

GAO

Report to the Chairman, Subcommittee
on Oversight and Investigations,
Committee on Veterans' Affairs, House
of Representatives

July 2004

VA AND DOD HEALTH CARE

Resource Sharing at Selected Sites





Highlights of [GAO-04-792](#), a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Congress has long encouraged the Department of Veterans Affairs (VA) and the Department of Defense (DOD) to share health resources to promote cost-effective use of health resources and efficient delivery of care. In February 2002, the House Committee on Veterans' Affairs described VA and DOD health care resource sharing activities at nine locations. GAO was asked to describe the health resource sharing activities that are occurring at these sites. GAO also examined seven other sites that actively participate in sharing activities. Specifically, GAO is reporting on (1) the types of benefits that have been realized from health resource sharing activities and (2) VA- and DOD-identified obstacles that impede health resource sharing.

GAO analyzed agency documents and interviewed officials at DOD and VA to obtain information on the benefits achieved through sharing activities. The nine sites reviewed by the Committee and reexamined by GAO are: 1) Los Angeles, CA; 2) San Diego, CA; 3) North Chicago, IL; 4) Albuquerque, NM; 5) Las Vegas, NV; 6) Fayetteville, NC; 7) Charleston, SC; 8) El Paso, TX; and 9) San Antonio, TX. The seven additional sites GAO examined are: 1) Anchorage, AK; 2) Fairfield, CA; 3) Key West, FL; 4) Pensacola, FL; 5) Honolulu, HI; 6) Louisville, KY; and 7) Puget Sound, WA. In commenting on a draft of this report, the departments generally agreed with our findings.

www.gao.gov/cgi-bin/getrpt?GAO-04-792.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

VA AND DOD HEALTH CARE

Resource Sharing at Selected Sites

What GAO Found

At the 16 sites GAO reviewed, VA and DOD are realizing benefits from sharing activities, specifically better facility utilization, greater access to care, and reduced federal costs. While all 16 sites are engaged in health resource sharing activities, some sites share significantly more resources than others. For example, at one site VA was able to utilize Navy facilities to provide additional sources of care and reduce its reliance on civilian providers, thus lowering its purchased care cost by about \$385,000 annually. Also, because of the sharing activity taking place at this site, VA has modified its plans to build a new \$100 million hospital and instead plans to build a clinic that will cost about \$45 million. However, at another site the sharing activity was limited to the use of a nurse practitioner to assist with primary care and the sharing of a psychiatrist and a psychologist.

GAO found that the primary obstacle cited by almost all of the agency officials interviewed was the inability of VA and DOD computer systems to communicate and exchange patient health information between departments. VA and DOD medical facilities involved in treating both agencies' patient populations must expend staff resources to enter information on the health care provided into the patient records in both systems. Local VA officials also expressed a concern that security screening procedures have increased the time it takes for VA beneficiaries and their families to gain entry to facilities located on Air Force, Army, and Navy installations during periods of heightened security.

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Abbreviations

CMAC	Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge
CMOP	Consolidated Mail Outpatient Pharmacy
DOD	Department of Defense
ICU	Intensive Care Unit
MRI	magnetic resonance imaging
MTF	military treatment facility
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VAMC	VA medical center

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G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

July 21, 2004

The Honorable Steve Buyer
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

In 1982, Congress passed the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Sharing Act) to promote cost-effective use of health care resources and efficient delivery of care.¹ Specifically, Congress authorized the Department of Veterans Affairs (VA)² medical centers and the Department of Defense (DOD) military treatment facilities to enter into sharing agreements with each other to buy, sell, and barter medical and support services. Following the Sharing Act, Congress passed legislation to encourage and foster sharing of resources between VA and DOD—including start-up funds for sharing projects, expanded legal authority to enter into agreements, and funding for demonstration projects.³ You have an interest in the benefits that result from sharing activities and the obstacles that impede sharing. At your request, this report provides information on (1) the types of benefits that have been realized from health resource sharing activities and (2) VA- and DOD-identified obstacles that impede health resource sharing.

This report describes the benefits that are being realized at 16 VA and DOD sites that are engaged in health resource sharing activities. Nine of the sites⁴ were the focus of a February 2002 House Committee on

¹Pub. L. No. 97-174, 96 Stat. 70.

²The Department of Veterans Affairs was established on March 15, 1989, succeeding the Veterans Administration.

³Bob Stump National Defense Authorization Act for Fiscal Year 2003, Pub. L. No. 107-314, Sections 721, 722, 116 Stat. 2589-98 (2002).

⁴The nine sites in the report were: Los Angeles, California; San Diego, California; North Chicago, Illinois; Fayetteville, North Carolina; Albuquerque, New Mexico; Las Vegas, Nevada; Charleston, South Carolina; El Paso, Texas; and San Antonio, Texas.

Veterans' Affairs report⁵ that described health resource sharing activities between VA and DOD. We selected seven other sites that actively participated in sharing activities⁶ to ensure representation from each service at locations throughout the nation. We analyzed agency documents and interviewed officials at VA and DOD, including headquarters staff and field office staff who manage sharing activities at the 16 sites. We made field visits to six of them. We obtained documentation on improvements or enhancements to the delivery of health care to beneficiaries, and on cost reductions. Ten sites provided information on estimated cost reductions. We reviewed the supporting documentation and obtained clarifying information from agency officials. We also obtained documentation and the opinions of agency officials on the obstacles that exist either internally (within their own agency) or externally (with their sharing partner) to resource sharing activities. We obtained and reviewed VA and DOD policies and regulations governing sharing agreements and reviewed relevant reports from the DOD Inspector General, DOD contractors, and our prior work. Our work was performed from June 2003 through June 2004 in accordance with generally accepted government auditing standards. For more details on our scope and methodology, see appendix I.

