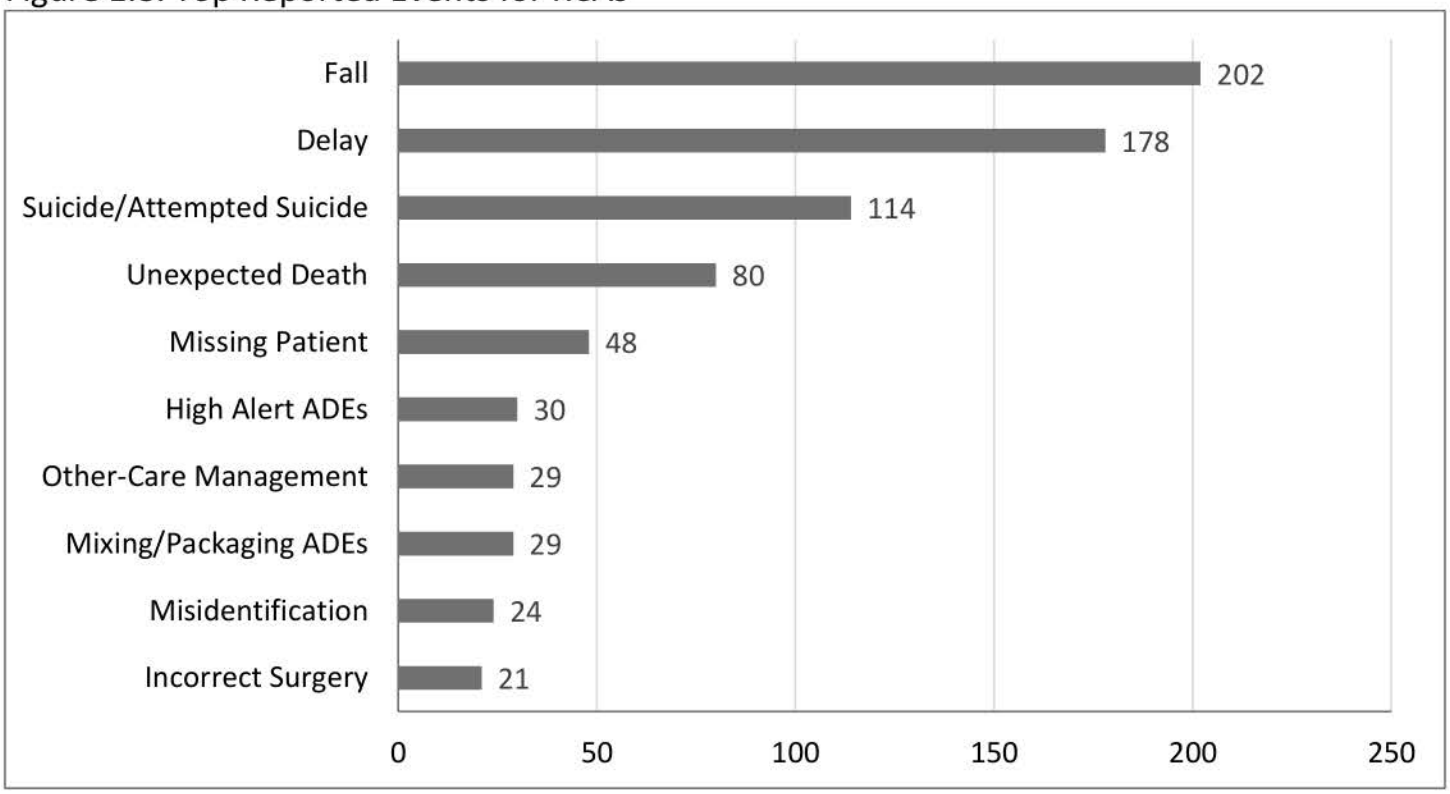
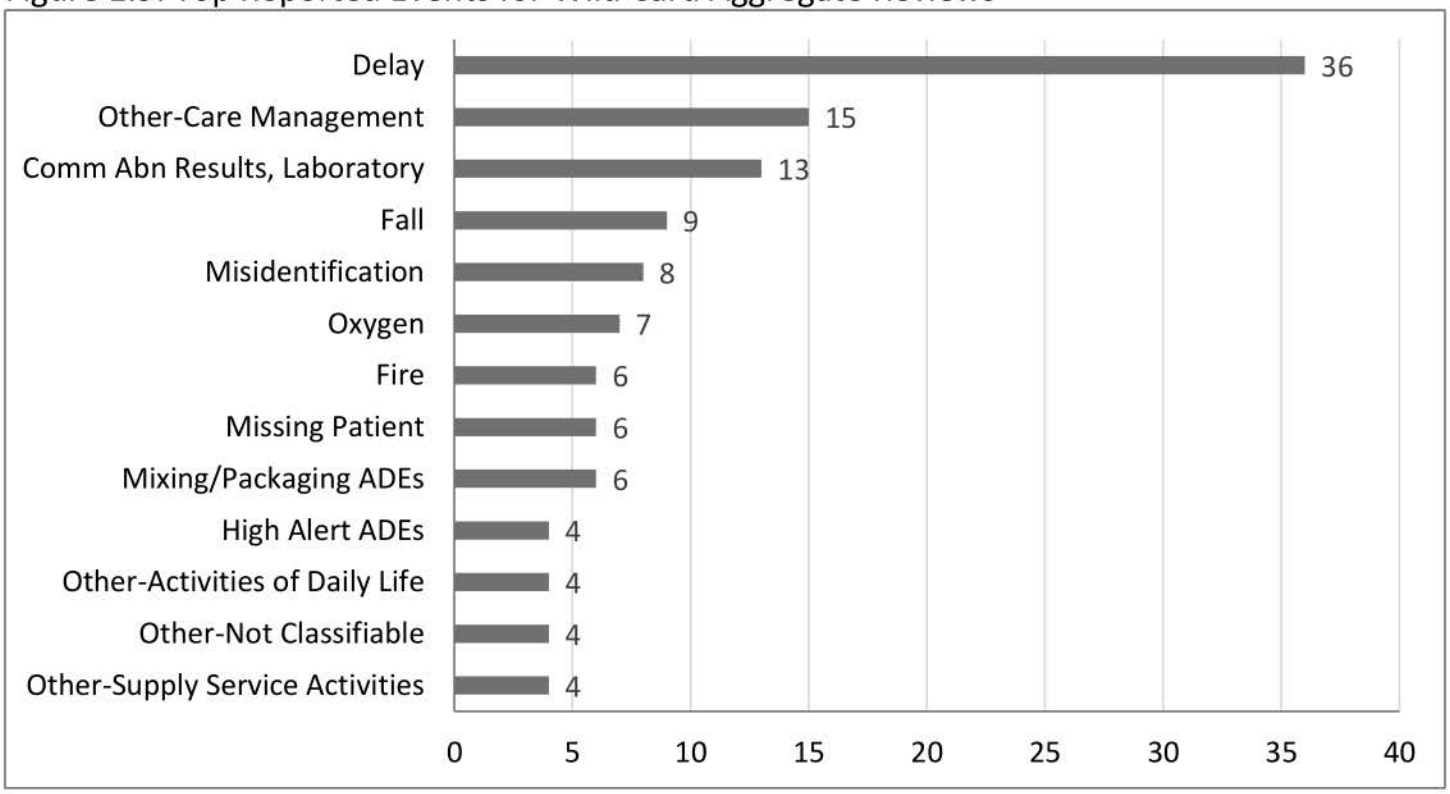


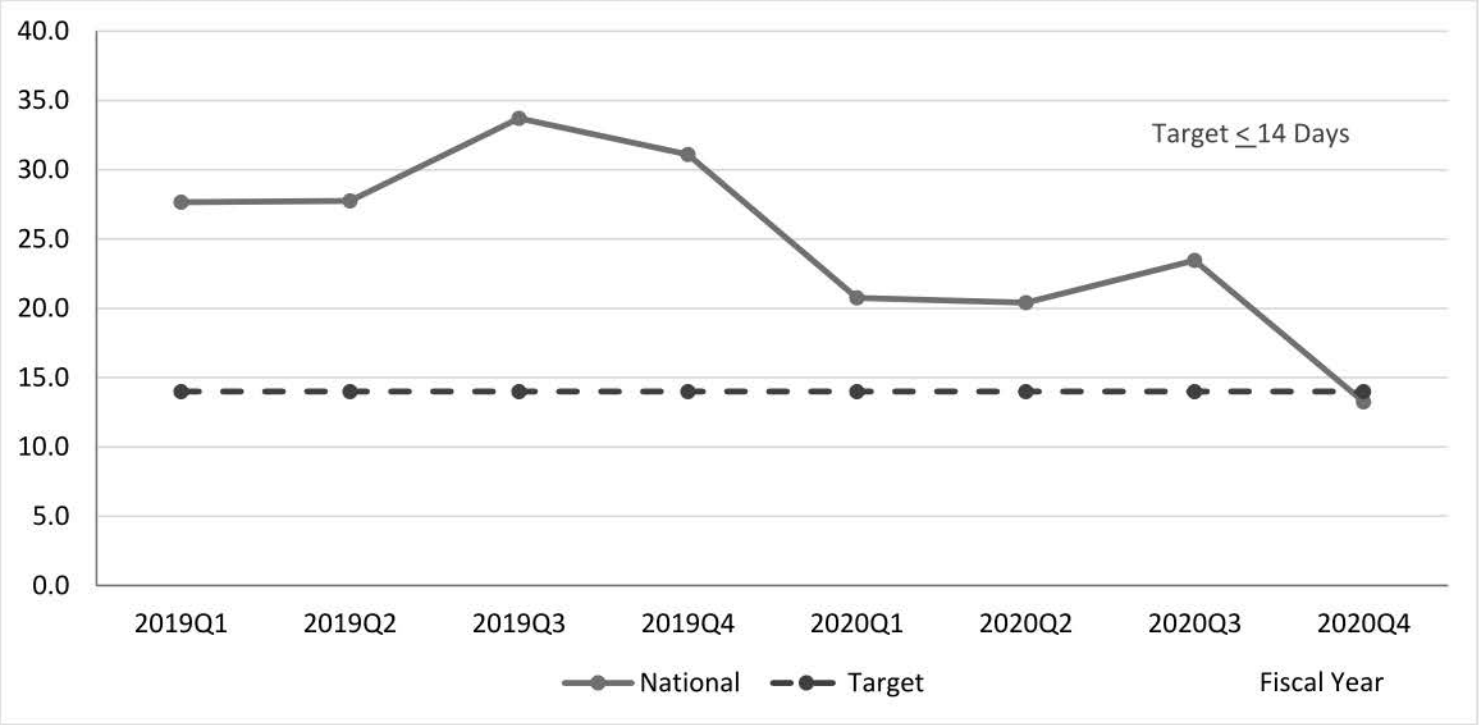
Figure 1.9: Top Reported Events for Wild Card Aggregate Reviews



Notes: Figures 1.7 and 1.8 data pulled 1/11/2021 for period October 1, 2019 to September 30, 2020.
Source: SPOT

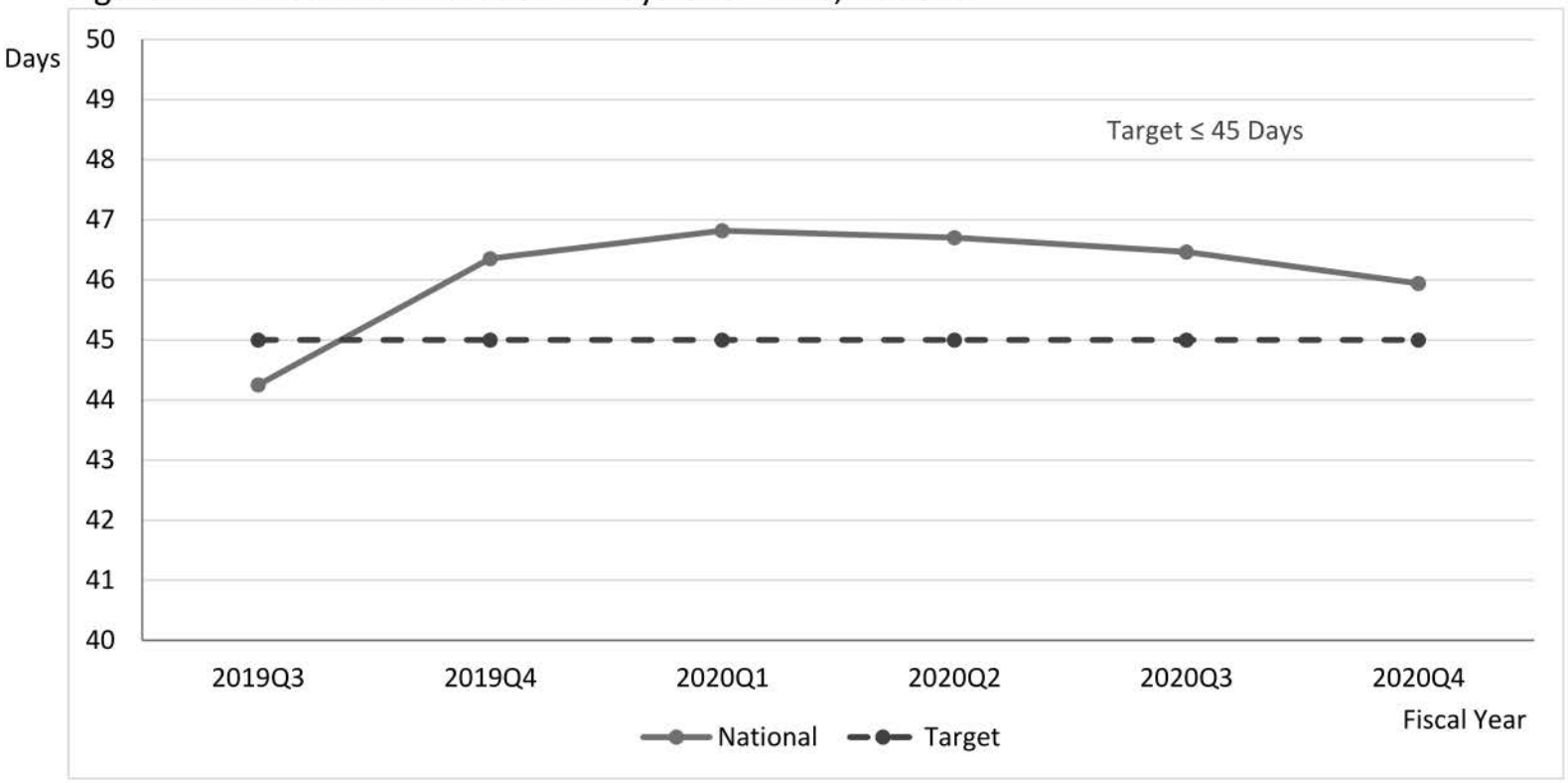
NCPS publishes the JPSR Business Rule and Guidebook with instruction to PSMs to investigate patient safety events entered in JPSR, assign a harm score, and finalize the event report within 14 days of report entry. In accordance with VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, an RCA must be completed, signed by the facility Director and submitted to the NCPS within 45 days of the facility becoming aware that an RCA is required. In FY 2020, the national JPSR mean time to finalize JPSR entries decreased from 20.8 days to 13.3 days, with VISNs in Q4-FY 2020 ranging from 3.8 to 42.3 days (Figure 1.10). The national RCA mean time to submit an RCA remained essentially unchanged and was 45.9 days in Q4-FY 2020, with VISNs ranging from 37.6 to 65.7 days (Figure 1.11).

Figure 1.10: National Mean Time to Finalize JPSR Entries in Days Over Time



Notes: Data pulled 11/12/2020 includes finalized events.
Source: Joint Patient Safety Reporting (JPSR) System

Figure 1.11: Mean RCA Duration in Days Over Time, National



Notes: Data pulled 11/12/2020. Mean duration in days covers rolling year. To be timely, an RCA must be completed and signed by the facility Director within 45 days of the facility becoming aware that an RCA is required.
Source: SPOT

In accordance with VHA Directive 1068, NCPS oversees the VHA Alerts and Recalls web application to facilitate the recall of defective medical devices and medical products, including food and food products and administers and tracks Patient Safety Alerts, Advisories, and Notices.[3] In FY 2020, NCPS administered 592 recalls and published one Patient Safety Alert and thirteen Patient Safety Notices. Sixteen of the VISNs were ≥ 95% compliant with Class I Recalls requiring immediate action and only one VISN was < 98% compliant with All Other Recalls (Table 1.5). Eleven of the VISNs were ≥ 95% compliant with actions required in response to the published Patient Safety Alerts, Advisories, and Notices (Table 1.6).

Table 1.5: Recall Totals and Action Compliance

	Class 1 Recalls		All Other Recalls	
VISN	Compliant/Total	Percent Compliant	Compliant/Total	Percent Compliant
V 1	101/104	97.12	4,563/4,576	99.72
V 2	142/143	99.30	6,233/6,293	99.05
V 4	117/117	100.00	5,124/5,145	99.59
V 5	77/78	98.72	3,414/3,436	99.36
V 6	81/91	89.01	3,852/4,013	95.99
V 7	101/104	97.12	4,556/4,592	99.22
V 8	89/91	97.80	3,945/4,033	97.82
V 9	64/65	98.46	2,852/2,874	99.23
V 10	137/143	95.80	6,280/6,296	99.75
V 12	103/104	99.04	4,576/4,578	99.96
V 15	104/104	100.00	4,513/4,582	98.49
V 16	99/104	95.19	4,519/4,581	98.65
V 17	91/91	100.00	4,004/4,008	99.90
V 19	104/104	100.00	4,577/4,578	99.98
V 20	98/104	94.23	4,527/4,589	98.65
V 21	103/104	99.04	4,570/4,590	99.56
V 22	100/104	96.15	4,693/4,721	99.48
V 23	118/120	99.04	4,680/4,699	99.63

Notes: Data pulled 10/5/2020 for the period October 1, 2019 through September 30, 2020.
Source: NCPS Alerts and Recalls Web Application

[3] VHA Directive 1068, Recall of Defective Medical Devices and Medical Products, Including Food and Food Products.

Table 1.6: Patient Safety Alerts, Advisories, and Notices and Action Compliance

	Patient Safety Alerts, Advisories and Notices	
VISN	Compliant/Total	Percent Compliant
V 1	107/112	95.54
V 2	147/154	95.45
V 4	119/126	94.44
V 5	80/84	95.24
V 6	96/98	97.96
V 7	102/112	91.07
V 8	92/98	93.88
V 9	66/70	94.29
V 10	133/154	86.36
V 12	111/112	99.11
V 15	96/112	85.71
V 16	103/112	91.96
V 17	98/98	100.00
V 19	108/112	96.43
V 20	110/112	98.21
V 21	109/112	97.32
V 22	80/88	92.86
V 23	110/112	98.21

Notes: Data pulled 10/5/2020 for the period October 1, 2019 through September 30, 2020.
Source: NCPS Alerts and Recalls Web Application

Chapter 2: Inpatient Hospital

This chapter represents the collection of inpatient hospital metrics related to patient safety infrastructure and process sourced from a number of data sources; including falls, catheter associated urinary tract infections, central line associated blood stream infections, pressure ulcers, operating room adverse events, 30-day standardized mortality rates, and 30-day readmission rates. VHA national data and published data are referenced when available for benchmarking. In addition, the number of peer reviews performed for quality management (protected under 38 USC 5705) are identified to provide perspective regarding the number of peer reviewed events and determinations of level of care.[4]

NCPS facilitates the quarterly facility PSM submission of patient falls data to the Inpatient Evaluation Center (IPEC) Falls Database. Falls, falls with injury, and falls with major injury rates for All Units and separately for Acute Care, Intensive Care Units (ICU), Community Living Centers (CLC), and Behavioral Health (BH) are found in Tables 2.1-2.5, respectively. In FY 2020, IPEC collected 24,785 falls nationally for All Units of which 7,791 (31.4%) were falls with injury including a subset of 399 falls with major injury, representing 1.6% of total falls reported and 5.1% of falls with injury. The national falls rate for All Units was 4.46 per 1,000 Bed Day of Care (BDOC), the falls with injury rate was 1.40/1,000 BDOC, and the falls with major injury rate was 0.07/1,000 BDOC. VISN falls rates ranged from 2.72 to 7.73/1,000 BDOC, the falls with injury rate ranged from 0.74 to 2.71/1,000 BDOC and falls with major injury rates ranged from 0.03 to 0.31/1,000 BDOC. These findings are consistent with published data reporting a range in fall rates for acute care settings from 1.3 to 8.9 per 1,000 BDOC.[5]

National data shows the majority of falls, falls with injury, and falls with major injury occur in the CLC (59%, 61%, and 55% respectively), followed by Acute Care (28%, 27%, and 36% respectively), BH (11%, 11%, and 7% respectively), and ICU (2%, 2%, and 2% respectively). The national CLC rate for falls, falls with injury, and falls with major injury was 5.58/1,000 BDOC, 1.80/1,000 BDOC, and 0.08/1,000 BDOC, respectively. These findings are consistent with published data stating that falls occur at different rates in a variety of clinical settings.[6]

In comparison to FY 2019, the overall number of falls reported decreased 22% however the fall rate per 1000 BDOC increased from 4.18 to 4.46 most likely due to a decrease in inpatient care including Community Living Centers (CLCs) associated with the COVID-19 pandemic.

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[4] VHA Directive 1190, Peer Review for Quality Management.

[5] Soncrant C, Neily J, Bulat R, and Mills P. Recommendations for Fall-Related Injury Prevention: A 1-Year Review of Fall-Related Root Cause Analyses in the Veterans Health Administration. *J Nurs Care Qual* 2019;35 (1): 77-82.

[6] Bouldin ED, Andresen EM, Dunton NE, et al. Falls Among Adult Patients Hospitalized in the United States: Prevalence and Trends. *J Patient Saf* 2013;9(1): 13-17.

Table 2.1: All Unit (Acute Care, ICU, CLC, BH) Patient Fall Events Total and Rates per 1,000 Bed Days of Care (BDOC)

VISN	Bed Days	Number Falls	Fall Rate (per 1,000 BDOC)	Number Falls with Injury	Rate of Falls with Any Injury (per 1,000 BDOC)	Number Falls with Major Injury	Maj Injury Rate (per 1,000 BDOC)
V 1	271,034	1,260	4.65	735	2.71	17	0.06
V 2	423,011	2,008	4.75	699	1.65	32	0.08
V 4	330,987	1,779	5.37	443	1.34	31	0.09
V 5	251,021	1,448	5.77	322	1.28	19	0.08
V 6	303,589	1,245	4.10	338	1.11	19	0.06
V 7	267,975	730	2.72	199	0.74	20	0.07
V 8	515,369	1,875	3.64	640	1.24	26	0.05
V 9	248,322	942	3.79	199	0.80	11	0.04
V 10	456,066	2,592	5.68	836	1.83	38	0.08
V 12	292,973	1,250	4.27	395	1.35	16	0.05
V 15	160,273	674	4.21	169	1.05	11	0.07
V 16	286,490	886	3.09	275	0.96	13	0.05
V 17	365,946	1,202	3.28	493	1.35	23	0.06
V 19	157,500	910	5.78	267	1.70	19	0.12
V 20	176,642	1,138	6.44	498	2.82	54	0.31
V 21	354,430	1,419	4.00	427	1.20	10	0.03
V 22	424,276	1,327	3.13	391	0.92	19	0.04
V 23	271,790	2,100	7.73	465	1.71	21	0.08
National	5,557,694	24,785	4.46	7,791	1.40	399	0.07

Notes: Data pulled 11/16/2020.
Source: VA Inpatient Evaluation Center (IPEC), Falls Cube

Table 2.2: Acute Care Patient Fall Events Total and Rates per 1,000 Bed Days of Care (BDOC)

VISN	Bed Days	Number Falls	Fall Rate (per 1,000 BDOC)	Number Falls with Injury	Rate of Falls with Any Injury (per 1,000 BDOC)	Number Falls with Major Injury	Major Injury Rate (per 1,000 BDOC)
V 1	78,934	201	2.55	60	0.76	3	0.04
V 2	100,412	446	4.44	137	1.36	9	0.09
V 4	60,606	225	3.71	68	1.12	7	0.12
V 5	68,077	328	4.82	72	1.06	3	0.04
V 6	101,836	341	3.35	100	0.98	8	0.08
V 7	97,320	320	3.29	70	0.72	8	0.08
V 8	238,715	732	3.07	260	1.09	16	0.07
V 9	112,812	486	4.31	104	0.92	7	0.06
V 10	126,295	467	3.70	159	1.26	12	0.10
V 12	107,047	442	4.13	125	1.17	5	0.05
V 15	72,115	240	3.33	66	0.92	7	0.10
V 16	101,640	297	2.92	144	1.42	8	0.08
V 17	103,728	301	2.90	120	1.16	7	0.07
V 19	66,025	459	6.95	130	1.97	9	0.14
V 20	73,813	328	4.44	123	1.67	21	0.28
V 21	110,689	398	3.60	113	1.02	3	0.03
V 22	193,087	553	2.86	145	0.75	7	0.04
V 23	77,987	454	5.82	102	1.31	2	0.03
National	1,891,138	7,018	3.71	2,098	1.11	142	0.08

Notes: Data pulled 11/16/2020.
Source: VA Inpatient Evaluation Center (IPEC), Falls Cube

Table 2.3: Intensive Care Unit (ICU) Patient Fall Events Total and Rates per 1,000 Bed Days of Care (BDOC)

VISN	Bed Days	Number Falls	Fall Rate (per 1,000 BDOC)	Number Falls with Injury	Rate of Falls with Any Injury (per 1,000 BDOC)	Number Falls with Major Injury	Major Injury Rate (per 1,000 BDOC)
V 1	12,020	15	1.26	6	0.52	1	0.10
V 2	19,614	25	1.32	9	0.47	1	0.05
V 4	18,357	27	1.51	6	0.31	1	0.08
V 5	15,393	21	1.43	5	0.33	0	0.00
V 6	21,902	25	1.11	12	0.51	1	0.04
V 7	20,641	11	0.63	5	0.29	0	0.00
V 8	36,601	39	1.07	11	0.30	0	0.00
V 9	19,396	24	1.23	5	0.24	0	0.00
V 10	26,547	29	1.09	11	0.41	0	0.00
V 12	16,952	30	1.73	7	0.38	1	0.05
V 15	14,184	20	1.43	4	0.29	0	0.00
V 16	19,513	12	0.73	3	0.16	0	0.00
V 17	17,484	18	1.03	5	0.28	0	0.00
V 19	12,570	35	2.92	6	0.52	0	0.00
V 20	8,681	19	2.11	7	0.81	4	0.45
V 21	13,598	15	1.12	7	0.54	0	0.00
V 22	28,436	30	1.15	11	0.40	0	0.00
V 23	10,132	21	2.06	6	0.59	0	0.00
National	332,021	416	1.27	126	0.38	9	0.03

Notes: Data pulled 11/16/2020.
Source: VA Inpatient Evaluation Center (IPEC), Falls Cube

Table 2.4: Community Living Center (CLC) Patient Fall Events Total and Rates per 1,000 Bed Days of Care (BDOC)

VISN	Bed Days	Number Falls	Fall Rate (per 1,000 BDOC)	Number Falls with Injury	Rate of Falls with Any Injury (per 1,000 BDOC)	Number Falls with Major Injury	Major Injury Rate (per 1,000 BDOC)
V 1	129,281	849	6.59	590	4.57	9	0.07
V 2	252,663	1,394	5.51	501	1.98	22	0.08
V 4	215,434	1,412	6.53	346	1.61	21	0.10
V 5	134,148	1,033	7.62	228	1.72	14	0.11
V 6	130,873	661	4.98	171	1.27	7	0.06
V 7	125,242	315	2.44	100	0.76	10	0.07
V 8	189,946	853	4.50	273	1.41	9	0.05
V 9	82,016	318	3.81	59	0.72	4	0.05
V 10	251,836	1,818	7.15	569	2.22	24	0.09
V 12	143,860	677	4.45	235	1.54	10	0.08
V 15	50,868	323	6.53	75	1.49	2	0.04
V 16	121,517	464	4.03	99	0.73	4	0.04
V 17	168,056	733	4.35	301	1.85	16	0.10
V 19	51,409	290	5.63	98	1.88	10	0.19
V 20	72,873	684	9.66	320	4.71	25	0.38
V 21	198,453	903	4.52	279	1.41	7	0.03
V 22	140,988	533	3.64	168	1.14	7	0.04
V 23	159,026	1,464	9.06	319	1.96	18	0.11
National	2,618,489	14,724	5.58	4,731	1.80	219	0.08

Notes: Data pulled 11/16/2020.
Source: VA Inpatient Evaluation Center (IPEC), Falls Cube

Table 2.5: Inpatient Behavioral Health (BH) Patient Fall Events Total and Rates per 1,000 Bed Days of Care (BDOC)

VISN	Bed Days	Number Falls	Fall Rate (per 1,000 BDOC)	Number Falls with Injury	Rate of Falls with Any Injury (per 1,000 BDOC)	Number Falls with Major Injury	Major Injury Rate (per 1,000 BDOC)
V 1	50,799	195	3.82	79	1.55	4	0.07
V 2	50,322	143	2.96	52	1.01	0	0.00
V 4	36,590	115	3.18	23	0.62	2	0.06
V 5	33,403	66	1.77	17	0.54	2	0.09
V 6	48,978	218	4.53	55	1.13	3	0.06
V 7	24,772	84	3.27	24	0.89	2	0.07
V 8	50,107	251	5.00	96	1.91	1	0.02
V 9	34,098	114	3.28	31	0.97	0	0.00
V 10	51,388	278	5.47	97	1.90	2	0.03
V 12	25,114	101	3.80	28	0.96	0	0.00
V 15	23,106	91	3.95	24	0.94	2	0.07
V 16	43,820	113	2.79	29	0.76	1	0.01
V 17	76,678	150	2.09	67	0.96	0	0.00
V 19	27,496	126	4.50	33	1.26	0	0.00
V 20	13,727	98	7.48	41	3.16	4	0.28
V 21	31,690	103	3.62	28	1.00	0	0.00
V 22	61,765	211	3.41	67	1.08	5	0.08
V 23	24,645	161	6.57	38	1.54	1	0.04
National	708,498	2,618	3.76	829	1.19	29	0.04

Notes: Data pulled 11/16/2020.
Source: VA Inpatient Evaluation Center (IPEC), Falls Cube

National and VISN pressure ulcer total counts and rates per 1,000 discharges are identified in Table 2.6. Note that the data source provides pressure ulcer counts and rates using 2 years (24 months) of data, in this case combining FY 2019 and FY 2020. Accordingly, VHA national data identified 310 recorded pressure ulcers related to patient care for this period, with VISN totals ranging from 4 to 37 and rates/1,000 discharges ranging from 0.23 to 1.19. A pressure ulcer statistical model produces an observed to expected pressure ulcer ratio, ranging from 0.42 to 1.90. Published data identifies VHA hospital acquired pressure ulcer rates to be significantly lower than external benchmark data captured by the Centers for Medicare and Medicaid (CMS) and reported by the Agency for Healthcare Research and Quality (AHRQ).[7]

Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Bloodstream Infection (CLABSI) totals and rates are shown in Table 2.7. Note that the rolling year FY 2020 data included only reporting for Q1 and Q4 due to COVID-19. FY 2020 National data identified a total number of 179 CAUTI and 253 CLABSI events, with a CAUTI rate of 0.96 infections per 1,000 catheter days and CLABSI rate of 0.91 infections per 1,000-line days. VISN CAUTI rates ranged from 0.18 to 1.46 infections per 1,000-catheter days and VISN CLABSI rates ranged from 0.14 to 1.75 infections per 1,000-line days. Published CAUTI rates range from 0.1-5.3 infections/1,000 discharges depending on the clinical setting.[8] Studies have identified CLABSI rates range from 0.8-1.4 infections/1,000-line days for patients in the ICU and are optimal if as low as 1.7 to 3.7 infections/1,000-line days for the entire hospital.[9]

In comparison to FY 2019, the number of recorded pressure ulcers decreased 4%, the number of recorded CAUTIs decreased 45%, and the number of recorded CLABSIs increased 2%. The calculated rates however increased due to a decrease in the denominator of VHA discharges, catheter days, and line days: the pressure ulcer rate per 1,000 discharges increased from 0.62 to 0.66; the CAUTI rate per 1,000 catheter days increased from 0.79 to 0.96, and the CLABSI rate per 1,000 line days increased from 0.73 to 0.91.

[7] AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014–2017. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacreport-2019.pdf.

[8] Hollenbeak CS, Schilling, AL. The Attributable Cost of Catheter-Associated Urinary Tract Infections in the United States: A systemic Review. *Am J Inf Control* 2018; 46:751-757.

[9] Nuckols TK, Keeler E, Morton SC, et al. Economic Evaluation of Quality Improvement interventions for Bloodstream Infections Related to Central Catheters: A Systemic Review. *JAMA Int Med* 2016; 176(12): 1843-1854.

Table 2.6: Pressure Ulcer Event Totals and Rates per 1,000 Discharges (Rolling 24 Months)

VISN	Number of Pressure Ulcers	Number of Discharges	Observed rate of ulcers per 1,000 discharges	Expected Rate of ulcers per 1,000 discharges	Observed/ Expected	Risk adjusted Rate per 1,000	Risk Adjusted Lower Confidence Limit	Risk Adjusted Upper Confidence Limit
V 1	4	17,484	0.23	0.55	0.42	0.27	0.00	0.68
V 2	13	25,906	0.50	0.58	0.86	0.56	0.23	0.89
V 4	8	17,683	0.45	0.56	0.81	0.53	0.12	0.93
V 5	11	18,230	0.60	0.53	1.14	0.74	0.33	1.15
V 6	29	24,470	1.19	0.63	1.90	1.23	0.91	1.56
V 7	19	25,181	0.76	0.61	1.23	0.8	0.48	1.12
V 8	37	53,467	0.69	0.56	1.24	0.8	0.57	1.03
V 9	22	25,428	0.87	0.66	1.30	0.85	0.54	1.16
V 10	20	35,028	0.57	0.63	0.91	0.59	0.32	0.86
V 12	17	28,585	0.60	0.55	1.08	0.70	0.38	1.02
V 15	18	20,626	0.87	0.59	1.47	0.96	0.59	1.32
V 16	25	30,905	0.81	0.74	1.09	0.71	0.44	0.97
V 17	12	24,506	0.49	0.65	0.75	0.49	0.17	0.8
V 19	9	19,278	0.47	0.63	0.74	0.48	0.12	0.85
V 20	16	15,827	1.01	0.67	1.51	0.98	0.59	1.37
V 21	13	25,195	0.52	0.62	0.84	0.54	0.22	0.87
V 22	25	43,871	0.57	0.60	0.95	0.62	0.37	0.86
V 23	12	21,007	0.57	0.68	0.84	0.55	0.21	0.89
National	310	472,677	0.66	0.61	1.07	0.70	0.62	0.77

Notes: Stage III or IV pressure ulcers or unstageable (secondary diagnosis) per 1,000 discharges among surgical or medical patients ages 18 years and older. Excludes stays less than 3 days; cases with a principal stage III or IV (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage III or IV pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders. Numerator-discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for pressure ulcers stage III or IV (or unstageable) (DECUBVD*). Denominator-surgical or medical discharges for patients aged 18 years and older. Data reflects eight quarters of data ending September 30, 2020.

