

In Reply Refer To: FOIA Request 21-00860-F

04/29/2021

Austin Evers
American Oversight
1030 15th Street, NW
Washington, DC, 20005

Dear Austin Evers:

This letter is the initial agency decision on one the Veterans Health Administration referred portions of your July 28, 2020, 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:

"All calendars and calendar entries for the agency officials listed below, including any calendars maintained on their behalf, reflecting events that took place from January 1, 2020 to the date the search is conducted. For calendar entries created in Outlook or similar programs, the documents should be produced in "memo" form to include all invitees, any notes, and all attachments. Please do not limit your search to Outlook calendars—we request the production of any calendar—paper or electronic, whether on government-issued or personal devices—used to track or coordinate how these individuals allocate their time on agency business. The search should include any calendars associated with an agency official's individual email account, as well as any official calendars maintained for the official, including by his or her administrative assistant or scheduler.

Specified Agency Officials:

CFBP

- a. Director Kathy Kraninger
- b. Deputy Director Tom Pahl
- c. Chief of Staff Kirsten Sutton

COMM

- a. Secretary Wilbur Ross
- b. Deputy Secretary Karen Dunn Kelley
- c. Chief of Staff Michael J. Walsh Jr.

DOE

- a. Secretary Dan Brouillette
- b. Under Secretary Mark Menezes
- c. Chief of Staff James Colgary

DOL

- a. Secretary Eugene Scalia
- b. Deputy Secretary Patrick Pizzella
- c. Chief of Staff Rachel Mondl

ED

- a. Secretary Betsy DeVos
- b. Nate Bailey, or any other person serving as Chief of Staff
- c. Deputy Secretary Mitchell Zais
- d. Assistant Secretary, Office of Elementary and Secondary Education, Frank Brogan
- e. Assistant Secretary, Office of Planning, Evaluation and Policy Development, James Blew
- f. Principal Deputy Under Secretary Diane Auer Jones

EPA

- a. Administrator Andrew Wheeler
- b. Chief of Staff Mandy Gunasekara

HUD

- a. Secretary Ben Carson
- b. Deputy Secretary Brian Montgomery
- c. Chief of Staff Andrew Hughes

STATE

- a. Secretary Mike Pompeo
- b. Senior Advisor Toni Porter
- c. Counselor Thomas Ulrich Brechbuhl
- d. Chief of Protocol Cam Henderson
- e. Global AIDS Coordinator and Special Representative for Global Health Diplomacy, Deborah Birx

USDA

- a. Secretary Sonny Perdue
- b. Chief of Staff Ray Starling

VA

- a. Secretary Robert Wilkie
- b. Acting Deputy Secretary Pamela J. Powers
- c. Acting Chief of Staff Brooks D. Tucker."

As indicated in their November 6, 2020 letter (fifth interim Initial Agency Decision), your request was referred to the VA Office of the Secretary (OSVA) on August 7, 2020. Per OSVA's August 7, 2020 letter, they notated that you clarified your request with the following on August 7, 2020: "American Oversight agrees to limit the calendars for Mr. Tucker and Ms. Powers to positions held in the Office of the

Secretary...American Oversight further understands that Ms. Powers has not changed positions during the relevant time period.”

VA Office of the Secretary (OSVA) in their fifth interim released determined that two hundred and thirty five (235) pages of the responsive records originated with the Department of Veterans Affairs, Veterans Health Administration (VHA), and as a result, OSVA referred these two hundred and thirty five (235) pages to the VHA Central Office FOIA Office for further processing and direct response on November 06, 2020 to you under the FOIA tracking number of 21-00860-F. No further searches were completed. VHA FOIA Central Office FOIA received your request on November 06, 2020 under the above mentioned FOIA tracking number.

My review of the documents revealed that they contained information that falls within the disclosure protections of FOIA Exemption 6, 5 U.S.C. § 552(b)(6). FOIA Exemption 6 permits VA to withhold a document or information contained 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 employee names, as the individuals associated with this information have a personal privacy interest in it.

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 provided, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest in this case. The individuals associated with this information have a personal privacy interest in information that outweighs any public interest served by disclosure of their identities under FOIA. Consequently, I am denying your request for this information under FOIA Exemption 6, 5 U.S.C. § 552 (b)(6).

If you disagree with my determination to withhold the information under FOIA Exemption 6, please be advised you may appeal 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:

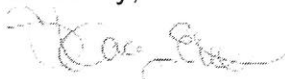
VHA FOIA Public Liaison:
Email Address: vhafoia2@va.gov
Phone Number: (877) 461-5038

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 (785) 230-8430 or via email at stacy.ekis@va.gov.

Sincerely,



Stacy Ekis
VHA FOIA Officer

Enclosure:

Veterans Health Administration Moving Forward Plan: *Safe Care is Our Mission*



VA

U.S. Department
of Veterans Affairs

Veterans Health Administration Moving Forward Plan

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DRAFT

Veterans Health Administration Moving Forward Plan

Veterans Health Administration Moving Forward Plan April 30, 2020

In accordance with the *White House Guidelines for Opening Up America Again*, the Veterans Health Administration (VHA) will use the following approach for addressing continued engagement of safe access to care for both VA direct services and community care services. This plan applies to general/elective surgery, other procedural cases and inpatient and outpatient services. This plan will provide standardized guidelines which can be tailored to individual Veterans Integrated Service Networks (VISN) and VA Medical Centers (VAMC), in consideration of Federal, state and local guidance, and is interoperable with other formal guidance provided by VA.

Key Principles

- As a High Reliability Organization (HRO), the safety of Veterans¹ and staff is, and must be, the highest priority when considering the provision of health care services, items and procedures during the COVID-19 pandemic. Before any clinical care is delivered, safe infrastructure and support must be in place.
- VA will adhere to Centers for Disease Control and Prevention (CDC), and relevant federal, state and local public health guidance and recommendations; the safety of our Veterans and staff members is paramount and part of VHA's culture.
- Facilities must develop a process for Veterans and staff to be screened for COVID-19 symptoms and fever. If symptomatic, testing is offered by VA.
- Symptomatic staff will be triaged by occupational health or designated staff.
- If appropriate, appointments/procedures will be postponed for symptomatic patients to mitigate risks.
- Virtual care modalities should be provided as clinically appropriate. Virtual care should be expanded to include clinical care for all patients, unless it is required that care be performed face-to-face.
- Under these conditions, facilities should work to continually expand their capacity to provide medically appropriate care that reduces risk of COVID-19 transmission to Veterans and staff.
- Procedures and surgeries will be prioritized in accordance with state, local and professional society guidance, as they have been put on hold like in other health systems.
- Decisions on which time-sensitive care to further deliver is a local decision and based on clinician determination of risk.

¹ In referencing "Veterans," this document may include, where appropriate, non-Veteran patients receiving VA treatment or services through VA's 4th Mission.

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- Medically indicated surgical, medical or dental treatments or procedures at a VA facility should be based on patient preference, as well as the professional judgement and risk assessment of the treating clinician in collaboration with a local multidisciplinary leadership team (e.g., Chief of Staff, Associate Director for Patient Care Services, etc.) that can provide information about resource and infrastructure capacity.
- It is critical that leadership creates an environment that facilitates and encourages staff members to speak up, offer suggestions, innovate and be heard. Every staff member can anticipate risk and be a problem solver as their perspectives and insights help us identify safety concerns and develop solutions.
- In a Culture of Safety, all providers should follow guidelines for personal protection, physical distancing and environmental cleaning recommendations outlined by CDC and VA guidance to protect their Veterans and staff both during procedures and business operations.
- All facilities must have a process to inquire about signs/symptoms and/or testing for COVID-19 in any Veteran who undergoes an invasive medical, surgical or dental procedure. This contact will occur within 10-14 days after the procedure, and additional recommendations for testing must be developed for any Veteran who responds affirmatively.
- Veterans and staff should comply with physical distancing at all times when inside a facility or Community Based Outpatient Clinic (CBOC). Everyone has a role in maintaining a safe environment. Each facility should determine the necessary workflows, patient/staff flow and required equipment, supplies and space needed to support necessary physical distancing.
- Consider initial ceilings for face-to-face care (for example: increase by 10 or 20%, increase by 25%, etc.) so that each facility can monitor the downstream impact on care needed, personal protective equipment (PPE) utilization and supply chain sustainability. As impacts and utilization are evaluated, a focus on root cause analysis and continuous process improvement must be implemented to ensure the safety of all Veterans and staff.

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Gating Criteria

In alignment with the *White House Guidelines for Opening Up America Again*, VA guidance and federal, state and local guidance (e.g., CDC guidance), the following Gating Criteria shall be used:

Symptoms ²	Cases	Medical Facilities
The state or region in which the facility is located has a downward trajectory of influenza-like illnesses reported within a 14-day period	The state or region in which the facility is located has a downward trajectory of documented cases of COVID-19 within a 14-day period	The facility is able to treat all patients within the normal standard of care (i.e., not the crisis standard of care)
AND	OR	AND
A downward trajectory of COVID-like syndromic cases reported within a 14-day period	A downward trajectory of positive COVID-19 tests as a percent of total COVID-19 tests within a 14-day period (flat or increasing volume of tests)	A robust testing program is in place for at-risk healthcare workers, including emerging antibody testing
<i>VISNs and VAMCs may need to tailor application of these criteria to local circumstances (e.g., metropolitan areas that have suffered severe COVID outbreaks, rural and suburban areas where outbreaks have not occurred or have been mild).</i>		

Communications and Outreach

VA has developed a national communications campaign in conjunction with this plan, *Moving Forward Together: Safe Care is Our Mission*. The campaign includes:

- A customizable package featuring products on a deployable timeline (t-minus schedule) for Lead Sites, and then VISNs and VAMCs as they move into the next phase of operations.
- A coordinated approach with program offices, VISN and VAMC Public Affairs teams who will review the plan and products to ensure unified messaging.
- The six essential change management questions for product development, including “What’s in it for me” (WIIFM) messaging and HRO principles and values.

² Sources: CDC; National Surveillance Tool; if market-specific data is unavailable, consider facility Emergency Department Dashboard.

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- Safety is VA's number one priority and how VHA is leading the national recovery phase by ensuring safety principles and guidelines are the foundation of plan.
- Veterans Top Line Messages:
 - We, at VA, are here to ensure we meet your needs in a safe environment. (HRO Value: Support a Safety Culture)
 - VA continues to make your safety a priority. We screen everyone entering our facility for COVID-19 to ensure minimum exposure for Veterans, caregivers and staff. (HRO Principle: Preoccupations with Failure)
 - Please feel free to talk to our staff about our facility screening process and the precautions that we are taking to ensure your safety. (HRO Value: Respect for People)
 - You may be tested for COVID-19 within VA. We may ask you to distance yourself from others while waiting for your results. (HRO Principle: Preoccupations with Failure)
 - Non-VA facilities may not follow the same guidelines that VA is practicing. Feel free to ask your community providers about their safety practices and policies, such as screening, distancing and any other measures they are taking to ensure the safest access to treatment. (HRO Value: Duty to Speak Up)
 - You and your provider will discuss your treatment options and overall health status while COVID-19 safety restrictions still exist. Your VA provider will discuss the risks of undergoing certain treatments or procedures, taking into account your overall health status, risk for complications and urgency of the considered treatment. Your VA provider may recommend that you continue to postpone routine but highest risk procedures, including dental and eye examinations. (HRO Values: It's About the Veterans, Support a Safety Culture, Respect for People, Preoccupation with Failure)
- VA Leadership and Staff Top Line Messages
 - Our facility will expand operations in an environment that is safe for our Veterans and staff. Our goal is to care for the Veterans who have the greatest clinical need while ensuring a safe environment for all involved. To accomplish this goal, we will provide health services, taking into account guidance from various agencies including state and local government. (HRO: Sensitivity to Operations)
 - Even before COVID-19, VHA was committed to High Reliability (HRO) principles. HRO principles teach us to empower and value expertise – and we are all empowered to determine what is needed for our Veterans. You have proven this on many occasions by anticipating risks and solving problems through innovations and engagement that supports our mission and keeps both employees and Veterans safe. We are grateful for your dedication, your talents and your willingness to be creative while performing your duties in this COVID-19 environment. (HRO statement)

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- Our dedicated staff has always worked in partnership with our Veterans. Our leadership knows you are committed to continuing VHA's noble mission of safely caring for Veterans. (HRO Principle: Sensitivity to Operations; HRO Value: Respect for People)
- You have earned the trust of our Veterans, which the latest VA trust scores reflect. To maintain that trust, we will re-introduce areas of healthcare as it is safe to do so, and our facility will join community partners in moving forward. (HRO Principle: Deference to Expertise)

Risk/Benefit-Based Assessment for Expanding Procedural Face-to-Face Services

VHA will incorporate the following framework to integrate clinical and supporting considerations in prioritizing and scheduling non-urgent procedures:

- VA will utilize a risk-based framework³ to prioritize which non-urgent procedures may be scheduled in addition to the urgent procedures currently being performed.
- The risk-based guidance below outlines a framework for prioritizing clinical activities for the safety of the Veteran and considering state and local public health guidance.
- Since patient and disease factors are assessed in this framework, care for members of vulnerable populations will be prioritized.
- Facilities will establish multidisciplinary teams to utilize the framework using the following process:
 - Confirm indication for procedure,
 - Determine urgency of procedure,
 - Assess resource impacts on facility,
 - Confirm resources or define gaps, and
 - Determine location of procedure [in-house, other VA facility, affiliate, agency partner (e.g., Indian Health Service, Defense Health Agency, Federally Qualified Health Center) or community care].

³ It is recommended that VA Office of Research and Development evaluate the usage of the framework for more objective application in the future.

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Category		Factor
Patient Specific	Patient Factors	Age
		Lung Disease
		Other Comorbidities Result in Impact on Patient Outcome
		Obstructive Sleep Apnea
		Cardiovascular Disease/Hypertension
		Diabetes
		Immunocompromised
		Influenza-like symptoms
		Positive/Negative Indication of COVID-19
		Exposure to COVID-19
		Recent Travel
	Disease Factors	Non-operative Effectiveness
		Non-operative Resource Exposure
		2-wk Delay Disease Outcome Impact
		2-wk Delay Surgical Risk Impact
		6-wk Delay Disease Outcome Impact
		6-wk Delay Surgical Risk Impact
Facility Specific	Staff Safety	Staff Member Health and Risk Profile Associated with Exposure to COVID-19 (low, medium or high risk based on respiratory droplet exposure ⁴)
	Resource Considerations ⁵ Facilities Staffing Equipment Supplies Pharmaceuticals	Volume of pending cases
		Pre-admission resource consumption/readiness (e.g., supplies, radiology, imaging)
		Intra-procedure resource consumption/readiness (e.g., PPE, staffing)
		Intra-procedure factors (e.g., procedure length, estimated stay, Post-Op ICU Need, Anticipated Blood Loss, Surgical Size Team, Intubation Probability, Surgical Site)
		Post-Procedure factors (e.g., PPE, staffing)
		Post-Discharge resource consumption (e.g., radiology, imaging, subacute care, physical therapy)

Site-Specific Phasing to Expand Services

- VA will put in place and ensure safety of the environment and clinical care and then employ lead sites to quickly assess impact of this risk-based approach and adjust as necessary through regular reassessment.
 - Charter cross-service prioritization work groups to perform advance planning on management of Veterans through pre-admission, procedure,

⁴ Low risk (minimal risk to respiratory droplet exposure), e.g., lower extremities (podiatry, ortho, physical therapy, prosthesis), primary care and mental health (caution when prolonged exposure, limit of guests/traffic), women's health procedures, OR procedures; Medium risk, e.g., mammogram (technician proximity), colonoscopy (20% shed in mucosal lining), audiology fitting, optometry/ophthalmology; High risk, e.g. oral cavity with exposure to respiratory droplets (dental, ENT), Domiciliary Residential Rehabilitation Treatment Program (DOM/RRTP) and other group therapy (due to volume of exposure, communal activity, lack of physical distancing, back-and-forth usage), Upper GI, ERCP, bronchoscopy, EUS

⁵ Includes required support services – required to be in place regardless of nature of care being provided – regular cleaning and disinfecting of physical space (e.g. Audiology testing booth), SPS services, PPE supply chain, Staff testing, transitions of care post-procedure.

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post-procedure and post-discharge resource (e.g., support services, PPE, workforce) consumption.

- Identify priorities to achieving face-to-face workload target at the facility-level of at least a 25% increase of current state procedures over the past four weeks.
- Analyze both pre-COVID and current volumes to determine demand and remodel modalities used to provide safe care.
- Model PPE burn-rate for forecasted workload to include pre-admission, intra-procedure, post-procedure and post-discharge processes, considering local forecasted demands due to external health system demand.
- Maintain 30% active bed capacity and other resources (e.g., support services, PPE, workforce) and ensure VISN surge plans are updated based on COVID-19 transitioning plans.
- Lead with communications campaigns at facilities to educate Veterans and staff on continued delivery of safe care.
- Decisions to reduce or expand services must be continuously reassessed based on local circumstances. Local processes and guidelines should be revised to reflect these changes.
- Concurrent to Lead Site planning, VISNs will begin to establish strategies to expand services for each VAMC and its corresponding clinic services.
 - VISNs should follow the same approach as Lead Sites, analyzing incremental ceilings for increased face-to-face care (for example: increase by 10 or 20%, increase by 25%, etc.) so that each facility can monitor the downstream impact on safety and resources.
 - VISNs should incorporate guidance from Central Office based on learning from Lead Sites' planning.

Key Considerations When Determining When, Where and How Care Will Be Delivered

Virtual Care:

- VA will prioritize virtual modalities for delivery of primary care and mental health services.
- Optimize and prioritize virtual modalities of delivery for specialty care and surgical services when clinically appropriate:
 - Pre-op conversations
 - Post discharge appointments and care
 - Follow-up appointments
- Provide guidance, communications and education to Veterans on remote care/appointments. Educate Veterans and help dispel the myth that virtual care does not work and instead focus on the positive aspects.

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VA Direct Care - VA Medical Center/Community Based Outpatient Clinic:

- Take universal precautions and implement 100% mask utilization and handwashing soon after entry into the healthcare system for employees, Veterans, their family/caregivers, vendors and any other visitor.
 - 100% mask utilization is in alignment with Joint Commission and CDC guidance.
 - Continuously evaluate PPE and materiel burn rates and ability of local and national sources of supply to sustain operations.
 - Customize burn rates based on types of PPE being used in each facility (e.g., face shields, face masks, gowns, etc.).
 - Conduct simulations on supply need.
 - Establish feedback loop based on PPE. If supply levels are low, limit non-urgent/non-emergent procedures until supply levels have increased and stabilize.
 - Continue to limit non-patient visitors until further guidance is provided.
 - Consider four zones of inpatient beds where possible and maintain surge capacity: Surgery (including surgery step down), non-COVID medicine ward, COVID positive isolation ward and ICU.
 - Identify opportunities to improve wellness and social interaction, in keeping with physical distancing, either through new or existing virtual programs and advertise to Veterans.
 - Consider external partnerships, including Veterans Service Organizations, for further engagement.
 - Continuously evaluate and improve on processes and procedures to ensure staff and Veteran safety.
- Remodeling the environment of care and patient flows to establish a Veteran-centric care delivery model is a priority for expanding care to Veterans.
 - VHA Healthcare Environment and Facilities Programs (HEFP) are establishing guidance for VA medical centers and CBOCs.
 - For each service and location, the facility/site should plan and respond to changes in the frequency and demand for support services, such as:
 - Cleaning/Housekeeping/Decontamination/Sterilization
 - Modifications required (per local, State and VA requirements) to reduce disease transmission and spread:
 - Patient Care Rooms
 - Procedure Rooms
 - Business Operations/Check-in
 - Waiting Room Areas
 - Triage Areas at Clinics
 - Parking areas
 - Restroom Areas
 - Need for negative pressure rooms

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- Make risk-based decisions and communicate with local communities when assessing PPE and cleaning needs for drivers and Veterans using Transportation Services.
 - Veterans Transportation Service/Disabled American Veterans-government owned or leased vehicles
 - Contracted services
- Remote Service (exterior to building w/clinic)
 - Conduct path modeling to ensure safe physical distancing throughout patient flow.
 - Screening at entrances and pathways dependent on screening results, with appropriate triaging
 - Handwashing stations (including location signage)
 - Limited waiting areas for group activities and encouragement of returning to cars or areas conducive to physical distancing requirement
 - Paperwork drop off
 - Pre-identified exam rooms
 - Concierge approach of providers meeting a Veteran in the exam room, instead of a Veteran moving around facility to receive different services, in order to streamline treatment and minimize exposure
 - Physical distance reminders (plexiglass; floor markings; removing chairs for spacing; waiting processes for pharmacy, lab and diagnostic imaging; signage)
 - Grab and go options for Canteen Services
 - Operationalize “drive thru” clinics when feasible and safe for Veterans and staff (e.g., pharmacy, testing and laboratory, etc.).
 - Temporary Shelter/Tent-Concierge Team approach:
 - Pharmacy
 - Lab
 - Other
- Determine longer-term needs/complex actions. Changes/additions that may require more complex facility infrastructure changes, such as changes to HVAC systems, furniture improvements/additions, partitions, plexiglass/sneeze shields, build-outs (temporary or permanent) to accommodate increased social distancing requirements.
 - Testing
 - Diagnostic
 - Rapid testing to be available at all VAMC to expedite diagnosis and conserve PPE.
 - Create a clinical assessment prioritization of needs for rapid testing.
 - Apply testing availability to the priority list.

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- Additional guidance will be provided by Integrated Clinical Communities (ICC) as details, testing availability and needs evolve.
- Perform rapid testing day of procedure, when possible.
- Hub/Spoke testing model available to provide 48-hour turn around service for non-emergent tests (e.g., general surveillance) and for testing volume above rapid test capabilities.
- Antibody tests
 - Availability of several testing platforms in place at VAMCs.
 - IgM testing will be available after IgG and total antibody tests are characterized and validated.
 - VA will conduct validation work as part of the Food and Drug Administration Emergency Use Authorization to characterize antibody development in relationship to active disease.
 - Messaging to clarify difference between VA testing protocols and state protocols.
 - Policies under consideration:
 - Implementation of universal testing of Veterans and staff.
 - Screening and testing for COVID-19 of Veterans prior to initiation of specific procedures
 - Surveillance of staff and Veterans for COVID-19 disease.
 - Guidance on providing non-emergent care (VA and community) to Veterans with active COVID-19 infection.
 - Guidance on personal protective equipment for employees and Veterans.

Community Care:

- Implement community care eligibility determination per the MISSION Act and its associated policies and procedures.
- Continue to work with third party administrators to assess availability of community providers and, if available, safety precautions being utilized.
- Communicate with local community providers regarding VA policies and procedures and local expansion plans in order to assure necessary wrap-around and support services are available.
- Communicate with Veterans regarding expectations of referral requests as local guidance and surge needs for non-emergent care may change availability and wait times over time.
- Empower Veterans to identify and expect safe practices in community settings, with VA as a model (e.g. screening expectations, mask utilization, environmental physical distance promotion).

Care Coordination:

- VA is committed to providing the safest and highest quality care to Veterans whether they are receiving their care within VA or in the community. VA will

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- continue to incorporate Referral Coordination Teams to advise Veterans using shared and informed decision making when discussing all care options.
- For those Veterans referred to community care, VA will continue to offer a choice of providers who can meet their healthcare needs.
 - To maintain Veteran-centric care and allow them to be active participants in their own care delivery, VA will promote the preferred option of Veteran self-scheduling with community providers.
 - For those Veterans who request that VA arrange their community care appointments, VA will work to streamline communication and handoffs with community care staff members.
 - Veterans will be empowered to work directly with the community providers at their own pace, with VA at their side working to retrieve medical documentation and other needs to assure continuity of quality care between VA and our non-VA community partners.
 - VA will be the integrator and coordinator of care while addressing Veteran concerns about having more control in the scheduling process.

DRAFT

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Clinical Consult/Referral Prioritization

- Ensure appropriate support services/capabilities are in place before expanding care.
- Each Integrated Clinical Community (ICC) has developed draft plans to give guidance on prioritizing active consults/referrals.
- ICCs are part of VISN-level governing bodies. Collaboration and learning among VISNs and their ICCs can ensure strong practice sharing.
- VISN level ICCs can use this guidance and align based on local facility needs.

Specialty Area	Guidance Provided
Anesthesia	3-phased plan for expanding service
Cardiology	Cardiac Electrophysiologic (EP) Procedures, Diagnostic and Interventional Invasive Procedures, Outpatient Clinics
Diabetes/ Endocrinology	General Outpatient Consult Prioritization
Gastroenterology	Prioritization of Endoscopy Consults (Specifics for Priority 1-4)
Hematology/Oncology	Outpatient consult prioritization (Specifics for priority 1-4)
Infectious Disease	Outpatient consult prioritization (Specifics for priority 1-4)
HIV	Outpatient consult prioritization (Specifics for priority 1-4)
Mental Health	General principles to consider when expanding care
Neurology	Outpatient consult prioritization (Specifics for priority 1-4)
Ophthalmology	Outpatient consult prioritization (Specifics for priority 1-4)
Optometry	Outpatient consult prioritization (Specifics for priority 1-4)
Physical Medicine and Rehab	Outpatient consult prioritization (Specifics for priority 1-4)
Podiatry	Outpatient consult prioritization (Specifics for priority 1-4)
Primary Care	TBD
Pulmonary	Outpatient consult prioritization (Specifics for priority 1-4)
Pain Management	Outpatient consult prioritization (Specifics for priority 1-4)
Radiology	Interim guidance for management and clinical review of orders placed on hold
Surgery	3-phased plan for expanding elective procedures

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Human Resources: Changes in Staffing and Training Needs

Volunteer Staff and Transition from COVID-19 Response Roles

- Staff returning from volunteer deployments (intra- or inter-VISN or 4th Mission) or direct patient care positions may self-quarantine for 14 days after returning to their home station. This time should be considered in facility staffing requirements and planning for return of staff, as well as overall staff wellness and employee health approaches.
- Hiring
 - Hiring for non-COVID-related roles may continue.
 - Temporary details resulting in a promotion can be done noncompetitively for up to 120 days. Temporary promotions for longer than 120 days must be competed. This does not apply to lateral details. VISNs and facilities should monitor waivers (e.g. pre-employment drug testing) to ensure timely completion.
 - VISNs should continue to monitor and address staff turnover and retirement. Hiring should support predicted needs and future staff losses (taking into consideration expected COVID-19 waves, surge in routine care, rehab, etc.).
 - VISNs and facilities should consider local market conditions in tailoring hiring approaches, including private industry healthcare workers out of business due to COVID-19 response.
- Balancing Staff Workload
 - VISNs may consider multiple options to balance surges or workload demands, including:
 - Expedited Temporary Hiring of Staff
 - Travel Nurse Corps deployments
 - Surgical Care Affiliates Nurses and technicians
 - Disaster Emergency Medical Personnel System assignments
 - Intra- and inter-VISN staff sharing
 - Surge Staffing Models (model 2 and 3), which advise on training up additional staff to augment ICU staff based on individual considerations (e.g., Veteran population, staff experience, layout of facility)
 - Telework: VISNs and facilities have discretion on their approach for maintaining or revising facility telework policies. Due to COVID-19 stay-at-home orders, dependent care or illness, telework approaches should be continually reassessed.
- Training
 - To continue to support ongoing COVID-19 care, VA will leverage clinical up-training for nurses and physicians to augment COVID-19 patient care.
 - Each facility should evaluate their unique circumstances to determine the types and manner of training needed. Virtual training via VA Talent Management System and other modalities will continue to be available to staff.

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Information Technology: Continued Expansion for Virtual Care Modalities

- VA seeks to sustain current expanded capabilities in primary care and mental health, while leveraging momentum to further develop video capabilities and innovations in Tele Critical Care and specialty care for appropriate clinical care delivery.
- Telehealth provides increased access to care regardless of geographic areas and promotes physical distancing. As a modality, it should be incorporated as fully as possible into VA's plan to provide expanded care.

VHA Enterprise Monitoring and Reporting

- VA's Healthcare Operations Center will be the centralized hub for VA's Common Operating Picture of COVID-19 operations, leading enterprise monitoring and reporting in coordination with VISN Directors.
- VA will establish centralized reporting and monitoring tools and common data sources and definitions for enterprise, regional and local reporting.
- VA-National Surveillance Tool (VA-NST):
 - Refine and use a single, authoritative VA data source for outbreaks, to provide a common denominator for all reporting and metrics during the course of an event.
 - Harmonize data from critical sources for Veteran information, system capacity, staffing and inventory, to serve multiple reporting and monitoring needs, from patient-level status to system-level readiness.
 - Provide a national surveillance summary, capturing relevant information for Strategic, Operational and Tactical response to an outbreak.
- Key measure categories will include:
 - COVID-19 Case Growth
 - Clinic Capacity
 - Bed Capacity
 - Equipment and Supplies
 - Workforce
 - Testing
 - Outpatient Operational Metrics

Veterans Health Administration Moving Forward Plan

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Draft, Pre-Decisional, Deliberative Document – Internal VA Use Only

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VETERANS HEALTH ADMINISTRATION

Moving Forward Plan

Safe Care is Our Mission COVID-19 Response

Key Principles

Safety of Veterans and VA Staff

High Reliability Organization principles and values

Prioritize, expand and maximize virtual care

Gradual capacity expansion with assessment of safety

Adherence to relevant federal, state and local guidance

Veteran-centric patient flow with physical distancing

Communications and Outreach

Leading with a comprehensive National Communications Campaign and messaging for leaders and staff

- ***Moving Forward Plan: Safe Care is Our Mission***
- **Customizable package featuring products on a deployable timeline (t-minus schedule) for Lead Sites, and then VISNs and VAMCs**
- **The six essential change management questions for product development, including “What’s in it for me” (WIIFM) messaging and HRO principles and values**
- **Safety is VA’s number one priority and how VHA is leading the national recovery phase by ensuring safety principles and guidelines are the foundation of plan**

Risk/Benefit-Based Approach

Developed a risk and benefit assessment framework to expand procedural face-to-face services

- **VA utilizes a risk-based framework to prioritize urgent and non-urgent procedures considering both patient and facility factors**
- **Localized prioritization of clinical activities for the safety of Veterans while considering state and local public health guidance**
- **Care for vulnerable populations is a priority**
- **Multidisciplinary team process through Integrated Clinical Communities and supporting services**

Site-Specific Analysis

Provides use case testing of risk-based assessment framework to inform local and enterprise deployment

- **VA will employ lead sites to quickly assess impact of the risk-based assessment approach and adjust as necessary through regular reassessment**
- **VISNs will establish strategies to expand services for each VAMC and its corresponding clinic services**
- **Lead with communications campaigns at facilities to educate Veterans and staff on continued delivery of safe care**
- **Decisions to reduce or expand services must be continuously reassessed based on local circumstances**

Key Considerations – Delivering Care

Optimize and prioritize expanded virtual modalities for delivery of care

- **Virtual Modalities**
 - Maximize virtual modalities for delivery of primary care and mental health services
 - Prioritize virtual modalities of delivery for specialty care and surgical services when clinically appropriate
- **VA Direct Care – VA Medical Center/Community Based Outpatient Clinics**
 - Take universal precautions and implement 100% mask utilization and handwashing
 - Remodeling the environment of care and patient flows to establish a Veteran-centric care delivery model is a priority for expanding care to Veterans

Key Considerations – Delivering Care (cont.)