Results in Brief

VA and DOD are realizing benefits from sharing activities, specifically, better facility utilization, greater access to care, and reduced federal costs at the 16 sites we reviewed. While all 16 sites are engaged in health resource sharing activities, some sites share significantly more resources than others. For example, at one site VA was able to utilize Navy facilities to provide additional sources of care and reduce its reliance on civilian providers, thus lowering its purchased care cost by about \$385,000 annually. Also, because of the sharing activity taking place at this site, VA has modified its plans to build a new \$100 million hospital and instead plans to build a clinic that will cost about \$45 million. However, at another site the sharing activity was limited to the use of a nurse practitioner to assist with primary care and the sharing of a psychiatrist and a psychologist.

⁵*Department of Veterans Affairs and Department of Defense Health Resources Sharing: Staff Report to the Committee on Veterans' Affairs*, U.S. House of Representatives 107th Congress, February 25, 2002, Washington, D.C.

⁶The seven sharing sites are Anchorage, Alaska; Fairfield, California; Key West, Florida; Pensacola, Florida; Honolulu, Hawaii; Louisville, Kentucky; and Puget Sound, Washington.

The primary obstacle cited by almost all of the officials we interviewed from both agencies was the inability of VA and DOD computer systems to communicate and exchange patient health information between departments. Hence, VA and DOD medical facilities involved in treating both agencies' patient populations must expend staff resources to enter health care information into both systems. Local VA officials also expressed a concern that security screening procedures have increased the time it takes for VA beneficiaries and their families to gain entry to facilities located on Air Force, Army, and Navy installations during periods of heightened security.

VA and DOD commented on a draft of this report and generally agreed with our findings.

Background

VA operates one of the nation's largest health care systems, spending about \$26.5 billion a year to provide care to approximately 5.2 million veterans who receive health care through 158 VA medical centers (VAMC) and almost 900 outpatient clinics nationwide. DOD spends about \$26.7 billion on health care for over 8.9 million beneficiaries, including active duty personnel and retirees, and their dependents. Most DOD health care is provided at more than 530 Army, Navy, and Air Force military treatment facilities (MTF) worldwide, supplemented by civilian providers.

To encourage sharing of federal health resources between VA and DOD, in 1982, Congress passed the Sharing Act. Previously, VA and DOD health care facilities, many of which are collocated or in close geographic proximity, operated virtually independent of each other. The Sharing Act authorizes VAMCs and MTFs to become partners and enter into sharing agreements to buy, sell, and barter medical and support services. The head of each VA and DOD medical facility can enter into local sharing agreements. However, VA and DOD headquarters officials review and approve agreements that involve national commitments such as joint purchasing of pharmaceuticals. Agreements can be valid for up to 5 years. The intent of the law was not only to remove legal barriers, but also to encourage VA and DOD to engage in health resource sharing to more effectively and efficiently use federal health resources.

VA and DOD sharing activities fall into three categories:

- Local sharing agreements allow VA and DOD to take advantage of their capacities to provide health care by being a provider of health services, a receiver of health services, or both. Health services shared under these

agreements can include inpatient and outpatient care; ancillary services, such as diagnostic and therapeutic radiology; dental care; and specialty care services such as service for the treatment of spinal cord injury. Other services shared under these agreements include support services such as administration and management, research, education and training, patient transportation, and laundry. The goals of local sharing agreements are to allow VAMCs and MTFs to exchange health services in order to maximize their use of resources and provide beneficiaries with greater access to care.

- Joint venture sharing agreements, as distinguished from local sharing agreements, aim to avoid costs by pooling resources to build a new facility or jointly use an existing facility. Joint ventures require more cooperation and flexibility than local agreements because two separate health care systems must develop multiple sharing agreements that allow them to operate as one system at one location.
- National sharing initiatives are designed to achieve greater efficiencies, that is, lower cost and better access to goods and services when they are acquired on a national level rather than by individual facilities—for example, VA and DOD’s efforts to jointly purchase pharmaceuticals for nationwide distribution.

Resource Sharing Activities Result in Better Access and Reduced Costs

VA and DOD are realizing benefits from sharing activities, specifically greater access to care, reduced federal costs, and better facility utilization at the 16 sites we reviewed. While all 16 sites were engaged in health resource sharing activities, some sites share significantly more resources than others.

In 1994 VA and DOD opened a joint venture hospital in Las Vegas, Nevada, to provide services to VA and DOD beneficiaries. The joint venture improved access for VA beneficiaries by providing an alternative source for care other than traveling to VA facilities in Southern California. It also improved access to specialized providers for DOD beneficiaries. Examples of the types of services provided include vascular surgery, plastic surgery, cardiology, pulmonary, psychiatry, ophthalmology, urology, computed tomography scan, magnetic resonance imaging (MRI); nuclear medicine, emergency medicine and emergency room, and respiratory therapy.⁷ The site is currently in the process of enlarging the emergency room.

⁷On May 7, 2004, the Secretary of Veterans Affairs announced that a new VA medical center would be opened in Las Vegas, NV. According to the Secretary, VA will continue its sharing activities with DOD in Las Vegas, NV.

