

VHA COVID-19 Equity Response

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Foreword

From the start of pandemic lockdown in March 2020 and continuing to the present day, the U.S. Department of Veterans Affairs (VA) has been a national leader in addressing COVID-19 related healthcare disparities. Notably, VA's leadership is rooted in its institutional commitment made more than decade ago to assuring healthcare equity for all Veterans, and its subsequent incorporation of key practices into clinical care, resource allocation, community support and programming.

- *The VHA COVID-19 Equity Response* shows how this commitment has been foundational to VA's immediate and ongoing response to the inequities substantially amplified by this once-in-a-century pandemic. More specifically, the *Response* demonstrates the outstanding leadership of the Office of Healthcare Equity (OHE) in helping VA quickly mobilize its unique assets. These assets include:
- An *embedded research program* that enabled VA to hit the ground running with an extensive literature review of prior US epidemics, and thereby develop an evidence base for gauging COVID-19's potential impact on minority Veteran population groups. OHE also engaged one of VA's top health services researchers to coordinate "an analytic space" that OHE created to inform operations, and which paved the way for an impressive portfolio of COVID-19-related research to follow.
- An *electronic health record (EHR) system*, which enabled VA to learn that in the pandemic's first 6 months, Black and Hispanic Veterans who received VHA care were more likely to test positive than their non-Hispanic White counterparts (but that 30-day mortality did not differ). VA's EHR was also instrumental to calculating rates of infection, treatment and death among minority Veterans receiving VA care.
- VA's *early leadership in telehealth*, beginning 2003, which positioned it to rapidly expand virtual care, and over time, develop deep expertise. With these foundational pieces in place, OHE was able to work collaboratively with VA partners to address key barriers revealed by COVID-19 (connectivity issues, lack of required devices or software).
- *Partnerships at the regional and local levels*, leading to collaboration with VISN 1's Assessing Circumstances and Offering Resources for Needs (ACORN) initiative to develop a screening tool for COVID-19 social risk factors. Additionally, OHE successfully tapped into the "general sense of community" fostered by individual facilities to reach specific groups of Veterans.
- *Relationships with individual Veterans and Veterans Service Organizations* which enabled OHE to create targeted communications materials and mobilize communications campaigns aimed at overcoming distrust and/or addressing misinformation.
- *Outreach to Veterans of color*, an OHE-led effort that anticipated both Veteran and public concern about COVID-19 vaccinations. Through purposeful engagement and dialogue, OHE learned that Veterans were most likely to trust vaccine information shared by their primary care provider. As a result, in a few short months vaccine uptake by older Black Veterans exceeded that of all other groups.

These are just a few of the ways OHE has led the nation’s largest healthcare system – and continues to serve as a model for all healthcare systems – in addressing health care inequities during this unprecedented time.



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Overview

When the novel coronavirus 2019 disease (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), appeared across the U.S. in early 2020, many public health and health care systems rapidly experienced unprecedented demands on resources. At the same time, data showed that COVID-19 affected Americans at disproportionate rates; infection rates, morbidity and mortality all impacted minority and at-risk populations incommensurately (Clapp, et al., 2020; Tai, Shah, Doubeni, Sia, & Wieland, 2021; Brandt, Beck, & Mersha, 2020; Shah, Sachdeva, & Dodiuk-Gad, 2020; Sciacqua, Pujia, Arturi, Hribal, & Montalcini, 2020). As the largest integrated health care system in the U.S., the Department of Veterans Affairs (VA) immediately initiated plans to mitigate COVID-19 inequities that could affect Veterans and the American public.

Established in 2012, the Office of Health Equity (OHE) was one of the offices activated to ensure all Veterans had equitable access to COVID-19 information, testing and treatment. OHE champions eliminating health disparities and achieving health equity for all Veterans. The VA Health Equity Action Plan serves as OHE's guiding document for equity implementation and sustainment (Moy, 2019). Achieving health equity required valuing everyone equally with focused and ongoing tailored efforts to address avoidable inequities, historical and contemporary injustices and the elimination of health and healthcare disparities (Centers for Disease Control, 2020). Since OHE's health equity processes and procedures were already well established, scaling to demand during the COVID-19 pandemic was manageable.

In this report, we discuss how VA leveraged existing resources and designed new approaches to advance health equity by providing equitable COVID-19 care for all Veterans given known marginalizing risk factors that many experience. We describe (1) responses by VA and OHE supporting equity in the design of VA COVID-19 operations; (2) the use of data and health services research to gauge the success of efforts and areas of need in real time; and (3) strengths, areas for improvement and lessons learned that other health care systems might use for informing future work in ensuring health equity during a pandemic scenario.

Understanding COVID-19 Inequities

As early as March 2020, anecdotal information suggested COVID-19 was disproportionately affecting people of color and those residing in low-income neighborhoods. Leveraging its electronic health records, VA was able to calculate rates of infection, treatment, and death among Veterans cared for by VA. For example, Rentsch et al. (2020a) found that in the first 6 months of the pandemic, Black and Hispanic individuals who received care in the VA were more likely to test positive than their non-Hispanic White counterparts, but that 30-day mortality did not differ (Exhibit 1). Similarly, male Veterans and urban Veterans were more likely to test positive than female and rural Veterans respectively, but mortality did not differ. In contrast, age was identified as the most significant predictor of dying from COVID-19. Other researchers quickly confirmed these inequities among Veterans (Ferguson, et al., 2022; McCleery, et al., 2022; Rentsch, et al., 2020a, 2020b, 2020c, 2021; Wong, et al., 2021a, 2021b; Upchurch, et al., 2022). Determined to minimize disparities in COVID-19 among Veterans, VA embarked on a multi-pronged effort to understand COVID-19 inequities.

Exhibit 1.

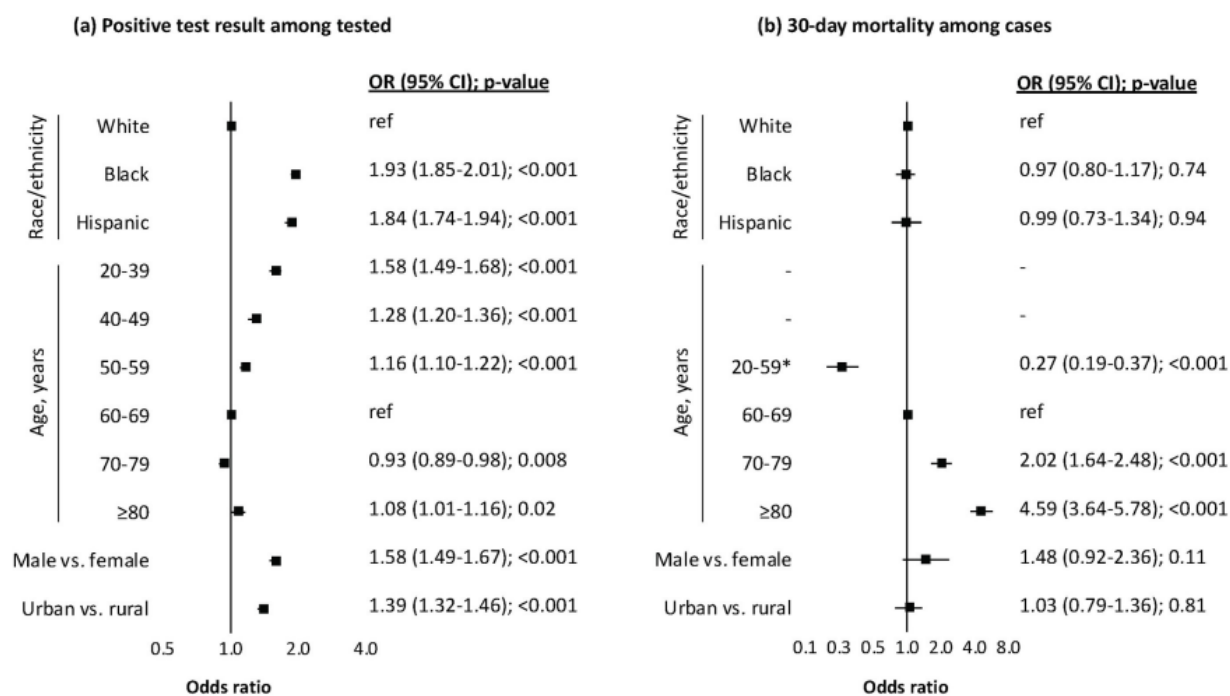


Fig 2. Adjusted associations of demographic characteristics with testing positive for COVID-19 and subsequent 30-day mortality as of July 22, 2020. (a) Positive test result among tested; (b) 30-day mortality among cases. Both models were conditioned on site of care and adjusted for baseline comorbidity (asthma, cancer, chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, liver disease, vascular disease), substance use (alcohol consumption, alcohol use disorder, smoking status), and medication history (angiotensin converting enzyme inhibitor, angiotensin II receptor blocker). *Low number of mortality events in age groups 20-39 and 40-49 thus grouped with 50-59. CI, confidence interval; COVID-19, coronavirus disease 2019; OR, odds ratio. Rentsch, C. T., Kidwai-Khan, F., Tate, J. P., Park, L. S., King, J. T., Skanderson, M., . . . Justice, A. C. (2020a). Patterns of COVID-19 testing and mortality by race and ethnicity among United States veterans: A nationwide cohort study. *PLoS Med*, 17(9), e1003379.

