THE DEPARTMENT OF VETERANS AFFAIRS
AND
THE DEPARTMENT OF DEFENSE
FY 2004 REPORT ON HEALTH CARE RESOURCE SHARING

"The Department of Veterans Affairs (VA) and the Department of Defense (DoD) Health Resources Sharing and Emergency Operations Act" (38 USC 8111(f)), and Public Law 107-314, the "National Defense Authorization Act of 2003," require the Secretary of Veterans Affairs and the Secretary of Defense to submit a joint report to Congress on the implementation of that portion of the law dealing with sharing of health care resources between the two Departments. The following information is submitted for the period October 1, 2003, through September 30, 2004.

I. VA/DOD SHARING GUIDELINES

In 1983, VA and DoD promulgated joint guidelines for the promotion of sharing of health care resources between the Departments. A copy of the 1983 Memorandum of Understanding (MOU) establishing the basic guidelines is at Appendix A.

II. ASSESSMENT OF SHARING OPPORTUNITIES

A. VA/DoD Joint Executive Council (JEC)

In November 2003, the National Defense Authorization Act (Public Law 108-136) codified the VA/DoD Joint Executive Committee (JEC) under 38 USC 8111. The statue requires the JEC submit an annual report to the Secretary of Veterans Affairs and the Secretary of Defense and the Congress containing such recommendations as the JEC considers appropriate to enhance VA/DoD collaboration. Because of this requirement, this report will not address activities during Fiscal Year (FY) 2004 of the JEC, the VA/DoD Benefits Executive Council, or the VA/DoD Capital Asset Planning and Coordination Steering Committee. The Annual Report of the Executive Committee required by Title 38 USC 811(c) (4) has been transmitted under separate cover. The Departments plan to combine these two reports for the FY 2005 reporting period.

B. VA/DoD Health Executive Council (HEC)

The HEC provides oversight and accountability between the two Departments on the activities and initiatives associated with health care resources sharing. The HEC was placed under the auspices of the JEC in 2002. It is co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs.

The HEC is supported by work groups established according to strategic need and specific policy areas. These work groups have achieved significant success in improving interagency cooperation in such areas as: information management/information technology (IM/IT), financial management, joint facility utilization and resource sharing, pharmacy, medical-surgical supplies and equipment, patient safety, deployment health, and clinical practice guidelines.

The HEC approved a Memorandum of Agreement (MOA) on the "Referral of Active Duty Service Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services," which was signed on April 20, 2004. Other high priority issues for the past year included the standardization of billing and reimbursement for health care services, Federal Health Information Exchange (FHIE) initiatives, and joint pharmaceutical purchases. The following is a summary of progress on these and other issues:

1. Information Management and Technology: This work group was established for DoD and VA to share existing products and collaborate in development of medical information management and technology. Numerous initiatives are addressed in Section D.

2. Clinical Practice Guidelines (CPGs): DoD and VA are collaborating to publish jointly used clinical practice guidelines for disease management. DoD and the Veterans Health Administration (VHA) are now using the same explicit clinical practice guidelines to improve patient outcomes. Clinical practice guidelines have provided consistent, high-quality health care delivery in both Departments. Guidelines have been updated and published for the following clinical areas: asthma, chronic kidney disease, chronic obstructive pulmonary disease (COPD), cardiovascular disease, hyperlipidemia, ischemic heart disease and chronic heart failure, depression, diabetes mellitus, dysuria in women, low back pain, medically unexplained symptoms: chronic pain and fatigue, post-operative pain management, redeployment health, substance abuse and tobacco cessation. The VA/DoD Evidence-Based Clinical Practice Guidelines Working Group finalized a new guideline for stroke rehabilitation and updated guidelines for diabetes mellitus and hypertension. The working group also completed a new CPG for use of opioids in the management of chronic pain and for post-traumatic stress disorder. Other guidelines pending or planned include hypertension and tobacco use cessation. All CPGs are posted to the Agency for Healthcare Research and Quality National Clearinghouse at www.ahrq.gov. The work group also developed and disseminated Biological, Chemical and Ionizing Radiation Terrorism Pocket Cards for practitioners.

3. Patient Safety: DoD and VA are collaborating on internal and external reporting systems for patient safety. DoD has established a "Patient Safety Center" at the Armed Forces Institute of Pathology using the VA National Center for Patient Safety as a model. VA continued to work with the National Aeronautics and Space Administration (NASA) to develop an external system to complement their internal reporting system. DoD is seeking confidentiality protection for its data to facilitate participation with the NASA/VA Patient Safety Reporting System.

4. Pharmacy: The HEC established the VA/DoD Federal Pharmacy Executive Steering Committee to improve the management of pharmacy benefits for both VA and DoD beneficiaries. Joint partnerships for contracting for pharmaceuticals have been very successful. The Departments have conducted a pilot test where VA Consolidated Mail Out Pharmacy (CMOP)-Leavenworth refills outpatient prescription medications from DoD's Military Treatment Facilities (MTFs) at the option of the beneficiary. DoD sites are at: Naval Medical Center, San Diego, CA; Fort Hood Army Community Hospital, Killeen, TX; and the 377th Medical Group, Kirtland AFB, NM. The Departments have reviewed an analysis of

the joint VA/DoD CMOP Pilot prepared by the Center for Naval Analysis (CNA), and have found the program to be feasible, with high participation by DoD beneficiaries, and high satisfaction among users of the program. The CNA report is inconclusive on whether the CMOP program is cost-effective for DoD. Relative cost data will continue to be assessed by DoD.

While DoD continues to be interested in exploring this joint activity with VA, it will not centrally fund the CMOP initiative. Continuation of CMOP services to the pilot sites will be at the discretion of each MTF Commander and respective Military Service. The status of the program at the end of the fiscal year was:

- The Army is considering continuation of the program at a different site.
- The Navy is considering continuation of the program at Naval Medical Center, San Diego, CA.
- The Air Force is considering continuation of the program at Kirtland AFB, NM.

5. Medical Surgical Supplies and Equipment: VA and DoD have modified their current high cost equipment contracts to open them for use by the other Department. As the current contracts expire, they will be replaced by joint contracts with awards alternating between the Departments. Efforts towards a single joint medical catalog continue as VA data is added to DoD's Medical Electronic Catalog. Both Departments are collaborating on medical/surgical data synchronization efforts with industry.

6. Financial Management: This work group was established to develop policies and procedures for reimbursement and recommendations for streamlined financial processes and business practices for direct VA/DoD sharing agreements. In a follow up to a memorandum of agreement implementing a standardized billing rate based on DoD's CHAMPUS Maximum Allowable Charges schedule, the work group developed guidelines and procedures for waiver request applications for outpatient services.

   The Financial Management Work Group also established a process for soliciting and selecting incentive fund proposals as required by the National Defense Authorization Act (NDAA) of 2003. See Section V, A, 1. "DoD/VA Health Care Sharing Incentive Fund."

7. Joint Facility Utilization and Resource Sharing: This work group was established to examine such issues as removing barriers to resource sharing and streamlining the process for approving sharing agreements. The work group continued to provide oversight of the VA Joint Assessment Study mandated by the FY 2002 National Defense Appropriations Act. A contract was awarded in November 2002, to study beneficiary utilization within three Federal health care markets: Puget Sound, WA; Honolulu, HI; and the Gulf Coast between Biloxi, MS, and Panama City, FL. The contractor delivered its formal report containing an analytic framework, based on analysis of approximately 56 million patient encounter records from 20 disparate information systems between the two Departments on December 31, 2003. A joint planning exercise to assess the feasibility and applicability of this business planning method was in the last stage of being coordinated at the conclusion of the fiscal year. The work group also had responsibility for overseeing compliance with Sections 722, and 723 of the FY 2003 NDAA. These activities are discussed in Section V of this report.