In Pensacola, Florida, under a sharing agreement entered into in 2000, VA buys most of its inpatient services from Naval Hospital Pensacola. Through this agreement VA is able to utilize Navy facilities and reduce its reliance on civilian providers, thus lowering its purchased care cost by about \$385,000 annually. Further, according to a VA official, the agreement has allowed VA to modify its plans to build a new hospital and instead build a clinic at significantly reduced cost to meet increasing veteran demand for health care services. Using VA's cost per square foot estimates for hospital and clinic construction, the agency estimates that it will cost \$45 million⁸ to build a new clinic compared to \$100 million for a hospital.

In Louisville, Kentucky, since 1996, VA and the Army have been engaged in sharing activities to provide services to beneficiaries that include primary care, audiology, radiology, podiatry, urology, internal medicine, and ophthalmology. For fiscal year 2003, a local VA official estimated that VA reduced its cost by \$1.7 million as compared to acquiring the same services in the private sector through its agreements with the Army; he also estimated that the Army reduced its cost by about \$1.25 million as compared to acquiring the same services in the private sector. As an example of the site's efforts to improve access to care and reduce costs, in 2003 VA and DOD jointly leased a MRI unit. The unit reduces the need for VA and DOD beneficiaries to travel to more distant sources of care. A Louisville VA official stated that the purchase reduced the cost by 20 percent as compared to acquiring the same services in the private sector.

In San Antonio, Texas, VA and the Air Force share a blood bank. Under a 1991 sharing agreement, VA provides the staff to operate the blood bank and the Air Force provides the space and equipment. According to VA, the blood bank agreement saves VA and DOD about \$400,000 per year. Further, VA entered into a laundry service agreement with Brooke Army Medical Center in 2002 to utilize some of VA's excess laundry capacity. Under the contract VA processes 1.7 million pounds of laundry each year for the Army at an annual cost of \$875,000.

Sites such as Las Vegas, Nevada; Pensacola, Florida; Louisville, Kentucky; and San Antonio, Texas shared significant resources compared to sites at

⁸Authorization for the construction of the clinic was given in Pub. L. No. 108-170, Section 211, 117 Stat. 2042, 2048. The statute provides that funding for the construction must come either from funds appropriated for 2004, or funds appropriated before 2004 for construction and major projects that are still available. Pub. L. No. 108-170, §214, 117 Stat. 2049.

Los Angeles, California and Charleston, South Carolina. For example, the sharing agreement at Los Angeles provided for the use of a nurse practitioner to assist with primary care and the sharing of a psychiatrist and a psychologist. See appendix II for the VA and DOD partners at each of the 16 sites and examples of the sharing activities taking place.

VA and DOD Identified Two Obstacles that Impede Resource Sharing

The primary obstacle cited by officials at 14 of 16 sites we interviewed was the inability of computer systems to communicate and share patient health information between departments. Furthermore, local VA and DOD officials involved with sharing activities raised a concern that security check-in procedures implemented since September 11, 2001, have increased the time it takes to gain entry to medical facilities located on military installations during periods of heightened security.

VA and DOD Computer Systems Cannot Share Patient Record Information

VA's and DOD's patient record systems cannot share patient health information electronically. The inability of VA's and DOD's patient record systems to quickly and readily share information on the health care provided at medical facilities is a significant obstacle to sharing activities. One critical challenge to successfully sharing information will be to standardize the data elements of each department's health records. While standards for laboratory results were adopted in 2003, VA and DOD face a significant undertaking to standardize the remaining health data. According to the joint strategy that VA and DOD have developed, VA will have to migrate over 150 variations of clinical and demographic data to one standard, and DOD will have to migrate over 100 variations of clinical data to one standard.

The inability of VA and DOD computer systems to share information forces the medical facilities involved in treating both agencies' patient populations to expend staff resources to maintain patient records in both systems. For example, at Travis Air Force Base, both patient records systems have been loaded on to a single workstation in each department, so that nurses and physicians can enter patient encounter data into both systems. However, the user must access and enter data into each system separately. In addition to VA and DOD officials' concerns about the added costs in terms of staff time, this method of sharing medical information

raises the potential for errors—including double entry and transcription—possibly compromising medical data integrity.⁹

VA and DOD have been working since 1998 to modify their computer systems to ensure that patient health information can be shared between the two departments. In May 2004, we reported that they have accomplished a one-way transfer of limited health data from DOD to VA for separated service members.¹⁰ Through the transfer, health care data for separated service members are available to all VA medical facilities. This transfer gives VA clinicians the ability to access and display health care data through VA's computerized patient record system remote data views¹¹ about 6 weeks after the service member's separation. The health care data include laboratory, pharmacy, and radiology records, and are available for approximately 1.8 million personnel who separated from the military between 1987 and June 2003. A second phase of the one-way transfer, completed in September 2003, added to the base of health information available to VA clinicians by including discharge summaries,¹² allergy information, admissions information, and consultation results.¹³

VA and DOD are developing a two-way transfer of health information for patients who obtain care from both systems. Patients involved include those who receive care and maintain health records at multiple VA or DOD medical facilities within and outside the United States. Upon viewing the medical record, a VA clinician would be provided access to clinical information on the patient residing in DOD's computerized health record systems. In the same manner, when a veteran seeks medical care at an MTF, the attending DOD clinician would be provided access to the veteran's health information existing in VA's computerized health record systems.

⁹See U.S. General Accounting Office, *VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients*, [GAO-02-1017](#) (Washington, D.C.: Sept. 27, 2002).