Optimize and prioritize expanded virtual modalities for delivery of care

- **Community Care**
 - Implement community care eligibility determination per the MISSION Act and its associated policies and procedures
 - Empower Veterans to identify and expect safe practices in community settings, with VA as a model
- **Clinical Referral Coordination**
 - VA is committed to providing the safest and highest quality care to Veterans whether they are receiving their care within VA or in the community
 - Continue to incorporate Referral Coordination Teams to advise Veterans using shared and informed decision making when discussing all care options

Clinical Consult/Referral Prioritization

Ensuring informed decision making to plan for expanding care, and sharing across Integrated Clinical Communities and VISNs

- **Ensure appropriate support/capabilities are in place before expanding care**
- **Each Integrated Clinical Community (ICC) has developed draft plans to give guidance on prioritizing active consults/referrals**
- **ICCs are a part of VISN-level governing bodies, so collaboration and learning among VISNs and their ICCs can ensure sharing of strong practices**
- **VISN ICCs can use this guidance and align based on local facility needs**

Managing reintegration of COVID-19 Response volunteers, hiring, workload and training requirements

- **Volunteer Staff and Transition from COVID-19 Response Roles**
 - Considered 14-day quarantine in facility staffing requirements and planning for return of staff
- **Hiring**
 - Hiring for non-COVID-related roles may continue
 - Temporary details resulting in a promotion can be done noncompetitively for up to 120 days
- **Balancing Staff Workload**
- **Training**
 - Leverage clinical up-training for nurses and physicians
 - Evaluate their unique circumstances to determine the types and manner of training needed

Continuing expansion for virtual care modalities

- **Sustain current expanded capabilities in primary care and mental health**
- **Leverage momentum to further develop video capabilities and innovations in Tele Critical Care and specialty care for appropriate clinical care delivery**
- **Telehealth provides increased access to care regardless of geographic areas and promotes physical distancing. As a modality, it should be incorporated as fully as possible into VA's plan to provide expanded care**

Establishing and utilizing common reporting and monitoring tools and procedures across the Enterprise

- **VA's Healthcare Operations Center will be the centralized hub for enterprise Central Office monitoring and VISN reporting**
- **VA will establish common reporting and monitoring tools, common data definitions, common data sources for enterprise, regional and local reporting**
- **Key measure categories will include: COVID-19 Case Growth, Inpatient Capacity, Outpatient Clinic Capacity, Equipment and Supplies, Workforce and Testing**

Moving Forward Plan: Safe Care is Our Mission



As a **High Reliability Organization (HRO)**, VA recognizes the safety of patients and staff is – and must be – the highest priority when considering the provision of health care services during the expansion of COVID-19 pandemic related care.

Veterans Health Administration Framework for Expanding Services

- Continued engagement of safe access to care
 - ✓ Includes VA virtual care, direct face-to-face services, and community care services
 - ✓ General/elective surgery, other procedural cases and inpatient and outpatient services
- Standardized guidelines that can be tailored to individual VISNs and VAMCs
- Initiated when disease prevalence decreases with a 14-day downward trend in new cases
- Considers Federal, state, and local guidance

Key Principles

Focus on Safety

- Screen all staff for signs of infection and clear to work
- Adhere to public health guidance and recommendations
- Prefer telehealth in all appropriate areas
- Maintain appropriate physical distancing while in the facility

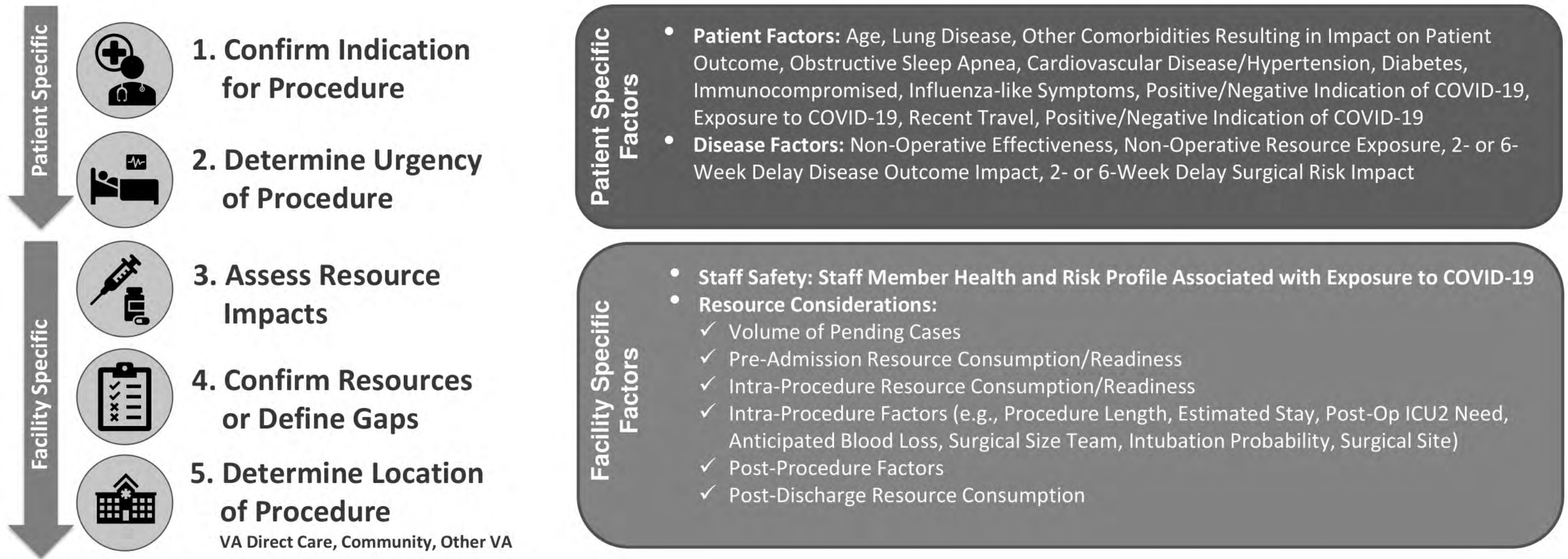
High Reliability

- Defer to expertise of senior clinical leadership
- Duty to Speak Up: Create an environment where staff members feel safe to speak up, offer suggestions and are heard
- Support a Safety Culture: Follow PPE, physical distancing, and environmental cleaning recommendations outlined by the Centers for Disease Control and Prevention

Learning Organization

- Contact patients after procedure to inquire about signs/symptoms and/or testing for COVID-19
- Screen patients and postpone care for symptomatic patients, when clinically appropriate
- Implement initial incremental increases for face-to-face care; monitor downstream impact on care and PPE utilization

Risk/Benefit-Based Assessment for Expanding Services



Site-Specific Phasing To Expand Services VA Lead Sites

Expand Beyond Most Urgent/Emergent Needs

Further Expand Care Delivery

Transition to New Care Model Complete

Explore How to Keep Patients Safe and Deliver Care Moving Forward

Redesign and Remodel Systems

Veterans Health Administration
Moving Forward Plan:
Safe Care is Our Mission



VA

U.S. Department
of Veterans Affairs

Veterans Health Administration Moving Forward Plan

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**Veterans Health Administration
Moving Forward Plan**

**Veterans Health Administration Moving Forward Plan
April 30, 2020**

In accordance with the *White House Guidelines for Opening Up America Again*, the Veterans Health Administration (VHA) will use the following approach for addressing continued engagement of safe access to care for both VA direct services and community care services. This plan applies to general/elective surgery, other procedural cases and inpatient and outpatient services. This plan will provide standardized guidelines which can be tailored to individual Veterans Integrated Service Networks (VISN) and VA Medical Centers (VAMC), in consideration of Federal, state and local guidance, and is interoperable with other formal guidance provided by VA.

Key Principles

- As a High Reliability Organization (HRO), the safety of Veterans¹ and staff is, and must be, the highest priority when considering the provision of health care services, items and procedures during the COVID-19 pandemic. Before any clinical care is delivered, safe infrastructure and support must be in place.
- VA will adhere to Centers for Disease Control and Prevention (CDC), and relevant federal, state and local public health guidance and recommendations; the safety of our Veterans and staff members is paramount and part of VHA's culture.
- Facilities must develop a process for Veterans and staff to be screened for COVID-19 symptoms and fever. If symptomatic, testing is offered by VA.
- Symptomatic staff will be triaged by occupational health or designated staff.
- If appropriate, appointments/procedures will be postponed for symptomatic patients to mitigate risks.
- Virtual care modalities should be provided as clinically appropriate. Virtual care should be expanded to include clinical care for all patients, unless it is required that care be performed face-to-face.
- Under these conditions, facilities should work to continually expand their capacity to provide medically appropriate care that reduces risk of COVID-19 transmission to Veterans and staff.
- Procedures and surgeries will be prioritized in accordance with state, local and professional society guidance, as they have been put on hold like in other health systems.
- Decisions on which time-sensitive care to further deliver is a local decision and based on clinician determination of risk.

¹ In referencing "Veterans," this document may include, where appropriate, non-Veteran patients receiving VA treatment or services through VA's 4th Mission.

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- Medically indicated surgical, medical or dental treatments or procedures at a VA facility should be based on patient preference, as well as the professional judgement and risk assessment of the treating clinician in collaboration with a local multidisciplinary leadership team (e.g., Chief of Staff, Associate Director for Patient Care Services, etc.) that can provide information about resource and infrastructure capacity.
- It is critical that leadership creates an environment that facilitates and encourages staff members to speak up, offer suggestions, innovate and be heard. Every staff member can anticipate risk and be a problem solver as their perspectives and insights help us identify safety concerns and develop solutions.
- In a Culture of Safety, all providers should follow guidelines for personal protection, physical distancing and environmental cleaning recommendations outlined by CDC and VA guidance to protect their Veterans and staff both during procedures and business operations.
- All facilities must have a process to inquire about signs/symptoms and/or testing for COVID-19 in any Veteran who undergoes an invasive medical, surgical or dental procedure. This contact will occur within 10-14 days after the procedure, and additional recommendations for testing must be developed for any Veteran who responds affirmatively.
- Veterans and staff should comply with physical distancing at all times when inside a facility or Community Based Outpatient Clinic (CBOC). Everyone has a role in maintaining a safe environment. Each facility should determine the necessary workflows, patient/staff flow and required equipment, supplies and space needed to support necessary physical distancing.
- Consider initial ceilings for face-to-face care (for example: increase by 10 or 20%, increase by 25%, etc.) so that each facility can monitor the downstream impact on care needed, personal protective equipment (PPE) utilization and supply chain sustainability. As impacts and utilization are evaluated, a focus on root cause analysis and continuous process improvement must be implemented to ensure the safety of all Veterans and staff.

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Gating Criteria

In alignment with the *White House Guidelines for Opening Up America Again*, VA guidance and federal, state and local guidance (e.g., CDC guidance), the following Gating Criteria shall be used:

Symptoms ²	Cases	Medical Facilities
The state or region in which the facility is located has a downward trajectory of influenza-like illnesses reported within a 14-day period	The state or region in which the facility is located has a downward trajectory of documented cases of COVID-19 within a 14-day period	The facility is able to treat all patients within the normal standard of care (i.e., not the crisis standard of care)
AND	OR	AND
A downward trajectory of COVID-like syndromic cases reported within a 14-day period	A downward trajectory of positive COVID-19 tests as a percent of total COVID-19 tests within a 14-day period (flat or increasing volume of tests)	A robust testing program is in place for at-risk healthcare workers, including emerging antibody testing
<i>VISNs and VAMCs may need to tailor application of these criteria to local circumstances (e.g., metropolitan areas that have suffered severe COVID outbreaks, rural and suburban areas where outbreaks have not occurred or have been mild).</i>		

Communications and Outreach

VA has developed a national communications campaign in conjunction with this plan, Moving Forward Together: **Safe** Care is Our Mission. The campaign includes:

- A customizable package featuring products on a deployable timeline (t-minus schedule) for Lead Sites, and then VISNs and VAMCs as they move into the next phase of operations.
- A coordinated approach with program offices, VISN and VAMC Public Affairs teams who will review the plan and products to ensure unified messaging.
- The six essential change management questions for product development, including “What’s in it for me” (WIIFM) messaging and HRO principles and values.

² Sources: CDC; National Surveillance Tool; if market-specific data is unavailable, consider facility Emergency Department Dashboard.

Veterans Health Administration Moving Forward Plan

- Safety is VA's number one priority and how VHA is leading the national recovery phase by ensuring safety principles and guidelines are the foundation of plan.
- Veterans Top Line Messages:
 - We, at VA, are here to ensure we meet your needs in a safe environment. (HRO Value: Support a Safety Culture)
 - VA continues to make your safety a priority. We screen everyone entering our facility for COVID-19 to ensure minimum exposure for Veterans, caregivers and staff. (HRO Principle: Preoccupations with Failure)
 - Please feel free to talk to our staff about our facility screening process and the precautions that we are taking to ensure your safety. (HRO Value: Respect for People)
 - You may be tested for COVID-19 within VA. We may ask you to distance yourself from others while waiting for your results. (HRO Principle: Preoccupations with Failure)
 - Please be sure to inform your VA provider if you receive a COVID-19 diagnostic test outside of VA.
 - Non-VA facilities may not follow the same guidelines that VA is practicing. Feel free to ask your community providers about their safety practices and policies, such as screening, distancing and any other measures they are taking to ensure the safest access to treatment. (HRO Value: Duty to Speak Up)
 - You and your provider will discuss your treatment options and overall health status while COVID-19 safety restrictions still exist. Your VA provider will discuss the risks of undergoing certain treatments or procedures, taking into account your overall health status, risk for complications and urgency of the considered treatment. Your VA provider may recommend that you continue to postpone routine but highest risk procedures, including dental and eye examinations. (HRO Values: It's About the Veterans, Support a Safety Culture, Respect for People, Preoccupation with Failure)
 - If you experience serious and urgent non-COVID-19 concerns (e.g., chest pains), immediately seek medical attention. Safety for all Veterans – including those needing emergency care not related to COVID-19 – is VA's top priority. VA medical facilities are taking every precaution (e.g., 100% mask utilization, physical distancing, etc.) to ensure a safe environment for anyone who enters.
- VA Leadership and Staff Top Line Messages
 - Our facility will expand operations in an environment that is safe for our Veterans and staff. Our goal is to care for the Veterans who have the greatest clinical need while ensuring a safe environment for all involved. To accomplish this goal, we will provide health services, taking into account guidance from various agencies including state and local government. (HRO: Sensitivity to Operations)

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- Even before COVID-19, VHA was committed to High Reliability (HRO) principles. HRO principles teach us to empower and value expertise – and we are all empowered to determine what is needed for our Veterans. You have proven this on many occasions by anticipating risks and solving problems through innovations and engagement that supports our mission and keeps both employees and Veterans safe. We are grateful for your dedication, your talents and your willingness to be creative while performing your duties in this COVID-19 environment. (HRO statement)
- Our dedicated staff has always worked in partnership with our Veterans. Our leadership knows you are committed to continuing VHA's noble mission of safely caring for Veterans. (HRO Principle: Sensitivity to Operations; HRO Value: Respect for People)
- You have earned the trust of our Veterans, which the latest VA trust scores reflect. To maintain that trust, we will re-introduce areas of healthcare as it is safe to do so, and our facility will join community partners in moving forward. (HRO Principle: Deference to Expertise)

Risk/Benefit-Based Assessment for Expanding Procedural Face-to-Face Services

VHA will incorporate the following framework to integrate clinical and supporting considerations in prioritizing and scheduling non-urgent procedures:

- VA will utilize a risk-based framework³ to prioritize which non-urgent procedures may be scheduled in addition to the urgent procedures currently being performed.
- The risk-based guidance below outlines a framework for prioritizing clinical activities for the safety of the Veteran and considering state and local public health guidance.
- Since patient and disease factors are assessed in this framework, care for members of vulnerable populations will be prioritized.
- Facilities will establish multidisciplinary teams to utilize the framework using the following process:
 - Confirm indication for procedure,
 - Determine urgency of procedure,
 - Assess resource impacts on facility,
 - Confirm resources or define gaps, and
 - Determine location of procedure [in-house, other VA facility, affiliate, agency partner (e.g., Indian Health Service, Defense Health Agency, Federally Qualified Health Center) or community care].

³ It is recommended that VA Office of Research and Development evaluate the usage of the framework for more objective application in the future.

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Category		Factor
Patient Specific	Patient Factors	Age
		Lung Disease
		Other Comorbidities Result in Impact on Patient Outcome
		Obstructive Sleep Apnea
		Cardiovascular Disease/Hypertension
		Diabetes
		Immunocompromised
		Influenza-like symptoms
		Positive/Negative Indication of COVID-19
		Exposure to COVID-19
		Recent Travel
	Disease Factors	Non-operative Effectiveness
		Non-operative Resource Exposure
		2-wk Delay Disease Outcome Impact
		2-wk Delay Surgical Risk Impact
		6-wk Delay Disease Outcome Impact
		6-wk Delay Surgical Risk Impact
Facility Specific	Staff Safety	Staff Member Health and Risk Profile Associated with Exposure to COVID-19 (low, medium or high risk based on respiratory droplet exposure ⁴)
	Resource Considerations ⁵ Facilities Staffing Equipment Supplies Pharmaceuticals	Volume of pending cases
		Pre-admission resource consumption/readiness (e.g., supplies, radiology, imaging)
		Intra-procedure resource consumption/readiness (e.g., PPE, staffing)
		Intra-procedure factors (e.g., procedure length, estimated stay, Post-Op ICU Need, Anticipated Blood Loss, Surgical Size Team, Intubation Probability, Surgical Site)
		Post-Procedure factors (e.g., PPE, staffing)
		Post-Discharge resource consumption (e.g., radiology, imaging, subacute care, physical therapy)

Site-Specific Phasing to Expand Services

- VA will put in place and ensure safety of the environment and clinical care and then employ lead sites to quickly assess impact of this risk-based approach and adjust as necessary through regular reassessment.
 - Charter cross-service prioritization work groups to perform advance planning on management of Veterans through pre-admission, procedure,

⁴ Low risk (minimal risk to respiratory droplet exposure), e.g., lower extremities (podiatry, ortho, physical therapy, prosthesis), primary care and mental health (caution when prolonged exposure, limit of guests/traffic), women's health procedures, OR procedures; Medium risk, e.g., mammogram (technician proximity), colonoscopy (20% shed in mucosal lining), audiology fitting, optometry/ophthalmology; High risk, e.g. oral cavity with exposure to respiratory droplets (dental, ENT), Domiciliary Residential Rehabilitation Treatment Program (DOM/RRTP) and other group therapy (due to volume of exposure, communal activity, lack of physical distancing, back-and-forth usage), Upper GI, ERCP, bronchoscopy, EUS

⁵ Includes required support services – required to be in place regardless of nature of care being provided – regular cleaning and disinfecting of physical space (e.g. Audiology testing booth), SPS services, PPE supply chain, Staff testing, transitions of care post-procedure.

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post-procedure and post-discharge resource (e.g., support services, PPE, workforce) consumption.

- Identify priorities to achieving face-to-face workload target at the facility-level of at least a 25% increase of current state procedures over the past four weeks.
- Analyze both pre-COVID and current volumes to determine demand and remodel modalities used to provide safe care.
- Model PPE burn-rate for forecasted workload to include pre-admission, intra-procedure, post-procedure and post-discharge processes, considering local forecasted demands due to external health system demand.
- Maintain 30% active bed capacity and other resources (e.g., support services, PPE, workforce) and ensure VISN surge plans are updated based on COVID-19 transitioning plans.
- Lead with communications campaigns at facilities to educate Veterans and staff on continued delivery of safe care.
- Decisions to reduce or expand services must be continuously reassessed based on local circumstances. Local processes and guidelines should be revised to reflect these changes.
- Concurrent to Lead Site planning, VISNs will begin to establish strategies to expand services for each VAMC and its corresponding clinic services.
 - VISNs should follow the same approach as Lead Sites, analyzing incremental ceilings for increased face-to-face care (for example: increase by 10 or 20%, increase by 25%, etc.) so that each facility can monitor the downstream impact on safety and resources.
 - VISNs should incorporate guidance from Central Office based on learning from Lead Sites' planning.

Key Considerations When Determining When, Where and How Care Will Be Delivered

Virtual Care:

- VA will prioritize virtual modalities for delivery of primary care and mental health services.
- Optimize and prioritize virtual modalities of delivery for specialty care and surgical services when clinically appropriate:
 - Pre-op conversations
 - Post discharge appointments and care
 - Follow-up appointments
- Provide guidance, communications and education to Veterans on remote care/appointments. Educate Veterans and help dispel the myth that virtual care does not work and instead focus on the positive aspects.

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VA Direct Care - VA Medical Center/Community Based Outpatient Clinic:

- Take universal precautions and implement 100% mask utilization and handwashing soon after entry into the healthcare system for employees, Veterans, their family/caregivers, vendors and any other visitor.
 - 100% mask utilization is in alignment with Joint Commission and CDC guidance.
 - Continuously evaluate PPE and materiel burn rates and ability of local and national sources of supply to sustain operations.
 - Customize burn rates based on types of PPE being used in each facility (e.g., face shields, face masks, gowns, etc.).
 - Conduct simulations on supply need.
 - Establish feedback loop based on PPE. If supply levels are low, limit non-urgent/non-emergent procedures until supply levels have increased and stabilize.
 - Continue to limit non-patient visitors until further guidance is provided.
 - Consider four zones of inpatient beds where possible and maintain surge capacity: Surgery (including surgery step down), non-COVID medicine ward, COVID positive isolation ward and ICU.
 - Identify opportunities to improve wellness and social interaction, in keeping with physical distancing, either through new or existing virtual programs and advertise to Veterans.
 - Consider external partnerships, including Veterans Service Organizations, for further engagement.
 - Continuously evaluate and improve on processes and procedures to ensure staff and Veteran safety.
- Remodeling the environment of care and patient flows to establish a Veteran-centric care delivery model is a priority for expanding care to Veterans.
 - VHA Healthcare Environment and Facilities Programs (HEFP) are establishing guidance for VA medical centers and CBOCs.
 - For each service and location, the facility/site should plan and respond to changes in the frequency and demand for support services, such as:
 - Cleaning/Housekeeping/Decontamination/Sterilization
 - Modifications required (per local, State and VA requirements) to reduce disease transmission and spread:
 - Patient Care Rooms
 - Procedure Rooms
 - Business Operations/Check-in
 - Waiting Room Areas
 - Triage Areas at Clinics
 - Parking areas
 - Restroom Areas
 - Need for negative pressure rooms

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- Make risk-based decisions and communicate with local communities when assessing PPE and cleaning needs for drivers and Veterans using Transportation Services.
 - Veterans Transportation Service/Disabled American Veterans-government owned or leased vehicles
 - Contracted services
- Remote Service (exterior to building w/clinic)
 - Conduct path modeling to ensure safe physical distancing throughout patient flow.
 - Screening at entrances and pathways dependent on screening results, with appropriate triaging
 - Handwashing stations (including location signage)
 - Limited waiting areas for group activities and encouragement of returning to cars or areas conducive to physical distancing requirement
 - Paperwork drop off
 - Pre-identified exam rooms
 - Concierge approach of providers meeting a Veteran in the exam room, instead of a Veteran moving around facility to receive different services, in order to streamline treatment and minimize exposure
 - Physical distance reminders (plexiglass; floor markings; removing chairs for spacing; waiting processes for pharmacy, lab and diagnostic imaging; signage)
 - Grab and go options for Canteen Services
 - Operationalize “drive thru” clinics when feasible and safe for Veterans and staff (e.g., pharmacy, testing and laboratory, etc.).
 - Temporary Shelter/Tent-Concierge Team approach:
 - Pharmacy
 - Lab
 - Other
- Determine longer-term needs/complex actions. Changes/additions that may require more complex facility infrastructure changes, such as changes to HVAC systems, furniture improvements/additions, partitions, plexiglass/sneeze shields, build-outs (temporary or permanent) to accommodate increased social distancing requirements.
 - Testing
 - Diagnostic
 - Rapid testing to be available at all VAMC to expedite diagnosis and conserve PPE.
 - Create a clinical assessment prioritization of needs for rapid testing.
 - Apply testing availability to the priority list.

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- Additional guidance will be provided by Integrated Clinical Communities (ICC) as details, testing availability and needs evolve.
- Perform rapid testing day of procedure, when possible.
- Hub/Spoke testing model available to provide 48-hour turn around service for non-emergent tests (e.g., general surveillance) and for testing volume above rapid test capabilities.
- Antibody tests
 - Availability of several testing platforms in place at VAMCs.
 - IgM testing will be available after IgG and total antibody tests are characterized and validated.
 - VA will conduct validation work as part of the Food and Drug Administration Emergency Use Authorization to characterize antibody development in relationship to active disease.
 - Messaging to clarify difference between VA testing protocols and state protocols.
 - Policies under consideration:
 - Implementation of universal testing of Veterans and staff.
 - Screening and testing for COVID-19 of Veterans prior to initiation of specific procedures
 - Surveillance of staff and Veterans for COVID-19 disease.
 - Guidance on providing non-emergent care (VA and community) to Veterans with active COVID-19 infection.
 - Guidance on personal protective equipment for employees and Veterans.

Community Care:

- Implement community care eligibility determination per the MISSION Act and its associated policies and procedures.
- Continue to work with third party administrators to assess availability of community providers and, if available, safety precautions being utilized.
- Communicate with local community providers regarding VA policies and procedures and local expansion plans in order to assure necessary wrap-around and support services are available.
- Communicate with Veterans regarding expectations of referral requests as local guidance and surge needs for non-emergent care may change availability and wait times over time.
- Empower Veterans to identify and expect safe practices in community settings, with VA as a model (e.g. screening expectations, mask utilization, environmental physical distance promotion).

Care Coordination:

- VA is committed to providing the safest and highest quality care to Veterans whether they are receiving their care within VA or in the community. VA will

**Veterans Health Administration
Moving Forward Plan**

- continue to incorporate Referral Coordination Teams to advise Veterans using shared and informed decision making when discussing all care options.
- For those Veterans referred to community care, VA will continue to offer a choice of providers who can meet their healthcare needs.
 - To maintain Veteran-centric care and allow them to be active participants in their own care delivery, VA will promote the preferred option of Veteran self-scheduling with community providers.
 - For those Veterans who request that VA arrange their community care appointments, VA will work to streamline communication and handoffs with community care staff members.
 - Veterans will be empowered to work directly with the community providers at their own pace, with VA at their side working to retrieve medical documentation and other needs to assure continuity of quality care between VA and our non-VA community partners.
 - VA will be the integrator and coordinator of care while addressing Veteran concerns about having more control in the scheduling process.

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Veterans Health Administration Moving Forward Plan

Clinical Consult/Referral Prioritization

- Ensure appropriate support services/capabilities are in place before expanding care.
- Each Integrated Clinical Community (ICC) has developed draft plans to give guidance on prioritizing active consults/referrals.
- ICCs are part of VISN-level governing bodies. Collaboration and learning among VISNs and their ICCs can ensure strong practice sharing.
- VISN level ICCs can use this guidance and align based on local facility needs.

Specialty Area	Guidance Provided
Anesthesia	3-phased plan for expanding service
Cardiology	Cardiac Electrophysiologic (EP) Procedures, Diagnostic and Interventional Invasive Procedures, Outpatient Clinics
Diabetes/ Endocrinology	General Outpatient Consult Prioritization
Gastroenterology	Prioritization of Endoscopy Consults (Specifics for Priority 1-4)
Hematology/Oncology	Outpatient consult prioritization (Specifics for priority 1-4)
Infectious Disease	Outpatient consult prioritization (Specifics for priority 1-4)
Hepatitis C and Liver Disease	Outpatient consult prioritization (Specifics for priority 1-4)
HIV	Outpatient consult prioritization (Specifics for priority 1-4)
Mental Health	General principles to consider when expanding care
Neurology	Outpatient consult prioritization (Specifics for priority 1-4)
Ophthalmology	Outpatient consult prioritization (Specifics for priority 1-4)
Optometry	Outpatient consult prioritization (Specifics for priority 1-4)
Physical Medicine and Rehab	Outpatient consult prioritization (Specifics for priority 1-4)
Podiatry	Outpatient consult prioritization (Specifics for priority 1-4)
Primary Care	TBD
Pulmonary	Outpatient consult prioritization (Specifics for priority 1-4)
Pain Management	Outpatient consult prioritization (Specifics for priority 1-4)
Radiology	Interim guidance for management and clinical review of orders placed on hold
Surgery	3-phased plan for expanding elective procedures

Veterans Health Administration Moving Forward Plan

Human Resources: Changes in Staffing and Training Needs

Volunteer Staff and Transition from COVID-19 Response Roles

- Staff returning from volunteer deployments (intra- or inter-VISN or 4th Mission) or direct patient care positions may self-quarantine for 14 days after returning to their home station. This time should be considered in facility staffing requirements and planning for return of staff, as well as overall staff wellness and employee health approaches.
- Hiring
 - Hiring for non-COVID-related roles may continue.
 - Temporary details resulting in a promotion can be done noncompetitively for up to 120 days. Temporary promotions for longer than 120 days must be competed. This does not apply to lateral details. VISNs and facilities should monitor waivers (e.g. pre-employment drug testing) to ensure timely completion.
 - VISNs should continue to monitor and address staff turnover and retirement. Hiring should support predicted needs and future staff losses (taking into consideration expected COVID-19 waves, surge in routine care, rehab, etc.).
 - VISNs and facilities should consider local market conditions in tailoring hiring approaches, including private industry healthcare workers out of business due to COVID-19 response.
- Balancing Staff Workload
 - VISNs may consider multiple options to balance surges or workload demands, including:
 - Expedited Temporary Hiring of Staff
 - Travel Nurse Corps deployments
 - Surgical Care Affiliates Nurses and technicians
 - Disaster Emergency Medical Personnel System assignments
 - Intra- and inter-VISN staff sharing
 - Surge Staffing Models (model 2 and 3), which advise on training up additional staff to augment ICU staff based on individual considerations (e.g., Veteran population, staff experience, layout of facility)
 - Telework: VISNs and facilities have discretion on their approach for maintaining or revising facility telework policies. Due to COVID-19 stay-at-home orders, dependent care or illness, telework approaches should be continually reassessed.
- Training
 - To continue to support ongoing COVID-19 care, VA will leverage clinical up-training for nurses and physicians to augment COVID-19 patient care.
 - Each facility should evaluate their unique circumstances to determine the types and manner of training needed. Virtual training via VA Talent Management System and other modalities will continue to be available to staff.