C. Medical Research

The VA/DoD collaborative research program selects projects based on merit-based scientific review and relevance to the health concerns of veterans and military members. A wide array of research protocols and investigations are supported. Research during the last year includes: a new center to develop state-of-the-art care for veteran amputees returning from Operations Iraqi Freedom and Enduring Freedom; a clinical drug trial to treat Amyotrophic Lateral Sclerosis (ALS), a condition that is more prevalent among Gulf War veterans than their non-deployed counterparts; and a population-based study of post-traumatic stress disorder in female veterans, the largest such study of its kind. VA/DoD collaborative research also continues in implantable cardioverter defibrillators, clinical treatment trials of chronic health problems among veterans of the Gulf War, protocols aimed at improving health risk communication of military unique risk factors among veterans and the Millennium Cohort Study, a 21-year prospective study of the health outcomes of deployed and non-deployed veterans.

D. Health Information Management and Technology Sharing

VA and DoD recognize the need to securely share appropriate beneficiary health information to support continuity of care and patient safety for veterans and our shared patient population. Examples of specific VA/DoD joint IM/IT efforts to accomplish this follow.

1. VA/DoD Joint Electronic Health Records Interoperability (JEHRI) Program: This program addresses the Departments' current, near-term, and long-range plans to improve sharing of health information; adopt common standards for architecture, data, communications, security, technology and software; seek joint procurement and/or building of applications, where appropriate; seek opportunities for sharing existing systems and technology, and explore convergence of DoD and VA health information applications consistent with mission requirements. JEHRI also responds to the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans recommendation regarding sharing electronic health information. VA and DoD are committed to exchanging appropriate health information in the most efficient and effective means possible while continuing to meet their own agency needs.

VA and DoD are finalizing the JEHRI Program Management Plan (PMP). The JEHRI PMP guides the management oversight, progress reporting, and continued development of JEHRI projects. JEHRI projects are laying the ground work for the clinical information exchange that will enable a consolidated view of health data from DoD and VA medical records.

2. Federal Health Architecture (FHA): DoD and VA are lead partners participating in this new initiative. FHA offers an excellent opportunity to build partnerships throughout the nation's health care environment towards the development of an integrated and effective health information exchange network. FHA will enable the utilization of existing systems to meet health care delivery requirements, while providing clear rules for the development of architecture framework for defining the National Electronic Health Record and access to health related information and services throughout the national health arena. DoD and VA are co-leads on the Health Care Delivery – Electronic Health Record (EHR) Work Group formed in May 2004. The work group's initial focus is the federal EHR business architecture. The first vertical line of

business being addressed is public health surveillance. This effort will serve as a proof-of-concept for continuing to develop additional lines of business building to a full Federal Health Architecture. To support the framework for the DoD architecture, the Department has drafted guiding principles, determined oversight bodies, drafted joint charters and initiated a program reference model (PRM) based upon the framework of the Office of Management and Budget PRM.

3. Health Information Standards: VA and DoD are lead partners in the Consolidated Health Informatics (CHI) initiative, one of the 24 eGov initiatives supporting the President's Management Agenda. The goal of CHI is to establish Federal health information interoperability standards as the basis for electronic health data transfer in Federal health activities and projects. Health information interoperability standards enable agencies to "speak the same language," and share information without the high cost of translation or data entry. The Department of Health and Human Services (HHS) serves as managing partner for CHI

In March 2003, HHS, Defense, and VA announced the first set of uniform standards to be adopted from the CHI effort. They included standards in clinical laboratory results, health messaging, prescription drug codes, digital imaging, and connectivity of medical devices to computers. The standards adopted will be used in new acquisitions and systems development initiatives.

On May 6, 2004, HHS, DoD, and VA announced the adoption of the following 15 additional standards recommended by CHI:

- Health Level 7 (HL7) vocabulary standards for demographic information, units of measure, immunizations, and clinical encounters and HL7s Clinical Document Architecture standard for text based reports.
- College of American Pathologists (CAP) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) for laboratory result contents, non-laboratory interventions and procedures, anatomy, diagnosis and problems, and nursing.
- Logical Observation Identifier Name Codes (LOINC®) for electronic exchange of laboratory test orders.
- Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets for electronic exchange of health related information to perform billing or administrative functions.
- The Food and Drug Administration's names and codes for ingredients, manufactured dosage forms, drug products and medication packages; National Library of Medicine's RxNORM for describing clinical drugs; and VA's National Drug File Reference Terminology (NDF-RT) for specific drug classifications.
- Human Gene Nomenclature (HUGN) for the role of genes in biomedical research.
- Environmental Protection Agency's Substance Registry System (SRS) for non-medicinal chemicals of importance to health care.

VA and DoD engaged in discussions regarding CHI Phase II and the impact of CHI now being a work group under the Federal Health Architecture Initiative. For CHI Phase II there are three key activities:

1) Implementation of adopted standards,
2) Maintenance and enhancement of adopted standards, and
3) Continuation of new standards adoption needed to support business priorities.

VA and DoD co-chair CHI Phase II new standards development effort with particular emphasis on e-Prescribing and allergy standardization. VA and DoD are also leading partners in many national standards development efforts. Both Departments participate in multiple standards boards to collaborate and share expertise. The VA/DoD standards convergence group continues to work towards leveraging synergies and avoiding duplication and inconsistencies with their respective Enterprise Architecture (EA) development. EA links the business mission, strategy, and processes of an organization to its Health Technology strategy. It is documented using multiple architectural models or views that show how the current and future needs of an organization will be met. Compatible DoD/VA architectures foster systems interoperability and information sharing both inside and between the Departments.

4. The Federal Health Information Exchange (FHIE): FHIE is the initial VA/DoD effort at sharing appropriate clinical health data electronically. The transfer of data on Service members at the point of separation is a one time (per beneficiary) transfer, in keeping with applicable privacy laws and regulations, from DoD's Composite Health Care System (CHCS) to VA's Veterans Health Information System and Technology Architecture (VistA) for use by VA providers and benefits claims specialists.

DoD has transmitted electronic health information on 2.3 million unique patients containing information on laboratory results (clinical chemistry, blood bank information, microbiology, surgical pathology, and cytology); radiology results; outpatient pharmacy data from military treatment facilities, retail network pharmacies, and DoD mail order pharmacy; allergy information; discharge summaries (inpatient history, diagnosis, and procedures); admission, disposition, and transfer information (admission and discharge dates); consult reports (referring physician and physical findings); standard ambulatory data record (diagnosis and procedure codes, treatment provided, encounter date and time, and clinical services); and patient demographic information (name, social security number, date of birth, sex, race, religion, patient category, marital status, primary language, and address). This amount of data transferred continues to grow as health information on recently separated Service members is extracted and transferred to VA monthly.

VA providers at over 200 facilities nationwide have access to data on separated Service members. The FHIE data repository contains historical clinical health data from 1989 to the present that significantly contributes to the delivery and continuity of care and adjudication of disability claims of separated Service members as they transition to veterans' status. All health information exchanges are executed in a manner that is fully compliant with Health Information Portability and Accountability Act (HIPAA) regulations.

As Co-Chairs of the Health Executive Council (HEC) Information Management/ Information Technology (IM/IT) Work Group, the Chief Information Officers of the Military Health System, DoD, and *Acting* Deputy Chief Information Officer for Health, VA, have worked closely to provide the oversight and management for this project. FHIE is an excellent example of Departmental collaboration. It is a significant step toward the President's Health Information Technology Plan and is demonstrating that clinical data can be transferred from one health care

system to another in a safe, secure manner.

5. VA/DoD Bidirectional Health Information Exchange (BHIE): BHIE leverages already developed FHIE joint DoD/VA infrastructure, IT investments, VA/DoD test facilities, and existing personnel resources to create a near real-time, bi-directional interface. While FHIE provides joint health care facilities access to pre-separation DoD health care data on separated service members, BHIE will provide secure, near real-time, bi-directional access to electronic health information on shared patients. This project is an incremental step in the accomplishment of the goal to create a bi-directional interface between DoD's and VA's health information systems.