¹⁰See U.S. General Accounting Office, *Computer-Based Patient Records: Improved Planning and Project Management Are Critical to Achieving Two-Way VA-DOD Health Data Exchange*, [GAO-04-811T](#) (Washington, D.C.: May 19, 2004).

¹¹VA's remote data views allow authorized users to access patient health care data from any VA medical facility.

¹²Discharge summaries include inpatient histories, diagnoses, and procedures.

¹³See U.S. General Accounting Office, *Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems*, [GAO-04-271T](#) (Washington, D.C.: Nov. 19, 2003).

In May 2004, we reported that VA's and DOD's approach to achieving the two-way transfer of health information lacks a solid foundation and that the departments have made little progress toward defining how they intend to accomplish it.¹⁴ In March 2004 and June 2004,¹⁵ we also reported that VA and DOD have not fully established a project management structure to ensure the necessary day-to-day guidance of and accountability for the undertaking, adding to the challenge and uncertainties of developing two-way information exchange. Further, we reported that the departments were operating without a project management plan that describes their specific development, testing, and deployment responsibilities. These issues cause us to question whether the departments will meet their 2005 target date for two-way patient health information exchange.

Security Procedures Increase Time to Gain Access to MTFs During Periods of Heightened Security

During times of heightened security since September 11, 2001, according to VA and DOD officials, screening procedures have slowed entry for VA beneficiaries, and particularly for family members who accompany them, to facilities located on Air Force, Army, and Navy installations. For example, instead of driving onto Nellis Air Force Base in Las Vegas and parking at the medical facility, veterans seeking treatment there must park outside the base perimeter, undergo a security screening, and wait for shuttle services to take them to the hospital for care.

Although sharing occurs in North Carolina between the Fayetteville VA Medical Center and the Womack Army Medical Center, Ft. Bragg, the VA hospital administrator expressed concerns regarding any future plans to build a joint VA and DOD clinic at Ft. Bragg due to security precautions—identity checks and automobile searches—that VA beneficiaries encounter when attempting to access care. Consequently, the administrator prefers that any new clinics be located on VA property for ease of access for all beneficiaries.

¹⁴See [GAO-04-811T](#).

¹⁵See U.S. General Accounting Office, *Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data*, [GAO-04-402T](#) (Washington, D.C.: Mar. 17, 2004) and U.S. General Accounting Office, *Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management*, [GAO-04-687](#) (Washington, D.C. : June 7, 2004).

VA provided an example of how it and DOD are working to help resolve these problems. In Pensacola, Florida, VA is building a joint ambulatory care clinic on Navy property through a land-use arrangement. According to VA, veterans' access to the clinic will be made easier. A security fence will be built around the building site on shared VA and Navy boundaries and a separate entrance and access road to a public highway will allow direct entry. Special security arrangements will be necessary only for those veterans who are referred for services at the Navy medical treatment facility. Veterans who come to the clinic for routine care will experience the same security measures as at any other VA clinic or medical center. VA believes this arrangement gives it optimal operational control and facilitates veterans' access while addressing DOD security concerns.

Agency Comments and Our Evaluation

We requested comments on a draft of this report from VA and DOD. Both agencies provided written comments that are found in appendix III. VA and DOD generally agreed with our findings. They also provided technical comments that we incorporated where appropriate.

In commenting on this draft, VA stated that VA and DOD are developing an electronic interface that will support a bidirectional sharing of health data. This approach is set forth in the Joint VA/DOD Electronic Health Records Plan. According to VA, the plan provides for a documented strategy for the departments to achieve interoperable health systems in 2005. It included the development of a health information infrastructure and architecture, supported by common data, communications, security, software standards, and high-performance health information. VA believes these actions will achieve the two-way transfer of health information and communication between VA's and DOD's information systems.

In their comments, DOD acknowledged the importance of VA and DOD developing computer systems that can share patient record information electronically. According to DOD, VA and DOD are taking steps to improve the electronic exchange of information. For example, VA and DOD have implemented a joint project management structure for information management and information technology initiatives—which includes a single Program Manager and a single Deputy Program Manager with joint accountability and day-to-day responsibility for project implementation. Further, VA and DOD continue to play key roles as lead partners to establish federal health information interoperability standards as the basis for electronic health data transfer.

We recognize that VA and DOD are taking actions to implement the Joint VA/DOD Electronic Health Records Plan and the joint project management structure, and that they face significant challenges to do so. Accomplishing these tasks is a critical step for the departments to achieve interoperable health systems by the end of 2005.

DOD also agreed with the GAO findings on issues relating to veterans access to military treatment facilities located on Air Force, Army, and Navy installations during periods of heightened security. DOD stated that they are working diligently to solve these problems, but are unlikely to achieve an early resolution. They also stated that as VA and DOD plan for the future, they will consider this issue during the development of future sharing agreements and joint ventures.

We are sending copies of this report to the Secretary of Veterans Affairs, the Secretary of Defense, interested congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, this report is available at no charge on GAO's Web site at <http://www.gao.gov>. If you or your staff have any questions about this report, please call me at (202) 512-7101 or Michael T. Blair, Jr., at (404) 679-1944. Aditi Shah Archer and Michael Tropauer contributed to this report.

Sincerely yours,



Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: Scope and Methodology

This report describes the benefits that are being realized at 16 Department of Veterans Affairs (VA) and Department of Defense (DOD) sites that are engaged in health resource sharing activities. Nine of the sites¹ were the focus of a February 2002 House Committee on Veterans' Affairs report² that described health resource sharing activities between VA and DOD. We selected seven other sites that actively participated in sharing activities³ to ensure representation from each service at locations throughout the nation. To obtain information on the resources that are being shared we analyzed agency documents and interviewed officials at VA and DOD headquarters offices and at VA and DOD field offices who manage sharing activities at the 16 sites.

