ALL-HAZARDS EMERGENCY CACHES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Directive establishes authority and policy for configuration, maintenance, and activation of caches to be used in response to natural or man-made disasters, pandemics and epidemics, catastrophes, terrorist attacks, or weapons of mass destruction events.

2. SUMMARY OF MAJOR CHANGES: This VHA Directive clarifies roles and responsibilities and adds Appendix F with information about VA’s authority to provide assistance during a disaster or emergency.

3. RELATED ISSUES: VHA Handbooks 1108.01 and 1108.02.

4. RESPONSIBLE OFFICE: The Office of Public Health (10P3) is responsible for the contents of this Directive. Questions may be addressed to the Office of Public Health 202-461-1000.


6. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of December 2019.

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Interim Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on 12/31/2014.
ALL-HAZARDS EMERGENCY CACHES

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy for the configuration, maintenance, and activation of caches to be used in response to natural or man-made disasters, pandemics and epidemics, catastrophes, terrorist attacks, or weapons of mass destruction events. These caches are known as Department of Veterans Affairs (VA) All-Hazards Emergency Caches.

AUTHORITY: 42 U.S.C. 5170a(1), 5170b(a), 5192; 42 U.S.C. 300hh-11(b); 38 U.S.C. 1785; 38 CFR 17.86.

2. BACKGROUND: For purposes of this Directive, the term “mass casualty event” is inclusive of the entire range of events discussed in this section and the term “casualties” includes both individuals directly injured by an event and those individuals requiring intervention to prevent potential illness or injury.

a. Casualties from mass casualty events can rapidly overload any health care system. Potential hazards consist of:

(1) Natural and unintentional disasters, such as hurricanes, floods, fires or explosions, tornadoes, earthquakes;

(2) Epidemic or pandemic events such as influenza; and

(3) Terrorist or hostile attacks.

b. The sources of mass-casualty producing events fall into four major categories:

(1) Conventional explosive;

(2) Biological;

(3) Chemical agents; and

(4) Radiological agents.

c. Casualties from a conventional explosive incident will likely present with trauma, burn, crush, laceration, and physiological injuries. Biological events are dependent on the causative organism, the host, and the environment, but affected patients can quickly overwhelm the emergency response and health care system. Casualties from a chemical incident could exhibit respiratory distress, convulsions, contamination of skin and clothing, massive blistering, burns, and, in addition, present a contamination hazard to health care providers. Chemically-exposed patients must be decontaminated prior to entry into a health care facility.

Radiological incidents include nuclear explosion, but the most likely radiological event would be atmospheric contamination. A radiological dispersion device (dirty bomb) or reactor "meltdown" accident likely would result in radiation exposure to those in the area with contamination of clothing and skin requiring decontamination prior to entry into a health care facility.
d. Today, most VA medical centers (VAMCs) maintain limited stocks of pharmaceuticals, fluids, and other items needed for a mass casualty event. Even with activation of the Centers for Disease Control and Prevention’s (CDC) Strategic National Stockpile (SNS), there will be some delay in receiving assets. CDC’s SNS delivery goal is 12 hours or less from notification and approval of request to delivery at the designated site. From that site, states are responsible for further distribution of assets to designated hospitals or other facilities. SNS Program deploys its Stockpile Service Advance Group (SSAG) that coordinates with state and local officials so that the SNS assets can be efficiently received and distributed upon arrival. In a mass casualty event, most hospitals will need to function with on-hand stocks and limited re-supply for at least 12-24 hours.

e. VAMCs may find themselves in the position of receiving casualties from a mass casualty event. In such an event, a large influx of casualties could be received quickly, overwhelming the usual inventory of medication and supplies. As part of the facility’s Emergency Operations Plan, the VAMCs must prepare to provide care, on a humanitarian basis, for these victims, and provide necessary support and protection to Veterans and VAMC staff.

f. The all-hazards caches are to treat Veterans, staff, and other victims that may present to the local VAMC. The caches are designed to:

(1) Ensure short-term preservation of the VA health care infrastructure until other resources can be made available in the immediate area; and

(2) Support the facility’s involvement in the local community disaster plan.

g. For large scale events, the VA All-Hazard Emergency Cache is intended to provide medications and supplies only until significant additional resources arrive such as through facility participation with the SNS program.

h. Facilities should insure acquisition and timely access to medical countermeasures from the SNS by incorporating it into the Emergency Operations Plan and, by developing memorandums of understanding (MOUs)/interagency agreements (IAAs) with their state and local counterparts.

