DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents

MANAGEMENT ADVISORY MEMORANDUM | MEMO # 21-00913-91 | APRIL 14, 2021

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The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation for competency, independence, professional judgement, quality control, planning, data collection and analysis, evidence, records maintenance, timeliness, fraud, and reporting.

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DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20001

February 16, 2021[1]

MANAGEMENT ADVISORY MEMORANDUM

TO: Dr. Richard Stone, Acting Under Secretary for Health
Veterans Health Administration (10)

FROM: Larry Reinkemeyer, Assistant Inspector General
VA Office of Inspector General's Office of Audits and Evaluations (52)

SUBJECT: Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents

While reviewing the Veterans Health Administration's (VHA) plans to document receipt and distribution of the COVID-19 vaccine, the Office of Inspector General (OIG) determined that VHA facilities did not consistently document the COVID-19 vaccination status of veterans living in VA's community living centers (CLCs). This management advisory memorandum is meant to provide information to help VHA leaders determine if there is a need for additional national guidance or other remedial action before the OIG releases its full report on vaccine distribution.

CLC Residents Are in VHA's Highest-Priority Vaccination Group

As of January 2021, VA had 132 CLCs, which used to be called nursing homes.[2] Most CLCs are affiliated with and located on or near VA medical facilities. CLCs are intended to offer inpatients a homelike environment in which a range of care services can provide comfort at the end of life.[3] Veterans can receive nursing and medical care, as well as help with activities of daily living (such as bathing or dressing) for either short stays—90 days or less—or long term. Services available during short stays include rehabilitation, skilled nursing care, restorative care,

[1] This memorandum was sent to the Veterans Health Administration (VHA) on February 16, 2021, to provide the opportunity to review and comment. Following that period, their comments were given full consideration and any requests for change supported by sufficient evidence were addressed before the publication process was completed.

[2] VHA had two additional CLCs in Madison, Wisconsin, and Ann Arbor, Michigan, that did not have residents during the period of this review and were not included in the review. In addition, according to VHA officials, 12 of the 18 residents the review team identified as being located at the Decatur, Georgia, CLC were actually located at the Carrollton, Georgia, CLC, part of the same healthcare system.

[3] VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012. This VHA Handbook was scheduled for recertification on or before the last working day of September 2017. The handbook has not been renewed. However, per VHA policy, the handbook remains valid until it is rescinded, recertified, or superseded by a more recent policy or guidance. See Under Secretary for Health Memorandum, *Validity of VHA Policy Document,* June 29, 2016.

continuing care for those awaiting alternative placement, mental health services, geriatrics evaluation and management, and respite and hospice care.[4] Services for long stays (greater than 90 days) help maintain the resident's highest practicable level of well-being and functioning and are meant to prevent further decline. These services include dementia care, continuing care, mental health recovery, and services related to spinal cord injuries and disorders.[5] Not all services are offered at every CLC.

Because of the communal nature of CLCs and the prevalence of adverse health conditions among CLC residents, these individuals are particularly vulnerable to COVID-19. Unfortunately, the number of COVID-19 infections increased at VHA CLCs from about 17 percent in November 2020 to 26 percent in January 2021.[6] On December 1, 2020, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices recommended that residents of long-term care facilities and their healthcare personnel be offered COVID-19 vaccinations first. VHA's recommendations on risk stratification and prioritization for the vaccine are based on this guidance. VHA's risk stratification plan makes veterans residing in CLCs and the staff who care for them the highest-priority groups.[7] According to VHA officials, Veterans Integrated Service Network (VISN) directors and local VA medical facility leaders are responsible for prioritizing veterans and CLC staff for vaccines.[8] VA VISN directors were instructed to follow VHA's stratification plan to the extent possible, with local flexibility to maximize access and efficiency and limit potential waste.

VHA first began offering the Pfizer vaccine the week of December 14, 2020, and began offering the Moderna vaccine the week of December 21, 2020. Vaccines were allocated to all VA medical facilities or healthcare systems with associated CLCs.