To further understand equity issues during pandemics, the VA Evidence Synthesis Program conducted a rapid literature review of prior epidemics in the U.S. to provide insight on how COVID-19 might affect minority populations (Kondo, et al., 2020). Although this report was not focused specifically on Veterans, it provided valuable insight about “potentially modifiable factors” (Kondo, et al., 2020, p. 1) that may have played a role in health outcomes and infection rates in previous epidemics. Findings included that minority populations and those of lower socioeconomic status were more likely to be infected and less likely to be vaccinated. Importantly, it suggested that higher infection rates among people of color and those residing in low-income neighborhoods were primarily related to occupational exposures and inability to socially distance (Exhibit 2) (Kondo, et al., 2020). Applying these findings to the COVID-19 pandemic response suggested that additional outreach to minority Veterans groups, addressing specific concerns, would help ensure that all populations had accessible and accurate information and medical care.

Exhibit 2.

Table 11. Strength of the Evidence for Studies of H1N1 Vaccine Uptake

Population of interest	Comparator population	# of studies	vaccine uptake likelihood	Strength	SOE justification
AA/Black		6	Less likely	Moderate	
Latino		7	Less likely	Low	Inconsistency
Asian		2	Unclear	Insufficient	Inconsistency, imprecision, indirectness
AI/AN	White	2	Unclear	Insufficient	Indirectness, imprecision
Pacific Islander		1	Unclear	Insufficient	Indirectness
Asian/Pacific Islander		1	Unclear	Insufficient	Indirectness, imprecision
Lower SES (education and/or income)	Higher SES	3	Less likely	Low	Inconsistency
Rural	Urban	1	Unclear	Insufficient	Single, small study with multiple limitations
With Disabilities	Without Disabilities	0	No evidence	---	---

Abbreviations: AA = African American, AI = American Indian, AN = Alaska Native, SES = socioeconomic status

Kondo, K., et. al., (2020, November). *Health Inequalities in Infectious Disease Epidemics Pre-dating COVID-19 in the United States: A Rapid Review*. Retrieved from VHA Health Services Research & Development Service: <https://www.hsrd.research.va.gov/publications/esp/pre-covid-19-inequalities.pdf>

To coordinate equity analyses of COVID-19 cases and care, VA asked OHE to establish a dedicated analytic space with complete COVID-19 Veteran data to inform pandemic operations. Staff in OHE set up a health equity COVID-19 database to meet those needs based on case data gathered by the VA National Surveillance Team (NST). The first step was to extract available information on patients who received COVID-19 testing, the results from those tests, and any COVID-19-related lab work. The initial NST tables contained the patient's age, gender, death status and Veteran status. Next, OHE included equity measures including patient's race/ethnicity, geographic information, service connectedness, period of service, body mass index and over 30 medical and mental health conditions (e.g., hypertension, diabetes and serious mental illness and other mental health concerns). Health equity staff used a similar approach for organizing vaccination data and vaccination tables included the patient age, sex

and race/ethnicity. Staff then set up a system where partner researchers and program offices could request access to the database and tables. A comprehensive health equity COVID-19 data SharePoint site stored codebooks, research articles and other materials relevant to COVID-19 and health equity. Staff refresh testing and vaccination tables weekly.

The analytic space, coordinated by Dr. Donna Washington, enabled OHE to create a VA-wide equity data community early in the pandemic, inviting researchers to put forth efforts in exploring health inequities and COVID-19, encouraging collaboration, strategic planning and minimizing duplication.

Sharing Information on COVID-19 Inequities

Early in the pandemic, OHE collaborated with VHA's Center for Health Equity and Promotion and the Assessing Circumstances and Offering Resources for Needs (ACORN) Initiative in Veteran Integrated Services Network (VISN) 1 to create a screener for COVID-19 social risk factors for VA employees to use when interacting with Veterans (Exhibit 3) (Cohen & Kennedy, 2022; VHA Health Services Research and Development, 2020). This screener, which was eventually integrated into a script that staff assigned to triage incoming phone calls could use during conversations with Veterans who reported symptoms or an exposure, captured information about frequency of leaving home for work and critical activities like picking up groceries, accessing medical care and using public transportation or ridesharing (Exhibit 4). The information was collected in VA's Computerized Patient Record System (CPRS). The goal was to identify Veterans at high risk of social determinants of health insecurities and provide them with appropriate counselling and services.

Exhibit 3a. VHA COVID-19 Provider Social Risks Screening Questions

COVID-19 Provider Social Risks Screening Questions

- Exposures
 - Work
 - Do you or anyone you live with go to work in places where they may be exposed to COVID-19?
 - No*
 - Yes, Veteran Only⁺
 - Yes, someone Veteran lives with
 - Yes, Veteran and someone Veteran lives with⁺
 - Transportation
 - In the past 2 weeks, how often have you or someone you live with used public transportation or rideshare services?
 - Almost daily⁺
 - 2-3 times a week
 - Once a week or less
 - Never*
 - Shopping/supplies
 - In the past 2 weeks, how often have you or someone you live with left your home to get essential items like groceries or medications?
 - Almost daily⁺
 - 2-3 times a week
 - Once a week or less*
 - Never*
 - Social interactions
 - In the past 2 weeks, how often have you or someone you live with left your home to visit friends or family?
 - Almost daily⁺
 - 2-3 times a week
 - Once a week or less*
 - Never*
- Housing Density
 - How many people do you live with, yourself included?
 - 1*
 - 2*
 - 3-4
 - 5+
 - Do you share a bedroom with anyone?
 - Yes
 - No

Exhibit 3b. VHA COVID-19 Provider Social Risks Screening Questions

COVID-19 Provider Social Risks Screening Questions (continued)

- Prevention
 - Do you consider yourself to be at high risk of COVID-19 infection?
 - Yes
 - No
 - Don't know
 - In the past 2 weeks, how often have you and everyone you live with stayed 6 feet away from others and worn a mask when closer than 6 feet?
 - Never⁺
 - Rarely⁺
 - Sometimes
 - Often*
 - Always*
 - Which of the following items do you have access to at home? Check all that apply:
 - In the past 2 weeks, how often have you or someone you live with left your home to get essential items like groceries or medications?
 - Disinfectant
 - Hand sanitizer
 - Masks
 - Thermometer

COVID-19 Provider Social Risks Screening Questions Scoring and Application

Scoring

- Only responses with * = Low Social Risk
- 2 or more Responses with ⁺ = High Social Risk
- All Other Combinations = Average Social Risk

Application

- Sites should use social risk scores to help prioritize patients for testing. The following prioritization is recommended:
 1. Symptoms + Clinical Risk + High Social Risk
 2. Symptoms + Clinical Risk + Average Social Risk
 3. Symptoms + Clinical Risk + Low Social Risk
 4. Symptoms + No Clinical Risk + High Social Risk
 5. Symptoms + No Clinical Risk + Average Social Risk
 6. Symptoms + No Clinical Risk + Low Social Risk
 7. No Symptoms + Clinical Risk + High Social Risk
 8. No Symptoms + Clinical Risk + Average Social Risk
 9. No Symptoms + Clinical Risk + Low Social Risk

Exhibit 4. VA Social Determinants Risks Screener in CPRS

Social Determinants:
Emerging data on COVID-19 cases in the U.S. suggests that social factors may increase risk for COVID-19
[CDC COVID-19 Others at Risk](#) . As a result, VHA recommends that clinicians identify key social factors that can increase risk.

How often in the past two weeks have you, or someone you live with, left the house for work and tasks (grocery shopping, healthcare appointments, etc.)? *

Almost daily
 2-3 times per week
 (CONSIDER PCR TESTING for High Risk social conditions)
 Weekly
 Never

In the last two weeks how often have you, or someone you live with, used public transportation or rideshare services?*

Almost daily
 (CONSIDER PCR TESTING for High Risk social conditions)
 2-3 times per week
 Weekly
 Never

A COVID-19 Equity Dashboard visible to all staff allowed VA leaders and providers to identify VISNs and counties with high numbers of community and VA COVID-19 infections (Exhibit 5). VA patient infections were stratified by race/ethnicity so counties with higher positive test rates among Black, Hispanic or White Veterans could be targeted for outreach and intervention (Exhibit 6). Testing could be tracked over time (Exhibit 7) and guidance provided to individual VISNs (Exhibit 8). This Dashboard was also used to supplement regular reports to VA leadership and Congress on the state of disparities in COVID-19 care among Veterans.