NOTE: While Title 38 United States Code (U.S.C.) §8111 allows VA to share health care resources with the Department of Defense (DoD), VA can only enter into IAAs with other federal agencies under appropriate statutory authority, usually the Economy Act (31 U.S.C. §1535) unless a more specific authority is found. VA can share resources with states and other non-federal political subdivisions only when the White House has invoked the Stafford Act, 42 U.S.C. §5170 et seq. or under the National Disaster Medical System, 42 U.S.C. §300hh (NDMS). The NDMS allows direct payment of claims or contracts for care, and the vehicles would be sole-source contracts. MOUs could be used to form frameworks for the logistics, chains of communications, common understandings, and operating procedures to be followed between VA and the other non-federal party in the event that a disaster triggers...
NDMS or the Stafford Act. Caveat: VA cannot enter into IAAs with non-federal entities.

VA can provide hospital and outpatient care as a humanitarian service in emergency cases under 38 U.S.C. §1784, and may provide health care services and supplies under 38 U.S.C. §8153, sharing agreements. See Appendix F for further details.

i. These caches are considered a standardized program for procurement purposes. The contents that need to be procured are selected by a committee of experts and have specific sizes that are needed to fit into standard containers.

3. POLICY: It is VHA policy that VAMCs designated by the Under Secretary for Health store a cache of pharmaceuticals and medical supplies reserved specifically for the treatment of casualties from a mass casualty event, training exercises, and other contingencies. Determination of when to use a cache (also known as ‘activation’ of a cache) is a local decision to be made by the VA medical center Director or designee.

4. RESPONSIBILITIES:

   a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

      (1) Determining which VA medical facilities receive a cache and the size of that cache. The caches are sized to treat either 1,000 casualties (small cache) or 2,000 casualties (large cache) for a 1- to 2-day period;

      (2) Ensuring that, to the extent permitted by applicable law or regulation, the contents or locations of the All-Hazards Emergency Caches are proprietary for VA and are not released to any person or agency external to VA without approval of the Under Secretary for Health; and

      (3) Ensuring that aggregated data consisting of all cache locations, contents, or capabilities are not released, but will remain in the exclusive control of Emergency Pharmacy Service (EPS) personnel. **NOTE:** VA personnel with a need to know the contents (but not locations) can receive this information if it is essential to perform their disaster-related duties (for example VA emergency department staff members and Office of Emergency Management staff).

   b. **VA All-Hazards Emergency Cache Program Review Committee.** The VA All-Hazards Emergency Cache Program Review Committee is responsible for:

      (1) Ongoing review and evaluation of the VA All-Hazards Emergency Cache;

      (2) Recommending to the Under Secretary for Health when revisions in cache products, quantities, locations, and sizes are required;

      (3) Making operational decisions concerning the cache;
(4) Developing associated Directives and Handbooks to meet VA’s role in disaster preparedness and response;

(5) Developing standardized training and educational materials and providing VAMC staff training, educational materials, and information regarding the cache and its contents; and

(6) This committee is composed of members from the:

(a) Office of Patient Care Services, including EPS of the Pharmacy Benefits Management Service (PBM);

(b) Office of Public Health;

(c) Office of Emergency Management; and

(d) Other subject matter experts, as needed.

c. **Office of Public Health.** The Office of Public Health (OPH) is responsible for:

(1) Providing representation on the VA All-Hazards Emergency Cache Program Review Committee;

(2) Providing leadership of the committee, coordinating committee activities, and serving as a member of the Executive Cache Subcommittee;

(3) Providing subject matter expertise in public health and cache contents; and

(4) Reviewing and updating the caches and associated Directives.

d. **Office of Emergency Management.** The Office of Emergency Management (OEM) is responsible for:

(1) Providing representation on the VA All-Hazards Emergency Cache Program Review Committee;

(2) Providing a representative to serve as a member of the Executive Cache Subcommittee;

(3) Conducting an annual inspection and review of each VA All-Hazards Emergency Cache in accordance with VHA Directive 2010-016, Inspection of VA All Hazard Emergency Caches by the Emergency Management Strategic Health Care Group, or subsequent policy issue;

(4) Report the functional status and operational capabilities to include expired and out of date cache products; and

(5) Providing subject matter expertise in response planning and linkage with the VHA First Receivers Decontamination Program.
e. **Emergency Pharmacy Service.** The Emergency Pharmacy Service is responsible for:

(1) Providing representation on the VA All-Hazards Emergency Cache Program Review Committee;

(2) Providing representation to serve as a member of the Executive Cache Subcommittee;

(3) Providing subject matter expertise for cache logistics and pharmacy issues;

(4) Maintaining a central or regional cache of limited items at the direction of the Committee;

(5) Centrally purchasing products, standardizing the cache configuration based on category of product (burn, biological, chemical, radiological) and shipping the caches;

