Department of Veterans Affairs **VHA HANDBOOK 0320.04**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **December 26, 2007**

DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE CONTINGENCY PLAN

1. REASON FOR ISSUE. This revised Veterans Health Administration (VHA) Handbook defines VHA's role in the Department of Veterans Affairs (VA)-Department of Defense (DOD) Contingency Plan.

2. SUMMARY OF CONTENTS/MAJOR CHANGES. This is a new VHA Handbook which provides implementation guidance for the activation and operation of the VA-DOD Contingency Plan.

3. RELATED ISSSUE. VHA Directive 0320.

4. RESPONSIBLE OFFICE. Chief, Public Health and Environmental Hazards (13), is responsible for the contents of this VHA Handbook. Questions may be addressed to (304) 264-4800.

5. RESCISSION. None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last day of December 2012.

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook outlines how VHA supports the Department of Defense (DOD) during armed conflicts or national emergencies.

2. BACKGROUND

a. The Department of Veterans Affairs (VA)-DOD Health Resources Sharing and Emergency Operations Act (Public Law 97-174) was enacted on May 4, 1982. Under this statute, VA serves as the principal health care backup to DOD during and immediately following a period of war or a period of national emergency declared by the President or the Congress that involves the use of Armed Forces in armed conflict. In addition to the contingency mission, this public law amended Title 38, United States Code to promote greater peacetime sharing of health care resources between VA and DOD.

b. In response to Public Law 97-174, a Memorandum of Understanding was established in 1982 to specify each agency's responsibilities. It was revised as a Memorandum of Agreement (MOA) in November 2006, signed by the Secretaries of Defense and VA. The MOA establishes a "VA-DOD Contingency Plan." The current plan is in Appendix A of the MOA, but is subject to change pursuant to paragraph 4.4 of that MOA.

c. During a period of war or national emergency that involves armed conflict, the Commander of the United States (U.S.) Northern Command is responsible for integrated Continental U.S. (CONUS) military medical operations. Pursuant to the MOA, VHA may support the U.S. Northern Command in this effort.

3. TERMS

a. **Available Beds.** Available beds are the beds that are vacant as of 12 midnight on the day previous to the day of the report, to which the DOD Global Patient Movement Requirements Center (GPMRC) can regulate and to which patients can immediately be transported. They must be in a functioning medical treatment facility set up and ready for all aspects for the care of a patient. Available beds must include supporting space, equipment, medical material, ancillary and support services and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. Beds are reported in categories as instructed by GPMRC.

b. **Bed Report.** The bed report is the submission of a medical facility’s real-time capacity to receive, admit, and treat patients from a disaster or war, or the submission of a Primary Receiving Centers (PRCs) capacity for hospitalization.

c. **Burns (SBN).** SBN is the U.S. Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES) code referring to patients having burn injuries meeting

the American Burn Association's (ABA) burn unit referral criteria, including, but not limited to: partial thickness burns of 10 percent or more of the total body surface; all patients with third-degree burns of 10 percent or more of the total body surface; or patients with significant burns involving the face, hands, feet, genitalia, perineum or major joints. Burn beds are generally defined as those associated with burn centers on the joint ABA and American College of Surgeons (ACS) verification list.

d. **Capability.** Capability equals the maximum number of patients a facility can accommodate.

e. **Capacity.** Capacity equals the number of patients that a facility can accommodate at a given point in time.

f. **Category.** Category is a specific areas of medical care, used to identify the nature of a patient's illness or injury, as well as to identify the capability and capacity of a medical facility. The five contingency categories (as well as their TRAC2ES codes in parentheses) are:

(1) Critical Care (CC),

(2) Medical and Surgery (MM-SS),

(3) Psychiatry (MP),

(4) Burns (SBN), and

(5) Pediatrics (MC).

g. **Critical Care (CC).** CC refers to an adult or pediatric patient requiring sophisticated intervention to restore or maintain life processes to the patient's dynamic equilibrium. This involves the requirement to provide immediate and continuous attention and monitoring using specialized facilities, equipment and personnel. ***NOTE:*** *CC beds are generally defined as those in licensed intensive care units.*

h. **Installation Support Center (ISC).** An ISC is a VA medical center, proximal to a military installation, designated to provide health care services and other health care resource support to military forces in the event of armed conflict or national emergency.