Exhibit 5. COVID-19 Equity Dashboard: Positive Test Rates by Race/Ethnicity and VISN

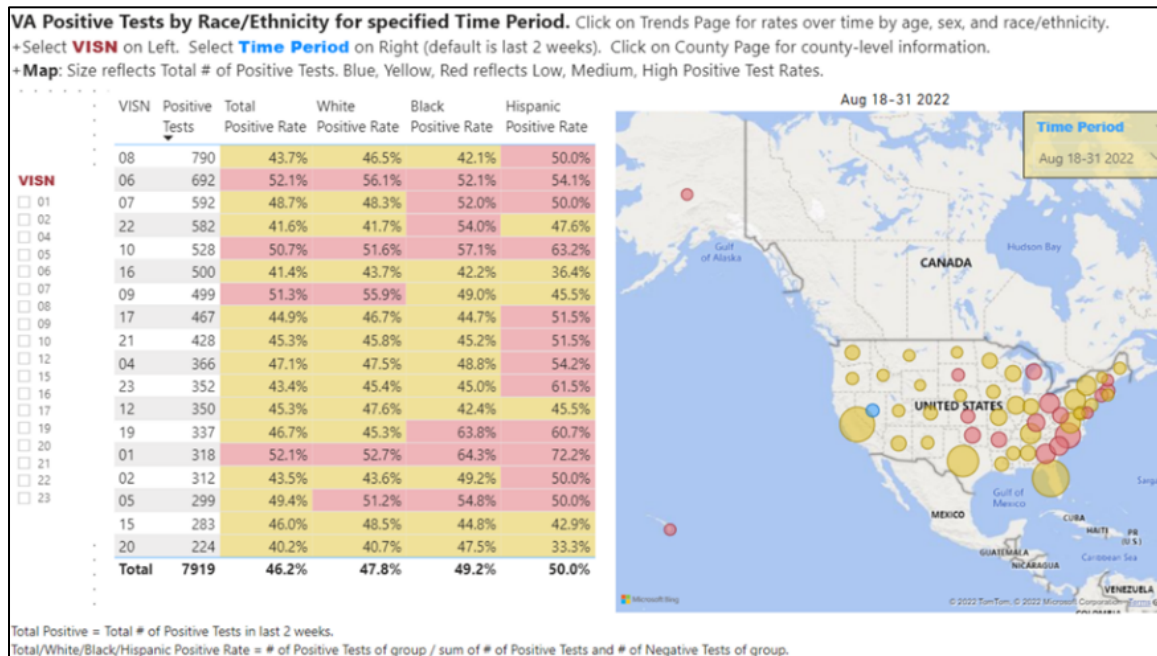


Exhibit 6. COVID-19 Equity Dashboard: Positive Test Rates by Race/Ethnicity and County within VISN 17

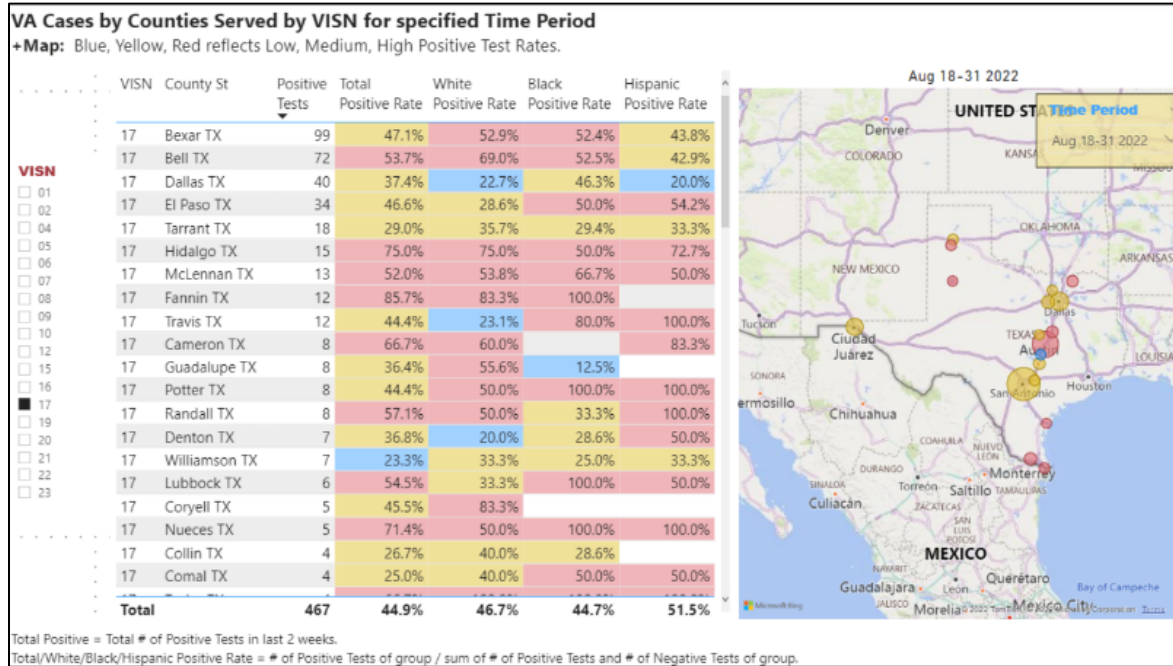


Exhibit 7. COVID-19 Equity Dashboard: Positive Test Rates by Race/Ethnicity over Time

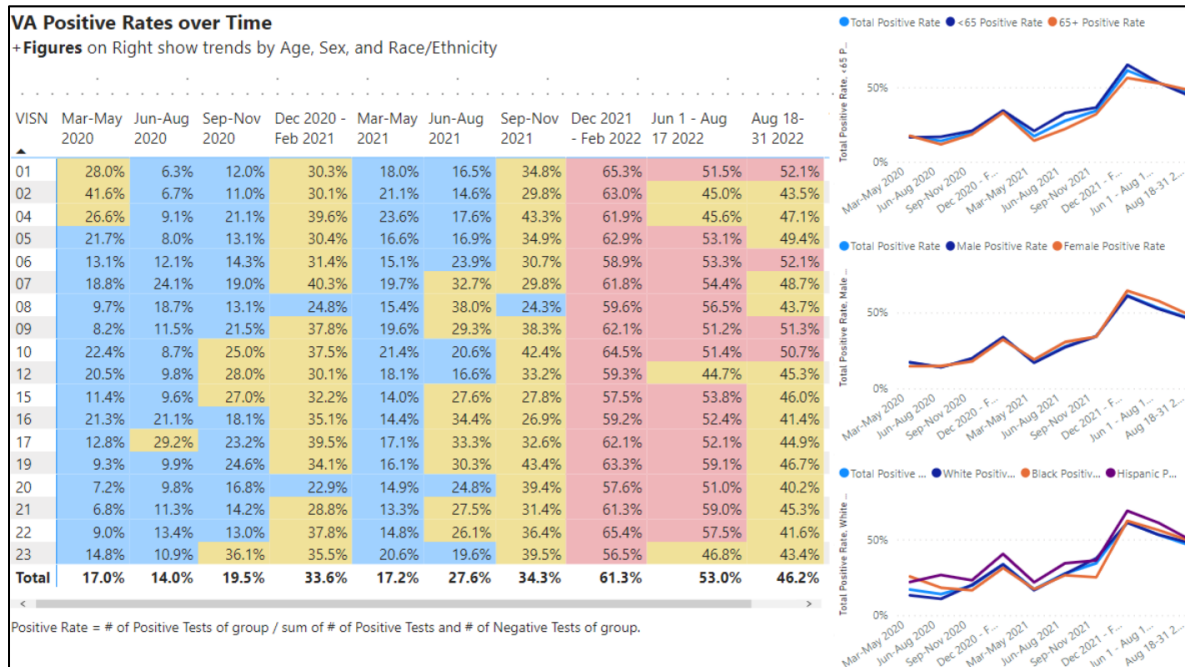


Exhibit 8. VHA COVID-19 Disparities Updates for VISNs

VHA COVID-19 DISPARITIES UPDATE

VA New England Healthcare System (VISN 01) – July 2021 Snapshot

Overview

Through 7/28/2021, VISN 01 had vaccinated the 6th highest % of VHA users age 65+ (47%) for COVID. For the week ending on 7/28/2021, VISN 01 counties had the 3rd lowest number of new VA cases in the last 2 weeks (206) & the 3rd lowest rate of daily new cases (6.9 per 100K) compared to other VISNs.

Disparities Alert:

Racial/ethnic disparities in COVID vaccination were not observed.

Hispanic Veterans had higher positive test rates.

Recommended Action:

Consider vaccination outreach to All Veterans in White River Junction.

Consider testing outreach to Black Veterans in Fairfield, Hartford, & Providence Counties, Hispanic Veterans in Fairfield & Providence Counties.

COVID VACCINATIONS & VACCINATION REFUSALS, VHA USERS AGE 65+

VISN	Total Vaccinations	Total Vaccination Rate	White Vaccination Rate	Black Vaccination Rate	Hispanic Vaccination Rate	Total Refusals	Total Refusal Rate	White Refusal Rate	Black Refusal Rate	Hispanic Refusal Rate
1	65,890	47%	46%	46%	62%	54%	7,029	5.0%	5.1%	3.7%
518 Bedford	8,276	65%	64%	68%	63%	168	1.3%	1.4%	2.1%	2.6%
523 Brockton	11,588	57%	57%	62%	59%	1,116	5.5%	5.7%	5.8%	4.1%
609 Newington	14,372	52%	52%	66%	62%	353	1.3%	1.3%	1.5%	1.6%
631 Leeds	6,499	46%	45%	56%	47%	1,068	7.5%	7.5%	7.7%	9.2%
608 Manchester	5,523	42%	42%	60%	45%	507	3.9%	4.0%		1.5%
650 Providence	7,368	40%	40%	55%	47%	1,489	8.1%	8.4%	5.0%	4.0%
402 Togus	7,850	35%	35%	44%	40%	2,110	9.4%	9.3%	7.1%	13.6%
405 White River Junction	4,414	34%	34%	36%	28%	218	1.7%	1.7%		4.8%
Total	65,890	47%	46%	46%	62%	54%	7,029	5.0%	5.1%	3.7%

COVID POSITIVE TESTS

VISN	County St	Positive Tests	Total Positive Rate	White Positive Rate	Black Positive Rate	Hispanic Positive Rate
01	New Haven CT	24	9.6%	9.3%	8.3%	5.0%
01	Fairfield CT	23	21.0%	13.3%	35.0%	50.0%
01	Hartford CT	18	11.5%	9.8%	21.3%	5.9%
01	Providence RI	16	14.7%	11.1%	26.3%	20.0%
01	Middlesex MA	15	15.2%	17.1%	11.1%	
01	Suffolk MA	12	16.7%	19.5%		16.7%
01	Norfolk MA	11	15.1%	16.9%	12.5%	
01	Bristol MA	9	15.0%	10.0%		100.0%
01	Kennebec ME	8	8.2%	9.4%		
01	Plymouth MA	8	11.2%	13.5%		50.0%
01	Hampden MA	7	26.5%	40.0%	16.7%	16.7%
01	Merrimack NH	6	10.0%	31.3%		
01	Essex MA	4	10.0%	7.4%	16.7%	33.3%
01	Litchfield CT	4	20.0%	16.8%	100.0%	
01	Tolland CT	4	13.3%	16.7%		
01	Windham CT	4	25.0%	23.1%		100.0%
01	Worcester MA	4	8.9%	11.8%		
01	Hampshire MA	3	23.1%	33.3%		
01	Hillsborough NH	3	7.9%	6.7%		