Source: VA Inpatient Evaluation Center (IPEC)/Agency for Healthcare Research and Quality (AHRQ) Quality Indicators Report

Table 2.7: Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Bloodstream Infection (CLABSI) Rates

	CAUTI			CLABSI		
VISN	Catheter Days	CAUTI Infections	CAUTI Infection Rate	Line Days	CLABSI Infections	CLABSI Infection Rate
V 1	6,612	5	0.76	10,375	8	0.77
V 2	10,271	10	0.97	13,387	12	0.90
V 4	5,590	1	0.18	10,155	7	0.69
V 5	5,221	5	0.96	7,045	11	1.56
V 6	9,935	12	1.21	13,671	19	0.14
V 7	10,692	2	0.19	16,850	17	1.01
V 8	23,829	25	1.05	42,020	31	0.74
V 9	11,993	6	0.50	19,807	10	0.50
V 10	9,717	12	1.23	17,037	16	0.94
V 12	8,893	12	1.35	20,937	11	0.53
V 15	6,482	5	0.77	9,264	6	0.65
V 16	15,134	20	1.32	17,156	12	0.70
V 17	11,695	6	0.51	16,245	14	0.86
V 19	7,871	8	1.02	9,267	12	1.29
V 20	6,372	5	0.78	12,068	12	0.99
V 21	10,196	12	1.18	17,561	21	1.20
V 22	18,527	27	1.46	18,298	32	1.75
V 23	6,725	6	0.89	7,106	2	0.28
National	185,755	179	0.96	278,249	253	0.91

Notes: Rolling 12 months contains data from Q1 and Q4. CAUTI Infections=Number of urinary tract infections. CAUTI Infection Rate=Number of infections per 1,000 catheter days. Reported totals are based only on the data entered. The rate does not include missing/incomplete data. The cells will be blank for sites that have not entered data for the past 12 months. CLABSI Infections=Number of central line associated blood stream infections. CLABSI Infection Rate=Number of infections per 1,000-line days. Reported totals are based only on the data entered. The rate does not include missing/incomplete data. The cells will be blank for sites that have not entered data for the past 12 months

Source: VA Inpatient Evaluation Center (IPEC)

National and VISN operating room adverse events are listed in Table 2.8. In FY 2020, the 138 VHA Surgery Programs performed 299,518 procedures performed in one of 849 operating rooms (OR). Fourteen Wrong Site Surgery (WSS) and 16 procedures associated with a Retained Surgical Item (RSI) were reported through the Critical Incident and Tracking Notification (CITN) process. No wrong patient procedures were recorded. The VHA rate for WSS (0.47 per 10,000 procedures) was unchanged from FY 2019 and was within the published rate of 0-3.9 events per 10,000 procedures.[10] Note that the VHA rate includes wrong implant procedure counts not traditionally included in the reporting of WSS. The VHA rate for RSI events (0.53 per 10,000 procedures) was unchanged from FY 2019 and below median published rate of 1.32 events per 10,000 procedures.[11] In addition, the CITN process identified 6 OR Fires (0.20 events per 10,000 procedures) and 9 Burns in the OR (0.30 events per 10,000 procedures).[12]

Table 2.8: Operating Room Adverse Events

	Incorrect Surgery				Retained Surgical Items (RSI)				Fire Events	
VISN	Wrong Patient	Wrong Site/ Side	Wrong Procedure	Wrong Implant	RSI-Sharp	RSI-Soft Good/ Sponge	RSI-Instrument	RSI-Drain	OR Fire	Burns in the OR
V 1	0	0	0	1	0	0	0	0	1	1
V 2	0	0	0	0	1	0	0	0	1	0
V 4	0	0	0	2	0	0	0	0	0	0
V 5	0	1	0	2	0	0	0	1	1	0
V 6	0	0	0	0	0	0	0	2	0	1
V 7	0	1	0	0	0	0	0	0	0	0
V 8	0	0	0	1	1	0	1	1	0	1
V 9	0	1	0	0	0	0	0	0	0	1
V 10	0	2	0	1	0	0	0	0	1	2
V 12	0	0	0	0	0	1	0	0	0	0
V 15	0	0	0	0	0	0	0	0	1	1
V 16	0	0	0	0	0	0	1	0	0	0
V 17	0	0	0	1	0	1	0	1	1	0
V 19	0	0	0	1	0	0	0	0	1	0
V 20	0	0	0	0	0	0	0	0	0	0
V 21	0	0	0	0	1	0	0	0	0	1
V 22	0	0	0	0	0	2	1	0	0	1
V 23	0	0	0	0	0	0	1	0	0	1
National	0	5	0	9	3	4	4	5	6	9

Notes: Data are reported for period October 1, 2019 to September 30, 2020.
Source: CITN, SPOT, JPSR

[10] Neily J, Soncrant C, Mills PD, et al. Assessment of Incorrect Surgical Procedures Within and Outside the Operating Room: A Follow-up Study from US Veterans Health Administration Medical Centers. *JAMA Netw Open* 2018;1(7): e185147. doi:10.1001/jamanetworkopen.2018.5147.

[11] Hempel S, Maggard-Gibbons M, Nguyen DK, et al. Wrong-Site Surgery, Retained Surgical Items, and Surgical Fires: A Systemic Review of Surgical Never Events. *JAMA Surg* 2015;150(8): 796-805.

[12] See Critical Incident Tracking Notification information available on the VHA National Surgery Office intranet site, available at https://vaww.nso.med.va.gov/apps/VASQIP/Pages/CITNInfo.aspx.

Table 2.9 shows the national and VISN data for 30-Day Standardized Mortality Rate (SMR-30) for ICU and Acute Care. VISN ICU SMR-30 ranges from 0.88 to 1.12 and Acute Care SMR-30 ranges from 0.89 to 1.16. Table 2.10 shows the 30-Day unadjusted and risk-adjusted Readmission Rates (RR), identifying VISN unadjusted RR to range from 11.18% to 15.12% and the VISN risk-adjusted RR to range from 12.00% to 13.24%. Level 3 Protected Peer Reviews represents the evaluation of care events in which systems issues were identified that did not meet the standard of care. Table 2.11 identifies a national total of 1,571 Level 3 Peer Reviews representing a rate of 2.44 Level 3 Peer Reviews per 10,000 uniques. VISN Level 3 Peer Review totals ranged from 24-208 and rates ranged from 0.94-4.08 per 10,000 uniques. Compared to FY 2019, the total number of Level 3 Peer Reviews decreased by 17% associated with a Peer Review Level 3 rate per 10,000 uniques from 2.86 to 2.44.

Table 2.9: 30-Day Standardized Mortality Ratio (SMR-30) for ICU and Acute Care

	ICU SMR-30			Acute Care SMR-30		
VISN	N	ND	SMR-30	N	ND	SMR-30
V 1	1,942	207	0.96	11,370	601	1.07
V 2	3,725	492	1.04	16,932	1,086	1.05
V 4	2,023	262	1.10	12,018	575	1.05
V 5	2,354	220	1.05	12,414	573	1.06
V 6	4,060	367	**0.90**	16,271	804	**0.89**
V 7	3,919	461	**1.11**	17,958	940	**1.12**
V 8	7,077	853	**1.12**	33,063	1,780	**1.08**
V 9	3,510	469	**1.11**	17,983	1,079	**1.16**
V 10	4,433	479	1.05	23,852	1,176	1.02
V 12	3,030	316	**0.88**	18,489	819	**0.90**
V 15	3,063	287	1.00	15,149	754	**1.14**
V 16	4,829	591	0.95	20,077	1,147	**0.93**
V 17	3,174	288	0.94	16,959	687	0.94
V 19	2,596	289	0.99	13,766	682	0.97
V 20	2,096	193	0.99	10,492	435	**0.89**
V 21	2,852	318	1.01	17,750	870	0.99
V 22	5,160	626	1.01	30,294	1,484	1.00
V 23	2,069	216	1.06	13,981	700	1.06
National	61,912	6,934	1.04	319,092	16,187	1.08

Notes: *=Data unavailable; N=Total Number of admissions, ND=Number of observed deaths.
SMR-30 - Standardized Mortality Ratio (observed mortality/predicted mortality) at 30 days from hospital admission
X - Group did not have 20 or more cases and 5 or more predicted deaths
Bold - Statistically significant (95% Confidence Interval does not contain 1). Less than one is better.
Rolling 12 months – Current quarter + prior three quarters
Source: VA Inpatient Evaluation Center (IPEC)

Table 2.10: 30-Day Readmission Rates and Predicted Readmission Rates

VISN	Readmissions	Predicted Readmissions	Discharges	RR	RSRR
V 1	1,513	1,526.09	10,633	14.23%	12.95%
V 2	2,185	2,303.81	15,321	14.26%	12.38%
V 4	1,435	1,494.85	11,293	12.71%	12.53%
V 5	1,459	1,540.60	11,529	12.66%	12.37%
V 6	1,692	1,801.63	15,128	11.18%	12.26%
V 7	1,900	1,988.14	16,022	11.86%	12.48%
V 8	4,546	4,708.02	31,387	14.48%	12.61%
V 9	2,422	2,474.30	17,258	14.03%	12.78%
V 10	2,774	2,807.02	21,917	12.66%	12.90%
V 12	2,698	2,661.79	17,840	15.12%	13.24%
V 15	1,863	1,861.93	13,827	13.47%	13.07%
V 16	2,418	2,491.78	18,763	12.89%	12.67%
V 17	1,956	2,028.43	15,342	12.75%	12.59%
V 19	1,440	1,566.63	12,536	11.49%	12.00%
V 20	1,171	1,191.97	9,663	12.12%	12.83%
V 21	1,943	1,956.53	16,196	12.00%	12.97%
V 22	3,660	3,845.66	27,977	13.08%	12.43%
V 23	1,519	1,555.46	12,935	11.74%	12.75%
National	38,594	39,804.66	295,567	13.06%	12.66%

Notes: Readmissions=number of unplanned all cause 30 day readmissions; predicted readmissions=number of unplanned all-cause 30 day readmission based on individual patients' predicted readmission probability; discharges=number of index hospitalizations; RR=unadjusted readmission rate (Readmissions/Discharges)*100%; RSRR=risk standardized hospital wide readmission rate= SRR * $\bar{Y}$, where $\bar{Y}$ is the overall national raw readmission rate for all index admissions in all cohorts.
Source: Hospital-Wide All Cause Unplanned Readmission Cube

Table 2.11: Protected Peer Review Totals and Rates Per 10,000 Uniques

VISN	Uniques	Final Level 1	Final Level 2	Final Level 3	Final Level 1 per 10,000 Uniques	Final Level 2 per 10,000 Uniques	Final Level 3 per 10,000 Uniques
V 1	256,676	143	31	24	5.57	1.21	0.94
V 2	293,613	375	128	59	12.77	4.36	2.01
V 4	300,251	342	119	69	11.39	3.96	2.30
V 5	230,636	371	80	84	16.09	3.47	3.64
V 6	422,526	284	84	55	6.72	1.99	1.30
V 7	477,565	349	108	96	7.31	2.26	2.01
V 8	626,067	799	193	95	12.76	3.08	1.52
V 9	292,754	272	69	62	9.29	2.36	2.12
V 10	510,097	584	127	208	11.45	2.49	4.08
V 12	338,981	374	121	87	11.03	3.57	2.57
V 15	260,461	361	67	56	13.86	2.57	2.15
V 16	449,710	357	97	70	7.94	2.16	1.56
V 17	447,169	303	90	122	6.78	2.01	2.73
V 19	339,066	413	82	78	12.18	2.42	2.30
V 20	339,079	271	87	98	7.99	2.57	2.89
V 21	377,874	329	99	78	8.71	2.62	2.06
V 22	528,060	306	80	122	5.79	1.51	2.31
V 23	334,047	268	113	108	8.02	3.38	3.23
National	6,427,081	6,501	1,775	1,571	10.12	2.76	2.44

Notes: Data reported quarterly, pulled 12/31/2020. This combined report provides a rolling summary of Derived Metrics for each facility.

Source: VHA Support Service Center (VSSC)

Chapter 3: Mental Health

In FY 2020, across all campuses, VHA experienced 303 on-campus suicide attempts and 19 on-campus suicide deaths, including three suicide deaths on an inpatient non-mental health unit, and 16 suicide deaths on the campus grounds and clinics (Table 3.1). NCPS also identified 23 suicide deaths of patients within 3 days of an inpatient hospital discharge and 27 suicide deaths within 7 days of an inpatient mental health discharge. VHA recorded 61,452 Mental Health Unit admissions at 114 VA medical facilities with at least one Mental Health Unit. No suicide deaths occurred on a VHA mental health unit. As of Q2-FY 2020, the VHA requires the instillation of over-the-door alarms on all Mental Health Units to mitigate the risk of suicide by hanging.[13]

In comparison to FY 2019, the total number of on-campus suicide deaths, including suicide deaths in the hospital, outpatient clinics, parking lots, and grounds decreased from 26 to 19. The number of deaths within 3 days of a hospital discharge increased from 16 to 23 and 7 days from a Mental Health Unit discharge decreased from 30 to 27. For the past 5 years, VHA's suicide death rate on Mental Health Units was 0.83/100,000 admissions and below published rates.[14]

[13] Mills, PD, Soncrant, C, Bender, J, Gunnar, W. Impact of Over-the-Door Alarms: Root Cause Analysis Review of Suicide Attempts and Deaths on Veteran Health Administration Mental Health Units. *Gen Hosp Psych* 2020; 64:41-45.
[14] Williams SC, Schmaltz SP, Castro GM, Baker DW. Incidence and Method of Suicide in Hospitals in the United States. Joint Comm J Qual Pat Saf. 2018;44(11): 643-650.

Table 3.1: Suicide Death and Attempt Events

VISN	On Campus-Total: All Suicide Deaths (inpatient and outpatient on grounds)	On Campus Suicide Deaths-non-inpatient (clinics, on grounds)	On Campus Inpatient Mental Health Suicide Deaths	On Campus Suicide Deaths-non-mental health inpatient (includes CLC, domiciliary, ED, Acute Care, ICU)	Suicide Death within 3 days of hospital discharge (all non MH units)	Suicide Death within 7 days of MH unit discharge	On Campus Grounds-Total: All Suicide Attempts (inpatient and outpatient on grounds)
V 1	1	0	0	1	2	1	20
V 2	1	1	0	0	2	2	20
V 4	1	1	0	0	1	4	12
V 5	0	0	0	0	1	0	8
V 6	0	0	0	0	1	0	14
V 7	1	1	0	0	0	1	14
V 8	3	3	0	0	3	3	29
V 9	1	1	0	0	0	2	11
V 10	2	1	0	1	3	2	23
V 12	3	3	0	0	0	1	19
V 15	1	0	0	1	2	22	11
V 16	0	0	0	0	1	1	26
V 17	1	1	0	0	1	0	13
V 19	0	0	0	0	1	1	21
V 20	0	0	0	0	1	1	12
V 21	1	1	0	0	3	2	8
V 22	2	2	0	0	0	1	36
V 23	1	1	0	0	1	3	3
National	19	16	0	3	23	27	303

Notes: Data pulled 2/5/2021. Data are reported for period October 1, 2019 to September 30, 2020.
Sources: Joint Patient Safety Reporting (JPSR) system, Issue Brief, SPOT

Chapter 4: Dental Adverse Events

In FY 2020, NCPS added dental adverse events in collaboration with the VHA Office of Dentistry (11DEN). The data source is the Dental Record Manager Plus with data fields in the Corporate Data Warehouse (CDW), JPSR and SPOT. A total of 20 Aspirations or Ingestion of a Foreign Body during a dental procedure were identified, with VISNs ranging from 0 to 3 events, and 16 wrong site procedures performed with VISNs ranging from 0-2 events (Table 4.1). For reference, in FY 2020 the VHA performed 2,921,797 dental procedures for 462,823 Veterans resulting in a dental adverse reporting rate of 0.12/10,000 procedures. Published literature for accidental aspiration or ingestion of foreign bodies in dentistry acknowledges the serious potential for harm and the variable risk associated with the procedure type and the patient age[15,16]. A seven-year retrospective study available on-line identifies an incident rate for accidental foreign body aspiration and ingestion in dental practice to be 0.15 events/10,000 procedures[17]. The published rate for wrong tooth extraction is 4.72 per 10,000 procedures[18], however recent data suggests the rate is much higher[19].

Table 4.1: Dental Adverse Events by Rolling Year

Station Number/ Name	Aspiration or Ingestion of Foreign Body	Wrong Site	Wrong Patient	Wrong Treatment	Wrong Diagnosis
V 1	1	1	0	0	0
V 2	2	2	0	0	0
V 4	2	1	0	0	0
V 5	1	2	0	0	0
V 6	0	0	0	0	0
V 7	1	1	0	0	0
V 8	0	1	0	0	0
V 9	0	2	0	0	0
V 10	0	1	0	0	0
V 12	1	0	0	0	0
V 15	3	0	0	0	0
V 16	0	0	0	0	0
V 17	1	0	0	0	0
V 19	1	1	0	0	0
V 20	3	1	0	0	0
V 21	0	1	0	0	0
V 22	1	2	0	0	0
V 23	3	0	0	0	0
National	20	16	0	0	0

Notes: Data pulled 11/19/2020. Data are reported for period October 1, 2019 to September 30, 2020.
Sources: CDW, JPSR, SPOT

[15] Hou R, Zhou H, Ju K, et al. Thorough documentation of the accidental aspiration and ingestion of foreign objects during dental procedure is necessary: review and analysis of 617 cases. Head & face Med. 2016; 12:23.
[16] Yadav RK, Yadav HK, Chandra A, et al. Accidental aspiration/ingestion of foreign bodies in dentistry: A clinical and legal perspective. Natl J Maxillofac Surg. 2015 Jul-Dec;6(2): 144-151.
[17] : Huh J, Kim K, Jung S, et al. Risk factors for Accidental Foreign Body Aspiration and ingestion in Dental Practice: A seven-year retrospective study. Available at https://doi.org/10.21203/rs.3.rs-21596/v1.
[18] Jan AM, Albenayan R, Alsharkawi D, Jadu FM. The prevalence and causes of wrong tooth extraction. Niger J Clin Pract. 2019 Dec;22(12): 1706-1714.
[19] Lee JS, Curley AW, Smith RA. Prevention of wrong-site tooth extraction: clinical guidelines. J Oral Maxillofac Surg. Sep 2007;65(9):1973-1799

Chapter 5: Health Information Technology (HIT)

JPSR events implicating Health Information Technology (HIT) are identified in Table 5.1. In FY 2020, 13,195 total HIT events were reported of which 6,604 (50%) were adverse events and 6,563 (50%) were close calls (28 unassigned). Fifteen severe harm (SAC 3) events, VISNs ranging from 0-3 and 574 potential severe harm (potential SAC 3) events were identified, VISNs ranging from 1-187. The national alert box identifies an issue that should be considered for national attention and was marked 164 times; with VISNs ranging from 0 to 42 events in JPSR with national attention. NCPS refers HIT national box and emerging trends to the VHA Office of Health Informatics (105) for collaborative investigation. The JPSR HIT reports by event type are identified in Table 5.2. Eighty-two percent of HIT reports were attributable to medication events (41%), clinical administration including delays in care (27%) and product/device (14%).

Table 5.1: JPSR Health Information Technology (HIT) Event Totals

VISN	Total Events	Adverse Events	Close Calls	Actual SAC 3	Potential SAC 3	National Alert
V 1	434	235	199	0	13	7
V 2	401	233	168	1	55	0
V 4	378	187	191	1	3	2
V 5	228	118	108	2	8	1
V 6	1,062	348	714	0	6	5
V 7	692	316	375	0	26	10
V 8	647	355	287	1	7	9
V 9	446	240	205	0	2	42
V 10	1,279	655	624	2	134	23
V 12	1,069	503	566	1	187	15
V 15	863	417	446	0	21	5
V 16	441	233	206	1	12	0
V 17	508	252	255	1	7	2
V 19	1,045	649	393	0	10	12
V 20	796	416	380	3	26	8
V 21	1,025	525	487	0	1	6
V 22	812	428	384	1	33	6
V 23	1,069	494	575	1	23	11
National	13,195	6,604	6,563	15	574	164

Notes: Data pulled 11/12/2020 includes finalized events. Includes data for the period of October 1, 2019 through September 30, 2020.
October and November data were pulled using: Event Type: Product or Device (including Health IT)
Event Sub-types: Device defect all electronic clinical documentation-INPATIENT; Device defect all electronic clinical documentation-OUTPATIENT
All data since December was pulled using Health IT drop down.
Source: Joint Patient Safety Reporting (JPSR) System

Table 5.2: JPSR Health Information Technology (HIT) Events by Event Details

VISN	Medication	Clinical Admin	Product/ Device	Laboratory	Radiology	All Other
V 1	195	109	31	63	5	31
V 2	255	53	8	16	7	62
V 4	114	154	45	26	10	29
V 5	116	57	19	13	4	19
V 6	228	179	524	29	36	66
V 7	315	202	59	36	32	48
V 8	350	146	37	29	24	61
V 9	160	135	65	27	10	49
V 10	654	342	59	103	39	82
V 12	615	191	85	33	13	132
V 15	316	326	89	47	26	59
V 16	163	158	36	20	18	46
V 17	292	109	20	34	8	45
V 19	315	428	75	73	44	110
V 20	341	327	27	18	26	57
V 21	299	110	343	106	36	131
V 22	334	190	34	113	33	108
V 23	374	347	234	39	20	55
National	5,436	3,563	1,790	825	391	1,190

Notes: Data pulled 11/12/2020 includes finalized events. Includes data for the period of October 1, 2019 through September 30, 2020.

October and November data were pulled using: Event Type: Product or Device (including Health IT)

Event Sub-types: Device defect all electronic clinical documentation-INPATIENT; Device defect all electronic clinical documentation-OUTPATIENT

All data since December was pulled using Health IT drop down.

Source: Joint Patient Safety Reporting (JPSR) System

Chapter 6: Medication Safety

In FY 2020, JPSR identified 3,867 medication safety reports of which 2,049 (53%) were adverse events and 1,817 (47%) were close calls (1 unassigned; Table 6.1). Zero actual severe harm (SAC 3) events were reported and 367 (9.5%) were identified as potential severe harm (Potential SAC 3) events. JPSR events can be characterized in multiple categories, with most medication safety events characterized as either incorrect medication (2,171; 56%) or incorrect patient (1,387; 36%). Incorrect route was identified in 309 (8%) of the event reports. In comparison to FY 2019, the JPSR medication event totals decreased from 5,120 to 3,867 (24%) associated a decrease in actual and potential SAC-3 events.

The national average rates of Barcoded Medication Administration (BCMA) scan rates for wrist bands and medications are 96% and 99%, respectively (Table 6.2). In FY 2020, all but three VISNs had an average wrist band BCMA scan rate of ≥ 95% and all but three VISNs had an average BCMA medication scan rate of ≥ 98%.

Table 6.1: JPSR Medication Event Totals

VISN	Total Events	Adverse Events	Close Calls	Actual SAC 3	Potential SAC 3	Incorrect Medication	Incorrect Patient	Incorrect Route
V 1	128	63	65	0	6	69	55	4
V 2	133	61	72	0	19	69	52	12
V 4	105	47	58	0	2	57	36	12
V 5	128	61	67	0	5	69	50	9
V 6	198	104	94	0	3	113	69	16
V 7	255	125	130	0	11	135	85	35
V 8	299	192	106	0	13	183	97	19
V 9	128	72	56	0	1	68	52	8
V 10	325	167	158	0	55	185	110	30
V 12	354	151	203	0	121	192	141	21
V 15	181	93	88	0	2	105	66	10
V 16	167	92	75	0	31	91	50	26
V 17	181	106	75	0	3	89	74	18
V 19	196	127	69	0	9	106	75	15
V 20	200	126	74	0	10	110	82	8
V 21	312	168	144	0	0	192	105	15
V 22	279	127	152	0	42	163	89	27
V 23	298	167	131	0	34	175	99	24
National	3,867	2,049	1,817	0	367	2,171	1,387	309

Notes: Data pulled 11/12/2020 and includes finalized events. Includes data for the period of October 1, 2019 to September 30, 2020.
Event Type: Care Management Events
Event Sub-types: Medication/biological/nutritional error; Contrast media or radiopharmaceutical error
Event Details: Incorrect medication/substance; Incorrect patient; Incorrect route of administration
Source: Joint Patient Safety Reporting (JPSR) System

Table 6.2: Barcoded Medication Administration (BCMA) Scan Rates for Wrist Bands and Medications

VISN	Wrist Bands	Medications
V 1 Average	97%	99%
V 2 Average	93%	98%
V 4 Average	95%	97%
V 5 Average	98%	99%
V 6 Average	97%	99%
V 7 Average	97%	99%
V 8 Average	97%	99%
V 9 Average	97%	100%
V 10 Average	96%	99%
V 12 Average	98%	100%
V 15 Average	97%	99%
V 16 Average	89%	96%
V 17 Average	98%	99%
V 19 Average	97%	99%
V 20 Average	92%	94%
V 21 Average	97%	99%
V 22 Average	96%	99%
V 23 Average	97%	99%
National Average	96%	99%

Notes: Data pulled 12/10/2020 for Fiscal Year 2020.
Source: VHA Support Service Center (VSSC), Managing Scanning Failures-Facility Comparison

VHA tracks the number of patients receiving anticoagulation therapy with warfarin (Coumadin) and their test values for International Normalized Ratio (INR). Studies have shown time in therapeutic range (TTR) to be strongly predictive of both bleeding and thromboembolic events and INR > 6 to be associated with bleeding episodes and related complications. Patients with measured TTR > 70% are considered to be optimally managed.[20] In FY 2020, 43,548 Veterans were receiving warfarin and INR testing of which 7,288 (16.74%) were identified to have triggered an INR > 6. VISNs ranged from 8.76% to 24.24% of their warfarin patients triggering an INR > 6. The national mean percent time in therapeutic range (TTR) is 68.80%, with VISNs ranging from 66.10% to 74.00% (Table 6.3). In comparison to FY 2019, the national mean TTR decreased from 69.3% to 68.8% and the INR >6 increased from 13.94% to 16.74% which identifies an opportunity for improvement in anticoagulation therapy.

Table 6.3: Patients with International Normalized Ratio (INR) > 6 and Mean Percent Time in Therapeutic Range (TTR)

VISN	Number of Unique Warfarin Patients	INR >6 Rolling 12 Months Total	Percent of INR >6 of Unique Warfarin Patients	Mean Percent Time in TTR
V 1	1,441	254	17.63%	72.70%
V 2	2,457	545	22.18%	65.60%
V 4	1,719	252	14.66%	69.20%
V 5	1,373	232	16.90%	68.10%
V 6	1,929	233	12.08%	70.10%
V 7	2,196	409	18.62%	68.60%
V 8	3,602	873	24.24%	72.40%
V 9	2,190	247	11.28%	70.40%
V 10	4,363	753	17.26%	65.50%
V 12	3,110	386	12.41%	71.50%
V 15	1,703	371	21.79%	68.00%
V 16	2,684	473	17.62%	68.80%
V 17	2,202	399	18.12%	65.10%
V 19	1,712	286	16.71%	66.90%
V 20	2,088	183	8.76%	74.00%
V 21	2,340	341	14.57%	68.80%
V 22	3,349	604	18.04%	67.50%
V 23	3,090	447	14.47%	68.70%
National	43,548	7,288	16.74%	68.80%

Notes: INR=International Normalized Ratio. Number of Warfarin unique patients is derived from Clinical Pharmacy Program Office (CPPO) Business Intelligence (BI) Site TTR Report. Data current as of 12/22/2020 for TTR. Mean TTR by facility for patients with active warfarin prescription, atrial fibrillation or VTE and at least 3 INRs in the last 160 days. VHA Pharmacy Benefits Management, Clinical Pharmacy Program Office (CPPO) Business Intelligence (BI) Site TTR Report
Sources: VA MedSafe, VHA Pharmacy Benefits Management

[20] Razouki Z, Ozonoff A, Zhao S, Jasuja GK, Rose AJ. Improving Quality Measurement for Anticoagulation: Adding International Normalized Ratio Variability to Percent Time in Therapeutic Range. *Circ Cardiovasc Qual Outcomes* 2014 Sep;7(5):664-9.

In the US, opioid medication prescribing increased dramatically in the past two decades and correspondingly there was a rise in opioid related overdoses and related deaths.[21] Furthermore, 27% of fatal opioid related overdoses are reported to include benzodiazepines.[22] Table 6.4 identifies VHA patients dispensed opioid medications with a breakdown new to FY 2020 showing community care only and VA only. In Q4-FY 2020, VHA dispensed opioid medication to 345,910 Veterans representing 8.26% of the total medications dispensed to Veterans as an outpatient, with VISNs ranging from 5.52% to 10.78%. Community care only dispensed opioid medication to 18,166 Veterans representing 7.01% of the total medications dispensed, with VISNs ranging from 3.79% to 10.48%. VA only dispensed opioid medication to 332,079 Veterans representing 8.02% of the total medications dispensed to Veterans as an outpatient, with VISNs ranging from 5.36% to 10.61%. In comparison to Q4-FY 2019, the percent Veterans dispensed opioid medications decreased from 9.70% to 8.26%.

Table 6.4: Patients Dispensed - Opioid Medication

VISN	All			Community Care Only			VA Only		
	Unique Veterans	Unique Outpatient Pharmacy Patients	Percent of Patients Dispensed Opioid Medication	Unique Veterans	Unique Outpatient Pharmacy Patients	Percent of Patients Dispensed Opioid Medication	Unique Veterans	Unique Outpatient Pharmacy Patients	Percent of Patients Dispensed Opioid Medication
V1	10,489	157,578	6.66%	261	5,669	4.60%	10,297	156,353	6.59%
V2	10,529	174,715	6.03%	239	6,299	3.79%	10,364	173,675	5.97%
V4	13,939	183,213	7.61%	633	6,042	10.48%	13,616	182,625	7.46%
V5	8,699	131,871	6.60%	305	4,588	6.65%	8,461	131,611	6.43%
V6	24,487	273,359	8.96%	673	11,020	6.11%	23,990	271,558	8.83%
V7	24,363	313,848	7.76%	1,315	17,814	7.38%	23,416	311,507	7.52%
V8	21,309	386,210	5.52%	842	12,389	6.80%	20,598	384,484	5.36%
V9	18,616	191,814	9.71%	1,506	23,951	6.29%	17,472	186,293	9.38%
V10	27,735	336,781	8.24%	1,263	16,382	7.71%	26,802	334,847	8.00%
V12	15,857	184,424	8.60%	359	7,272	4.94%	15,584	183,220	8.51%
V15	16,327	167,202	9.76%	1,435	17,496	8.20%	15,328	164,529	9.32%
V16	22,693	296,868	7.64%	1,739	22,544	7.71%	21,296	291,919	7.30%
V17	24,386	286,242	8.52%	2,085	28,934	7.21%	22,567	278,856	8.09%
V19	22,137	206,327	10.73%	1,639	18,725	8.75%	20,941	201,446	10.40%
V20	20,786	200,428	10.37%	1,839	25,435	7.23%	19,311	191,906	10.06%
V21	22,941	212,658	10.78%	705	9,980	7.06%	22,385	210,929	10.61%
V22	24,903	308,702	8.07%	1,104	20,315	5.43%	24,065	304,760	7.90%
V23	16,504	217,985	7.57%	231	4,625	4.99%	16,235	217,534	7.50%
National	345,910	4,198,412	8.26%	18,166	259,280	7.01%	332,079	4,138,740	8.02%

Notes: Data pulled 2/10/2021. Data reflects FY2020 Q4. For Opioid Medication Dispensed-Unique Veterans=VA Patients receiving opioid medication or VA, Unique Outpatient Pharmacy Patients=VA Patient Population Count, %=Percentage of patients dispensed opioids. Numerator: Patients Dispensed Opioids. Denominator=All Outpatient Pharmacy Patients. Opioids = every drug in the VA drug class CN101 Opioid Analgesics AND tramadol which is currently in VA drug class CN101 Opioid Analgesics.
Source: VHA Pharmacy Benefits Management Opioid Safety Initiative

[21] Park TW, Saitz D, Ilgen MA, Bohnert AS. Benzodiazepine Prescribing Patterns and Deaths from Drug Overdose Among US Veterans Receiving Opioid Analgesics: Case-Cohort Study. BMJ 2015;350:h2698.
[22] Sun EC, Dixit A, Humphreys K, Darnell BD, Baker LC, Mackey S. Association Between Concurrent Use of Prescription Opioids and Benzodiazepines and Overdose: Retrospective Analysis. *BMJ* 2017;356: j760.