To gain information on the benefits of sharing and the problems that impede sharing at selected VA and DOD sites, we asked VA and DOD personnel at 16 sites to provide us with information on:

- shared services provided to beneficiaries including improvements or enhancements to delivery of health care to beneficiaries,
- reduction in costs,
- and their opinions on barriers or obstacles that exist either internally (within their own agency) or externally (with their partner service or agency).

Ten sites provided information on estimated cost reductions. We reviewed the supporting documentation and obtained clarifying information from agency officials. Based on our review of the documentation and subsequent discussions with agency officials we accepted the estimates as reasonable.

From the 16 sites, we judgmentally selected the following 6 sites to visit: 1) Fairfield, California; 2) Pensacola, Florida; 3) Louisville, Kentucky; 4) Fayetteville, North Carolina; 5) Las Vegas, Nevada; and 6) Charleston, South Carolina. At the sites we visited, we interviewed local VA and DOD

¹The nine sites in the report were: Los Angeles, California; San Diego, California; North Chicago, Illinois; Fayetteville, North Carolina; Albuquerque, New Mexico; Las Vegas, Nevada; Charleston, South Carolina; El Paso, Texas; and San Antonio, Texas.

²*Department of Veterans Affairs and Department of Defense Health Resources Sharing: Staff Report to the Committee on Veterans' Affairs*, U.S. House of Representatives 107th Congress, (Washington, D.C. : Feb. 25, 2002).

³The seven sharing sites are Anchorage, Alaska; Fairfield, California; Key West, Florida; Pensacola, Florida; Honolulu, Hawaii; Louisville, Kentucky; and Puget Sound, Washington.

officials to obtain their views on resource-sharing activities and obtained documents from them on the types of services that were being shared. The sites were selected based on the following criteria: 1) representation from each military service; 2) geographic location; and 3) type of sharing agreement—local sharing agreement, joint venture, or participant in a national sharing initiative.

We conducted telephone interviews with agency officials at the 10 sites that we did not visit and requested supporting documentation from them to gain an understanding of the sharing activities underway at each site.

We obtained and reviewed VA and DOD policies and regulations governing sharing agreements and reviewed our prior work⁴ and relevant reports issued by the DOD Inspector General and DOD contractors. Our work was performed from June 2003 through June 2004 in accordance with generally accepted government auditing standards.

⁴See Related GAO Products.

Appendix II: Resource Sharing at 16 Sites

Anchorage, Alaska

Partners: Alaska VA Healthcare System and 3rd Medical Group, Elmendorf Air Force Base

The Department of Veterans Affairs (VA) and the Air Force have had a resource-sharing arrangement since 1992. Building upon that arrangement, in 1999, VA and the Air Force entered into a joint venture hospital. According to VA and Air Force officials, they have been able to efficiently and effectively provide services to both VA and the Department of Defense (DOD) beneficiaries in the Anchorage area that would not have been otherwise possible. The services to VA and DOD beneficiaries include emergency room, outpatient, and inpatient care. Other services the Air Force provides VA includes diagnostic radiology, clinical and anatomical pathology, nuclear medicine, and MRI. VA contributes approximately 60 staff toward the joint venture. VA staff are primarily responsible for operating the 10-bed intensive care unit (ICU). For fiscal year 2002, a DOD official estimated that the Air Force avoids costs of about \$6.6 million by utilizing the ICU as compared to acquiring the same services in the private sector. Other VA staffing in the hospital lends support to the emergency department, medical and surgical unit, social work services, supply processing and distribution, and administration.

Fairfield, California

Partners: VA Northern California Health Care System and 60th Medical Group, Travis Air Force Base

In 1994, VA and the Air Force entered into a joint venture at Travis Air Force Base. Under this joint venture, VA contracts for inpatient care, radiation therapy, and other specialty, ancillary, and after-hours teleradiology services it need from the Air Force. In return, the Air Force contracts for ancillary and pharmacy support from VA. The most recent expansion of the joint venture in 2001 included activation of a VA clinic located adjacent to the Air Force hospital—this clinic includes a joint neurosurgery clinic.

Each entity currently reimburses the other at 75 percent of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC)¹ rate. In March 2004, a VA official

¹To reimburse civilian physicians, DOD has established a fee schedule—the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) rates—which is the highest amount DOD will pay civilian network physicians for providing medical services to DOD patients.

estimated that the VA saves about \$500,000 per year by participating in the joint venture and an Air Force official estimated that the Air Force saves about \$300,000 per year through the joint venture.

Los Angeles, California

Partners: Veterans Affairs Greater Los Angeles Healthcare System and 61st Medical Squadron, Los Angeles Air Force Base

The Air Force contracts for mental health services from the Veterans Affairs medical center (VAMC). According to Air Force and VA local officials, there are two agreements in place; first, VA provides a psychologist and a psychiatrist who provide on-site services to DOD beneficiaries (one provider comes once a week, another provider comes 2 days a month). The total cost of this annual contract is about \$200,000. According to the Air Force, it is paying 90 percent of the CMAC rate for these services and is thereby saving about \$20,000 to \$22,000 a year. Second, the Air Force is using a VA nurse practitioner to assist with primary care. The cost savings were not calculated but the Air Force stated that VA was able to provide this staffing at a significantly reduced cost as compared to contracting with the private sector.