i. **Medical Regulating.** Medical regulating refers to the actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities ensuring that bed space is available.

j. **Medical and Surgery (MM-SS).** MM-SS beds are for patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. MM-SS beds are generally defined as those licensed, certified, or otherwise authorized, with adequate space, equipment, medical materiel, and ancillary support services,

and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

k. **Patient Movement Items (PMI).** Medical equipment and supplies used by the DOD to support a patient during evacuation are referred to as PMI. PMI must be certified for use in DOD aircraft by DOD testing agencies.

(1) When a patient requires evacuation, it is generally the originating medical facility's responsibility to provide the PMI required to support the patient during evacuation. PMI often accompanies a patient through numerous stops and layovers from the originating medical facility to the destination medical facility.

(2) The PMI system:

(a) Supports in-transit medical capability without removing equipment from patients,

(b) Works to exchange in-kind PMI without degrading medical capabilities, and

(c) Provides prompt recycling of PMI. ***NOTE:*** *During a contingency, the U.S. Air Force may establish a PMI Cell in the vicinity of the PRC in order to assist with the tracking, refurbishment, redistribution, and return of PMI collected from destination medical facility.*

l. **Patient Reception Area (PRA).** PRA is a geographic locale containing: one or more airfields, adequate patient staging facilities, and adequate local patient transport assets to support DOD patient reception and transport to VA medical centers and/or to local healthcare providers capable of providing care.

m. **Primary Receiving Center (PRC).** A PRC is a Military Medical Treatment Facility (MTF) or VA Medical Center designated for coordinating and providing treatment to sick and wounded military personnel returning from armed conflict or national emergency. PRCs may be designated as Federal Coordinating Centers of the National Disaster Medical System.

(1) **Primary Receiving Center (PRC) Director.** The PRC Director is a military medical treatment facility commander, medical center Director, or other individual responsible for the management of a PRC and associated patient reception area(s).

(2) **Primary Receiving Center (PRC) Coordinator.** The PRC Coordinator is a DOD, VA, or other principal staff officer assigned to assist the PRC Director.

n. **Patient Reception Team (PRT).** The PRT is a multi-function group established to stage patients received at airfields, train stations, or bus depots, and to assist with the transport of patients from these locations to medical centers. The PRT consists mainly of clinical staff, but includes appropriate support from medical administration and communications personnel, logistics personnel, litter bearers, and drivers.

o. **Pediatrics (MC).** MC is the TRAC2ES code referring to patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.

p. **Psychiatry (MP).** MP is the TRAC2ES code referring to patients who require specialized psychiatric care in a medical treatment facility, including patients with disorders defined by the American Psychiatric Association as severe mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism). Psychiatric beds are generally defined as those supported by a licensed psychiatrist, or a licensed practical nurse, registered nurse, social worker, psychologist or professional counselor when those services are part of a treatment plan authorized by a licensed psychiatrist.

` q. **Secondary Support Center (SSC).** An SSC is an MTF or VA medical center designated to accept transfers from, or sharing resources with, a PRC to maximize health care services support to DOD.

r. **Throughput.** "Throughput" means the maximum number of patients that can be received at the Patient Reception Area, off-loaded, staged, triaged, transported, and admitted to the destination medical facility(s) within any 24-hour period. It is an estimate, subjectively derived from various considerations, such as: reception site and local transportation limitations, personnel limitations for patient reception, staging and transport, as well as any other factors deemed relevant.

4. SCOPE

a. There may be little warning prior to activation of the VA-DOD Plan.

b. Activation of VA employees subject to military mobilization could occur rapidly.

c. Patients could arrive within 24 hours of activation of the VA-DOD Contingency Plan. Patients may be routed directly from a wartime theater to a civilian or military airport near the destination VA medical center, or may be transported from other DOD CONUS medical facilities.

d. Active duty patients will be placed into medical facilities that can best meet the following criteria:

(1) Capability to deliver the most appropriate medical care,

(2) Nearest to home or unit of record, and

(3) Capability to provide seamless transition from military to veteran status, if required.

e. During a time of military conflict or national emergency, VHA will provide the maximum number of staffed beds possible to active duty military patients.

f. Beds in VA medical facilities reported as available to the DOD GPMRC may be fully utilized by DOD patients.

g. VA medical facilities will receive reimbursement from the DOD for treatment provided to DOD beneficiaries in accordance with Appendix B of the VA-DOD MOA.