New Haven County, CT

- Most new VA cases in last 2 weeks (24)
- Low community new case rate (8 per 100K)
- No racial/ethnic disparities

Fairfield County, CT

- 2nd most VA cases in last 2 weeks (23)
- Low community new case rate (7 per 100K)
- Black, Hispanic > White Veteran positive rate

Hartford County, CT

- 3rd most VA cases in last 2 weeks (18)
- Low community new case rate (9 per 100K)
- Black > White Veteran positive rate

Providence County, RI

- 4th most VA cases in last 2 weeks (16)
- Low community new case rate (8 per 100K)
- Black, Hispanic > White Veteran positive rate

For more information & interactive dashboard, see: <https://dvagov.sharepoint.com/sites/VACOVHAOHE/SitePages/BI-Test.aspx>

In September 2020, OHE hosted virtual listening sessions with Veterans of color with the goal of increasing vaccination rates and determining best practices for disseminating accurate information about COVID-19. These listening sessions shaped VA’s tailored messaging to include anticipated Veteran questions and concerns. For example, OHE learned that having professionals with similar demographic backgrounds present information at appointments or meetings with Veterans was crucial for trust-building and addressing vaccine hesitancy. OHE learned that explicitly addressing past injustices such as the United States Public Health Service Tuskegee Syphilis Study (Centers for Disease Control and Prevention, 2022) and emphasizing VA’s role as ensuring all Veterans had the information needed to make a decision for themselves and their families was critical when discussing new treatments with minority Veterans.

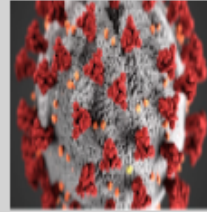
Reducing COVID-19 Inequities

VA OHE worked closely with VISNs, Veterans Affairs Medical Centers (VAMCs) across the country, and offices in Veterans Affairs Central Office developed tools, strategic plans and targeted communications and interventions in order to reach at-risk populations and provide scientific information about COVID-19 and behaviors to mitigate viral spread (Veterans Health Administration, n.d., 2020a, 2020b). Central to OHE's efforts were identifying Veterans who may be at greater risk of serious illness from COVID-19 and working to provide care and messaging to these higher risk populations. OHE accomplished this goal by working in four major areas: a social risks screener, regular updates to VA leadership, operational tracking in the OHE Equity Dashboard and listening sessions with Veterans. These activities allowed OHE to identify and target information products to specific groups of Veterans. For example, by late April 2020, OHE recognized the rapid spread of COVID-19 in rural areas and began disseminating information for rural Veterans (Exhibit 9). Targeted information products were also produced for Veterans of color (Exhibit 10), older Veterans, pregnant Veterans and Operation Enduring Freedom / Operation Iraqi Freedom / Operation New Dawn Veterans. They are available on [the Office of Health Equity's website](#).

Exhibit 9. Information Brief Highlighting COVID-19 Trends in Rural Areas and the Implications for Veterans

Trends in Coronavirus in Rural Areas: Implications for Veterans

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SUMMARY

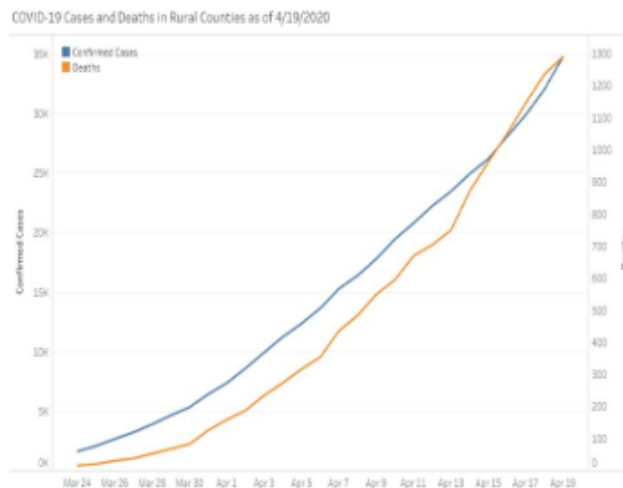
Analyses of data compiled by the Johns Hopkins CSSE 2019 Novel Coronavirus COVID-19 Data Repository show that numbers of COVID-19 cases and deaths in rural counties increased from March 24 to April 19 at a rate faster than in urban counties.

INTRODUCTION


Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission. VA champions the elimination of health disparities, including addressing social determinants of health to achieve health equity for all Veterans. Coronavirus (COVID-19) is a respiratory illness that can spread from person to person. People at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

WHERE VETERANS LIVE AND CORONAVIRUS DISEASE


Veterans are more likely to live in less populated areas. Analyses of data compiled by the Johns Hopkins CSSE 2019 Novel Coronavirus COVID-19 Data Repository indicate that numbers of COVID-19 cases in rural counties increased over 21-fold from 1,625 on March 24 to 34,804 on April 19, a rate faster than in urban counties, which increased 14-fold. Also, COVID-19 deaths in rural counties increased over 80-fold; in urban counties deaths increased 66-fold. It is possible that delayed testing rates in rural areas may have contributed to this significantly high rate of cases in rural areas.



10 ways to get the care and support you need from VA during COVID-19



A coronavirus disease (COVID-19) resource for Black, Hispanic, and Native American Veterans



We know that COVID-19 is severely impacting Black, Hispanic, and Native American communities across the country. We're here to connect you with the information and resources you need to stay healthy during this time.


Here are 10 ways to get care and support from VA:

- 1. If you're not enrolled in VA health care, find out if you're eligible and how to apply.** If you weren't eligible for VA health care in the past but you've had a decrease in income, you may be eligible now. Find out at www.va.gov/health-care/eligibility/.
- 2. Stay informed about how COVID-19 may impact your VA health care and other benefits.** Get the latest updates at www.va.gov/coronavirus-veteran-frequently-asked-questions/.
- 3. Get care when you need it.** Please don't delay routine health appointments. And keep up with recommended health screenings based on your age and other risk factors. Screenings are tests that help to find health problems (like heart issues or certain cancers) early, when they're easier to treat.
- 4. Make sure you have enough of your prescription medicines.** Order your new prescription as soon as you can. Always order at least 10 days before you need more. Learn more about refilling VA prescriptions online at www.va.gov/health-care/refill-track-prescriptions/.
- 5. Get your flu shot.** Both the flu and COVID-19 can lead to serious illness and even death. They may be even more dangerous if you get them at the same time. Getting a flu vaccine is an essential part of protecting your and your family's health this season. It's the best protection against flu available.

If you're enrolled in VA health care, you can get a no-cost flu shot safely at your nearest VA health care facility or many community locations. Learn more at www.publichealth.va.gov/flu/index.asp and www.va.gov/COMMUNITYCARE/flushot.asp. If you're not enrolled in VA health care, go to www.cdc.gov/flu/.
- 6. Know what to do if you get sick.** Sign up for our Annie coronavirus precautions messages at www.mobile.va.gov/app/annie-app-veterans. You'll get text messages to help you monitor your COVID-19 symptoms and know when to contact your provider. You'll also get tips to help you stay healthy and prevent COVID-19.

Exhibit 10b. A COVID-19 Resource for Black, Hispanic and Native American Veterans

10 ways to get the care and support you need from VA during COVID-19



7. If you think you may have been exposed to the coronavirus, request a COVID-19 test. We offer no-cost diagnostic testing for Veterans who are enrolled in VA health care and meet the CDC testing criteria. To get a test, you must have an appointment.

You can request an appointment in any of these 3 ways:

- Send a secure message your VA health care provider: www.va.gov/health-care/secure-messaging/
- Call your provider: www.va.gov/find-locations
- Or schedule an appointment online: www.va.gov/health-care/schedule-view-va-appointments/

For your safety, please don't go in person to a VA health care facility without an appointment. Everyone who enters our facilities must wear a mask that covers their mouth and nose. They must also complete our COVID-19 screening.

If you're not enrolled in VA health care, find out where you can get a free COVID-19 test near you: www.hhs.gov/coronavirus/community-based-testing-sites/.

8. Get support for stress and mental health. It's normal to feel more stressed, anxious, or lonely during this time. We're here to help. Learn how to get started with VA mental health care services at www.va.gov/health-care/health-needs-conditions/mental-health. You can use some services even if you're not enrolled in VA health care.

You can also get helpful tools at www.mentalhealth.va.gov/coronavirus. These include our COVID-19 Coach app: www.mobile.va.gov/app/covid-coach.

If you need to talk to someone now, call our Veterans Crisis Line. You can call for confidential (private) help anytime, day or night. Many of our caring, qualified responders are Veterans themselves. Call **800-273-8255** and **select 1**, or text **838255**. If you have hearing loss, call TTY: **800-799-4889**.

9. Get help traveling to VA appointments. Ask your provider to connect you with your VA health facility's Veterans transportation service office. They can help you find free transportation. You can also find out if you're eligible and how to file a claim for VA travel pay reimbursement at www.va.gov/health-care/get-reimbursed-for-travel-pay.