The focus of this interface is exchanging data on shared VA/DoD patients such as at joint venture sites and to support other local sharing agreements. BHIE permits a Military Treatment Facility (MTF) to share clinical data capable of computational actions with VA medical centers where a shared patient presents for care and for VA to likewise share data with MTFs. With BHIE, clinicians will have the ability to view allergy, pharmacy, radiology, demographic and laboratory data.

The initial data shared in the first quarter of FY 2005, will be patient demographic data (name, patient category, social security number, gender, and date of birth), DoD and VA outpatient pharmacy data (MTF data for all shared beneficiaries, DoD mail order pharmacy and retail pharmacy network for separated service members, and VA pharmacy data), and allergy information. Additional data elements that will be added in FY 2005 are: DoD mail order pharmacy and retail pharmacy network data for other DoD shared beneficiaries, laboratory results (surgical pathology reports, cytology, microbiology, chemistry, hematology, and lab orders data), and radiology results.

The initial test site is Madigan Army Medical Center/VA Puget Sound Health Care System. The Seattle/Puget Sound site, serving Madigan Army Medical Center and VA Puget Sound Health, WA, Care System is also an NDAA Demonstration Site as well as serving as the initial test site. In addition, through the FY 2003 NDAA Demonstration Site Program, the Departments will implement BHIE in FY 2005 at the El Paso site, serving William Beaumont Army Medical Center and the El Paso, TX, VA Health Care System.

6. E-portal Systems: TRICARE Online (TOL) is an enterprise-wide, secure e-health portal intended for use by DoD beneficiaries, providers, health care managers, and purchased care support contractors. TOL provides the 9 million-plus beneficiaries worldwide with secure access to more than 18 million pages of trusted health care information, and provides information on local MTF providers and services. *MyHealtheVet* is VA's web-based e-health portal that creates a new, online environment where veterans, family, and clinicians may come together to optimize veterans' health care. TOL and *MyHealtheVet* use the same health content provider which supports continuity of care as Service Members transition to veterans' status. Recently, VA and DoD have begun collaborative efforts to identify e-health secure portal best practices and information sharing opportunities.

7. DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR): To provide a more robust bi-directional real-time exchange of clinical health care data in the future, VA and DoD are working on interoperability between the DoD's CDR and VA's HDR utilizing

the Departments' next generation of systems, DoD CHCS II and VA HealtheVet VistA.

The initial interface between DoD's CDR and VA's HDR is the pharmacy prototype. The Departments' technical and functional teams successfully completed a demonstration of the bi-directional pharmacy prototype in a lab environment on September 1, 2004. The data exchanged through the pharmacy prototype includes patient demographic data (sufficient to correlate patients), provider demographic data (sufficient to identify the ordering provider), medication lists, and allergy lists from one agency repository to the other. In addition, the prototype provides the capability for drug to drug interaction screening between departments (based on the integrated VA-DoD medication list) and local (intra-departmenatal) database drug to drug allergy interaction screening (based on the integrated VA/DoD allergy list).

Phase II will include the exchange of patient demographics, outpatient pharmacy (MTF, DoD mail order, and retail pharmacy network data), laboratory, and allergy information which will occur by October 2005. The Departments will examine and define requirements for any subsequent capabilities beyond 2005 to support an on-going exchange of health data.

FHIE, BHIE, and CHDR projects share clinical health care data and are complimented by the following projects which share supporting types of data:

Laboratory Data Sharing Interface (LDSI): LDSI focuses on sharing real-time laboratory order entry and laboratory results retrieval between DoD, VA, and commercial reference laboratories. Employing LDSI, a VA provider using VistA writes an order for lab work. That order is electronically transferred to DoD, which is acting as a reference lab to VA for fulfillment. The results are electronically transferred from DoD to VA and included in the patients' record in VistA. LDSI provides laboratory order portability between VA-DoD sites that have a local sharing agreement regarding laboratory services. Testing is underway on similar electronic order entry and results retrieval to support VA functioning as a reference lab for DoD. As part of the NDAA Demonstration Site initiatives, the Departments have implemented LDSI in El Paso, TX, for use by William Beaumont Army Medical Center and the El Paso VA Health Care System and will implement LDSI in San Antonio, TX, for use by Wilford Hall Medical Center, Brooke Army Medical Center, and the South Texas VA Healthcare System.

DoD's Central Credentials Quality Assurance System (CCQAS) and VHA's VetPro Credentialing System (CCQAS/VetPro): The Departments piloted the CCQAS/VetPro project to improve the process of initial provider credentialing. The project enabled the electronic sharing of provider credentialing data elements between VA and DoD. This allowed both Departments to expend fewer resources to initially credential a provider that had already been credentialed in the other Department. The interface supports the exchange of approximately 50 credentials data elements between the Departments. The interface meets the content of the Joint Commission for the Accreditation of Health Care Organization guidance regarding the acceptance of credentials data verified by another source.

Pilot testing of the interface between the VA and DoD credentialing systems took place at Naval Hospital Great Lakes/North Chicago VA Health Care System/Hines VA Hospital IL, Ireland Army Community Hospital/Louisville, KY, VA Medical Center, and Mike O'Callaghan Federal Hospital, Las Vegas, NV. The pilot test was completed in the third quarter of FY 2004. Credentialers participating in the pilot test agreed that the integration reduced duplicative

work/paperwork and resulted in a time savings. The Departments are now implementing CCQAS/VetPro credentials interface into the San Antonio area for use by Wilford Hall Medical Center, Brooke Army Medical Center, and the South Texas Veterans Healthcare System, as part of the NDAA Demonstration Site initiatives. This will provide a longer period of use and a more in-depth evaluation of the merits of the interface.

III. RECOMMENDATIONS TO PROMOTE SHARING BETWEEN THE DEPARTMENTS

The initiatives examined and discussed throughout this report fell within the purview of the VA Deputy Secretary and the Under Secretary for Health and the Under Secretary of Defense (Personnel and Readiness) and the Assistant Secretary of Defense (Health Affairs), and did not require submission to the Secretaries of the respective Departments.

IV. REVIEW OF AGREEMENTS AND ACTIVITIES

A. Facilities with Sharing Agreements

VA and DoD coordinate health services through direct sharing agreements, TRICARE contracting, joint contracting for pharmaceuticals and medical/surgical supplies, information technology collaboration, training cooperation, and joint facilities.

One hundred fifty seven VA medical facilities were involved in sharing agreements with 264 MTFs and 152 reserve units around the country. There were 473 sharing agreements covering 2,403 health services with the military. In 2003, there were 468 agreements covering 2,694 services. The drop in the number of services being shared is due largely to the termination of sharing agreements with the Military Medical Support Office and transfer of workload to TRICARE. Eighty-six VAMCs reported reimbursements from TRICARE. Appendix B is a list of health services provided in agreements with the military and under TRICARE.

VA and DoD continue to make progress on joint procurement activities in the pharmaceutical arena. As of September 2004, there were 81 joint VA/DoD contracts, 13 Blanket Purchase Agreements (BPAs) and 2 Temporary Price Reductions (TPR) in place. FY 2004 cost avoidance is estimated at $262 million for VA and $158 million for DoD. Fourteen joint requirement solicitations are pending action by VA's National Acquisition Center (NAC) or Defense Supply Center (DSCP), Philadelphia, PA. Eighteen drugs have been identified for joint contracting possibilities in FY 2005.

VA continues to work with DoD on the medical/surgical supplies conversion, converting DoD's Distribution and Pricing Agreements (DAPA) to VA's Federal Supply Services (FSS) pricing. Both Departments are planning to combine all of these contracts to eliminate redundancies. An appendix to the overarching Memorandum of Agreement (MOA) was signed in January 2004. This appendix enables the Departments to build a single Federal pricing catalog that will be searchable and on-line for their respective customers. Data mapping was to be completed by December 2004. The resultant product is to be released by February 2005. It is expected that this initiative will have the effect of leveraging both Departments' buying power, eliminate duplication and accelerate the conversion process.