Table 6.5 identifies the number of Veterans receiving opioid and benzodiazepine medications and the percent of dispensed medications represented by both opioid and benzodiazepine medications for FY 2020 Q4. VHA dispensed opioid and benzodiazepine medication to 21,828 Veterans representing 0.52% of the total medications dispensed to Veterans as an outpatient, with VISNs ranging from 0.28% to 0.83%. Community care only dispensed opioid and benzodiazepine medication to 1,403 Veterans representing 0.54% of the total medications dispensed, with VISNs ranging from 0.17% to 0.86%. VA only dispensed opioid and benzodiazepine medication to 20,771 Veterans representing 0.50% of the total medications dispensed to Veterans as an outpatient, with VISNs ranging from 0.25% to 0.82%. In comparison to Q4-FY 2019, the percent Veterans dispensed opioid and benzodiazepine medications decreased from 0.67% to 0.52%

Table 6.5: Patients Dispensed - Opioid and Benzodiazepine Medication

VISN	All			Community Care Only			VA Only		
	Unique Veterans	Unique Outpatient Pharmacy Patients	Percent of Patients Dispensed Opioid and Benzo-diazepine Medication	Unique Veterans	Unique Outpatient Pharmacy Patients	Percent of Patients Dispensed Opioid and Benzo-diazepine Medication	Unique Veterans	Unique Outpatient Pharmacy Patients	Percent of Patients Dispensed Opioid and Benzo-diazepine Medication
V1	1,303	157,578	0.83%	30	5,669	0.53%	1,285	156,353	0.82%
V2	960	174,715	0.55%	31	6,299	0.49%	942	173,675	0.54%
V4	985	183,213	0.54%	52	6,042	0.86%	950	182,625	0.52%
V5	523	131,871	0.40%	25	4,588	0.54%	505	131,611	0.38%
V6	1,745	273,359	0.64%	65	11,020	0.59%	1,704	271,558	0.63%
V7	1,174	313,848	0.37%	100	17,814	0.56%	1,100	311,607	0.35%
V8	1,484	386,210	0.38%	71	12,389	0.57%	1,427	384,484	0.37%
V9	530	191,814	0.28%	70	23,951	0.29%	470	186,293	0.25%
V10	1,662	336,781	0.49%	98	16,382	0.60%	1,597	334,847	0.48%
V12	1,181	184,424	0.64%	35	7,272	0.48%	1,158	183,220	0.63%
V15	1,192	167,202	0.71%	127	17,496	0.73%	1,100	164,529	0.67%
V16	1,270	296,868	0.43%	144	22,544	0.64%	1,150	291,919	0.39%
V17	1,350	286,242	0.47%	193	28,934	0.67%	1,178	278,856	0.42%
V19	1,301	206,327	0.63%	122	18,725	0.65%	1,220	201,446	0.61%
V20	1,229	200,428	0.61%	117	25,435	0.46%	1,138	191,906	0.59%
V21	1,352	212,658	0.64%	60	9,980	0.60%	1,305	210,929	0.62%
V22	1,534	308,702	0.50%	55	20,315	0.27%	1,492	304,760	0.49%
V23	1,127	217,985	0.52%	8	4,625	0.17%	1,121	217,534	0.52%
National	21,828	4,198,412	0.52%	1,403	259,280	0.54%	20,771	4,138,740	0.50%

Notes: Data pulled 2/10/2021. Data reflects FY 2020 Q4. For Opioid Medication Dispensed-Unique Veterans=VA Patients receiving opioid and benzodiazepine medication or VA, Unique Outpatient Pharmacy Patients=VA Patient Population Count, %=Percentage of patients dispensed opioid and benzodiazepine. Numerator: Patients Dispensed Opioid and Benzodiazepine. Denominator=Opioid Patients. Opioids = every drug in the VA drug class CN101 Opioid Analgesics AND tramadol which is currently in VA drug class CN101 Opioid Analgesics. Sedatives=every drug in the VA drug class CN302 Benzodiazepine Derivative Sedatives/Hypnotics.
Source: VHA Pharmacy Benefits Management Opioid Safety Initiative

Chapter 7: Community Care

Community care represents the authorization of health care and services of an VHA enrolled Veteran to a community (non-VA employee) provider. NCPS and the Office of Community Care (13) actively collaborate to promote the reporting and investigation of patient safety events related to the VHA authorized care and services by community providers. VHA staff are directed to enter safety events associated with the delivery of community care into JPSR when identified. In FY 2020, JPSR and the SPOT database recorded a total of 7,616 separate patient safety events related to community care, of which 5,511 (72%) were adverse events and 2,070 (27%) were close calls (35 unassigned; Table 7.1). VISN total community care events ranged between 221 and 837. Sixty severe harm (SAC 3) events and 442 potential severe harm (Potential SAC 3) events were identified nationally.

Delay in care, falls, and medication events were the most frequently identified reasons for JPSR entry, representing respectively 23%, 22%, and 15% of the total number of community care events (Table 7.2). The All Other category identified numerous different reasons that collectively represent 37% of the total. In comparison to FY 2019, the number of Community Care patient safety events in JPSR increased from 1,707 to 7,616.

Table 7.1: Community Care Total Events, Adverse Events, Close Calls, SAC 3 and Potential SAC 3 Events

VISN	Total Events	Adverse Events	Close Calls	SAC 3	Potential SAC 3
V 1	378	298	77	7	75
V 2	484	391	93	3	110
V 4	290	208	80	8	13
V 5	246	186	59	3	19
V 6	321	223	97	0	4
V 7	380	269	110	2	5
V 8	408	332	72	5	7
V 9	260	198	61	0	4
V 10	622	506	116	6	69
V 12	221	133	86	2	8
V 15	641	399	242	0	25
V 16	286	214	66	0	6
V 17	427	290	135	0	13
V 19	553	441	111	3	12
V 20	514	332	176	8	28
V 21	224	138	85	0	2
V 22	837	579	255	6	36
V 23	524	374	149	7	6
National	7,616	5,511	2,070	60	442

Notes: Data pulled 11/12/2020 for period October 1, 2019 through September 30, 2020. Includes events found in both JPSR and SPOT. For October and November data, Event Descriptions were searched for various terms related to Community Care. Beginning December 2019, the Community Care check box data was used. Additional information is available in the Interpretation Document.
Source: Joint Patient Safety Reporting (JPSR) System and SPOT

Table 7.2: Community Care Events by Event Type

VISN	Delay Events	Fall	Medication Events	Patient Follow-up Discharge	Communication of Abnormal Results	All Other
V 1	28	151	53	4	7	138
V 2	53	240	32	3	0	157
V 4	39	96	31	5	1	120
V 5	55	89	30	1	2	70
V 6	88	42	36	4	1	150
V 7	79	92	44	15	2	150
V 8	34	181	59	3	0	131
V 9	42	95	10	7	0	106
V 10	88	193	93	12	6	233
V 12	56	20	61	3	1	81
V 15	286	42	83	6	4	225
V 16	62	63	23	4	1	134
V 17	94	75	96	8	16	150
V 19	112	77	92	4	3	266
V 20	243	23	93	5	3	150
V 21	48	16	84	4	7	72
V 22	102	181	167	3	8	377
V 23	249	10	80	47	1	138
National	1,758	1,686	1,167	138	63	2,848

Notes: Data pulled 11/12/2020 for period October 1, 2019 through September 30, 2020. Includes events found in both JPSR and SPOT. For October and November data, Event Descriptions were searched for various terms related to Community Care. Beginning December 2019, the Community Care check box data was used. Additional information is available in the Interpretation Document.
Source: Joint Patient Safety Reporting (JPSR) System and SPOT

Chapter 8: Patient Safety Culture

Patient safety culture has been defined as follows: "The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures."[23] A culture of safety is foundational to a High Reliability Organization.[24]

Beginning in 2000, NCPS administered a Patient Safety Culture Survey (PSCS) every 2-3 years. The intent of the NCPS-PSCS was to provide a snapshot regarding the overall psychological safety, just culture, communication and teamwork, learning and continuous process improvement, leadership engagement, patient safety event reporting, and staff job satisfaction at the VA medical center level. The NCPS-PSCS was administered in 2018 with the longstanding standardized 64 questions in 14 dimensions and a free text question (so-named Q65) requesting a "perception of overall patient safety grade." The NCPS-PSCS typically received 41,000-43,000 responses.

In FY 2019, NCPS collaborated with the VHA National Center for Organization Development (106C) to embed a 15 question Patient Safety Culture Module in the All Employee Survey (AES). These questions in addition to 5 standard AES questions comprise the AES-PSCS with 20 questions in 14 dimensions identical to and in alignment with past administered NCPS-PSCS. The AES-PSCS was first administered in June 2019 and will be incorporated into the AES going forward. The FY 2020 AES-PSCS was delayed due to the COVID-19 pandemic and distributed in September 2020 to all VISN and VA medical center staff.

The FY 2020 AES-PSCS received 227,101 respondents that provided a response to at least one question, with between 167,670 and 224,135 respondents completing all questions in any single dimension (Table 8.1). Tables 8.2-8.15 summarize the results of the FY 2020 AES-PSCS by 14 dimensions and shows the following: dimension results with a mean score >4.0 were Overall Perceptions of Patient Safety (#1), Education, Training, and Resources (#3), Job Satisfaction (#10), and Perceptions of Patient Safety at your Facility (#12); dimension results with a mean score between 3.75-4.0 were Non-Punitive Response to Error (#2), Communication and Openness (#5), and Teamwork within Hospital Units (#6); dimension results with a mean score between 3.5-3.75 were Teamwork across Hospital Units (#7), Organizational Learning and Continuous Improvement (#8), Feedback and Communication about Error (#9), Patient Safety in Comparison to Other Facilities (#11), Senior Management Awareness and Actions in Promoting Safety (#13), and Frequency of Event Reporting (#14); and dimension results with a mean score of <3.5 was Shame (#4). Accordingly, lower scores were associated with a greater number of disagree/strongly disagree responses.

[23] AHRQ Hospital Survey on Patient Safety Culture: User's Guide. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

[24] Veazie S, Peterson K, Bourne D. Evidence Brief: Implementation of High Reliability Organization Principles. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2019. Available at https://www.hsrd.research.va.gov/publications/esp/high-reliability-org.pdf.

The following observations follow comparison of Patient Safety Culture Survey data for FY 2019 and FY 2020:

- The number of respondents to at least one AES-PSCS question increased from 205,051 to 227,101 (11%) associated with a corresponding increase in the number of respondents to any single AES-PSCS question;
- The distribution of AES-PSCS national mean scores by dimension were unchanged, for example the dimensions with a mean score >4.0 remained Overall Perceptions of Patient Safety (#1), Education, Training, and Resources (#3), Job Satisfaction (#10), and Perceptions of Patient Safety at your Facility (#12);
- The national mean AES-PSCS score increased in the following domains related to communication, teamwork, continuous improvement, and job satisfaction: Communication and Openness (#5), Teamwork within Hospital Units (#6), Teamwork across Hospital Units (#7), Organizational Learning and Continuous Improvement (#8), Feedback and Communication About Error (#9), Job Satisfaction (#10), and Frequency of Event Reporting (#14);
- The national mean AES-PSCS score decreased in the following domains related to perceptions of patient safety, just culture, and education: Overall Perception of Patient Safety (#1), Non-Punitive Response to Error (#2), Education, Training, and Resources (#3), Shame (#4); Patient Safety in Comparison to Other Facilities (#11), and Perceptions of Patient Safety at your Facility (#12); and
- The national mean AES-PSCS score was unchanged in Senior Management Awareness and Actions in Promoting Safety (#13).

Table 8.1: Dimensions of Patient Safety Culture

Dimension	FY 2019 National			FY 2020 National		
	N	Mean	SD	N	Mean	SD
1-Overall Perceptions of Patient Safety	183,464	4.23	0.85	215,759	4.22	0.83
2-Non-Punitive Response to Error	181,339	3.97	0.95	213,235	3.96	0.93
3-Education, Training, Resources	187,741	4.16	0.86	221,139	4.12	0.85
4-Shame	174,518	3.44	0.81	204,590	3.42	0.78
5-Communication, Openness	181,276	3.93	0.91	214,071	3.95	0.88
6-Teamwork within Hospital Units	186,686	3.82	1.05	220,920	3.90	0.99
7-Teamwork Across Hospital Units	180,728	3.51	1.10	212,506	3.59	1.04
8-Organizational Learning-Continuous Improvement	178,713	3.65	1.01	214,182	3.68	0.94
9-Feedback and Communication about Error	177,642	3.73	0.97	211,236	3.74	0.92
10-Job Satisfaction	188,452	4.13	0.97	224,135	4.14	0.93
11-Patient Safety in Comparison to Other Facilities	172,189	3.64	1.05	209,957	3.63	1.00
12-Perceptions of Patient Safety at your Facility	185,761	4.22	0.89	221,286	4.21	0.85
13-Senior Management Awareness/Actions in Promoting Safety	181,636	3.73	1.13	217,665	3.73	1.08
14-Frequency of Event Reporting	142,508	3.60	1.20	167,670	3.63	1.20

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation
Source: 2019 All Employee Survey and 2020 All Employee Survey, Patient Safety Module

Table 8.2: Dimension 1 - Overall Perceptions of Patient Safety

VISN	Question 1 N (%) Disagree/Strongly Disagree	Question 1 N (%) Neutral	Question 1 N (%) Agree/Strongly Agree
V 1	244 (2.59)	862 (9.17)	8,299 (88.24)
V 2	439 (4.14)	1,139 (10.75)	9,016 (85.10)
V 4	290 (3.14)	857 (9.27)	8,097 (87.59)
V 5	253 (3.46)	745 (10.18)	6,321 (86.36)
V 6	375 (3.16)	1,245 (10.50)	10,235 (86.33)
V 7	569 (4.29)	1,542 (11.62)	11,162 (84.10)
V 8	585 (3.08)	1,968 (10.35)	16,460 (86.57)
V 9	309 (3.37)	952 (10.37)	7,920 (86.27)
V 10	627 (4.00)	1,651 (10.54)	13,391 (85.46)
V 12	478 (3.55)	1,516 (11.27)	11,456 (85.17)
V 15	335 (3.70)	979 (10.83)	7,729 (85.47)
V 16	516 (3.91)	1,558 (11.82)	11,108 (84.27)
V 17	482 (3.57)	1,348 (9.97)	11,685 (86.46)
V 19	431 (4.35)	1,070 (10.81)	8,401 (84.84)
V 20	334 (3.38)	992 (10.05)	8,542 (86.56)
V 21	411 (3.06)	1,446 (10.76)	11,580 (86.18)
V 22	638 (3.54)	1,985 (11.02)	15,394 (85.44)
V 23	288 (2.94)	939 (9.59)	8,565 (87.47)
National	7,604 (3.52)	22,794 (10.56)	185,361 (85.91)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 1: "We take the time to identify and assess risks to patient safety."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.3: Dimension 2 - Non-Punitive Response to Error by Question

VISN	Question 2 N (%) Disagree/ Strongly Disagree	Question 2 N (%) Neutral	Question 2 N (%) Agree/ Strongly Agree	Question 3 N (%) Disagree/ Strongly Disagree	Question 3 N (%) Neutral	Question 3 N (%) Agree/ Strongly Agree
V 1	489 (5.14)	1,020 (10.73)	8,001 (84.13)	1,270 (13.05)	1,483 (15.24)	6,980 (71.71)
V 2	822 (7.71)	1,426 (13.38)	8,410 (78.91)	1,778 (16.36)	1,832 (16.86)	7,259 (66.79)
V 4	576 (6.16)	1,025 (10.96)	7,747 (82.87)	1,401 (14.78)	1,378 (14.54)	6,698 (70.68)
V 5	416 (5.64)	840 (11.40)	6,114 (82.96)	1,045 (13.95)	1,168 15.59)	5,278 (70.46)
V 6	736 (6.16)	1,499 (12.55)	9,707 (81.28)	1,890 (15.58)	1,969 (16.23)	8,272 (68.19)
V 7	1,017 (7.58)	1,700 (12.67)	10,703 (79.75)	2,389 (17.57)	2,238 (16.46)	8,968 (65.97)
V 8	1,206 (6.30)	2,311 (12.07)	15,635 (81.64)	2,627 (13.51)	3,097 (15.93)	13,722 (70.56)
V 9	635 (6.84)	1,107 (11.92)	7,548 (81.25)	1,495 (15.74)	1,403 (14.77)	6,603 (69.50)
V 10	1,118 (7.05)	1,924 (12.14)	12,806 (80.81)	2,610 (16.19)	2,500 (15.51)	11,009 (68.30)
V 12	783 (5.77)	1,774 (13.06)	11,024 (81.17)	2,069 (15.01)	2,146 (15.57)	9,568 (69.42)
V 15	610 (6.66)	1,121 (12.24)	7,428 (81.10)	1,495 (16.00)	1,507 (16.13)	6,343 (67.88)
V 16	940 (7.06)	1,812 (13.61)	10,562 (79.33)	2,265 (16.67)	2,265 (16.67)	9,056 (66.66)
V 17	857 (6.28)	1,535 (11.25)	11,249 (82.46)	1,883 (13.66)	2,009 (14.57)	9,893 (71.77)
V 19	722 (7.20)	1,227 (12.24)	8,074 (80.55)	1,700 (16.64)	1,670 (16.35)	6,846 (67.01)
V 20	576 (5.76)	1,030 (10.30)	8,395 (83.94)	1,385 (13.52)	1,408 (13.75)	7,450 (72.73)
V 21	798 (5.90)	1,638 (12.10)	11,100 (82.00)	1,800 (13.02)	2,075 (15.00)	9,955 (71.98)
V 22	1,185 (6.52)	2,300 (12.66)	14,685 (80.82)	2,797 (15.11)	2,933 (15.84)	12,781 (69.05)
V 23	496 (4.99)	962 (9.68)	8,482 (85.33)	1,284 (12.71)	1,352 (13.38)	7,470 (73.92)
National	13,982 (6.42)	26,251 (12.05)	177,670 (81.54)	33,183 (14.96)	34,433 (15.53)	154,151 (69.51)

Notes: Based on Question 2: "I will not be punished if I report a patient safety problem or unsafe act." and Question 3: "I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal."
Source:2020 All Employee Survey, Patient Safety Module

Table 8.4: Dimension 3 - Education, Training, Resources

VISN	Question 4 N (%) Disagree/Strongly Disagree	Question 4 N (%) Neutral	Question 4 N (%) Agree/Strongly Agree
V 1	331 (3.43)	1,101 (11.40)	8,230 (85.18)
V 2	647 (5.96)	1,501 (13.82)	8,714 (80.22)
V 4	375 (3.96)	1,045 (11.02)	8,059 (85.02)
V 5	280 (3.75)	874 (11.70)	6,315 (84.55)
V 6	543 (4.49)	1,459 (12.07)	10,084 (83.44)
V 7	692 (5.10)	1,701 (12.53)	11,183 (82.37)
V 8	839 (4.31)	2,332 (11.97)	16,305 (83.72)
V 9	412 (4.35)	1,118 (11.82)	7,932 (83.83)
V 10	765 (4.77)	1,995 (12.43)	13,292 (82.81)
V 12	587 (4.26)	1,737 (12.60)	11,466 (83.15)
V 15	417 (4.50)	1,123 (12.12)	7,729 (83.39)
V 16	644 (4.78)	1,848 (13.71)	10,992 (81.52)
V 17	571 (4.13)	1,618 (11.71)	11,633 (84.16)
V 19	523 (5.15)	1,295 (12.76)	8,331 (82.09)
V 20	433 (4.25)	1,185 (11.62)	8,582 (84.14)
V 21	629 (4.56)	1,836 (13.30)	11,338 (82.14)
V 22	874 (4.73)	2,450 (13.27)	15,144 (82.00)
V 23	348 (3.47)	1,015 (10.12)	8,667 (86.41)
National	9,910 (4.48)	27,233 (12.31)	183,996 (83.20)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 4: "Safety education and training provided to me are enough to accomplish my job safely."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.5: Dimension 4 – Shame by Question

VISN	Question 5 N (%) Disagree/ Strongly Disagree	Question 5 N (%) Neutral	Question 5 N (%) Agree/ Strongly Agree	Question 6 N (%) Disagree/ Strongly Disagree	Question 6 N (%) Neutral	Question 6 N (%) Agree/ Strongly Agree
V 1	2,954 (30.93)	2,456 (25.71)	4,142 (43.36)	1,004 (10.88)	2,058 (22.31)	6,163 (66.81)
V 2	3,468 (32.60)	2,607 (24.51)	4,562 (42.89)	1,412 (13.60)	2,460 (23.69)	6,514 (62.72)
V 4	2,901 (31.07)	2,379 (25.48)	4,056 (43.44)	1,126 (12.43)	1,967 (21.71)	5,968 (65.86)
V 5	2,615 (35.40)	1,626 (22.01)	3,147 (42.60)	800 (11.19)	1,522 (21.28)	4,829 (67.53)
V 6	3,740 (31.25)	2,864 (23.93)	5,365 (44.82)	1,518 (13.17)	2,635 (22.85)	7,377 (63.98)
V 7	3,891 (29.12)	2,899 (21.69)	6,574 (49.19)	1,882 (14.46)	2,919 (22.43)	8,211 (63.10)
V 8	6,428 (33.68)	4,586 (24.03)	8,069 (42.28)	2,271 (12.21)	4,079 (21.92)	12,256 (65.87)
V 9	3,235 (34.47)	2,233 (23.80)	3,916 (41.73)	1,093 (12.01)	1,905 (20.92)	6,106 (67.07)
V 10	5,108 (32.06)	3,843 (24.12)	6,983 (43.82)	2,011 (13.09)	3,555 (23.13)	9,801 (63.78)
V 12	4,570 (33.46)	3,422 (25.05)	5,668 (41.49)	1,765 (13.39)	3,013 (22.85)	8,406 (63.76)
V 15	3,018 (32.63)	2,284 (24.69)	3,948 (42.68)	1,177 (13.09)	1,979 (22.00)	5,838 (64.91)
V 16	4,256 (31.96)	3,073 (23.08)	5,987 (44.96)	1,813 (13.91)	3,005 (23.06)	8,216 (63.04)
V 17	4,669 (34.21)	3,097 (22.69)	5,881 (43.09)	1,720 (12.97)	2,771 (20.90)	8,769 (66.13)
V 19	3,450 (34.18)	2,538 (25.14)	4,106 (40.68)	1,247 (12.85)	2,109 (21.74)	6,346 (65.41)
V 20	3,332 (32.92)	2,563 (25.33)	4,225 (41.75)	1,095 (11.37)	2,068 (21.47)	6,470 (67.16)
V 21	4,743 (34.82)	3,481 (25.56)	5,397 (39.62)	1,466 (11.19)	2,903 (22.16)	8,729 (66.64)
V 22	6,343 (34.84)	4,691 (25.77)	7,172 (39.39)	2,163 (12.30)	3,974 (22.60)	11,447 (65.10)
V 23	3,499 (34.91)	2,510 (25.04)	4,015 (40.05)	1,109 (11.59)	2,015 (21.05)	6,447 (67.36)
National	72,220 (33.04)	53,152 (24.32)	93,213 (42.64)	26,672 (12.61)	46,937 (22.19)	137,893 (65.20)

Notes: Based on Question 5: "I am ashamed when I make a mistake in front of my co-workers." and Question 6: "Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review or risk of termination)."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.6: Dimension 5 - Communication, Openness by Question

VISN	Q7 N (%) Disagree/ Strongly Disagree	Q7 N (%) Neutral	Q7 N (%) Agree/ Strongly Agree	Q8 N (%) Disagree/ Strongly Disagree	Q8 N (%) Neutral	Q8 N (%) Agree/ Strongly Agree	Q9 N (%) Disagree/ Strongly Disagree	Q9 N (%) Neutral	Q9 N (%) Agree/ Strongly Agree
V 1	549 (5.74)	1,202 (12.56)	7,816 (81.70)	1,247 (12.73)	1,592 (16.25)	6,959 (71.02)	922 (9.29)	1,133 (11.41)	7,872 (79.30)
V 2	902 (8.38)	1,562 (14.51)	8,304 (77.12)	1,700 (15.53)	1,976 (18.05)	7,270 (66.42)	1,369 (12.32)	1,403 (12.62)	8,342 (75.06)
V 4	634 (6.74)	1,230 (13.08)	7,541 (80.18)	1,322 (13.85)	1,562 (16.36)	6,663 (69.79)	1,026 (10.64)	1,029 (10.67)	7,588 (78.69)
V 5	487 (6.56)	941 (12.68)	5,992 (80.75)	972 (12.94)	1,214 (16.17)	5,323 (70.89)	756 (9.94)	866 (11.39)	5,981 (78.67)
V 6	830 (6.92)	1,712 (14.27)	9,455 (78.81)	1,777 (14.59)	2,164 (17.77)	8,237 (67.64)	1,419 (11.48)	1,467 (11.87)	9,472 (76.65)
V 7	1,118 (8.30)	1,978 (14.68)	10,378 (77.02)	2,145 (15.78)	2,277 (16.75)	9,174 (67.48)	1,752 (12.69)	1,675 (12.13)	10,384 (75.19)
V 8	1,291 (6.67)	2,705 (13.98)	15,349 (79.34)	2,569 (13.15)	3,292 (16.86)	13,670 (69.99)	2,087 (10.53)	2,305 (11.63)	15,435 (77.85)
V 9	672 (7.21)	1,226 (13.15)	7,428 (79.65)	1,401 (14.71)	1,520 (15.96)	6,603 (69.33)	1,094 (11.36)	1,079 (11.20)	7,458 (77.44)
V 10	1,206 (7.57)	2,230 (14.00)	12,498 (78.44)	2,569 (15.91)	2,719 (16.84)	10,859 (67.25)	1,883 (11.51)	1,877 (11.47)	12,603 (77.02)
V 12	954 (6.99)	2,036 (14.92)	10,655 (78.09)	2,107 (15.22)	2,516 (18.17)	9,222 (66.61)	1,580 (11.28)	1,768 (12.62)	10,656 (76.09)
V 15	644 (6.99)	1,230 (13.36)	7,334 (79.65)	1,513 (16.16)	1,525 (16.29)	6,323 (67.55)	1,112 (11.76)	1,092 (11.54)	7,255 (76.70)
V 16	1,084 (8.07)	1,975 (14.69)	10,381 (77.24)	2,076 (15.23)	2,450 (17.98)	9,104 (66.79)	1,640 (11.92)	1,758 (12.77)	10,365 (75.31)
V 17	964 (7.03)	1,789 (13.05)	10,960 (79.92)	1,922 (13.88)	2,215 (15.99)	9,714 (70.13)	1,569 (11.18)	1,633 (11.64)	10,829 (77.18)
V 19	821 (8.15)	1,319 (13.09)	7,938 (78.77)	1,578 (15.38)	1,600 (15.59)	7,082 (69.03)	1,287 (12.43)	1,164 (11.24)	7,907 (76.34)
V 20	629 (6.24)	1,273 (12.62)	8,186 (81.15)	1,292 (12.58)	1,562 (15.20)	7,420 (72.22)	1,032 (9.91)	1,097 (10.53)	8,284 (79.55)
V 21	910 (6.66)	2,054 (15.04)	10,691 (78.29)	1,683 (12.13)	2,295 (16.54)	9,894 (71.32)	1,481 (10.54)	1,710 (12.17)	10,860 (77.29)
V 22	1,281 (7.00)	2,646 (14.45)	14,382 (78.55)	2,548 (13.72)	3,075 (16.56)	12,950 (69.72)	1,994 (10.58)	2,302 (12.22)	14,544 (77.20)
V 23	586 (5.89)	1,204 (12.10)	8,157 (82.00)	1,550 (15.31)	1,739 (17.17)	6,837 (67.52)	1,111 (10.87)	1,199 (11.73)	7,909 (77.40)
National	15,562 (7.10)	30,312 (13.82)	173,445 (79.08)	31,971 (14.36)	37,293 (16.76)	153,304 (68.88)	25,114 (11.14)	26,557 (11.78)	173,744 (77.08)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 7 (Q7): "Members in my workgroup are able to bring up problems and tough issues" and Question 8 (Q8): "My supervisor listens to what I have to say" and Question 9 (Q9): "Staff will freely speak up if they see something that may negatively affect patient care."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.7: Dimension 6 - Teamwork within Hospital Units by Question

VISN	Question 10 N (%) Disagree/ Strongly Disagree	Question 10 N (%) Neutral	Question 10 N (%) Agree/ Strongly Agree	Question 11 N (%) Disagree/ Strongly Disagree	Question 11 N (%) Neutral	Question 11 N (%) Agree/ Strongly Agree
V 1	811 (8.34)	1,470 (15.12)	7,441 (76.54)	1,094 (11.02)	1,390 (14.00)	7,442 (74.97)
V 2	1,174 (10.77)	1,954 (17.92)	7,777 (71.32)	1,578 (14.20)	1,843 (16.58)	7,694 (69.22)
V 4	983 (10.36)	1,508 (15.89)	7,000 (73.75)	1,295 (13.41)	1,444 (14.95)	6,919 (71.64)
V 5	670 (8.97)	1,191 (15.95)	5,608 (75.08)	932 (12.26)	1,105 (14.53)	5,566 (73.21)
V 6	1,199 (9.87)	2,084 (17.15)	8,866 (72.98)	1,654 (13.39)	1,874 (15.17)	8,826 (71.44)
V 7	1,501 (11.00)	2,402 (17.60)	9,741 (71.39)	2,050 (14.82)	2,181 (15.77)	9,597 (69.40)
V 8	1,772 (9.07)	3,336 (17.08)	14,425 (73.85)	2,206 (11.14)	2,921 (14.75)	14,683 (74.12)
V 9	924 (9.73)	1,528 (16.09)	7,045 (74.18)	1,257 (13.04)	1,356 (14.06)	7,029 (72.90)
V 10	1,739 (10.78)	2,664 (16.52)	11,726 (72.70)	2,269 (13.87)	2,481 (15.16)	11,613 (70.97)
V 12	1,346 (9.72)	2,467 (17.82)	10,029 (72.45)	1,948 (13.89)	2,233 (15.92)	9,846 (70.19)
V 15	1,020 (10.90)	1,566 (16.74)	6,771 (72.36)	1,422 (15.01)	1,465 (15.47)	6,586 (69.52)
V 16	1,429 (10.54)	2,564 (18.91)	9,569 (70.56)	1,953 (14.16)	2,345 (17.01)	9,490 (68.83)
V 17	1,363 (9.81)	2,396 (17.25)	10,134 (72.94)	1,839 (13.13)	2,072 (14.79)	10,100 (72.09)
V 19	1,038 (10.12)	1,583 (15.43)	7,638 (74.45)	1,332 (12.86)	1,487 (14.35)	7,541 (72.79)
V 20	764 (7.42)	1,478 (14.36)	8,051 (78.22)	1,050 (10.06)	1,325 (12.70)	8,059 (77.24)
V 21	1,092 (7.88)	2,169 (15.66)	10,591 (76.46)	1,479 (10.51)	2,076 (14.75)	10,516 (74.74)
V 22	1,525 (8.22)	3,026 (16.31)	14,005 (75.47)	2,171 (11.52)	2,749 (14.59)	13,924 (73.89)
V 23	937 (9.30)	1,591 (15.79)	7,550 (74.92)	1,317 (12.86)	1,566 (15.29)	7,358 (71.85)
National	21,287 (9.58)	36,977 (16.64)	163,967 (73.78)	28,846 (12.79)	33,913 (15.04)	162,789 (72.17)

Notes: Based on Question 10: “People treat each other with respect in my workgroup” and Question 11: “People support one another in my unit.”