San Diego, California

Partners: VA San Diego Healthcare System and Naval Medical Center San Diego

VA provides graduate medical education, pathology and laboratory testing, and outpatient and ancillary services to the Navy. According to Navy officials, the sharing agreements resulted in a cost reduction of about \$100,000 per year for fiscal years 2002 and 2003. As of June 2004, VA and the Navy were in the process of finalizing agreements for sharing radiation therapy, a blood bank, and mammography services.

In fiscal year 2003, San Diego was selected as a pilot location for the VA/DOD Consolidated Mail Outpatient Pharmacy (CMOP) program.² A naval official at San Diego considers the pilot a success at this location

²VA and DOD are conducting a pilot test to provide DOD beneficiaries with a mail-order pharmacy benefit. Under the pilot, VA's CMOP program located in Leavenworth, Kansas will refill prescription medications on an outpatient basis for DOD beneficiaries who had their original prescriptions filled at the Darnall Army Community Hospital, Fort Hood, Texas; the Naval Medical Center, San Diego, California; or the 377th Medical Group, Kirtland Air Force Base, New Mexico.

because participation was about 75 percent and it helped eliminate traffic, congestion, and parking problems associated with beneficiaries on the Navy's medical campus who come on site for medication refills—an average of 350 patients per day. According to a DOD official, the CMOP pilot in San Diego will likely continue through fiscal year 2004.

Key West, Florida

Partners: VA Miami Medical Center and Naval Hospital Jacksonville

VA and the Navy have shared space and services since 1987. The Key West Clinic became a joint venture location in 2000. VA physically occupies 10 percent of the Navy clinic in Key West. The clinic is a primary care facility. However, the clinic provides psychiatry, internal medicine, and part-time physical therapy. According to Navy officials, there are two VA physicians on call at the clinic and seven Navy physicians. The Navy's physicians examine VA patients when needed, and the Navy bills the VA at 90 percent of CMAC. Further, VA reimburses the Navy 10 percent of the total cost for housekeeping and utilities. VA and the Navy share laboratory and pathology, radiology, optometry, and pharmacy services. The VA reimburses the Navy \$4 for the packaging and dispensing of each prescription.

Pensacola, Florida

Partners: VA Gulf Coast Veterans Health Care System and Naval Hospital Pensacola

Since 2000, the Navy has provided services to VA beneficiaries at its hospital through sharing agreements that include emergency room services, obstetrics, pharmacy services, inpatient care, urology, and diagnostic services. In turn, VA provides mental health and laundry services to Navy beneficiaries.

In fiscal year 2002, the Naval Hospital Pensacola met about 88 percent of VA's inpatient needs. The Navy provided 163 emergency room visits, 112 outpatient visits, and 8 surgical procedures for orthopedic services to VA beneficiaries. Through this agreement VA has reduced its reliance on civilian providers, thus lowering its purchased care cost by about \$385,000 annually. Further, according to a VA official, the agreement has allowed VA to modify its plans to build a new hospital to meet increasing veteran demand for health care services. Rather than build a new hospital VA intends to build a clinic to meet outpatient needs. Using VA's cost per square foot estimates for hospital and clinic construction, the agency

estimates that it will cost \$45 million³ to build a new clinic compared to \$100 million for a new hospital.

Honolulu, Hawaii

Partners: VA Pacific Islands Healthcare System and Tripler Army Medical Center

VA and the Army entered into a joint venture in 1991. According to VA and Army officials, over \$50 million were saved in construction costs when VA built a clinic adjacent to the existing Army hospital. According to a VA official, the Army hospital is the primary facility for care for most VA and Army beneficiaries. The Army provides VA beneficiaries with access to the following services: inpatient care, intensive care, emergency room, chemotherapy, radiology, laboratory, dental, education and training for physicians, and nurses. Also, as part of the joint venture agreement, VA physicians are assigned to the Army hospital to provide care to VA patients. VA and the Army provided services to about 18,000 VA beneficiaries in 2003.

According to an Army official, the joint venture as a whole provides no savings to the Army. The benefit to the Army is assured access for its providers to clinical cases necessary for maintenance of clinical skills and Graduate Medical Education through the reimbursed workload.

North Chicago, Illinois

Partners: North Chicago VA Medical Center and Naval Hospital Great Lakes

VA provides inpatient psychiatry and intensive care, and outpatient clinic visits, for example, pulmonary care, neurology, gastrointestinal care, diabetic care, occupational and physical therapy, speech therapy, rehabilitation, and diagnostic tests to Navy beneficiaries. VA also provides medical training to Naval corpsmen, nursing staff, and dental residents. The Navy provides selected surgical services for VA beneficiaries such as joint replacement surgeries and cataract surgeries. In addition, as available, the Navy provides selected outpatient services, mammograms,

³Authorization for the construction of the clinic was given in Pub. L. No. 108-170, Section 211, 117 Stat. 2042, 2048. The statute provides that funding for the construction must come either from funds appropriated for 2004, or funds appropriated before 2004 for construction and major projects that are still available. Pub. L. No. 108-170, §214, 117 Stat. 2049.

magnetic resonance imaging (MRI) examinations, and laboratory tests. The 2-year cost under this agreement from October 2001 through September 2003 is about \$295,000 for VA and about \$502,000 for the Navy. According to VA officials, VA and DOD pay each other 90 percent of the CMAC rate for these services. As a result, for the 2-year period VA and DOD reduced their costs by about \$88,000 through this agreement, as opposed to contracting with the private sector for these services. VA officials also stated that other benefits were derived from these agreements, including sharing of pastoral care, pharmacy support, educational and training opportunities, imaging, and the collaboration of contracting and acquisition opportunities, all resulting in additional services being provided to patients at an overall reduced cost, plus more timely and convenient care.