The Departments are working to eliminate duplicate contracting vehicles. At the end of Fiscal Year 2004, VA and DoD had a total of 14 joint contracts in place. Eight are for radiation oncology, five are for high-tech medical equipment maintenance and related services, and one is for vital signs monitors. VA and DoD are working on a joint procurement for surgical instruments and are in the process of transitioning VA requirements to DoD's 23 medical equipment contracts, which is expected to be completed by December 31, 2004. With the process in place and through a strong commitment to working together, VA and DoD continue to identify potential joint contracting opportunities in the medical/surgical and medical equipment areas.

B. Examples of sharing activities are:

- Fort Knox, and Louisville VA Medical Center (VAMC), KY. Louisville VAMC and Ft. Knox have recently developed a VA/DoD sharing agreement which staffs a mobilization/demobilization clinic to medically process Reserve and National Guard soldiers to Ireland Army Community Hospital (IACH). It is estimated that IACH will process more than 26,000 soldiers during the next fiscal year. Louisville VAMC and IACH are also working to establish a PTSD treatment center located at the mobilization/demobilization clinic.

- Charleston VAMC and Charleston Naval Hospital, SC. Charleston VAMC has received approval to activate a new Community Based Outpatient Clinic (CBOC), which will be located within the new Naval ambulatory care facility at the Naval Weapons Station in Goose Creek, SC. VA also has an approved minor construction project to construct this new CBOC. All design and construction efforts are being coordinated by the Navy. VA design funds have been transferred to the Navy for this project. VA has been an active participant in all design efforts. Charleston VAMC and Navy staff feel there are significant sharing opportunities, especially for ancillary (laboratory and radiology) services with this project. VA Medical Center Charleston, SC, continues to operate a CBOC in leased space within Beaufort, SC, Naval Hospital.

- Central Alabama Veterans Health Care System (CAVHCS) and Maxwell Air Force Base, AL. CAVHS relocated its West Campus Podiatry Clinics to Maxwell AFB. This program will provide comprehensive care to our veterans, Air Force personnel and their dependents. The new clinic space allows CAVHCS to treat additional veterans and DoD beneficiaries within existing staffing resources. CAVHCS podiatry clinics are now able to provide additional innovative services such as a high-risk foot clinic at Maxwell. This clinic was developed as part of an integrated model of care to address the needs of a large diabetic population at high risk of amputation. This venture lays the foundation for sharing and the expansion of other agreements with Maxwell.

- VA Puget Sound Health Care System (VAPSHCS) and Madigan Army Medical Center (MAMC), WA. The successful transfer of the inpatient ward and staffing from VAPSHCS to MAMC is credited with a year long joint planning effort. As planned, this project has improved the health care, safety and convenience for VA patients in the South Sound (WA) area, while avoiding costly VA inpatient seismic upgrades. It has also drastically improved MAMC's Graduate Medical Education program both in terms of numbers of specialty cases and complexity of care. Consensus was achieved between both Human Resources Departments and three separate labor unions for policies related

to staffing, replacement hiring practices, training, leave scheduling, and timekeeping.

- Anchorage VA and Elmendorf Air Force Base, AK. VA has approved the design of a new clinic to be constructed next to the VA/DOD Joint Venture Hospital on Elmendorf AFB. The new VA clinic will be approximately 175,000 gross square feet. Completion is planned by FY2009. The Alaska VA and the 3rd Medical Group Hospital have identified key areas where integration can take place in the hospital that will have a positive impact on joint operations, and reduce the square footage requirements of the new clinic. The areas under study include: central sterile supply, warehouse, bio-medical services, laboratory, radiology, operating room, and library functions.

- Anchorage VA, and Bassett Army Community Hospital (BACH), Fairbanks, AK. VA had 62 admissions to BACH and purchased ancillary care (pharmacy, radiology, and lab) in support of 8,000 VA clinic visits provided at the VA CBOC housed within the hospital. VA and Army are working together to expand VA clinic space with the opening of the new BACH scheduled to open in FY 2006. At that time the VA clinic space will expand from the current 1,911 square feet to over 3,000 square feet of clinic space. It is estimated that VA will increase enrollment within the clinic from the current 1,500 patients to nearly 2,600 patients.

C. VA Participation in TRICARE

Funds generated from TRICARE patients provide benefits to VA beneficiaries, such as adding additional services and providing extended access hours for care. Eighty-six VAMCs reported reimbursable earnings during the year. VA has a performance goal that eighty percent of its medical centers participate in TRICARE networks in FY 2005.

D. Education and Training Agreements

There are 210 VA/DoD agreements involving education and training support, including training for physicians and nurses. These agreements typically involve training opportunities in exchange for staffing assistance. Most agreements are between VAMCs and reserve units. Under a typical agreement, a VAMC provides space for weekend training drills and, in return, the VAMC receives staffing support. Erie, PA, VAMC, for example, provides use of its dental office and laboratories for the US Navy and Marine Corps Center, Erie, PA, for health care services. The Salisbury, NC, VAMC provides training for nursing assistants for the 3297th US Army Hospital, Charlotte, NC, in return for staff support. Tampa, FL, VAMC provides space for physical therapy training for the National AMEDD (Army Medical Department) Augmentation Detachment, Ft. McPherson, GA, in return for staff support.

E. Seamless Transition of Returning Service Members to VA

In 2003, the VA Under Secretary for Health and the VA Under Secretary for Benefits charged a task force to formally work on coordination activities for the seamless transition of returning service members. The group was charged to coordinate and streamline Veterans Benefits Administration (VBA) and VHA activities as well as work with DoD on long-range initiatives.

The Task Force has made strides toward the seamless transition of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) service members into civilian life. It has also encountered roadblocks that have served as "Lessons Learned" in the road toward achieving the goal of seamless transition. These accomplishments and Lessons Learned are valuable ones, and form the foundation for the future plans.

As of the end of July 2004, 168,528 Iraqi Freedom veterans and 45,880 Enduring Freedom veterans who served in a combat theater have separated from the military. Sixteen percent of OIF veterans and eleven percent of OEF veterans have sought VA health care since deployment. A higher percentage of active duty troops (23 percent) have sought VA health care than Reservist/National Guard personnel (13 percent). Recent war veterans are presenting to VA with a wide range of both medical and psychological conditions. At present, no unusual health problems stand out. The most common health problems of war veterans have been musculoskeletal ailments, principally joint and back disorders, and dental problems.

Case management activities for the year were:

- Seven full-time social workers have been assigned to major MTFs including Walter Reed Army Medical Center, Washington, DC, and National Naval Medical Center, Bethesda, MD. They assisted the MTF treatment team with discharge planning activities, provided an orientation to VA for service members, and expedited transfer of care and enrollment to VA medical facilities.
- VA case management guidance and a cover memo signed were updated and redistributed to VA medical facilities in February.
- VBA assigned full-time benefits counselors to Walter Reed and assigned a part-time employee to Bethesda Naval Medical Center. A full-time supervisor from VBA was detailed and permanently assigned in July 2004 to Walter Reed.
- VBA appointed a point of contact (POC) at each VBA regional office. VBA case managers are also assigned for each MTF.
- Each VA medical facility named a POC to work with VA social workers, as necessary, and coordinate with their local VBA staff. This list has been shared with all VA medical facilities, with the VA social worker liaisons, and with VBA.
- VA's Social Work Service and VA's Employee Education Service are developing a new veterans health initiative (VHI) to help VA staff better understand what it was like to serve in the military. The new military experience sensitization module will help all clinical staff provide better care to veterans, including taking a better military history. The project is to be completed in early 2005.
- The Seamless Transition Task Force briefed the HEC and the JEC regarding the goals of the Task Force, activities, and ongoing issues needing resolution. As a result of the meetings, DoD leadership agreed to review VA information requirements and formed a task force to review options for expediting electronic transfer of patient health records.