Source: 2020 All Employee Survey, Patient Safety Module

Table 8.8: Dimension 7 - Teamwork Across Hospital Units

VISN	Question 12 N (%) Disagree/Strongly Disagree	Question 12 N (%) Neutral	Question 12 N (%) Agree/Strongly Agree
V 1	1,182 (12.79)	2,319 (25.09)	5,743 (62.13)
V 2	1,613 (15.34)	2,736 (26.01)	6,169 (58.65)
V 4	1,370 (14.99)	2,285 (25.00)	5,484 (60.01)
V 5	1,127 (15.55)	1,855 (25.60)	4,264 (58.85)
V 6	1,693 (14.51)	3,071 (26.33)	6,900 (59.16)
V 7	2,116 (16.19)	3,519 (26.93)	7,433 (56.88)
V 8	2,293 (12.31)	4,525 (24.30)	11,804 (63.39)
V 9	1,257 (13.90)	2,311 (25.56)	5,475 (60.54)
V 10	2,479 (16.06)	4,139 (26.81)	8,819 (57.13)
V 12	1,853 (13.92)	3,532 (26.53)	7,928 (59.55)
V 15	1,440 (16.06)	2,384 (26.60)	5,140 (57.34)
V 16	2,150 (16.57)	3,439 (26.50)	7,390 (56.94)
V 17	1,792 (13.53)	3,229 (24.37)	8,228 (62.10)
V 19	1,701 (17.47)	2,613 (26.84)	5,420 (55.68)
V 20	1,244 (12.86)	2,502 (25.86)	5,930 (61.29)
V 21	1,590 (12.07)	3,278 (24.88)	8,309 (63.06)
V 22	2,404 (13.52)	4,550 (25.58)	10,831 (60.90)
V 23	1,420 (14.72)	2,423 (25.11)	5,805 (60.17)
National	30,724 (14.46)	54,710 (25.75)	127,072 (59.80)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 12: "There is good cooperation among hospital units/areas that need to work together."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.9: Dimension 8 - Organizational Learning-Continuous Improvement

VISN	Question 13 N (%) Disagree/Strongly Disagree	Question 13 N (%) Neutral	Question 13 N (%) Agree/Strongly Agree
V 1	725 (7.77)	2,773 (29.71)	5,835 (62.52)
V 2	1,129 (10.73)	3,154 (29.98)	6,238 (59.29)
V 4	816 (8.91)	2,773 (30.29)	5,567 (60.80)
V 5	601 (8.31)	2,088 (28.87)	4,543 (62.82)
V 6	971 (8.29)	3,588 (30.63)	7,155 (61.08)
V 7	1,370 (10.49)	4,033 (30.89)	7,654 (58.62)
V 8	1,565 (8.35)	5,291 (28.22)	11,895 (63.44)
V 9	791 (8.64)	2,603 (28.42)	5,765 (62.94)
V 10	1,499 (9.65)	4,838 (31.16)	9,191 (59.19)
V 12	1,110 (8.29)	4,000 (29.88)	8,276 (61.83)
V 15	791 (8.69)	2,710 (29.76)	5,606 (61.56)
V 16	1,322 (10.13)	4,010 (30.74)	7,713 (59.13)
V 17	1,130 (8.42)	3,744 (27.91)	8,542 (63.67)
V 19	1,027 (10.42)	3,094 (31.40)	5,733 (58.18)
V 20	762 (7.71)	2,969 (30.04)	6,151 (62.24)
V 21	1,041 (7.79)	3,926 (29.37)	8,400 (62.84)
V 22	1,564 (8.73)	5,193 (28.99)	11,158 (62.28)
V 23	719 (7.37)	2,848 (29.18)	6,192 (63.45)
National	18,933 (8.84)	63,635 (29.71)	131,614 (61.45)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 13: "Mistakes have led to positive changes here."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.10: Dimension 9 - Feedback and Communication about Error

VISN	Question 14 N (%) Disagree/ Strongly Disagree	Question 14 N (%) Neutral	Question 14 N (%) Agree/ Strongly Agree	Question 15 N (%) Disagree/ Strongly Disagree	Question 15 N (%) Neutral	Question 15 N (%) Agree/ Strongly Agree
V 1	1,179 (12.64)	2,547 (27.31)	5,600 (60.05)	716 (7.59)	1,537 (16.29)	7,185 (76.13)
V 2	1,586 (15.06)	2,934 (27.85)	6,014 (57.09)	1,035 (9.69)	1,987 (18.60)	7,661 (71.71)
V 4	1,282 (13.89)	2,400 (26.00)	5,549 (60.11)	813 (8.76)	1,501 (16.17)	6,969 (75.07)
V 5	932 (12.78)	1,855 (25.45)	4,503 (61.77)	567 (7.71)	1,197 (16.27)	5,594 (76.03)
V 6	1,680 (14.30)	3,199 (27.22)	6,872 (58.48)	1,053 (8.87)	2,184 (18.40)	8,635 (72.73)
V 7	1,939 (14.65)	3,506 (26.49)	7,791 (58.86)	1,290 (9.66)	2,330 (17.45)	9,731 (72.89)
V 8	2,448 (12.95)	4,765 (25.20)	11,693 (61.85)	1,632 (8.54)	3,169 (16.58)	14,316 (74.89)
V 9	1,269 (13.79)	2,368 (25.73)	5,568 (60.49)	787 (8.48)	1,549 (16.68)	6,950 (74.84)
V 10	2,498 (16.04)	4,254 (27.31)	8,822 (56.65)	1,503 (9.54)	2,840 (18.02)	11,416 (72.44)
V 12	1,803 (13.46)	3,607 (26.93)	7,986 (59.61)	1,138 (8.41)	2,438 (18.01)	9,961 (73.58)
V 15	1,419 (15.58)	2,461 (27.03)	5,225 (57.39)	860 (9.37)	1,539 (16.77)	6,778 (73.86)
V 16	1,923 (14.58)	3,543 (26.86)	7,723 (58.56)	1,237 (9.32)	2,525 (19.03)	9,506 (71.65)
V 17	1,708 (12.60)	3,181 (23.47)	8,664 (63.93)	1,157 (8.49)	2,139 (15.70)	10,330 (75.81)
V 19	1,745 (17.70)	2,805 (28.46)	5,306 (53.84)	1,006 (10.05)	1,808 (18.06)	7,198 (71.89)
V 20	1,493 (15.16)	2,696 (27.38)	5,659 (57.46)	840 (8.35)	1,692 (16.81)	7,531 (74.84)
V 21	1,637 (12.28)	3,491 (26.19)	8,202 (61.53)	995 (7.32)	2,250 (16.55)	10,351 (76.13)
V 22	2,357 (13.14)	4,721 (26.33)	10,854 (60.53)	1,473 (8.11)	3,094 (17.03)	13,603 (74.87)
V 23	1,492 (15.38)	2,582 (26.62)	5,627 (58.00)	834 (8.44)	1,697 (17.18)	7,349 (74.38)
National	30,390 (14.14)	56,915 (26.48)	127,658 (59.39)	18,936 (8.71)	37,476 (17.23)	161,064 (74.06)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 14: "In this unit, we discuss ways to prevent errors from happening again" and Question 15: "We are given feedback about changes put into place based on event reports."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.11: Dimension 10 - Job Satisfaction

VISN	Question 16 N (%) Disagree/Strongly Disagree	Question 16 N (%) Neutral	Question 16 N (%) Agree/Strongly Agree
V 1	328 (3.34)	1,262 (12.84)	8,236 (83.82)
V 2	718 (6.52)	1,882 (17.09)	8,412 (76.39)
V 4	469 (4.88)	1,240 (12.89)	7,910 (82.23)
V 5	372 (4.92)	1,154 (15.28)	6,028 (79.80)
V 6	618 (5.04)	1,918 (15.65)	9,723 (79.31)
V 7	1,007 (7.33)	2,433 (17.71)	10,296 (74.96)
V 8	807 (4.10)	2,607 (13.24)	16,274 (82.66)
V 9	473 (4.95)	1,378 (14.41)	7,712 (80.64)
V 10	792 (4.87)	2,392 (14.70)	13,091 (80.44)
V 12	690 (4.95)	2,141 (15.35)	11,121 (79.71)
V 15	471 (5.01)	1,365 (14.51)	7,573 (80.49)
V 16	741 (5.41)	2,301 (16.81)	10,648 (77.78)
V 17	642 (4.60)	1,904 (13.64)	11,410 (81.76)
V 19	626 (6.07)	1,571 (15.22)	8,124 (78.71)
V 20	518 (4.99)	1,500 (14.44)	8,372 (80.58)
V 21	613 (4.38)	2,092 (14.95)	11,285 (80.66)
V 22	904 (4.84)	2,848 (15.23)	14,943 (79.93)
V 23	389 (3.81)	1,258 (12.33)	8,553 (83.85)
National	11,178 (4.99)	33,246 (14.83)	179,711 (80.18)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 16: "I am proud to work for this facility."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.12: Dimension 11 - Patient Safety in Comparison to Other Facilities

VISN	Question 17 N (%) Disagree/Strongly Disagree	Question 17 N (%) Neutral	Question 17 N (%) Agree/Strongly Agree
V 1	640 (7.05)	3,379 (37.23)	5,058 (55.72)
V 2	1,158 (11.25)	3,872 (37.61)	5,265 (51.14)
V 4	764 (8.49)	3,110 (34.57)	5,121 (56.93)
V 5	740 (10.31)	2,514 (35.03)	3,922 (54.65)
V 6	1,230 (10.65)	4,375 (37.87)	5,947 (51.48)
V 7	1,733 (13.39)	5,053 (39.03)	6,159 (47.58)
V 8	1,356 (7.34)	5,856 (31.68)	11,271 (60.98)
V 9	781 (8.67)	3,124 (34.69)	5,101 (56.64)
V 10	1,532 (10.03)	5,957 (39.02)	7,779 (50.95)
V 12	1,123 (8.59)	4,731 (36.18)	7,223 (55.23)
V 15	823 (9.31)	3,321 (37.58)	4,693 (53.11)
V 16	1,479 (11.42)	4,796 (37.02)	6,680 (51.56)
V 17	1,184 (8.95)	4,337 (32.78)	7,708 (58.27)
V 19	1,048 (10.96)	3,913 (40.92)	4,601 (48.12)
V 20	822 (8.59)	3,901 (40.75)	4,850 (50.66)
V 21	1,073 (8.22)	4,634 (35.52)	7,341 (56.26)
V 22	1,612 (9.27)	6,379 (36.68)	9,402 (54.06)
V 23	679 (7.16)	3,573 (37.67)	5,234 (55.18)
National	19,777 (9.42)	76,825 (36.59)	113,355 (53.99)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 17: "The patient safety processes and procedures in this facility are better than the processes and procedures found in other facilities."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.13: Dimension 12 - Perceptions of Patient Safety at your Facility

VISN	Question 18 N (%) Disagree/Strongly Disagree	Question 18 N (%) Neutral	Question 18 N (%) Agree/Strongly Agree
V 1	229 (2.37)	980 (10.16)	8,441 (87.47)
V 2	495 (4.56)	1,462 (13.45)	8,910 (81.99)
V 4	297 (3.14)	982 (10.37)	8,192 (86.50)
V 5	266 (3.56)	924 (12.38)	6,272 (84.05)
V 6	438 (3.62)	1,598 (13.21)	10,065 (83.17)
V 7	735 (5.41)	2,049 (15.09)	10,798 (79.50)
V 8	622 (3.19)	2,159 (11.09)	16,691 (85.72)
V 9	338 (3.58)	1,102 (11.69)	7,989 (84.73)
V 10	578 (3.59)	1,998 (12.41)	13,518 (83.99)
V 12	459 (3.33)	1,740 (12.63)	11,574 (84.03)
V 15	333 (3.58)	1,163(12.51)	7,801 (83.91)
V 16	596 (4.41)	2,067 (15.30)	10,851 (80.29)
V 17	515 (3.72)	1,645 (11.89)	11,673 (84.39)
V 19	411 (4.03)	1,291 (12.67)	8,489 (83.30)
V 20	315 (3.09)	1,143 (11.20)	8,750 (85.72)
V 21	406 (2.94)	1,749 (12.68)	11,638 (84.38)
V 22	661 (3.58)	2,392 (12.96)	15,408 (83.46)
V 23	233 (2.31)	969 (9.61)	8,886 (88.08)
National	7,927 (3.58)	27,413 (12.39)	185,946 (84.03)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 18: "We take great pride in the quality of care we deliver."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.14: Dimension 13 - Senior Management Awareness/Actions in Promoting Safety

VISN	Question 19 N (%) Disagree/Strongly Disagree	Question 19 N (%) Neutral	Question 19 N (%) Agree/Strongly Agree
V 1	863 (9.09)	2,251 (23.70)	6,382 (67.21)
V 2	1,386 (12.97)	2,757 (25.79)	6,546 (61.24)
V 4	993 (10.62)	2,216 (23.70)	6,141 (65.68)
V 5	822 (11.18)	1,761 (23.94)	4,772 (64.88)
V 6	1,258 (10.59)	2,914 (24.52)	7,712 (64.89)
V 7	1,823 (13.65)	3,447 (25.82)	8,082 (60.53)
V 8	1,808 (9.45)	4,301 (22.47)	13,031 (68.08)
V 9	1,059 (11.40)	2,193 (23.62)	6,034 (64.98)
V 10	2,188 (13.84)	4,242 (26.83)	9,378 (59.32)
V 12	1,556 (11.49)	3,330 (24.58)	8,660 (63.93)
V 15	1,103 (12.00)	2,322 (25.27)	5,764 (62.73)
V 16	1,765 (13.23)	3,471 (26.03)	8,100 (60.74)
V 17	1,396 (10.23)	3,069 (22.50)	9,176 (67.27)
V 19	1,417 (14.19)	2,652 (26.55)	5,920 (59.27)
V 20	1,158 (11.56)	2,597 (25.94)	6,258 (62.50)
V 21	1,422 (10.51)	3,265 (24.14)	8,837 (65.34)
V 22	1,963 (10.81)	4,515 (24.86)	11,685 (64.33)
V 23	1,053 (10.63)	2,502 (25.26)	6,349 (64.11)
National	25,033 (11.50)	53,805 (24.72)	138,827 (63.78)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 19: "Senior managers set the example for compliance with policy and procedure that promote safe patient care."
Source: 2020 All Employee Survey, Patient Safety Module

Table 8.15: Dimension 14 - Frequency of Event Reporting

VISN	Question 20 N (%) Never/Rarely	Question 20 N (%) Sometimes	Question 20 N (%) Very Often/Always
V 1	1,248 (17.81)	1,841 (26.28)	3,917 (55.91)
V 2	1,706 (20.95)	1,981 (24.32)	4,457 (54.73)
V 4	1,156 (16.60)	1,832 (26.31)	3,975 (57.09)
V 5	968 (16.72)	1,403 (24.24)	3,417 (59.04)
V 6	1,671 (18.08)	2,423 (26.22)	5,146 (55.69)
V 7	1,975 (19.28)	2,534 (24.73)	5,737 (55.99)
V 8	2,761 (18.72)	3,234 (21.93)	8,754 (59.35)
V 9	1,406 (19.54)	1,892 (26.29)	3,898 (54.17)
V 10	2,147 (17.63)	3,331 (27.35)	6,699 (55.01)
V 12	1,976 (18.64)	2,839 (26.78)	5,787 (54.58)
V 15	1,373 (19.00)	2,059 (28.49)	3,796 (52.52)
V 16	2,042 (19.97)	2,412 (23.59)	5,770 (56.44)
V 17	2,210 (20.31)	2,494 (22.92)	6,176 (56.76)
V 19	1,522 (20.12)	2,229 (29.46)	3,814 (50.42)
V 20	1,339 (17.81)	2,116 (28.15)	4,063 (54.04)
V 21	1,919 (18.38)	2,592 (24.82)	5,931 (56.80)
V 22	2,701 (19.17)	3,573 (25.36)	7,815 (55.47)
V 23	1,320 (17.34)	2,363 (31.04)	3,930 (51.62)
National	31,440 (18.75)	43,148 (25.73)	93,082 (55.51)

Notes: N=number of survey responses; Mean=Dimension Average based on 5-point Likert scale; SD=Standard Deviation.
Based on Question 20: "When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?"
Source: 2020 All Employee Survey, Patient Safety Module

Chapter 9: NCPS Publications

Over the past two decades, NCPS has published more than 500 articles in patient safety and related topics. The nineteen publications listed below were authored by NCPS staff, often in collaboration with other VHA Program Offices, and either published or accepted for publication during FY 2020.

1. Arsan C, Baker C, Wong J, Scott R, Felde A, Mills P, Stern TA, Rustad JK. Delirious Mania: An Approach to Diagnosis and Treatment. The Primary Care Companion for CNS Disorders 2020 (in press).
2. Arnold, T., Fuller, H. J., Bagian, T. M., & Gunnar, W. P. (2020, July). Design of a Fellowship Learning-by-Teaching Experience for Reflecting on Safety and Change. In International Conference on Applied Human Factors and Ergonomics (pp. 39-46). Springer, Cham.
3. Bagian, T. M., Fuller, H. J., & Arnold, T. (2020, July). Systems Engineering for Healing Healthcare: The Journey from Compliance to Resilience. In International Conference on Applied Human Factors and Ergonomics (pp. 54-61). Springer, Cham.
4. Fuller, H. J., Arnold, T., Bagian, T. M., & Gunnar, W. P. (2020, July). A Human Factors Framework and Heuristics for Diffusion of Innovations. In International Conference on Applied Human Factors and Ergonomics (pp. 47-53). Springer, Cham.
5. Gill, S., Mills, P. D., Watts, B. V., Paull, D. E., & Tomolo, A. (2020). A Review of Adverse Event Reports from Emergency Departments in the Veterans Health Administration. Journal of patient safety, 10.1097/PTS.0000000000000636. Advance online publication. https://doi.org/10.1097/PTS.0000000000000636
6. Gunnar, W., Soncrant, C., Lynn, M. M., Neily, J., Tesema, Y., & Nylander, W. (2020). The Impact of Surgical Count Technology on Retained Surgical Items Rates in the Veterans Health Administration. Journal of patient safety, 16(4), 255–258. https://doi.org/10.1097/PTS.0000000000000656
7. Kulju, S., Morrish, W., King, L., Bender, J., & Gunnar, W. (2020). Patient Misidentification Events in the Veterans Health Administration: A Comprehensive Review in the Context of High-Reliability Health Care. Journal of patient safety, 10.1097/PTS.0000000000000767. Advance online publication. https://doi.org/10.1097/PTS.0000000000000767
8. Kulju, S., McIntosh, B. A., Fuller, H. J., Arnold, T., & Gunnar, W. (2020). Assessment of unintended volume loss of six closed system transfer devices. Journal of oncology pharmacy practice: official publication of the International Society of Oncology Pharmacy Practitioners, 26(5), 1134–1140. https://doi.org/10.1177/1078155219888682
9. Mills, P. D., Soncrant, C., & Gunnar, W. (2020). Retrospective analysis of reported suicide deaths and attempts on veterans health administration campuses and inpatient units. BMJ quality & safety, bmjqs-2020-011312. Advance online publication. https://doi.org/10.1136/bmjqs-2020-011312
10. Mills, P. D., Soncrant, C., Bender, J., & Gunnar, W. (2020). Impact of over-the-door alarms: Root cause analysis review of suicide attempts and deaths on veterans health administration mental health units. General hospital psychiatry, 64, 41–45. https://doi.org/10.1016/j.genhosppsych.2020.01.005
11. Rajendran, S., Mills, P. D., Watts, B. V., & Gunnar, W. (2020). Suicide and Suicide Attempts on Veterans Affairs Medical Center Outpatient Clinic Areas, Common Areas, and Hospital Grounds. Journal of patient safety, 10.1097/PTS.0000000000000796. Advance online publication. https://doi.org/10.1097/PTS.0000000000000796

12. Sculli, G. L., Pendley-Louis, R., Neily, J., Anderson, T. M., Isaacks, D. B., Knowles, R., Young-Xu, Y., & Gunnar, W. (2020). A High-Reliability Organization Framework for Health Care: A Multiyear Implementation Strategy and Associated Outcomes. Journal of patient safety, 10.1097/PTS.0000000000000788. Advance online publication. https://doi.org/10.1097/PTS.0000000000000788
13. Shiner, B., Neily, J., Mills, P. D., & Watts, B. V. (2020). Identification of Inpatient Falls Using Automated Review of Text-Based Medical Records. Journal of patient safety, 16(3), e174–e178. https://doi.org/10.1097/PTS.0000000000000275
14. Soncrant, C., Mills, P. D., Neily, J., Paull, D. E., & Hemphill, R. R. (2020). Root Cause Analyses of Reported Adverse Events Occurring During Gastrointestinal Scope and Tube Placement Procedures in the Veterans Health Association. Journal of patient safety, 16(1), 41–46. https://doi.org/10.1097/PTS.0000000000000236
15. Soncrant, C., Neily, J., Bulat, T., & Mills, P. D. (2020). Recommendations for Fall-Related Injury Prevention: A 1-Year Review of Fall-Related Root Cause Analyses in the Veterans Health Administration. Journal of nursing care quality, 35(1), 77–82. https://doi.org/10.1097/NCQ.0000000000000408
16. Soncrant, C., Mills, P., Zubkoff, L., Neily, J., Mazzia, L., Warner, L., and Gunnar, W. Power Failures During Surgery: A 2000-2019 Review of Reported Events in the Veterans Health Administration. Journal of patient safety. July 2020. Published ahead of print. DOI: 10.1097/PTS.0000000000000717.
17. Veazie, S., Peterson, K., Bourne, D., Anderson, J., Damschroder, L., & Gunnar, W. (2020). Implementing High-Reliability Organization Principles Into Practice: A Rapid Evidence Review. Journal of patient safety, 10.1097/PTS.0000000000000768. Advance online publication. https://doi.org/10.1097/PTS.0000000000000768
18. Young-Xu, Y., Soncrant, C., Neily, J., Boar, S., Bulat, T., & Mills, P. D. (2020). Falls in Veterans Healthcare Administration Hospitals: Prevalence and Trends. Journal for healthcare quality: official publication of the National Association for Healthcare Quality, 42(3), 113–121. https://doi.org/10.1097/JHQ.0000000000000215
19. Zubkoff, L., Neily, J., McCoy-Jones, S., Soncrant, C., Young-Xu, Y., Boar, S., & Mills, P. (2020). Implementing Evidence-Based Pressure Injury Prevention Interventions: Veterans Health Administration Quality Improvement Collaborative. Journal of nursing care quality, 10.1097/NCQ.0000000000000512. Advance online publication. https://doi.org/10.1097/NCQ.0000000000000512

Chapter 10: Patient Safety Centers of Inquiry

Patient safety centers of inquiry (PSCI) were first funded in 1999 to promote the study of patient safety areas of interest and over the years have made valuable contributions to the improvement of patient safety within VHA and beyond. From conception, NCPS has administered and monitored the PSCI program and guided translational research in Patient Safety. These small research groups aim to evaluate and translate patient safety research findings into standard practices that are disseminated and implemented to improve patient safety across the VHA system. Over the years PSCIs in partnership with NCPS have developed, and distributed tools and products designed to promote patient safety (e.g. clinical tools, cognitive aids, educational materials, measurement tools, policy reports; handbooks and directives). Over this twenty-year period PSCIs have contributed to improvements and products in multiple areas; including suicide prevention and treatment, patient safety measurement, simulation training, fall and fall related injury prevention, drug prescribing and administration practices, reduction of hospital acquired infections, among others. PSCIs are funded for a three-year period through Veterans Equitable Resource Allocation (VERA) Specific Purpose Funds. There are currently ten funded PSCIs. A summary of each PSCIs focus and aims and the sixty-eight FY 2020 publications related to PSCI activity are as follows:

Ann Arbor PSCI:

Focus: Hospital Acquired Infections

Aims: The goal of this PSCI is to promote the safe and appropriate use of catheters to prevent hospital-acquired complications, including infection. Specifically, this project will focus on the appropriate use of urinary catheters in the peri- and post-operative setting, as well as the appropriate use of peripherally inserted central catheters (PICCs) hospital-wide.

FY 2020 Publications:

1. Greene, M. T., Gilmartin, H. M., & Saint, S. (2020). Psychological safety and infection prevention practices: Results from a national survey. American journal of infection control, 48(1), 2–6. https://doi.org/10.1016/j.ajic.2019.09.027
2. Saint, S., Meddings, J., Fowler, K. E., Vaughn, V. M., Ameling, J. M., Rohde, J. M., Popovich, K. J., Calfee, D. P., Krein, S. L., & Chopra, V. (2019). The Guide to Patient Safety for Health Care-Associated Infections. Annals of internal medicine, 171(7_Suppl), S7–S9. https://doi.org/10.7326/M18-3443
3. Saint S, Berendt AR. 10 minutes with Sanjay Saint, Chief of Medicine, Veterans Administration Ann Arbor Healthcare System, Michigan, USA. BMJ Leader 2020; 4(3):144-146. https://bmjleader.bmj.com/content/4/3/144
4. Vaughn, V. M., Greene, M. T., Ratz, D., Fowler, K. E., Krein, S. L., Flanders, S. A., Dubberke, E. R., Saint, S., & Patel, P. K. (2020). Antibiotic stewardship teams and Clostridioides difficile practices in United States hospitals: A national survey in The Joint Commission antibiotic stewardship standard era. Infection control and hospital epidemiology, 41(2), 143–148. https://doi.org/10.1017/ice.2019.313
5. Vaughn, V. M., Saint, S., Greene, M. T., Ratz, D., Fowler, K. E., Patel, P. K., & Krein, S. L. (2020). Trends in Health Care-Associated Infection Prevention Practices in US Veterans Affairs Hospitals From 2005 to 2017. JAMA network open, 3(2), e1920464. https://doi.org/10.1001/jamanetworkopen.2019.20464

The Bronx PSCI:

Focus: Geriatric Safety

Aims: The objectives of this PSCI are to identify promising practices for medication deprescribing for older veterans and those with dementia, support implementation of deprescribing interventions in multiple VAMCs and settings and evaluate the impact of medication deprescribing interventions.

FY 2020 Publications:

1. Anderson TS, Steinman MA. Antihypertensive Prescribing Cascades as High-Priority Targets for Deprescribing. JAMA Intern Med. 2020 May 1;180(5):651-652.
2. Anderson, T. S., Lee, S., Jing, B., Fung, K., Ngo, S., Silvestrini, M., & Steinman, M. A. (2020). Prevalence of Diabetes Medication Intensifications in Older Adults Discharged From US Veterans Health Administration Hospitals. JAMA network open, 3(3), e201511. https://doi.org/10.1001/jamanetworkopen.2020.1511.
3. Boockvar, K. S., Song, W., Lee, S., & Intrator, O. (2020). Comparing Outcomes Between Thiazide Diuretics and Other First-line Antihypertensive Drugs in Long-term Nursing Home Residents. Clinical therapeutics, 42(4), 583–591. https://doi.org/10.1016/j.clinthera.2020.02.016
4. Boockvar, K. S., Song, W., Lee, S., & Intrator, O. (2019). Hypertension Treatment in US Long-Term Nursing Home Residents With and Without Dementia. Journal of the American Geriatrics Society, 67(10), 2058–2064. https://doi.org/10.1111/jgs.16081
5. Brandt, N., & Steinman, M. A. (2020). Optimizing Medication Management During the COVID-19 Pandemic: An Implementation Guide for Post-Acute and Long-Term Care. Journal of the American Geriatrics Society, 68(7), 1362–1365. https://doi.org/10.1111/jgs.16573
6. Elias, A. M., Ogunwale, A. N., Pepin, M. J., Bailey, J. C., Adams, A. D., Colón-Emeric, C. S., Vognsen, J. D., Schmader, K. E., & Pavon, J. M. (2020). High Prevalence of Fall-Related Medication Use in Older Veterans at Risk for Falls. Journal of the American Geriatrics Society, 68(2), 438–439. https://doi.org/10.1111/jgs.16233
7. Ellenbogen, M. I., Wang, P., Overton, H. N., Fahim, C., Park, A., Bruhn, W. E., Carnahan, J. L., Linsky, A. M., Balogun, S. A., & Makary, M. A. (2020). Frequency and Predictors of Polypharmacy in US Medicare Patients: A Cross-Sectional Analysis at the Patient and Physician Levels. Drugs & aging, 37(1), 57–65. https://doi.org/10.1007/s40266-019-00726-0
8. Goyal P, Anderson TS, Bernacki GM, Marcum ZA, Orkaby AR, Kim D, Zullo A, Krishnaswami A, Weissman A, Steinman MA, Rich MW. (2020). Physician Perspectives on Deprescribing Cardiovascular Medications for Older Adults. J Am Geriatr Soc, Jan;68(1):78-86.
9. Howren, M. B., Steinman, M. A., Carter, B., Vander Weg, M. W., & Kaboli, P. J. (2020). Effect of a patient activation intervention on hypertension medication optimization: results from a randomized clinical trial. The American journal of managed care, 26(9), 382–387. https://doi.org/10.37765/ajmc.2020.88488
10. Linsky, A., Gellad, W. F., Linder, J. A., & Friedberg, M. W. (2019). Advancing the Science of Deprescribing: A Novel Comprehensive Conceptual Framework. Journal of the American Geriatrics Society, 67(10), 2018–2022. https://doi.org/10.1111/jgs.16136
11. Linsky, A., Stolzmann, K., Simon, S. R., Cabral, H., & Rosen, A. K. (2019). Patient Possession of Excess Medication Supply in the VA: A Retrospective Database Study. Medical care, 57(11), 898–904. https://doi.org/10.1097/MLR.0000000000001211
12. Nicosia FM, Spar MJ, Stebbins M, Sudore RL, Ritchie CS, Lee KP, Rodondi K, Steinman MA. (2020). What Is a Medication-Related Problem? A Qualitative Study of Older Adults and Primary Care Clinicians. J Gen Intern Med, Mar;35(3):724-731.

13. Sawan M, Reeve E, Turner J, Todd A, Steinman MA, Petrovic M, Gnjidic D. (2020). A systems approach to identifying the challenges of implementing deprescribing in older adults across different health-care settings and countries: a narrative review. Expert Rev Clin Pharmacol, Mar;13(3):233-245.
14. Zimmerman, KM, Linsky, AM; Donohoe, KL, Hobgood, SE, Sargent, L, Salgado, TM. (2020). An interprofessional workshop to enhance de-prescribing practices among health care providers. J of Continuing Education in the Health Professions, 40: 49-57. PMID: 32149948.
15. Zullo, A. R., Ofori-Asenso, R., Wood, M., Zuern, A., Lee, Y., Wu, W. C., Rudolph, J. L., Liew, D., & Steinman, M. A. (2020). Effects of Statins for Secondary Prevention on Functioning and Other Outcomes Among Nursing Home Residents. Journal of the American Medical Directors Association, 21(4), 500–507.e8. https://doi.org/10.1016/j.jamda.2020.01.102

Charleston PSCI:

Focus: Transitions of care between VHA and community care

Aims: The goal of this PSCI is to improve the safety of care transitions between VA and non-VA care settings through the development and testing of novel tools and interventions to improve information exchange, medication management, and care coordination across healthcare systems.

FY 2020 Publications:

1. Mendhi, M. M., Pope, C., Newman, S. D., Cartmell, K. B., & Premji, S. (2020). Perceptions of traditional birth attendants and midwives related to neonatal airway management in rural Uganda: a focused ethnographic qualitative study. Journal of Global Health Reports, 4, e2020088.
2. Mendhi, M. M., Premji, S., Cartmell, K. B., Newman, S. D., & Pope, C. (2020). Self-efficacy measurement instrument for neonatal resuscitation training: An integrative review. Nurse education in practice, 43, 102710.

Denver PSCI:

Focus: Suicide Prevention

Aims: The goal of this PSCI is to develop empirically supported and replicable methods of outreach to Veterans who do not use VA for healthcare to connect them with suicide prevention services.

FY 2020 Publications:

1. DeBeer, B. B., Baack, S., Bongiovanni, K., Borah, E., Bryan, C., Bryant, K., Cassidy, R., Clafferty, S., Degutis, L., Franciosi, G., Heise, J., Hoffmire, C., Keene, Mignogna, J., Mohatt, N., Monteith, L., Peterson, A., Pierson, D., Villarreal, E., Weinberg K., Williams, M., Synett, S., & Benzer, J. (2020). The Veterans Affairs Patient Safety Center of Inquiry—Suicide Prevention Collaborative: Creating Novel Approaches to Suicide Prevention Among Veterans Receiving Community Services. Federal practitioner, 37(11), 512.

Greater Los Angeles PSCI:

Focus: Transitions of care for complex, geriatric patients

Aims: The goal of this PSCI focuses on transitions of care for complex Veterans, particularly elderly Veterans, with their transitions into and out of the hospital for surgical procedures and for medical conditions, with a goal of testing the transition-specific tools and processes in the reduction of adverse events/targeted patient safety areas with subsequent dissemination to other sites.

FY 2020 Publications:

1. Wilkins SS, Melrose RJ, Hall KS, Blanchard E, Castle SC, Kopp T, Katzel LI, Holder A, Alexander N, McDonald MKS, Tayad A, Forman DE, Abbate LM, Harris R, Valencia WM, Morey MC, Lee CL. (2020). PTSD Improvement Associated with Social Connectedness in Gerofit Veterans Exercise Program. J Am Geriatri Soc, doi: 10.1111/jgs.16973 PMID: 33368144
2. Jennings SC, Manning KM, Prvu Bettger J, Hall KM, Pearson M, Mateas C, Briggs BC, Oursler KK, Blanchard E, Lee CL, Castle S, Valencia WM, Katzel LI, Giffuni M, Kopp T, McDonald M, Harris R, Bean JF, Athuis K, Alexander NB, Padala KP, Abbate LM, Wellington T, Kostra J, Allsup K, Forman DE, Tayade AS, Wesley AD, Holder A, Morey MC. (2020) Rapid Transition to Telehealth Group Exercise and Functional Assessments in Response to COVID-19. Gerontology & Geriatric Medicine vol 6:1-11 https://doi.org/10.1177/2333721420980313
3. Weiner DK, Gentili A, Fang MA, Garay E, Annaswamy T, Castle S, Joseph L, Lawson L, Lee CC, Makris UE, Rossi MI, Thorn B, Clemens K, Newman D, Perera S. (2020). Caring for older veterans with chronic low back pain using a geriatric syndrome approach: Rationale and methods for the aging back clinics (ABC) trial. Contemp Clin Trials, Aug; 95:106077. doi: 10.1016/j.cct.2020.106077. Epub 2020 Jun 25. PubMed PMID: 32593717.

Houston PSCI:

Focus: Diagnostic errors and delays

Aims: The goal of this PSCI is to develop, implement, and evaluate tools and strategies for measurement and feedback related to missed test results using collaborative approaches to engage clinicians and facility leadership to improve diagnostic safety.

FY 2020 Publications:

1. Bergl PA, Taneja A, El-Kareh R, Singh H, Nanchal RS. (2019). Frequency, Risk Factors, Causes, and Consequences of Diagnostic Errors in Critically Ill Medical Patients: A Retrospective Cohort Study. Crit Care Med, Nov;47(11): e902-e910. doi: 10.1097/CCM.0000000000003976. PMID: 31524644.
2. Gandhi TK, Singh H. (2020) Reducing the Risk of Diagnostic Error in the COVID-19 Era. J Hosp Med, Jun;15(6):363-366. doi: 10.12788/jhm.3461. PMID: 32490798; PMCID: PMC7289509.
3. Kravet S, Bhatnagar M, Dwyer M, Kjaer K, Evanko J, Singh H. (2019). Prioritizing Patient Safety Efforts in Office Practice Settings. J Patient Saf, Dec;15(4): e98-e101. doi: 10.1097/PTS.0000000000000652. PMID: 31764534.
4. Mahajan P, Basu T, Pai CW, Singh H, Petersen N, Bellolio MF, Gadepalli SK, Kamdar NS. (2020). Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department. JAMA Netw Open, Mar 2;3(3): e200612. doi: 10.1001/jamanetworkopen.2020.0612. PMID: 32150270; PMCID: PMC7063499.
5. Mahajan P, Mollen C, Alpern E, Baird-Cox, Boothman R, Chamberlain J, Cosby K, Epstein HM, Genenheimer-Holmes J, Gerardi M, Giardina TD, Patel V, Ruddy R, Saleem J, Shaw K, Sittig DF, Singh H. (2019). An Operational Framework to Study Diagnostic Errors in Emergency Departments. Journal of Patient safety, Nov 25. doi: 10.1097/PTS.0000000000000624. PMID: 31790012

6. Meyer AND, Upadhyay DK, Collins CA, Fitzpatrick MH, Kobylinski M, Bansal AB, Torretti D, Singh H. (2020). A Program to Provide Clinicians with Feedback on Their Diagnostic Performance in a Learning Health System. Jt Comm J Qual Patient Saf, Aug 29: S1553-7250(20)30234-8. doi: 10.1016/j.jcjq.2020.08.014. Epub ahead of print. PMID: 32980255.
7. Murphy DR., Giardina TD, Satterly T, Sittig DF, Singh H. (2019). An Exploration of Barriers, Facilitators, and Suggestions for Improving Electronic Health Record Inbox-Related Usability. A Qualitative Analysis. JAMA Network Open, 2(10): e1912638. doi:10.1001/jamanetworkopen.2019.12638. PMID: 31584683
8. Powell L, Sittig DF, Chrouser K, Singh H. (2020). Assessment of Health Information Technology-Related Outpatient Diagnostic Delays in the US Veterans Affairs Health Care System: A Qualitative Study of Aggregated Root Cause Analysis Data. JAMA Netw Open, Jun; 3(6): e206752. doi: 10.1001/jamanetworkopen.2020.6752. PMID: 32584406
9. Singh H, Bradford A, Goeschel C. (2020). Operational Measurement of Diagnostic Safety: State of the Science. Diagnosis (Berl), Jul 25:/j/dx.ahead-of-print/dx-2020-0045/dx-2020-0045.xml. doi: 10.1515/dx-2020-0045. Online ahead of print. PMID: 32706749
10. Singh H, Graber ML, Hofer TP. (2019). Measures to Improve Diagnostic Safety in Clinical Practice. J Patient Saf, Dec;15(4):311-316. doi: 10.1097/PTS.0000000000000338. PMID: 27768655; PMCID: PMC5398940.
11. Singh H, Sittig DF, Gandhi TK. (2020). Fighting a Common Enemy: A Catalyst to Close Intractable Safety Gaps. BMJ Quality & Safety Published Online First, 16 July. doi: 10.1136/bmjqs-2020-011390
12. Singh H, Sittig DF. (2020). A Sociotechnical Framework for Safety-Related Electronic Health Record Research Reporting: The SAFER Reporting Framework. Ann Intern Med, 172: S92-S100. doi:10.7326/M19-0879
13. Singh H, Upadhyay DK, Torretti D. (2020). Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan. Acad Med, Aug;95(8):1172-1178. doi: 10.1097/ACM.0000000000003062. PMID: 31688035; PMCID: PMC7402609.
14. Sittig DF, Singh H. (2020). COVID-19 and the Need for a National Health Information Technology Infrastructure. JAMA, Jun 16;323(23):2373-2374. doi: 10.1001/jama.2020.7239. PMID: 32421178.
15. Sittig, DF, Ash JS, Wright A, Chase D, Gebhardt E, Russo EM, Tercek C, Mohan V, Singh H. (2020). How Can We Partner with Electronic Health Record Vendors on the Complex Journey to Safer Health Care? Journal of Healthcare Risk Management.
16. Zhou Y, van Melle M, Singh H, Hamilton W, Lyratzopoulos G, Walter FM. (2019). Quality of the diagnostic process in patients presenting with symptoms suggestive of bladder or kidney cancer: a systematic review. BMJ Open, Oct 3;9(10): e029143. doi: 10.1136/bmjopen-2019-029143. PMID: 31585970; PMCID: PMC6797416.
17. Zhou, Y, Abel GA, Hamilton W, Singh H, Walter FM, Lyratzopoulos G. (2020). Imaging Activity Possible Signalling Missed Diagnostic Opportunities in Bladder and Kidney Cancer: A Longitudinal Data-Linkage Study Using Primary Care Electronic Health Records, April 22. Available at: https://authors.elsevier.com/sd/article/S1877782120300370
18. Zwaan L, Singh H. (2020). Diagnostic Error in Hospitals: Finding Forests not Just the Big Trees. BMJ Quality & Safety.