10. Consider volunteering to help us find ways to prevent and treat COVID-19—for your family, your community, and others across the country. As a research participant, you can help us make sure treatments are safe and effective in people of all ages, genders, races, and ethnicities. Learn more and sign up at www.va.gov/coronavirus-research/.

Get the latest guidance for preventing COVID-19 at www.cdc.gov/coronavirus/2019-ncov.

VA leveraged a general sense of community fostered at its VAMCs to prepare staff and Veterans for vaccination by increasing their awareness and knowledge over time. Equity considerations were centered in prioritizing vaccinations for specific groups of Veterans, delivering customized messaging to Veteran groups and examining needs as the pandemic continued (Ferguson, et al., n.d., 2022; Rentsch, et al., 2020b; Wong, et al., 2021a). Throughout the pandemic, VA approached educational efforts through marketing campaigns, multi-dimensional outreach programs and local practices which facilitated ongoing dialogue and a bidirectional exchange of information and perspectives with Veterans and their communities. Outreach included use of a [new OHE podcast series, Leave No Veteran Behind](#) (Exhibit 11), as well as the Focus on Health Equity and Action Cyberseminar series which can be found [here](#) (Exhibit 12). Intentional efforts to counter COVID-19 misinformation were initiated, especially among Veterans of color (Exhibit 13). This comprehensive approach improved disease management, enabled the system to maximize its capabilities and ensured opportunities to address potential issues of inequity – thus assuring each Veteran of their importance to VA and VA’s willingness to be an active agent for them.

Exhibit 11. Collection of VHA Office of Health Equity Leave No Veteran Behind Podcast Episodes

The screenshot shows a Spreaker podcast page for the 'Leave No Veteran Behind' series. At the top, it says 'Podcasts' and 'Listen Now to Seasons 2 and 3'. The main player area features a large play button and the title 'S3EP1: Identifying Differences in COVID-19 Infection, Mortality, and Vaccine Receipt in Veterans'. Below the player, it indicates '18 episodes' and a total duration of '4 hours, 43 minutes'. A list of five episodes is shown below, each with a play button, a thumbnail, the episode title, an information icon, and a duration.

18 episodes		4 hours, 43 minutes	
		S3EP1: Identifying Differences in COVID-19 Infection, Mortality, and V...	11:26
		S3EP2: Health Equity and Medical Legal Partnerships	10:41
		S3EP3: VA's Campaign for Inclusive Care and Equity	12:27
		S3EP4: Using Arts to Heal	16:34
		S3EP5: COVID-19, Vaccination, and Women Veterans	14:41

Exhibit 12. Focus on Health Equity and Action CyberSeminar

Focus on Health Equity and Action

Identifying Differences in COVID-19 Infection, Mortality, and Vaccine Receipt in Veterans

by Jacqueline Ferguson, PhD ; Taona Haderlein, PhD, MA ; Michelle Wong, PhD

Seminar date: 1/12/2022

Description: The coronavirus pandemic has disproportionately impacted racial and ethnic minority communities in the United States. This Cyberseminar will highlight research that explored patterns of disparities in Veterans who tested positive for, and died of, COVID-19 and racial and ethnicity differences in VA COVID-19 vaccination rates. Audience: Researchers, clinicians, care coordinators, policy makers, educators, data analysts, Veteran stakeholders and representatives of vulnerable Veteran groups who are interested in understanding and/or promoting equitable health among all Veterans.


View archived session video:


The image shows a YouTube video player interface. The video title is "Identifying Differences in COVID-19 Infection, M...". The video content is a slide from a presentation. The slide title is "COVID-19 Mortality Decreased for All Groups & Disparities Changed". Below the title is the subtitle "Predicted probability of mortality over time by race/ethnicity among Veterans with COVID-19". The graph plots "Predicted Probability" (0% to 14%) on the y-axis against "Time Period" (Spring 2020, Summer 2020, Fall 2020) on the x-axis. The legend includes: BH White (ref), AI/AN, Asian, BH Black, Hispanic, BH/CPI, Stat sig (disadvantage), and Stat sig (advantage). The graph shows a general downward trend in mortality probability for all groups from Spring to Fall 2020. A red play button is overlaid on the graph. At the bottom of the slide, there are logos for VA, the U.S. Department of Veterans Affairs, and the VA Office of Health Equity. A "Watch on YouTube" button is visible in the bottom left corner of the video player.


Exhibit 13. Racial and Ethnic Minority Health: Debunking COVID-19 Vaccine Myths


Racial and Ethnic Minority Health: Debunking COVID-19 Vaccine Myths


The vaccines developed to fight COVID-19 have been shown to be safe and highly effective at preventing the disease. You may have heard some inaccurate information about how they can affect minorities. Let's set the record straight, with truths from the Centers for Disease Control and Prevention (CDC), Johns Hopkins University, the Mayo Clinic, the National Medical Association, and other respected health organizations.


**Myth:** "Vaccines were not tested on minorities in the clinical trials."
Fact: *False.* In clinical trials, each vaccine was tested and effective in diverse groups of people across all age, gender, racial and ethnic backgrounds. *About 30% of U.S. participants were Hispanic, Black, Asian, or Native American, and about half were older adults.* There were no significant safety concerns identified in these or any other groups.



**Myth:** "COVID-19 vaccination is similar to the abuses at Tuskegee."
Fact: *No, these are not similar.* After the Tuskegee Study, the government changed its research practices to prevent a repeat of mistakes made in Tuskegee. A major issue in Tuskegee was a lack of transparency and consent. By contrast, the highest ethical standards were used in the COVID-19 trials. VA is committed to transparency and is making every effort to give you all of the information on COVID-19 vaccines, so you can make an informed choice. VA's primary goal is to provide safe health care.

**Myth:** "Current COVID-19 vaccines will not work against the new variants."
Fact: *False.* Experts believe—and some research shows—that current vaccines offer some protection against the new COVID-19 variants. Vaccine boosters are being developed to further enhance this protection.

**Myth:** "COVID-19 vaccines are unsafe because they were developed so quickly."
Fact: *False.* COVID-19 vaccines were authorized under the U.S. Food and Drug Administration's Emergency Use Authorization (EUA). An EUA includes the same steps taken in full-term clinical trials—including testing the vaccine on thousands of human participants—only with a consolidated timeline. Independent groups such as the National Medical Association, *the leading professional society of Black doctors, have reviewed trial results to ensure vaccine safety.*

**Myth:** "I can't spread COVID-19 after I get the vaccine."
Fact: *Scientists don't know yet.* Getting the COVID-19 vaccine prevents you from getting severely ill and dying. However, it's uncertain whether people who have been vaccinated can still carry and transmit the virus.

**Myth:** "I'm younger and won't get sick so I don't need the vaccine."
Fact: *False.* *CDC data suggests that the virus is affecting younger age groups at an increasing rate.* Young Black and Hispanic people are more at risk than Caucasian people due to racial health inequities and social determinants of health. Plus, getting vaccinated helps promote community immunity, which makes it hard for the disease to spread from person to person, and protects those who cannot be vaccinated

Your safe care is our mission.   U.S. Department of Veterans Affairs

Without considering how social factors intersect, it is impossible to have a comprehensive understanding of what barriers Veterans faced during the pandemic. VA has been working on increasing access to telehealth for Veterans living in rural areas or who have limited broadband connectivity, but “rapid expansion of virtual care was central to the VA national response to the COVID-19 pandemic” (Ferguson, et al., 2021, p. 454). Yet, Ferguson et al. found that Veterans who lived in urban areas, were not experiencing homelessness, or were younger than 45 years old were more likely to utilize virtual video care than those who lived in rural areas, were experiencing homelessness, or were over the age of 45 (Exhibit 14) (Ferguson, et al., 2021). Though expanding virtual care options increases access, barriers including lack of appropriate devices or software, connectivity issues and need for technical assistance persist (Ferguson, et al., 2021; Padala, et al., 2020). OHE worked collaboratively with others to address these barriers.

TELEHEALTH

Telehealth was a crucial component to the VA’s response to providing health care during the pandemic. To reach Veterans without internet access or capable devices, the VA worked to bridge the digital divide. Learn more about these efforts in [Appendix C](#).

Exhibit 14.