VHA has done an admirable job setting up systems and processes to vaccinate a large majority of CLC residents in a short time. It had vaccinated almost 69 percent of CLC residents as of January 19, 2021.[9] The review team's observations address a lack of clarity that, if resolved, could result in better tracking of the vaccination status of CLC residents at a national level.

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[4] VHA Handbook 1142.02.

[5] VHA Handbook 1142.02.

[6] The OIG Data Modeling Group's analysis of data from VHA's Corporate Data Warehouse. VHA's Corporate Data Warehouse is a national repository of data from several VHA clinical and administrative systems. It is designed to facilitate reporting and data analysis at the enterprise level by incorporating data from multiple data sets throughout VHA into one standard database structure. Appendix A provides additional information on how CLC residents are defined.

[7] VHA, *Interim Guidance on Risk-Stratification for COVID-19 Vaccinations in VHA*, Version 1.1.

[8] VHA's 18 VISNs are regional networks for healthcare delivery. These networks work together to meet local healthcare needs and provide safe, high-quality care to veterans at medical facilities in the network.

[9] The OIG Data Modeling Group's analysis of data from VHA's Corporate Data Warehouse and the Social Security Administration.

This memorandum focuses on VHA's lack of clear national guidance for vaccination documentation and patient discussions, which complicates national tracking. VHA developed guidance on how to use a COVID-19 vaccination clinical reminder to document refusals and contraindications in veterans' electronic health records. VHA did not develop guidance on documenting other vaccination decisions and discussions, such as when veterans cannot yet obtain a vaccination. In addition, no guidance was provided to CLCs on how to manage vaccinations for veterans in short stays, veterans leaving CLCs before receiving both doses, or newly admitted veterans. Consequently, the national offices that oversee CLCs and vaccine data lacked important information on CLC residents' vaccine status.

VHA Lacks Clear National Guidance for Some COVID-19 Vaccine-Related Documentation and Patient Discussions for CLC Residents

The OIG found that vaccination rates for veterans at CLCs varied across the 132 CLCs that had residents as of January 2021.[10] In early January, the overall vaccination rate for CLC residents was about 60 percent, including one CLC that had no documented vaccinations and three with rates around 20 percent.[11] The vaccination rates increased nationally and at individual CLCs during January as VHA started administering more of the vaccine and after the review team discussed its results with VHA officials. However, the OIG determined that VHA could not know at a national level whether the vaccine was offered to some CLC residents and, if so, what their status was. As of January 19, 2021, the OIG's analysis of national data on vaccinations identified 1,899 CLC veteran residents (23 percent) who did not have documentation of receiving the vaccination. The residents also did not have documentation of refusing the vaccination, having a contraindication, or being deceased.[12] At a national level, VHA did not know why these CLC residents had not been vaccinated or what proportion had not been offered the vaccine.

[10] The OIG Data Modeling Group's analysis of data from VHA's Corporate Data Warehouse and the Social Security Administration. In all, 8,267 veterans were CLC residents between December 14, 2020, and January 19, 2021. Appendix A provides information on how CLC residents and vaccination status were defined by OIG's Data Modeling Group.

[11] The OIG Data Modeling Group's analysis of data from VHA's Corporate Data Warehouse.

[12] The review team examined a judgmental sample of CLC residents' medical records and found that some had medical record notes or addendums documenting why they did not have the vaccine or memorializing related conversations. However, not all residents whose medical records the review team examined had notes, including some veterans waiting to recover from COVID-19 before vaccination. Refusals and conversations also were not always captured or noted in a consistent manner.