According to VA, in October 2003 the Navy transferred its acute inpatient mental health program to North Chicago VA medical center, where staff operate a 10-bed acute mental health ward, which has resulted in an estimated cost reduction of \$323,000. This unit also included a 10-bed medical hold unit.

Further, VA and the Navy are pursuing a joint venture opportunity planned for award in fiscal year 2004, which will integrate the medical and surgical inpatient programs. This will result in the construction of four new operating rooms and the integration of the acute outpatient evaluation units at VA. The Navy would continue to provide surgical procedures and related inpatient follow-up care for Navy patients at the VA facility. The joint venture would eliminate the need for the Navy to construct replacement inpatient beds as part of the Navy's planned Great Lakes Naval hospital replacement facility. According to VA, this joint venture would result in an estimated cost reduction of about \$4 million.

Louisville, Kentucky

Partners: VA Medical Center Louisville and Ireland Army Community Hospital, Ft. Knox

Since 1996, in Louisville, Kentucky, VA and the Army have been engaged in sharing activities to provide services to beneficiaries that include primary care, acute care pharmacy, ambulatory, blood bank, intensive care, pathology and laboratory, audiology, podiatry, urology, internal medicine, and ophthalmology. For fiscal year 2003, a local VA official estimated that VA reduced its cost by \$1.7 million as compared to acquiring the same services in the private sector through its agreements with the Army; he also estimated that the Army reduced its cost by about \$1.25 million as

compared to acquiring the same services in the private sector. As an example of the site's efforts to improve access to care, in 2003 VA and DOD jointly leased an MRI unit. The unit eliminates the need for beneficiaries to travel to more distant sources of care. A Louisville VA official stated that the purchase reduced the cost by 20 percent as compared to acquiring the same services in the private sector.

Las Vegas, Nevada

Partners: VA Southern Nevada Healthcare System and 99th Medical Group, Nellis Air Force Base

In this joint venture, VA and the Air Force operate an integrated medical hospital. Prior to 1994, VA had no inpatient capabilities in Las Vegas. This required VA beneficiaries to travel to VA facilities in Southern California for their inpatient care. This joint venture also improved access to specialized providers for DOD beneficiaries. The following services are available at the joint venture: anesthesia, facility and acute care pharmacy, blood bank, general surgery, mental health, intensive care, mammography, obstetrics and gynecology, orthopedics, pathology and laboratory, vascular surgery, plastic surgery, cardiology, pulmonary, psychiatry, ophthalmology, urology, podiatry, computed tomography scan, MRI, nuclear medicine, emergency medicine and emergency room, and pulmonary and respiratory therapy. VA and Air Force officials estimate that the joint venture reduces their cost of health care delivery by over \$15 million annually.⁴ Currently, the site is in the process of enlarging the hospital's emergency room.

According to a VA official, during periods of heightened security, veterans seeking treatment from the hospital at Nellis Air Force base in Las Vegas must park outside the base perimeter, undergo a security screening, and wait for shuttle services to take them to the hospital for care.

⁴On May 7, 2004, the Secretary of Veterans Affairs announced that a new VA medical center would be opened in Las Vegas, NV. According to the Secretary, VA will continue to its sharing activities with DOD in Las Vegas, NV.

Albuquerque, New Mexico

Partners: New Mexico VA Health Care System and 377th Medical Group, Kirtland Air Force Base

According to VA and Air Force officials, Albuquerque is the only joint venture site where VA provides the majority of health care to Air Force beneficiaries. The Air Force purchases all inpatient clinical care services from the VA. The Air Force also operates a facility, including a dental clinic adjacent to the hospital. According to an Air Force official, for fiscal year 2003 the Air Force avoided costs of about \$1,278,000 for inpatient, outpatient, and ambulatory services needs. It also avoided costs of about \$288,000 for emergency room and ancillary services. The Air Force official estimates that under the joint venture it has saved about 25 percent of what it would have paid in the private sector. Further, according to the Air Force official, additional benefits are derived from the joint venture that are important to beneficiaries such as: 1) continuity of care, 2) rapid turnaround through the referral process, 3) easier access to specialty providers, and 4) an overall increase in patient satisfaction.

Additionally, both facilities individually provide women's health (primary care, surgical, obstetrics and gynecology) to their beneficiaries. The Air Force official reported in March 2004 that they were evaluating how they can jointly provide these services. In fiscal year 2003 Kirkland Air Force Base was selected as a pilot location for the CMOP program. According to a DOD official, the CMOP pilot at Kirtland Air Force Base will likely continue through fiscal year 2004.

Fayetteville, North Carolina

Partners: Fayetteville VA Medical Center and Womack Army Medical Center, Fort Bragg

According to a VA official, VA and Army shared resources include blood services, general surgery, pathology, urology, the sharing of one nuclear medicine physician, one psychiatrist, a dental residency program, and limited use by VA of an Army MRI unit.