Veterans Health Administration Moving Forward Plan

Information Technology: Continued Expansion for Virtual Care Modalities

- VA seeks to sustain current expanded capabilities in primary care and mental health, while leveraging momentum to further develop video capabilities and innovations in Tele Critical Care and specialty care for appropriate clinical care delivery.
- Telehealth provides increased access to care regardless of geographic areas and promotes physical distancing. As a modality, it should be incorporated as fully as possible into VA's plan to provide expanded care.

VHA Enterprise Monitoring and Reporting

- VA's Healthcare Operations Center will be the centralized hub for VA's Common Operating Picture of COVID-19 operations, leading enterprise monitoring and reporting in coordination with VISN Directors.
- VA will establish centralized reporting and monitoring tools and common data sources and definitions for enterprise, regional and local reporting.
- VA-National Surveillance Tool (VA-NST):
 - Refine and use a single, authoritative VA data source for outbreaks, to provide a common denominator for all reporting and metrics during the course of an event.
 - Harmonize data from critical sources for Veteran information, system capacity, staffing and inventory, to serve multiple reporting and monitoring needs, from patient-level status to system-level readiness.
 - Provide a national surveillance summary, capturing relevant information for Strategic, Operational and Tactical response to an outbreak.
- Key measure categories will include:
 - COVID-19 Case Growth
 - Clinic Capacity
 - Bed Capacity
 - Equipment and Supplies
 - Workforce
 - Testing
 - Outpatient Operational Metrics

Veterans Health Administration Moving Forward Plan

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VHA Bed Expansion-Space Toolkit:
<https://r03cleapp06.r03.med.va.gov/hub2/covid19/>.

VHA COVID-19 Surge Staffing Models:
<https://dvagov.sharepoint.com/sites/VHAWMC/COVID19/ClinicalHR/Forms/AllItems.aspx> (under Attachments).

VHA Healthcare Environment and Facilities Programs (HEFP) COVID-19 Portal:
<https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/10NA5/HealthcareEngineering/Pages/COVID-19.aspx>.

VHA Integrated Clinic Communities Prioritization Guidance:
<https://dvagov.sharepoint.com/sites/VHAOHT/SP-Directory/COVID-19%20Response%20Team/PPFP/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAOHT%2FSP%2DDirectory%2FCOVID%2D19%20Response%20Team%2FPPFP%2FICC&FolderCTID=0x012000DE35EFB4B3BDAB46956B4A13D1B8171B&View=%7B6F99568B%2DAACA%2D48A6%2D8E2B%2D8310EC31C33B%7D>.

VHA Moving Forward Together: **Safe** Care is Our Mission:
<https://dvagov.sharepoint.com/sites/VHAOHT/SP-Directory/COVID-19%20Response%20Team/Toolkits/Forms/AllItems.aspx>.

Draft, Pre-Decisional, Deliberative Document – Internal VA Use Only

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VHA OEM COVID-19 Response Plan:

https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf.

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White House Guidelines for Opening Up America Again (2020),

<https://www.whitehouse.gov/wp-content/uploads/2020/04/Guidelines-for-Opening-Up-America-Again.pdf>.

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Moving Forward Plan: Safe Care is Our Mission



As a **High Reliability Organization (HRO)**, VA recognizes the safety of patients and staff is – and must be – the highest priority when considering the provision of health care services during the expansion of COVID-19 pandemic related care.

Veterans Health Administration Framework for Expanding Services

- Continued engagement of safe access to care
 - ✓ Includes VA virtual care, direct face-to-face services, and community care services
 - ✓ General/elective surgery, other procedural cases and inpatient and outpatient services
- Standardized guidelines that can be tailored to individual VISNs and VAMCs
- Initiated when disease prevalence decreases with a 14-day downward trend in new cases
- Considers Federal, state, and local guidance

Key Principles

Focus on Safety

- Screen all staff for signs of infection and clear to work
- Adhere to public health guidance and recommendations
- Prefer telehealth in all appropriate areas
- Maintain appropriate physical distancing while in the facility

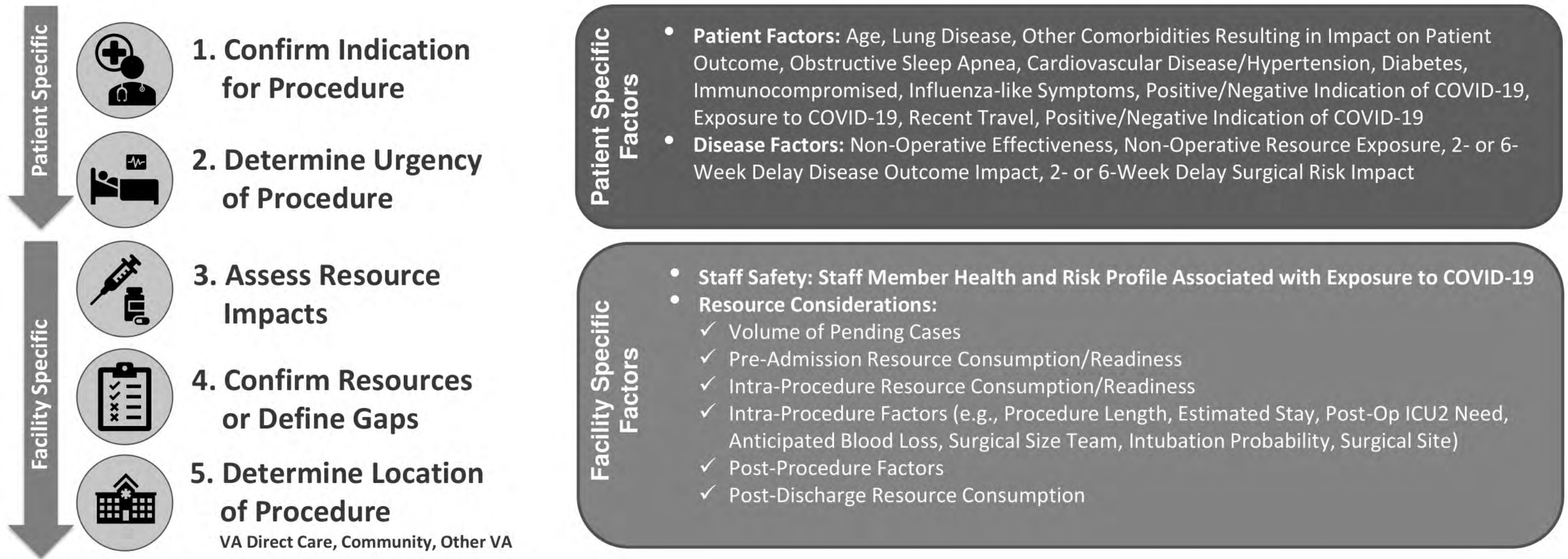
High Reliability

- Defer to expertise of senior clinical leadership
- Duty to Speak Up: Create an environment where staff members feel safe to speak up, offer suggestions and are heard
- Support a Safety Culture: Follow PPE, physical distancing, and environmental cleaning recommendations outlined by the Centers for Disease Control and Prevention

Learning Organization

- Contact patients after procedure to inquire about signs/symptoms and/or testing for COVID-19
- Screen patients and postpone care for symptomatic patients, when clinically appropriate
- Implement initial incremental increases for face-to-face care; monitor downstream impact on care and PPE utilization

Risk/Benefit-Based Assessment for Expanding Services



Site-Specific Phasing To Expand Services VA Lead Sites

Expand Beyond Most Urgent/Emergent Needs

Further Expand Care Delivery

Transition to New Care Model Complete

Explore How to Keep Patients Safe and Deliver Care Moving Forward

Redesign and Remodel Systems

VETERANS HEALTH ADMINISTRATION

Moving Forward Plan

Safe Care is Our Mission COVID-19 Response

Key Principles

Safety of Veterans and VA Staff

High Reliability Organization principles and values

Prioritize, expand and maximize virtual care

Gradual capacity expansion with assessment of safety

Adherence to relevant federal, state and local guidance

Veteran-centric patient flow with physical distancing

Communications and Outreach

Leading with a comprehensive National Communications Campaign and messaging for leaders and staff

- ***Moving Forward Plan: Safe Care is Our Mission***
- **Customizable package featuring products on a deployable timeline (t-minus schedule) for Lead Sites, and then VISNs and VAMCs**
- **The six essential change management questions for product development, including “What’s in it for me” (WIIFM) messaging and HRO principles and values**
- **Safety is VA’s number one priority and how VHA is leading the national recovery phase by ensuring safety principles and guidelines are the foundation of plan**

Risk/Benefit-Based Approach

Developed a risk and benefit assessment framework to expand procedural face-to-face services

- **VA utilizes a risk-based framework to prioritize urgent and non-urgent procedures considering both patient and facility factors**
- **Localized prioritization of clinical activities for the safety of Veterans while considering state and local public health guidance**
- **Care for vulnerable populations is a priority**
- **Multidisciplinary team process through Integrated Clinical Communities and supporting services**

Site-Specific Analysis

Provides use case testing of risk-based assessment framework to inform local and enterprise deployment

- **VA will employ lead sites to quickly assess impact of the risk-based assessment approach and adjust as necessary through regular reassessment**
- **VISNs will establish strategies to expand services for each VAMC and its corresponding clinic services**
- **Lead with communications campaigns at facilities to educate Veterans and staff on continued delivery of safe care**
- **Decisions to reduce or expand services must be continuously reassessed based on local circumstances**

Key Considerations – Delivering Care

Optimize and prioritize expanded virtual modalities for delivery of care

- **Virtual Modalities**
 - Maximize virtual modalities for delivery of primary care and mental health services
 - Prioritize virtual modalities of delivery for specialty care and surgical services when clinically appropriate
- **VA Direct Care – VA Medical Center/Community Based Outpatient Clinics**
 - Take universal precautions and implement 100% mask utilization and handwashing
 - Remodeling the environment of care and patient flows to establish a Veteran-centric care delivery model is a priority for expanding care to Veterans

Key Considerations – Delivering Care (cont.)

Optimize and prioritize expanded virtual modalities for delivery of care

- **Community Care**
 - Implement community care eligibility determination per the MISSION Act and its associated policies and procedures
 - Empower Veterans to identify and expect safe practices in community settings, with VA as a model
- **Clinical Referral Coordination**
 - VA is committed to providing the safest and highest quality care to Veterans whether they are receiving their care within VA or in the community
 - Continue to incorporate Referral Coordination Teams to advise Veterans using shared and informed decision making when discussing all care options

Clinical Consult/Referral Prioritization

Ensuring informed decision making to plan for expanding care, and sharing across Integrated Clinical Communities and VISNs

- **Ensure appropriate support/capabilities are in place before expanding care**
- **Each Integrated Clinical Community (ICC) has developed draft plans to give guidance on prioritizing active consults/referrals**
- **ICCs are a part of VISN-level governing bodies, so collaboration and learning among VISNs and their ICCs can ensure sharing of strong practices**
- **VISN ICCs can use this guidance and align based on local facility needs**

Managing reintegration of COVID-19 Response volunteers, hiring, workload and training requirements

- **Volunteer Staff and Transition from COVID-19 Response Roles**
 - Considered 14-day quarantine in facility staffing requirements and planning for return of staff
- **Hiring**
 - Hiring for non-COVID-related roles may continue
 - Temporary details resulting in a promotion can be done noncompetitively for up to 120 days
- **Balancing Staff Workload**
- **Training**
 - Leverage clinical up-training for nurses and physicians
 - Evaluate their unique circumstances to determine the types and manner of training needed

Continuing expansion for virtual care modalities

- **Sustain current expanded capabilities in primary care and mental health**
- **Leverage momentum to further develop video capabilities and innovations in Tele Critical Care and specialty care for appropriate clinical care delivery**
- **Telehealth provides increased access to care regardless of geographic areas and promotes physical distancing. As a modality, it should be incorporated as fully as possible into VA's plan to provide expanded care**

Establishing and utilizing common reporting and monitoring tools and procedures across the Enterprise

- **VA's Healthcare Operations Center will be the centralized hub for enterprise Central Office monitoring and VISN reporting**
- **VA will establish common reporting and monitoring tools, common data definitions, common data sources for enterprise, regional and local reporting**
- **Key measure categories will include: COVID-19 Case Growth, Inpatient Capacity, Outpatient Clinic Capacity, Equipment and Supplies, Workforce and Testing**

Caregivers Program Status

May 13, 2020

Agenda

1. Caregiver Record Management Application (CARMA)
2. Regulation Status
3. Caregivers Support Program MISSION Act Implementation

Caregiver Record Management Application (CARMA)

Presented by: Lloyd Thrower Deputy CIO, Account Manager for Health, Office of Information and Technology

BLUF: Caregiver Status

The Caregiver Record Management Application (CARMA) is the workflow management tool used by the Caregiver Support Program (CSP). With delivery of CARMA, VA now has a new case management system for the Caregiver program - one that offers many new features and is designed for the future. That said, significant challenges remain before certification: Contractor Risk – The long list of backlog issues associates with Phase 1 and 2 delivery combined with more complex regulatory updates to stipend processing and the vendor's initial projection of a seven-month Level of Effort, increases risk of on-time delivery. COVID – COVID-19 priorities or needs of other programs (e.g. EHRM) could impact availability of resources needed for CARMA test and deployment.

While significant risks exist, IT Systems enhancements needed for Certification are projected for delivery in September

Caregiver Program – Phase 3 Status

CARMA Phase 3 delivery has three major components. Online Registration Form 10-10CG team has established connectivity with the CARMA QA environment. Dark release on schedule for May followed by soft release in July. Integration With Backend Systems Master Person Index (MPI) Release 13 has been deployed putting MPI in position to accept Caregiver information from CARMA. ES/VISTA Interface with MPI has been successfully tested. VHA Corporate Data Warehouse (CDW) Workgroup has been created and the interface/connectivity with CARMA has been established and tested. Five CPRS templates have been completed - 1 is deployed, 3 are ready for deployment, and 1 is in site-testing. An additional 20 CPRS templates are under development. VA Profile work to verify and update non-identity information for caregivers is in progress. Coding of Regulations First of six Regulatory Changes development sprints are underway. Team

Caregiver Program – Risks

- **Contractor Risk:** If vendor has similar difficulties in delivering a more complex stipend payment process in a shorter time period that was experienced with a more simplified stipend processing model for Release 2, then the final release is at risk of being delayed. Mitigations: On 5/6 OIT implemented weekly Program Management Reviews (PMRs) with programming team and contractor to closely monitor progress. Exploring option to leverage MITRE as systems integrator on effort. Conducting more detailed elaboration sessions early and working with both the vendor and VHA for options that may require short term manual work arounds to ensure timely certification. Identifying requirements related to the regulation that could be deferred to post-certification – either handled temporarily via manual work arounds or not needed until later in the year. COVID: If COVID-19 priorities redirect OIT and/or VHA resources supporting CARMA or ancillary applications, then final testing or downstream integrations will be delayed. Mitigation: Monitoring both OIT and VHA Caregiver resources closely to ensure certification success. Both OIT and VHA are well aware of the requirement and do not foresee resources being reassigned.

Caregiver Program – Implementation Timeline

Updated 4/23/2020

October 2019: CARMA Phase 1, Release 1.0 Health Eligibility Center (HEC), Caregiver Support Coordinators (CSC) Enrollment Contract Awarded

December 2019: CAT Read Only Data Migration complete CARMA Phase 1, Release 1.1 CSL December 5, 2019: Master Person Index Work Begins

February 2020: CARMA Stipend Payments Run

April 2020: MPI-E Salesforce Compliance Code Complete Incarceration Data Partial Delivery

June 2020: Enrollment System Release – CARMA Integration CPRS Templates (independent of Regulatory changes)

August 2020: Regulatory System Changes into final testing BGS Incarceration Data to CARMA

OCT 2019 NOV 2019 DEC 2019 JAN 2020 FEB 2020 MAR 2020 APR 2020 MAY 2020 JUN 2020 JUL 2020 AUG 2020 SEP 2020 OCT 2020

November 2019: Agile Dark Release

March 2020: CARMA Phase 2 Complete

May 2020: Enrollment System Release VHA CDW Hospitalization Data to CARMA MPI related activities including Caregiver Letter for patronage benefit 1 Regulatory Changes public comment due 5/29: Online 10-10CG Form (Dark Release)

July 2020: Vista REE National Release CARMA Address from VA Profile CARMA to MPI to ES/Vista Data Flow 10-10CG Form Automation (Soft Release)

September 21, 2020: Certification and Go Live

Phase 1
Deliverables
Phase 2
Deliverables
Phase 3
Deliverables

- Automation of letter generation utilizing EDIPI is dependent on MPI-E work being completed. There is a further dependency on DoD's ability/willingness to accept data.

Timeline assumes no changes to regulations as a result of public comment period

Regulation Status

AQ48 - Program of Comprehensive Assistance for Family Caregivers

Presented by: (b)(6) Regulation Specialist, Office of Regulatory Affairs,
VHA

Regulation Status

- Proposed rule published on March 6, 2020 with 60-day public comment period. Public comment period closed on May 5, 2020. Proposed timeline for publishing final rule: June 26, 2020: VA sends OMB final rule. (Need OMB to agree to expedited review) July 24, 2020: OMB publishes final rule publishes. 60-day delay in publishing final rule. Administrative Review Act. (Need to reauthorize the Act in order to expand the Act's authority to be effective. in order to expand the Act's authority to be effective.

Total Comments Received	273 Received Duplicate 271 Total unique	1 1 Withdrawn
	257 individual comments 14 organizational comments	

Caregiver Support Program MISSION Act Implementation

Presented by: Lisa M. Pape, LISW Deputy Chief Patient Care Services Officer for
Care Management and Social Work, VHA

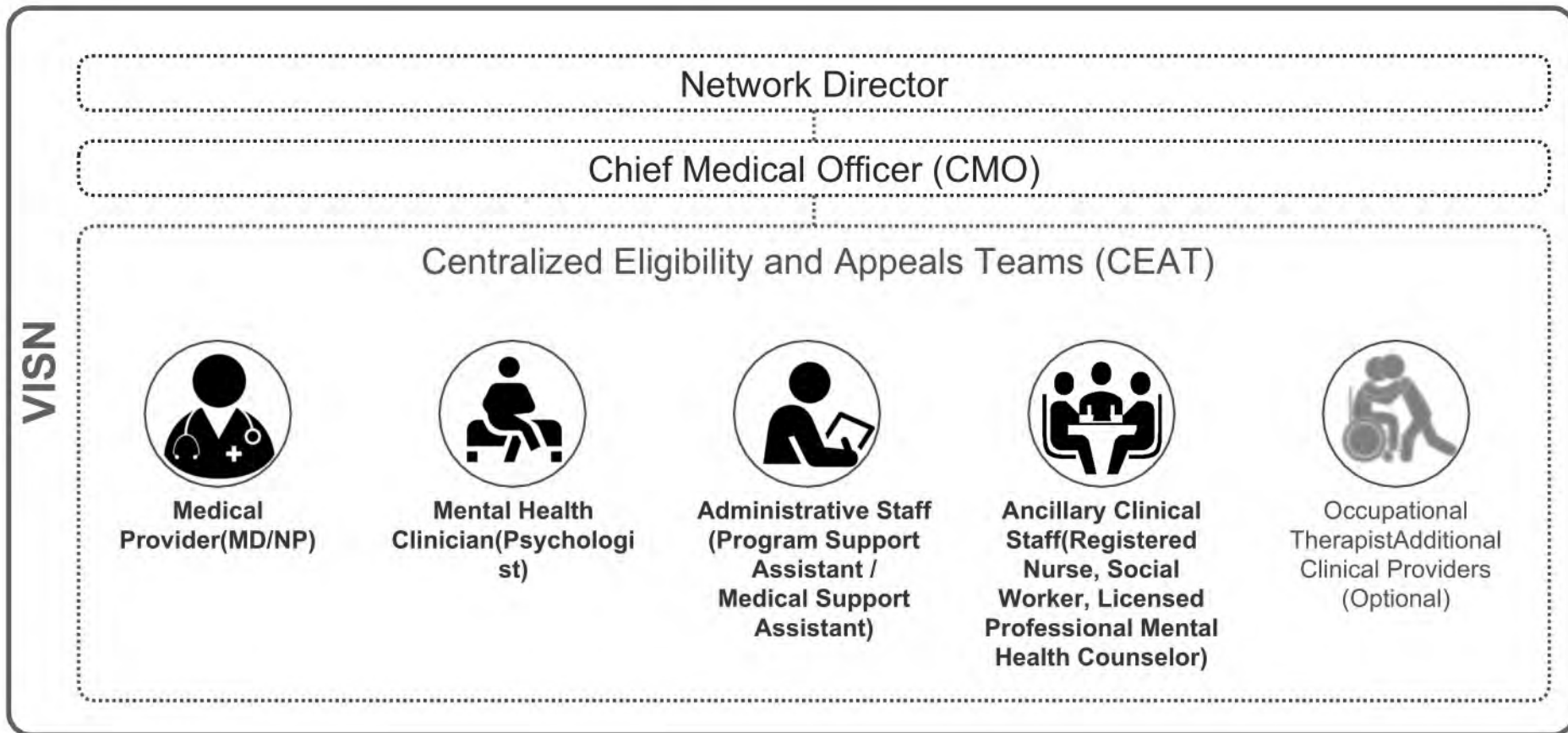
Centralized Eligibility and Appeals Teams (CEAT)

- CEATs are a critical component of MISSION Act expansion The CEAT model articulates the people, processes and technologies necessary to administer the delivery of clear, consistent and objective Program of Comprehensive Assistance for Family Caregivers (PCAFC) eligibility determination outcomes (the future state) in attainable timeframes

Current State Findings		Future State	
Decentralized Processes	Caregiver eligibility processes performed at VA Medical Center (VAMC) -level by collateral staff	Eligibility processes performed at Veterans Integrated Service Network (VISN)-level by full-time inter-professional Centralized Eligibility Teams	Centralized Infrastructure
Lack of Standardization	Eligibility processes are fragmented and unstandardized, resulting in varying eligibility determinations	Standardized eligibility determinations and appeals processes	Standardized Processes
Unclear Measures of Success	No standardized metrics at VISN or national level for measuring efficiency and effectiveness	Uniform national performance measures to identify successes, best practices, and opportunities for improvement	Outcome-Based Measurement

CEAT Composition

By centralizing the PCAFC eligibility/appeals decision making and utilizing trained, dedicated, full-time clinical staff, VA will **reduce variation** and **increase outcome validity and reliability** of decisions



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CEAT Status

Phased CEAT Stand-up: Stand-Up: January - June 2020 (In Process) Full Mission Capability: September 2020 Hiring: CEAT hiring rate is 60% (52) as of April 24, 2020 Total CEAT to be Hired: 87 Total CEAT Selected: 22 (25%) Total Full Time Equivalent (FTE) posting/process: 5 Total FTE Stalled: 8 (VISNs 4, 5, 15, 19 and 22) Training: Mandatory virtual training planned for July 14-16, 2020 Risks: Two identified risks are being addressed COVID-19: Some of the selected staff are being held in clinical positions to support VA's COVID-19 response. Staff expected to return to CEAT role by late June 2020 VISN 15 lagging on CEAT hiring: Met with VISN Chief Medical Officer (CMO) to discuss plan to hire As of April 27, 2020, VISN 15 is close to hiring the physician position and preparing to post two positions this coming week Assistant Under Secretary for Health for Operations informed of discussion with the VISN

Appeals Standard Operating Procedure

- Update to Caregiver Support Program Appeals process in Veterans Health Administration (VHA) Directive 1041 “Appeal of VHA Clinical Decisions” needed as part of expansionTo ensure agility and ease to adjust process, a Standard Operating Procedure (SOP) for Caregiver Appeals is drafted and will be linked to VHA Directive 1041 “Appeal of VHA Clinical Decisions” and VHA Directive 1152(1) “Caregiver Support Program” as an appendixThe process of how appeals will be adjudicated was approved by Network Directors on April 29, 2020 and will be briefed to CMO in the coming weeksThe SOP is concurrently undergoing informal review by the Office of General CounselAnticipated final approval June 1, 2020

Veteran Functional Assessment Instrument

- The Veteran Functional Assessment Instrument assesses and re-assesses a Veteran's functional needs (i.e. need for assistance with Activities of Daily Living [ADLs]) and/or need for supervision or protection. The instrument is based on widely researched, reliable assessments commonly used across the industry: FASIMnCHOICES Risks: April 27, 2020 - Veterans Service Organization (VSO) Briefing: Concerns expressed by VSOs about the assessment/re-assessment process and ensuring the Veteran Functional Assessment Instrument is valid. Follow-up call with Independence Fund. Extend the regulation public comment period for four weeks. Ruling by Office of Information and Regulatory Affairs on whether Office of Management and Budget will require VA to restart the Caregivers rule making process if the scope of the original regulation is expanded to include the Veteran Functional Assessment Instrument, reassessment process and appeals process. May 7, 2020 - 4 Corners Briefing: To address concerns expressed about not validating the instrument before use and validating the instrument by means other than chart review.

Veteran Functional Assessment Instrument Impact

WILL



STANDARDIZE COLLECTION OF
FUNCTIONAL IMPAIRMENT ALIGNED TO
ELIGIBILITY REQUIREMENTS



IMPROVE CONSISTENCY AND
UNIFORMITY ACROSS VAMCS



RELY ON VETERAN-CENTRIC ASSESSMENT
TECHNIQUES [OBSERVATION, PROBING
QUESTIONS, AND MOTIVATIONAL
INTERVIEWING]



ALLOW FOR IMPROVED DATA COLLECTION
AND MONITORING

WILL NOT



DETERMINE VETERAN/CAREGIVER
ELIGIBILITY



ASSESS THE CAREGIVER



RELY ON SELF-REPORT ONLY



REQUIRE SPECIALIZED EXPERTISE OR
RESULT IN A DIAGNOSIS OR TREATMENT
PLAN



COLLECT INFORMATION NOT ALIGNED
WITH PCAFC REQUIREMENTS



Veteran Functional Assessment Instrument

Phased Stand Up:

- Phase 1:** Over 360 draft instruments were completed to ensure that the instrument measures ADLs/Supervision/Protection, as defined in regulation
- Phase 2:** Over 170 Clinical and Qualitative Multidisciplinary Case Reviews completed
- Phase 3:** Deep Dive Consultations completed
- Phase 4:** Operationalizing the Instrument (Phase 2 Hiring, finalizing training, drafting policy, Computerized Patient Record System Template and other tools) (In progress)

Hiring: To include additional FTE to perform assessments: Assessor at each VAMC based on Milliman projections of estimated # of eligible Veterans/Caregivers

Short Term Plan: Utilize current Home Visit/Eligibility Team staff to conduct assessments, Ongoing discussion regarding use of Physician Assistants and current Caregiver Support Coordinators (CSC)

Training: Deploy a series of eight trainings on assessment and instrument use prior to September 1, 2020

VSO's Concerns: Is the instrument valid/reliable? VA CARES Partnered Evaluation Center endorsed the instrument

VA CARES to conduct quality assurance review and monitoring plan to include:

- Reliability of instruments within the target population; and
- Examining correlations between instruments and validated measures, such as the Jen Frailty Index (which is a proxy measure for functional status)

Overall Caregiver Support Program (CSP) Hiring Initiative

Prior to CSP Hiring Initiative: 480 Staff were funded by CSP. Currently, 70% of these positions remain filled. (Many of the existing staff were promoted into new CSP leadership positions). Phase 1 of the CSP Hiring Initiative: Addition of 684 staff. National Phase 1 Hire Rate: 80%. VISN Leads: 100%. PCAFC Program Manager hiring rate: 90%. PGCSS Program Coordinator hiring rate: 81%. CEAT hiring rate: 60%. The National Program office conducting VISN staffing calls, providing support and structure and developing HR Smart to monitor staffing. A special population code is in development with VA Manpower and VHA Workforce Management to identify all positions funded by the National Office. The code will be assigned to all position numbers identified by the National Program Office. Reports can be developed to track the status of each position number i.e. vacant, hired, selection, etc. Deployment anticipated in June 2020. Phase 2 (under development): Program expansion projections and staffing models and estimated costs to being finalized now (May 2020). FTE to be funded by National CSP Office. Focus on providing additional front line staff to meet the needs of the expanded program. General program staff. Additional CSC Assessor staff to administer functional assessments.

CSP Education and Training

CSP Calls and Training The National CSP Office provides ongoing education and training to field staff on four standing calls a month. In fiscal year (FY) 2019, over 7,000 clinical staff throughout the nation participated in these calls (total does not represent unique staff numbers). A Training Plan has been developed targeting specific audiences and includes a variety of modalities: TMS webinars, face-to-face, virtual conferences, e-learning, program manuals and live training on CSP education calls.

Staff Education and Training As CSPs evolve and new staff join the program, a variety of trainings have been developed to train staff and educate on CSP expansion. Program manuals and guides have been created, along with regularly scheduled Community of Practice Calls, specifically for the following:

- CSCs
- CSP VISN Leads
- CSP Program Managers
- Program of General Caregiver Support and Services (PGCSS) Staff
- CEATs

CSP Education and Training cont.