The OIG's analysis of CLC resident and vaccination data from VA's Corporate Data Warehouse showed the vaccination statuses displayed in table 1.[13]

Table 1. COVID-19 Vaccine Data for Community Living Center Residents Showing Large Percentage with Unclear Vaccination Status (as of January 19, 2021)

Status	Count	Proportion of total Community Living Center residents (%)
Vaccinated: had at least one dose of vaccine	5,698	68.9
Unable to determine if vaccine was offered without additional information	1,899	23.0
Not vaccinated: documented reason for not getting vaccination (according to three categories below)	670	8.1
*Death of veteran between December 14, 2020, and January 19, 2021**	*491*	*5.9*
Refusal of vaccine documented in medical record	*165*	*2.0*
Contraindication to vaccine documented in medical record	*14*	*0.2*
Total	**8,267**	**100**

Source: The OIG Data Modeling Group analysis of data from VHA's Corporate Data Warehouse and from the Social Security Administration Death Files.

Note: VHA uses a Power Business Intelligence (Power BI) dashboard, named the VHA Support Service Center COVID Vaccine Surveillance Dashboard, to monitor veteran and employee vaccination metrics. As of January 19, 2021, the data showed that the proportion of nursing home (CLC) residents who have resided in a VA nursing home since December 14, 2020, and received the vaccine was about 74 percent with 135 vaccine refusals. Data on contraindications and deaths are not included. These counts differ from OIG counts because of different ways of defining the population of CLC residents and because this dashboard does not include veterans who are deceased, whether or not they received the vaccine, while the OIG counts do include veterans who were vaccinated before they passed away.

**Two deceased veterans also had vaccine contraindications documented in their health record, and two deceased veterans also had a documented refusal of the vaccine.*

Because CLC residents are in the highest-priority COVID-19 vaccine group, they should be offered the vaccine, when possible, before other groups of veterans. While VA medical facilities were authorized to begin vaccinating lower-risk priority groups simultaneously with higher-risk

[13] Because this memorandum is time sensitive, the data reliability and validity procedures used to test the data were limited to discussions with VHA officials and OIG's Data Modeling Group. The discussions covered how CLC residents were defined and how vaccination events, refusals, contraindications, and veteran deaths are captured. The review team also examined a sample of CLC residents' records to make sure that what was captured in the aggregate data matched the veterans' medical health records.

groups when the vaccine supply was sufficient, VHA should know which CLC residents still need to be vaccinated and continue offering this population the vaccine. This information is especially important considering VHA has faced restrictions on the amount of vaccine available and, according to VHA's data on vaccine allocation, many VA medical facilities have administered most of the first doses they received.

To gather additional information about the variations in documented vaccination status at CLCs, the review team spoke with officials from a sample of CLCs with low documented vaccination rates.[14] This included one CLC with a 0 percent rate and three with rates around 20 percent. The team spoke with officials from 12 CLCs. Overall, the officials reported following VHA's risk stratification policy and offering CLC residents vaccinations as a first priority.

Vaccine Refusals and Contraindications Were Not Consistently Tracked

Vaccine refusals and contraindications can be captured using a clinical reminder built into the electronic health records.[15] Refusals can also be captured through local templates with the national health factor notation "VA-SARS-COV-2 VACCINE Refusal."[16] However, the OIG found not all CLCs were documenting vaccine refusals or contraindications using these methods, which were only documented for a small percentage of CLC residents—2 percent for refusals and 0.2 percent for contraindications. Using either the clinical reminder or the national health factor notation allows VHA to compile the site-specific data.

The OIG's Data Modeling Group used VHA's Corporate Data Warehouse to identify 165 veterans with a documented refusal and 14 with a documented contraindication of the COVID-19 vaccine.[17] When the review team spoke with some CLCs with low or no documented refusals, some of the sites described documenting refusals in a locally developed tracker or in

[14] In January 2021, while selecting a judgmental sample of VA medical facilities to interview about COVID-19 vaccination documentation and data systems, the team included CLC vaccination rates in the site selection criteria. Vaccination rates continually change. At the time of selection, CLCs with low rates were those with documented vaccination rates in the 30 percent range or lower. The OIG also contacted a few CLCs with high rates of vaccinations, about 70 percent or more, to see if these CLCs had different ways of documenting and communicating information about the vaccine.