(6) Maintaining a centralized inventory record. **NOTE:** An exact inventory of the stockpile items must be maintained at all times in a central database that includes product, location, lot number, and expiration dates. All cart numbers must also be maintained in the central database system;

(7) Centrally purchasing and shipping replacement products to each cache site in advance of product expiration dates;

(8) Managing the shelf life extension of selected pharmaceuticals in the cache using the DoD and the Food and Drug Administration Shelf Life Extension Program (SLEP);

(9) Providing new labels and guidance on labeling of shelf life extended pharmaceuticals;

(10) Managing the stock rotation program which is performed by local VAMC staff;

(11) Developing specific operating procedures for VAMC storage, handling, and inspection of the cache. **NOTE:** The operating procedures ensure that all caches are continuously maintained in a secured environmentally controlled space and ready for immediate utilization;

(12) Providing guidance as to the proper management of the caches; and

(13) Posting and maintaining VA All-Hazards Emergency program information on the PBM/EPS intranet Web site.

f. **Executive Cache Subcommittee.** The Executive Cache Subcommittee is composed of the VA All-Hazards Emergency Cache Program Review Committee
members representing OPH, OEM, and EPS. The Executive Cache Subcommittee is responsible for:

(1) Resolving minor cache-related issues and questions that do not require full VA All-Hazards Emergency Cache Program Review Committee decisions (e.g., whether a medication in the cache can be used when there is a short term medication shortage);

(2) Scheduling and determining the agenda for VA All-Hazards Emergency Cache Program Review Committee conference calls and meetings;

(3) Preparing minutes and summaries of VA All-Hazards Emergency Cache Program Review Committee conference calls and meetings for review and approval of members; and

(4) Reporting on minor cache-related issues and questions made between routine meetings and conference calls to the VA All-Hazards Emergency Cache Program Review Committee.

g. **Veterans Integrated Service Network Directors.** Veterans Integrated Service Network (VISN) Directors are responsible for:

(1) Ensuring that VISN Emergency Operations Plans incorporate access, distribution, and use of the cache(s) located within the VISN; and

(2) Ensuring each VAMC within the VISN maintains compliance with cache program guidance.

h. **VA Medical Center Director.** Each medical center Director is responsible for:

(1) Coordinating with the OEM Regional Managers and Area Emergency Managers to work with local and state public health and emergency officials to encourage understanding of VA medical centers’ potential roles in planning and response activities and establishing agreements with applicable agencies as appropriate, including acquisition of medical countermeasures from Strategic National Stockpile. **NOTE:** Please refer to Appendix F for guidance from the VA Office of General Counsel regarding VA roles in preparedness and response. Appendix A provides a ready reference of information regarding VA All-Hazards Emergency Cache capabilities that VA personnel can discuss with the public;

(2) Activating the cache when a local, regional, or national emergency warrants its use. **NOTE:** Drug shortages are not a valid reason for activating the cache; however, excluding pharmaceuticals extended in the SLEP, the medical center. Director may activate the cache and use up to 50 percent of the stock of a particular drug during a shortage when patients are in a life threatening situation. Activation of the cache for this purpose must follow the normal process with required notifications;
(3) Ensuring the VHA Watch Office is notified immediately upon activation of cache by contacting 202-461-0268 or 202-461-0269, or by emailing WatchOfficer-VHA@va.gov;

(4) Ensuring caches are stored and secured in compliance with criteria in this Directive (see Appendix B);

(5) Ensuring VA personnel comply with their responsibilities for public discussion of the VA cache (see Appendix A), which outlines publicly releasable information;

(6) Providing the necessary space to assure cache items are not intermingled with VAMC pharmacy inventory;

(7) Ensuring designated cache space is capable of maintaining appropriate controlled room temperature for pharmaceuticals and supplies. **NOTE:** Controlled room temperature is 68 to 77 degrees Fahrenheit. Brief deviations between 59 to 86 degrees Fahrenheit are allowed;

(8) Ensuring the cache space meets the building and life safety codes requirements and has the required fire, smoke, and intrusion alarm systems;

(9) Ensuring all cache controlled substances are subject to the unannounced monthly controlled substance inspection process;

(10) Appointing a VA medical center liaison to PBM/EPS;

(11) Providing all necessary training for emergency and medical personnel, as appropriate, on use of non-formulary pharmaceuticals, medical supplies and equipment contained in the cache;

(12) Ensuring policy on access, distribution, and use of the cache is incorporated into the facility’s Emergency Operations Plan that includes tracking of intended receivers and distributed pharmaceutical products as part of the plan; and