Table 3. Adjusted risk ratios and 95% confidence intervals for virtual care use between March 11, 2020 and June 6, 2020 in Veterans in active care at the Veterans Health Administration (N = 5 400 878)

	Model 1: Any Virtual Care	Model 2: Any Video care
Age category (ref: 18–44)		
45–64	1.04 (1.04, 1.05)	0.80 (0.79, 0.82)
65+	1.05 (1.04, 1.06)	0.50 (0.48, 0.52)
Sex (ref: Male)		
Female	1.02 (1.02, 1.03)	1.31 (1.28, 1.33)
Race (ref: White)		
Black/African American	1.02 (1.01, 1.03)	0.96 (0.94, 0.97)
Asian	0.96 (0.95, 0.98)	0.97 (0.94, 1.01)
American Indian/Alaska Native	1.00 (0.99, 1.01)	0.99 (0.95, 1.02)
Native Hawaiian/Pacific Islander	1.01 (1.00, 1.01)	0.98 (0.95, 1.01)
Unknown/missing	0.99 (0.99, 1.00)	0.96 (0.94, 0.97)
Ethnicity (ref: Not Hispanic/Latino)		
Hispanic/Latino	1.00 (1.00, 1.01)	1.00 (0.98, 1.02)
Unknown/missing	0.98 (0.97, 0.99)	1.01 (0.99, 1.04)
Rural/urban status (ref: Urban)		
Rural	1.00 (0.99, 1.00)	0.88 (0.86, 0.90)
Highly rural	0.99 (0.97, 1.00)	0.83 (0.78, 0.87)
Priority category (ref: No disability)		
Low income	1.07 (1.06, 1.08)	1.01 (0.99, 1.03)
Low/moderate disability	1.03 (1.02, 1.03)	1.21 (1.19, 1.23)
High disability	1.10 (1.09, 1.10)	1.35 (1.33, 1.38)
Homeless (ref: No)		
Yes	1.02 (1.01, 1.03)	0.89 (0.86, 0.92)
Chronic conditions (ref: 1–2)		
3–4 Conditions	1.11 (1.10, 1.11)	1.11 (1.10, 1.12)
5+ Conditions	1.10 (1.10, 1.11)	1.18 (1.16, 1.20)
Mental health condition (ref: None)		
Any	1.03 (1.03, 1.04)	1.22 (1.19, 1.26)
Prior video care (ref: None)		
Yes	1.07 (1.06, 1.08)	2.52 (2.36, 2.68)
Prior phone care (ref: None)		
Yes	1.18 (1.17, 1.20)	1.24 (1.22, 1.26)
Prior supp. remote care (ref: None)		
Yes	1.04 (1.03, 1.04)	1.15 (1.13, 1.18)
Prior primary care (ref: Average: 2–4)		
Low (0–1 encounters)	0.89 (0.88, 0.90)	1.00 (0.98, 1.01)
High (5+ encounters)	1.08 (1.07, 1.08)	1.14 (1.13, 1.16)
Prior mental health care (ref: Low: 0–1)		
High (2+ encounters)	1.26 (1.24, 1.27)	1.92 (1.84, 2.00)
Prior specialty/rehab care (ref: Average 1–6)		
Low (0 encounters)	0.87 (0.87, 0.88)	0.87 (0.85, 0.88)
High (7+ encounters)	1.11 (1.10, 1.12)	1.35 (1.32, 1.37)
Prior diagnostic/ancillary care (ref: Average 3–9)		
Low (1–2 encounters)	0.81 (0.80, 0.82)	0.84 (0.82, 0.85)
High (10+ encounters)	1.12 (1.11, 1.13)	1.16 (1.15, 1.18)

Note: Virtual care includes either phone-based or video-based care.

Models mutually adjusted for variables presented in table and also adjusted for current marital status. Standard errors clustered on VA medical center (N = 140). Prepandemic period is March 11, 2019–March 10, 2020; pandemic period is March 11, 2020–June 6, 2020.

Abbreviations: ref, reference category; rehab, rehabilitation; supp., supplementary.

Ferguson JM, Jacobs J, Yefimova M, et al. Virtual care expansion in the Veterans Health Administration during the COVID-19 pandemic: Clinical services and patient characteristics associated with utilization. *J Am Med Inform Assoc* 2021;28(3):453-462.

Outcomes

[The VA COVID-19 Response Report](#), originally released in October 2020, provided a summary of VA's initial response to the COVID-19 pandemic (Veterans Health Administration, 2020b). Annex A, published in May 2021, highlighted interagency coordination, vaccination planning, clinical operations, and work done to support VA's Fourth Mission, which includes improving U.S. preparedness for national emergencies (Veterans Health Administration, 2021a, 2022). Most recently, Annex B was issued in December 2021 and expands on VA's role in mass vaccinations, clinical operations, mental health initiatives and continued Fourth Mission responses (Veterans Health Administration, 2021b). While each of these reports focuses on different time periods, all address aspects of health equity for Veteran populations (race/ethnicity, sex, sexual orientation, age and rurality) (Veterans Health Administration, 2020a, 2021a, 2021b). Here, we summarize outcomes related to COVID-19 equity. VA's COVID-19 Equity Dashboard provided VA with specific areas and populations on which to prioritize focus. After the initial COVID-19 surge, testing and mortality disparities related to race/ethnicity were small within VA in contrast to larger differences observed outside VA. VA leadership worked to shrink vaccination rate disparities between Veterans of color and White Veterans (Exhibit 15). VAMCs with low rates of vaccination among specific groups of Veterans were targeted for outreach. To touch as many different Veteran populations as possible, OHE created educational materials for Veteran populations and their families. Ultimately, many groups such as Veterans of color had higher vaccination rates than their White counterparts (Exhibit 16). However, rural Veterans have persistently had low vaccination rates compared with urban Veterans.

VA'S FOURTH MISSION

As a part of the Fourth Mission, VA worked closely with Indian Health Services and Tribal Health Systems. This work included sending VA Staff to communities experiencing overwhelming COVID-19 surges and expanding reimbursement agreements. To read more about these efforts, please refer to **Appendix D**.

Exhibit 15. COVID-19 Equity Dashboard: VA Vaccinations & Refusal by Veterans by VISN/VAMC and Race/Ethnicity

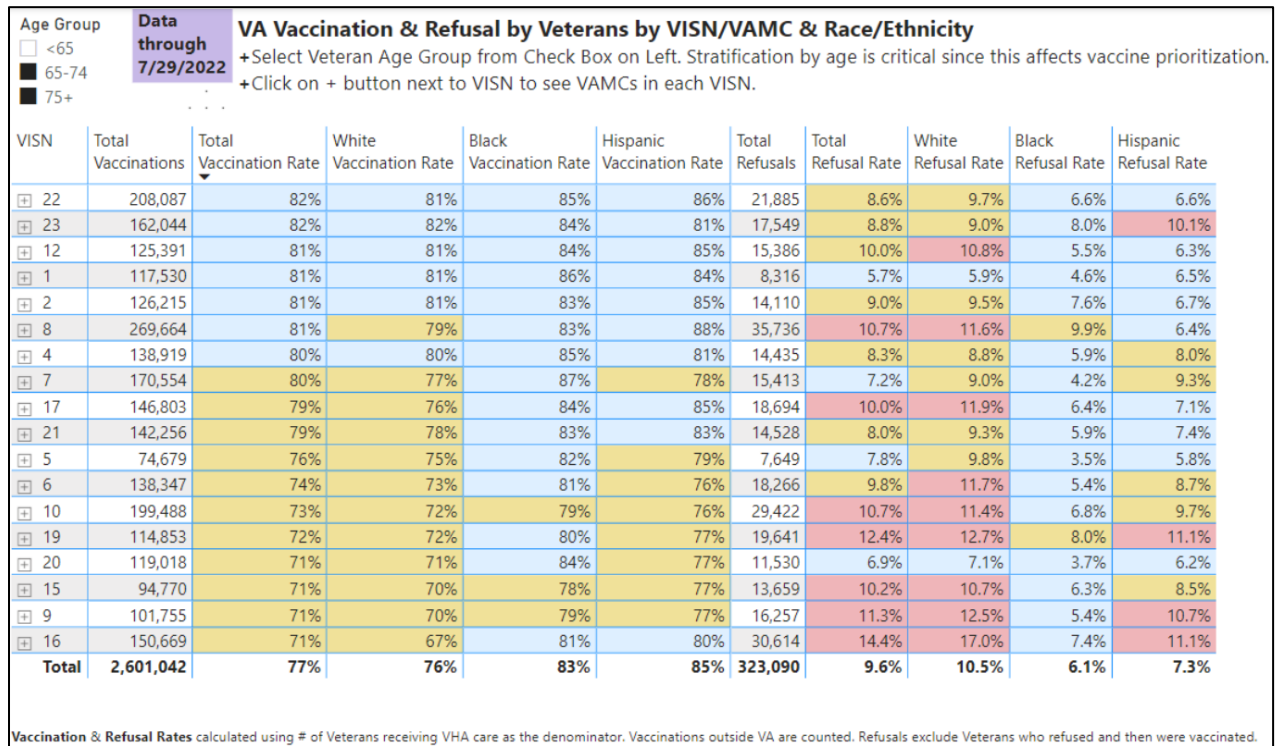
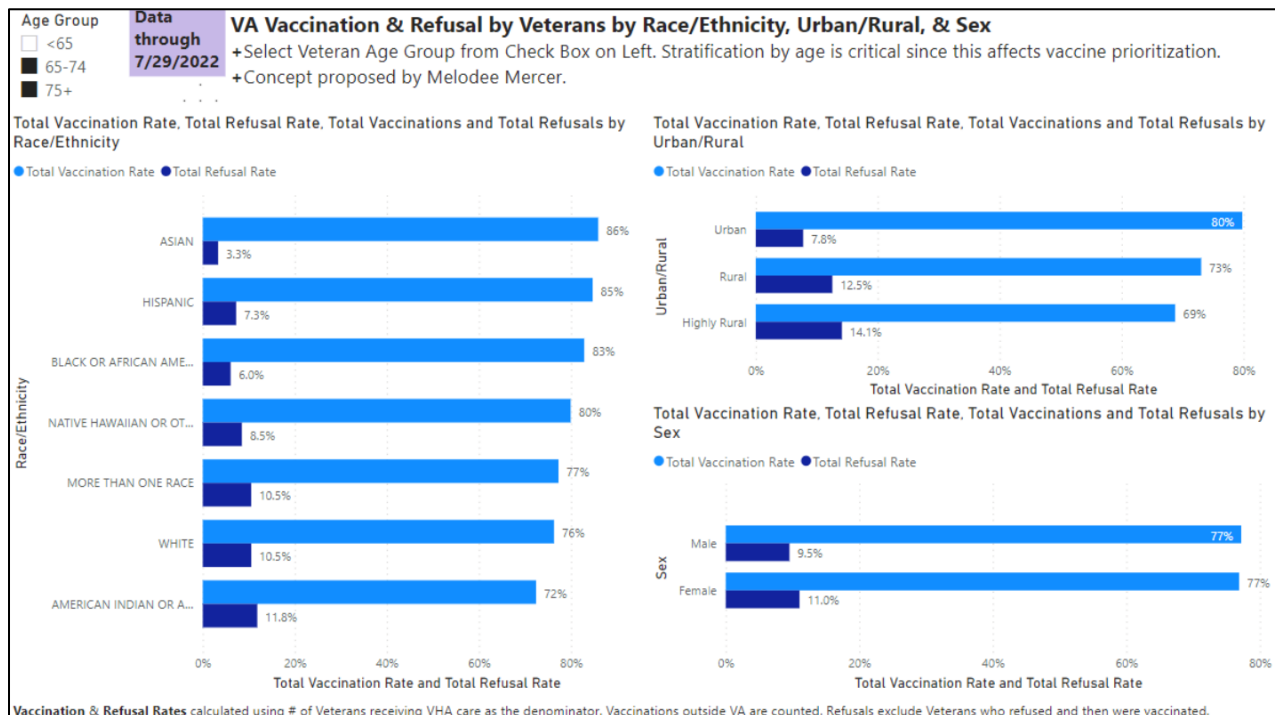