Iowa City PSCI:

Focus: Antimicrobial Stewardship and Prevention of Multidrug resistant Organisms

Aims: The goal of this PSCI is to develop and test automated risk-adjusted metrics for antimicrobial stewardship programs (ASPs) that are adaptable to the diverse care settings across VHA facilities; to develop evaluation tools for ASPs and the MDRO prevention program that are adaptable to the diverse nature of care settings among VHA facilities; and to develop outcome tracking system for ASP and MDRO prevention program utilizing information technologies.

Puget Sound PSCI:

Focus: Opioid Safety

Aims: The goal of this PSCI is to reduce the distribution of opioid medication through using a stepped care model of using real time alerts for visits, office based pharmacologic treatment using a chronic care management team (CCM).

Tampa PSCI:

Focus: Falls and Mobility

Aims: The goal of this PSCI is to prevent adverse events related to mobility through the evaluation of best practices in fall injury prevention in the VHA, looking at assisted falls in the VHA, post fall virtual simulation training, and evaluation of injury prevention practices related to sling and transfer device utilization.

FY 2020 Publications:

1. Alderden, J., Cowan, L. J., Dimas, J. B., Chen, D., Zhang, Y., Cummins, M., & Yap, T. L. (2020). Risk Factors for Hospital-Acquired Pressure Injury in Surgical Critical Care Patients. American Journal of Critical Care, 29(6), e128-e134.
2. Allen L, Bulat T, Uphold CR, Johnson T 2nd, Winkler SL. (2020). Using a Post Fall Assessment Simulation to Examine Nurse Thought Processes [published online ahead of print, Jul 10]. J Nurses Prof Dev. 2020;10.1097/NND.0000000000000662. doi:10.1097/NND.0000000000000662
3. Barrett B, Schultz SK, Luther SL, Friedman Y, Cowan L, Bulat T. (2020). Mortality and Associated Risk Factors in Community-Dwelling Persons with Early Dementia. Alzheimer Disease Associated Disorders, Jan-Mar;34(1):40-46. doi: 10.1097/WAD.0000000000000343. PMID: 31478918.
4. Barrett, B., Peterson, M. J., Phillips, S., Lloyd, J., Cowan, L., Friedman, Y., Ramaiah, P., Neily, J., & Bulat, T. (2020). Evaluation of protective properties of commercially available medical helmets: Are medical helmets protective? Journal of Patient Safety, June.DOI: 10.1097/PTS.0000000000000736
5. Cowan L, Broderick V, Alderden JG. (2020). Pressure Injury Prevention Considerations for Older Adults. Crit Care Nurs Clin North Am, Dec;32(4):601-609. doi: 10.1016/j.cnc.2020.08.009. PMID: 33129417.
6. Rugs, D., Barrett, B., Chavez, M., Cowan, L., Melillo, C., Cox Sullivan, S., Engstrom, C., Witz Rugen, K., Toyinbo, P., & Powell-Cope, G. (2020). Doctoral-prepared nurses in the Veterans Health Administration: A cross-sectional survey. Journal of Professional Nursing. 36 (1), January-February 2020, 62-68. https://www.sciencedirect.com/science/article/pii/S8755722319300900?dgcid=author
7. Rugs, D., Powell-Cope, G., Campo, M., Darragh, A., Harwood, K., Kuhn, J., & Rockefeller, K. (2020). The use of safe patient handling and mobility equipment in Veterans Health Administration. Work: A Journal of Prevention, Assessment & Rehabilitation, 66(1):31-40. doi: 10.3233/WOR-203148.

White River Junction PSCI:

Focus: Suicide Prevention

Aims: The goals of this PSCI include working with VA-BIC at White River Junction by conducting a non-randomized pilot study of the intervention in Veterans being discharged from inpatient mental health. The PSCI also aims to complete three database projects looking at analyzing clinical notes to determine if clinicians use increased distancing language with patients how later die by suicide, looking at hypoxia-related and geographic links to suicide, and the effect of medications for opioid use disorder on preventing death by suicide.

FY 2020 Publications:

1. Aboumrad M, Shiner B, Mucci L, Neupane N, Schroeck FR, Klaassen Z, Freedland SJ, Young-Xu Y. (2020). Posttraumatic stress disorder and suicide among veterans with prostate cancer. Psychooncology, Nov 28. doi: 10.1002/pon.5605. Epub ahead of print. PMID: 33247977.
2. Levis M, Leonard Westgate C, Gui J, Watts BV, Shiner B. (2020). Natural language processing of clinical mental health notes may add predictive value to existing suicide risk models. Psychol Med 2020. doi: 10.1017/S0033291720000173
3. Peltzman T, Gottlieb DJ, Shiner B, Riblet N, Watts BV. (2020). Electroconvulsive therapy in Veterans Health Administration Hospitals: Prevalence, Patterns of Use, and Patient Characteristics. J ECT, 36: 130-136. doi: 10.1097/YCT.0000000000000635.
4. Peltzman T, Shiner B, Watts BV. Effects of electroconvulsive therapy on short-term suicide mortality in a risk- matched patient population. (2020). J ECT. doi: 10.1097/YCT.0000000000000665
5. Riblet NB, Gottlieb DJ, Hoyt JE, Watts BV, Shiner B. (2020). An analysis of the relationship between chronic obstructive pulmonary disease, smoking and depression in an integrated healthcare system. Gen Hosp Psychiatry; 64: 72-79. Doi: 10.1016/j.genhosppsych.2020.03.007.
6. Riblet NB, Gottlieb DJ, Shiner B, Cornelius SL, Watts BV. (2020). Associations between Medication Assisted Therapy Services Delivery and Mortality in a National Cohort of Veterans with Posttraumatic Stress Disorder and Opioid Use Disorder. J Dual Diagnosis, 16: 228-238. doi: 10.1080/15504263.2019.1701218.
7. Riblet NB, Kenneally L, Shiner B, Watts BV. (2019). Healthcare processes contributing to suicide risk in veterans during and after residential substance abuse treatment. Journal of Dual Diagnosis, 15: 217-225.
8. Riblet NB, Shiner B, Schnurr P, Bruce ML, Wasserman D, Cornelius S, Scott R, Watts BV. (2019). A pilot study of an intervention to prevent suicide after psychiatric hospitalization. J Nerv Ment Dis, 207: 1031-1038. doi: 10.1097/NMD.0000000000001061.
9. Riblet NB, Shiner B, Watts BV, Britton P. (2019). Comparison of national and local approaches to detecting suicides in healthcare settings. Mil Med, 184: e555-e560. doi: 10.1093/milmed/usz045
10. Riblet NB, Stevens SP, Watts BV, Shiner, B. (2020). A pandemic of body, mind, and spirit: the burden of “social distancing” in rural communities during an era of heightened suicide risk. J Rural Health. doi: 10.1111/jrh.12456.
11. Shiner B, Peltzman T, Cornelius SL, Gui J, Forehand J, Watts BV. (2020). Recent trends in the rural-urban suicide disparity among veterans using VA health care. J Behav Med, Sep 11. doi: 10.1007/s10865-020-00176-9. Epub ahead of print. PMID: 32915350.

Chapter 11: NCPS Tools and Products

NCPS produces policy and guidance to further high quality and safe patient care across the VA organization. There is a current effort to update the NCPS resources available on the updated intranet website https://vaww.qps.med.va.gov/divisions/ncps/ncpsDefault.aspx. In FY 2020, NCPS updated the following guidance documents:

1. Healthcare Failure Modes and Affects Analysis HFMEA Guidebook, HFMEA Guidebook
2. Joint Patient Safety Reporting (JPSR) system Business Rules and Guidebook, JPSR Guidebook
3. Guide to Performing a Root Cause Analysis (RCA), RCA Guidebook

From: Lieberman, Steven
Sent: Fri, 30 Jul 2021 19:57:14 +0000
To: (b)(6)
Subject: RE: Operations Update

Sir,

Thank you for taking the time to reach out and sharing your thoughts with me. I find it helpful to hear all perspectives from staff.

Thank you also for what you do at VA.

From: (b)(6) (b)(6)
Sent: Friday, July 30, 2021 3:25 PM
To: Lieberman, Steven (b)(6)
Subject: RE: Operations Update

Dear Sir,

I believe the decision to mandate vaccinations is not the answer. There are many studies, and even admission from the CDC, that the Covid-19 vaccine does not offer complete protection from Covid-19 . It does not ensure that once vaccinated that you cannot get the virus, nor does it ensure that you cannot transmit the virus to others. Even today both the CDC and the Whitehouse acknowledged as much. The vaccine itself has not yet been FDA approved and I find it troubling that the manufacturer are exempt from any liability with regard to any and all adverse outcomes after receiving the vaccine. Many feel that the risks outweigh the rewards and I guess that this is OK if you are not one of the "risk" citizens who suffer an adverse reaction or dies as a result of receiving the vaccine. When first introduced we were told that the vaccine was completely safe and that one could expect a sore arm at the injection site. Soon afterwards, when people were becoming ill after receiving the vaccine, we were told that one could expect "mild flu-like symptoms". Notice that they didn't say "Covid-like" symptoms. I guess that would have been too alarming to the general public. Next there were some people who developed, and some who died from, blood clots. This was never mentioned as a possible adverse reaction to the vaccine. So either they knew about the possibility and didn't disclose it, or this was an unexpected event that they hadn't anticipated. I personally have two friends that developed clots; one of which died as a result of it. So for them the rewards did not outweigh the risks. There are also now the cases if myocarditis and pericarditis. Again, I do not recall these being listed as possible side effects or adverse reactions to this not yet FDA approved vaccine. These are precisely the types of incident that one can expect when there is a rush to market of a drug. Thalidomide, Ranitidine, and various other drugs, once thought to be safe are examples of drugs with good intentions that have ended up harming the population that they were developed to help.

Why the rush to mandate vaccination? If masks work, then why force vaccination? If people feel vulnerable, then let them take the precautions that they need in order to feel safe? Why can't the VA, like other institutions, provide its employees the option of frequent testing and masking as an option to vaccination? In his speech earlier today President Biden stated *that "every federal government employee*

and on-site contractor will be asked to attest to their vaccination status. Employees who have not been vaccinated will be required to wear a mask on the job no matter their geographic location, physically distance from all other employees and visitors, comply with a weekly or twice weekly screening testing requirement, and be subject to restrictions on official travel." I ask why this option is not available to us?

If forced vaccination is the way the VA wants to proceeded, then in order to ensure the safety of all veterans and families who enter our facilities, then why isn't it being required off all VA employees such as Title 5 employees, GS workers, etc.? It would seem that if one has the authority to force vaccination on Title 38 employees, and were truly concerned about the health of anyone entering a VA facility, one would make the requirement applicable to all employees. One would have to agree that the chance of a veteran coming in contact with non-Title 38 employees, in a hallway, clinic, canteen, etc. is an almost a certainty.

I respectfully ask you to reconsider the forced vaccination requirement.

From: US Department of Veterans Affairs (b)(6)
Sent: Thursday, July 29, 2021 10:23 AM
To: US Department of Veterans Affairs (b)(6)
Subject: Operations Update

MESSAGE FROM THE VHA OFFICE OF THE UNDER SECRETARY FOR HEALTH
July 29, 2021
Operations Update

Today, as I promised in my last message, I want to give you some insight into my leadership style. One of the styles I prefer is servant leadership. Servant leadership is a timeless concept, but the phrase itself was coined by Robert K. Greenleaf, who believed that a servant-leader organization can change the world. He said, "caring for persons, the more able and the less able serving each other, is the rock upon which is a good society is built." To me that means empowering you, the VHA staff, to ensure your success and to give you the opportunity to have as much input into leadership decisions as possible.

As a leader, listening is important because it enables me to learn best practices – both internally and externally. As an organization, implementing these best practices across the enterprise consistently is critical to ensuring all our Veterans can benefit from these best practices. I also believe in communicating often, including before deciding, while deciding, and then after a decision has been made. For example, this week the Secretary mandated the COVID-19 vaccine for Title 38 employees. This includes physicians, registered nurses, physician's assistants, podiatrists, chiropractors, optometrists, and dentists. We did not make this decision lightly. As I mentioned in my last message, we are going through another tough time with the pandemic. We are seeing a surge in cases due to the Delta variant and low vaccination rates. These increases in cases are resulting in increased hospitalizations and deaths. Unfortunately, this includes the Veterans we care for and our colleagues.

I am saddened by the fact that in the past few weeks, we have lost 5 more of our coworkers to COVID-19. The scientific data tells us that almost everyone who gets seriously ill or dies from the virus was not vaccinated. That is why we made the decision to require Title 38

employees to get vaccinated. The decision is about protecting the Veterans we serve and about protecting you.

It's important to hear from you. If you have something to tell me or if you have any ideas, I want to hear what you have to say. So, please email and let me know what's on your mind. Thank you for all you are doing, and please stay safe.

View today's video message.

Steven L. Lieberman, M.D.
Deputy to the Deputy Under Secretary for Health
Performing the Delegable Duties of Under Secretary for Health
Employee Wellness Resources

From: Lieberman, Steven
Sent: Fri, 30 Jul 2021 11:44:38 +0000
To: (b)(6)
Subject: RE: Operations Update

(b)(6)

Thank you for taking the time to reach out and share your thoughts with me. I have been hearing from a lot of staff and appreciate getting the perspectives of our staff.

From: (b)(6) (b)(6)
Sent: Thursday, July 29, 2021 11:12 PM
To: Lieberman, Steven (b)(6)
Subject: RE: Operations Update

In response to your attached email, and your invitation for response emails from concerned employees regarding the recent mandate for all VA Title 38 employees to receive the COVID-19 immunization:

Having over twenty-seven years of nursing experience and nearly seventeen years with the VA Healthcare System, in addition to many hours of research on the COVID-19 and subsequent injection, I have multiple concerns for myself, my peers, and the veteran's that I care for. Our veterans had a choice to take the immunization, and several declined to receive it. We, as community based nurses followed preventative guidelines and never stopped working, even though many other employees at the VA exercised their work from home privileges. Did we ask for, or receive, any incentive or bonus monies that were allocated? No. We continued the professional care that our veteran's deserve and receive through our program. Now that much more information is available, albeit not accurately on the mainstream media or accurately on the CDC and VAERS websites, I believe that staff should be allowed to make educated decisions of their own.

Testing: It is now known that PCR testing has not been accurate and recently the CDC has even changed their views and will be changing future testing to differentiate between Coronavirus and Influenza virus. The cycle threshold has also been addressed(decreased).

Immunizations: These are still classified and administered under "Emergency Use Authorization" by the F.D.A. and not fully approved. These injections are still in a clinical trial and the trials do not end until 2023. The injection itself is not a vaccine for a virus. It is an injection of a spike protein mRNA sequence which is computer generated and not derived from nature. This technology has been known of and patented for several years. In fact, the original patent for mRNA vaccine was rejected because it did not meet the legal definition of a vaccine.

Adverse effects: As these injections are still in clinical trials, data is still being collected, however recent numbers on the Vaccine Adverse Event Reporting System(VAERS), listed adverse reactions of greater that 450,000 and deaths at near 11,000. This number is questionable at best as numbers have altered randomly with no reason. Per the site, actual reporting is generally 1%-10% . That allows for a large discrepancy in actual adverse reactions or deaths.

I have attached a copy of the Nuremberg Code(1947). The Nuremberg Code is a set of ethical research principles, created in the wake of Nazi atrocities, specifically the inhumane and often fatal experimentation on humans without consent during World War 2. The first code itself reads as follows;

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision".

There are a total of ten standards, and I can give my interpretation of each and the reason that I believe that mandating an E.U.A. injection vs a fully approved one, is a direct ignorance of principles that some intelligent people developed years ago to prevent history from repeating itself. It is important that all parties involved in this recent mandate familiarize themselves with the Nuremberg Code and give dedicated caregivers a choice. I will be doing my part in educating people that want to continue delivering the great care that we do to our veterans.

Thank you for your time,

Sincerely,

(b)(6)

From: US Department of Veterans Affairs (b)(6)
Sent: Thursday, July 29, 2021 12:23 PM
To: US Department of Veterans Affairs (b)(6)
Subject: Operations Update

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July 29, 2021
Operations Update

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I am saddened by the fact that in the past few weeks, we have lost 5 more of our coworkers to COVID-19. The scientific data tells us that almost everyone who gets seriously ill or dies from the virus was not vaccinated. That is why we made the decision to require Title 38 employees to get vaccinated. The decision is about protecting the Veterans we serve and

about protecting you.

It's important to hear from you. If you have something to tell me or if you have any ideas, I want to hear what you have to say. So, please email and let me know what's on your mind. Thank you for all you are doing, and please stay safe.

View today's video message.

Steven L. Lieberman, M.D.
Deputy to the Deputy Under Secretary for Health
Performing the Delegable Duties of Under Secretary for Health
Employee Wellness Resources

From: (b)(6)
Sent: Fri, 30 Jul 2021 03:11:49 +0000
To: Lieberman, Steven
Subject: RE: Operations Update
Attachments: NC.docx

In response to your attached email, and your invitation for response emails from concerned employees regarding the recent mandate for all VA Title 38 employees to receive the COVID-19 immunization:

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Thank you for your time,
Sincerely,
(b)(6)

From: US Department of Veterans Affairs (b)(6)
Sent: Thursday, July 29, 2021 12:23 PM
To: US Department of Veterans Affairs (b)(6)
Subject: Operations Update

MESSAGE FROM THE VHA OFFICE OF THE UNDER SECRETARY FOR HEALTH
July 29, 2021
Operations Update

Today, as I promised in my last message, I want to give you some insight into my leadership style. One of the styles I prefer is servant leadership. Servant leadership is a timeless concept, but the phrase itself was coined by Robert K. Greenleaf, who believed that a servant-leader organization can change the world. He said, "caring for persons, the more able and the less able serving each other, is the rock upon which is a good society is built." To me that means empowering you, the VHA staff, to ensure your success and to give you the opportunity to have as much input into leadership decisions as possible.

As a leader, listening is important because it enables me to learn best practices – both internally and externally. As an organization, implementing these best practices across the enterprise consistently is critical to ensuring all our Veterans can benefit from these best practices. I also believe in communicating often, including before deciding, while deciding, and then after a decision has been made. For example, this week the Secretary mandated the COVID-19 vaccine for Title 38 employees. This includes physicians, registered nurses, physician's assistants, podiatrists, chiropractors, optometrists, and dentists. We did not make this decision lightly. As I mentioned in my last message, we are going through another tough time with the pandemic. We are seeing a surge in cases due to the Delta variant and low vaccination rates. These increases in cases are resulting in increased hospitalizations and deaths. Unfortunately, this includes the Veterans we care for and our colleagues.

I am saddened by the fact that in the past few weeks, we have lost 5 more of our coworkers to COVID-19. The scientific data tells us that almost everyone who gets seriously ill or dies from the virus was not vaccinated. That is why we made the decision to require Title 38 employees to get vaccinated. The decision is about protecting the Veterans we serve and about protecting you.

It's important to hear from you. If you have something to tell me or if you have any ideas, I want to hear what you have to say. So, please email and let me know what's on your mind. Thank you for all you are doing, and please stay safe.

View today's video message.

Steven L. Lieberman, M.D.
Deputy to the Deputy Under Secretary for Health
Performing the Delegable Duties of Under Secretary for Health
Employee Wellness Resources

Introduction

The judgment by the war crimes tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human subjects in a new code that is now accepted worldwide. This judgment established a new standard of ethical medical behaviour for the post World War II human rights era. Amongst other requirements, this document enunciates the requirement of voluntary informed consent of the human subject. The principle of voluntary informed consent protects the right of the individual to control his own body. This code also recognizes that the risk must be weighed against the expected benefit, and that unnecessary pain and suffering must be avoided. This code recognizes that doctors should avoid actions that injure human patients. The principles established by this code for medical practice now have been extended into general codes of medical ethics. The Nuremberg Code (1947) Permissible Medical Experiments The great weight of the evidence before us to effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10.During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experime

Sent: Fri, 30 Jul 2021 19:52:57 +0000
To: (b)(6)
Subject: RE: Operations Update

I appreciate your taking the time to reach out and sharing your thoughts with me including about the mandate.

I am in favor of mandating for all staff that come into our facilities. It was a big hurdle to get the title 38 staff mandate to go forward. There are additional legal barriers for the other classifications of staff which we are being worked through. We believed it worthwhile going live with Title 38 rather than wait for the other groups to be approved, as the sooner more are vaccinated, the more our patients and staff will be protected. I hope we can get those other groups as part of the mandate soon. This is a priority.

Thank you again and thank you for what you do at VA.

From: (b)(6) b)(6)
Sent: Friday, July 30, 2021 3:25 PM
To: Lieberman, Steven (b)(6)
Subject: RE: Operations Update

Dear Sir,

I believe the decision to mandate vaccinations is not the answer. There are many studies, and even admission from the CDC, that the Covid-19 vaccine does not offer complete protection from Covid-19 . It does not ensure that once vaccinated that you cannot get the virus, nor does it ensure that you cannot transmit the virus to others. Even today both the CDC and the Whitehouse acknowledged as much. The vaccine itself has not yet been FDA approved and I find it troubling that the manufacturer are exempt from any liability with regard to any and all adverse outcomes after receiving the vaccine. Many feel that the risks outweigh the rewards and I guess that this is OK if you are not one of the “risk” citizens who suffer an adverse reaction or dies as a result of receiving the vaccine. When first introduced we were told that the vaccine was completely safe and that one could expect a sore arm at the injection site. Soon afterwards, when people were becoming ill after receiving the vaccine, we were told that one could expect “mild flu-like symptoms”. Notice that they didn’t say “Covid-like” symptoms. I guess that would have been too alarming to the general public. Next there were some people who developed, and some who died from, blood clots. This was never mentioned as a possible adverse reaction to the vaccine. So either they knew about the possibility and didn’t disclose it, or this was an unexpected event that they hadn’t anticipated. I personally have two friends that developed clots; one of which died as a result of it. So for them the rewards did not outweigh the risks. There are also now the cases if myocarditis and pericarditis. Again, I do not recall these being listed as possible side effects or adverse reactions to this not yet FDA approved vaccine. These are precisely the types of incident that one can expect when there is a rush to market of a drug. Thalidomide, Ranitidine, and various other drugs, once thought to be safe are examples of drugs with good intentions that have ended up harming the population that they were developed to help.

Why the rush to mandate vaccination? If masks work, then why force vaccination? If people feel vulnerable, then let them take the precautions that they need in order to feel safe? Why can't the VA, like other institutions, provide its employees the option of frequent testing and masking as an option to vaccination? In his speech earlier today President Biden stated *that "every federal government employee and on-site contractor will be asked to attest to their vaccination status. Employees who have not been vaccinated will be required to wear a mask on the job no matter their geographic location, physically distance from all other employees and visitors, comply with a weekly or twice weekly screening testing requirement, and be subject to restrictions on official travel."* I ask why this option is not available to us?

If forced vaccination is the way the VA wants to proceeded, then in order to ensure the safety of all veterans and families who enter our facilities, then why isn't it being required off all VA employees such as Title 5 employees, GS workers, etc.? It would seem that if one has the authority to force vaccination on Title 38 employees, and were truly concerned about the health of anyone entering a VA facility, one would make the requirement applicable to all employees. One would have to agree that the chance of a veteran coming in contact with non-Title 38 employees, in a hallway, clinic, canteen, etc. is an almost a certainty.

I respectfully ask you to reconsider the forced vaccination requirement.

From: US Department of Veterans Affairs (b)(6)
Sent: Thursday, July 29, 2021 10:23 AM
To: US Department of Veterans Affairs (b)(6)
Subject: Operations Update

MESSAGE FROM THE VHA OFFICE OF THE UNDER SECRETARY FOR HEALTH
July 29, 2021
Operations Update

Today, as I promised in my last message, I want to give you some insight into my leadership style. One of the styles I prefer is servant leadership. Servant leadership is a timeless concept, but the phrase itself was coined by Robert K. Greenleaf, who believed that a servant-leader organization can change the world. He said, "caring for persons, the more able and the less able serving each other, is the rock upon which is a good society is built." To me that means empowering you, the VHA staff, to ensure your success and to give you the opportunity to have as much input into leadership decisions as possible.

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Steven L. Lieberman, M.D.
Deputy to the Deputy Under Secretary for Health
Performing the Delegable Duties of Under Secretary for Health
Employee Wellness Resources

From: Taylor, Beth A
Sent: Tue, 4 May 2021 18:09:58 +0000
To: Lieberman, Steven;Matthews, Kameron
Cc: Llorente, Maria D.;Strawn, Jennifer A.;Kelley, Kimberly
Subject: RE: opiate use during covid
Attachments: 2021_03_OSI All Metrics (003).pptx, 2021_03_Pain_Fact_Sheet (003).docx

I hope these will open for you!

From: Lieberman, Steven (b)(6)
Sent: Monday, May 3, 2021 9:16 PM
To: Taylor, Beth A (b)(6) Matthews, Kameron (b)(6)
Cc: Llorente, Maria D. (b)(6) Strawn, Jennifer A. (b)(6) Kelley, Kimberly (b)(6)
Subject: RE: opiate use during covid

Thanks. Both of these files appear restricted, such that I am unable to open them.

From: Taylor, Beth A (b)(6)
Sent: Monday, May 3, 2021 1:01 PM
To: Matthews, Kameron (b)(6) Lieberman, Steven (b)(6)
Cc: Llorente, Maria D. (b)(6) Strawn, Jennifer A. (b)(6) Kelley, Kimberly (b)(6)
Subject: FW: opiate use during covid

Some follow up from your questions this morning. Mike looped additional folks into the conversation as well.

From: Valentino, Michael (VACO) (b)(6)
Sent: Monday, May 3, 2021 11:37 AM
To: Taylor, Beth A (b)(6) Kligler, Benjamin (b)(6) Llorente, Maria D. (b)(6)
Cc: Strawn, Jennifer A. (b)(6) Sandbrink, Friedhelm (b)(6) Emmendorfer, Thomas (PBM) (b)(6) Carroll, David (VACO) (b)(6) Mole, Larry A. (b)(6)
Subject: RE: opiate use during covid

(b)(5)

(b)(5)

(b)(5)

Adding Drs. Sandbrink, Carroll, Mole and Emmendorfer for additional input.

Mike

From: Taylor, Beth A (b)(6)
Sent: Monday, May 3, 2021 11:08 AM
To: Valentino, Michael (VACO) (b)(6) Kligler, Benjamin (b)(6) Llorente, Maria D. (b)(6)
Cc: Strawn, Jennifer A. (b)(6)
Subject: FW: opiate use during covid

Forwarding for response to Dr. Lieberman. Please include other SME's who might contribute. Thanks all!

From: Lieberman, Steven (b)(6)
Sent: Monday, May 3, 2021 10:44 AM
To: Taylor, Beth A (b)(6) Matthews, Kameron (b)(6)
Cc: Kelley, Kimberly (b)(6)
Subject: opiate use during covid

There was a recent publication highlighting that opiate use is up for managing long-term sequelae of covid. Sec VA and A Dep Sec were discussing this today.

(b)(5)

(b)(5)

(b)(5)

Any other thoughts on this topic?

Thank you very much

VA | U.S. Department of Veterans Affairs

Opioid Safety Initiative

VIEWPOINT

Addressing the Opioid Epidemic in the United States

Lessons From the Department of Veterans Affairs

Walid F. Gellad, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

Chester B. Good, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

David J. Shulkin, MD
Office of the Under Secretary for Health, US Department of Veterans Affairs, Washington, DC.

Over the past 15 years, more than 165 000 people in the United States have died from overdoses related to prescription opioids,[1] and millions more have suffered adverse consequences.[2,3] The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.[1]

Patients treated in the health care system of the Department of Veterans Affairs (VA) are part of this epidemic. C… impacts half of veterans using the VA, com… …hiatric comorbidities suc… stress … office … tices, opio… near… VA …

ti… a… ment's data capabili… tives reduced the use of opioid me… proved the safety of opioid prescribing, while expanding alternative pain therapies (**Figure**). By mid-2016 compared with mid-2012, the number of veterans dispensed an opioid each quarter had decreased by 172 000, or about 25%. Moreover, there were 57 000 (47%) fewer patients receiving concomitant opioids and benzodiazepines and 22 000 (36%) fewer patients receiving daily opioid dosages of more than 100 morphine-milligram equivalents, both measures of potentially unsafe opioid use. Between 2010 and 2015, the rate of

pharmacists engage directly with opioid prescribers, similar to detailing by pharmaceutical representatives. The VA detailers use sophisticated dashboards with real-time prescriber-level data to engage clinicians in adopting best practices around opioid prescribing. This focus is not simply on reducing opioid medications, but rather on improving the safe use of opioids. Beyond detailing, the VA developed an overdose education and naloxone distribution system that has distributed tens of thousands of naloxone doses and developed standardized patient and provider education to comple… …r educational efforts outside of the VA that

Strategies to Address the Opioid Epidemic
The VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment (eTable in the Supplement).

…macologic (… expanded mini-residency … consult capabilities for primary care clinici… prove their management of pain.