CSP Conferences FY 2020 (planned in collaboration with EES)VISN Lead Training
Face-to-Face Conference; March 3-5, 2020All newly hired VISN CSP Leads attended the conference in Washington DC
CEATs Planned virtual conference; July 14-16, 2020Approximately 150 CEAT members and VISN CSP Leads to be trained on initial/ongoing PCAFC eligibility and appeal processes
CSP MISSION Act ExpansionPlanned virtual conference; September 15-17, 2020 Approximately 750-1000 CSP field staff to be trained on CSP and changes under the MISSION Act expansion
Primary audience: CSCs, PGCSS Staff, CSP Program Managers and VISN CSP Leads
Webinars: 7 webinars have been completed and 10+ additional webinars are underwayCompleted webinars are available on TMS

CSP Directive, Templates and Consult Development

VHA Directive 1152(1) CSP The CSP Directive and its corresponding SOPs are being updated and consolidated This effort will be prioritized over the next several weeks with the goal of publishing the CSP Directive immediately after the Final Rule Concurrence timelines may need to be expedited to meet the publishing target of September 2020 Templates and Consult Development Templates and consults support expansion and are being developed for both CPRS and Cerner with a target date of completion of August 2020 15 templates under development Four field-level workgroups are meeting weekly to develop content. Content must ensure regulatory requirements are captured and documented in the Electronic Health Record (EHR) Templates include: Intakes; Primary Care Collaboration; In-home, Wellness Contacts; Approval/Denial/Discharge Status notes; Caregiver Assessment; CEAT Documentation; Veteran Assessment; Appeals Documentation Two consults under development Assessor Referral to administer a functional assessment CEAT Referral to adjudicate program eligibility

Questions and Answers

Additional Information

AQ48 Individual Comments

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Summary of major concerns raised in individual comments received Positive (whole or in part): 14% Significant comments received by volume:

Section	Topic	High Level Summary
Definition of Primary Care Team	Primary Care Team (9%)	•Maintain current definition •Proposed definition is too vague Will allow non-physician or other qualified health care professionals to make determinations •Maintain current requirement of including a primary care provider
Eligibility Requirements	Two Phase Expansion (12%)	•Expand immediately to Veterans of all eras
	Eligibility Requirements (43%)	•Expanding at expense of post-9/11 Veterans •Should make this a permanent program for 100% P&T •Should have two separate criteria for pre- and post-9/11 Veterans •Definitions: Serious Injury: 70% SCD is too high, should not use VBA rating because it is not clinical inability to perform an ADL: requirement of each time is too stringent - Need for supervision, protection, or instruction: too vague
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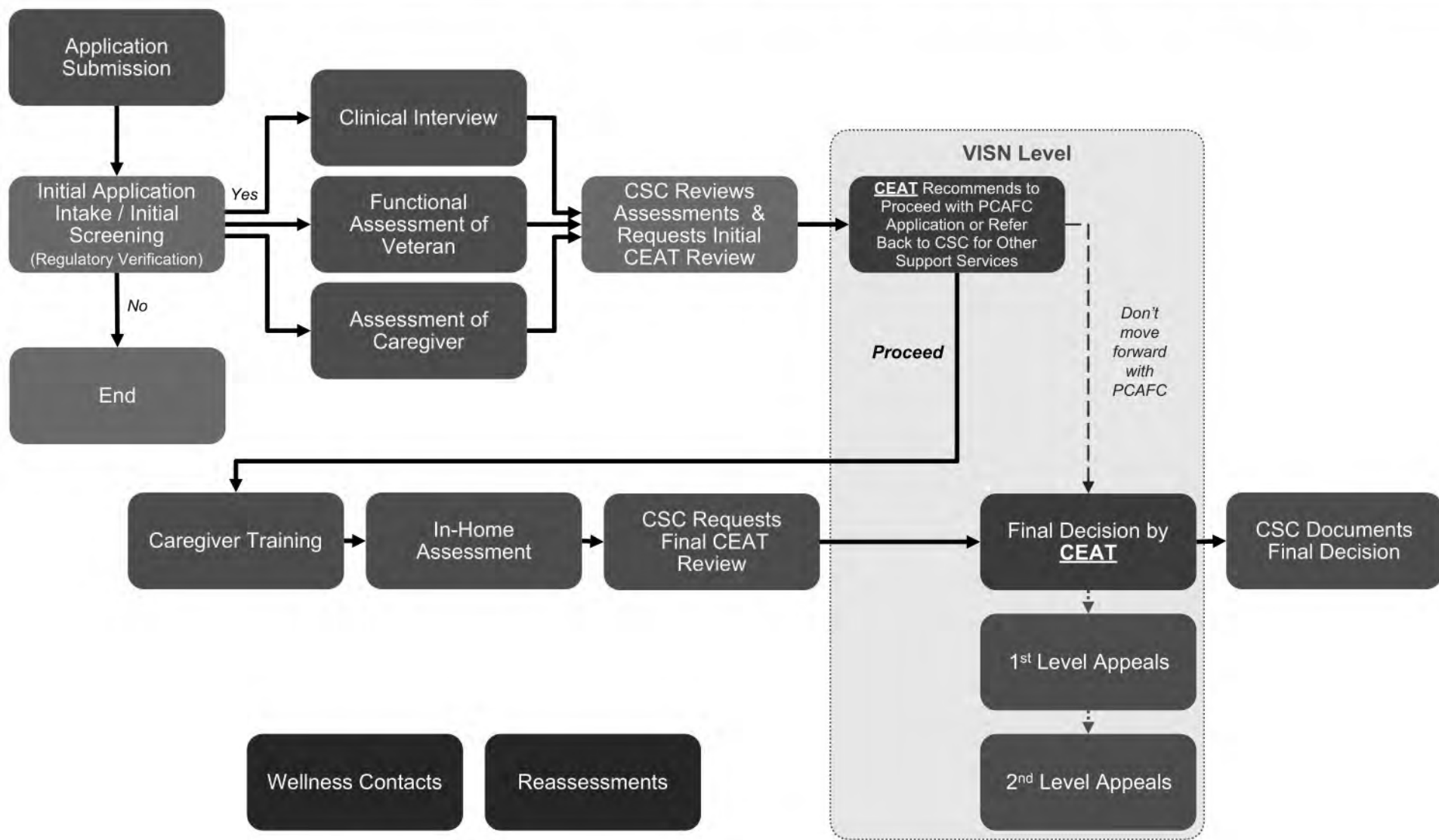
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Reliance on Policy for Eligibility Determinations	•Proposed rule does not provide any/sufficient information regarding eligibility evaluation (including assessment instruments), initial reassessments, reassessments, advanced notice and appeals 7, 10, 11, 14

- | | | |
|---|--|-----------------------------|
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| 3. Elizabeth Dole Foundation | 7. Paralyzed Veterans of America | Legal Service |
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| | 12. | |

Standard PCAFC Application Process with CEAT



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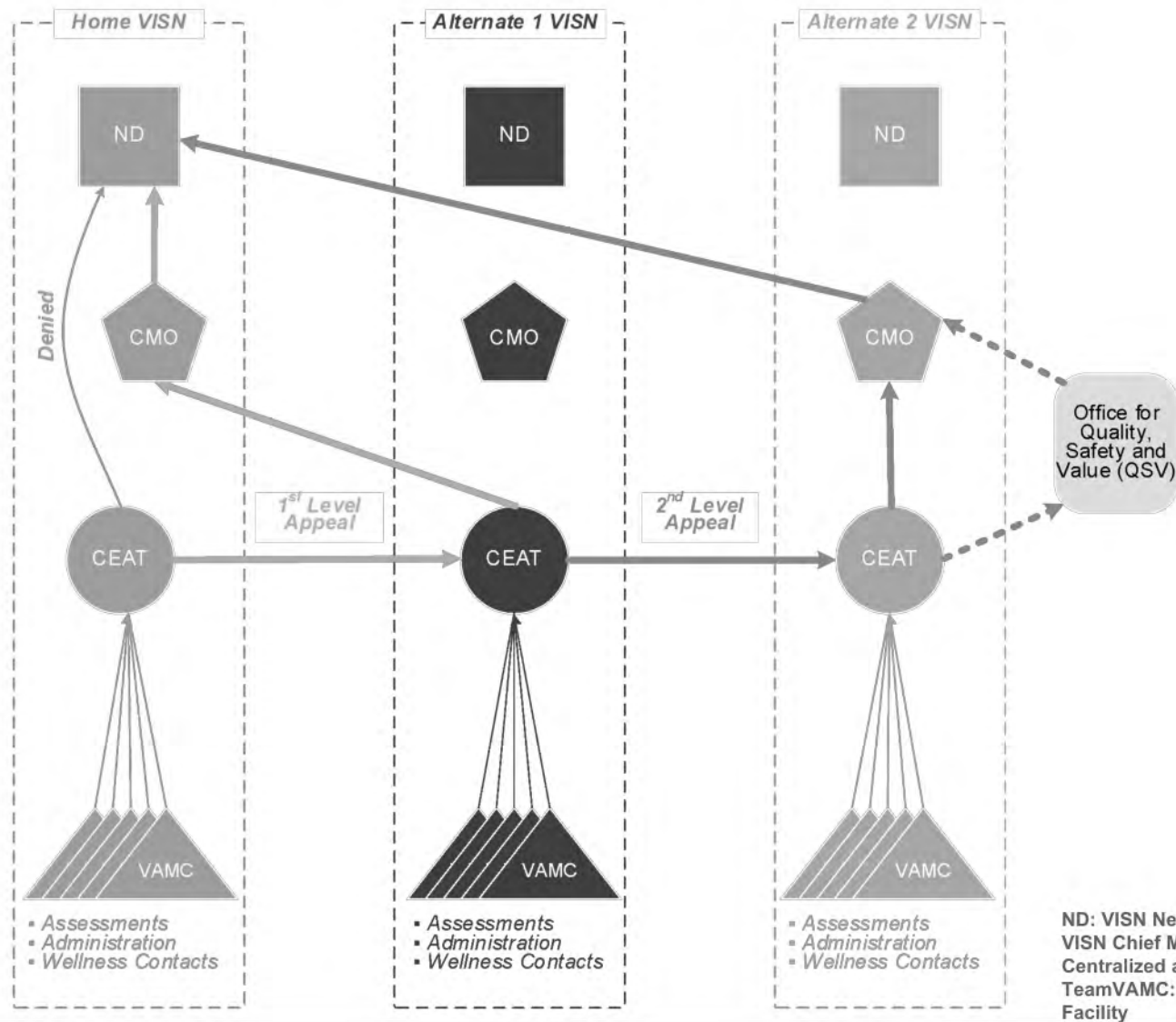
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2nd Level Appeal

Future State Appeals Model

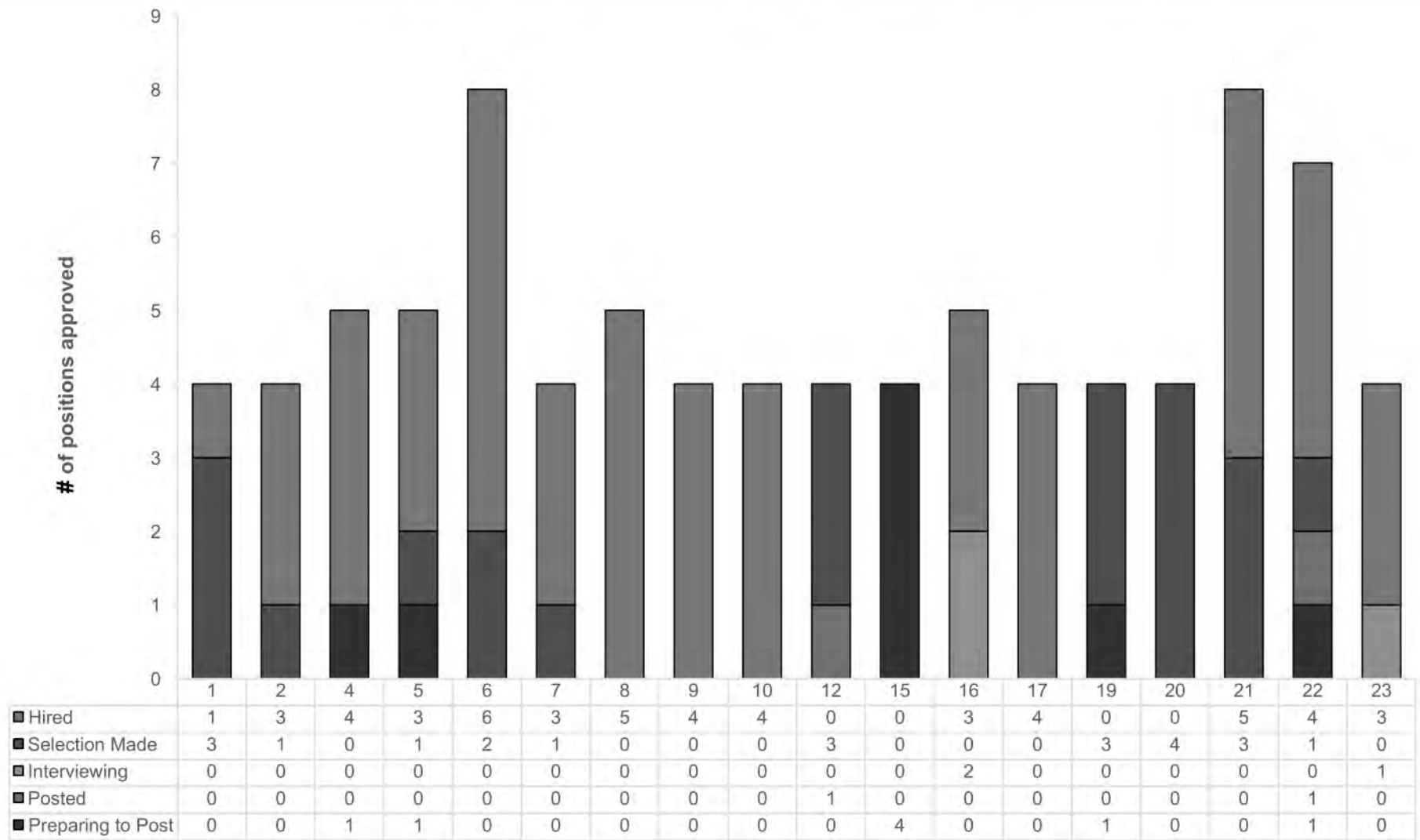


Veteran Functional Assessment Instrument Operational Requirements

- The instrument can be completed by a licensed social worker, nurse, occupational therapist, or other clinical staff, per Special Medical Advisory Group (SMAG) recommendations. Policy will be developed that states each assessor must complete the required Instrument training before assessing Veterans. CEATs will receive additional training on the application of instrument thresholds. Best practice would be an RN with experience/training in both rehabilitation and mental health. Location to complete the assessment may be via telehealth modality and/or in the home. The instrument should be completed once a year unless clinically indicated (aligns with industry standards). National CSP Office will likely fund additional positions to conduct assessments with input from VISN leads and VAMCs.

Caregiver Support Program Phase 1

"Hired" Status of CEATs by VISN (as of 04/17/2020)



04/17/2020

Caregiver Support Program - Education and Training

Course Title	Completions (as of 4/21/2020)
Implementation of Purple Heart and Disabled Veterans Equal Access Act of 2018	84
Program of Comprehensive Assistance for Family Caregivers (PCAFC): Veterans Eligibility Criteria for Providers	766
PCAFC SOP Changes in Functional Status & Continued Eligibility	704
Caregiver Support Program (CSP) MISSION Act Toolkit	393
Program of Comprehensive Assistance for Family Caregivers (PCAFC): Veterans Eligibility Criteria	235
Caregiver Support Program (CSP) VHA Directive 1152(1) Overview	349
VHA Caregiver Support Program Overview	349

Caregivers Program Status

May 13, 2020

Agenda

1. Caregiver Record Management Application (CARMA)
2. Regulation Status
3. Caregivers Support Program MISSION Act Implementation

Caregiver Record Management Application (CARMA)

Presented by: Lloyd Thrower Deputy CIO, Account Manager for Health, Office of Information and Technology

BLUF: Caregiver Status

The Caregiver Record Management Application (CARMA) is the workflow management tool used by the Caregiver Support Program (CSP). With delivery of CARMA, VA now has a new case management system for the Caregiver program - one that offers many new features and is designed for the future. That said, significant challenges remain before certification: Contractor Risk – The long list of backlog issues associates with Phase 1 and 2 delivery combined with more complex regulatory updates to stipend processing and the vendor's initial projection of a seven-month Level of Effort, increases risk of on-time delivery. COVID – COVID-19 priorities or needs of other programs (e.g. EHRM) could impact availability of resources needed for CARMA test and deployment.

While significant risks exist, IT Systems enhancements needed for Certification are projected for delivery in September

Caregiver Program – Phase 3 Status

CARMA Phase 3 delivery has three major components. Online Registration Form 10-10CG team has established connectivity with the CARMA QA environment. Dark release on schedule for May followed by soft release in July. Integration With Backend Systems Master Person Index (MPI) Release 13 has been deployed putting MPI in position to accept Caregiver information from CARMA. ES/VISTA Interface with MPI has been successfully tested. VHA Corporate Data Warehouse (CDW) Workgroup has been created and the interface/connectivity with CARMA has been established and tested. Five CPRS templates have been completed - 1 is deployed, 3 are ready for deployment, and 1 is in site-testing. An additional 20 CPRS templates are under development. VA Profile work to verify and update non-identity information for caregivers is in progress. Coding of Regulations First of six Regulatory Changes development sprints are underway. Team

Caregiver Program – Risks

- **Contractor Risk:** If vendor has similar difficulties in delivering a more complex stipend payment process in a shorter time period that was experienced with a more simplified stipend processing model for Release 2, then the final release is at risk of being delayed. Mitigations: On 5/6 OIT implemented weekly Program Management Reviews (PMRs) with programming team and contractor to closely monitor progress. Exploring option to leverage MITRE as systems integrator on effort. Conducting more detailed elaboration sessions early and working with both the vendor and VHA for options that may require short term manual work arounds to ensure timely certification. Identifying requirements related to the regulation that could be deferred to post-certification – either handled temporarily via manual work arounds or not needed until later in the year. COVID: If COVID-19 priorities redirect OIT and/or VHA resources supporting CARMA or ancillary applications, then final testing or downstream integrations will be delayed. Mitigation: Monitoring both OIT and VHA Caregiver resources closely to ensure certification success. Both OIT and VHA are well aware of the requirement and do not foresee resources being reassigned.

Caregiver Program – Implementation Timeline

Updated 4/23/2020

October 2019: CARMA Phase 1, Release 1.0 Health Eligibility Center (HEC), Caregiver Support Coordinators (CSC) Enrollment Contract Awarded

December 2019: CAT Read Only Data Migration complete CARMA Phase 1, Release 1.1 CSL December 5, 2019: Master Person Index Work Begins

February 2020: CARMA Stipend Payments Run

April 2020: MPI-E Salesforce Compliance Code Complete Incarceration Data Partial Delivery

June 2020: Enrollment System Release – CARMA Integration CPRS Templates (independent of Regulatory changes)

August 2020: Regulatory System Changes into final testing BGS Incarceration Data to CARMA

OCT 2019 NOV 2019 DEC 2019 JAN 2020 FEB 2020 MAR 2020 APR 2020 MAY 2020 JUN 2020 JUL 2020 AUG 2020 SEP 2020 OCT 2020

November 2019: Agile Dark Release

March 2020: CARMA Phase 2 Complete

May 2020: Enrollment System Release VHA CDW Hospitalization Data to CARMA MPI related activities including Caregiver Letter for patronage benefit 1 Regulatory Changes public comment due 5/29: Online 10-10CG Form (Dark Release)

July 2020: Vista REE National Release CARMA Address from VA Profile CARMA to MPI to ES/Vista Data Flow 10-10CG Form Automation (Soft Release)

September 21, 2020: Certification and Go Live

Phase 1
Deliverables
Phase 2
Deliverables
Phase 3
Deliverables

- Automation of letter generation utilizing EDIPI is dependent on MPI-E work being completed. There is a further dependency on DoD's ability/willingness to accept data.

Timeline assumes no changes to regulations as a result of public comment period

Regulation Status

AQ48 - Program of Comprehensive Assistance for Family Caregivers

Presented by: (b)(6) Regulation Specialist, Office of Regulatory Affairs,
VHA

Regulation Status

- Proposed rule published on March 6, 2020 with 60-day public comment period. Public comment period closed on May 5, 2020. Proposed timeline for publishing final rule: June 26, 2020: VA sends OMB final rule. (Need OMB to agree to expedited review) July 24, 2020: OMB reviews rule. Final rule publishes. 60-day delay. (Need to re-examine rule under Administrative Review Act. in order to expand effective.

Total Comments Received	273 Received Duplicate 271 Total unique	1 1 Withdrawn
	257 individual comments 14 organizational comments	

Caregiver Support Program MISSION Act Implementation

Presented by: Lisa M. Pape, LISW Deputy Chief Patient Care Services Officer for
Care Management and Social Work, VHA

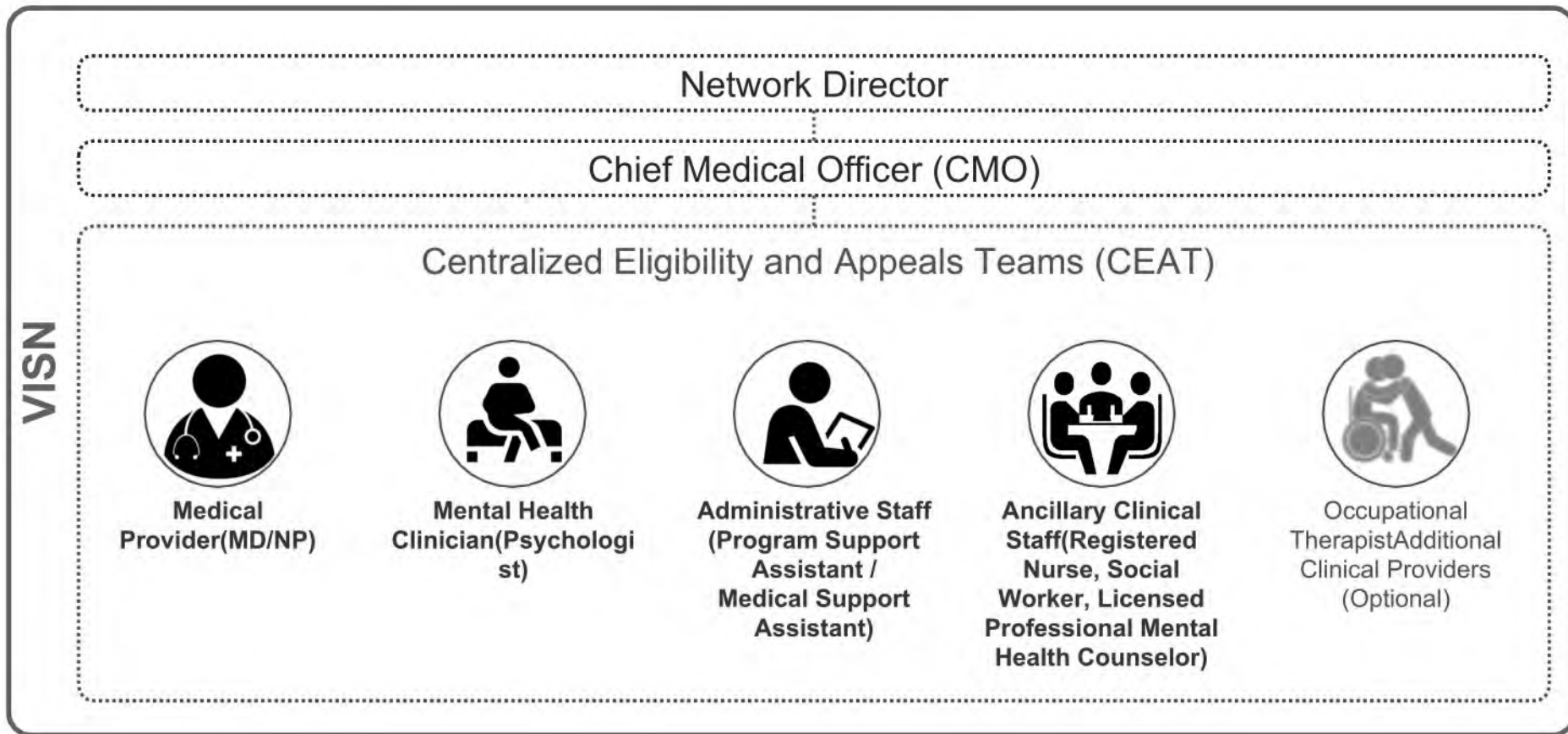
Centralized Eligibility and Appeals Teams (CEAT)

- CEATs are a critical component of MISSION Act expansion The CEAT model articulates the people, processes and technologies necessary to administer the delivery of clear, consistent and objective Program of Comprehensive Assistance for Family Caregivers (PCAFC) eligibility determination outcomes (the future state) in attainable timeframes

Current State Findings		Future State	
Decentralized Processes	Caregiver eligibility processes performed at VA Medical Center (VAMC) -level by collateral staff	Eligibility processes performed at Veterans Integrated Service Network (VISN)-level by full-time inter-professional Centralized Eligibility Teams	Centralized Infrastructure
Lack of Standardization	Eligibility processes are fragmented and unstandardized, resulting in varying eligibility determinations	Standardized eligibility determinations and appeals processes	Standardized Processes
Unclear Measures of Success	No standardized metrics at VISN or national level for measuring efficiency and effectiveness	Uniform national performance measures to identify successes, best practices, and opportunities for improvement	Outcome-Based Measurement

CEAT Composition

By centralizing the PCAFC eligibility/appeals decision making and utilizing trained, dedicated, full-time clinical staff, VA will **reduce variation** and **increase outcome validity and reliability** of decisions



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CEAT Status

Phased CEAT Stand-up: Stand-Up: January - June 2020 (In Process) Full Mission Capability: September 2020 Hiring: CEAT hiring rate is 60% (52) as of April 24, 2020 Total CEAT to be Hired: 87 Total CEAT Selected: 22 (25%) Total Full Time Equivalent (FTE) posting/process: 5 Total FTE Stalled: 8 (VISNs 4, 5, 15, 19 and 22) Training: Mandatory virtual training planned for July 14-16, 2020 Risks: Two identified risks are being addressed COVID-19: Some of the selected staff are being held in clinical positions to support VA's COVID-19 response. Staff expected to return to CEAT role by late June 2020 VISN 15 lagging on CEAT hiring: Met with VISN Chief Medical Officer (CMO) to discuss plan to hire As of April 27, 2020, VISN 15 is close to hiring the physician position and preparing to post two positions this coming week Assistant Under Secretary for Health for Operations informed of discussion with the VISN

Appeals Standard Operating Procedure

- Update to Caregiver Support Program Appeals process in Veterans Health Administration (VHA) Directive 1041 “Appeal of VHA Clinical Decisions” needed as part of expansionTo ensure agility and ease to adjust process, a Standard Operating Procedure (SOP) for Caregiver Appeals is drafted and will be linked to VHA Directive 1041 “Appeal of VHA Clinical Decisions” and VHA Directive 1152(1) “Caregiver Support Program” as an appendixThe process of how appeals will be adjudicated was approved by Network Directors on April 29, 2020 and will be briefed to CMO in the coming weeksThe SOP is concurrently undergoing informal review by the Office of General CounselAnticipated final approval June 1, 2020

Veteran Functional Assessment Instrument

- The Veteran Functional Assessment Instrument assesses and re-assesses a Veteran's functional needs (i.e. need for assistance with Activities of Daily Living [ADLs]) and/or need for supervision or protection. The instrument is based on widely researched, reliable assessments commonly used across the industry: FASIMnCHOICES. Risks: April 27, 2020 - Veterans Service Organization (VSO) Briefing: Concerns expressed by VSOs about the assessment/re-assessment process and ensuring the Veteran Functional Assessment Instrument is valid. Follow-up call with Independence Fund. Extend the regulation public comment period for four weeks. Ruling by Office of Information and Regulatory Affairs on whether Office of Management and Budget will require VA to restart the Caregivers rule making process if the scope of the original regulation is expanded to include the Veteran Functional Assessment Instrument, reassessment process and appeals process. May 7, 2020 - 4 Corners Briefing: To address concerns expressed about not validating the instrument before use and validating the instrument by means other than chart review.

Veteran Functional Assessment Instrument Impact

WILL



STANDARDIZE COLLECTION OF
FUNCTIONAL IMPAIRMENT ALIGNED TO
ELIGIBILITY REQUIREMENTS



IMPROVE CONSISTENCY AND
UNIFORMITY ACROSS VAMCS



RELY ON VETERAN-CENTRIC ASSESSMENT
TECHNIQUES [OBSERVATION, PROBING
QUESTIONS, AND MOTIVATIONAL
INTERVIEWING]



ALLOW FOR IMPROVED DATA COLLECTION
AND MONITORING

WILL NOT



DETERMINE VETERAN/CAREGIVER
ELIGIBILITY



ASSESS THE CAREGIVER



RELY ON SELF-REPORT ONLY



REQUIRE SPECIALIZED EXPERTISE OR
RESULT IN A DIAGNOSIS OR TREATMENT
PLAN



COLLECT INFORMATION NOT ALIGNED
WITH PCAFC REQUIREMENTS



Veteran Functional Assessment Instrument

Phased Stand Up:

- Phase 1:** Over 360 draft instruments were completed to ensure that the instrument measures ADLs/Supervision/Protection, as defined in regulation
- Phase 2:** Over 170 Clinical and Qualitative Multidisciplinary Case Reviews completed
- Phase 3:** Deep Dive Consultations completed
- Phase 4:** Operationalizing the Instrument (Phase 2 Hiring, finalizing training, drafting policy, Computerized Patient Record System Template and other tools) (In progress)

Hiring: To include additional FTE to perform assessments: Assessor at each VAMC based on Milliman projections of estimated # of eligible Veterans/Caregivers

Short Term Plan: Utilize current Home Visit/Eligibility Team staff to conduct assessments, Ongoing discussion regarding use of Physician Assistants and current Caregiver Support Coordinators (CSC)

Training: Deploy a series of eight trainings on assessment and instrument use prior to September 1, 2020

VSO's Concerns: Is the instrument valid/reliable? VA CARES Partnered Evaluation Center endorsed the instrument

VA CARES to conduct quality assurance review and monitoring plan to include:

- Reliability of instruments within the target population; and
- Examining correlations between instruments and validated measures, such as the Jen Frailty Index (which is a proxy measure for functional status)

Overall Caregiver Support Program (CSP) Hiring Initiative

Prior to CSP Hiring Initiative: 480 Staff were funded by CSP. Currently, 70% of these positions remain filled. (Many of the existing staff were promoted into new CSP leadership positions). Phase 1 of the CSP Hiring Initiative: Addition of 684 staff. National Phase 1 Hire Rate: 80%. VISN Leads: 100%. PCAFC Program Manager hiring rate: 90%. PGCSS Program Coordinator hiring rate: 81%. CEAT hiring rate: 60%. The National Program office conducting VISN staffing calls, providing support and structure and developing HR Smart to monitor staffing. A special population code is in development with VA Manpower and VHA Workforce Management to identify all positions funded by the National Office. The code will be assigned to all position numbers identified by the National Program Office. Reports can be developed to track the status of each position number i.e. vacant, hired, selection, etc. Deployment anticipated in June 2020. Phase 2 (under development): Program expansion projections and staffing models and estimated costs to being finalized now (May 2020). FTE to be funded by National CSP Office. Focus on providing additional front line staff to meet the needs of the expanded program. General program staff. Additional CSC Assessor staff to administer functional assessments.