NOTE: *DOD patient movement operations will be supported by the TRAC2ES and the DOD Joint Patient Tracking Application (JPTA).*

5. RESPONSIBILITIES OF THE DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT

The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for:

a. Providing policy direction to ensure the successful implementation of VA-DOD Contingency Plan.

b. Providing Department-level program implementation guidance and technical assistance to VA Central Office and to the Veterans Integrated Service Networks (VISNs).

c. Promoting access to VHA health care services to active duty patients by ensuring that liaisons are assigned to military medical facilities receiving significant numbers of DOD patients. These VHA liaisons must ensure that patients receive information and counseling about VHA programs, and arrange for seamless transition into the VHA system, as required.

6. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

The VISN Director is responsible for:

a. Provide operational and policy direction to VA medical centers to ensure the successful implementation of VA-DOD Contingency Plan.

b. Monitors implementation of network and VA medical center contingency plans and implements corrective actions as necessary.

7. RESPONSIBILITIES OF THE CHIEF CONSULTANT, EMERGENCY MANAGEMENT STRATEGIC HEALTHCARE GROUP (EMSHG)

The Chief Consultant, EMSHG, is responsible for:

a. Serving as principal staff advisor in developing and maintaining the VA-DOD Contingency Plan.

b. Providing guidance and technical assistance to VA Central Office, VISNs, and medical center staff on the preparation of supporting plans.

c. Serving as the operational POC to the GPMRC.

d. Providing staffing to VHA Joint Operations Center (JOC) in order to coordinate operations with VA field elements, various DOD Headquarters, and the GPMRC.

8. VHA FACILITY DIRECTORS OF PRCS

Each VA medical center Director who is in charge of a PRC is responsible for:

a. Developing plans for, training, exercising, and maintaining the capability to receive DOD patients from other regions by land, air, or sea.

b. Providing health care services, or to coordinate with other healthcare providers within their area for services, for DOD patients received.

c. Appointing a PRC Coordinator responsible for the readiness and the operation of the PRC Program.

d. Actively coordinating with associated SSCs to develop and maintain a PRC Plan. At a minimum, each PRC Plan is to address the following areas:

(1) Concept of Operations,

(2) System Activation,

(3) Alerting SSCs,

(4) Bed Availability Reporting,

(5) Patient Reception,

(6) Patient Administration and Tracking,

(7) Communications,

(8) Transportation,

(9) PMI,

(10) Personnel Administration,

(11) Exercises and Evaluations, and

(12) Public Relations and Media Information.

e. Review and update the PRC Plan annually.

f. Training appropriate staff to support and manage local patient reception and distribution operations (e.g., TRAC2ES contingency bed reporting).

g. Ensuring that PRC staff, and other individuals designated to augment the PRC staff, annually receive detailed education and training on their specific duties.

h. Organizing, within the constraints of existing resources, patient reception teams to receive military patients from local airfields, bus stations, and train depots.

i. Identifying shortfalls and submitting a request for any resources needed to rectify the shortfall(s) and to enhance their PRC Plan.

j. Coordinating with associated SSCs to ensure that reports on available beds and throughput capabilities are consolidated and reported when requested.

k. Participating in annual exercises to evaluate the provisions of the PRC plan. Although some PRCs will conduct comprehensive exercises more frequently, PRC Directors are to conduct a full-scale patient reception exercise at least once every 3 years.

l. Reporting, during exercises and operations, available beds in accordance with instructions received from GPMRC.

m. Designating, during exercises and operations, an administrative point of contact (POC) and a clinical POC, each available 24 hours a day, 7 days a week (24/7) to coordinate with GPMRC. POC contact information must be provided to GPMRC using TRAC2ES, as well as by telephone at (800) 303-9301 or at (618) 229-4200, and by e-mail to: ustc-gpmrc-dutyofficer@ustranscom.mil.