V. OTHER PLANNING AND ACTIVITIES INVOLVING EITHER DEPARTMENT IN PROMOTING COORDINATION

A. FY 2003 NDAA VA-DoD initiatives are:

1. DoD/VA Health Care Sharing Incentive Fund (Section 721): Section 721, FY 2003 NDAA, requires a fund to be established to "carry out a program to identify, provide incentives to, implement, fund, and evaluate creative coordination and sharing initiatives at the facility, interregional, and nationwide levels." Both Departments contributed $15 million to the fund in FY 2004. A charter was approved and implementation guidelines developed for administration of the JIF in July 2004. The VA-DoD Financial Management Work Group (FMWG) received 58 proposals in response to the initial call for proposals. The FMWG approved 29 of these proposals to proceed to the second round. In the second round, 19 projects were scored and 12 recommended for funding at a total cost of $29.9 million. Funding will be allocated to the selected projects upon certification that they are self sustaining. Proposals recommended for funding involve a wide range of services including various tele-health projects, women's health services, a joint cardiac catheterization lab, a joint dialysis unit and the opening of a joint clinic.

2. Health Care Resources Sharing and Coordination Project (Section 722): This section requires the two Departments to conduct at least three coordinated management systems demonstration projects. At least one of the following elements is to be tested: budget and financial management, staffing and assignment system, medical information and information technology.

Seven sites are participating:

- Budget and financial management systems:
  - VA Pacific Islands Health Care System and Tripler Army Medical Center (HI);
  - Alaska VA Health Care System and 3rd USAF Medical Group (AK);
- Coordinated staffing and assignment systems:
  - Augusta VA Medical Center and Eisenhower Army Medical Center (GA)
  - Hampton VA Medical Center and the 1st USAF Medical Group (VA)
- Medical information/information technology management systems:
  - Puget Sound Health Care System and Madigan Army Medical Center (WA)
  - El Paso VA Health Care System and William Beaumont Army Medical Center (TX)
  - South Texas VA Health care System, Wilford Hall Medical Center, and Brooke Army Medical Center (TX).

Each Department made $6 million available to the seven sites in FY 2004, and are required to contribute $9 million in Fiscal Years 2005 through 2007. Additionally, the HEC has assigned oversight of these projects to the Joint Utilization/Resource Sharing Work Group, which is comprised of subject matter experts from both Departments, including the Military Services and representatives from each of the demonstration sites. Each site developed a detailed business plan in coordination with the work group. Funding was distributed to each of the seven sites based on cost information provided to the Joint Utilization/Resource Sharing Work Group. The Government Accountability Office (GAO) has been auditing the implementation of the pilot projects. GAO reviewed these proposals in August 2004. As part of this audit, GAO reviewed all of the Business Plans. The pilot programs will be implemented by October 1, 2004, in accordance with NDAA FY 2003 requirements.

3. GME Pilot Program (Section 725): DoD encouraged Military Service sponsored trainees in civilian graduate medical education (GME) programs to select programs in which VA also sponsors trainees. DoD and VA jointly track progress in this area. DoD, through the Military

Services, sponsored both Service-specific and integrated GME programs within the direct care system. With the exception of a small number of fellowships, VA does not directly sponsor GME training programs. However, VA does sponsor FTE positions in civilian GME programs. Public Law 107-314, section 725 states "The Secretary of Defense and the Secretary of VA shall jointly carry out a pilot program under which graduate medical education and training is provided to military physicians and physician employees of DoD and VA through one or more programs carried out in MTFs and VA Medical Centers. The pilot program shall begin not later than January 1, 2003." To comply with these requirements, multiple options are being pursued. VA sponsored trainees in DoD programs at two sites: William Beaumont Army Medical Center, (10 trainees in internal medicine and orthopedics) and Madigan Army Medical Center (2 trainees in geriatrics). For academic year 2003-2004, VA and DoD sponsored at least one or more trainee in 73 different civilian training programs. DoD sponsored 89 military trainees at these sites (Navy 34, Army 18, and Air Force 37).

To facilitate increased number of trainees in future years, VA provided a list of GME programs in which VA sponsors trainees to the GME offices of the Military Services to aid trainees who have been approved for sponsored civilian training. Additionally, the Rules of Engagement for the Joint Service GME Selection Board have been revised to encourage selection of programs in which VA participates.

At least 15 of the 213 military GME programs within the direct care system currently incorporate rotations at VA hospitals as part of their core training curriculum. Program directors will continue to give priority to VA facilities as sites for training when any revision of training curriculum occurs in the future. VA and DoD are considering identifying training positions that could be filled by Military Service-sponsored military trainees at civilian training programs where VA sponsors GME trainees for considered critically short DoD specialties.

VI. PROMOTING COORDINATION AND SHARING OF FEDERAL HEALTH CARE RESOURCES.

The 2004 TRICARE Conference featured a full track on collaboration between VA and DoD. Among the ten sessions offered were presentations on "DoD/VA Collaboration – The Way Ahead," "the VA DoD Joint Strategic Plan," "Demonstration Site Selection Process," and "VA/DoD Interoperability Update." Each presentation was co-presented by VA and DoD staff.

VA sponsored "VA and DoD Explore New Partnerships" a three-day conference, held April 20-22, 2004, in New Orleans, LA, that provided a forum for VA medical facilities, VISNs, MTFs, administrative commands, and TRICARE contractors to discus opportunities associated with direct resource sharing agreements and VA's participation in TRICARE networks. Approximately 300 representatives from the two Departments attended this conference.

The Air Force sponsored a two-day session, in February 2004, at Albuquerque, NM, on joint ventures. The theme for this session centered on "best practices" to standardize policies and practices.

VII. RECOMMENDATIONS FOR LEGISLATION

There are no recommendations for legislation.

MEMORANDUM OF UNDERSTANDING BETWEEN
THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF DEFENSE

VA/DoD HEALTH CARE RESOURCES SHARING GUIDELINES

ARTICLE I

INTRODUCTION

1-101 Purpose. This agreement establishes guidelines to promote greater sharing of health care resources between the Veterans Administration (VA) and the Department of Defense (DoD). Maximization of sharing opportunities is strongly encouraged. Greater sharing of health care resources will result in enhanced health benefits for veterans and members of the armed services and will result in reduced costs to the government by minimizing duplication and underuse of health care resources. Such sharing shall not adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency. In addition, these guidelines are not intended to interfere with existing sharing arrangements.

1-102 Authority. These guidelines are established by the Administrator of Veterans Affairs and the Secretary of Defense pursuant to "The Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," Public Law 97-174, §3, 96 Stat. 70, 70 - 73 (1982) (codified at 38 U.S.C. §5011).

ARTICLE II

DEFINITIONS

2-101 "Actual Cost" means the cost incurred in order to provide the health care resources specified in a sharing agreement.

2-102 "Reimbursement Rate" means the negotiated price cited in the sharing agreement for a specific health care resource. This rate will take into account local conditions and needs and the actual costs to the providing facility or organization for the specific health care resource provided. For example, actual cost includes the cost of communications, utilities, services, supplies, salaries,

depreciation, and related expenses connected with providing health care resources. Excluded from the reimbursement rate are building depreciation, interest on net capital investment and overhead expenses incurred at management levels above the medical facility or other organization providing the health care resources (e.g., Pentagon and Central Office overhead). Equipment depreciation is a component of actual cost to be considered in establishing a reimbursement rate, but facilities are strongly encouraged to exclude it. This rate will be used for billing purposes by the providing medical facility or organization.

2-103 "Beneficiary" means a person who is a primary beneficiary of the VA or DoD.

2-104 "Primary Beneficiary" (1) with respect to the VA, means a person eligible under title 38, United States Code (other than under sections 611(b), 613, or 5011 (d)) or any other provision of law for care or services in VA medical facilities; and (2) with respect to DoD, means a member or former member of the Armed Forces who is eligible for care under section 1074 of title 10.