[15] The Computerized Patient Record System (CPRS) is a Veterans Health Information Systems and Technology Architecture (VistA) application that enables electronic order entry and management of all information connected with any patient. CPRS supports clinical decision-making and enables users to review and analyze patient data.

[16] The health factors the team reviewed included the national health factors associated with COVID-19 vaccination refusals or contraindications, as well as any locally developed health factors associated with refusals or contraindications.

[17] The OIG's Data Modeling Group looked at veterans' electronic health records through the Corporate Data Warehouse for any health factor type and category combination that had language about the COVID-19 vaccine refusal, contraindication, or other related notation. While CLCs may be documenting refusals in other ways, they are not consistent or aligned with national guidance.

electronic health record clinical notes instead of through use of the national clinical reminder or national health factor notation. Identifying this information in the health record notes is a manual process involving a review of each individual health record. Using a local tracking tool or a health record note undermines the accuracy of compiled data on all refusals. Vaccine refusal information is not required to be reported to the Centers for Disease Control and Prevention under the vaccines' Emergency Use Authorization. However, without collecting information on vaccine refusals and contraindications, VHA will not know which CLC residents have declined the vaccine or cannot receive it because of the potential for adverse medical reaction; these residents will need to be managed differently to ensure COVID-19 safety precautions or restrictions are followed.

No Guidance Was Issued on Tracking Other Reasons for Not Being Vaccinated

At the time of this review, there was no national guidance for VHA to have a national picture of how CLCs should document the status of veterans waiting to be vaccinated, those who could not yet be vaccinated, or those who had not been offered vaccinations. As of January 2021, several of the CLCs the review team spoke with had developed local systems for tracking the status of CLC residents who had not yet been vaccinated, noting reasons such as COVID-19 convalescence or wanting more time to decide. However, CLCs were not documenting this information in a consistent way that allowed it to be aggregated nationally. As a result, for the 23 percent of CLC residents who had not received the vaccine and did not have a documented refusal, contraindication, or date of death between December 14, 2020, and January 19, 2021, there was no clear way to determine which of the following explanations applied:[18]

- The veteran had not been offered the vaccination, which should not have occurred because of the prioritization of this group.
- The veteran was not offered the vaccination because of clinical end-of-life decisions for hospice patients.[19]
- The veteran could not be offered the vaccination at the time because, for example, he or she was convalescing from COVID-19.

[18] Because documentation of vaccine refusals was not required at that time, it is possible that some of the 23 percent refused the vaccine. However, officials the review team spoke with from all 12 CLCs said they document refusals in some manner, even if they were not using the national tools.

[19] Although these occurrences could have been captured using the contraindication field in the health record, only 14 CLC residents had documented contraindications, even though many of the CLC officials the team spoke with said they had hospice patients who would not receive the vaccine for clinical reasons. One CLC official told the review team there may be reasons to consider offering the COVID-19 vaccine to end-of-life hospice patients. For example, this could allow them protection from COVID-19 to enable them to see a family member for a final time.

- The veteran was waiting for VHA to contact the individual with his or her power of attorney to assist with this decision-making.
- The veteran had been offered the vaccine but was still thinking about whether to receive or refuse it.[20]

Through interviews with VHA officials, follow-up with select CLC officials, and a review of VHA guidance on COVID-19 vaccinations, the review team determined national guidance did not describe how to document these explanations for not being vaccinated. Four CLC officials told the review team they were using locally developed tracking to document discussions with veterans about the vaccine and instances when veterans could not yet receive the vaccine. For example, one CLC used a local tracker to note if veterans could not yet receive the vaccine for reasons such as having COVID-19, or if they were still considering receiving the vaccine, so that the CLC staff would know to follow up with the veterans. While this strategy may work well at the local level, it does not provide VA leaders with a complete national picture of why a proportion of CLC residents have not been vaccinated at any point. It also does not allow other clinicians to easily locate this information if veterans transfer to other CLCs, are discharged, or are seen in another healthcare setting.