CSP Education and Training

CSP Calls and TrainingThe National CSP Office provides ongoing education and training to field staff on four standing calls a month. In fiscal year (FY) 2019, over 7,000 clinical staff throughout the nation participated in these calls (total does not represent unique staff numbers). A Training Plan has been developed targeting specific audiences and includes a variety of modalities: TMS webinars, face-to-face, virtual conferences, e-learning, program manuals and live training on CSP education calls.

Staff Education and TrainingAs CSPs evolve and new staff join the program, a variety of trainings have been developed to train staff and educate on CSP expansion. Program manuals and guides have been created, along with regularly scheduled Community of Practice Calls, specifically for the following:

- CSCs
- CSP VISN Leads
- CSP Program Managers
- Program of General Caregiver Support and Services (PGCSS) Staff
- CEATs

CSP Education and Training cont.

CSP Conferences FY 2020 (planned in collaboration with EES)VISN Lead Training
Face-to-Face Conference; March 3-5, 2020All newly hired VISN CSP Leads attended the conference in Washington DC
CEATs Planned virtual conference; July 14-16, 2020Approximately 150 CEAT members and VISN CSP Leads to be trained on initial/ongoing PCAFC eligibility and appeal processes
CSP MISSION Act ExpansionPlanned virtual conference; September 15-17, 2020
 Approximately 750-1000 CSP field staff to be trained on CSP and changes under the MISSION Act expansion
 Primary audience: CSCs, PGCSS Staff, CSP Program Managers and VISN CSP Leads
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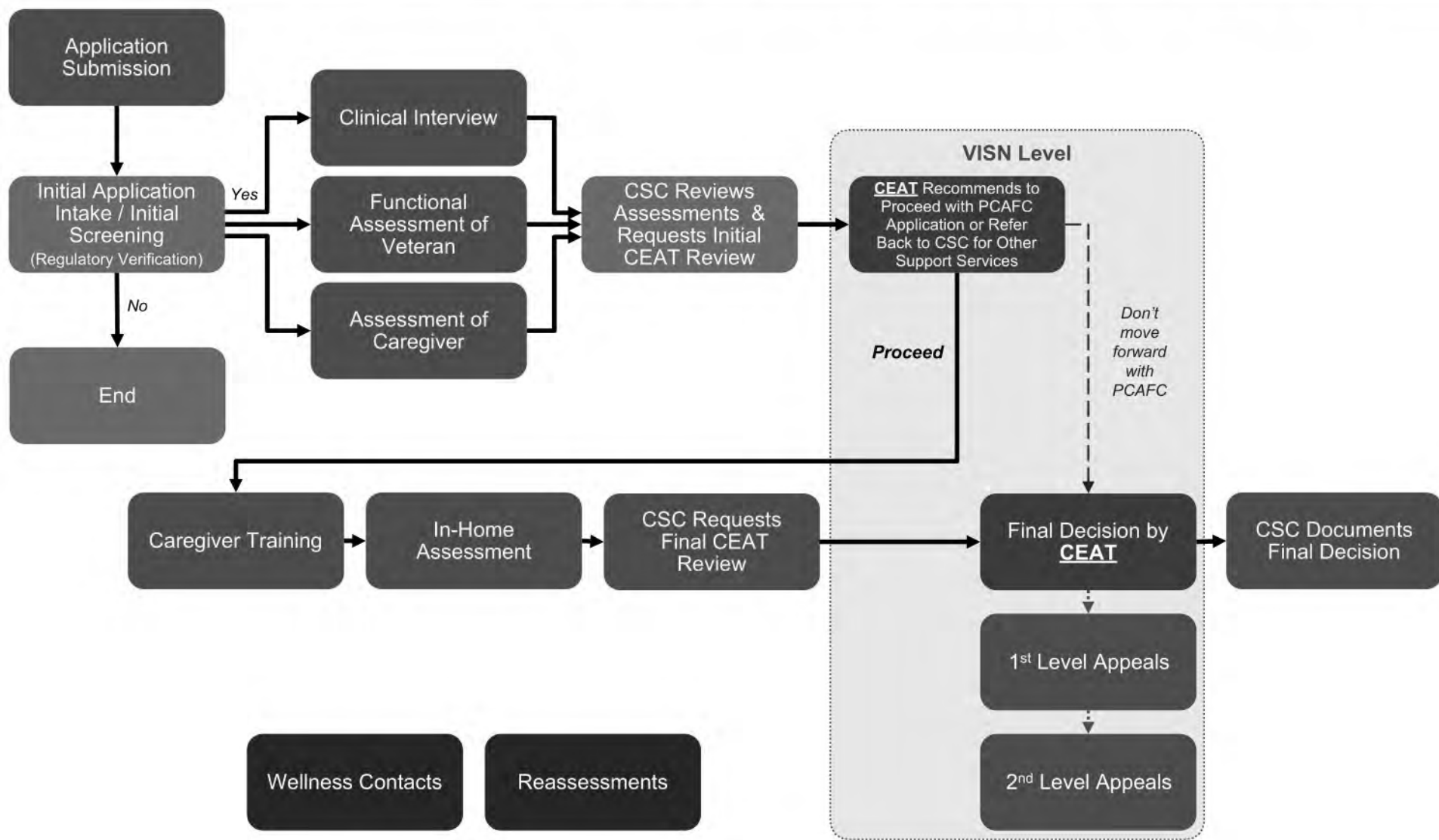
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Standard PCAFC Application Process with CEAT

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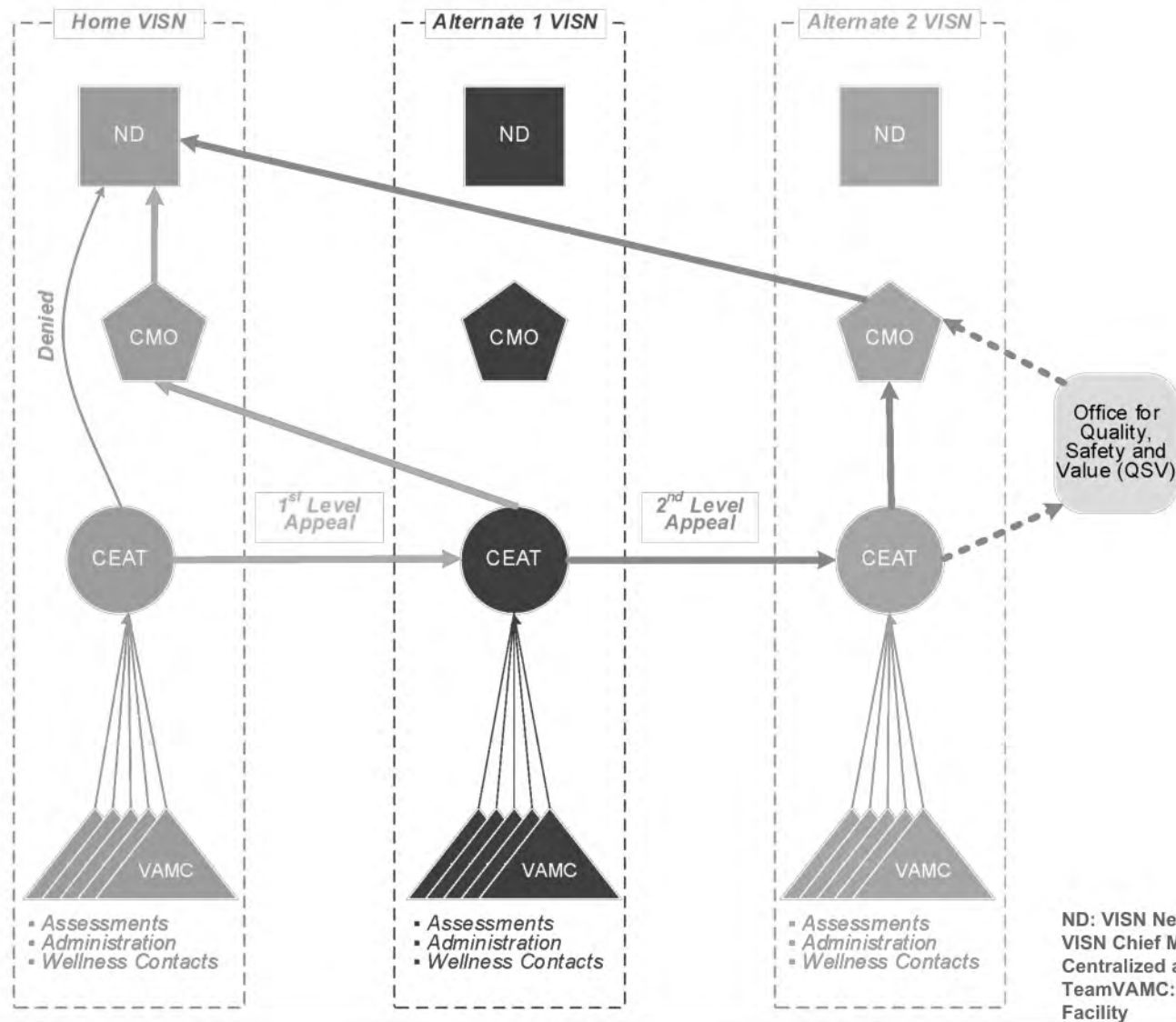
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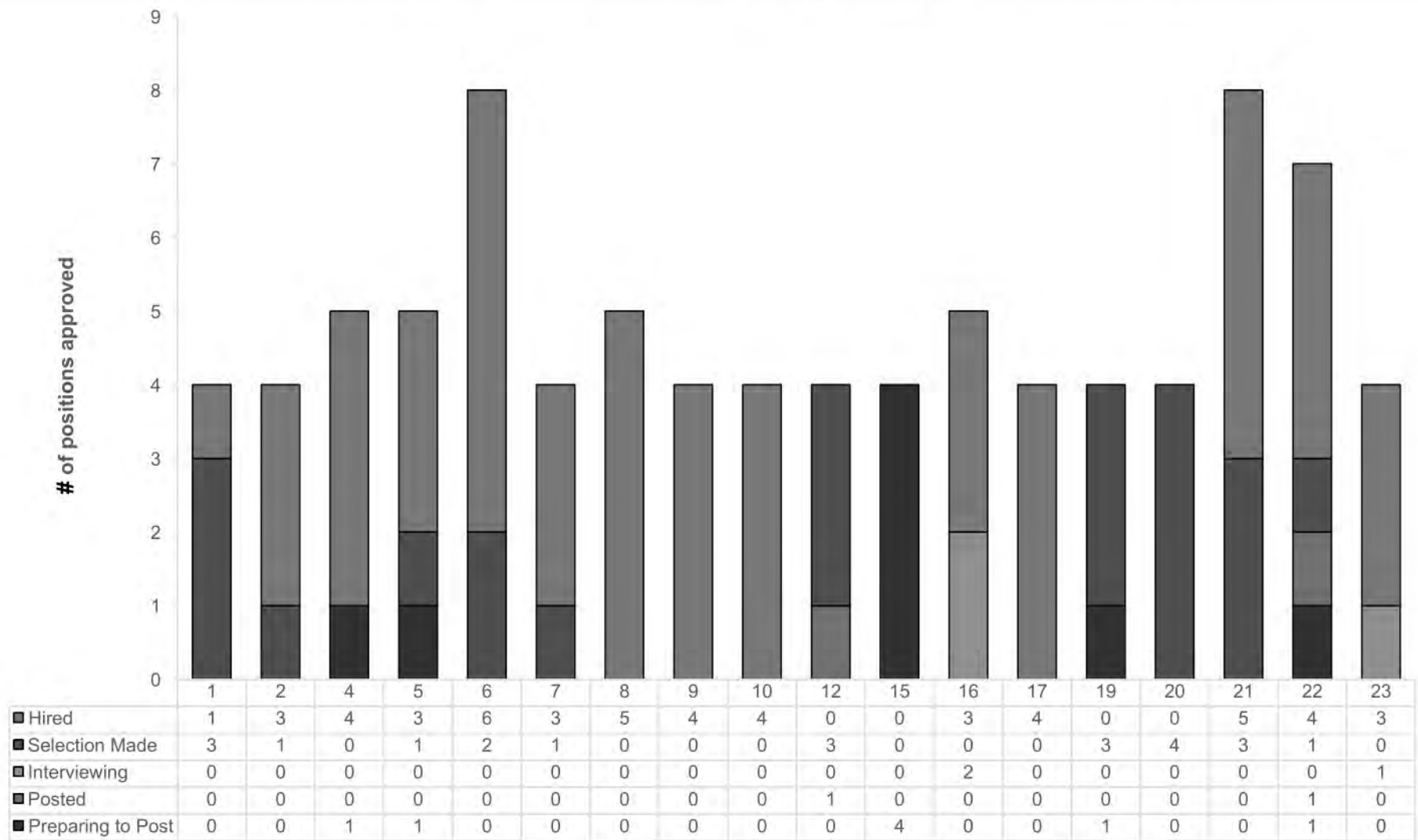


Veteran Functional Assessment Instrument Operational Requirements

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Caregiver Support Program Phase 1

"Hired" Status of CEATs by VISN (as of 04/17/2020)



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VHA Caregiver Support Program Overview	349

VETERANS HEALTH ADMINISTRATION

Caregiver Support Program MISSION Act Implementation Update

Presented by: Lisa M. Pape, LISW Deputy Chief Patient Care Services Officer for
Care Management and Social Work
Date of briefing: May 8, 2020

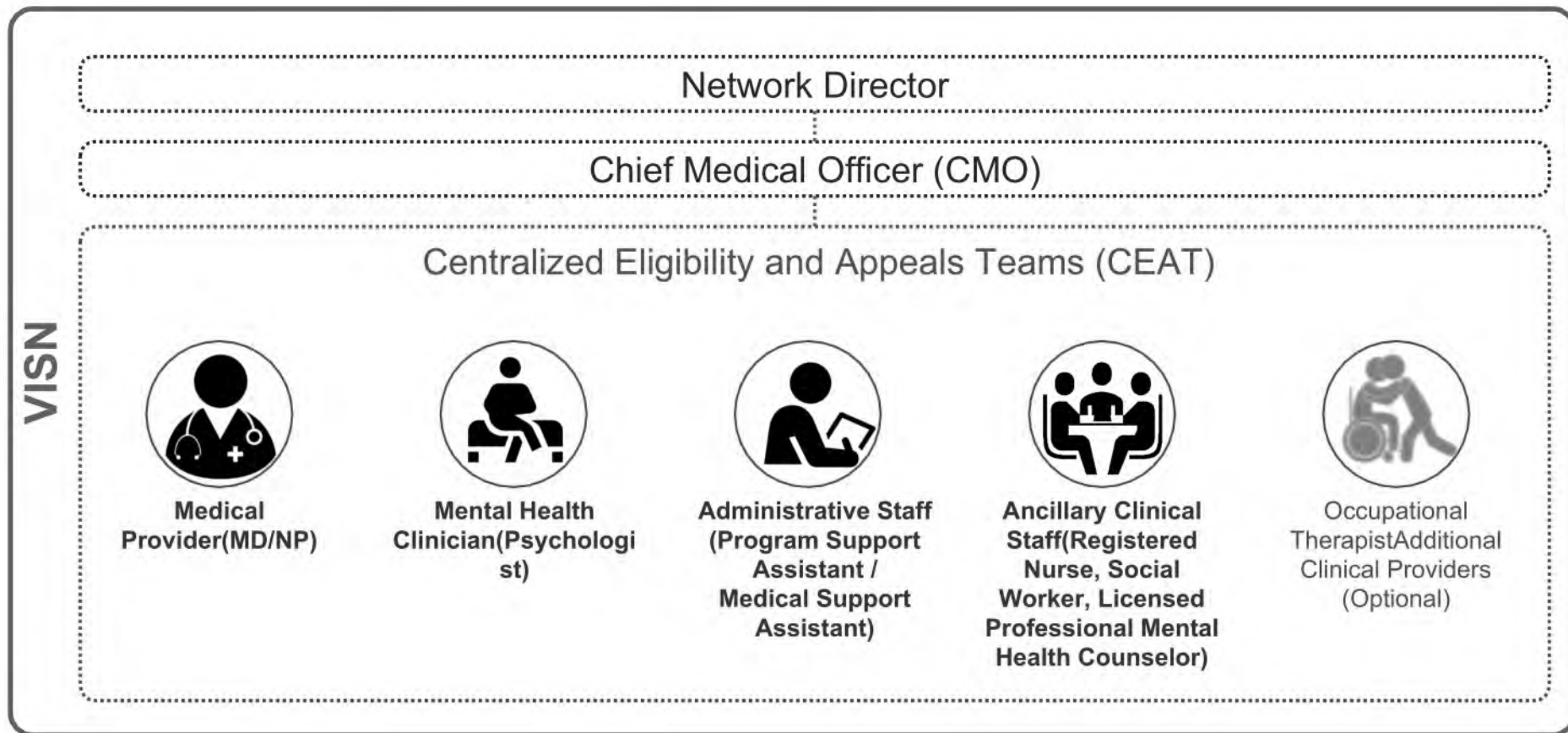
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By centralizing the PCAFC eligibility/appeals decision making and utilizing trained, dedicated, full-time clinical staff, VA will **reduce variation** and **increase outcome validity and reliability** of decisions



Centralized Eligibility and Appeals Teams (CEAT) Status

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Phased CEAT Stand-up: Stand-Up: January - June 2020 (In Process) Full Mission Capability: September 2020 Hiring: CEAT hiring rate is 60% (52) as of April 24, 2020 Total CEAT to be Hired: 87 Total CEAT Selected: 22 (25%) Total Full Time Equivalent (FTE) posting/process: 5 Total FTE Stalled: 8 (VISNs 4, 5, 15, 19 and 22) Training: Mandatory virtual training planned for July 14-16, 2020 Risks: Two identified risks are being addressed COVID-19: Some of the selected staff are being held in clinical positions to support VA's COVID-19 response. Staff expected to return to CEAT role by late June 2020 VISN 15 lagging on CEAT hiring: Met with VISN Chief Medical Officer (CMO) to discuss plan to hire As of April 27, 2020, VISN 15 is close to hiring the physician position and preparing to post two positions this coming week Assistant Under Secretary for Health for Operations informed of discussion with the VISN

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VA CARES to conduct quality assurance review and monitoring plan to include: Reliability of instruments within the target population; and Examining correlations between instruments and validated measures, such as the Jen Frailty Index (which is a proxy measure for functional status)

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Primary audience: CSCs, PGCSS Staff, CSP Program Managers and VISN CSP Leads
Webinars: 7 webinars have been completed and 10+ additional webinars are underway
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CSP Directive, Templates and Consult Development

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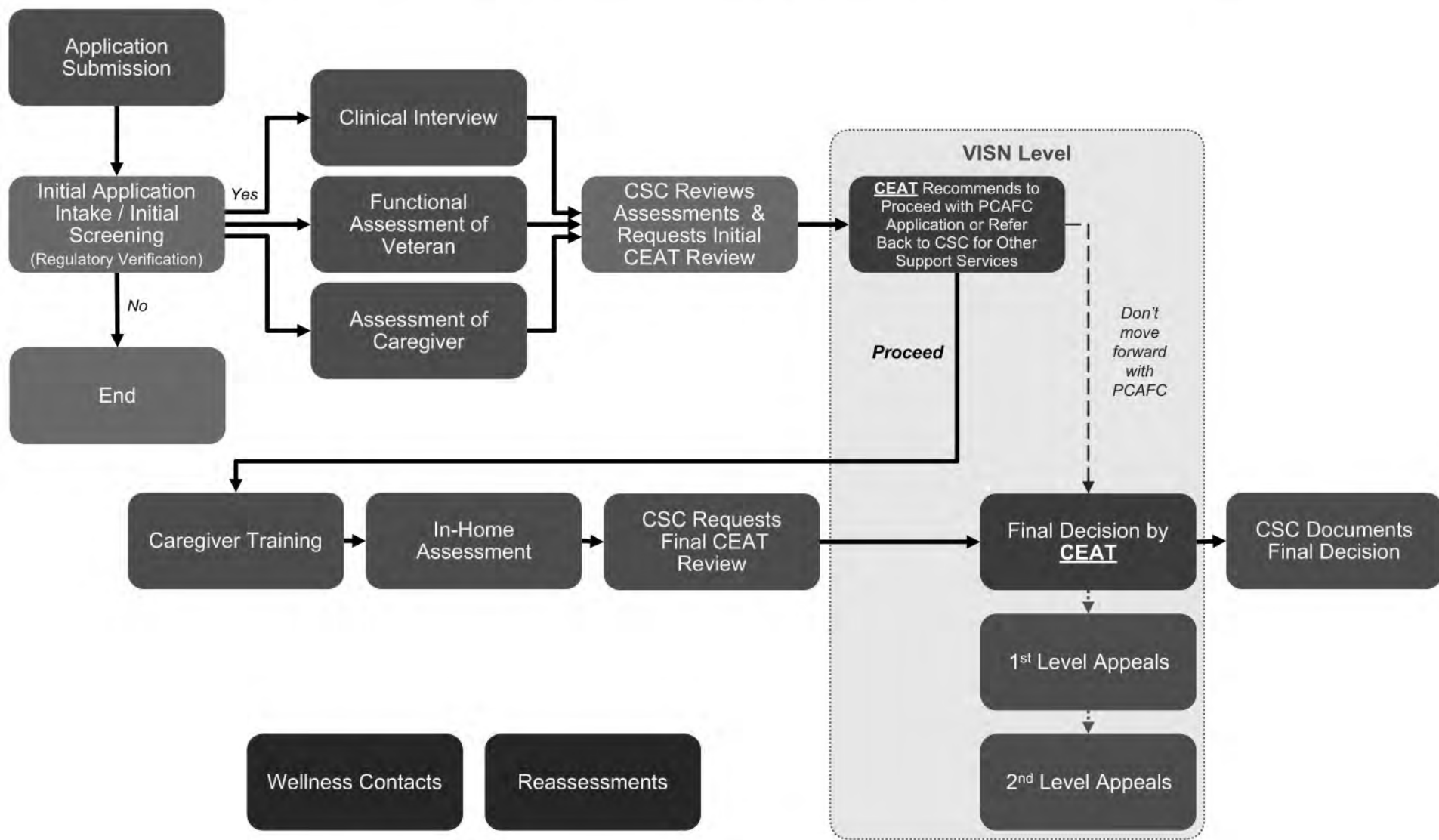
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Questions and Answers

Additional Information

Standard PCAFC Application Process with CEAT

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Future State Appeals Process Overview

Alternate 1 VISN

VISN Patient Advocate Coordinator (VPAC) will assign requests to the **home VISN CMO**, who will review the appeal and relevant clinical records.

Concurrently, the receiving VPAC will coordinate the reassignment of the appeal to the an alternate CEAT (**alternate 1 VISN**) for adjudication.

The **alternate 1 VISN CEAT** reviews the appeal and relevant clinical records, then prepares and submits their recommendations to the **home VISN CMO**.

The **home VISN CMO** reviews the recommendation, decides the appeal, finalizes and signs the Clinical Appeal Decision Memo, & forwards to the **home VISN Director**.

The **home VISN Director** ensures the Clinical Appeal Decision Letter is prepared, signed, and mailed to the patient.

The Patient decides whether to accept or decline determination. Patient can appeal (2nd level).

1st Level Appeal

Alternate 2 VISN

VPAC at next VISN will assign requests to the next alternate VISN CMO (**alternate 2 VISN**), who will review the appeal and relevant clinical records.

Concurrently, the receiving VPAC will coordinate the reassignment of the appeal to the next alternate CEAT (**alternate 2 VISN**) for adjudication.

The **alternate 2 VISN CEAT** reviews the appeal and relevant clinical records, then prepares and submits their recommendations to the **alternate 2 VISN CMO**.

The **alternate 2 VISN CMO** decides whether to consult with the Office for Quality, Safety and Value (QSV) to obtain an external review.

Office for QSV reviews appeal and provides recommendations to VISN CMO.

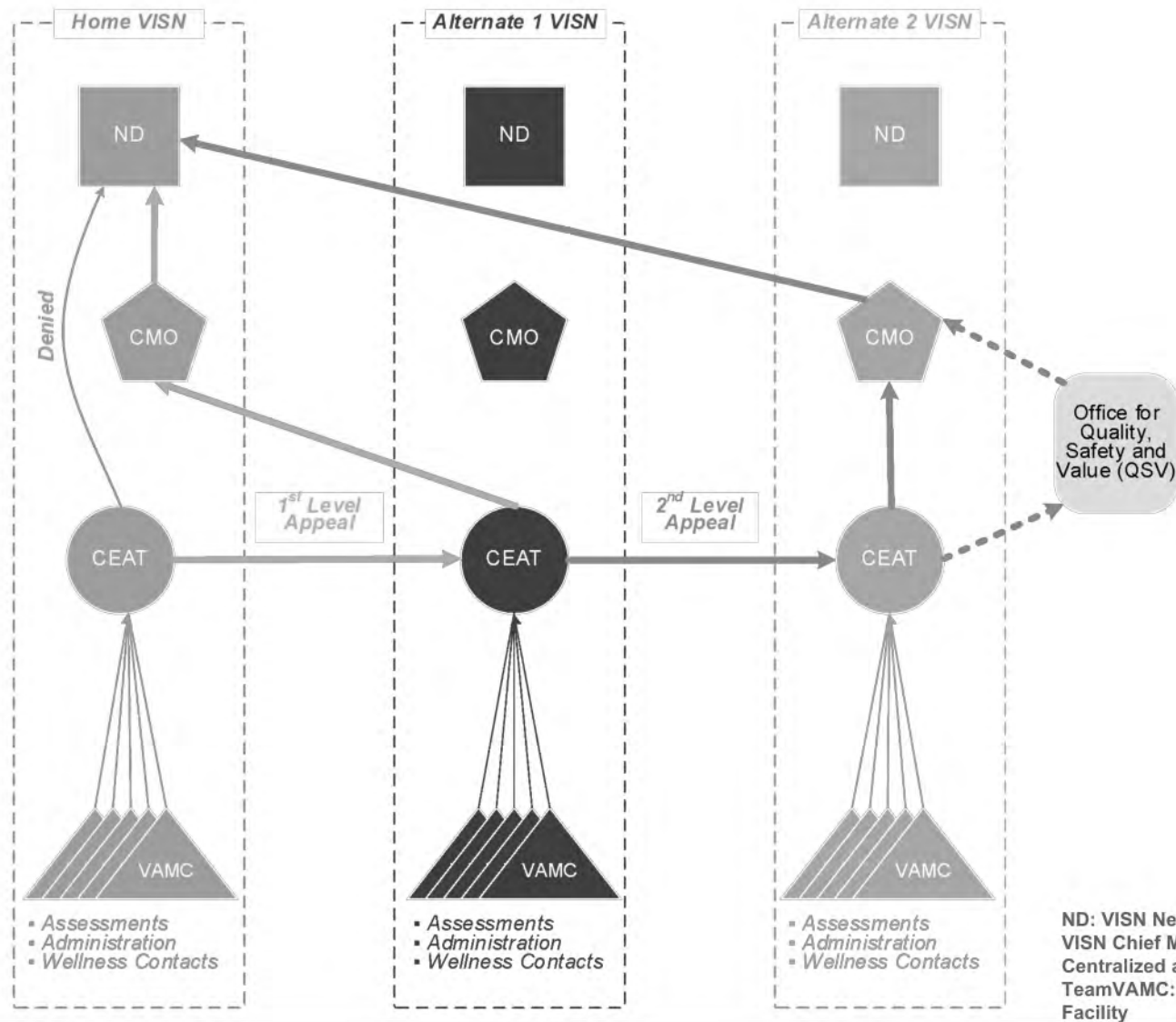
The **alternate 2 VISN CMO** reviews the recommendation(s), decides the appeal, finalizes and signs the Clinical Appeal Decision Memo, and forwards to the **home VISN Director**.

The **home VISN Director** ensures the Clinical Appeal Decision Letter is prepared, signed, & mailed to the patient.

Patient decides whether to accept or decline solution, if one is offered. No further appeal available.

2nd Level Appeal

Future State Appeals Model

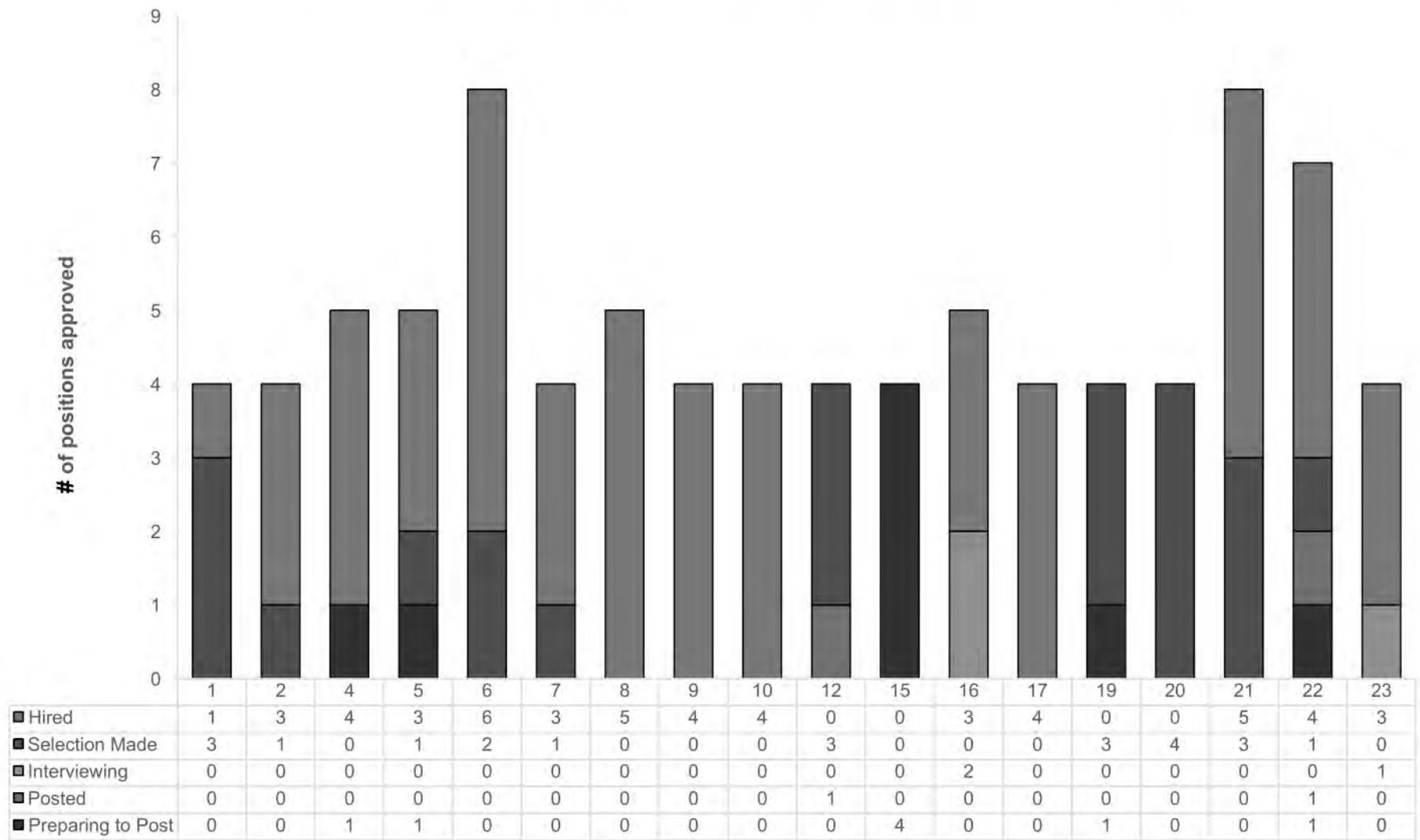


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Caregivers Program Status

May 13, 2020

Agenda

1. Caregiver Record Management Application (CARMA)
2. Regulation Status
3. Caregivers Support Program MISSION Act Implementation

Caregiver Record Management Application (CARMA)

Presented by: Lloyd Thrower Deputy CIO, Account Manager for Health, Office of Information and Technology

BLUF: Caregiver Status

The Caregiver Record Management Application (CARMA) is the workflow management tool used by the Caregiver Support Program (CSP). With delivery of CARMA, VA now has a new case management system for the Caregiver program - one that offers many new features and is designed for the future. That said, significant challenges remain before certification: Contractor Risk – The long list of backlog issues associates with Phase 1 and 2 delivery combined with more complex regulatory updates to stipend processing and the vendor's initial projection of a seven-month Level of Effort, increases risk of on-time delivery. COVID – COVID-19 priorities or needs of other programs (e.g. EHRM) could impact availability of resources needed for CARMA test and deployment.