9. VHA FACILITY DIRECTORS DESIGNATED AS A SSC DIRECTOR

Each VHA Facility Director designated as a SSC Director, is responsible for:

a. Coordinating with the designated PRC to develop a plan for providing additional beds, personnel, supplies, and equipment to assist in maximizing the number of DOD patients that can be received at the PRC. ***NOTE:*** *PRCs may be either a VA or a DOD medical facilities.*

b. Reporting, when requested, the number of beds available for DOD patients to the supported PRC.

c. Preparing to accept transfers of patients from PRCs, or to provide available resources to the PRC.

d. Identifying shortfalls and submitting a request for any resources needed to rectify the shortfall(s) and to enhance their PRC Plan.

e. Reviewing and updating the support plans annually.

10. VHA FACILITY DIRECTORS DESIGNATED AS AN ISC DIRECTOR

Each VHA Facility Director designated as an ISC Director is responsible for developing local plans to provide health care services and other health care resource support to military forces in the event of armed conflict or national emergency.

11. THE PROCESS

a. Upon activation of the VA-DOD Contingency Plan, PRCs and SSCs review current admission and discharge plans and coordinate among themselves to determine the maximum levels of support that can be made available within their PRA. The medical status of inpatients is reviewed to determine the appropriateness of discharge or transfer to: an SSC, a community medical facility, a nursing home, or a residence. Provisions must be made for the continuity of care of all patients discharged or transferred.

b. VA PRCs are activated by the Under Secretary for Health, or representative. Contingency bed reporting commences per detailed instructions received from GPMRC. Only PRCs report to GPMRC (bed availability reports rendered by the PRC must incorporate available SSC support).

(1) The instructions will include the time period during which reports are to be sent, the format to be followed, the mode of reporting, and points of contact.

(2) Upon receipt of instructions, the PRC collects bed availability data from SSCs, consolidates this, and reports to GPMRC.

(3) Reports may be submitted the using TRAC2ES. Alternatively, bed reports may be submitted by voice, fax, or e-mail using formats prescribed by the GPMRC.

(4) Regardless of the means of reporting, these reports must include two key elements: Available Beds and Throughput.

c. GPMRC regulates and coordinates individual patient movement missions directly with the PRC. PRCs will receive patients and distribute them locally, as established in the PRC Plan.

d. Prior to the arrival of patients, the PRC Director ensures that patient reception assets are alerted. Upon the arrival of patients at the airfield, train station, or bus depot, the PRC Coordinator notifies the GPMRC. The PRC Coordinator, or other designated individual, then further regulates and coordinates the movement of the patients to the VA medical facility, the SSC, or to other local healthcare providers as required.

e. VA PRC Coordinators, or other designated individuals, inform the nearest DOD MTF when DOD patients have been admitted to non-DOD facilities. DOD MTFs coordinate with applicable agencies to ensure that all subsequent administrative actions are accomplished (such as financial assistance to the patient; administrative, personnel and chaplain services; medical record keeping; re-equipping, re-supplying and transporting recovered DOD patients to duty; processing medical evaluation or physical evaluation board procedures for Temporary Disability

Retirement Listing; and mortuary services. ***NOTE:*** *If available, a Military Patient Administration Team may be dispatched to the PRC to assist in coordinating these actions.*

f. If available, GPMRC Liaisons may be dispatched to the PRC to assist in coordinating operations. GPMRC Liaisons:

(1) Are generally officers or senior enlisted medical administrative personnel under the operational control of the GPMRC.

(2) Advise the PRC on GPMRC policies and procedures, and support the PRC's responsibilities for bed reporting and coordinating with the GPMRC using automated systems or manual means.

(3) May assist the PRC in ensuring that required notifications are made and military patients are tracked.

12. REFERENCES

a. Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 1982. Codified at Title 38 United States Code (U.S.C.) Section 8011A and implemented at Title 38 ode of Federal Regulations (CFR) 17.230.

b. VA-DOD MOA "Regarding the Furnishing of Health-Care Services to Members of the Armed Forces in the Event of a War or National Emergency," November 16, 2006.