(13) Ensuring simulation of emergency activation and deployment of the cache is conducted at least annually. Examples include: annual emergency preparedness drills, table top reviews, or other exercises that will assist facilities in ensuring that issues such as cache storage, security, movement, location, training, and operability are considered. Training exercises using the actual cache carts are encouraged; removing the cache carts from the cache area and opening the cache carts for training purposes must be requested in advance via a memo to PBM/EPS (see Appendix C). **NOTE:** Documentation will include participation and risk assessment in the facility After Action Report as well as a follow up report on the closure of action items identified.

i. **VA Medical Facility Chief of Pharmacy Services or Pharmacy Manager.** Each VA medical center Chief of Pharmacy or Pharmacy Manager is responsible for:
(1) Ensuring all inspections and inventories are completed and documented in accordance with criteria established by PBM/EPS. **NOTE:** Inspections of the cache include a weekly visual inspection of the cache space to ensure security and environmental requirements are still intact;

(2) Ensuring completion of cache product rotation and inventory system entries in a timely manner and as required by PBM/EPS. **NOTE:** At least one signature by the VA medical center Chief of Pharmacy Services or Pharmacy Manager is required for receipt of cache supplies;

(3) Making available for VAMC use, any item rotated out of the cache in the PBM/EPS-managed rotation schedule. **NOTE:** These products, excluding pharmaceuticals extended in the SLEP, may be utilized at any VISN location for routine patient care prior to expiration;

(4) Processing expired items through the contracted reverse distributor with all credits being applied to the VAMC account using the Prime Vendor Program;

(5) Ensuring all cache items are stored separately from pharmacy inventory in order to maintain the integrity of the cache and continuous emergency preparedness. Emergency related supplies may be stored in the cache area if the facility has received a written waiver from PBM/EPS (see Appendix D). The waivers need to be renewed every 5 years. **NOTE:** Any C-II or C-III controlled substances in the cache may be stored in sealed totes within the facility pharmacy vault where they are to remain in the sealed totes to ensure they are not intermingled with other controlled substances at the facility;

(6) Ensuring that all cache items requiring refrigeration are stored in the refrigerator provided and maintained at the appropriate temperature; and

(7) Ensuring complete management of all cache controlled substances as follows:

(a) All C-II or C-III cache items must be stored in accordance with VA regulation and Title 21 Code of Federal Regulations (CFR);

(b) All cache C-II and C-III items must be inspected every 72 hours, unless the facility has received a written waiver from PBM/EPS (see Appendix E). **NOTE:** This waiver will only be considered for sites that are storing their cache C-II and C-III items in a vault or safe that is separate and distant from the facility pharmacy vault or safe. The waiver allows the facility to do a weekly inspection of those distant C-II and C-III items.

(c) All cache controlled substances must be included in the monthly controlled substance inspection process as mandated in VHA Handbook 1108.02, Inspection of Controlled Substances;

(d) Visual inspection is conducted monthly;
(e) Physical count is conducted, in the first month of each quarter;

(f) Any C-IV through C-V controlled substances stored in the sealed cache containers and secure cache space are exempt from the VA 72-hour inspection requirement; however, the cache cart seal must be inspected weekly to verify it is intact and the seal number is unchanged;

(g) All controlled substances in a sealed cache cart must be inventoried each time the cart seal is broken or immediately upon discovery of a broken or suspicious looking cart seal;

(h) All controlled substances inventory must be entered into and maintained in the Veterans Health Information System and Technology Architecture (VistA) Controlled Substance software as a separate narcotic area of use;

(i) All controlled substances in the cache must be included in the Drug Enforcement Agency’s (DEA’s) required biennial inventory; and

(j) Any loss of a cache controlled substance is immediately reported as mandated in VHA Handbook 1108.01, Controlled Substances (Pharmacy Stock).
5. REFERENCES:


f. VHA Handbook 1108.01, Controlled Substances (Pharmacy Stock).

g. VHA Handbook 1108.02, Inspection of Controlled Substances.
VA CACHE INFORMATION FOR PUBLIC DISCUSSION

1. Department of Veterans Affairs (VA) medical centers, designated by the Under Secretary for Health, store an All-Hazards Emergency Cache of pharmaceuticals and medical supplies reserved specifically for the treatment of casualties from a mass casualty event.

2. These caches are specifically intended to treat Veterans, staff, and others that may present to the local VA medical facility.

3. The All-Hazards Emergency Caches are designed to ensure short-term preservation of the VA health care infrastructure until other resources are available in the immediate area and to support the facility’s involvement in the local community disaster plan.

4. The VA medical facility Director where the cache is held is responsible for the management of the cache according to current Veterans Health Administration (VHA) policy.