Exhibit 16. COVID-19 Equity Dashboard: VA Vaccinations & Refusal by Veterans by Race/Ethnicity, Urban/Rural and Sex



Data also drove the early response to COVID-19 in VA-owned and operated Community Living Centers (CLC) (Rudolph, et al., 2021). Similar to community nursing homes, CLCs were hit hard by COVID-19 and staff adapted protocols “for symptom monitoring, resident and staff isolation, quarantine, and diagnostic and screen testing” (Rudolph, et al., 2021, p. 2091). CLCs followed Centers for Disease Control and Prevention (CDC) guidance regarding the prioritization of vaccine delivery and administration to CLC residents and staff (Rudolph, et al., 2021). By virtue of VA’s size and national presence, CLCs were better able to navigate the pandemic than some of the smaller community nursing home systems. Personal protective equipment, testing and vaccinations were all managed on a system level which ensured supply availability to CLCs (Rudolph, et al., 2021). Additionally, important information could be shared quickly between CLC staff and VA infection control experts or epidemiologists (Rudolph, et al., 2021). CLCs took significant steps to minimize potential exposure of residents and staff at the beginning of the pandemic including “restrict[ing] the entrance of nonessential staff to the CLC” (Rudolph, et al., 2021, p. 2093). Combined, these efforts limited the number of positive tests for residents. By December 20, 2020, 50 percent of CLC residents had received a first vaccination and by January 26, 2021, 82 percent had begun or completed vaccination (Rudolph, et al., 2021). At this point, positive COVID-19 tests started to significantly decline in VA CLCs and continued to decline for both vaccinated and unvaccinated residents adapted protocols (Rudolph, et al., 2021).

In addition to generating information to guide targeted interventions to high-risk groups of Veterans, the VA-wide community of diverse researchers and data analysts published over 100 papers that explored how COVID-19 affected various groups of Veterans (Appendix A). Importantly, a majority of these studies considered how multiple demographic factors (e.g., age, race/ethnicity, sex/gender, location, socioeconomic status, living setting and specific physical or mental health diagnoses) interacted and impacted Veterans’ lives and their experiences during the COVID-19 pandemic.

COMMUNITY LIVING CENTERS

VA worked to respond quickly and effectively in CLCs. To read more about resources created for residents and family members, please see **Appendix B**.

Though VA does not own or manage State Veterans Homes, these facilities were at the forefront of VA’s response to COVID-19. Learn more about the work VA accomplished with State Veterans Homes in **Appendix E**.

Key Takeaways: Addressing Health Equity During COVID-19 Operations

Challenges

While several operational components of VA's COVID-19 response were effective in curbing health disparities, there were some significant challenges throughout the course of the pandemic:

- Due to the inherently dynamic nature of COVID-19 (e.g., shutdowns, re-openings, availability of information and vaccination), equity needs varied over time as COVID-19 strains developed and disparities across the country changed.
- Misinformation and disinformation: As researchers and policy makers learned more about the virus and announced updated recommendations, the nation, including VA, was challenged due to misinformation and disinformation. Specifically, VA faced challenges in reaching rural Veterans and overcoming disinformation about COVID-19 disease and vaccination.

Strengths

VA's enduring commitment to addressing health equity dimensions in disease prevention and treatment, as well as incorporating equity values into its central mission, supported dynamic and rapid responses to the pandemic. Several effective components of VA's response include:

- Leadership understood that evidence-driven decision-making could yield evidence-based, tailored interventions. Since VA is the largest integrated health care system in the U.S., access to high-quality patient demographic and other data were readily available to provide rates of vaccination for different groups.
- Research and operations staff alike came together to share information and respond quickly to constant updates in order to produce accurate and reliable publications for both the general public and medical professionals.
- Through partnerships with VAMCs and Veteran Service Organizations, VA increased communication across the country to determine Veterans needs that were most critical. These partnerships also proved key as they served as locations where VA users could access information.
- Use of different modalities of care to reach at risk populations: VA quickly maximized its technological scope and converted face to face appointments to VA Video Connect and telephones to minimize public contact.

Lessons Learned

VA's efforts in managing COVID-19 provide vital lessons for the nation for future epidemics and pandemics. Addressing social and structural disparities must be intentionally incorporated to a pandemic's response strategy at the beginning to ensure it will be more equitable and accessible more people.

- VA leadership facilitated and coordinated communications to front line staff, researchers, clinicians, educators, VAMCs and VISNs to adapt as more information was known about COVID-19. Other health care systems may benefit

from incorporating flexibility and adaptability to create a strong response to national emergencies.

- VA strongly found that ongoing engagement with target populations and other organizations provided valuable insight for local, state, and national guidance and policy development.

VA serves as a model for its ability to identify and immediately address COVID-19 inequities in its ongoing and timely provision of services throughout the pandemic to both the Veteran population and those cared for through the VA's Fourth Mission. VA also maintained its decade-long practice of incorporating established health equity practices into its clinical treatments, community support programming and resource allocation processes. As VA developed strategic plans and communications to handle the pandemic, VA leadership ensured that resources were equitably distributed to minimize disparities (Veterans Health Administration, n.d., 2020b).

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Appendices

Appendix A: Office of Health Equity's COVID-19 Equity Bibliography

Please see the citation and table from the Office of Health Equity's COVID-19 Equity Bibliography. To view the download the Microsoft Excel version, please click on [this link](#).

Veteran Health Administration COVID-19 Equity Bibliography

Author: Sarah Leder, Office of Health Equity

Date: January 2023

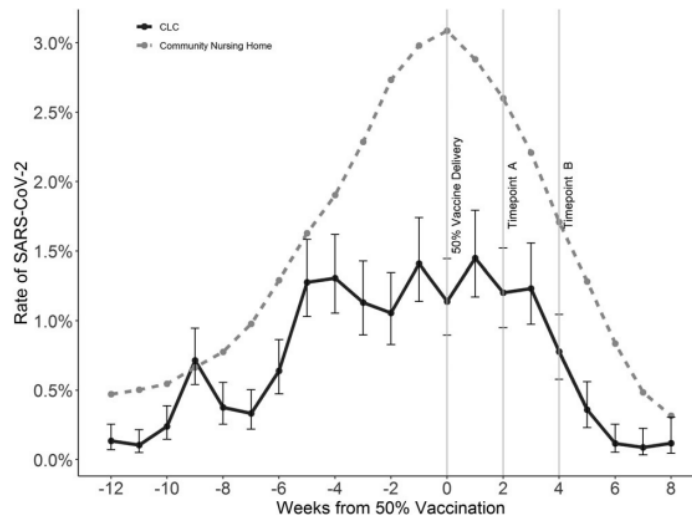
Citation: Leder, S. (2022). COVID Equity at the Department of Veterans Affairs. US Department of Veterans Affairs Office of Health Equity.

Document Description: This document serves as a bibliography with articles examining COVID-19 and health equity concerns among U.S. Veteran populations. The articles have been grouped into categories of some of the populations we track (age, sex, race/ethnicity, urban/rural, high-risk settings or shared housing, socio-economic status, specific mental health issue, and specific physical health issue). If an article covers multiple populations, it will be listed under each category. This bibliography is a living document and will be updated every quarter.

Last Updated: Tuesday, January 2023

Appendix B: Community Living Centers

Community Living Centers (CLCs) are VA-owned and operated nursing homes. Veterans living in CLCs may be there for a brief time or, in rare instances, for the rest of their life. CLCs provide nursing home level of care for Veterans, which may include help with activities of daily living, skilled nursing and medical care.¹ Like nursing homes, CLCs experienced high numbers of COVID-19 infections early in the pandemic. By November 24, 2020, over 100,000 residents and staff in “long-term care facilities” across the U.S. had passed away due to COVID-19.² VA worked rapidly to adopt CDC guidance and provide PPE and vaccines to CLCs. Since CLCs are VA-run, information was disseminated quickly across all locations. Protocols for “symptom monitoring, resident and staff isolation, quarantine, and diagnostic and screen testing” were implemented as the pandemic spread.³ Before the end of January 2021, 82 percent of CLC residents had begun or completed COVID-19 vaccination.⁴



Rudolph JL, Hartronft S, McConeghy K, et al. Proportion of SARS-CoV-2 positive tests and vaccination in Veterans Affairs community living centers. *J Am Geriat Soc* 2021;69(8)2090-2095; doi: 10.1111/jgs.17180.