Risk Mitigation

The VA implemented several strategies to support and track risk mitigation activities for opioid therapy (eTable in the Supplement). A key component of the Opioid

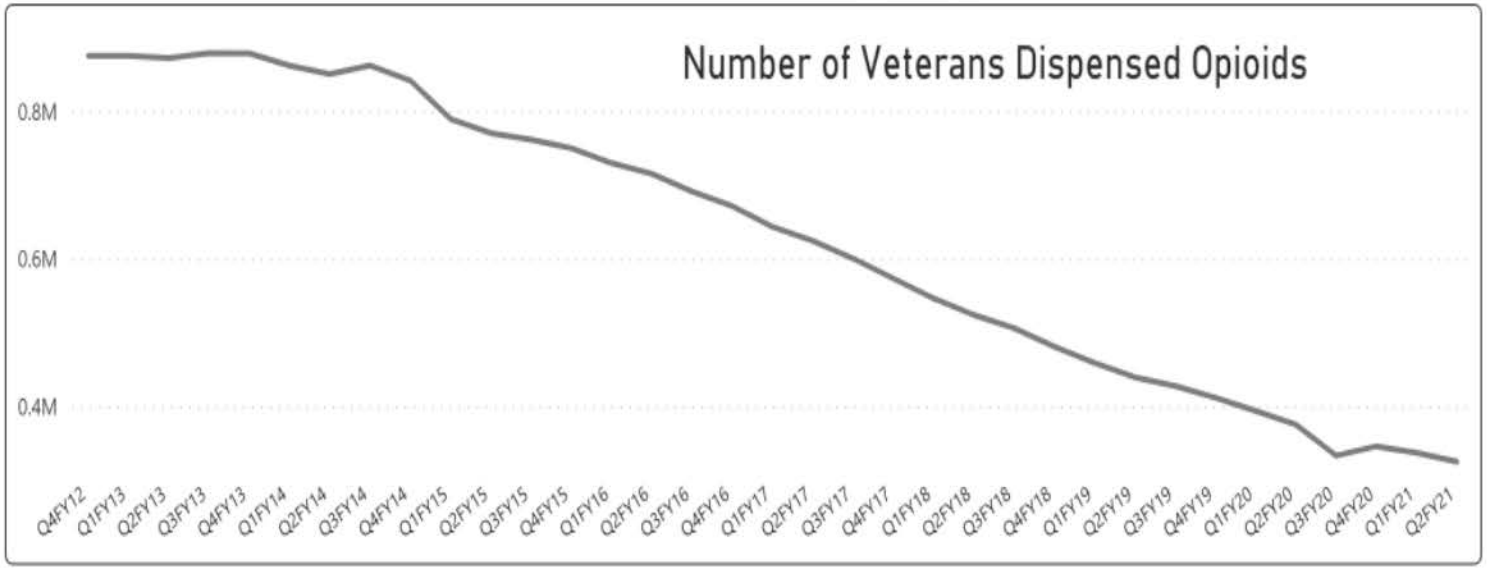
Opioid Safety Initiative (OSI) Dashboard

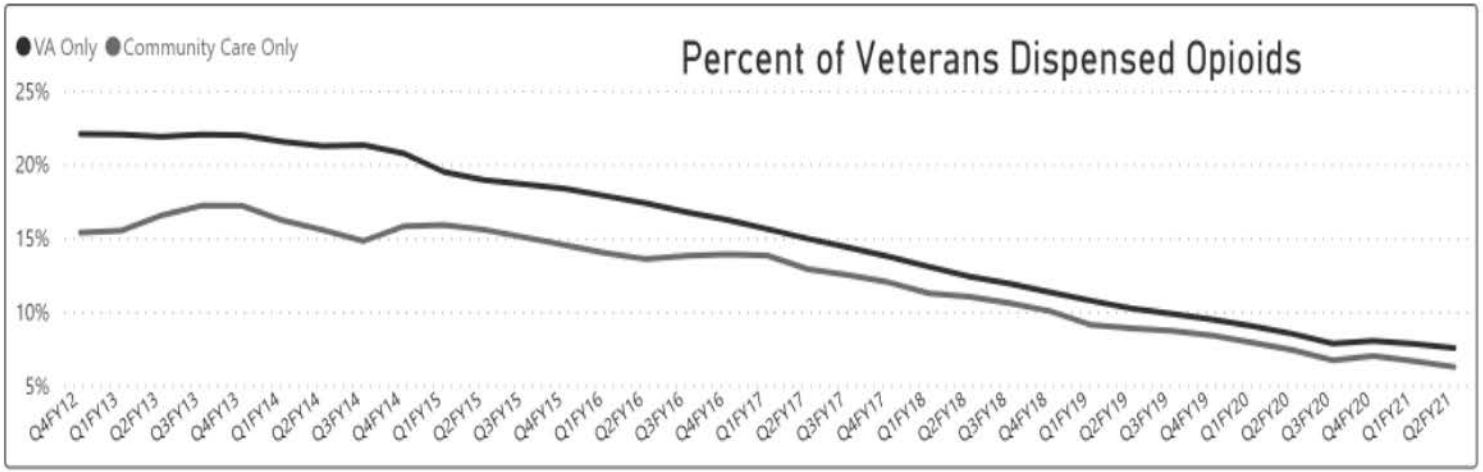
- **Purpose To make the totality of opioid use visible at all levels in the organization ReportsNationalVeterans Integrated Service Network (VISN)Medical facilityPrescriberPrescriber and patient**

OSI Dashboard Key Metrics

- **Outpatient pharmacy users:Dispensed an opioidDispensed an opioid and benzodiazepineLong-term opioid therapy (LTOT) patients (>/= 90 days) with a urine drug screen within the past 365 daysNew Long-term opioid therapy (New LTOT) patients (LTOT for current quarter, LTOT or not in prior quarter (3-6 months), but no prior LTOT in last 7-12 months)Morphine Equivalent Daily Dosing (MEDD) stratificationFrequency of report updatesQuarterly**

Veterans Dispensed Opioids Over Time





*Starting with Quarter 1, Fiscal Year 2021, data for VA medical facilities utilizing Cerner are incomplete.
At this time, National VA, Veterans Integrated Service Network (VISN) 20 and the Spokane VA medical facility OSI dashboard metrics are impacted.

Change

549,749

(Decrease)

Percent Change

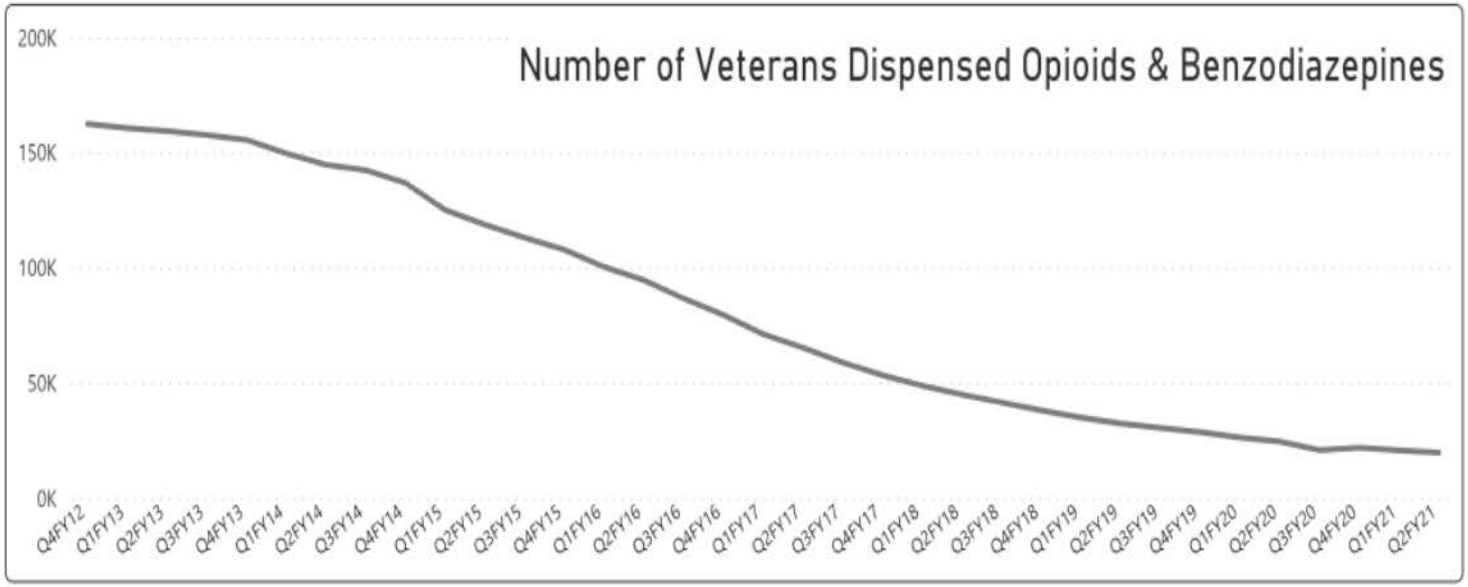
63 %

(Decrease)

Fiscal Quarter ▲	Total	Percent
Q4FY12	874,897	22.10%
Q2FY21	325,148	7.81%

Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report of Drug-Related Risk and Outcomes* definitions. For this metric, tramadol has been added.

Veterans Dispensed an Opioid and a Benzodiazepine



Change

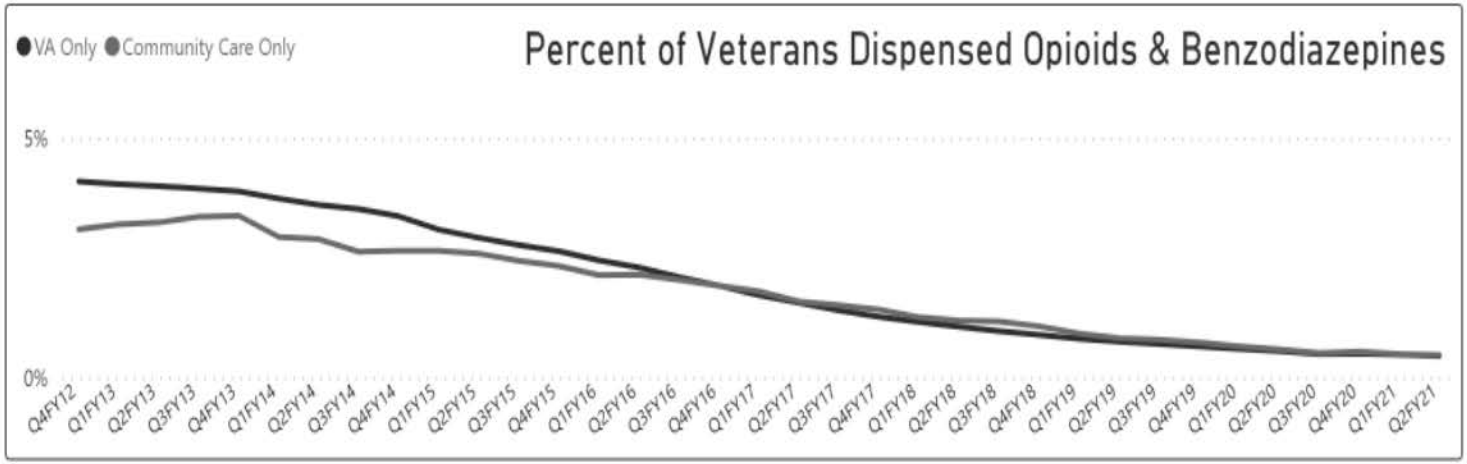
142,753

(Decrease)

Percent Change

88 %

(Decrease)



Fiscal Quarter ▲	Total	Percent
Q4FY12	162,444	4.10%
Q2FY21	19,691	0.47%

Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report of Drug-Related Risk and Outcomes* definitions. For this metric, clonazepam has been added.

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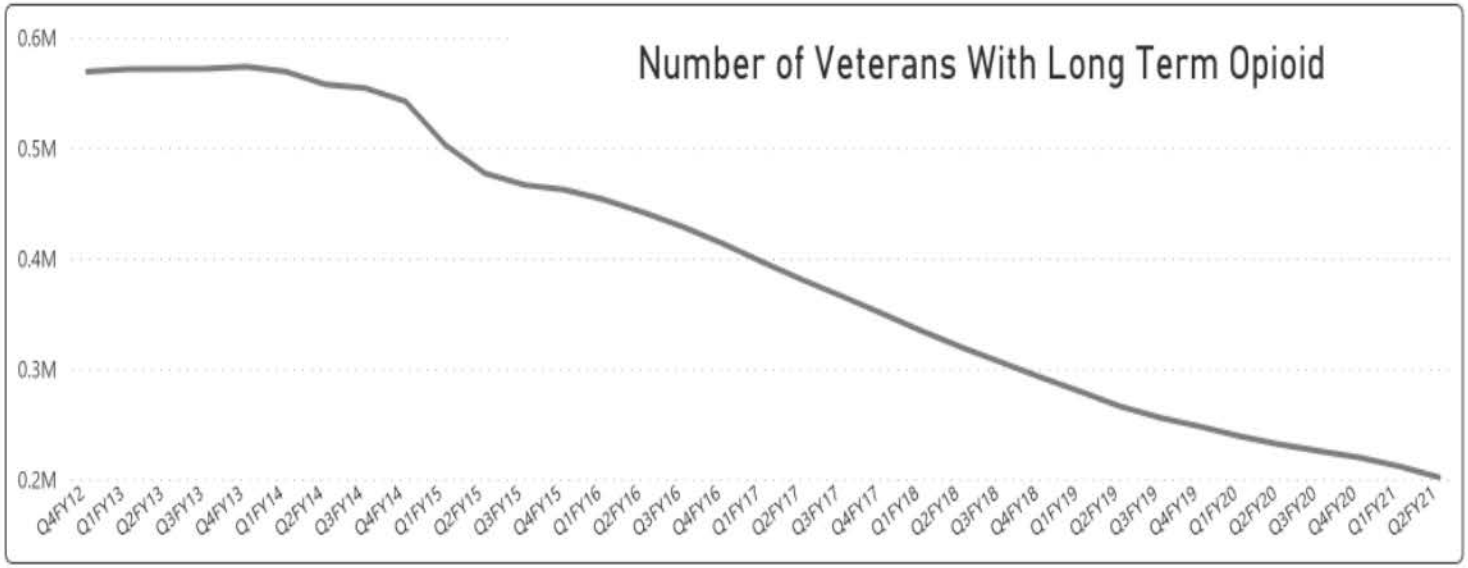
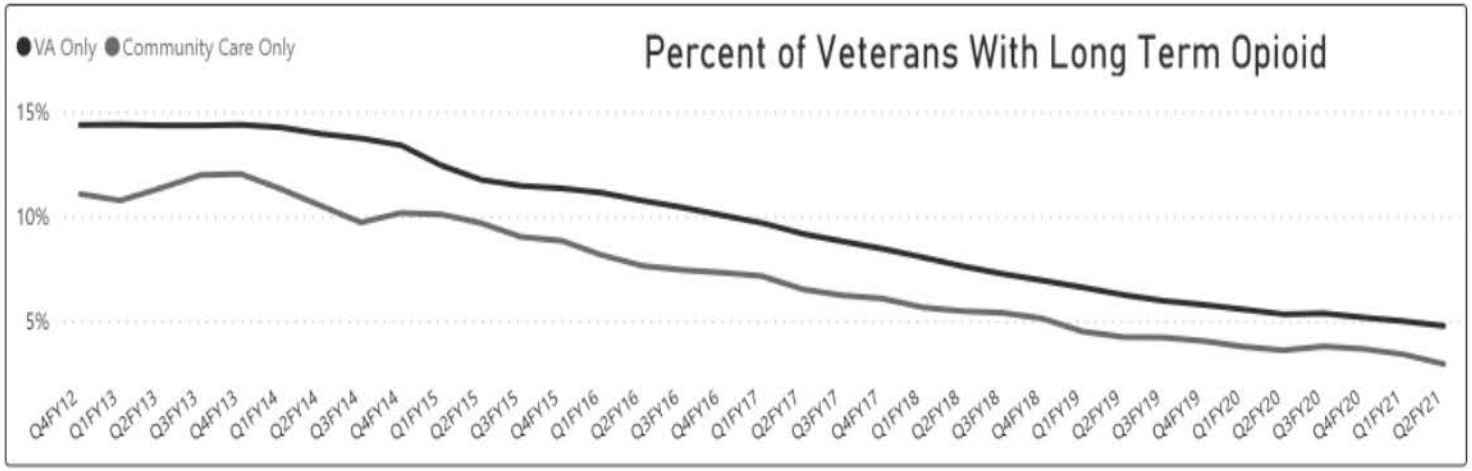
Veterans On Opioid Therapy Long-Term





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Change

367,229

(Decrease)

Percent Change

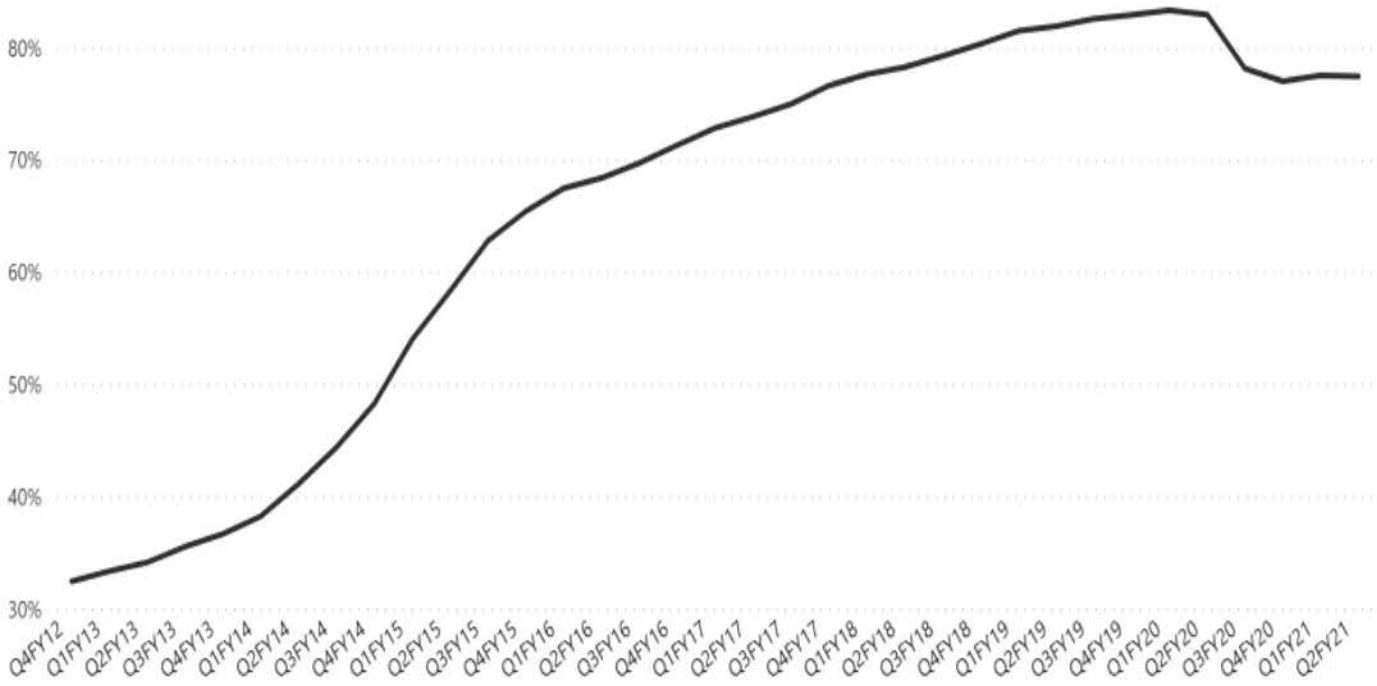
65 %

(Decrease)

Fiscal Quarter ▲	Total	Percent
Q4FY12	569,027	14.37%
Q2FY21	201,798	4.85%

Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report of Drug-Related Risk and Outcomes* definitions. For this metric, tramadol has been added.

Veterans on Long-Term Opioid Therapy With a Urine Drug Screen (UDS) Completed in the Last Year



Percent Change

45 %

(Increase)

Fiscal Quarter ▲	Percent
Q4FY12	32.46%
Q2FY21	77.45%

Comparisons are not available for community care providers as only the prescriptions are filled by VA medical facilities' pharmacies. The Urine Drug Screen (UDS) ordered and completed at non-VA laboratories are not available.

Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report of Drug-Related Risk and Outcomes* definitions. For this metric, tramadol has been added.

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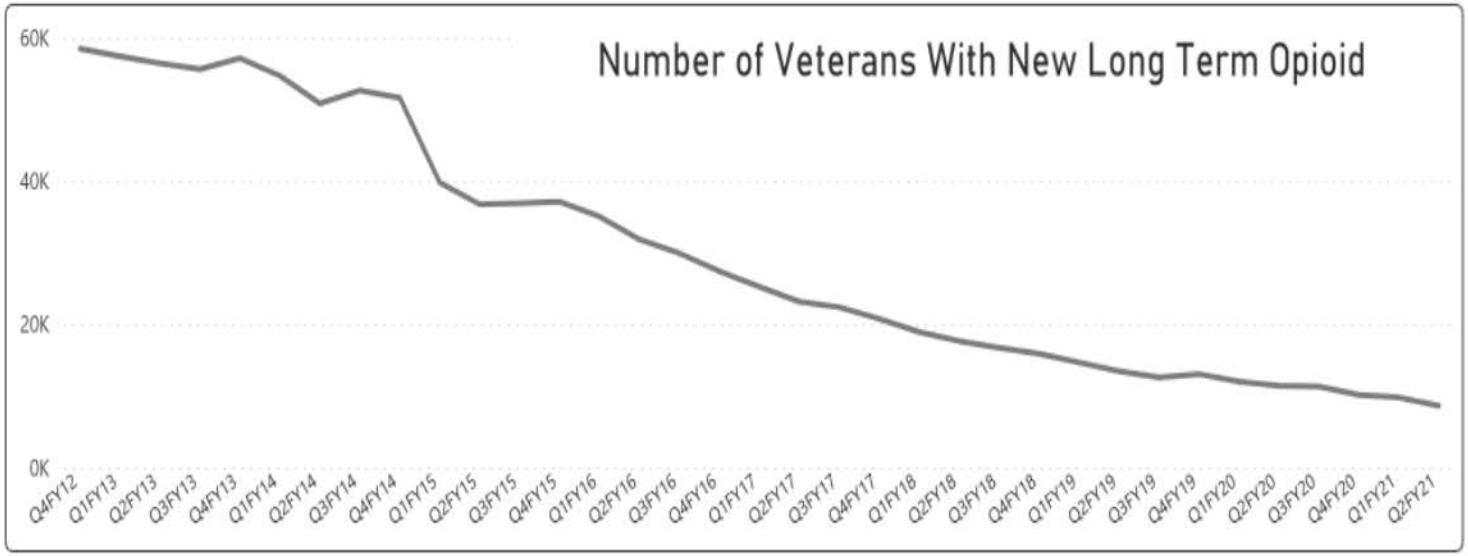
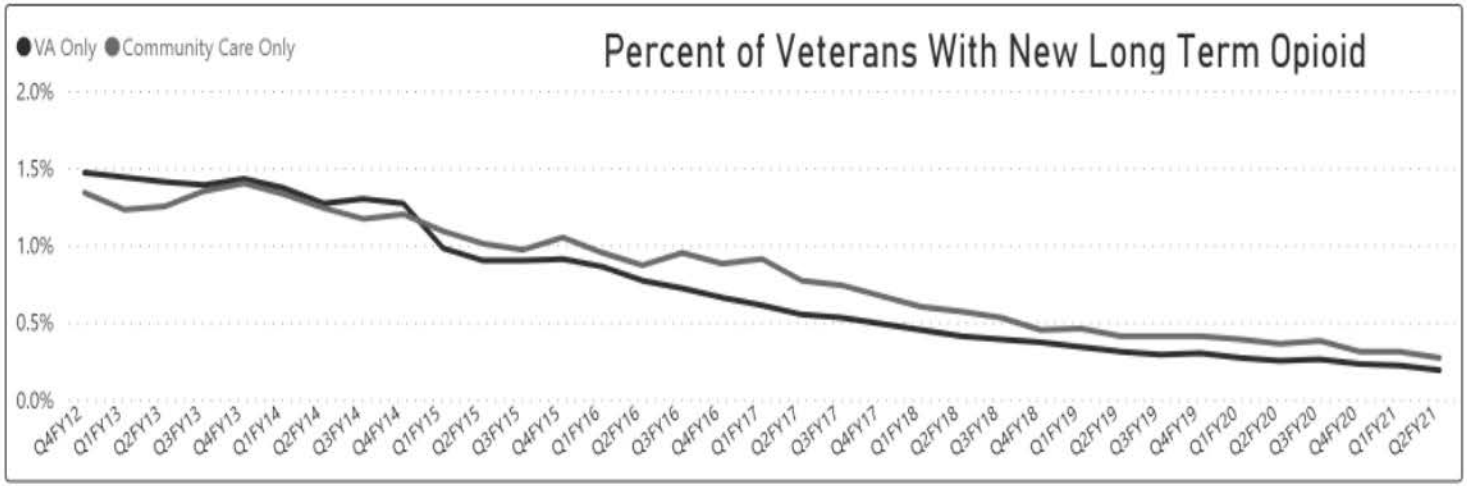
Veterans On New Long-Term Opioid Therapy





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Change

49,820

(Decrease)

Percent Change

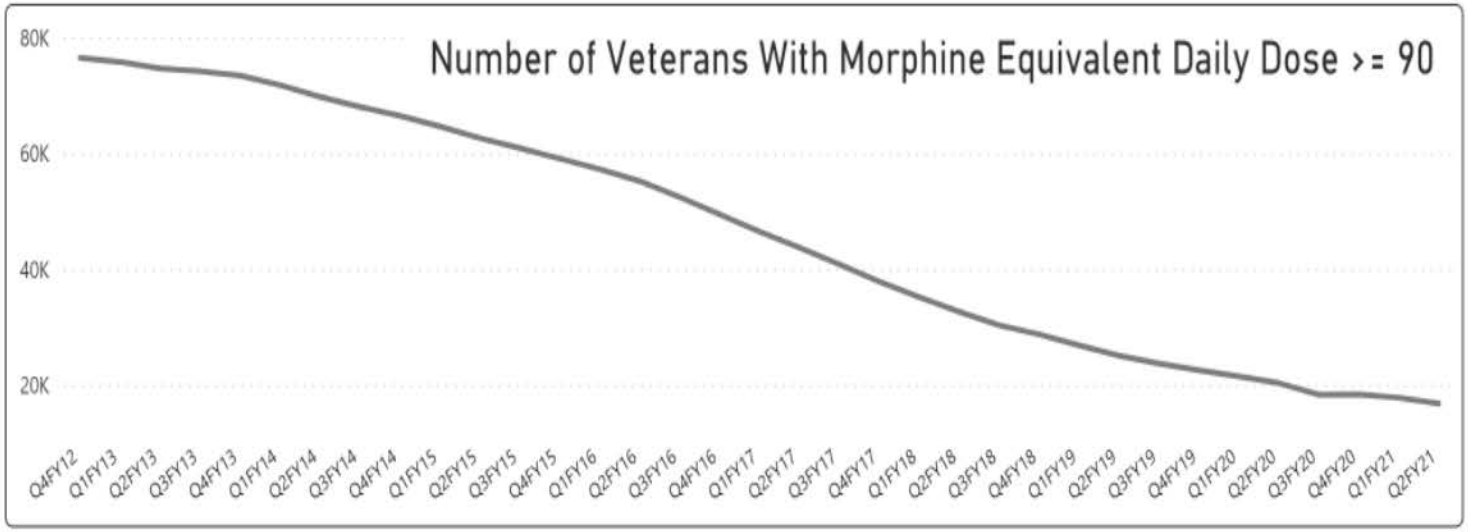
85 %

(Decrease)

Fiscal Quarter ▲	Total	Percent
Q4FY12	58,417	1.48%
Q2FY21	8,597	0.21%

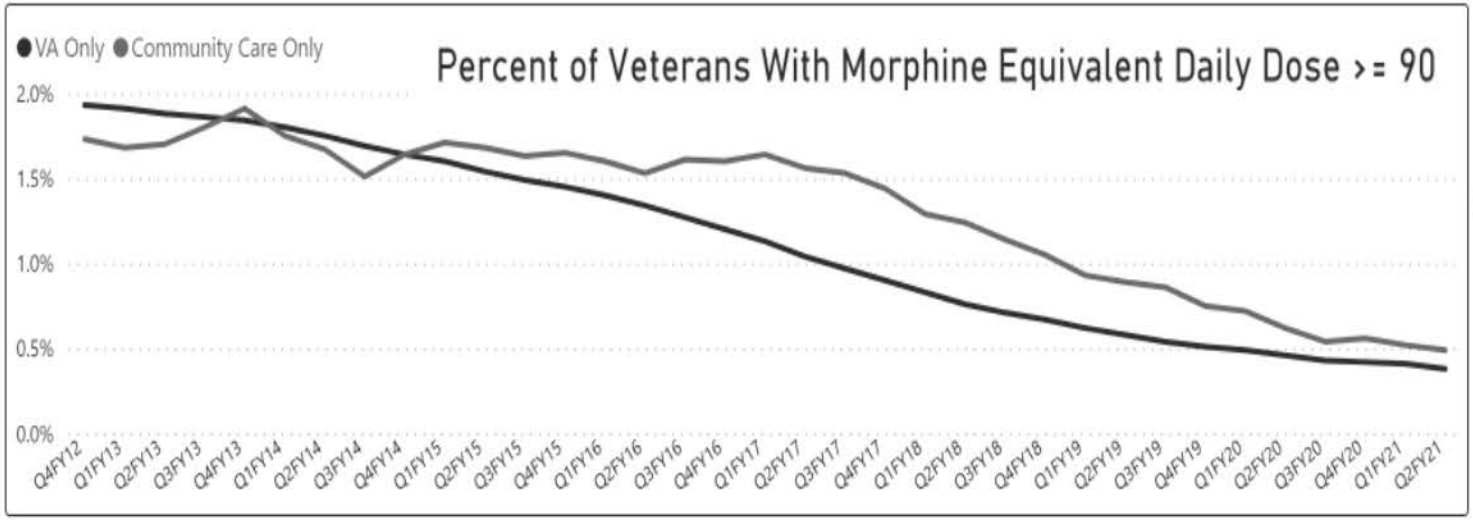
Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report of Drug-Related Risk and Outcomes* definitions. For this metric, tramadol has been added.

Veterans Dispensed Greater Than Or Equal to 90 MEDD*



Change
59.708
(Decrease)

Percent Change
78 %
(Decrease)



Fiscal Quarter ▲	Total	Percent
Q4FY12	76,466	1.93%
Q2FY21	16,758	0.40%

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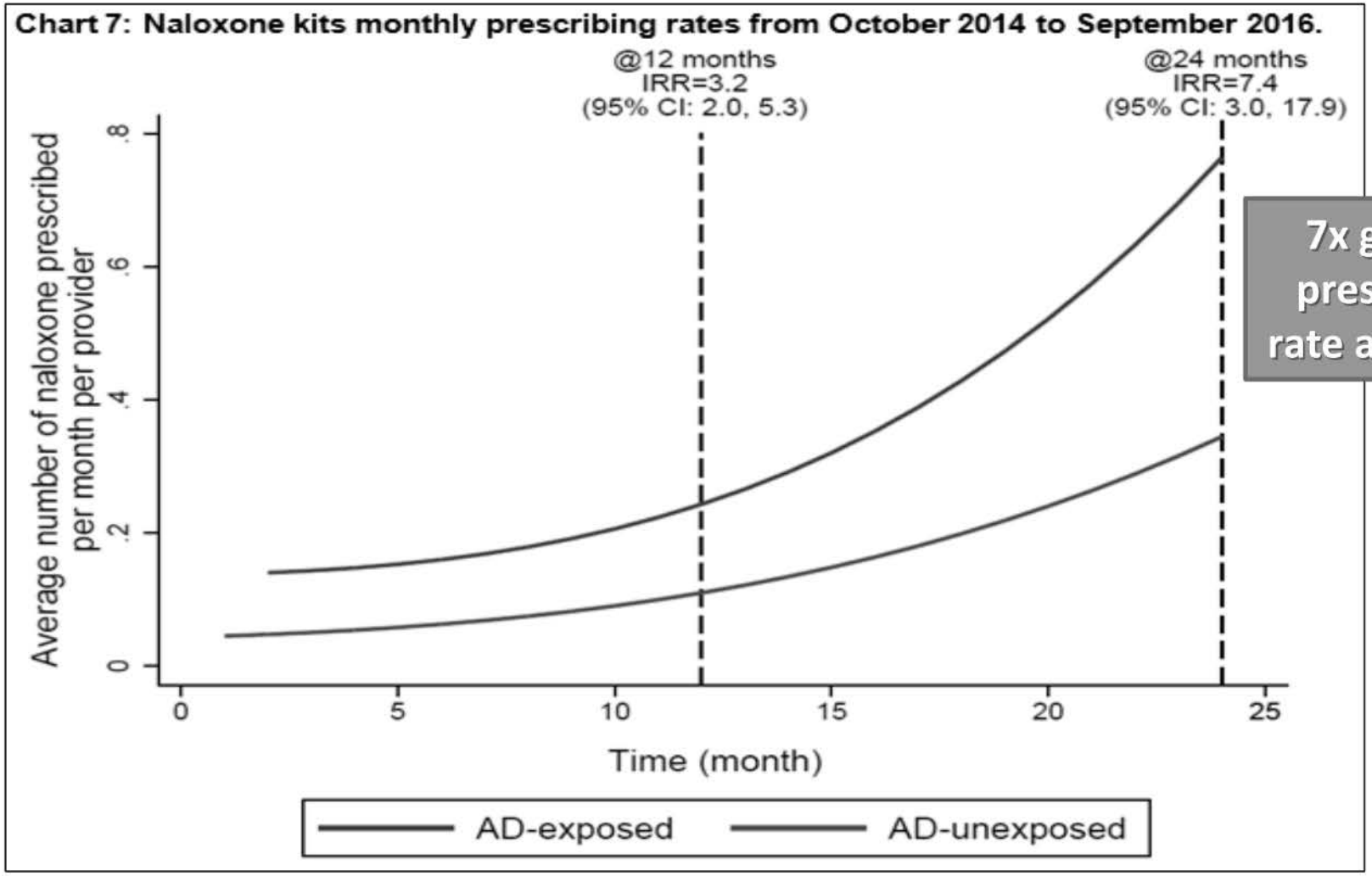
For this metric, the reporting has been changed from greater than or equal to 100 MEDD to 90.
***MEDD = Morphine Equivalent Daily Dose**

Opioid Safety Initiative (OSI)

- **Overdose Education and Naloxone Distribution (OEND): As of March 31, 2021, over 521,000 naloxone prescriptions were dispensed to Veterans. From May 2014 to February 2016, a voluntary pilot reversal capture program documented 172 overdose reversalsOMHSP developed a national reversal capture note. Through March 31, 2021, this note has captured 1,662 additional successful reversalsOne-on-One Provider Education (Academic Detailing): As of March 31, 2021, specially-trained VA pharmacists had 66,300 outreach visits with VA staff about OEND, opioid safety, opioid use disorder, and suicide prevention.State Prescription Drug Monitoring Programs (PDMP): 49 States and the District of Columbia, and Puerto Rico are activated for VA data transmissionMedication Take-Back Program: Veterans have returned over 224.3 tons of unneeded medications that have been destroyed in an environmentally responsible manner as of March 31, 2021Opioid Therapy Risk Report (OTRR): Allows Primary Care providers to review their panel of patients for a multitude of clinical parameters tracked by the toolSubstance Use Disorder: Medication Assisted Treatment (MAT) is available to Veterans receiving care in VA**