5. The VA medical facility Director is responsible for activating the cache when, in the medical facility Director’s judgment, a local, regional, or national emergency warrants its use.

6. When a cache is activated, the VA medical facility Director immediately notifies the Emergency Pharmacy Service of Pharmacy Benefits Management Service and the Office of Emergency Management using the contact systems according to current VHA policy.

7. Information about contents and locations of the All-Hazards Emergency Caches is proprietary for VA and is not to be released to any person or agency external to VHA without approval of the Under Secretary for Health.

8. VA personnel with a need to know the contents or locations may receive this information, if it is essential to perform their disaster related duties (for example, VA emergency department staff members).

9. Aggregate data consisting of all cache locations, contents, or capabilities will not be released.

10. If there is reason to believe that community emergency planners have built the routine use of VA caches into their local emergency plans in lieu of establishing their own separate capabilities, the VA medical center Director, or designee, is responsible for community coordination are to advise community planners that there is no guarantee that VHA caches will be made available to them, such as in a situation where the caches are already being used to support VHA infrastructure.
11. The All-Hazard Emergency Caches are not meant to replace VA’s need for the Centers for Disease Control and Prevention (CDC) Strategic National Stockpile.
PHYSICAL SECURITY REQUIREMENTS FOR WAREHOUSE AND VA MEDICAL CENTER ALL-HAZARDS EMERGENCY CACHE STORE ROOMS

1. LOCATION TO BE DETERMINED LOCALLY. The locations of All-Hazards Emergency Caches, whether stored in a Department of Veterans Affairs (VA) medical center cache store room or warehouse cache store room, can be determined locally, but must adhere to the security requirements outlined in the paragraphs 2.a.-2.j. of this Appendix.

2. REQUIREMENTS AND MEASURES DEFINED. All-Hazards Emergency Caches consist of medical supplies, intravenous (IV) solutions, non-controlled or legend drugs and C-IV to C-V controlled substances. Any cache C-II or C-III items must be stored in a vault or safe in compliance Drug Enforcement Agency (DEA) regulations as detailed in Title 21 Code of Federal Regulations (CFR) Part 1300.

   a. Windows. When below 12 meters (m) (40 feet (ft.)) from ground level or the roof of a lower abutment, or less than 7.5 m (25 ft.) from windows of an adjoining building, or accessible by a building ledge leading to windows of other floor rooms, security mesh screening for windows is required. Required specifications for stainless steel security mesh screening are:

      (1) All #304 stainless steel woven mesh 0.7 mm (.02 8 inch) wire diameter, with tensile strength of 15 kilograms (kg) per milliliter mm (800 pounds per lineal inch).

      (2) Mesh 12x12 per 25 mm (inch) with main and sub frames of 2.7 mm (12 gauge) carbon steel with baked enamel finish and internal key locking slide bolts.

   b. Building Walls. Exterior walls of brick and masonry construction are acceptable. Exterior walls, which are composed of wood frame and siding, require an interior backing of steel security screen mesh or sheet partition. Room perimeter walls must be full height (floor to underside of slab above).

   c. Doors and Door Locks.

      (1) Door Construction. Doors should be of 45 mm (1 and 3/4 in.) hardwood or hollow steel construction. Dutch or half doors are unacceptable. Removable hinge pins on door exteriors must be retained with set pins or spot-welded, preventing their removal.

      (2) Mechanical Locking Systems. All doors must be fitted with two lock sets.

         (a) Glass doors or doors with glass panes must have one lock set, key operated from the interior of the protected area.

         (b) If a door is not set in a steel frame, one of the two locks must be a jimmy-proof rim dead lock. Doors set in steel frames must be fitted with a mortise lock with a deadlock pin feature (or comparable). One lock (the day lock) must be automatically locking on the door closure, requiring re-entry to the room with key or lock.
combination and allowing egress from the room by use of an inside thumb latch. The
day lock on the main door must be automatically locking, with a minimum 19 mm (3/4
in.) dead bolt and inside thumb latch.

(c) Combinations or Keys. Combination or keys to day locks must be restricted
to service employees and combinations changed immediately on the termination or
reassignment of an employee who had access to the combination.

d. Other Room Access Means.

(1) Interstitial overhead areas which enable entry into a secure room from an
unsecured room must be barricaded by the installation of a suitable partition in the
interstitial space which prevents "up and over" access.

(2) Ventilation grills on doors and air circulation ducts which exceed 0.06 m² (100
square inches) in areas must be reinforced to prevent their removal from outside the
room. Other possible access means, such as dumbwaiter shafts, roof or wall
ventilator housings, and trapdoors must be secured by appropriate means.

e. Motion Intrusion Detector. A motion intrusion detector is an intrusion
detection alarm system that detects entry and then broadcasts a local alarm of
sufficient volume to cause an illegal entrant to abandon a burglary attempt. Intrusion
detector equipment which operates on the principles of narrow beam interception,
door contacts, microwave, or photoelectric eye is acceptable.