Some CLC officials also mentioned documenting vaccination discussions or decisions in the electronic health record's clinical notes. However, the review team's examination of a sample of veteran health records at CLCs did not consistently show notes about vaccination discussions in the records. For example, staff at one CLC had discussed the vaccine with one veteran who was COVID-19 positive, but the team could not locate notes for two other veterans who were also COVID-19 positive. Overall, documentation was not consistent in the medical records.

CLCs Did Not Consistently Manage Vaccinations for Short-Term Residents and Veterans Being Released or Admitted

There was no national guidance for managing vaccinations of short-term-stay CLC residents, coordinating vaccines for CLC residents not yet vaccinated at discharge or who required a second vaccination after discharge, or managing vaccinations for newly admitted CLC residents.

Officials the review team talked to at six of the CLCs said they offered short-term–stay services, and that this was why their vaccination rate for CLC residents was low: they did not always offer vaccinations to these veterans. For example, one of these CLCs was being used as a COVID-19 convalescent ward, and officials had not yet offered the vaccine to recovered veterans. Officials

[20] From the team's review of information provided by VHA, the clinical reminder for vaccination refusals appears to have a built-in option to select for deferrals. VHA officials did not provide any information to the review team about national guidance on using the reminder to capture deferrals. Such guidance on how to use this field would be one way to address the lack of consistency identified by the OIG.

from this CLC said they were still deciding how to manage CLC resident vaccinations but knew that they had to do so, since they will have ongoing rotations in their resident populations. Officials from another CLC said that for patients staying less than 21 days, they had not been giving a first dose of the vaccine because the CLC had not figured out how to schedule the second. Because a significant percentage of all CLC residents experience short-term stays up to 90 days, many could be offered the vaccine while in the CLC even if the second dose has to be scheduled at a VA medical facility. Any resident at a CLC for longer than 28 days would have time to receive both doses.

For CLC residents who are discharged before they receive the vaccine (including those not fully recovered from COVID-19) or before they receive their second dose, some local CLC officials said they coordinate with the patient's primary care provider, while others said they schedule the veteran for an appointment at the local vaccine clinic. However, managing the second dose is a local process, and an official from VHA's Patient Care Services said that while VHA suggests an appointment be made for the second dose at the time of discharge, the VA medical facility the CLC is part of is ultimately responsible for making sure the second dose appointment is scheduled.

For newly admitted CLC residents, VHA officials said there is no national guidance that indicates when the records of these veterans should be checked to determine if they have had the vaccine or how to handle unvaccinated veterans. An official from one CLC told the review team the CLC was still deciding how to manage vaccinations for new residents, about a month into providing vaccinations. The potential for unvaccinated residents to enter CLCs presents a risk to an already vulnerable population.

National Offices That Oversee CLCs and Vaccine Data Lacked Complete Information on Vaccination Status for Residents

The review team discussed the CLC vaccination rates, the number of refusals, and the variation in vaccination rates among CLCs with officials from

- VHA's Office of Geriatrics and Extended Care (overseeing VHA's CLCs),
- the National Center for Health Promotion and Disease Prevention (providing leadership and coordinating data systems and reporting for COVID-19 vaccinations), and
- the Office of Population Health and the Office of Quality and Patient Safety.

Officials from these offices did not provide any reasons for the OIG's data showing a vaccination rate of about 60 percent for CLC residents at the time of these discussions, or for the variation across CLCs.

The executive director of VHA's Office of Geriatrics and Extended Care told the team that in addition to looking at the vaccination rate, in his opinion vaccination data for CLC residents

should be reviewed from the perspective of CLC residents who have had the opportunity to be vaccinated. As previously detailed, there are many reasons the OIG identified for CLC residents not being vaccinated, including refusing, waiting for their power of attorney, or still recovering from COVID-19. The executive director also said, however, that he was not aware of any data dividing CLC residents into these categories nationally. In addition, the chief consultant for the Office of Population Health said that offering the vaccination is not a onetime event, and CLC staff will continue to communicate with the residents and their facilities to see if the residents have changed their minds.