Academic Detailing : Impact On Naloxone Prescribing

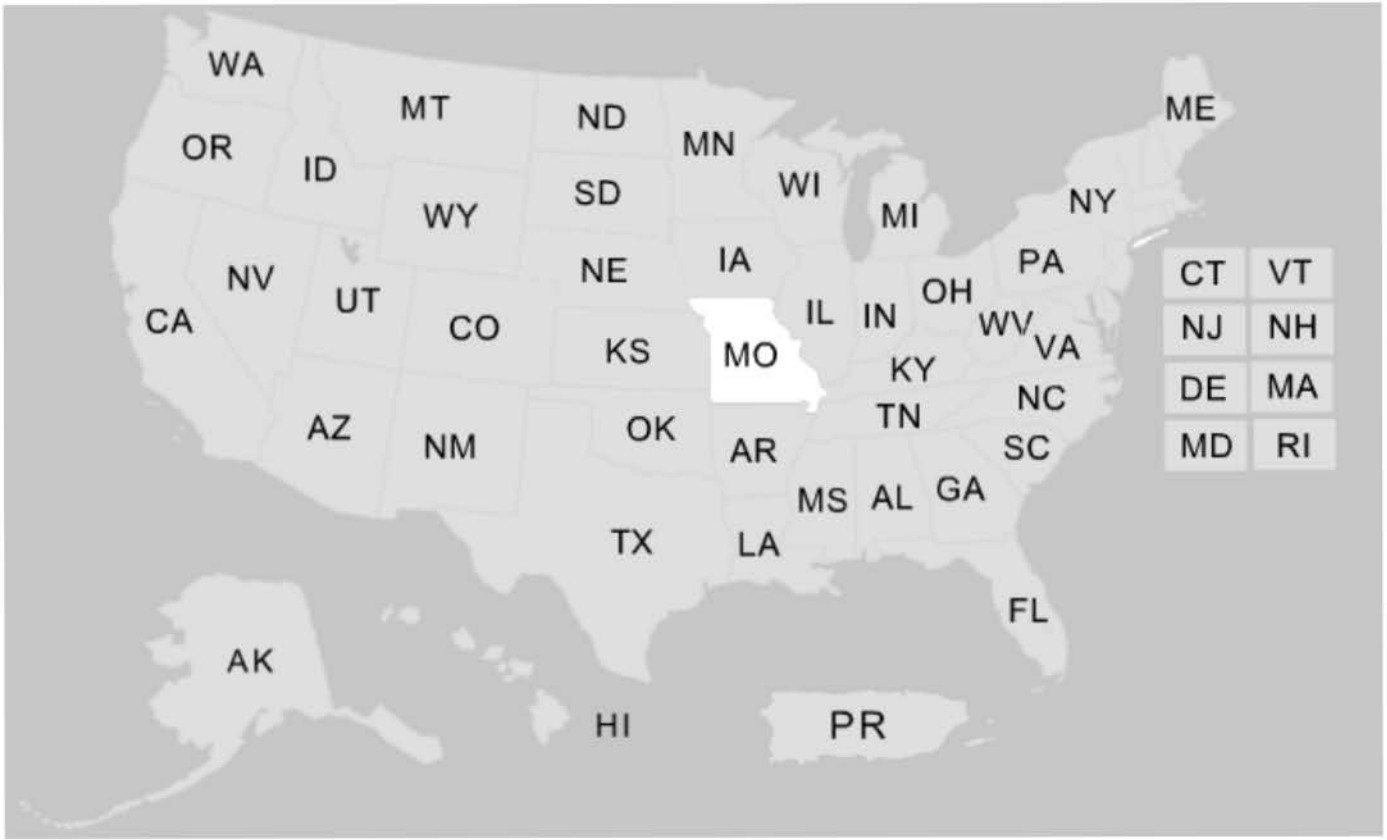


7x greater prescribing rate at 2 years

Opioid Safety Initiative (OSI)

- **Stratification Tool for Opioid Risk Mitigation (STORM): Allows providers to view information about risk factors for opioid overdose, suicide-related events and other harms along with potential risk mitigation strategies.Complementary and Integrative Medicine: As of March 31, 2020, over 4,600 VA providers completed the Acupuncture Training Across Clinical Settings (ATACS) program. This program has expanded Veterans' access to VA providers trained in auricular acupuncture. Opioid Safety Initiative Toolkit: Includes peer-reviewed education and guidance for both providers and Veterans and is available on the VA internet site.VA/DoD Joint Pain Education and Training Program (JPEP): Standardized training videos and 30 modules covering the full spectrum of pain management is available to VA and DoD providers.VA Patient Aligned Care Team (PACT) Pain Roadmap: Provides guidance to VA facility leadership and clinicians on VHA's " Six essential elements of good pain care" with an emphasis on Veterans' self-management skills, and supporting PACT by timely access to pain specialty care, complementary and integrative health modalities and opioid use disorder treatment.**

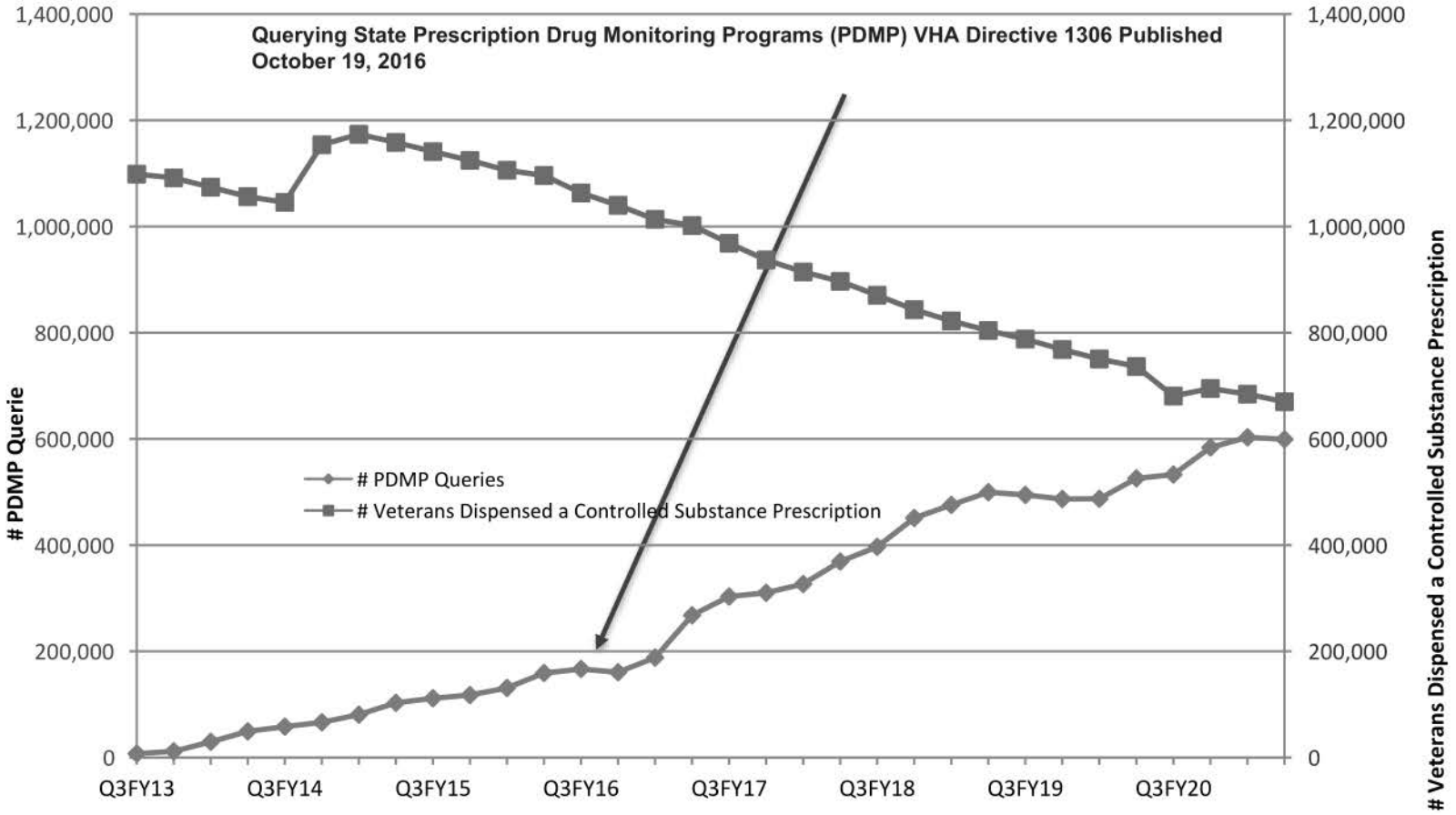
States Sharing VA Data with PDMPs



As of April 2019, 49 states, the District of Columbia, and Puerto Rico are activated for PDMP data transmission.

Missouri's state-wide program established by executive order is not set up to receive VA data. For all sites, VA-NSOC requires specific security documentation in order to open the firewall for outbound transmissions.

National: State Prescription Drug Monitoring Program (PDMP) Queries and the Number of Veterans Dispensed a Controlled Substance Prescription*



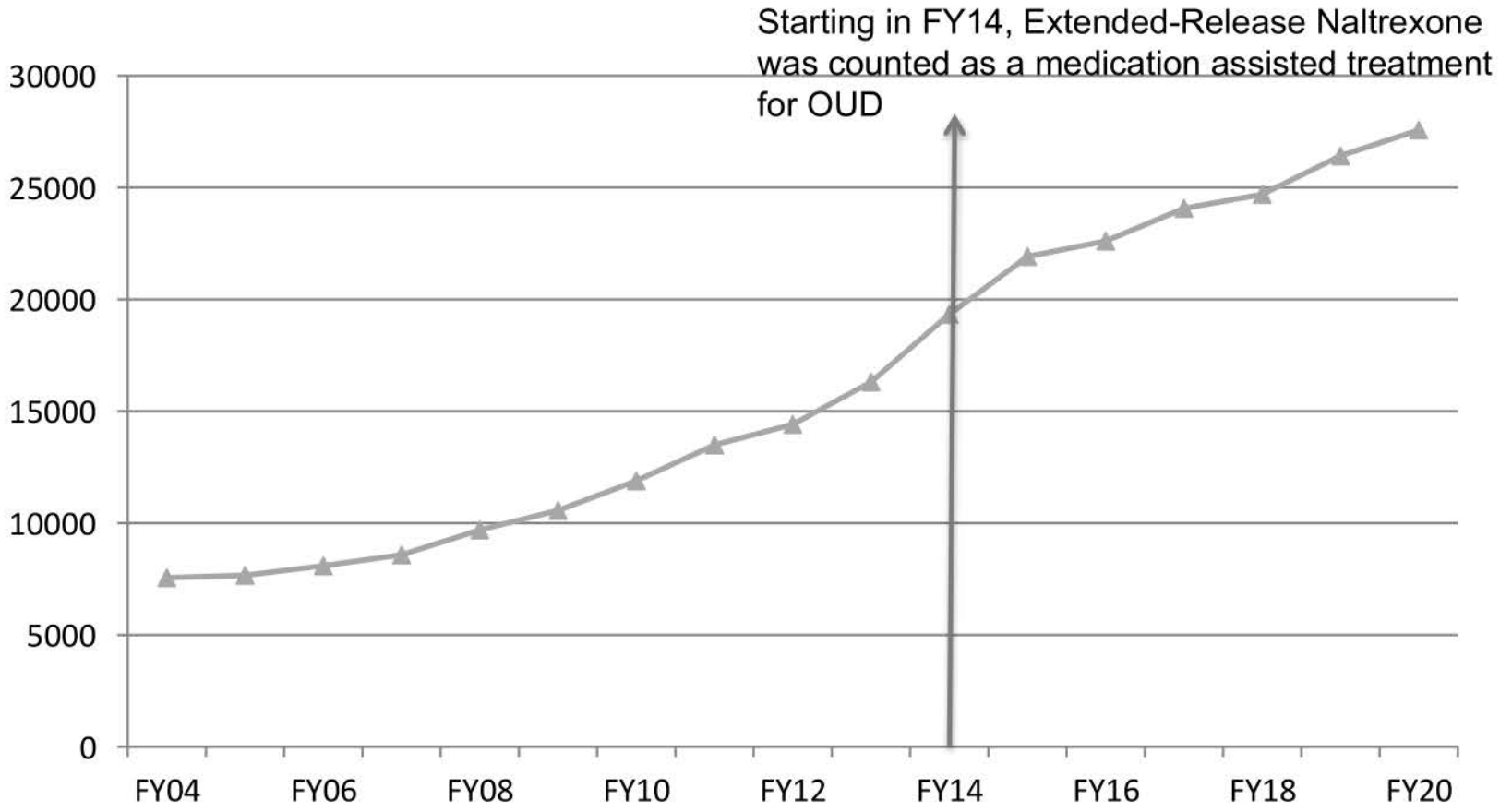
*Queries are underestimated because documentation was not standardized system-wide prior to publication of VHA Directive 1306

Source: Pharmacy Benefits Management (PBM) Services

Medication Take-Back Initiative

- **VA offers free medication take back services to Veterans though mail-back envelopes and on-site receptacles compliant with Drug Enforcement Administration (DEA) regulationsVHA Directive 1114, Controlled Substance Patient Prescription Disposal, mandates all VHA facilities offer at least one option to VeteransApproximately 195 on-site receptacles in place across the systemAs of March 31, 2021, Veterans have returned over 224.3 tons of unwanted/unneeded medication using these servicesImproves medication safety in the home by reducing the risk of mistakenly taking a discontinued medication and reducing the risk of accidental poisonings (especially in children)Reduces the risk of diversionKeeps pharmaceuticals out of the waterways and landfills - all returned medications are destroyed in an environmentally responsible manner!National SharePoint established with resources and marketing materials to assist facilities**

Opioid Use Disorder (OUD) Patients: Access to Medication Assisted Treatment (MAT) is Increasing



In Q4FY2020, 44.39% of OUD patients received MAT (methadone, buprenorphine or extended-release naltrexone)

Source: Program Evaluation Resource Center

VA | U.S. Department of Veterans Affairs

Opioid Safety Initiative (OSI) Fact Sheet

Bottom Line Up Front Message: VA began addressing the use of opioids for pain management in 2009 when it developed the Stepped Care Model for Pain Management and has continually built upon that early work so that today, VA is widely regarded as a leader in the United States in addressing the opioid epidemic.

Background: Chronic pain is a national public health problem as outlined in the 2011 study by the Institute of Medicine (IOM). At least 100 million Americans suffer from some form of chronic pain. The IOM study describes in detail many concerns of pain management, including system-wide deficits in the training of our Nation's health care professionals in pain management and substance use disorders prevention and management, and the problems caused by a fragmented health care system. The over-use and misuse of opioids for pain management in the United States is a consequence of a health care system that until recently was less than fully prepared to respond to these challenges. While about 30% of the USA's adult population experience chronic pain, a big number to manage, the problem of chronic pain in the VA is even more daunting.

- Almost 60 percent of returning Veterans from the Middle East and more than 50 percent of older Veterans in the VA health care system live with some form of chronic pain.
- Our Veterans' pain is often more complex. Many of our Veterans have survived severe battlefield injuries, some repeated, resulting in life-long moderate to severe pain related to damage to their musculoskeletal system and permanent nerve damage, which can not only impact their physical abilities but also impact their emotional health and brain structures.
- Many Veterans have also incurred head injuries, collectively referred to as traumatic brain injuries (TBI), which can compound psychological injuries such as post-traumatic stress (PTS) resulting from their experiences. TBI and PTS independently increase the risk for substance use disorders.
- Collectively, uncontrolled pain, distress and functional impairments make for a terrible quality of life for Veterans and their families, increasing the risk for overdose, substance abuse, and suicide.

- The extent and complexity of these multiple conditions can make effective pain management difficult and increase the risk for complications due to both over- and under-treatment with opioids and other therapies. Yet these Veterans call upon us every day, in great numbers, to do our very best to help them restore a reasonable quality of life in their families and communities.

Discussion: The VA health care system has identified and broadly responded to the many challenges of pain management through policies supporting clinical monitoring, education and training of health professionals and teams, and expansion of clinical resources and programs. VA's Pain Management Directive defines and describes policy expectations and responsibilities for the overall National Pain Management Strategy and Stepped Care pain model, which is evidence-based and has been adopted by the Department of Defense (DoD) as well. Our approach to managing opioid over-use fits into this plan, and the VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment. First, we must immediately address the problem of clinically inappropriate high-dose prescribing of opioids – this is being accomplished through the VA's national program, the Opioid Safety Initiative (OSI); Second, we must develop an effective system of interdisciplinary, patient-aligned pain management with the competency to provide safe and effective pain control and quality of life for Veterans for the remainder of their lives.

To further strengthen OSI and keep this trend moving in the right direction, VA has deployed state-of-the-art tools to help protect Veteran patients using high doses of opioids or with medical risk factors that put them at an increased risk of complications from opioid medications.

These tools, referred to as the Opioid Therapy Risk Report (OTRR) and the Stratification Tool for Opioid Risk Mitigation (STORM), are available to all staff in the Veterans Health Administration (VHA). These tools include information about the dosages of narcotics and other sedative medications, significant medical problems that could contribute to an adverse reaction and monitoring data to aid in the review and management of complex patients.

The Opioid Therapy Risk Report allows VA providers to review all pertinent clinical data related to pain treatment in one place, providing a comprehensive Veteran-centered and more efficient level of management not previously available to primary care providers. The Stratification Tool for Opioid Risk Mitigation allows VA providers to view information about risk factors for opioid overdose, suicide-related events and other harms along with potential risk mitigation strategies.

Additionally, VHA has formalized a system-wide Academic Detailing program that is in process of being implemented throughout the organization. Academic Detailing provides specialty teams to visit facilities and provide on-site support and education to providers to further enhance pain management efforts. The Academic Detailing program is another important step to improve mental health and pain management medication therapy across all VA medical care facilities. As of March 31, 2020, academic detailers have held 66,330 outreach visits related to Opioid Safety, Overdose Education and Naloxone Distribution, opioid use disorder, and suicide prevention.

As VA continues its efforts to address opioid over-use, complementary and integrative medicine treatments are an important component to VA's Pain Management Strategy. VA currently offers many complementary and integrative medicine treatments, many of which may be useful in chronic pain. These treatments include acupressure, acupuncture, biofeedback, chiropractic services, exercise, heated pool therapy, hypnosis/hypnotherapy, massage therapy, meditation, occupational therapy, physical therapy, recreational therapy, relaxation, tai chi, transcutaneous electrical nerve stimulation, yoga and other services.

VA has several other programs that are complementary to the Opioid Safety Initiative and include:

- Overdose Education and Naloxone Distribution (OEND): As of March 31, 2021, over 521,000 naloxone prescriptions were dispensed with 1,834 overdose reversals documented from May 2014 through March 31, 2021.

- State Prescription Drug Monitoring Programs (PDMP): 49 States, the District of Columbia, and Puerto Rico are activated for VA data transmission. From Quarter 3, Fiscal Year 2013 (ending in June 2013) to Quarter 2, Fiscal Year 2021 (ending March 2021), VA providers have documented over 8.5 million queries to State Prescription Drug Monitoring Programs to help guide treatment decisions.
- Substance Use Disorder: Medication Assisted Treatment (MAT) is available to Veterans receiving care in VA.
- Medication Take-Back Program: VA offers free medication take back services to Veterans through mail-back envelopes and on-site receptacles compliant with Drug Enforcement Administration (DEA) regulations. As of March 31, 2021, Veterans have returned over 224.3 tons of unwanted or unneeded medication using these services.

Summary: VA's own data, peer reviewed medical literature, and Centers for Medicare and Medicaid Services (CMS), suggest that VA is making progress relative to the rest of the nation. In December 2014, a study by Mark Edlund, MD, PhD and colleagues was published in journal PAIN, the premier research publication in the field of pain management. This study reviewed the duration of opioid therapy, the median daily dose of opioids, and the use of opioids in Veterans with substance abuse disorders and co-morbid chronic non-cancer pain. Edlund and colleagues found that:

- First, that half of all Veterans receiving opioids for chronic non-cancer pain, are receiving them short-term (i.e., for less than 90 days per year).
- Second, the study found that the daily opioid dose in VA is generally modest, with a median of 20 Morphine Equivalent Daily Dose (MEDD), which is considered low risk.
- Third, the use of high-volume opioids (in terms of total annual dose) is not increased in VA patients with substance use disorders as has been found to be the case in non-VA patients.

Dr. Edlund and the other authors concluded "this suggests appropriate vigilance at VA, which may be facilitated by a transparent and universal electronic medical record."

Sales of prescription opioids have nearly quadrupled in the United States from 1999 to 2014. The most recent opioid utilization data available for comparison to VA is CMS data for Part D beneficiaries which are available from calendar year (CY) 2013 to CY 2017. On April 2, 2018 CMS notified Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties of opioid utilization rates for Part D beneficiaries for CY 2013 through CY 2017 which VA used to make its comparison. There are several factors to consider when comparing CMS Part D to VA health care such as: 1- CMS Part D is a payer of care, and VA is predominantly a direct provider of care, therefore VA has the ability to control utilization better than CMS; and 2- CMS Part D beneficiaries are predominately over the age of 65, and 3- although 50 percent of VA patients are over 65 years of age, VA's beneficiary population is characterized as having multiple co-morbidities and a very heavy disease burden.

Although annual data isn't able to show the impact of organizational change as well as quarterly data can, the annual data in Table 1 demonstrates both CMS Part D and VA have experienced success reducing the percentage of enrollees utilizing opioids over time. From 2013 to 2017, the percentage of CMS Part D enrollees utilizing opioids decreased by 3.3 percent. From Fiscal Year 2013 to Fiscal Year 2018 the percentage of VA enrollees utilizing opioids decreased by 5.8 percent. The total number of CMS part D enrollees utilizing opioids increased 7.0 percent (11,794,908 to 12,619,655), while the total number of VA enrollees utilizing opioids decreased 34.9 percent (1,417,969 to 921,907).

However, the percent change in the number of enrollees utilizing opioids needs to be taken in context with the overall growth of enrollees between the two systems. CMS Part D has experienced a higher rate of growth of 19.5 percent (37,842,632 to 45,218,211) of enrollees, while the VA health care system only experienced a 2.7 percent rate of growth (8,926,610 to 9,169,123) of enrollees.

Table 1: CMS Part D and VA Opioid Utilization Rates, 2013-2018

Year*	Total CMS Part D Enrollees	Total CMS Part D Enrollees Utilizing Opioids**	% CMS Part D Enrollees Utilizing Opioids***	Total VA Enrollees	Total VA Enrollees Utilizing Opioids	% VA Enrollees Utilizing Opioids
2013	37,842,632	11,794,908	31.2%	8,926,610	1,417,969	15.9%
2014	39,982,962	12,308,735	30.8%	9,093,511	1,395,926	15.4%
2015	41,835,016	12,510,448	29.9%	8,965,923	1,299,968	14.5%
2016	43,569,035	12,885,620	29.6%	9,046,663	1,201,624 812,219#	13.3% 9.0%#
2017	45,218,211	12,619,655	27.9%	9,122,959	1,069,290 574,787#	11.7% 6.3%
2018	NA	NA	NA	9,169,123	921,907 510,200#	10.1% 5.6%
2019	NA	NA	NA	9,208,711	797,999 385,911#	8.6% 4.2%

* CMS Part D data is calendar year (January to December) and VA data is fiscal year (October to September). The April 1, 2020 CMS notification did not contain updated information for CY 2019 for opioid prescribing rates.

** CMS data excludes cancer and hospice patients for all years, while VA data only breaks out cancer/hospice/palliative care patients for 2016. The effect of this difference is that VA's success in reducing the utilization of opioids is under reported.

*** CMS Part D enrollees utilizing opioid excludes hospice and cancer patients.

VA enrollees utilizing opioids excludes hospice and cancer patients for 2016.

While there is still more work to do, the results of VA's complementary and synergistic activities in the management of chronic pain are very encouraging. In fact, although VA is implementing its plan, staff is also working with other Federal Agencies and VA Medical Center experts to implement the NIH-HHS National Pain Strategy, an outgrowth of the IOM study which recommends a transformation in the education of physicians and other health care professionals in pain management. By virtue of the VA's central national role in medical student education and residency training of primary care physicians and providers, we will be playing a major role in this national effort. VA has already started robust education and training programs for primary care, such as SCAN ECHO, Mini-residencies, Communities of Practice two Joint Incentive Fund (JIFs) training programs with the DoD, and dissemination of the OSI Toolkit.

The Opioid Safety Initiative (OSI) was chartered by the Under Secretary for Health in August 2012, was implemented nation-wide in August 2013, and is producing the desired results. The basis for the OSI is to make the totality of opioid use visible at all levels in the organization. The OSI includes key clinical indicators such as the number of VA pharmacy users dispensed an opioid, the number of VA pharmacy users receiving long-term opioids who also receive a urine drug screen, the number of VA pharmacy users receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average morphine equivalent daily dose (MEDD) of opioids.

Results of key clinical metrics measured by the OSI from Quarter 4, Fiscal Year 2012 (beginning in July 2012) to Quarter 2, Fiscal Year 2021 (ending in March 2021*) there are:

- 549,749 fewer patients receiving opioids (874,897 patients to 325,148 patients, a 63 percent reduction).
- 142,753 fewer patients receiving opioids and benzodiazepines together (162,444 patients to 19,691 patients, an 88 percent reduction).
- 367,229 fewer patients on long-term opioid therapy (569,027 to 201,798, a 65 percent reduction). The percentage of patients on long-term opioid therapy with a Urine Drug Screen (UDS) completed in the last year to help guide treatment decision has increased from 32 percent to 77 percent (45 percent increase). The number of new long-term opioid therapy patients has decreased by 49,820 patients (58,417 patients to 8,597 patients, an 85% decrease).
- The overall dosage of opioids is decreasing in the VA system as 59,708 fewer patients (76,466 patients to 16,758 patients, a 78 percent reduction) are receiving greater than or equal to 90 Morphine Equivalent Daily Dose.
- The desired results of the Opioid Safety Initiative have been achieved during a time that VA has seen an overall growth of patients (3,959,126 patients to 4,162,128 patients, a 5.1 percent increase) that have utilized VA outpatient pharmacy services.

NOTE: Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculate from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI

metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report of Drug-Related Risk and Outcomes* definitions. Tramadol is included in all of the metrics, clonazepam was added to the opioid and benzodiazepine concomitant use, and the MEDD metric was changed from greater than or equal to 100 to 90 MEDD.

*Starting with Quarter 1, Fiscal Year 2021, data for VA medical facilities utilizing Cerner is *incomplete*. At this time, National VA, Veterans Integrated Service Network (VISN) 20 and the Spokane VA medical facility OSI dashboard metrics are impacted.

From: Knott, Christina J. (OGC)
Sent: Fri, 21 May 2021 19:21:49 +0000
To: Newman, Mike (OGC);Griffin, Stephania;Tolbert, Randy L. FHCC Lovell;Varone, Jessica;Lieberman, Steven;Czarnecki, Tammy;Mole, Larry A.;Kim, Jane NCP;Califano, Sophia G;Peters, Shannon;Ocker, Danielle S.;Blauert, Susan (OGC);Kirchhoefer, Robert P. (OGC);Strobel, Karen;Chick, Marianne;Zeveski, James (WMC);Bonjorni, Jessica;Valentino, Michael (VACO);Belperio, Pamela S.;Walsh, Jason;Maenle, Nathan;Bateman, Patrick F.;Scavella, M.D., Erica;Baker, Lisa M.;Tarzian, Anita J.;Askey, Jennifer;Mercer, Melodee VBAPHILINS;Diamond, Sue OHT;Wallace, Patricia;Anderson, Eva M.
Cc: Taylor, Beth A;Oshinski, Renee;Rugen, Kathryn (b)(6) (b)(6) atano, Maura;Martin, Jennifer L. (Deputy Chief Consultant, PBM);Huycke, Amy S. (FAV);Woody, Edward L. (FAV);Kessler, Chad S DURVAMC;Vega, Ryan J;Kennedy, Kathleen J. FHCC Lovell; (b)(6) (Aptive HTG) (b)(6) (b)(6) [USA];Aklamati-Darko, Eva;Cogar, Dana (ATLAS);Villard, Douglas R. FNCVAMC;Patel, Neil (GLA);Geiger, Josh;Park, Glennon K;Pena, David A.;Weaver, Meaghann S.;Smith, Stacy C.;Rusch, Brett D.;Coldwell, Craig;Potter, Lucinda;Frazier, Raymond;Powell, Fawn M.;Ludwa, Cheryl;Goldberg, Kenneth;Havens, Nicholas S. CMOVAMC;Pantoja, Melanie, MS;Biester, Jacque, MS;Jordan, Will H.;Campbell, Stacey;Cillessen, Kathryn J.;Saulmon, John C.;DuFon, Jack;Morgan, Sean T.
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo
Attachments: Tort Liabilty Guidance and Eligibility for Vaccinating Minors (IAP TLG PLG).docx

Good afternoon!
Thank you for putting this together more formally. I provided some additional edits and comments, see attached.

Thank you,
v/r,
Christina

Christina Knott
Office of General Counsel (Personnel Law Group)
U. S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
P: (b)(6)
F: (b)(6)

From: Newman, Mike (OGC) (b)(6)
Sent: Friday, May 21, 2021 12:44 PM

To: Griffin, Stephania (b)(6) Tolbert, Randy L. FHCC Lovell (b)(6) Varone, Jessica (b)(6) Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) b)(6) (b)(6) (b)(6) Catano, Maura (b)(6) Martin, Jennifer L. (Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) (6) (b)(6) (b)(6) (b)(6) (b)(6) USA] (b)(6) Aklamati-Darko, Eva (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

(b)(5)

(b)(5) Mike

From: Griffin, Stephania (b)(6)
Sent: Friday, May 21, 2021 10:23 AM
To: Tolbert, Randy L. FHCC Lovell (b)(6) Varone, Jessica (b)(6)

Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6)
Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G
(b)(6) Peters, Shannon (b)(6) Ocker, Danielle S.
(b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC)
(b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen
(b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC)
(b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO)
(b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason
(b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F.
(b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M.
(b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer
(b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue
OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M.
(b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn
(b)(6) (b)(6) (b)(6) (b)(6)
(b)(6) Catano, Maura (b)(6) Martin, Jennifer L.
(Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV)
(b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC
(b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell
(b)(6) (b)(6) Aptive HTG) (b)(6) (b)(6)
(b)(6) (b)(6) (b)(6) JSA]
(b)(6) (b)(6) Aklamati-Darko, Eva (b)(6) Cogar, Dana
(ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil
(GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K
(b)(6) Pena, David A. (b)(6) Weaver, Meaghann S.
(b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D.
(b)(6) Coldwell, Craig (b)(6) Potter, Lucinda
(b)(6) Frazier, Raymond (b)(6) Powell, Fawn M.
(b)(6) Ludwa, Cheryl (b)(6) Newman, Mike (OGC)
(b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S.
CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester,
Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey
(b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C.
(b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

While there are no privacy concerns, comments are provided in the attached document based on a general review.

Thank you.

Stephania H. Griffin, JD
Director, Information Access and Privacy
VHA Privacy Officer
Office of Health Informatics (105HIG)
Veterans Health Administration
(b)(6)

From: Tolbert, Randy L. FHCC Lovell (b)(6)
Sent: Friday, May 21, 2021 11:06 AM
To: Varone, Jessica (b)(6) Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Griffin, Stephania (b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) Catano, Maura (b)(6) Martin, Jennifer L. (Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) Aptive HTG) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) Aklamati-Darko, Eva (b)(6) (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Newman, Mike (OGC) (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

Team,

Good morning.
With my DoD background, the only question I would have is:(b)(5)
(b)(5)

(b)(5)
(b)(5) Just wanted to put that out there to the experts.

R/s

Randy L. Tolbert
Regional Program Manager, Immunizations (RIPM)
Public Health - Fleet Directive
Captain James A. Lovell Federal Health Care Center
3001 Green Bay Road
North Chicago (Great Lakes), IL. 60064
Office: (b)(6) or Ext (b)(6)
Cell: (b)(6)

From: Varone, Jessica (b)(6)
Sent: Friday, May 21, 2021 9:46 AM
To: Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Griffin, Stephania (b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Tolbert, Randy L. FHCC Lovell (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
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(b)(6) Potter, Lucinda (b)(6) Frazier, Raymond
(b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl
(b)(6) Newman, Mike (OGC) (b)(6) Goldberg, Kenneth
(b)(6) Havens, Nicholas S. CMOVAMC (b)(6)
Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6)
Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen,
Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack
(b)(6) Morgan, Sean T. (b)(6)
Subject: PLEASE REVIEW: Adolescent Vaccination Memo

Good Morning adolescent vaccination IPT members –
We have a draft memo prepared, but your edits and input are crucial to ensure we are sharing accurate and clear information with the field.
Please review the draft memo on SharePoint and contribute your edits via track changes **no later than 2:30pm TODAY**. If you experience access issues, please let me know and we will rectify that ASAP. Our goal will be to send this up to VA leadership for review and approval late this afternoon, and distribution to the field by Monday at noon.

Note that the memo attachments are not yet finalized. I have attached the latest version of the OGC attachment, but I know the Clinical Guidelines and Vaccination Worksheet are still in progress. Please let me know once those are final!

Reach out with any questions.
Thanks once again for all of your work over this past week. It's been incredible to see what this group has managed to accomplish in such a short period of time!

Jessica Varone, MPM
Program Specialist
VHA Office of Healthcare Transformation (OHT) – 10A5
Phone (b)(6) | (b)(6)

Page 403 of 636

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information

From: Knott, Christina J. (OGC)
Sent: Fri, 21 May 2021 19:29:47 +0000
To: Newman, Mike (OGC);Griffin, Stephania;Tolbert, Randy L. FHCC Lovell;Varone, Jessica;Lieberman, Steven;Czarnecki, Tammy;Mole, Larry A.;Kim, Jane NCP;Califano, Sophia G;Peters, Shannon;Ocker, Danielle S.;Blauert, Susan (OGC);Kirchhoefer, Robert P. (OGC);Strobel, Karen;Chick, Marianne;Zeveski, James (WMC);Bonjorni, Jessica;Valentino, Michael (VACO);Belperio, Pamela S.;Walsh, Jason;Maenle, Nathan;Bateman, Patrick F.;Scavella, M.D., Erica;Baker, Lisa M.;Tarzian, Anita J.;Askey, Jennifer;Mercer, Melodee VBAPHILINS;Diamond, Sue OHT;Wallace, Patricia;Anderson, Eva M.
Cc: Taylor, Beth A;Oshinski, Renee;Rugen, (b)(6) (b)(6) Katz;Catano, Maura;Martin, Jennifer L. (Deputy Chief Consultant, PBM);Huycke, Amy S. (FAV);Woody, Edward L. (FAV);Kessler, Chad S DURVAMC;Vega, Ryan J;Kennedy, Kathleen J. FHCC (b)(6) (b)(6) (Aptive HTG);Yelena (b)(6) (b)(6) [USA];Aklamati-Darko, Eva;Cogar, Dana (ATLAS);Villard, Douglas R. FNCVAMC;Patel, Neil (GLA);Geiger, Josh;Park, Glennon K;Pena, David A.;Weaver, Meaghann S.;Smith, Stacy C.;Rusch, Brett D.;Coldwell, Craig;Potter, Lucinda;Frazier, Raymond;Powell, Fawn M.;Ludwa, Cheryl;Goldberg, Kenneth;Havens, Nicholas S. CMOVAMC;Pantoja, Melanie, MS;Biester, Jacque, MS;Jordan, Will H.;Campbell, Stacey;Cillessen, Kathryn J.;Saulmon, John C.;DuFon, Jack;Morgan, Sean T.
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo
Attachments: Tort Liabilty Guidance and Eligibility for Vaccinating Minors (IAP TLG PLG).docx

(b)(5)

Thank you,
v/r,

Christina Knott
Office of General Counsel (Personnel Law Group)
U. S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
P: (b)(6)
F: (b)(6)

From: Knott, Christina J. (OGC)
Sent: Friday, May 21, 2021 3:22 PM
To: Newman, Mike (OGC) (b)(6) Griffin, Stephania (b)(6) Tolbert, Randy L. FHCC Lovell (b)(6) Varone, Jessica (b)(6) Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G

(b)(6) Peters, Shannon (b)(6) Ocker, Danielle S.
(b)(6) Blauert, Susan (OGC) (b)(6) Kirchhoefer, Robert P. (OGC)
(b)(6) Strobel, Karen (b)(6) Chick, Marianne
(b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica
(b)(6) Valentino, Michael (VACO) (b)(6) Belperio, Pamela
S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan
(b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica
(b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J.
(b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS
(b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia
(b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn
(b)(6) (b)(6) (b)(6) (b)(6) Elise Katz
(b)(6) Catano, Maura (b)(6) Martin, Jennifer L.
(Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV)
(b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC
(b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell
(b)(6) (b)(6) (b)(6) (Aptive HTG) (b)(6) (b)(6)
(b)(6) (b)(6) (b)(6) (b)(6) [USA]
(b)(6) Aklamati-Darko, Eva (b)(6) Cogar, Dana
(ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil
(GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K
(b)(6) Pena, David A. (b)(6) Weaver, Meaghann S.
(b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D.
(b)(6) Coldwell, Craig (b)(6) Potter, Lucinda
(b)(6) Frazier, Raymond (b)(6) Powell, Fawn M.
(b)(6) Ludwa, Cheryl (b)(6) Goldberg, Kenneth
(b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja,
Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H.
(b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J.
(b)(6) Saulmon, John C. (b)(6) DuFon, Jack
(b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

Good afternoon!
Thank you for putting this together more formally. I provided some additional edits and comments, see attached.