(1) Intrusion detectors must have the following essential features:

(a) An internal, automatic charging direct current (DC) standby power supply and
a primary alternating current (AC) power operations.

(b) A remote, key-operated activation and deactivation switch installed outside the
room and adjacent to the room entrance door frame and/or a central alarm ON-OFF
control in the Police Office.

(c) An automatic reset capability following intrusion detection.

(d) A local alarm level of 80 decibels (dB) (minimum) to 90 dB (maximum) within
the configuration of the protected area.

(e) An integral capability for the attachment of wiring for remote alarm and
intrusion indicator equipment (visual or audio). **NOTE:** See paragraph 2.e.(2) of this
Appendix.

(f) A low nuisance alarm susceptibility.

(2) Installation Notes:
(a) A locally-sounding alarm is not to be installed in a room which is close to an Intensive Care Unit (ICU), cardiac care, or other special treatment areas where a loud alarm might have an injurious effect on patients.

(b) In addition to the locally-sounding alarm, remote visual and/or audio annunciators must be at a location within the facility which ensures 24-hour monitoring. These annunciators must have the capability of identifying individually-protected zones.

(c) In protected rooms of outpatient clinics not on facility grounds, intrusion detector alarms must be remote to a commercial security alarm monitoring firm, a local police department, or a security office charged with building security. **NOTE:** These remote alarms are in addition to locally broadcast alarms in the protected areas.

(d) Remote bulk storage warehouse facilities must have one or more local broadcasting alarms inside and outside of the protected area.

f. **Temperature.** Environmental controls must be in place to ensure that the temperature in the cache storage area is maintained between 68 to 77 degrees Fahrenheit. Brief deviations between 59 to 86 degrees Fahrenheit are allowed.

   (1) The cache space must contain a thermometer or equivalent electronic temperature monitoring.

   (2) A log of weekly temperature readings must be maintained and stored in the cache space or equivalent temperature monitoring.

   (3) All cache items that need refrigeration must be stored in the refrigerator provided and set at the proper temperature.

   (4) A log of weekly refrigerator temperature readings must be maintained and stored in the cache space.

g. **Bulk Drug Storage Safes and Vaults.** Drugs classified as scheduled I, II, or III (narcotic controlled substances under the Controlled Substance Act of 1970) must be stored in safes or vaults which conform to the following specifications:

   (1) Safes must be General Services Administration (GSA) class 5 security containers weighing no less than 340 kg (750 pounds).

   (2) Where bulk quantities or controlled substance handling requirements deem safes impractical, vaults must be used. Specifications for two types of vaults are given: Type I for outpatient clinic or center use, and Type II for construction in medical centers only. The type I vault is not as formidable and permanent a structure as the Type II concrete vault and, therefore, schedule I, II, and III (narcotic) controlled substances may not be stored on open shelving within the Type I vault. To
compensate for the lower security of Type I vaults, lockable steel cabinets installed within the vault must be used for schedule I, II, and III (narcotic) substances.

(3) Vault specifications are as follows:

(a) Type I Vault. Enclosure constructed of steel security screen, woven mesh, 1.2 mm (.047 in.) wire diameter alloy #304 stainless steel, with tensile strength of 29 kg/mm (1,600 pounds per lineal inch). Mesh 10 x 10 per 25 mm (inch) with mainframe and sub frames of 2.4 mm (13 gauge) alloy #304 steel. In rooms with dropped ceilings, the vertical frames and mesh walls must meet the actual ceiling or a security mesh ceiling installed below the false ceiling. In lieu of security mesh screening enclosures, Type I vaults may be constructed of 2.4 mm (13 gauge) steel wall partition material with corner brackets welded and floor/ceiling anchors firmly set to prevent disassembly. Mesh vaults may be enclosed with drywall or paneling with appropriate ventilation openings.

(b) Type II Vault. Constructed of walls, floors, and ceilings of minimum of 200 mm (8 in.) reinforced concrete or other substantial masonry, reinforced vertically and horizontally with 13 mm (1/2 in.) steel rods tied 150 mm (6 in.) on center.

(c) Doors and day gates must meet GSA class 5 criteria.