2-105 "Direct Health Care" means health care provided to a beneficiary in a medical facility operated by the VA or DoD.

2-106 "Head of a Medical Facility" (1) with respect to a VA medical facility, means the director of the facility, and (2) with respect to a medical facility of DoD, means the commanding officer, hospital or clinic commander, officer in charge, or the contract surgeon in charge.

2-107 "Health Care Resource" includes hospital care, medical services, and rehabilitative services, as those terms are defined in title 38 U.S.C. §601 (5), (6), (8); any other health care service, including such health care education, training, and research as the providing agency has authority to conduct; and any health care support or administrative resource or service.

2-108 "Medical Facility" (1) with respect to the VA, means facilities over which the Chief Medical Director has direct jurisdiction; and (2) with respect to DoD, means medical and dental treatment facilities over which DOD, or its organizational elements, or the component Services, have direct jurisdiction.

2-109 "Providing Agency" means (1) the VA, in the case of care or services furnished by a facility, or organizational elements, of the VA; or (2) DoD, in the case of care or services furnished by a facility, or organizational elements of DoD, or its component Military Services.

2-110 "Sharing Agreement" means a cooperative agreement authorized by Public Law 97-174, §3, 96 Stat. 70, 70-73 (1982) (codified at 38 U.S.C. §5011 (d)) for the use or exchange of use of one or more health care resources.

ARTICLE III

SHARING AGREEMENTS

3-101 Approval Process. Before a sharing agreement may be executed and implemented, the heads of the medical facilities involved shall submit the proposed agreement to: (1) the Chief Medical Director, through the appropriate Department of Medicine and Surgery channel, in the case of the VA; (2) the Assistant Secretary of Defense (Health Affairs), or his or her designees, through the appropriate chain of command, in the case of DoD. The agreement shall be effective in accordance with its terms (A) on the 46th calendar day after receipt of the proposed agreement by the designated Department of Medicine and Surgery office on behalf of the Chief Medical Director for the VA, and the next higher organizational element within the chain of command for DoD, unless earlier disapproved by either agency; or (B) if earlier approved by both agencies on the day of such approval. An office that disapproves a sharing agreement shall send a copy of the agreement and a written statement of its reasons for disapproval to the VA/DoD Health Care Resources Sharing Committee.

3-102 Acquiring or Increasing Resources. A head of a medical facility may request permission to acquire or increase health care resources that exceed the needs of the facility's primary beneficiaries but that would effectively serve the combined needs of both agencies. Justification for acquiring or increasing resources may be based on the projected workload from a sharing agreement. Such requests will be considered in the usual planning and budgeting processes. Consideration of such requests will necessarily take into account many factors governing resource allocation. Agreements will not be submitted until permission to increase existing resources or to acquire new resources has been obtained.

3-103 Eligibility. Agreements may permit the delivery of health care resources to primary beneficiaries of one agency at facilities of the other agency. Direct health care to primary beneficiaries of the agency requesting services should be on a referral basis. Delivery of health care resources will not (as determined by the head of the facility of the providing agency) adversely affect the range of services, the quality of care, or the established priorities for care provided to beneficiaries

of the providing agency.

3-104 Reimbursement and Rate Setting. Reimbursement for the cost of health care resources provided shall be credited to funds that have been allotted to the facility or organization that provided the care or services. The medical facility or organization providing the resources shall bill the recipient facility or organization directly. Billing frequency shall be established in the agreement. Reimbursement shall be forwarded to the providing medical facility in a timely manner. Heads of medical facilities and other organizations may negotiate a reimbursement rate that is less than actual cost to the providing facility or organization to account for local conditions and needs. (See definitions of "actual costs" and "reimbursement rate" in section 2-101 and 2-102.) The reimbursement rate may not be more than the actual cost to the providing facility or organization of the resources provided.

3-105 Scope of Agreements. The head of a medical facility or organization of either agency may agree to enter into a proposed sharing agreement with the head of a medical facility or organization of the other agency in accordance with these guidelines. Sharing agreements involving more than one medical facility of each agency may be developed. The Chief Medical Director and the Assistant Secretary of Defense for Health Affairs may agree to enter into regional or national sharing agreements. Sharing agreements shall identify the health-care resources to be shared. Exchange of resources without billing is permitted if costs are specified in the agreement.

3-106 Education, Training, and Research Sharing Agreements.

1. Education and Training - Situation-specific sharing is encouraged at the local, regional, and national levels. Continuing education, formal technical training, and professional education, are areas to be emphasized.

To facilitate educational sharing the Office of Academic Affairs, Department of Medicine and Surgery, VA; and the Office of the Assistant Secretary of Defense for Health Affairs will:

a. Initiate an educational "clearing house" process to exchange information on potential sharing opportunities. This process will encourage the development of timely and effective sharing of educational and training resources.

b. Encourage an ongoing dialogue between those responsible for education and training at all levels - local, regional, and national.

2. Biomedical Research - To encourage more collaboration, an information exchange will be established. The Assistant Secretary of Defense for Health Affairs and the Chief Medical Director will designate representatives to establish such an exchange.

In joint projects or protocols involving human subjects, each agency's procedures for approval of "human studies" protocols will be followed. However, at a minimum, the Department of Health and Human Services Guidelines will be complied with. Sharing agreements involving "human studies" protocols will not be considered without approval of the protocol by both agencies.

3-107 Modification, Termination, Renewal. Each agreement shall include a statement on how the agreement may be modified and terminated. Proposed changes in the quality and quantity of resources delivered, in actual costs, and in the performance in delivering the resources are grounds for modification or termination. Sharing agreements shall provide for modification or termination in the event of war or national emergency. Agreements may exceed one year, provided necessary cost adjustment amendments are included and a statement is included in the agreement to the effect that if the contract period extends beyond the current fiscal year, the sharing agreement is subject to the availability of appropriations for the period after the first September 30 during which the agreement is in effect. Each party to the sharing agreement shall annually review the agreement to make certain that the resources being provided are in accordance with the agreement. Sharing agreements may be renewed in accordance with procedures to be established by each agency.

3-108 Reporting Requirements. The VA/DoD Health Resources Sharing Committee will retain copies of agreements for an annual report to Congress, which is required by the law. A copy of each agreement entered into or renewed will be sent by the medical facilities or organizations entering into the agreements to the VA/DoD Health Care Resources Sharing Committee. It is the VA/DoD Sharing Committee's responsibility to prepare the annual report to Congress which the Secretary of Defense and the Administrator will submit.

ARTICLE IV

AGENCY PROCEDURES

4-101 Agency Guidance. Each agency will issue implementing and operating guidance to their organizational elements and medical facilities.

4-102 Review. Both agencies agree to refer existing policies, procedures, and practices relating to sharing of health-care resources between the agencies to the VA/DoD Health Care Resources Sharing Committee for its review, which is as required by 38 U.S.C. §5011 (b)(3)A.

4-103 Quality Assurance. Agency medical facilities shall maintain utilization review and quality assurance programs to ensure the necessity, appropriateness, and quality of health care services provided under this agreement. The content and operation of these programs shall, at a minimum, meet the requirements and guidelines set forth in the most recent editions of the Joint Commission on Accreditation of Hospitals accreditation manuals.

ARTICLE V

EFFECTIVE DATE, MODIFICATION, AND TERMINATION OF GUIDELINES

5-101 Duration. This memorandum becomes effective on the date of the last signature. Either party may propose amending these guidelines, but both must agree for amendments to take effect. Either party may terminate these guidelines upon 30 days written notice to the other party.