While significant risks exist, IT Systems enhancements needed for Certification are projected for delivery in September

Caregiver Program – Phase 3 Status

CARMA Phase 3 delivery has three major components. Online Registration Form 10-10CG team has established connectivity with the CARMA QA environment. Dark release on schedule for May followed by soft release in July. Integration With Backend Systems Master Person Index (MPI) Release 13 has been deployed putting MPI in position to accept Caregiver information from CARMA. ES/VISTA Interface with MPI has been successfully tested. VHA Corporate Data Warehouse (CDW) Workgroup has been created and the interface/connectivity with CARMA has been established and tested. Five CPRS templates have been completed - 1 is deployed, 3 are ready for deployment, and 1 is in site-testing. An additional 20 CPRS templates are under development. VA Profile work to verify and update non-identity information for caregivers is in progress. Coding of Regulations First of six Regulatory Changes development sprints are underway. Team



Choose A

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Caregiver Program – Risks

- **Contractor Risk:** If vendor has similar difficulties in delivering a more complex stipend payment process in a shorter time period that was experienced with a more simplified stipend processing model for Release 2, then the final release is at risk of being delayed. **Mitigations:** On 5/6 OIT implemented weekly Program Management Reviews (PMRs) with programming team and contractor to closely monitor progress. Exploring option to leverage MITRE as systems integrator on effort. Conducting more detailed elaboration sessions early and working with both the vendor and VHA for options that may require short term manual work arounds to ensure timely certification. Identifying requirements related to the regulation that could be deferred to post-certification – either handled temporarily via manual work arounds or not needed until later in the year. **COVID:** If COVID-19 priorities redirect OIT and/or VHA resources supporting CARMA or ancillary applications, then final testing or downstream integrations will be delayed. **Mitigation:** Monitoring both OIT and VHA Caregiver resources closely to ensure certification success. Both OIT and VHA are well aware of the requirement and do not foresee resources being reassigned.

Caregiver Program – Implementation Timeline

Updated 4/23/2020

October 2019: CARMA Phase 1, Release 1.0 Health Eligibility Center (HEC), Caregiver Support Coordinators (CSC) Enrollment Contract Awarded

December 2019: CAT Read Only Data Migration complete CARMA Phase 1, Release 1.1 CSL December 5, 2019: Master Person Index Work Begins

February 2020: CARMA Stipend Payments Run

April 2020: MPI-E Salesforce Compliance Code Complete Incarceration Data Partial Delivery

June 2020: Enrollment System Release – CARMA Integration CPRS Templates (independent of Regulatory changes)

August 2020: Regulatory System Changes into final testing BGS Incarceration Data to CARMA

OCT 2019 NOV 2019 DEC 2019 JAN 2020 FEB 2020 MAR 2020 APR 2020 MAY 2020 JUN 2020 JUL 2020 AUG 2020 SEP 2020 OCT 2020

November 2019: Agile Dark Release

March 2020: CARMA Phase 2 Complete

May 2020: Enrollment System Release VHA CDW Hospitalization Data to CARMA MPI related activities including Caregiver Letter for patronage benefit 1 Regulatory Changes public comment due 5/29: Online 10-10CG Form (Dark Release)

July 2020: Vista REE National Release CARMA Address from VA Profile CARMA to MPI to ES/Vista Data Flow 10-10CG Form Automation (Soft Release)

September 21, 2020: Certification and Go Live

Phase 1
Deliverables
Phase 2
Deliverables
Phase 3
Deliverables

- Automation of letter generation utilizing EDIPI is dependent on MPI-E work being completed. There is a further dependency on DoD's ability/willingness to accept data.

Timeline assumes no changes to regulations as a result of public comment period

Regulation Status

AQ48 - Program of Comprehensive Assistance for Family Caregivers

Presented by: (b)(6) Regulation Specialist, Office of Regulatory Affairs,
VHA

Regulation Status

- Proposed rule published on March 6, 2020 with 60-day public comment period. Public comment period closed on May 5, 2020. Proposed timeline for publishing final rule: June 26, 2020: VA sends OMB final rule. (Need OMB to agree to expedited review) July 24, 2020: OMB publishes final rule publishes. 60-day delay in publishing final rule. Administrative Review Act. (Need to reauthorize the Act in order to expand the Act's authority to be effective. in order to expand the Act's authority to be effective.

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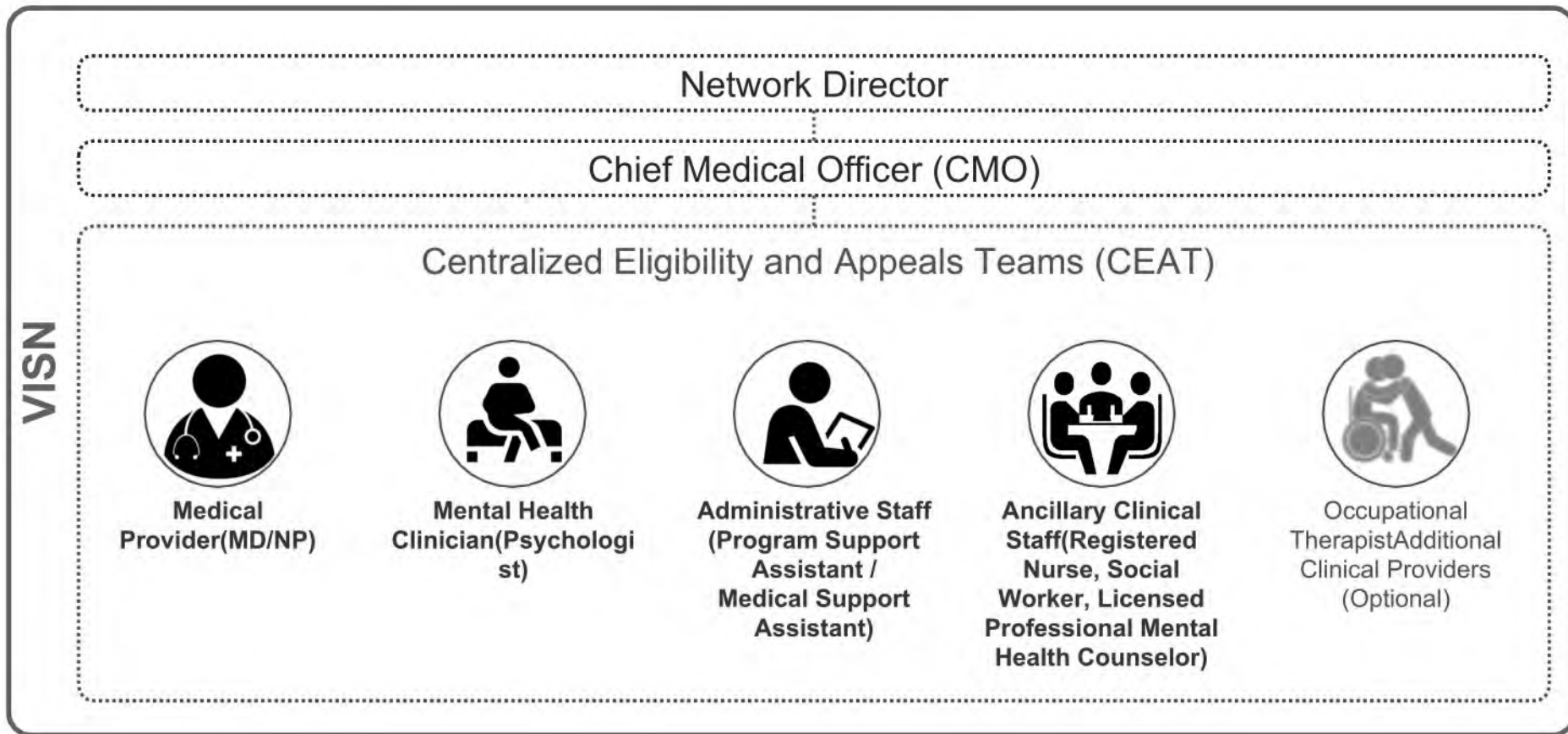
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Questions and Answers

Additional Information

AQ48 Individual Comments

Summary of major concerns raised in individual comments received Positive (whole or in part): 14% Significant comments received by volume:

Section	Topic	High Level Summary
Definition of Primary Care Team	Primary Care Team (9%)	•Maintain current definition •Proposed definition is too vague Will allow non-physician or other qualified health care professionals to make determinations •Maintain current requirement of including a primary care provider
Eligibility Requirements	Two Phase Expansion (12%)	•Expand immediately to Veterans of all eras
	Eligibility Requirements (43%)	•Expanding at expense of post-9/11 Veterans •Should make this a permanent program for 100% P&T •Should have two separate criteria for pre- and post-9/11 Veterans •Definitions: Serious Injury: 70% SCD is too high, should not use VBA rating because it is not clinical •Inability to perform an ADL: requirement of each time is too stringent •Need for supervision, protection, or instruction: too vague
Caregiver Benefits	Wellness Contacts (11%)	•Proposed schedule is insufficient to meet standard of care and will result in less accountability
	Monthly Stipend Rate and 2 Levels (20%)	•Insufficient explanation for removal of current tier criteria •Definitions: Monthly stipend rate: too low, should maintain BLS •Unable to self-sustain: too stringent (3 ADLs and continuous basis)

AQ48 Organizational Comments

Summary of major concerns raised in organizational comments received

Topic	High Level Summary
Eligibility Requirements	•Overall: MISSION Act did not impose any requirements other than an IT system for expansion, Congress did not intend for expansion to narrow eligibility, as a result of VA's failure to meet the statutory timeline in the MISSION Act the second phase of expansion should be no later than as intended by the Act 2, 3, 6, 7•Collaboration with primary care team: concern that only using primary care team for initial assessment (to maximum extent practicable) and removal from eligibility determinations gives too much deference to PCAFC staff (e.g., caregiver support coordinators, CEAT) 1, 4, 8Specific definitions•In the best interest: this should be an automatic presumption, too paternalistic and condescending, should explicitly state that veterans who fail to show improvement will not be excluded from the program 8, 11, 13•In need of personal care services: agree as long as it speaks to type of personal care services needed, otherwise too restrictive to require in person care by another individual at all times 2, 3, 7, 8, 13, 14,•Inability to perform an ADL: too restrictive to require assistance each time an ADL is performed, suggest adopting guidance applied to TSGLI under 38 U.S.C. § 1980A 2, 3, 6, 7, 8, 9, 12, 13, 14•Need for supervision, protection, or instruction: too restrictive, need to clearly define "ability to maintain his or her personal safety" and "on a daily basis" even if just intermittently each day, concern it will result in a narrow interpretation and will have the opposite effect of broadening the current eligibility criteria, incongruent with congressional intent 2, 3, 6, 8, 14•Serious injury: 70%: statute does not impose a minimum rating-based threshold, 70% is too high, concern over potential delay in rating decisions 2, 6, 7, 9
Caregiver Benefits	•3 tiers to 2 levels: disagree with removal of current lowest tier, effect of this change is unknown, VA must clearly state rationale for eliminating lowest tier 2, 3, 9, 12Specific definitions•Monthly stipend rate: impact unknown; using the GS scale is illogical and contrary to authorizing statute, basing pay based on a home health aide is an insult to the care caregivers provide 6, 7, 11•Unable to self-sustain in the community: too restrictive, concerned about consistency, lacks adequate information to determine "continuous", arbitrarily limits the flexibility to consider all relevant factors in determining how much help an eligible veteran needs 1, 3, 6, 7, 9, 14
Reliance on Policy for Eligibility Determinations	•Proposed rule does not provide any/sufficient information regarding eligibility evaluation (including assessment instruments), initial reassessments, reassessments, advanced notice and appeals 7, 10, 11, 14

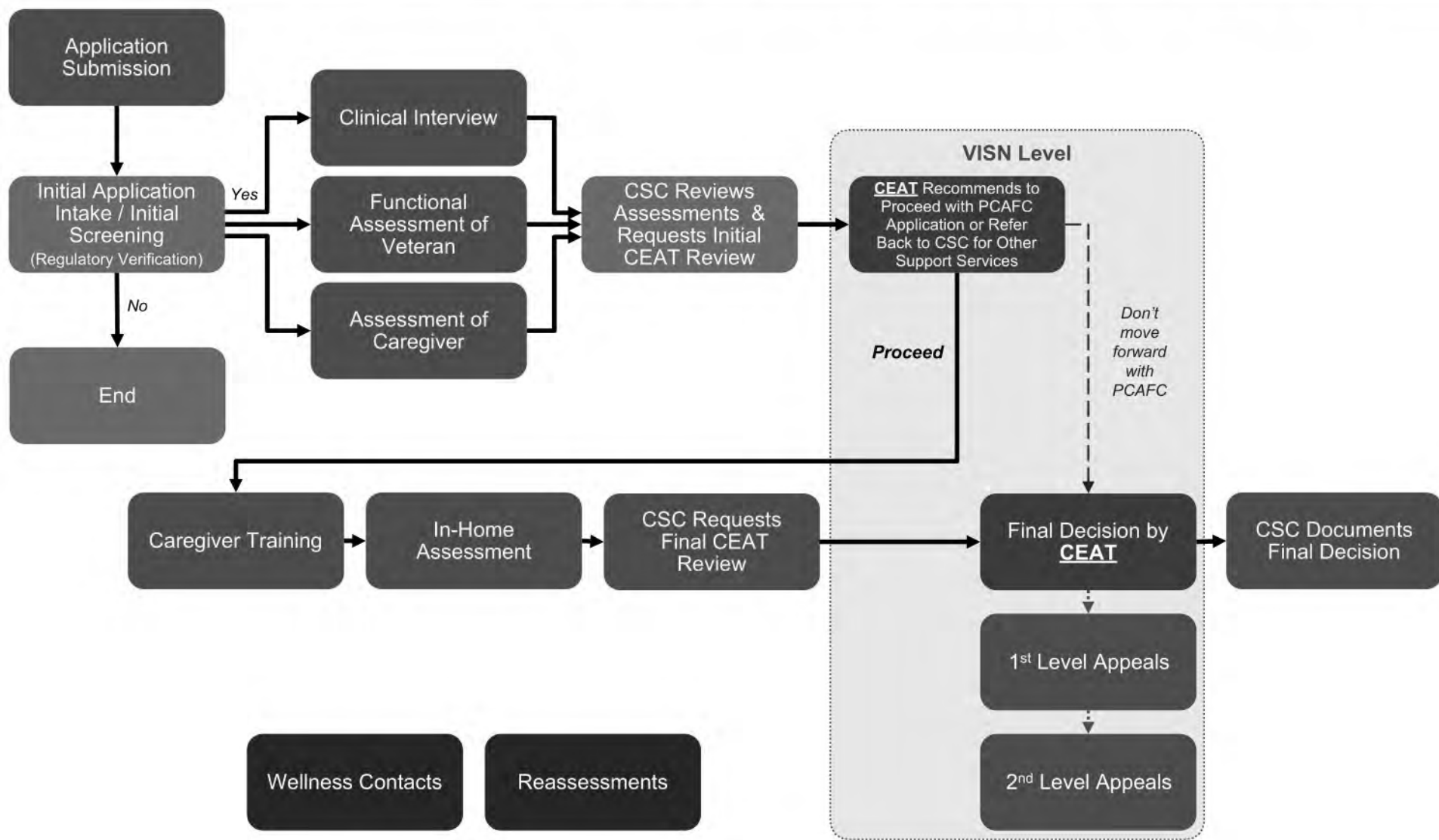
1. Coalition to Salute America's Heroes2. Disabled American Veterans3. Elizabeth Dole Foundation4. Legal Aid Foundation of Los Angeles5. Maxim Healthcare Services6. National Veterans Legal

Services Program and Veterans Warriors, Inc.7. Paralyzed Veterans of America8. Public Law Counsel9. Senate Committee on Veteran's Affairs10. The Enlisted Association11. The Independence Fund12.

Veterans of Foreign Wars13. Volunteers of Legal Service14. Wounded Warrior Project

Standard PCAFC Application Process with CEAT

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Future State Appeals Process Overview

Alternate 1 VISN

VISN Patient Advocate Coordinator (VPAC) will assign requests to the **home VISN CMO**, who will review the appeal and relevant clinical records.

Concurrently, the receiving VPAC will coordinate the reassignment of the appeal to the an alternate CEAT (**alternate 1 VISN**) for adjudication.

The **alternate 1 VISN CEAT** reviews the appeal and relevant clinical records, then prepares and submits their recommendations to the **home VISN CMO**.

The **home VISN CMO** reviews the recommendation, decides the appeal, finalizes and signs the Clinical Appeal Decision Memo, & forwards to the **home VISN Director**.

The **home VISN Director** ensures the Clinical Appeal Decision Letter is prepared, signed, and mailed to the patient.

The Patient decides whether to accept or decline determination. Patient can appeal (2nd level).

1st Level Appeal

Alternate 2 VISN

VPAC at next VISN will assign requests to the next alternate VISN CMO (**alternate 2 VISN**), who will review the appeal and relevant clinical records.

Concurrently, the receiving VPAC will coordinate the reassignment of the appeal to the next alternate CEAT (**alternate 2 VISN**) for adjudication.

The **alternate 2 VISN CEAT** reviews the appeal and relevant clinical records, then prepares and submits their recommendations to the **alternate 2 VISN CMO**.

The **alternate 2 VISN CMO** decides whether to consult with the Office for Quality, Safety and Value (QSV) to obtain an external review.

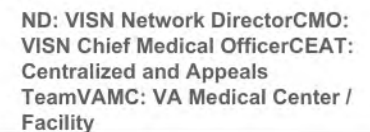
Office for QSV reviews appeal and provides recommendations to VISN CMO.

The **alternate 2 VISN CMO** reviews the recommendation(s), decides the appeal, finalizes and signs the Clinical Appeal Decision Memo, and forwards to the **home VISN Director**.

The **home VISN Director** ensures the Clinical Appeal Decision Letter is prepared, signed, & mailed to the patient.

Patient decides whether to accept or decline solution, if one is offered. No further appeal available.

2nd Level Appeal

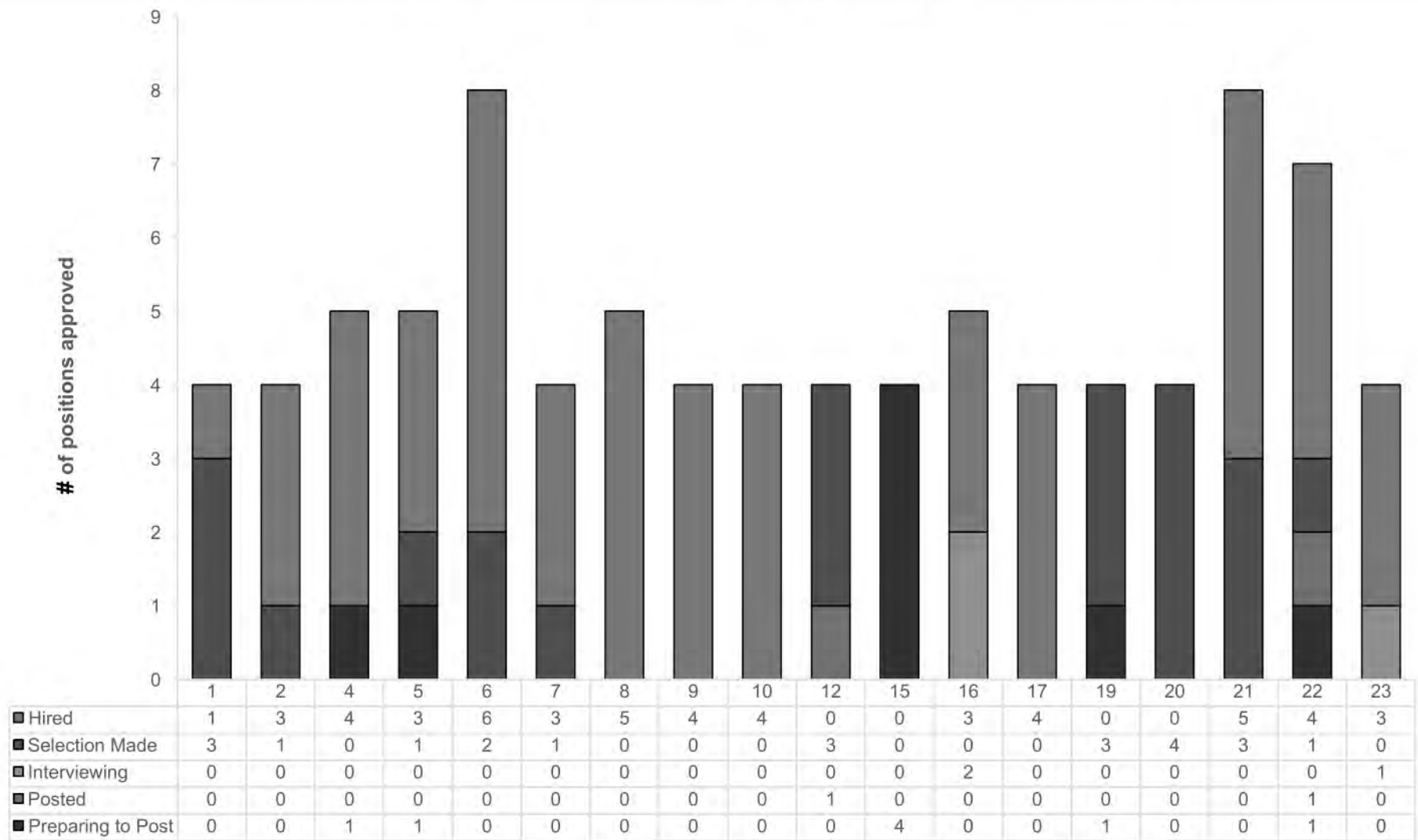


Veteran Functional Assessment Instrument Operational Requirements

- The instrument can be completed by a licensed social worker, nurse, occupational therapist, or other clinical staff, per Special Medical Advisory Group (SMAG) recommendations. Policy will be developed that states each assessor must complete the required Instrument training before assessing Veterans. CEATs will receive additional training on the application of instrument thresholds. Best practice would be an RN with experience/training in both rehabilitation and mental health. Location to complete the assessment may be via telehealth modality and/or in the home. The instrument should be completed once a year unless clinically indicated (aligns with industry standards). National CSP Office will likely fund additional positions to conduct assessments with input from VISN leads and VAMCs.

Caregiver Support Program Phase 1

"Hired" Status of CEATs by VISN (as of 04/17/2020)



04/17/2020

Caregiver Support Program - Education and Training

Course Title	Completions (as of 4/21/2020)
Implementation of Purple Heart and Disabled Veterans Equal Access Act of 2018	84
Program of Comprehensive Assistance for Family Caregivers (PCAFC): Veterans Eligibility Criteria for Providers	766
PCAFC SOP Changes in Functional Status & Continued Eligibility	704
Caregiver Support Program (CSP) MISSION Act Toolkit	393
Program of Comprehensive Assistance for Family Caregivers (PCAFC): Veterans Eligibility Criteria	235
Caregiver Support Program (CSP) VHA Directive 1152(1) Overview	349
VHA Caregiver Support Program Overview	349