(d) Vault ventilation and utility ports may not exceed 0.06 m² (100 square inches) in area.

h. **Special Key Control.** Room door lock keys and day lock combinations, where applicable, are special keys, which are keys that can only open a door lock in a specially protected area which cannot be opened by a great grand master, grand master, master, or any individual key.

i. **Electronic Access Control Security System.** For monitoring and controlling access to areas containing controlled substances, the following specifications are among those to be considered for inclusion:

(1) Access safeguards to prevent learning codes through keypad observations or use of stolen or found access cards.

(2) The ability to program access by user, shift, and day.

(3) The ability to program access by door and area for each individual user.

(4) Fail-safes to ensure the ability to maintain access security, if the system goes down (i.e., bypass key).

(5) Access records and/or audit trails that ensure the ability to provide for periodic or on-demand print out of names and time and/or dates of individual accessing.
(6) User coverage that indicates the number of individual access codes that the system must accommodate. **NOTE:** *The use of electronic access control systems may be expanded to other high security areas within the facility.*

**j. Warehouse Cage Area.** Pharmaceutical caches may be stored in a cage area within a warehouse building or warehouse area that is secured and monitored (see VA Handbook 0730/2, Appendix B for warehouse compliance instructions).

(1) The cage material must be made of a sturdy metal or wire material and must not contain openings in the material that are greater than 2.5” x 2.5”. Vertical opening in areas such as along the edges of gates or where the cage meets a wall or post must not be wider than 3”.

(2) Access to the cache cage area must be restricted and controlled as detailed in paragraph 2.i of this Appendix.

(3) Cage height must be at least 10 feet or to the ceiling of the warehouse, whichever is lower.
Memorandum

From: (Medical Facility Director, Facility Name)

Subj: VHA All-Hazards Emergency Cache Training Request

To: PBM Emergency Pharmacy Service (10P4P)

1. (Name of facility) is requesting to open the VHA All-Hazards Emergency Cache for the purposes of a training exercise on (Date(s) of training) at (Facility name and location).

2. The (Responsible official) will ensure that the security of the All-Hazards Emergency Cache contents are kept secure with cart labels clearly marked, visible and only viewed by VA employees with a need to know for training purposes.

3. The (Responsible official) will ensure that the All-Hazards Emergency Cache contents are returned to their original locations and carts sealed and returned to the storage area in accordance with current VHA Directive 1047, All-Hazards Emergency Caches.

Requestor Signature: ________________________________

Approved/Disapproved

PBM Signature ________________________________

Name of signer ________________________________ Date

Fax to: (708) 786-7798, Attention: PBM Emergency Pharmacy Service or sign, scan and send electronically to EPS Staff: pbmeps@va.gov
Department of Veterans Affairs

Memorandum

Date:

From: [Medical Facility Director or Chief of Staff, and Facility Name]

Subj: VHA All-Hazards Emergency Cache Storage Waiver Request

To: PBM Emergency Pharmacy Service (10P4P)

Thru:

1. [Name of facility] is requesting a waiver as provided in VHA Directive 1047 All-Hazards Emergency Caches to allow storage of the following emergency-related supplies and/or products in the VA Emergency Cache storage area.
   a) List Supply or Product (please specify)
   b) List Supply or Product
   c) List Supply or Product (continue as necessary, list each product or supply separately)

2. The supplies or products listed above will be clearly marked and stored separately from the All-Hazards Emergency Cache.

3. Access to and transport of the All-Hazards Emergency Cache items will not be impeded by these supplies and/or products.

4. All storage and security requirements will be maintained as outlined in current VHA Directive 1047 All-Hazards Emergency Caches, Appendix B.

Requestor Signature: ____________________________________________

Approved/Disapproved

PBM Signature ____________________________ ____________________________
Name of signer ____________________________ Date _______________________

Fax to: (708) 786-7798, Attention: PBM Emergency Pharmacy Service or sign, scan and send electronically to EPS Staff: pbmeps@va.gov
Department of Veterans Affairs

Memorandum

Date:

From: [Medical Facility Director or Chief of Staff, and Facility Name]

Subj: VHA All-Hazards Emergency Cache Controlled Substance Inspection Waiver Request

To: PBM Emergency Pharmacy Service (10P4P)

Thru:

1. [Insert Facility name] is requesting a waiver from requirements in VHA Directive 1047 All-Hazards Emergency Cache Controlled Substance for 72 hour inspections.

2. This waiver would allow our facility to conduct a weekly inspection of the C-II items (e.g., morphine injection) stored in the All-Hazards Emergency Cache. Currently the C-II items stored in the All-Hazards Emergency Cache are secured in a vault that is separate and distant from the facility pharmacy vault.

3. The All-Hazards Emergency Cache controlled substance inventories will be entered and maintained in the VISTA controlled substance software as a separate area of use.

4. The facility will continue with the weekly inspection of the C-IV items (e.g., diazepam injections and lorazepam tablets) stored in the cache.