Following the team's conversations with VHA officials in January 2021, the chief consultant for the Office of Population Health provided information from VISN leaders to the review team on CLC residents' vaccinations. The data aggregated by each VISN included information on CLC residents, the percentage vaccinated, the percentage who declined, the percentage who had medical issues delaying vaccination, and the percentage who were waiting for vaccination or consent. Vaccination rates ranged from 74 to 87 percent, refusals from 3 to 21 percent, delays from 1 to 16 percent, and those waiting from 0 to 6 percent. Each VISN provided data that accounted for close to 100 percent of its reported CLC residents at that time. The chief consultant for the Office of Population Health told the review team that VHA expects to have the VISNs start recording this data on an ongoing basis on a dashboard. He said that the dashboard would pull information from the COVID-19 clinical reminder and national health factor notations. These steps should give VHA a better picture of the vaccination status of all CLC residents.

However, the data collected by VISNs are subject to the same limitations the review team identified. During interviews with CLC officials, the team learned that some CLCs do not include all residents in their self-collected data on resident vaccination statuses. CLCs might not include residents convalescing from COVID-19 or those in hospice. In addition, the review team's work indicated that the veterans' reasons for not being vaccinated are not being documented consistently across all CLCs; the dashboard would only capture what is documented in the clinical reminder or health factor notation. VHA should also consider developing national guidance about how to manage vaccinations for short-term stays and exiting and entering CLC residents. Finally, if VISNs are collecting information on veterans who are waiting to receive vaccinations, doing so consistently and according to national guidance could help address challenges the OIG identified in tracking vaccine status for CLC residents. Unless VHA ensures data collection is conducted consistently by all CLCs, VHA cannot be sure the new dashboard will provide a full picture of the COVID-19 vaccination status for CLC residents.

Conclusion

VHA has made important strides in distributing vaccines to CLC residents, but improvements can be made by providing national guidance for more comprehensive and consistent data collection that can be aggregated to guide ongoing actions and protect this vulnerable population.

Doing so would include making sure all CLCs routinely track refusals and contraindications in a consistent manner. Guidance should be clear that entering notes in a patient's electronic health record is inadequate and that all communications should be consistently documented in accordance with VHA processes.

Similarly, clear guidance and consistent oversight should help ensure CLCs are properly tracking veterans who fall into the 23 percent of CLC residents missing information needed to determine their vaccination status. As of January 2021, it was not possible to establish which of the 1,899 veterans in this cohort had been offered the vaccine or any reasons for not offering the vaccine. With vaccine supply limited, it is important for VHA to know this information to continue to prioritize all CLC residents who are able and willing to receive the vaccine.

The information in this management advisory memorandum is meant to help VHA leaders determine if actions are warranted to address the identified issues.[21] The OIG will continue its oversight work on vaccinations within VHA and plans to issue a full report, including specific recommendations, at a later date.

Requested Action

The OIG requests that VHA inform the OIG what action, if any, VHA takes to mitigate the potential risks identified in this memorandum and the outcome of those actions.

Management Comments

On March 15, 2021, the acting under secretary for health's response thanked the OIG for bringing concerns about vaccinations at CLCs to VHA's attention. The response also stated that VHA will report to the OIG on actions taken to mitigate the identified risks. Specifically, the response noted that VHA would "identify and evaluate gaps in documentation of CLC provided vaccines and develop a corrective action plan to resolve these concerns." The response also stated that, as of February 15, 2021, 90 percent of CLC residents at that time had received at least one dose of a COVID-19 vaccine, according to data from the Corporate Data Warehouse. Appendix B provides the full text of the acting under secretary's comments.