Robust protocols to prevent viral transmission included closing CLCs to outside visitors. To reduce isolation, VA prepared information to assist Veterans’ use of mobile technology and provided mobile app information guides on how to download apps, make phone calls, send texts, and use video call apps for Apple and Android mobile devices.⁵ Additionally, a frequently asked questions (FAQ) page was published on the CLC website to provide answers to common questions concerning patient safety, patient admission and discharge, visiting loved ones, changes in care and more.⁶

Appendix C: Bridging the Digital Divide

In an effort to continue providing exceptional care to Veterans during the COVID-19 pandemic, VA adjusted its clinical operations. This included the postponement of non-urgent care as well as the shift to telehealth when possible. These “actions to increase capacity, access and utilization of telehealth generated an 18x increase in telehealth encounter volume.”⁷ While the increase in access to telehealth played a vital role in VA’s ability to provide care to Veterans throughout the pandemic, it should be noted that telephone encounters remained the predominant form of virtual care provided.⁸ The rapid adoption of virtual care was crucial, but also increased the demand for a broader array of virtual care tools.⁹

Though telehealth was vital in the continuing to provide high-quality care to Veterans and beneficiaries throughout the pandemic, it must be noted that many Americans, including Veterans, lack internet access and/or internet-connected devices. This gap is known as the digital divide.¹⁰

VA created the “Bridging the Digital Divide” website in to help provide information to Veterans about resources and benefits. When indicated, VA care teams can set up a referral to a VA social worker to place the Digital Divide Consults for a Veteran. These consults assess a Veteran’s technology needs. Additionally, during the consult, social workers can help a Veteran get internet access or obtain a technological device as well as determine if a Veteran is eligible for other government programs that provide access to technology supports.¹¹ Consults also support reliable internet access and services to rural Veteran communities.^{12, 13} As needs became more obvious, VA Medical Centers (VAMC), like Palo Alto VAMC, created mobile device information guides to assist Veterans with the basics of smart phones.¹⁴ In addition to providing information about apps, texting, phone calls and video calls, these guides included information on VA mobile apps designed to help “cope with PTSD, stress, anxiety, depression and other problems.”¹⁵

While access to health care is a significant factor in a patient’s health outcome, other social determinants play important roles (e.g., transportation, education, food insecurity, housing instability, social isolation/loneliness, etc.). To better understand what social needs impact Veterans, the Assessing Circumstances and Offering Resources for Needs (ACORN) initiative created a screener with 9 domains to identify and address social needs among all Veterans to improve health outcomes and promote health equity.¹⁶ In 2021, the ACORN team collaborated with the VA Office of Health Equity, National Social Work Program, and the Office of Connected Care to develop and integrate technology needs questions into the assisting ACORN screener as a way to more systematically identify Veterans who might benefit from a Digital Divide Consult.¹⁷ Among Veterans screened, issues concerning the “digital divide” (or technology) are some of the most common areas of need.

Appendix D: Collaboration with Indian Health Services and Tribal Health Systems

As a part of fulfilling its Fourth Mission – improving U.S. preparedness for national emergencies – VA provided assistance to the Indian Health Service (IHS) and Tribal Health Systems as requested. In addition to providing on-site provision of care in addition to consultation and acceptance of COVID-19 inpatient transfers,¹⁸ VA expanded reimbursement agreements for IHS to include more telehealth options.¹⁹ Throughout the pandemic, VA was able to provide sustained support to locations where COVID-19 outbreaks overwhelmed existing resources.²⁰ In particular, the surge of infections in the fall of 2020 led to sustained requests for aid from states, IHS, and Tribal Health systems.²¹ VA has more than one method to deploy Fourth Mission volunteers, but, the Disaster Emergency Medical Personnel System (DEMPS) serves as the main deployment program for staff to volunteer in response to an emergency or disaster.²²

For example, in early May 2020, VA sent staff on a Fourth Mission assignment to assist northeastern Arizona and northwestern New Mexico where Navajo Nation residents reside. These VA personnel assisted Tuba City Regional Health Care handle an influx of COVID-19 patients who required hospitalization.²³ Approximately 50 Registered Nurses and two Nurse Managers were on site from May 2020 through July 2020. Importantly, the first group of DEMPS volunteers created an onboarding presentation about cultural awareness to help future volunteers provide care to patients and work alongside their new co-workers.²⁴ As of early May 2022, VA had deployed personnel to 293 assignments in support of IHS and the Navajo Nation.²⁵

More generally, in 2021, VA and IHS signed a new Memorandum of Understanding (MOU) “aimed at improving the health status of American Indian and Alaska Native” Veterans.²⁶ This MOU, developed with input from tribes, tribal organizations, and urban Indian organizations, will enable VA and IHS to continue leveraging and sharing resources and investments to support the organizations’ mutual goals.²⁷ For example, the Office of Rural Health in VA created a pilot Rural Native Veteran Health Care Navigator Program to decrease barriers in accessing health care services in rural areas by pairing Native American Veterans with peers in their communities.^{28,29}

Appendix E: State Veterans Homes

State Veteran Homes (SVHs), which were first established following the Civil War, are facilities that provide Veterans with nursing home, domiciliary, or adult day care. Where CLCs are owned and operated by the VA, SVHs are run by a state's government.³⁰ Facilities interested in serving as an SVH must be certified by the VA. Though VA does not manage SVHs, facilities are subject to annual surveys to ensure they continue to meet VA standards.³¹ There are SVHs in all 50 states as well as Puerto Rico.³² To assist Veterans in choosing the option that works best for them, VA care teams are ready to discuss Advance Care Planning and have created the "Veteran Decision Aid for Care at home or in the Community."³³ Additionally, VA developed COVID-19 trainings in clinical crisis skills for State Veteran Homes Nurse Managers and CNAs.³⁴

As early as March 5, 2020, VA provided guidance for CLCs and SVHs. To track COVID-19 metrics at SVH skilled nursing facilities and domiciliaries, VA created the COVID-19 Oversight Dashboard and COVID-19 Weekly Reporting.³⁵ In performing its Fourth Mission responsibilities, VA placed a high priority on SVHs because they housed Veterans at high-risk for contracting COVID-19.³⁶ Between July 1, 2020 and December 31, 2020, approximately 30 percent of Fourth Mission deployments were to support SVHs.³⁷ Additionally, in March 2021, VA announced \$1 billion in grants to assist SVHs during the pandemic.³⁸ As vaccines became available, VA's role shifted from working in SVHs to focusing on vaccination events.³⁹ Moving forward, VA is working to become more proactive in supporting SVHs.⁴⁰

Additionally, throughout the COVID-19 pandemic, the Centers for Disease Control and Prevention's National Healthcare Safety Network Long-term Care Facility Component worked to with residences. Specifically, a SVH Tool was developed to assist facilities with "track[ing] and monitor[ing] residents and staff who test-positive for COVID-19."⁴¹ The tool includes printable data collection forms and instructions, recorded webinars and slide decks.⁴²

¹ U.S. Department of Veterans Affairs. Geriatrics and extended care: Community living centers (VA nursing homes). Available from: https://www.va.gov/geriatrics/pages/va_community_living_centers.asp [Last accessed 10/24/2022].

² Kaiser Family Foundation. COVID-19 has claimed the lives of 100,000 long-term care residents and staff. Available from: <https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/> [Last accessed: 10/24/2022].

³ Rudolph JL, Hartronft S, McConeghy K, et al. Proportion of SARS-CoV-2 positive tests and vaccination in Veterans Affairs community living centers. *J Am Geriat Soc* 2021;69(8)2090-2095; doi: 10.1111/jgs.17180.

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⁵ U.S. Department of Veterans Affairs. Staying connected during COVID-19. Available from: https://www.va.gov/GERIATRICS/news/Stay_Connected.asp?utm_source=geriatrics_left_menu [Last accessed 10/24/2022].

⁶ U.S. Department of Veterans Affairs. During the pandemic: Veterans in community living centers. Available from: https://www.va.gov/GERIATRICS/news/Veterans_in_Community_Living_Centers.asp [Last accessed 10/24/2022].

⁷ U.S. Department of Veterans Affairs. Veterans Health Administration (VHA) coronavirus disease 2019 (COVID-19) response report. 2020. Available from: https://www.va.gov/HEALTH/docs/VHA_COVID-19_Response_Report.pdf [Last accessed 10/24/2022].

⁸ Ibid.

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- ¹² U.S. Department of Veterans Affairs. Bridging the Digital Divide. Available from: <https://telehealth.va.gov/digital-divide> [Last accessed 10/24/2022].
- ¹³ U.S. Department of Veterans Affairs. Veterans Health Administration (VHA) coronavirus disease 2019 (COVID-19) response report – annex A. 2021. Available from: <https://www.va.gov/health/docs/VHA-COVID-19-Response-2021.pdf> [Last accessed 10/24/2022].
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- ¹⁵ Ibid.
- ¹⁶ Cohen AJ, Kennedy MA, Mitchell K, et al. U.S. Department of Veterans Affairs. The assessing circumstances & offering resources for needs (ACORN) initiative. 2022. Available from: [ACORN Screening Tool.pdf \(va.gov\)](#) [Last accessed: 09/29/2022].
- ¹⁷ Russell LE, Heyworth L, Cornell PY, Kennedy MA, Halladay C, Mitchell KM, Silva JW, Koget J, Moy E, Cohen AJ. Evaluating the Effectiveness of Routine Screening for Digital Needs Among Veterans. (Podium) American Public Health Association, Boston, Massachusetts, November 2022.
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