5. The All-Hazards Emergency Cache controlled substances will also be subject to the monthly unannounced controlled substance inventory to:

   a) Verify seals monthly
   b) Make a physical count in the first month of each quarter

6. All other storage and security requirements will be maintained as outlined in the VHA All-Hazards Emergency Cache Handbook, Appendix B.

Requestor Signature: ____________________________________________

Approved/Disapproved

PBM Signature ____________________________ __________________________
Name of signer ____________________________ Date ____________________________
Fax to: (708) 786-7798, Attention: PBM Emergency Pharmacy Service or sign, scan and send electronically to EPS Staff: pbmeps@va.gov
OFFICE OF GENERAL COUNSEL ADVISORY OPINION

On May 4, 2012, the Office of General Counsel issued an advisory opinion detailing Department of Veterans Affairs’ (VA’s) authority to provide medical countermeasures during a disaster or emergency. Key points from the opinion are summarized below:

VA’s authority to provide emergency and disaster assistance to non-Veterans must be authorized by statute, and VA's appropriation must authorize the expenditure.

The primary source of VA’s authority to respond to disasters and emergencies is the Stafford Act, which sets forth the Federal government's authority to respond to major disasters and emergencies. Following a declaration of a major disaster or emergency, the President may direct any Federal agency to use its authorities and resources in support of State and local assistance efforts. Title 42 United States Code (U.S.C.) §§5170a(1), 5170b(a), 5192. VA also has a role in providing care and services through the National Disaster Medical System (42 U.S.C. §300hh-11(b)). VA's authority to provide care and services during disasters and emergencies is codified at 38 U.S.C. §1785. Implementing regulations are at Title 38 Code of Federal Regulations (CFR) §17.86.

VA's authority to provide assistance pursuant to section 1785 should be evaluated within the context of the National Response Framework (NRF), which guides the Federal government in responding to disasters and emergencies and managing incidents. The NRF includes a series of Incident Annexes developed to provide specialized, incident-specific implementation of the NRF. The Biological Incident Annex outlines the actions, roles and responsibilities associated with response to a human disease outbreak of known or unknown origin requiring Federal assistance and describes the anticipated role of cooperating agencies (including VA).

In addition to the NRF, Executive Order 13527 directed the Secretaries of Homeland Security and Health and Human Services, in coordination with the Secretary of Defense, to develop a concept of operations and establish requirements for a Federal rapid response to dispense medical countermeasures to an affected population following a large-scale biological attack. There is applicable guidance for VA based on these discussions.

Outside the circumstances when VA is authorized to act under section 1785 pursuant to a Stafford Act tasking or declared public health emergency, several additional statutes authorize VA to provide care to non-VA beneficiaries.

Pursuant to 5 U.S.C. §7901, VA has authority to provide certain health services to employees. Further, employee health maintenance and the prevention of patient-threatening conditions is an integral part of providing health care and medical
services to eligible veterans. VA, therefore, has authority to provide medical countermeasures to employees.

With regard to family members of Veterans, VA has authority to provide medical care and services to certain family members eligible for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) care (38 U.S.C. §1781).

Pursuant to 38 U.S.C. §8111A, VA is authorized to provide care to members of the Armed Forces during a time of war or national emergency.

VA also has broad authority, pursuant to 38 U.S.C. §1784, to furnish hospital care and medical services as a humanitarian service in emergency cases.

Pursuant to 38 U.S.C. §8153, VA may enter into sharing agreements with other health-care providers, entities, or individuals. These agreements can be used to secure health-care resources that otherwise might not be feasibly available, or to effectively utilize health-care resources by furnishing such resources to these parties on a reimbursable basis.

In summary, the opinion advised that VA is authorized to provide care to individuals responding to, involved in, or otherwise affected by a disaster or emergency, as described in 38 U.S.C. §1785 and 38 CFR §17.86, the NRF and other guidance. VA has additional authority to furnish hospital care and medical services as a humanitarian service in emergency cases, but is required to charge for such care. 38 U.S.C. §1784; 38 CFR §17.102. Pursuant to 5 U.S.C. §7901, VA has authority to provide certain health services to employees, and pursuant to 38 U.S.C. §1781, VA has authority to provide care to certain family members of Veterans. Pursuant to 38 U.S.C. §8111A, VA is also authorized to provide care to members of the Armed Forces during a time of war or national emergency. Finally, 38 U.S.C. §8153 authorizes VHA to enter into sharing agreements with other health-care providers, entities, or individuals to secure health-care resources that otherwise might not be feasibly available, or to effectively utilize health-care resources by furnishing such resources to these parties on a reimbursable basis.