OIG Response

The OIG will review VHA's submitted plans for corrective actions. Regarding the vaccination rate for CLC residents as of February 15, 2021, the OIG appreciates that VHA is vaccinating so many veterans in this high-risk group. However, the reliability of those rates and the need to

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track unvaccinated veterans may be undermined by inconsistencies in how vaccination refusals, contraindications, deferrals, and other statuses are recorded for incoming, outgoing, and existing CLC residents. This information will help VHA continue to prioritize CLC residents for vaccinations as they enter and leave CLCs, as well as when they are CLC residents. It will also allow VHA to know when to engage residents who wanted more time to consider vaccination, how many CLC residents have refused rather than deferred the vaccine, and how to appropriately protect CLC residents who choose not to be vaccinated.

Appendix A: Sources and Dates of Information on Community Living Center Residents and Vaccination Outcomes

Table A.1 identifies the sources of information used to define veterans who resided at VHA CLCs at any point from December 14, 2020, through January 19, 2021. Table A.2 lists the data sources used to determine vaccination status. The OIG's Data Modeling Group used the data tables and sources in this appendix to identify this population of veterans.

Table A.1. Data Sources for Population of Community Living Center Residents (December 14, 2020, through January 19, 2021)

Corporate Data Warehouse table or source data system
Dim.Division
Dim.HealthFactorType
Dim.ImmunizationName
Dim.Institution
Dim.Location
Dim.PlaceOfDisposition
Dim.Specialty
HF.HealthFactor
Immun.Immunization
Inpat.Inpatient
Inpat.Inpatient501TransactionDiagnosis
Inpat.Inpatient501Transaction
Inpat.InpatientDiagnosis
Inpat.InpatientICDProcedure
Outpat.Visit
Spatient.Spatient
VitalStatus.Master
VBA Corporate Person Tables
Social Security Administration: Death Master File
Date of death

Source: The OIG Data Modeling Group's analysis of VHA's Community Living Center resident data.

Table A.2. Data Sources for COVID-19 Vaccination Status (December 14, 2020, through January 19, 2021)

Corporate Data Warehouse table or source data system
Dim.Division
Dim.ImmunizationName
Dim.Institution
Dim.Location
Immun.Immunization
Outpat.Visit
Spatient.Spatient

Source: The OIG Data Modeling Group's analysis of VHA's COVID-19 vaccination data.

Appendix B: Management Comments—Acting Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: March 15, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Management Advisory Memorandum: Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents (VIEWS 04653113)

To: Assistant Inspector General for Audits and Evaluations (52)

Thank you for the opportunity to review and comment on the Office Inspector General (OIG) Management Advisory Memorandum: Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents.

The Veterans Health Administration (VHA) is grateful to OIG for bringing concerns about vaccinations at VA Community Living Centers (CLC) to our attention and will report back on actions to mitigate these risks. VHA will identify and evaluate gaps in documentation of CLC provided vaccines and develop a corrective action plan to resolve these concerns. VHA appreciates the time and attention OIG committed to meeting with VHA subject matter experts to discuss the findings in this memorandum.

The Department of Veterans Affairs (VA) continues to deliver COVID-19 vaccines to Veterans at increased risk for experiencing severe illness from COVID-19. VA encourages all those at highest risk of infection to receive the new COVID-19 vaccine when they are eligible.

Due to their high risk of severe illness and death from COVID-19, Veterans residing in CLCs or at Spinal Cord Injury and Disorders Centers were among the first Veterans offered the newly FDA-authorized COVID-19 vaccines. Of the 5,887 residents living in CLCs on February 15, 2021, 5299 of them had received at least one dose of COVID-19 vaccine, according to the Corporate Data Warehouse.

The OIG removed point of contact information prior to publication.

(Original signed by)

Richard A. Stone, M.D.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Team	Jennifer L. McDonald, Director Christopher Bellin Cherelle Claiborne Kristin Nichols Carla Reid Douglas Rosales Brock Sittinger
Other Contributors	Dr. Peter Almenoff Darryl Joe Dr. Yu-fang Li Allison Tarmann

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