Thank you,
v/r,
Christina

Christina Knott
Office of General Counsel (Personnel Law Group)
U. S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
P: (b)(6)

F: (b)(6)

From: Newman, Mike (OGC) (b)(6)
Sent: Friday, May 21, 2021 12:44 PM
To: Griffin, Stephania (b)(6) Tolbert, Randy L. FHCC Lovell (b)(6) Varone, Jessica (b)(6) Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) b)(6) (b)(6) (b)(6) Catano, Maura (b)(6) Martin, Jennifer L. (Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) (b)(6) (Aptive HTG) (b)(6) (b)(6) (b)(6) (b)(6))(6) Aklamati-Darko, Eva (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J.

(b)(6) Saulmon, John C. (b)(6) DuFon, Jack
(b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

(b)(5)

(b)(5) Mike

From: Griffin, Stephania (b)(6)
Sent: Friday, May 21, 2021 10:23 AM
To: Tolbert, Randy L. FHCC Lovell (b)(6) Varone, Jessica (b)(6)
Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6)
Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G
(b)(6) Peters, Shannon (b)(6) Ocker, Danielle S.
(b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC)
(b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen
(b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC)
(b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO)
(b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason
(b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F.
(b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M.
(b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer
(b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue
OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M.
(b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn
(b)(6) (b)(6) (b)(6) b)(6) (b)(6)
(b)(6) Catano, Maura (b)(6) Martin, Jennifer L.
(Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV)
(b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC
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(b)(6) b)(6) (b)(6) [USA]
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CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester,
Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey
(b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C.

(b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

While there are no privacy concerns, comments are provided in the attached document based on a general review.

Thank you.

Stephania H. Griffin, JD
Director, Information Access and Privacy
VHA Privacy Officer
Office of Health Informatics (105HIG)
Veterans Health Administration
(b)(6)

From: Tolbert, Randy L. FHCC Lovell (b)(6)
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(b)(5)
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Randy L. Tolbert
Regional Program Manager, Immunizations (RIPM)
Public Health - Fleet Directive
Captain James A. Lovell Federal Health Care Center
3001 Green Bay Road
North Chicago (Great Lakes), IL. 60064
Office: (b)(6) or Ext 8-7785
Cell: (b)(6)

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Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) (b)(6) (b)(6) Elise Katz (b)(6) Catano, Maura (b)(6) Martin, Jennifer L. (Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) (b)(6) (Aptive HTG) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) Aklamati-Darko, Eva (b)(6) (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Newman, Mike (OGC) (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)

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Jessica Varone, MPM
Program Specialist
VHA Office of Healthcare Transformation (OHT) – 10A5
Phone (b)(6) | (b)(6)

Page 412 of 636

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information

From: Newman, Mike (OGC)
Sent: Fri, 21 May 2021 16:43:57 +0000
To: Griffin, Stephania;Tolbert, Randy L. FHCC Lovell;Varone, Jessica;Lieberman, Steven;Czarnecki, Tammy;Mole, Larry A.;Kim, Jane NCP;Califano, Sophia G;Peters, Shannon;Ocker, Danielle S.;Blauert, Susan (OGC);Knott, Christina J. (OGC);Kirchhoefer, Robert P. (OGC);Strobel, Karen;Chick, Marianne;Zeveski, James (WMC);Bonjorni, Jessica;Valentino, Michael (VACO);Belperio, Pamela S.;Walsh, Jason;Maenle, Nathan;Bateman, Patrick F.;Scavella, M.D., Erica;Baker, Lisa M.;Tarzian, Anita J.;Askey, Jennifer;Mercer, Melodee VBAPHILINS;Diamond, Sue OHT;Wallace, Patricia;Anderson, Eva M.
Cc: Taylor, Beth A;Oshinski, Renee;Rugen, (b)(6) (b)(6) (b)(6) atano, Maura;Martin, Jennifer L. (Deputy Chief Consultant, PBM);Huycke, Amy S. (FAV);Woody, Edward L. (FAV);Kessler, Chad S DURVAMC;Vega, Ryan J;Kennedy, Kathleen J. FHCC (b)(6) (b)(6) (Aptive HTG);Yelena (b)(6) (b)(6) [USA];Aklamati-Darko, Eva;Cogar, Dana (ATLAS);Villard, Douglas R. FNCVAMC;Patel, Neil (GLA);Geiger, Josh;Park, Glennon K;Pena, David A.;Weaver, Meaghann S.;Smith, Stacy C.;Rusch, Brett D.;Coldwell, Craig;Potter, Lucinda;Frazier, Raymond;Powell, Fawn M.;Ludwa, Cheryl;Goldberg, Kenneth;Havens, Nicholas S. CMOVAMC;Pantoja, Melanie, MS;Biester, Jacque, MS;Jordan, Will H.;Campbell, Stacey;Cillessen, Kathryn J.;Saulmon, John C.;DuFon, Jack;Morgan, Sean T.
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo
Attachments: OGC Tort Liabilty Guidance and Eligibility for Vaccinating Minors IAP TLG.docx

(b)(5)

(b)(5) Mike

From: Griffin, Stephania (b)(6)
Sent: Friday, May 21, 2021 10:23 AM
To: Tolbert, Randy L. FHCC Lovell (b)(6) Varone, Jessica (b)(6) Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) Catano, Maura (b)(6) Martin, Jennifer L.

(Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) (b)(6) (Aptive HTG) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) [USA] (b)(6) Aklamati-Darko, Eva (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Newman, Mike (OGC) (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)

Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

While there are no privacy concerns, comments are provided in the attached document based on a general review.

Thank you.

Stephania H. Griffin, JD
Director, Information Access and Privacy
VHA Privacy Officer
Office of Health Informatics (105HIG)
Veterans Health Administration
(b)(6)

From: Tolbert, Randy L. FHCC Lovell (b)(6)
Sent: Friday, May 21, 2021 11:06 AM
To: Varone, Jessica (b)(6) Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Griffin, Stephania (b)(6) Belperio, Pamela S. (b)(6) Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond,

Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) (b)(6) (b)(6) Elise Katz (b)(6) Catano, Maura (b)(6) Martin, Jennifer L. (Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) (b)(6) (Aptive HTG) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) [USA] (b)(6) (b)(6) Aklamati-Darko, Eva (b)(6) (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Newman, Mike (OGC) (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)
Subject: RE: PLEASE REVIEW: Adolescent Vaccination Memo

Team,

Good morning.
With my DoD background, the only question I would have is: (b)(5)
(b)(5)
(b)(5) Just wanted to put that out there to the experts.

R/s

Randy L. Tolbert
Regional Program Manager, Immunizations (RIPM)
Public Health - Fleet Directive
Captain James A. Lovell Federal Health Care Center
3001 Green Bay Road
North Chicago (Great Lakes), IL. 60064
Office: (b)(6) or Ext (b)(6)
Cell: (b)(6)

From: Varone, Jessica (b)(6)
Sent: Friday, May 21, 2021 9:46 AM
To: Lieberman, Steven (b)(6) Czarnecki, Tammy (b)(6) Mole, Larry A. (b)(6) Kim, Jane NCP (b)(6) Califano, Sophia G (b)(6) Peters, Shannon (b)(6) Ocker, Danielle S. (b)(6) Blauert, Susan (OGC) (b)(6) Knott, Christina J. (OGC) (b)(6) Kirchhoefer, Robert P. (OGC) (b)(6) Strobel, Karen (b)(6) Chick, Marianne (b)(6) Zeveski, James (WMC) (b)(6) Bonjorni, Jessica (b)(6) Valentino, Michael (VACO) (b)(6) Griffin, Stephania (b)(6) Belperio, Pamela S. (b)(6); Walsh, Jason (b)(6) Maenle, Nathan (b)(6) Bateman, Patrick F. (b)(6) Scavella, M.D., Erica (b)(6) Tolbert, Randy L. FHCC Lovell (b)(6) Baker, Lisa M. (b)(6) Tarzian, Anita J. (b)(6) Askey, Jennifer (b)(6) Mercer, Melodee VBAPHILINS (b)(6) Diamond, Sue OHT (b)(6) Wallace, Patricia (b)(6) Anderson, Eva M. (b)(6)
Cc: Taylor, Beth A (b)(6) Oshinski, Renee (b)(6) Rugen, Kathryn (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) Catano, Maura (b)(6) Martin, Jennifer L. (Deputy Chief Consultant, PBM) (b)(6) Huycke, Amy S. (FAV) (b)(6) Woody, Edward L. (FAV) (b)(6) Kessler, Chad S DURVAMC (b)(6) Vega, Ryan J (b)(6) Kennedy, Kathleen J. FHCC Lovell (b)(6) (b)(6) (b)(6) (Aptive HTG) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) [USA] (b)(6) (b)(6) Aklamati-Darko, Eva (b)(6) (b)(6) Cogar, Dana (ATLAS) (b)(6) Villard, Douglas R. FNCVAMC (b)(6) Patel, Neil (GLA) (b)(6) Geiger, Josh (b)(6) Park, Glennon K (b)(6) Pena, David A. (b)(6) Weaver, Meaghann S. (b)(6) Smith, Stacy C. (b)(6) Rusch, Brett D. (b)(6) Coldwell, Craig (b)(6) Potter, Lucinda (b)(6) Frazier, Raymond (b)(6) Powell, Fawn M. (b)(6) Ludwa, Cheryl (b)(6) Newman, Mike (OGC) (b)(6) Goldberg, Kenneth (b)(6) Havens, Nicholas S. CMOVAMC (b)(6) Pantoja, Melanie, MS (b)(6) Biester, Jacque, MS (b)(6) Jordan, Will H. (b)(6) Campbell, Stacey (b)(6) Cillessen, Kathryn J. (b)(6) Saulmon, John C. (b)(6) DuFon, Jack (b)(6) Morgan, Sean T. (b)(6)
Subject: PLEASE REVIEW: Adolescent Vaccination Memo

Good Morning adolescent vaccination IPT members –
We have a draft memo prepared, but your edits and input are crucial to ensure we are sharing accurate and clear information with the field.
Please review the draft memo on SharePoint and contribute your edits via track changes **no later than 2:30pm TODAY**. If you experience access issues, please let me know and we will

rectify that ASAP. Our goal will be to send this up to VA leadership for review and approval late this afternoon, and distribution to the field by Monday at noon.

Note that the memo attachments are not yet finalized. I have attached the latest version of the OGC attachment, but I know the Clinical Guidelines and Vaccination Worksheet are still in progress. Please let me know once those are final!

Reach out with any questions.
Thanks once again for all of your work over this past week. It's been incredible to see what this group has managed to accomplish in such a short period of time!

Jessica Varone, MPM
Program Specialist
VHA Office of Healthcare Transformation (OHT) – 10A5
Phone (b)(6) | (b)(6)

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From: Gnau, Andrew
Sent: Tue, 22 Jun 2021 12:19:13 +0000
To: Upton, Mark T.;Smith, Clifford A.;Cox, Gerard R. VHACO;Gleason, Theresa
Cc: Cunningham, Kristin;Frey, Natalie EG.;Carroll, David (VACO);Ballenger, David
Subject: RE: Prep Session: Mental Health Bills
Attachments: Murder Board Questions.docx

Good morning everyone,
Just sharing the latest version of the murder board questions received. (Feel free to share or re-attach to the calendar invitation.)

R/
Andy

-----Original Appointment-----
From: Upton, Mark T. (b)(6)
Sent: Monday, June 21, 2021 3:47 PM
To: Upton, Mark T.; Smith, Clifford A.; Gnau, Andrew; Cox, Gerard R. VHACO
Cc: Cunningham, Kristin; Frey, Natalie EG.; Carroll, David (VACO)
Subject: Prep Session: Mental Health Bills
When: Tuesday, June 22, 2021 9:00 AM-10:00 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

Prep for Thursday's hearing

Microsoft Teams meeting

Join on your computer or mobile app
Click here to join the meeting

Or call in (audio only)
(b)(6) United States, Chicago
Phone Conference ID (b)(6)
Find a local number | Reset PIN

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From: Upton, Mark T.
Sent: Thu, 1 Jul 2021 23:59:57 +0000
To: Flynn, Julianne
Subject: Re: Q2 Safety Report

Thanks, great idea. (b)(5)
(b)(5) Please feel free to discuss with him (and tell him I said hi). Appreciate it
Get Outlook for iOS
From: Flynn, Julianne (b)(6)
Sent: Thursday, July 1, 2021 7:06:06 PM
To: Upton, Mark T. (b)(6)
Subject: RE: Q2 Safety Report

Yes I plan to look at both reports tonight. Like most things, it may just come down to communication. If OCC sends to the VISNs, some probably send on and some, not so much.
This is the first time I have seen these myself.

One idea is Michael Charness – the COS at Boston VA heads up our weekly Wednesday COS meetings… He has led the way toward bridging some of these sorts of things. I am now on the COS field group so I can broach the idea with him as well.

-Julie

From: Upton, Mark T. (b)(6)
Sent: Thursday, July 1, 2021 3:29 PM
To: Flynn, Julianne (b)(6)
Subject: RE: Q2 Safety Report

Lot to digest in these but I'd like your thoughts (no need to respond today). (b)(5)
(b)(5)
(b)(5) Appreciate your input!

From: Beckett, Mary K. (b)(6)
Sent: Thursday, July 1, 2021 12:37 PM
To: Upton, Mark T. (b)(6) Greenstone, Clinton (b)(6)
Cc: Flynn, Julianne (b)(6)
Subject: Q2 Safety Report

Attached is the Q2 Safety Report Of note:

- With Elizabeth's input before she left, we created a new category "blood".
- We separated adverse events from close calls on some slides to get a clearer picture of adverse event reporting frequency.

- We reclassified some medication error events to delay of care since they were due to provider non-responsiveness related to Pharmacy requests.
- Increased numbers may represent more reporting/following procedure and not necessarily more events (VISN slides).
- 59% of reported falls are in CNHs (slide 27).
- Over 28% of medication events were due to incorrect or missing information (slide 35).
- COVID related analysis (slide 44) 25 events due to exposure, 25 due to delay in care, 10 of which were due to delayed scheduling, 6 events due to vaccine.

Let me know if you have any questions or feedback,

Katie

Katie Beckett, M.D.
Acting Chief Medical Officer
Office of Community Care
(b)(6) cell
(b)(6)

ChooseVA

"To lead people, walk behind them"
Lao Tzu

From: Upton, Mark T.
Sent: Thu, 1 Jul 2021 20:29:27 +0000
To: Flynn, Julianne
Subject: RE: Q2 Safety Report
Attachments: CC Patient Safety Quarterly Report_FY2021Q2_FINAL.pptx

Lot to digest in these but I'd like your thoughts (no need to respond today). (b)(5)
(b)(5)
(b)(5) Appreciate your inupt!

From: Beckett, Mary K. (b)(6)
Sent: Thursday, July 1, 2021 12:37 PM
To: Upton, Mark T. (b)(6) Greenstone, Clinton (b)(6)
Cc: Flynn, Julianne (b)(6)
Subject: Q2 Safety Report

Attached is the Q2 Safety Report Of note:

- With Elizabeth's input before she left, we created a new category "blood".
- We separated adverse events from close calls on some slides to get a clearer picture of adverse event reporting frequency.
- We reclassified some medication error events to delay of care since they were due to provider non-responsiveness related to Pharmacy requests.
- Increased numbers may represent more reporting/following procedure and not necessarily more events (VISN slides).
- 59% of reported falls are in CNHs (slide 27).
- Over 28% of medication events were due to incorrect or missing information (slide 35).
- COVID related analysis (slide 44) 25 events due to exposure, 25 due to delay in care, 10 of which were due to delayed scheduling, 6 events due to vaccine.

Let me know if you have any questions or feedback,

Katie

Katie Beckett, M.D.
Acting Chief Medical Officer
Office of Community Care
(b)(6) cell
(b)(6)

ChooseVA

"To lead people, walk behind them"
Lao Tzu

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Page 518 of 636

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From: Cox, Gerard R. VHACO
Sent: Wed, 21 Apr 2021 14:50:53 +0000
To: Gunnar, William
Cc: Maudlin, Karen;Upton, Mark T.;Brill, Elizabeth L. MD, MBA, FACOG;McInerney, Joan E.;Lisanne Bunce Ozanian;Willoughby-Brooker, Michelle;Campbell, Tamara, VHACIN
Subject: RE: QSVC Agenda
Attachments: OCC.NCPS Event Reporting.pdf, QSV Council Meeting April 2021.docx

Hi again Bill,

Let's discuss the next time we speak. The April GB agenda for next week is set, and we did not endorse this informational briefing for presentation at a higher level.

At the end of the QSV Council meeting last week I invited Elizabeth to come back to discuss ways to better integrate her office's activities with QPS so that we're not operating two parallel quality/safety organizations. That's the proposal that I'd really like to bring to the GB once we've designed new processes for working together.

Thanks,
Gerry

Gerard R. Cox, MD, MHA
Assistant Under Secretary for Health
Office of Quality & Patient Safety
Veterans Health Administration
U.S. Department of Veterans Affairs

810 Vermont Avenue, N.W., Room (b)(6)
Washington, DC 20420

Staff Assistant: Ms. Jamie Gordon (b)(6) or (b)(6)
Executive Officer: Mr. Yemi Arunsi (Yemi. (b)(6) or (b)(6)

A Legacy of Service. The Future of Care.

From: Gunnar, William (b)(6)
Sent: Wednesday, April 21, 2021 9:35 AM
To: Cox, Gerard R. VHACO (b)(6) McInerney, Joan E. (b)(6)
Cc: Maudlin, Karen (b)(6) Upton, Mark T. (b)(6) Brill, Elizabeth L.

MD, MBA, FACOG (b)(6) (b)(6) (b)(6)
Willoughby-Brooker, Michelle (b)(6) Campbell, Tamara, VHACIN
(b)(6) Gunnar, William (b)(6)
Subject: FW: QSVC Agenda

Dr. Cox and Dr. McInerney,
On behalf of OCC and NCPS, I am requesting the endorsement of the QSVC to present "OCC/NCPS Patient Safety Event Reporting" to the GB.
Respectfully,

William Gunnar
Executive Director, NCPS (17PS)
(b)(6)

From: Maudlin, Karen (b)(6)
Sent: Friday, April 9, 2021 3:46 PM
To: VHA GB Quality, Safety & Value Council (b)(6)
Cc: Rasmussen, Karen M. (b)(6) Twigg, Samantha (b)(6)
Brill, Elizabeth L. MD, MBA, FACOG (b)(6) Upton, Mark T. (b)(6)
Campbell, Tamara, VHACIN (b)(6) Willoughby-Brooker, Michelle
(b)(6) (b)(6) (b)(6) (b)(6)
(b)(6) (b)(6) (b)(6) (b)(6) Dowling, Keisha A.
(b)(6) Sandrow, Francine C. (b)(6) Liezert, Timothy W.
(b)(6) Nebeker, Jonathan R. (b)(6) McDonald, Jennifer
(b)(6)
Subject: QSVC Agenda

Good Afternoon,

Attached is the agenda for our QSV Council meeting next week.
Please reach out to (b)(6) if you need the invite.

We have a full agenda, so we are asking speakers to note the time frame and please adjust to allow time for Q&A.

Please don't hesitate to reach out if you have any questions.

Regards,
Karen

Karen Maudlin DHed, RN
Clinical Executive
Office of Quality and Patient Safety
Remote – Largo, Fl
(b)(6)

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Quality, Safety, and Value Council Meeting
April 14, 2021
2:00 pm- 3:30 pm (EST)

Time	Presentation	Topic	Speakers
2:00		Roll Call & Welcome	Dr. Maudlin Dr. Cox Dr. McInerney
2:05	March 16-17 GB Minutes_Signed.pdf Care Coordiniation Integrated Case Mar	Updates from March Governance Board Purpose: Informational	Dr. Cox Dr. McInerney
2:10	KMR_QSV_Council_ Presentation_Apr_2(	GAO-High Risk List Purpose: Informational	Karen Rasmussen, M.D., Director GAO-OIG Accountability Liaison (GOAL)
2:30	QSV_GB_CC Related PS Efforts_v1.0.pdf	VHA Community-Care Related Patient Safety and Quality Activities Purpose: Informational	Speaker: William Gunnar, Executive Director, NCPS, MD, JD and Elizabeth Brill, Senior Advisor to the Acting Assistant Undersecretary for Health for Community Care, VHA Office of Community Care (OCC), MD, MBA, FACOG Guests: Dr. Mark Upton (Acting Assistant Undersecretary for Health for Community Care, VHA OCC), Dr. Tamara Campbell (Acting Chief Medical Officer, OCC), Michelle Willoughby-Brooker (OCC), Lisanne Bunce Ozanian (OCC), Dawn Alayon (OCC), Cam Hunke (OCC)
2:50	Coming Soon	SAIL Governance Update Purpose: Informational with request for QSVC to sponsor to Governance Board	Joe Francis, MD, MPH, Executive Director, Analytics and Performance Integration

3:10	 ModernizeEnterpris eData_QSVCouncil_	Update on Data Modernization Lane of Effort <u>Purpose:</u> Informational with request for QSVC to sponsor to Governance Board	Joe Francis, MD, MPH, Executive Director, Analytics and Performance Integration Fran Sandrow, Chief Health Informatics Officer, Office of Community Care Additional members: Mr. Tim Liezert, Dr. Jennifer MacDonald, Dr. Jonathan Nebeker
	Old Business	None	
	New Business	No EDMs to Review	
3:30		Closing Comments/Adjourn	Dr. Cox

Next Meeting May 12, 2021

From: Hammonds, Michele
Sent: Thu, 1 Jul 2021 17:52:22 +0000
To: Ballesteros, Mark;Michaud, Gerald (Jerry);Williams, Kayla M.;Bryant, Melissa;Tallman, Gary
Cc: Lieberman, Steven;Bryant, Melissa
Subject: RE: Query - VA Vaccination Rates - NY Times

Mark – I am running your responses by the HOC and other SMEs.

Thanks,
Michele

From: Ballesteros, Mark (b)(6)
Sent: Thursday, July 1, 2021 1:48 PM
To: Michaud, Gerald (Jerry) (b)(6) Williams, Kayla M. (b)(6) Bryant, Melissa (b)(6) Tallman, Gary (b)(6)
Cc: Lieberman, Steven (b)(6) Hammonds, Michele (b)(6) Bryant, Melissa (b)(6)
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The part of the tape that is a little hard to hear is he says St. Cloud is 59 percent. Can you make sure that number is what he said. Presume that's MN?

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Just a few more examples would help and also daily updated number on number of covid cases as VA facilities inclusive of deaths

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Thanks. Adding Michele Hammonds, VHA media relations.

Jerry Michaud
Executive Director, Office of Communications (10BCOM)
Veterans Health Administration
(b)(6) | (b)(6)

75 YEARS VETERANS HEALTH ADMINISTRATION

A Legacy of Service. The Future of Care.

VHA 75th Anniversary

For appointments:
Monica.Kelson@va.gov | (b)(6)

From: Williams, Kayla M. (b)(6)
Sent: Thursday, July 1, 2021 10:50 AM
To: Ballesteros, Mark (b)(6) Bryant, Melissa (b)(6) Tallman, Gary (b)(6)

Cc: Lieberman, Steven (b)(6) Michaud, Gerald (Jerry) (b)(6)
Subject: RE: Query - VA Vaccination Rates - NY Times

Mark,

(b)(5)

Copied Dr. Lieberman & Jerry to add additional nuance / details if desired.
Kayla

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Sent: Thursday, July 1, 2021 7:56 AM
To: Williams, Kayla M. (b)(6) Bryant, Melissa (b)(6) Tallman, Gary (b)(6)
Subject: RE: Query - VA Vaccination Rates - NY Times

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v/r
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I'll see what I can get anecdotally. Not sure how I'll address the "not going so well" part of your request. I feel like it would be calling out someone if I say VAMC X, Y and Z have a low vaccination percentage.

I'll sleep on that one. Have a good evening.

v/r
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To: Ballesteros, Mark (b)(6)
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the entire system. For instance, is the 298,186 employees fully vaccinated out of 380,000 which is what website says is VA employees? That seems not horrible, 78 percent; but I am guessing you want a better yield since these are folks in critical roles?
I am not going to ask for the total number of employees per center -- that feels excessive -- but perhaps you could tell me three centers where you are closest to 100 and three where things are not going great? I need to listen to the tape but pretty sure the secretary named one in each category today. Tomorrow am is fine for this.
Thank you again
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There are a few efforts underway to get shots in arms: We just sent 5,000 Johnson and Johnson vaccines to the Philippines for Veterans, their spouses and caregivers. We're continuing to support individuals in Louisiana who were affected by last year's hurricanes. And we're planning on offering vaccines to those in the Northwest sheltering at cooling stations during their unprecedented heat wave.

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And as discussed towards the end of the avail, VA already had in place a program that allows employees an authorized absence of up to two days if they experience adverse reactions after receiving the vaccine. It falls under an administrative leave category and does not require the employee to use any of their accrued leave.

The best source for the numbers is here:
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You'll see that the current numbers are: 2,913,479 Veterans and 298,186 employees fully vaccinated. The website also has it broken down by facility.

Hopefully, this is what you are looking for. Please let me know if you need anything else.

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To: Hammonds, Michele;Michaud, Gerald (Jerry);Williams, Kayla M.;Bryant, Melissa;Tallman, Gary
Cc: Lieberman, Steven;Bryant, Melissa
Subject: RE: Query - VA Vaccination Rates - NY Times

Thanks, Michele.

v/r
Mark

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Sent: Thu, 1 Jul 2021 15:39:27 +0000
To: Ballesteros, Mark;Michaud, Gerald (Jerry);Williams, Kayla M.;Bryant, Melissa;Tallman, Gary
Cc: Lieberman, Steven
Subject: RE: Query - VA Vaccination Rates - NY Times

Mark – Once you draft something we will review it and provide input etc.

Thanks,
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Sent: Thursday, July 1, 2021 11:36 AM
To: Michaud, Gerald (Jerry) (b)(6) Williams, Kayla M. (b)(6) Bryant, Melissa (b)(6) Tallman, Gary (b)(6)
Cc: Lieberman, Steven (b)(6) Hammonds, Michele (b)(6)
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Subject: [EXTERNAL] Following up on covid vaccine states

Hey Mark

Per the secretary's remarks today I may well write on this topic as early as tomorrow. Any chance I can get some clarity on number of vets vaccinated that you are able to account for and some averages at least on employees? Some anecdotal data as that which he alluded to today at least? Also anything further you can offer on the incentive program he mentioned today or anything else you have cooking to get workers vaccinated? The attempt to vaccinate vets all over the place was interesting

(b)(6)

From: Cunningham, Kristin
Sent: Fri, 11 Jun 2021 17:44:55 +0000
To: Duran, Joseph;VHA 13 Community Care Support Staff;Upton, Mark T.
Cc: Brake, Cindy;Brown, Lisa M;Jobes, Kevin;Cline, Harold
Subject: RE: URGENT - FINAL CONCURRENCE - 6/23/21 SVAC Legislative Hearing
Attachments: 210610 Draft Testimony 6.10 OGC Cleared 13 Policy 13 06112021.docx

Thanks Joe and team. I've added my edits to this version. Adding Dr Upton so he can add his comments to this version.

Kristin J. Cunningham, PMP
Executive Officer to the Assistant Under Secretary
for Health for Community Care
Office of Community Care
P – (b)(6)
C – (b)(6)
Email: (b)(6)

From: Duran, Joseph (b)(6)
Sent: Friday, June 11, 2021 1:14 PM
To: Cunningham, Kristin (b)(6) VHA 13 Community Care Support Staff (b)(6)
Cc: Brake, Cindy (b)(6) Brown, Lisa M (b)(6) Jobes, Kevin (b)(6) Cline, Harold (b)(6)
Subject: RE: URGENT - FINAL CONCURRENCE - 6/23/21 SVAC Legislative Hearing

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(b)(5) I added in our document if we would like to submit again. Susan's comments were comments adding edits, not really comments for us to respond to.

Thanks -
Joe Duran
Director Policy and Planning (13BOA1)
(b)(6) (Mobile)
BOA (Policy Directorate) Customer Survey

From: Cunningham, Kristin (b)(6)
Sent: Friday, June 11, 2021 10:46 AM
To: Duran, Joseph (b)(6) VHA 13 Community Care Support Staff (b)(6)
Cc: Brake, Cindy (b)(6) Brown, Lisa M (b)(6) Jobes, Kevin (b)(6) Cline, Harold (b)(6)
Subject: RE: URGENT - FINAL CONCURRENCE - 6/23/21 SVAC Legislative Hearing

(b)(5)

Kristin J. Cunningham, PMP
Executive Officer to the Assistant Under Secretary
for Health for Community Care
Office of Community Care
P – (b)(6)
C – (b)(6)
Email: (b)(6)

From: Duran, Joseph (b)(6)
Sent: Friday, June 11, 2021 12:16 PM
To: VHA 13 Community Care Support Staff (b)(6)
Cc: Brake, Cindy (b)(6) Brown, Lisa M (b)(6) Jobes, Kevin (b)(6) Cline, Harold (b)(6)
Subject: RE: URGENT - FINAL CONCURRENCE - 6/23/21 SVAC Legislative Hearing

13 Support – Please see the attached I recommend concurrence with edits. Also I responded to one of Susan's comments regarding (b)(5)

Thanks -
Joe Duran
Director Policy and Planning (13BOA1)
(b)(6) (Mobile)
BOA (Policy Directorate) Customer Survey

From (b)(6) (b)(6)
Sent: Friday, June 11, 2021 8:12 AM
To: Kalis, Sarah (b)(6) VHA 10B3 Legislative Team (b)(6) VBACO_20 Exec Review (b)(6) Mehrotra, Shakti (b)(6) NCA 42E ACTION (b)(6) Joa, Elena R., VBAVACO (b)(6) OIT Congressional Support (b)(6) OIT Congressional Support (b)(6) Eskenazi, Laura H. (b)(6) Jeffries, Karen (HRA/OSP) (b)(6) Gawne, Amy Warnick (b)(6) VACO 007 Actions (b)(6) Simms, Brett (b)(6) Costa, Anthony (CFM) (b)(6) Madden, Robert W. (b)(6)
Cc: Cornacchio, Drew (OGC) (b)(6) Parsons, Amelia (OGC) (b)(6) Flanz, Meghan Serwin (OGC) (b)(6) Davenport, Robert L. (OGC) (b)(6) OGC HCLG Legislation (b)(6) Brower, Marilyn D. (b)(6) Ballenger, David (b)(6) Martinez, Martin (b)(6) Brooks, Aja (b)(6) Asgarali-Hoffman, Andrew (b)(6) VA OALC Actions (b)(6) OGC Personnel Law Group Supervisors (b)(6) OGC Benefits Law Group Supervisors (b)(6) OGC Real Property Law Group Supervisors (b)(6) OGC Information Law Group Supervisors

(b)(6) OGC Procurement Law Group Supervisors (b)(6) Hogan, Michael R. (OGC) (b)(6) Brick, Suzanne (OGC) (b)(6) VHA 12 PCS Action (b)(6) VHA 15MEM Member Svcs Action (b)(6) VHA 15 Operations Action (b)(6) VHA 108CSO Actions (b)(6) VHA 11 Clinical Services Action (b)(6) VHA 13 Community Care Action (b)(6) VHA 14 DEAN Action (b)(6) VHA 17QPS Action (b)(6) VHA 10A Action (b)(6) VHA 19 Support Svcs Action (b)(6) VHA 104 Finance Action (b)(6) Flanders, Malcolm C. (ERPi) (b)(6) VHA 12CC Action - Telehealth (b)(6) VHA 12CC Working Actions (b)(6) Galpin, Kevin MD (b)(6) Forney Sr., Heath A. (b)(6) Jones, Bruce L. (b)(6) Smith, Avery (b)(6)

Subject: URGENT - FINAL CONCURRENCE - 6/23/21 SVAC Legislative Hearing
Importance: High

Good morning everyone,

Please find attached for expedited review and final concurrence the testimony for the 6/23 SVAC legislative hearing (***1st attachment***). **Please provide concurrences to me NLT 1:00pm today, Friday, 6/11.** Please note that concurrences are required from the following offices: **VHA**, **VBA**, **NCA**, **OIT**, and **OALC** (*or OAEM / CFM? → specific to S. 102*).

As a reminder, **concurrence must come from an authorized signer** by either:

1. **(EASIEST)** E-mail
2. Signed Form 4265 (draft is attached as ***2nd attachment***)

Thank you!

R/

(b)(6)

(b)(6)
Congressional Relations Officer
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
(b)(6) | (b)(6)

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