Harry N. Walters
(Signature)
JUL 1 - 1983

Gaspar W. Kenberger
(Signature)
29 JUL 1983

APPENDIX B VA/DOD Sharing Agreements/Tricare Contracts
Total Services by Provider of Care

Active as of 9/30/2004

VA DOD Sharing Agreements

Provided by Department of Veterans Affairs

Total	**2,021**
Administration	37
Administration(VA)	1
Alcohol Abuse	2
Allergy	1
Allergy Clinic	1
Ambulatory Care Administration	11
Ambulatory Special Procedures	16
Anatomical Pathology	3
Anesthesiology	5
Area Dental Prosthetic Laboratory (Type 1)	2
Area Reference Laboratories	1
Associated Health Staffing	62
Audiology Clinic	31
Autopsy	1
Biomedical Equipment	8
Biomedical Equipment Repair - Contract	2
Blood Bank	4
Bone Marrow Transplant	1
Cardiac Catheterization	2
Cardiology Clinic	22
Cardiology Inpatient	2
Cardiovascular Thoracic Surgery	5
Central Sterile Supply	2
Clinical Dietetics	1
Clinical Pathology	65
Command	1
Communications	5
Community Health Clinic	1
Comp-Pension Exams	12
Continuing Health Education	2
Contract Services	36
CT Scans	23
Dental Depreciation	2
Dental Examination	40
Dental Laboratory	41
Dental Services	111
Dermatology	15
Diabetic Clinic	2
Diagnostic Test	6
Dietetics	1
Domiciliary Bed Section	2
Drug Screening and Testing	2
Education and Training	92

VA DOD Sharing Agreements

Provided by Department of Veterans Affairs

EEG	8
EKG	23
Emergency Medical Clinic	18
EMG	8
Endocrinology	12
Endocrinology (Metabolism) Clin	3
Engineering Support	4
ENT	6
Environmental Health Program	2
Equipment (medical)	10
Equipment (Other)	5
Family Planning Clinic	2
Family Practice Obstetrics	1
Family Practice Psychiatry	6
Field Studies	1
Food Operations	2
Gastroenterology	10
Groundskeeping	1
Gynecology-Inpatient	15
Gynecology-Outpatient	16
Hematology-Inpatient	9
Hematology-Outpatient	7
Hemodialysis	2
Histology	1
HIV Testing	8
Housekeeping	2
Immunizations	4
Immunizations-Hepatitis	1
Infectious Disease-Inpatient	3
Infectious Disease-Outpatient	4
Information Systems	3
Inpatient Care	4
Intermediate Care	1
Internal Medicine	2
Laboratory testing	23
Laundry	21
Lease of Real Property	7
Library Services	1
Maintenance of Real Property	14
Mammography	13
Materiel Services	4
Medical Care (Other)	13
Medical Clinics (Other)	15
Medical Examination	66
Medical Intensive Care Unit	17
Medicine Clinic	15
Mental Health Inpatient	21
Mental Health Outpatient	14
Mental Health Services	2

VA DOD Sharing Agreements

Provided by Department of Veterans Affairs

Military Patient Personnel Administration	3
MRI	19
Nephrology Clinic	2
Neurology	18
Neurology Clinic	18
Neurosurgery	3
Neurosurgery Clinic	1
Non-health related Training	3
Nuclear Medicine	18
Nuclear Medicine (Therapeutic)	1
Nurse Staffing	41
Nursing Home Care	7
Nursing Training	80
Nutrition Clinic	8
Obstetrics	1
Obstetrics Clinic	1
Occupational Therapy Clinic	7
Oncology	4
Operating Room Suite	5
Ophthalmology	4
Ophthalmology Clinic	6
Optometry	30
Oral Surgery	11
Orthopedics	7
Orthopedics Clinic	13
Otolaryngology	3
Otolaryngology Clinic	4
Pathology	3
Patient Food Operations	1
Patient Transportation	4
Pediatric Care	1
Peripheral Vascular Surgery	1
Pet Scans	2
Pharmacy	36
Pharmacy Technician	1
Physical Exam	4
Physical Medicine	8
Physical Therapy Clinic	22
Physician Assistant	3
Physician Staffing	22
Physician Training	35
Plastic Surgery	2
Podiatry Clinic	21
Police Protection	1
Pre-Discharge Physical	1
Primary Care	4
Primary Care Clinics	10
Proctology	1
Prosthetics/Orthotics	15

VA DOD Sharing Agreements

Provided by Department of Veterans Affairs

Psychiatric Clinic	21
Psychiatric -Inpatient	1
Psychiatric Interviews and Observations	2
Psychiatrist Staffing	5
Psychology Clinic	7
psychology staffing	2
PTSD Residential Rehabilitation Domiciliary	1
Pulmonary Disease Clinic	11
Pulmonary Function	6
Pulmonary/Upper Resp Disease	1
Radiation Health	8
Radiology	62
Radiology (Therapeutic)	4
Recovery Room	2
Rehab & Spt Services	5
Rehabilitation	13
Research Support	2
Respiratory Therapy	4
Rheumatology-Inpatient	2
Rheumatology-Outpatient	3
Sick Call	1
Signage	1
Sleep Laboratory	2
Social Work Clinic	3
Space	10
Speech Pathology Clinic	12
Spinal Cord Injury	9
Sterile Processing	1
Substance Abuse Clinic	7
Substance Abuse-Inpatient	13
Surgery Clinic	34
Surgery Recovery Room	19
Surgical Care (Other)	10
Surgical Intensive Care Unit	18
Technician Staffing	5
Technician Training	14
Tele-Dermatology	1
Tonometry	5
Toxicology	1
Transportation	7
Ultrasound	3
Urology	16
Urology Clinic	19

VA DOD Sharing Agreements

Provided by DOD

AIR FORCE	Total	91
Administration		2
Ambulatory Care Administration		1
Anesthesiology		1
Associated Health Staffing		1
Audiology Clinic		1
Cardiac Catheterization		1
Cardiology Clinic		1
Clinical Pathology		3
Communications		2
Comp-Pension Exams		1
CT Scans		2
Dental Services		1
Education and Training		2
EEG		1
EKG		1
Emergency Medical Clinic		2
EMG		1
Equipment (Other)		1
Family Practice Newborn Nursery		1
Family Practice Obstetrics		1
Family Practice Pediatrics		1
Gynecology-Inpatient		1
Gynecology-Outpatient		1
Hyperbaric Medicine		3
Mammography		1
Medical Care (Other)		2
Medical Clinics (Other)		1
Medical Intensive Care Unit		1
Medicine Clinic		2
Mental Health Inpatient		1
Mental Health Outpatient		1
MRI		2
Neonatal Intensive Care Unit		1
Nephrology Clinic		1
Neurology		1
Neurosurgery		1
Neurosurgery Clinic		1
Non-health related Training		1
Nuclear Medicine		1
Nurse Staffing		2
Obstetrics		1
Obstetrics Clinic		1
Oncology		1
Ophthalmology		1
Optometry		2
Orthopedics		1
Orthopedics Clinic		1

VA DOD Sharing Agreements

Provided by DOD

Otolaryngology		1
Otolaryngology Clinic		2
Pharmacy		3
Physical Therapy Clinic		1
Physician Assistant		1
Physician Staffing		4
Physician Training		1
Primary Care Clinics		1
Prosthetics/Orthotics		1
Radiology		4
Surgery Clinic		3
Surgery Recovery Room		2
Surgical Care (Other)		2
Surgical Implants		1
Surgical Intensive Care Unit		1
Urology		1
Urology Clinic		1
AIR FORCE RESERVE	**Total**	**20**
Administration		1
Associated Health Staffing		2
Education and Training		3
Equipment (medical)		1
Nurse Staffing		3
Nursing Training		5
Physician Staffing		1
Physician Training		1
Space		1
Technician Training		2
AIR NATIONAL GUARD	**Total**	**16**
Administration		1
Associated Health Staffing		2
Education and Training		4
Nurse Staffing		2
Nursing Training		5
Physician Training		2
ARMY	**Total**	**68**
Administration		3
Ambulatory Care Administration		1
Audiology Clinic		2
Biomedical Equipment		1
Blood Bank		2
Central Sterile Supply		1
Clinical Immunology		1
Clinical Pathology		1
Command		2
Communications		1
Community Health Clinic		1
CT Scans		1