VETERANS HEALTH ADMINISTRATION

Suicide Prevention Program: Update Post COVID-19

Presentation for: Acting VA Deputy Secretary Presented by: Dr. Dave
Carroll, Dr. Matt Miller and ^{(b)(6)} Office of Mental Health and
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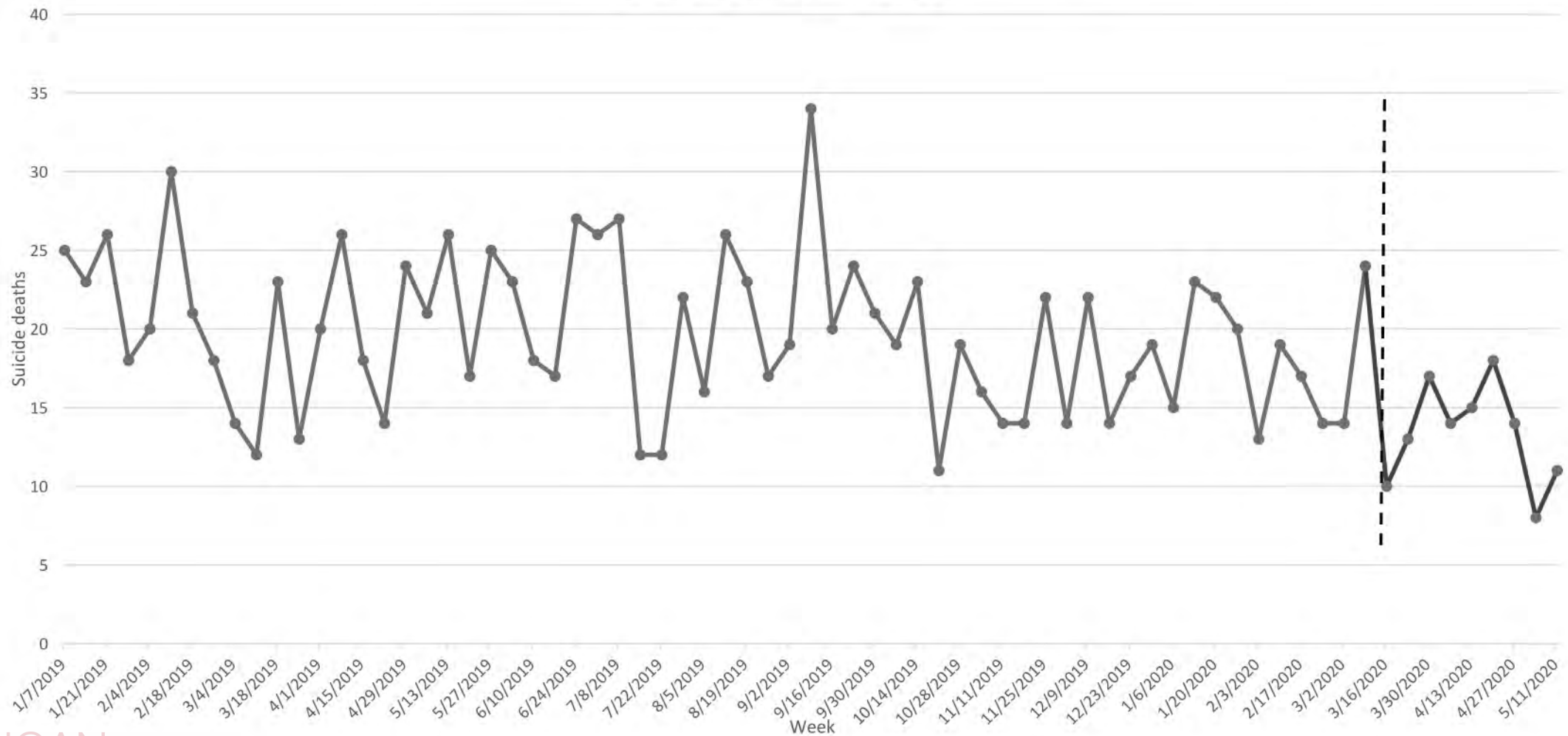
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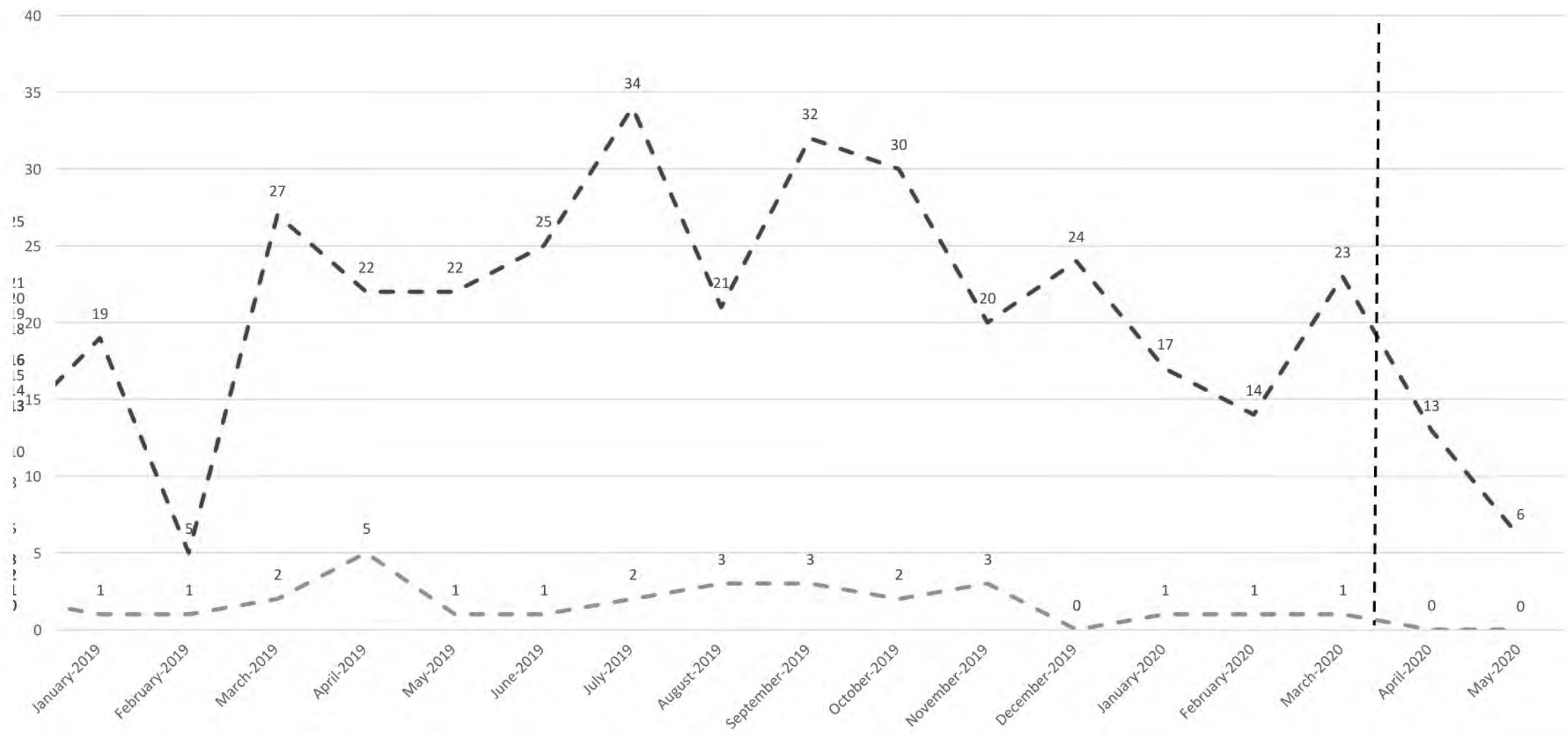
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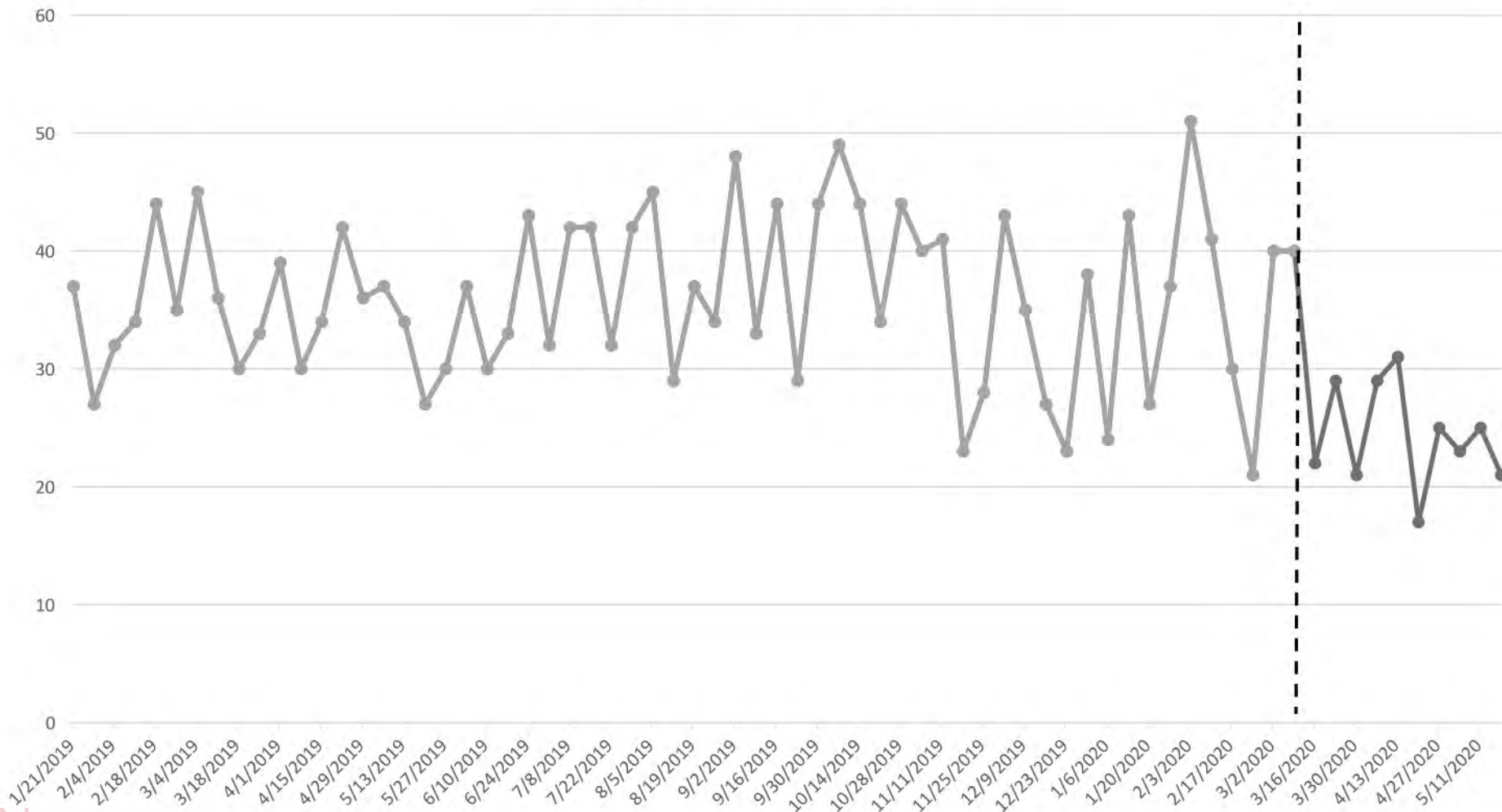


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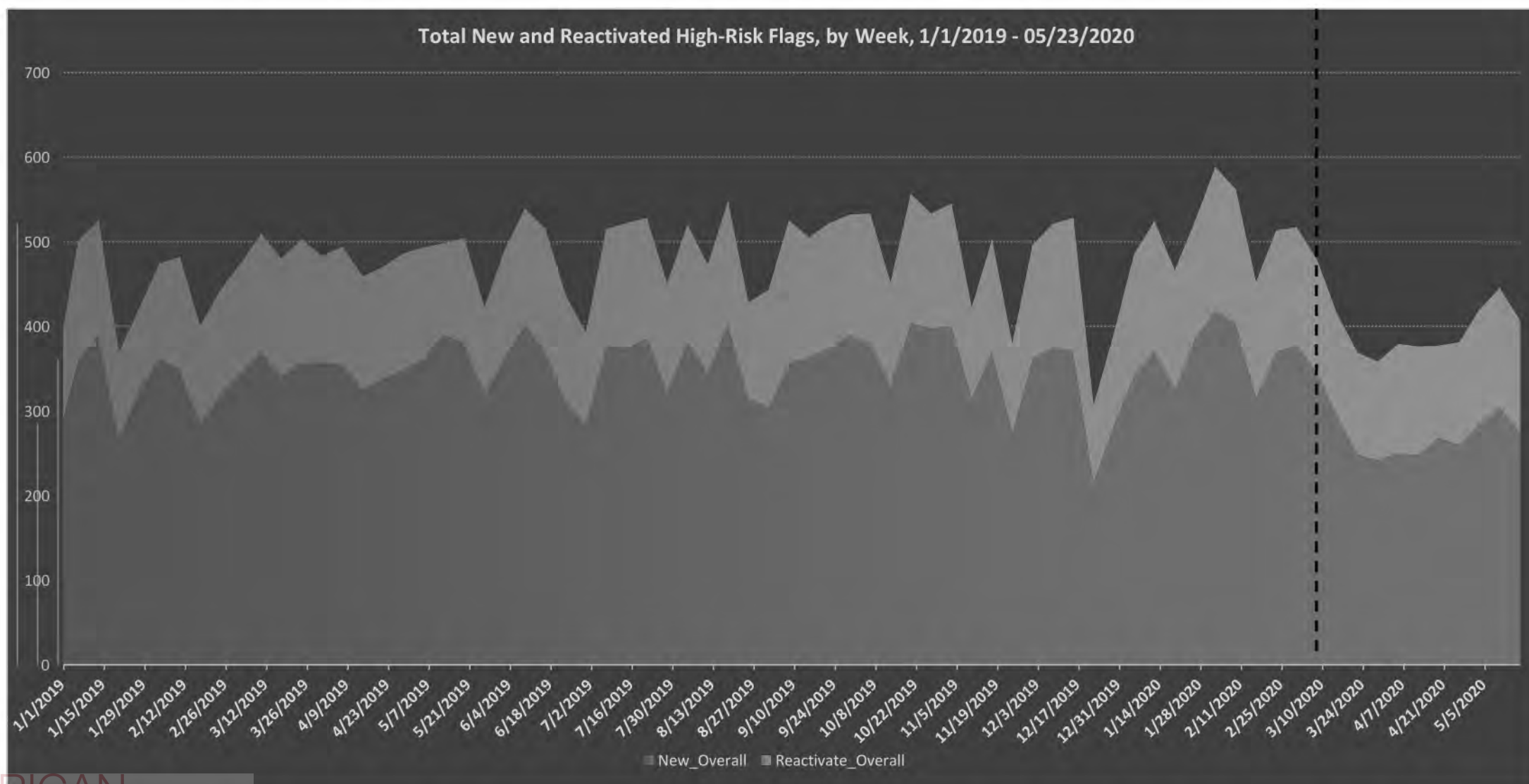


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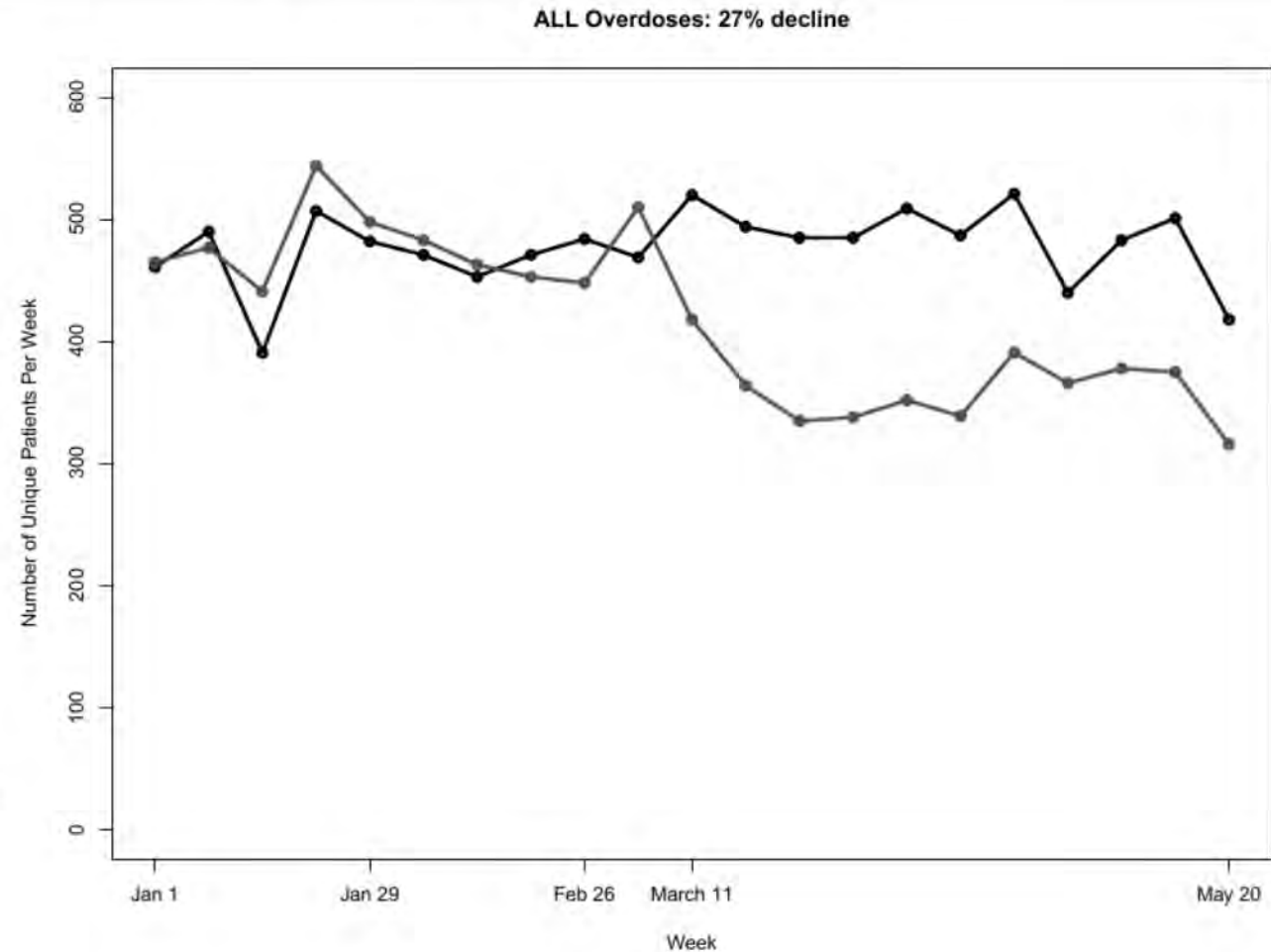


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Examples of Enhanced Mental Health and Suicide Prevention Efforts

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- Strengthening outreach to high risk populations through REACH-VET and SPED
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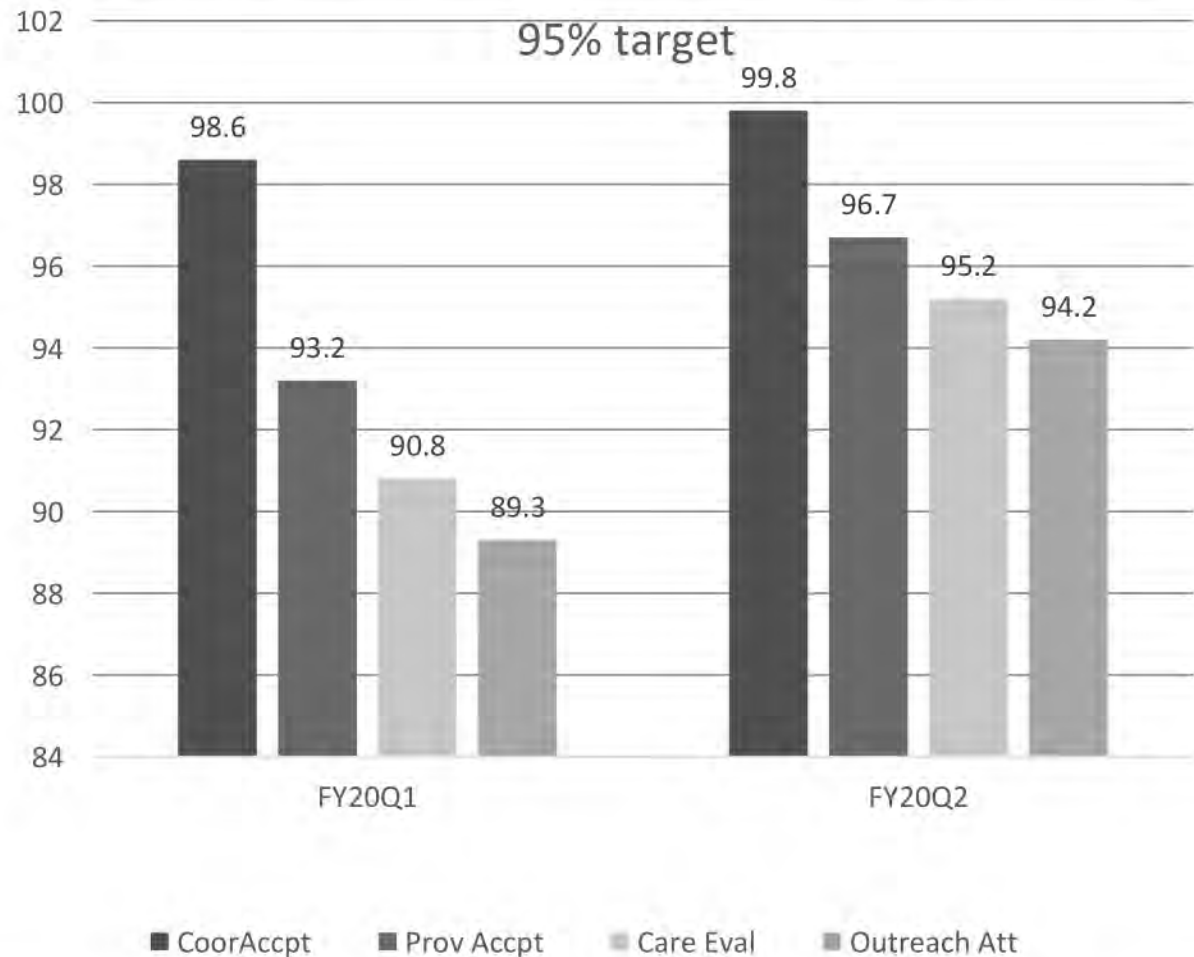
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Safety Planning in the Emergency Department (SPED) Update

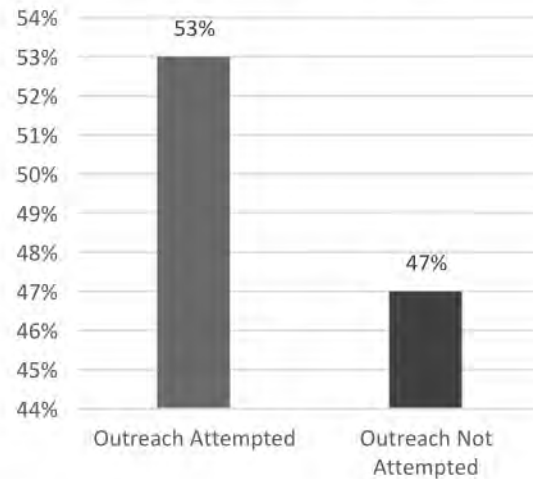
- Veterans presenting to the ED who have been assessed to be at risk of suicide, and are safe to be discharged home, receive suicide safety planning intervention (SPI) prior to discharge and follow-up outreach to facilitate engagement in outpatient mental health care. The program is based upon VA research finding that implementing an SPI and follow-up phone contact for patients who visited VA EDs for suicide-related concerns reduces suicidal behaviors by almost half (45%) in the 6 months following the ED visit (Brown et al., 2018). Safety plan completion in the ED has increased from 35.5% in FY19Q1 to 51.1% in FY20Q2. This increase demonstrates improved training and implementation of this evidence-based intervention. Current National data from 5/1/20-5/28/20:

Total Unique Patients	Pts with Safety Plan During Visit +/- 24 hours		Pts Decline Safety Plan During Visit +/- 24 hours		Combined Attempted Safety Plan
337	180	53.4%	36	10.7%	<u>64.1%</u>

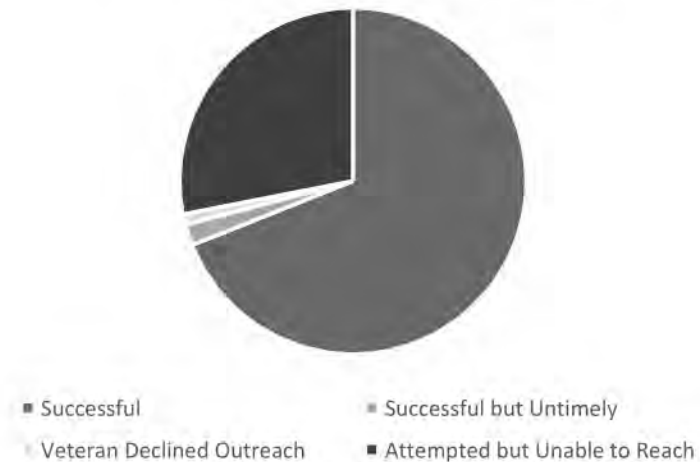
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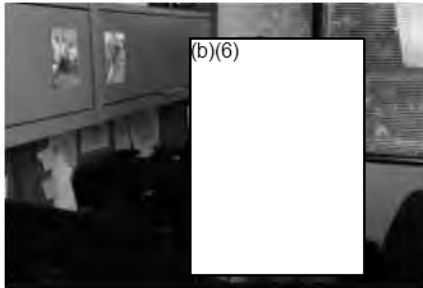
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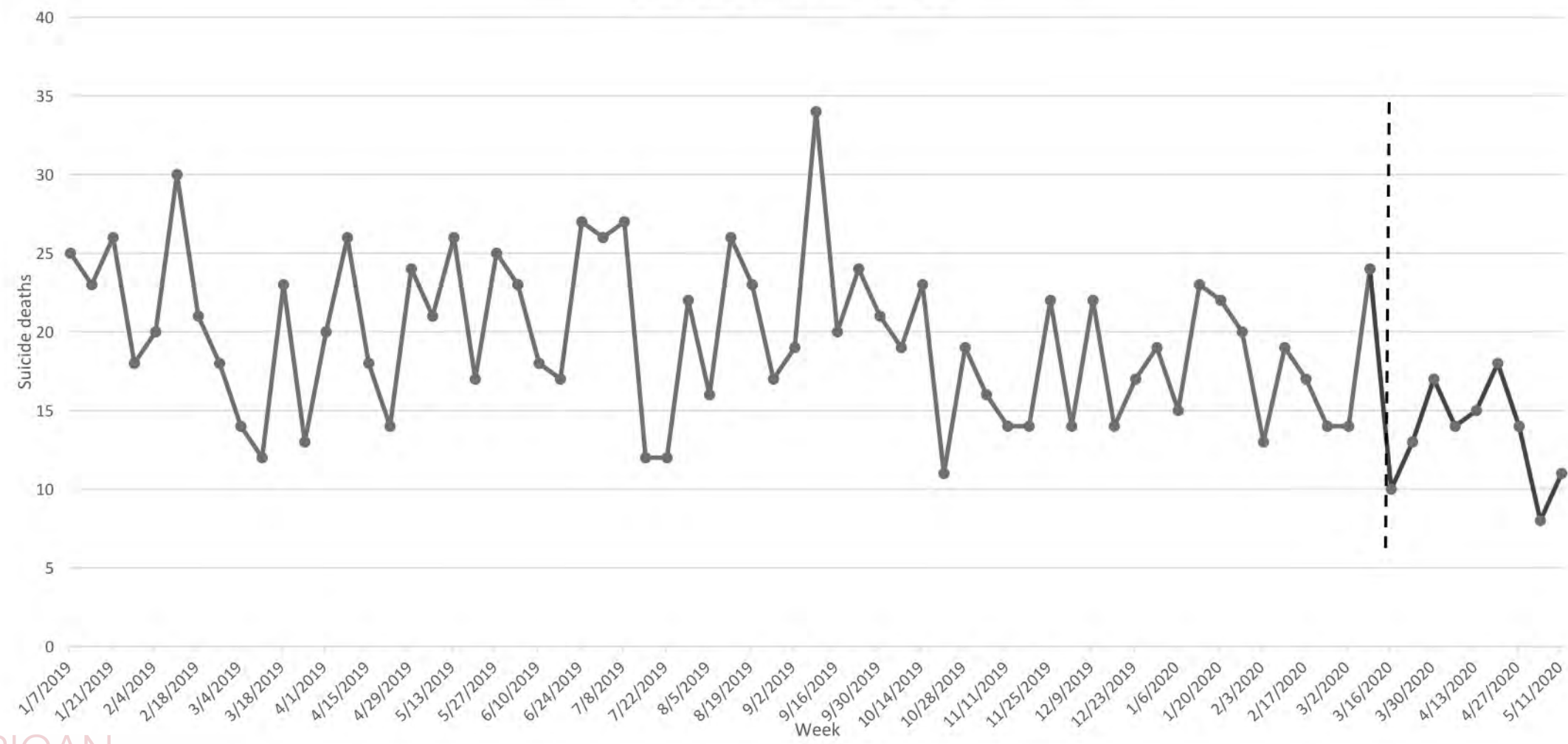
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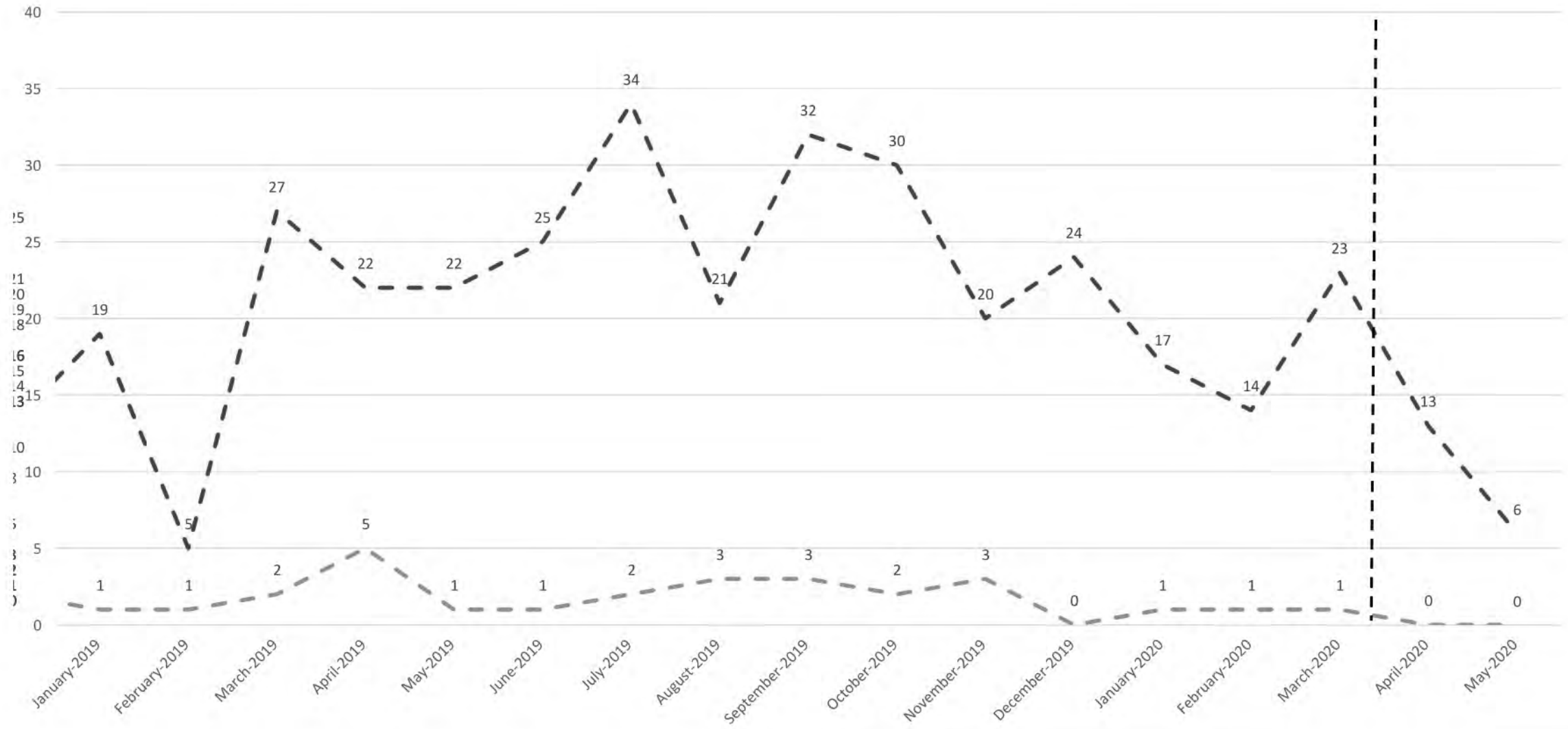
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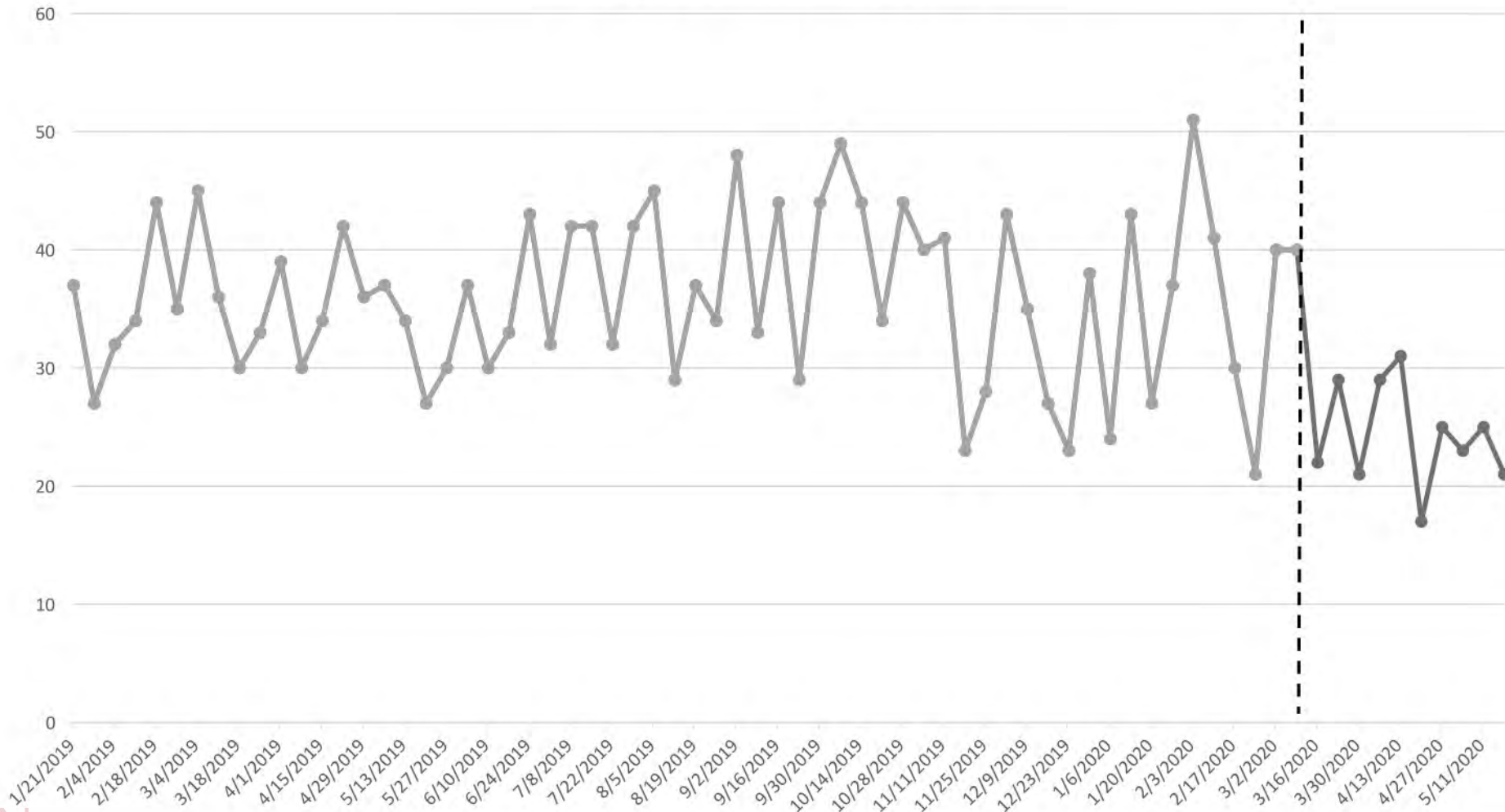


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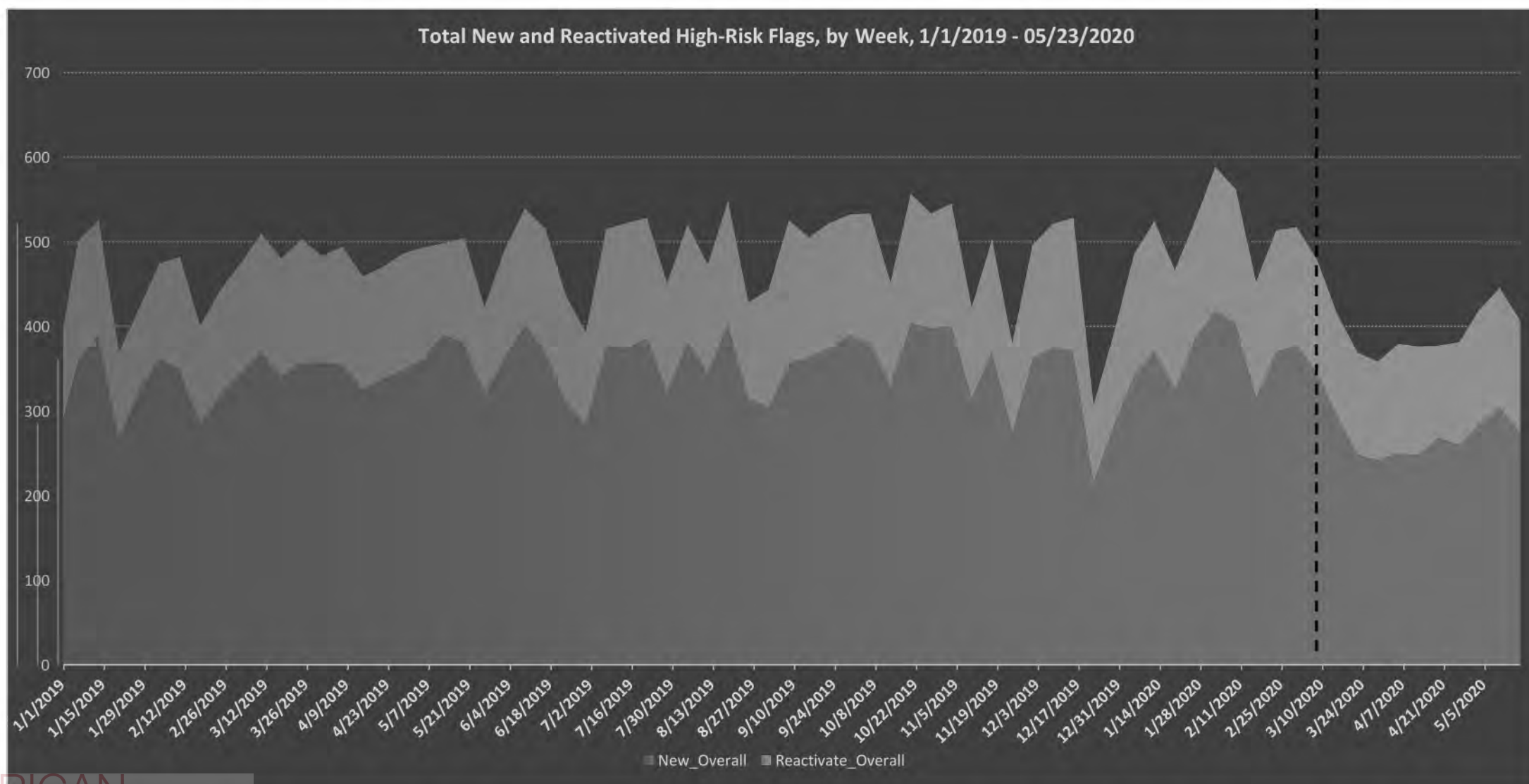


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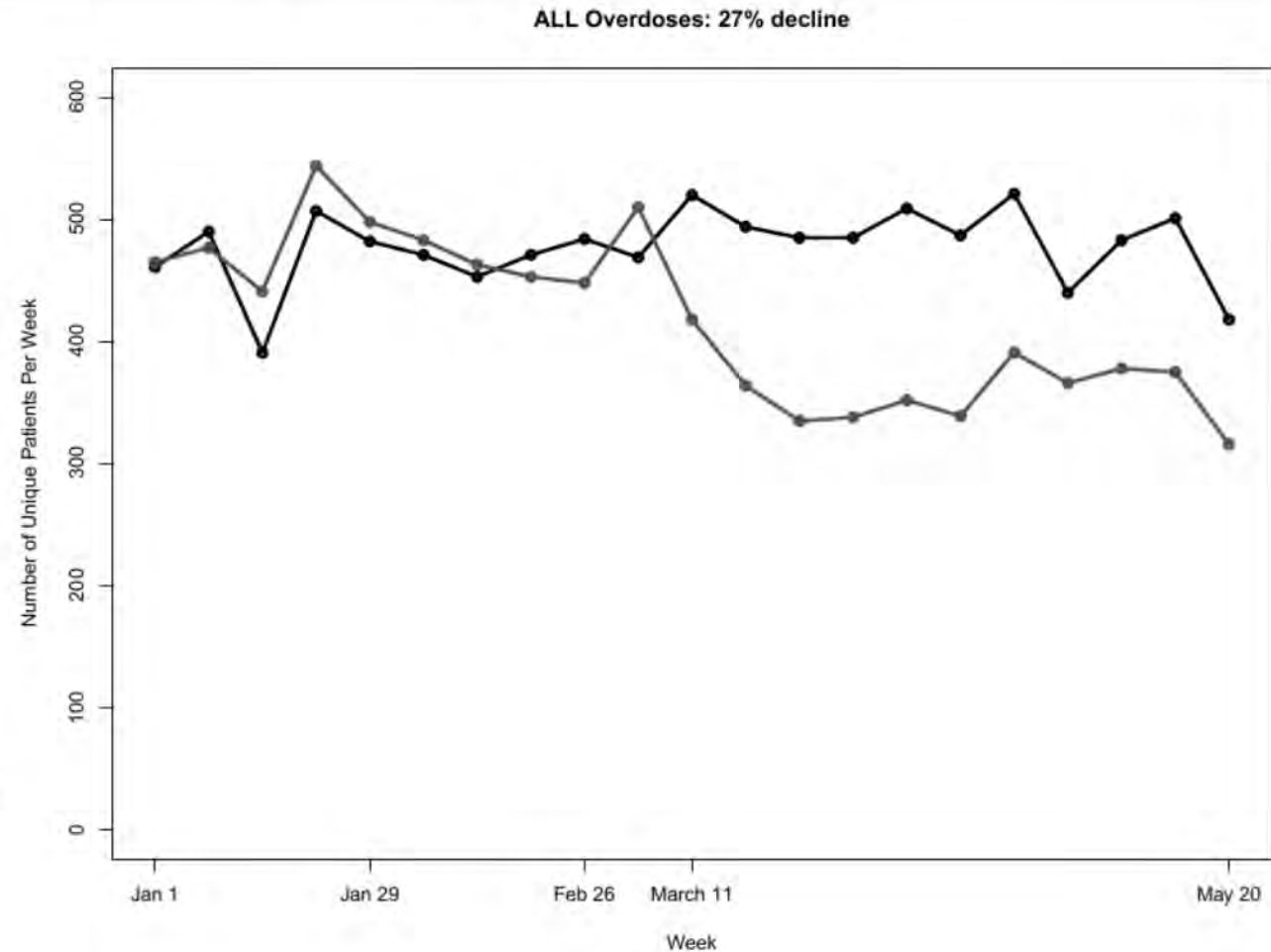


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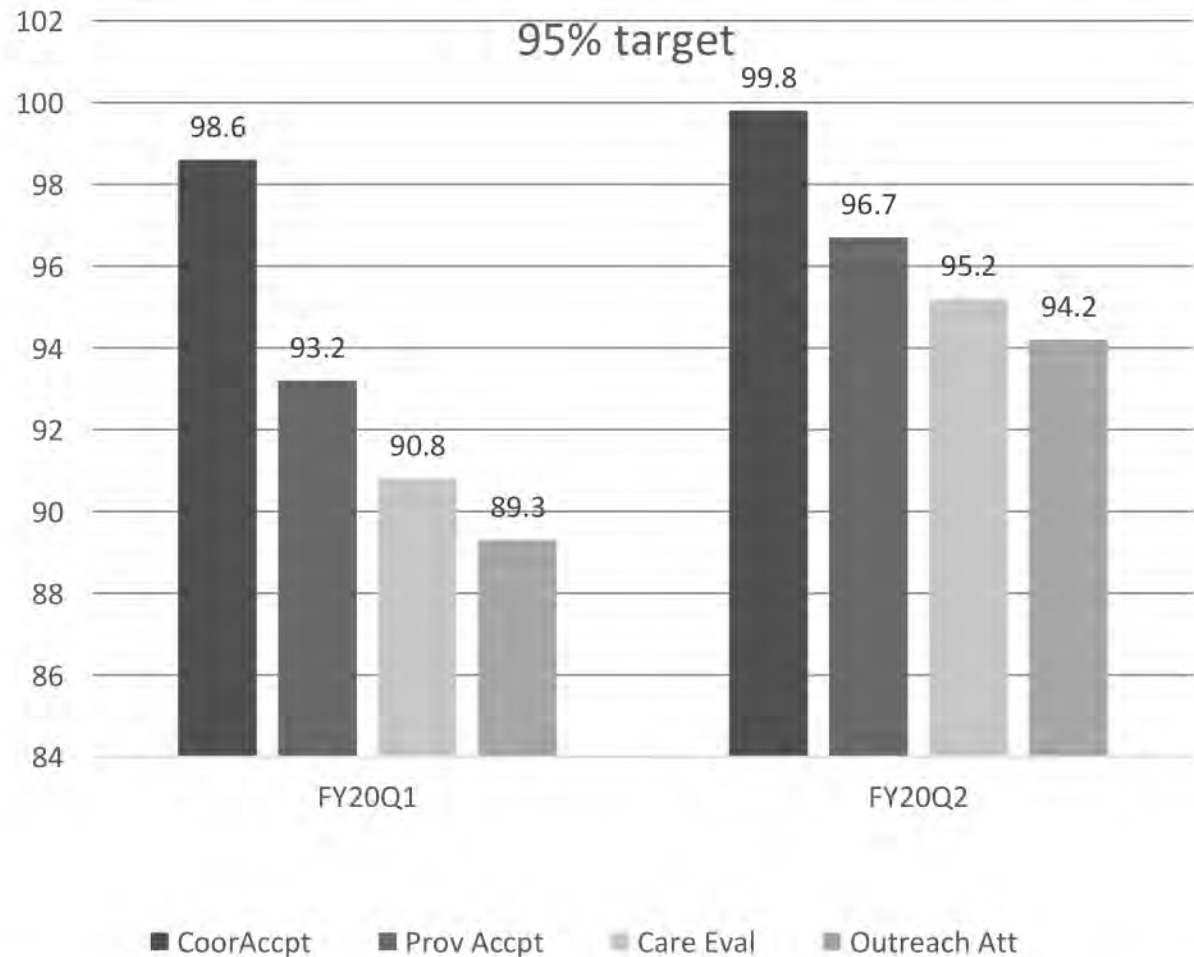
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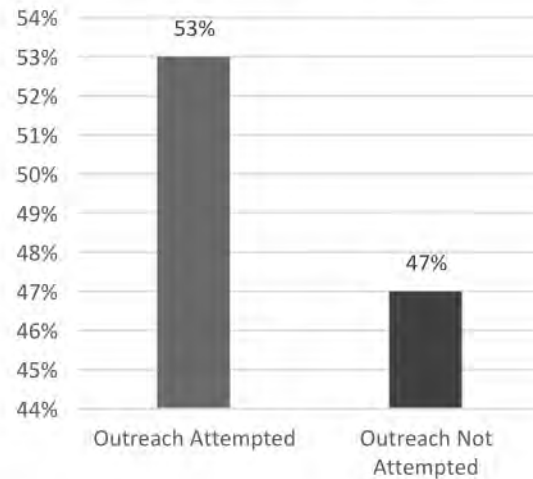
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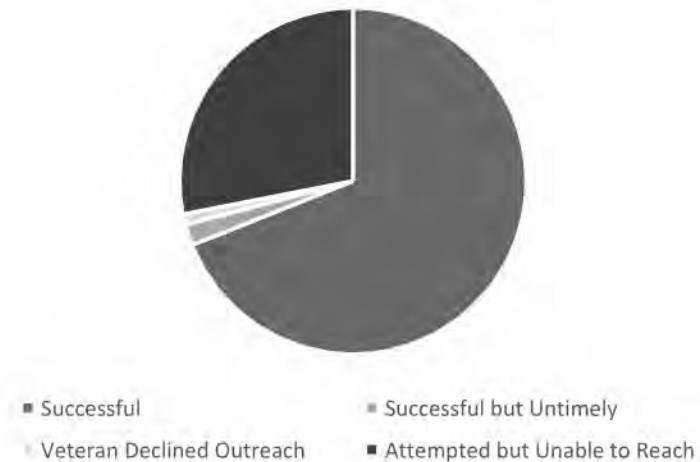
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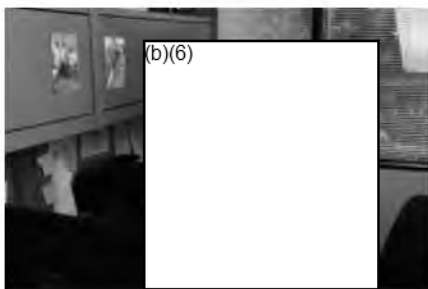
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Caregivers

Program Management Review (PMR) Veterans Health Administration

Date: 06/12/2020

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**Program Management Review (PMR) Accomplishments since last
PMR Follow-Up on Action Items since last PMR Expansion Integrated
Timeline Risks and Issues IT Development Regulation Program
Enhancement Directive, Notice, and SOPs Hiring Training Implementation
Readiness**

Program Management Review (PMR)

Accomplishments Since Last PMR

#	Item	Organizational POC	Completion Date
1	Office of General Counsel (OGC), VHA Regulations, and Office of Enterprise Integration (OEI) completed their initial response to the public comments	(b)(6)	5/28/2020
2	VHA has expedited the hiring of additional key field staff to support current program needs as well as anticipated expansion. As of 5/28, the program has achieved 85% of the Phase 1 goal of expanding from 480 to ~1,100 staff	(b)(6)	5/28/2020
3	Office of Information Technology (OIT) will expedite the development timeline and release the regulatory functionality required for SECVA certification by July 28	(b)(6)	5/29/2020
4	OIT completed CARMA integration with Corporate Data Warehouse (CDW)	(b)(6)	5/29/2020
5	Designed approaches to validate new business process required for expansion and regulation implementation	(b)(6)	6/2/2020
6	Summary of regulation public comments submitted to Office of Management and Budget (OMB) for review	(b)(6)	6/10/2020

Follow-Up on Action Items Since Last PMR

#	Item	Organizational POC	Completion Date
1	Understand how the rule impacts Veterans Benefits Administration (VBA), develop consistent data/assumptions to assess the impact on VBA to estimate the # of Veterans who may file for increased compensation ratings in order to qualify for Caregiver Stipend. VHA Milliman Exhibits submitted to VBA reviewKey contributors from VBA/VHA developing informed estimates of the # of increased compensation rating filingConvening workgroup meetings to write and clear a cost methodology of impact to VBA for Regulatory Impact Analysis (RIA)	Lisa Pape (b)(6)	6/17/2020
2	Working with OOReg, HR&A, VHA, OEI to finalize a hybrid staffing model using data modeling and VISN staffing needs assessments	(b)(6)	6/12/2020
3	Worked Jeff Goldstein and James Crowe at OMB to identify actions VA can take to help expedite OMB's regulatory review	(b)(6)	5/20/20
4	OEI is scheduling a briefing for DEPSEC in July on VA plans for Caregiver access to Army and Air Force Exchange Service (AAFES) and Commissaries (to include long-term approach to issuing a Caregiver ID card)	John Medve	



Risks and Issues

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Description

POC

Controls/Mitigation

Very Aggressive Implementation Schedule: If unanticipated events occur which significantly impact the critical development path they may jeopardize reaching the target SECVA certification date.

(b)(6)

By early August, Identify any potential for schedule slippage that might require adjustments to planned deliverables. Identify, define and execute training for any necessary manual workarounds.

OMB Expedited Review: If OMB does not agree to expedite the review of the proposed Caregiver Support Program (CSP) final rule, then the new regulation will not be in place in time for the program expansion

(b)(6)

- Request OMB waive Congressional Review Act

Legacy Participants: If unable to secure a large enough team to complete the ~20,000 reassessments of Legacy Participants within the first year, the timeliness of processing new applications for Vietnam and Korean War era Veterans will be jeopardized

Lisa Pape

- Consider use of VHA Traveling Nurse Corp to meet this need – meeting scheduled 6/19 Reassess current field-based staff roles and realign as needed/appropriate – in process Investigate contracting staffing services – in process

Risks and Issues

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Description	POC	Controls/Mitigation
Personnel: If unable to hire a qualified and seasoned permanent Program Director, the ability to establish necessary esprit de corps among the workforce weakens and impacts the ability to successfully expand the program	Lisa Pape	Detail announcement closed on 6/5 – 1 applicant Director announcement drafted for Social Worker/Psychologist/Nurse Relocation expenses requested awaiting final approval Announcement to post: Mid July 2020
Staffing Models/Funding: If unable to accurately estimate staffing models and associated funding that incorporate VAMC resource needs, VAMC staff will be unable to execute the increased workload expected due to the program expansion	(b)(6) (b)(6) Lisa Pape	HR&A/VHA/OEI/00 Reg working together to come up with best possible staffing estimates and associated costs for inclusion in RIA due to OMB 6/26
Program Office Requirements: If the Program Office is not adequately staffed to meet workload needs, VACO will be unable to effectively ensure consistent program operations and timely services to Veterans and Caregivers	Lisa Pape	Long Term: VHA Modernization calls for increased full-time equivalent (FTE) for Program Office; Proposed Org chart developed; Submitting task orders on 2 IDIQs for support and 1 contract Short Term: 2 additional details being pursued for CARMA; Supervisor, administrative, analytics, training, operational FTE needed; Detailed MD as Acting Medical Sr. Advisor 3 days a week

IT Development

1

Status

- Schedule currently on track, though very tight Weekly Program Management Reviews with all appropriate stakeholders being held to closely monitor progress VA Profile work to verify and update non-identity information for caregivers is in progress

2

Key Accomplishments

- CARMA 10-10CG Dark Release completed 5/22 CARMA integration with CDW completed 5/29

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Issues and Risks

- The schedule is extremely tight. Any unanticipated challenges (changes to requirements, difficulty in reducing backlog, unavailability of critical resources, etc.) will negatively affect the ability to deliver 100% of currently planned capabilities.

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Upcoming Key Milestones

Milestone	Est. Finish	Status
Release CARMA functionality to meet regulatory requirements	7/28/2020	
Soft Release of 10-10CG	7/31/2020	
National Release of all CPRS templates	8/31/2020	
Release of reassessment functionality	8/31/2020	
SecVA Certification and Go-Live	9/28/2020	

Project Status Legend:



Completed



On Track



At Risk (Plan in Place)



Issues (Additional Support Needed)

Regulation Status

1

Status

- CSP, OGC, VHA Regulations and OEI are meeting every day to refine the responses to the public comments and the final regulatory textIdentifying and preparing sections for OMB informal review throughout June

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Key Accomplishments

- CSP, OGC, VHA Regulations and OEI completed initial responses to the public comments on 5/28Initial draft of final regulation developed and sent to CSP, OGC, and OEI on 6/3; daily meetings scheduled the week of 6/8 to review and discuss; engaging VBA to discuss commentsSummary of public comments submitted to OMB for review

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Issues and Risks

- If OMB does not expedite review of the proposed final rule, then the new regulation will not be in place in time for the expansion that will occur when the required IT certification is completed

4

Upcoming Key Milestones

Milestone	Est. Finish	Status
Submit final rule to OMB for review	6/26/2020	☐
OMB clears the final rule	7/24/2020	☐
Final Rule is effective	10/1/2020	☐

Project Status Legend:



Completed



On Track



At Risk (Plan in Place)



Issues (Additional Support Needed)

Program Enhancement

Directive, Notice and Standard Operating Procedures (SOP)

1

Status

- Drafting VHA Notice and associated SOPs which will publish by 10/1 to align with the effective date of final rule. 3 Concurrent workgroups are underway: Writers, Reviewers, 2nd level Reviewers. As of 6/8, 16 SOPs are in progress. Target to have SOPs written by 6/30. The Appeals SOP is concurrently undergoing OGC review. VHA's Policy Office to review 3 most involved SOPs (Legacy, Discharge/Revocation, Application Processing) starting week of 6/8.

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Key Accomplishments

- The process of how appeals will be adjudicated was approved by the VISN Chief Medical Officers on 5/18.

3

Issues and Risks

- If Policy and SOPs are incomplete, then the enterprise will lack uniformed guidance directing VISN and VAMC program operations. If Program Office staff workload continues to be reassigned to prioritize SOP development, then field-based programing and implementation will be severely delayed impacting key expansion activities. If Field Guides are not disseminated to VISNs and VAMCs in advance of expansion and implementation, then program operations and decision making will vary across the enterprise. Stakeholders (VSO, Members of Congress) requesting inclusion in policy development. If full inclusion, then the program office will be setting precedent of including external entities in the development policy.

4

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Milestone	Est. Finish	Status
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Publish Appeals SOP	6/30/2020	
Complete drafting VHA Notice for entry into VHA concurrence	7/15/2020	
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Completed



On Track



At Risk (Plan in Place)



Issues (Additional Support Needed)

1

Status

- In process of hiring the final 85 FTE to complete Phase 1 Hiring InitiativeFinalizing staffing model on the Phase 2 hiring initiative; getting field input and will make adjustments as appropriate

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Key Accomplishments

- Hired 100% VISN LeadsHired 93% of the Phase 1 PCAFC Facility Program Managers/SupervisorsHired 90% of the PGCSS Facility CoordinatorsHired 69% of all Centralized Eligibility and Appeals Team (CEAT) staffSix VISNs have fully staffed CEATs

3

Issues and Risks

- If national policy guiding decision making among CEATs is not developed, then risk inconsistent practices among teams enterprise wide, resulting in inconsistent clinician assessment practices nationwide

4

Upcoming Key Milestones

Milestone	Est. Finish	Status
Four Corners Briefing	6/18/2020	■
Phase 2 Hiring Launch	7/13/2020	■
100% of CEAT staff are onboard	7/14/2020	■

Project Status Legend:



Completed



On Track



At Risk (Plan in Place)



Issues (Additional Support Needed)

1

Status

- Executing on the plan for two web-based conferences in July (CEAT) and September (CSP Expansion) Developing the presentations for CEAT conference. CEAT policy under development Planning for eligibility and appeals hands-on experiential training for CEAT staff Initial Veteran Functional Assessment Instrument modules planned completion by end of June to record with Employee Education Service

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Key Accomplishments

- Finalized agenda and accreditation for CEAT Training Conference Community of Practice Calls instituted to keep Field informed VISN lead calls instituted Eight CSP webinars are available on TMS with an additional nine webinars under development

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4

Upcoming Key Milestones

Milestone	Est. Finish	Status
Finalize CEAT Training Conference content	6/27/2020	■
Conduct CEAT Training Conference	7/24/2020	■
Deploy Veteran Functional Assessment Instrument training series	9/1/2020	■
Conduct Expansion Training Conference	9/17/2020	■

Project Status Legend:



Completed



On Track



At Risk (Plan in Place)



Issues (Additional Support Needed)

Implementation Readiness

1

Status

- Establishing support mechanisms to assist field staff with adopting new business processes, to monitor consistency of clinical decision making, and to complete reassessments of Legacy Participants
- Developing Table Top Exercises to test new business processes, identify weaknesses and create solutions prior to fully fielding the new program

2

Key Accomplishments

- VA-CARES QUERI, a partnered evaluation center, is partnering with the program office to conduct formative evaluation and monitoring of Eligibility/Assessments/CEAT Processes supporting consistency across VISNs and VAMCs

3

Issues and Risks

- If unable to secure a large enough team to complete the ~20,000 reassessments of Legacy Participants within the first year, the timeliness of processing new applications for Vietnam and Korean War era Veterans will be jeopardized. If current Program Office FTE are prioritized to focus on all aspects of field implementation, then no resources are available supporting day-to-day operations and general program oversight

4

Upcoming Key Milestones

Milestone	Est. Finish	Status
Develop processes for auditing VAMC and VISN performance	7/15/2020	
Complete implementation of WebVRAM	8/3/2020	

Project Status Legend:



Completed



On Track



At Risk (Plan in Place)



Issues (Additional Support Needed)

PMR Wrap Up

Program Management Review (PMR) Veterans Health Administration

AMERICAN OVERSIGHT

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Follow-Up on Action Items since last PMR
Expansion Integrated Timeline Risks and Issues
IT Development Regulation Program Enhancement Directive, Notice, and SOPs
Hiring Training Implementation Readiness

Program Management Review (PMR)

Accomplishments Since Last PMR

#	Item	Organizational POC	Completion Date
1	Office of General Counsel (OGC), VHA Regulations, and Office of Enterprise Integration (OEI) completed their initial response to the public comments	(b)(6)	5/28/2020
2	VHA has expedited the hiring of additional key field staff to support current program needs as well as anticipated expansion. As of 5/28, the program has achieved 85% of the Phase 1 goal of expanding from 480 to ~1,100 staff	(b)(6)	5/28/2020
3	Office of Information Technology (OIT) will expedite the development timeline and release the regulatory functionality required for SECVA certification by July 28	(b)(6)	5/29/2020
4	OIT completed CARMA integration with Corporate Data Warehouse (CDW)	(b)(6)	5/29/2020
5	Designed approaches to validate new business process required for expansion and regulation implementation	(b)(6)	6/2/2020
6	Summary of regulation public comments submitted to Office of Management and Budget (OMB) for review	(b)(6)	6/10/2020

Follow-Up on Action Items Since Last PMR

#	Item	Organizational POC	Completion Date
1	Understand how the rule impacts Veterans Benefits Administration (VBA), develop consistent data/assumptions to assess the impact on VBA to estimate the # of Veterans who may file for increased compensation ratings in order to qualify for Caregiver Stipend. VHA Milliman Exhibits submitted to VBA reviewKey contributors from VBA/VHA developing informed estimates of the # of increased compensation rating filingConvening workgroup meetings to write and clear a cost methodology of impact to VBA for Regulatory Impact Analysis (RIA)	Lisa Pape (b)(6)	6/17/2020
2	Working with 00Reg, HR&A, VHA, OEI to finalize a hybrid staffing model using data modeling and VISN staffing needs assessments	(b)(6)	6/12/2020
3	Worked Jeff Goldstein and James Crowe at OMB to identify actions VA can take to help expedite OMB's regulatory review	(b)(6)	5/20/20
4	OEI is scheduling a briefing for DEPSEC in July on VA plans for Caregiver access to Army and Air Force Exchange Service (AAFES) and Commissaries (to include long-term approach to issuing a Caregiver ID card)	(b)(6)	



Risks and Issues

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Description

POC

Controls/Mitigation

Very Aggressive Implementation Schedule: If unanticipated events occur which significantly impact the critical development path they may jeopardize reaching the target SECVA certification date.

(b)(6)

By early August, Identify any potential for schedule slippage that might require adjustments to planned deliverables. Identify, define and execute training for any necessary manual workarounds.

OMB Expedited Review: If OMB does not agree to expedite the review of the proposed Caregiver Support Program (CSP) final rule, then the new regulation will not be in place in time for the program expansion

(b)(6)

- Request OMB waive Congressional Review Act

Legacy Participants: If unable to secure a large enough team to complete the ~20,000 reassessments of Legacy Participants within the first year, the timeliness of processing new applications for Vietnam and Korean War era Veterans will be jeopardized

Lisa Pape

- Consider use of VHA Traveling Nurse Corp to meet this need – meeting scheduled 6/19 Reassess current field-based staff roles and realign as needed/appropriate – in process Investigate contracting staffing services – in process

Risks and Issues

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Description	POC	Controls/Mitigation
Personnel: If unable to hire a qualified and seasoned permanent Program Director, the ability to establish necessary esprit de corps among the workforce weakens and impacts the ability to successfully expand the program	Lisa Pape	Detail announcement closed on 6/5 – 1 applicant Director announcement drafted for Social Worker/Psychologist/Nurse Relocation expenses requested awaiting final approval Announcement to post: Mid July 2020
Staffing Models/Funding: If unable to accurately estimate staffing models and associated funding that incorporate VAMC resource needs, VAMC staff will be unable to execute the increased workload expected due to the program expansion	(b)(6) (b)(6) / Lisa Pape	HR&A/VHA/OEI/00 Reg working together to come up with best possible staffing estimates and associated costs for inclusion in RIA due to OMB 6/26
Program Office Requirements: If the Program Office is not adequately staffed to meet workload needs, VACO will be unable to effectively ensure consistent program operations and timely services to Veterans and Caregivers	Lisa Pape	Long Term: VHA Modernization calls for increased full-time equivalent (FTE) for Program Office; Proposed Org chart developed; Submitting task orders on 2 IDIQs for support and 1 contract Short Term: 2 additional details being pursued for CARMA; Supervisor, administrative, analytics, training, operational FTE needed; Detailed MD as Acting Medical Sr. Advisor 3 days a week

IT Development

1

Status

- Schedule currently on track, though very tight Weekly Program Management Reviews with all appropriate stakeholders being held to closely monitor progress VA Profile work to verify and update non-identity information for caregivers is in progress

2

Key Accomplishments

- CARMA 10-10CG Dark Release completed 5/22 CARMA integration with CDW completed 5/29

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