VA DOD Sharing Agreements

Provided by DOD

Education and Training		2
Engineering Support		1
Environmental Health Program		2
Equipment (medical)		1
Equipment (Other)		1
Fire Protection		2
Gynecology-Inpatient		2
Gynecology-Outpatient		2
Housekeeping		2
Information Systems		1
Inpatient Care		1
Internal Medicine		1
Laboratory testing		2
Laundry		1
Lease of Real Property		1
Maintenance of Real Property		4
Medical Clinics (Other)		1
Nurse Staffing		2
Nursing Training		2
Nutrition Clinic		1
Obstetrics		1
Obstetrics Clinic		1
Ophthalmology Clinic		1
Orthopedics		1
Otolaryngology Clinic		1
Pharmacy		2
Physician Staffing		1
Physician Training		1
Police Protection		2
Radiology		2
Social Work Clinic		1
Space		1
Space Management		1
Surgery Clinic		1
Technician Staffing		1
Transportation		1
ARMY NATIONAL GUARD	**Total**	**12**
Administration		1
Associated Health Staffing		3
Education and Training		3
Nursing Training		2
Physician Staffing		1
Physician Training		1
Transportation		1
ARMY RESERVE	**Total**	**68**
Administration		3
Area Reference Laboratories		1
Associated Health Staffing		7

VA DOD Sharing Agreements

Provided by DOD

Biomedical Equipment Repair - Contract		1
Clinical Pathology		1
Education and Training		14
Engineering Support		1
Lease of Real Property		1
Maintenance of Real Property		2
Minor Construction		1
Non-health related Training		1
Nurse Staffing		5
Nursing Training		13
Patient Food Operations		1
Physician Staffing		3
Physician Training		10
Radiology		1
Technician Staffing		1
Utilities		1
COAST GUARD	**Total**	**1**
Maintenance of Real Property		1
DEPARTMENT OF DEFENSE	**Total**	**2**
Command		1
Prosthetics/Orthotics		1
NAVAL RESERVE	**Total**	**43**
Anesthesiology		1
Associated Health Staffing		6
Education and Training		6
Emergency Medical Clinic		1
Maintenance of Real Property		1
Medical Examination		1
Mental Health Inpatient		1
Non-health related Training		1
Nurse Staffing		7
Nursing Training		9
Operating Room Suite		1
Pharmacy		2
Physician Staffing		3
Physician Training		3
NAVY (BUMED)	**Total**	**57**
Administration		1
Anatomical Pathology		1
Cast Clinic		1
Clinical Pathology		3
Dental Services		1
Education and Training		1
EEG		1
EKG		1
Emergency Medical Clinic		2
EMG		1
Fire Protection		1

VA DOD Sharing Agreements

Provided by DOD

Housekeeping		1
Immunizations		1
Laboratory testing		2
Mammography		1
Medical Care (Other)		2
Medical Clinics (Other)		2
Medical Examination		1
Medical Intensive Care Unit		1
Medicine Clinic		1
Mental Health Inpatient		1
Mental Health Outpatient		1
MRI		1
Operation of Utilities		1
Optometry		1
Pharmacy		3
Physical Exam		1
Physical Therapy Clinic		1
Physician Training		2
Podiatry Clinic		1
Primary Care		1
Primary Care Clinics		2
Psychiatric Clinic		1
Radiology		4
Recovery Room		1
Social Work Clinic		2
Surgery Clinic		2
Surgery Recovery Room		1
Surgical Care (Other)		3
Surgical Intensive Care Unit		1
NAVY (OTHER)	**Total**	**4**
Cast Clinic		1
Engineering Support		1
Maintenance of Real Property		1
Materiel Services		1
	Grand Total	**382**

Tricare Contracts

Provided by Department of Veterans Affairs

	Total	1,885
Administration		32
Administration(VA)		1
Allergy		5
Allergy Clinic		4
Ambulatory Care Administration		33
Ambulatory Special Procedures		43
Anatomical Pathology		4
Anesthesiology		10
Audiology Clinic		40
Blood Bank		3
Bone Marrow Transplant		5
Burn Unit		4
Cardiac Catheterization		2
Cardiology Clinic		7
Cardiovascular Thoracic Surgery		2
Clinical Dietetics		7
Clinical Immunology		4
Clinical Pathology		61
Cobalt Treatment		1
Community Health Clinic		1
Continuing Health Education		1
Coronary Care Unit		1
CT Scans		18
Dental Examination		1
Dental Laboratory		1
Dental Services		6
Dermatology		7
Diabetic Clinic		2
Domiciliary Substance Abuse		2
Drug Screening and Testing		1
EEG		16
EKG		19
Emergency Medical Clinic		10
EMG		6
Endocrinology		4
Endocrinology (Metabolism) Clin		5
EPT		3
Family Planning Clinic		3
Family Practice Newborn Nursery		1
Family Practice Obstetrics		1
Family Practice Pediatrics		2
Family Practice Psychiatry		22
Family Practice Surgery		1
Gastroenterology		8
Geriatric Evaluation		1
Gynecology-Inpatient		33
Gynecology-Outpatient		35

Tricare Contracts

Provided by Department of Veterans Affairs

Otolaryngology	3
Otolaryngology Clinic	2
Pathology	4
Patient Food Operations	2
Patient Transportation	3
Pediatric Care	1
Pediatric Intensive Care Unit	2
Pediatric Surgery	1
Pet Scans	2
Pharmacy	19
Physical Medicine	40
Physical Therapy Clinic	47
Plastic Surgery	2
Plastic Surgery Clinic	1
Podiatry Clinic	2
Preventive Medicine	4
Primary Care	3
Primary Care Clinics	49
Proctology	1
Proctology Clinic	1
Prosthetics/Orthotics	13
Psychiatric Clinic	58
Psychiatric -Inpatient	2
Psychiatric Interviews and Observations	1
Psychology Clinic	58
PTSD Clinical Team	3
PTSD Residential Rehabilitation Domiciliary	2
Pulmonary Disease Clinic	6
Pulmonary Function	5
Pulmonary/Upper Resp Disease	3
Radiation Health	4
Radiology	70
Radiology (Therapeutic)	5
Recovery Room	1
Rehab & Spt Services	7
Rehab Counseling	3
Rehabilitation	47
Respiratory Therapy	11
Rheumatology-Inpatient	6
Rheumatology-Outpatient	6
Sleep Laboratory	1
Social Work Clinic	9
Speech Pathology Clinic	17
Spinal Cord Injury	9
Substance Abuse Clinic	61
Substance Abuse Disorder Clinic	4
Substance Abuse-Inpatient	69
Surgery Clinic	70
Surgery Recovery Room	16

Tricare Contracts

Provided by Department of Veterans Affairs

Surgical Care (Other)	47
Surgical Intensive Care Unit	40
Toxicology	1
Ultrasound	4
Urology	6
Urology Clinic	9

A	B	C	D	E	F	G
Short Title of Report:	FY 2004 VA/DoD Health Resources Sharing Report					
Report Required by:	Title 38 USC 8111 (f)					
Section 1 - Manpower Estimate						
Grade Level	Hourly Rate[1]	Benefits Percent[2]	Salary + Benefit Rate	Approx. Number of Hours[3]	Subtotal (DxE)	
	$53.10	25.10%	$ 66.43	100.0	$6,643	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
		25.10%	$ -		$0	
Subtotal - Manpower				100	$6,643	
[1] Calculate this by dividing the annual salary rate by 2080 hours.						
[2] For FY 2003, use 25.56%; for FY 2004, use 25.10%.						
[3] Include all effort required to prepare the report. Once it moves forward in the supervisory chain for review and signature, do not include any of this effort in the cost.						
Section 2 - Contract Costs						
Type of Contract					Cost	
Subtotal - Contract(s)						
Section 3 - Other						
					Cost	
Identify_____						
Subtotal - Other						
Total Estimated Cost to Prepare Report:					**$ 6,642.81**	