Charleston, South Carolina

Partners: Ralph H. Johnson VA Medical Center and Naval Hospital Charleston

According to Navy officials, with the downsizing of the Naval Hospital Charleston and transfer of its inpatient workload to Trident Health Care system (a private health care system), VA and the Navy no longer share inpatient services, except in cases where the Navy requires mental health

inpatient services. However, in June 2004, VA has approved a minor construction joint outpatient project totaling \$4.9 million (scheduled for funding in fiscal year 2006 with activation planned for fiscal year 2008). Design meetings are underway. Among the significant sharing opportunities for this new facility are laboratory, radiology, and specialty services.

El Paso, Texas

Partners: El Paso VA Health Care System and William Beaumont Army Medical Center, Fort Bliss

In this joint venture, the VA contracts for emergency department services, specialty services consultation, inpatient services for medicine, surgery, psychiatric, and intensive care unit from the Army. The Army contracts for backup services from the VA including computerized tomography, and operating suite access. According to VA officials, the Army provides all general and vascular surgery services so that no veteran has to leave El Paso for these services. This eliminates the need for El Paso's veterans to travel over 500 miles round-trip to obtain these surgical procedures from the Albuquerque VAMC—the veterans' closest source of VA medical care. The Army provides these services at 90 percent of the CMAC rate or in some cases at an even lower rate.

According to a VA official in June 2004, VA and the Army have agreed to proceed with a VA lease of the 7th floor of the William Beaumont Army Medical Center. VA would use the space to operate an inpatient psychiatry ward and a medical surgery ward. VA will staff both wards.

In fiscal year 2004 El Paso was approved as a pilot location for testing a system that stores VA and DOD patient laboratory results electronically.

San Antonio, Texas

Partners: South Texas Veterans Health Care System; Wilford Hall Medical Center, Lackland Air Force Base; and Brooke Army Medical Center, Fort Sam Houston

As of March 2004, a VA official stated that VA and DOD have over 20 active agreements in place in San Antonio. Some of the sharing activities between VA and the Air Force include radiology, maternity, laboratory, general surgery, and a blood bank. Since 2001, VA staffs the blood bank and the Air Force provides the space and equipment—the blood bank provides services to VA and Air Force beneficiaries. According to VA, the blood bank agreement saves VA and DOD about \$400,000 per year.

Further, according to Air Force officials, as of June 2004 VA and the Air Force were negotiating to jointly operate the Air Force's ICU. The Air Force would supply the acute beds and VA would provide the staff. This joint unit would provide services to both beneficiary populations.

In addition, VA and Army agreements include the following areas of service: gynecology, sleep laboratory, radiology, and laundry. According to VA officials, VA entered into a laundry service agreement with Brooke Army Medical Center in 2002 to utilize some of VA's excess laundry capacity. Under the contract VA processes about 1.7 million pounds of laundry each year for the Army at an annual cost of \$875,000.

Puget Sound, Washington

Partners: VA Puget Sound Health Care System and Madigan Army Medical Center, Ft. Lewis

As of June 2004, VA and the Army have two sharing agreements in place that encompass several shared services. For example, the Army provides VA beneficiaries with emergency room, inpatient, mammography, and cardiac services. The VA provides the Army with computer training services, laboratory testing, and radiology and gastrointestinal physician services on-site at Madigan. In addition, VA nursing and midlevel staff provide support to the Army inpatient medicine service. In turn, the Army provides 15 inpatient medicine beds for veterans.

During fiscal year 2002, VA paid the Army \$900 per ward day per patient for inpatient care and \$1,720 per ICU day. During fiscal year 2002, there were 69 VA patients discharged, with 117 ward days and 101 ICU days, averaging \$1,280 per day. According to VA officials, this agreement resulted in a cost reduction, in that to contract with private providers the average cost per day would have been \$1,939. The cost reduction to VA was \$143,752. The VA and Army jointly staff clinics for otolaryngology (1/2 day per week) and ophthalmology (3 half-day clinics per month). This agreement results in a cost reduction of about \$25,000 per year to VA compared to contracting with the private sector. Other services such as mammography do not result in a cost reduction, but according to VA officials they provide their beneficiaries with another source for accessing care.

Appendix III: Comments from the Department of Veterans Affairs and the Department of Defense



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
July 14, 2004

Ms. Cynthia A. Bascetta
Director
Health Care Team
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed the General Accounting Office's (GAO) draft report, **VA and DOD HEALTH CARE: Resource Sharing at Selected Sites**, (GAO-04-792). The report found that VA and Department of Defense (DoD) realized benefits from sharing activities at all of the 16 sites reviewed, resulting in better facility utilization, greater access to care, and reduced federal costs. VA agrees with GAO's findings. We have provided technical edits and updated comments on the resource sharing activities at the selected sites separately.

The report notes concerns at the majority of the sites reviewed regarding the inability of VA's and DoD's computer systems to communicate and conduct a two-way transfer of health information. VA, in cooperation with DoD, is developing an electronic interface that will support a bi-directional sharing of health data. This approach is set forth in the Joint VA/DoD electronic Health Records plan "HealthPeople (Federal)", and was approved by the Office of Management and Budget (OMB) in April 2003. The plan provides for a documented strategy for the Departments to achieve interoperable health systems in 2005. It includes the development of a health information infrastructure and architecture, supported by common data, communications, security, software standards and high-performance health information. VA believes these actions will achieve the two-way transfer of health information and communication between VA's and DoD's information systems.

VA and DoD are actively engaged in several activities relating to the development of the final architecture for the electronic interface between the agencies' health information systems. The Departments expect to complete the final architecture by 1st Quarter, FY 2005. Initiatives included in this architecture are:

- **Joint Electronic Health Records** – This initiative will allow health care providers in both Departments access to relevant medical information.

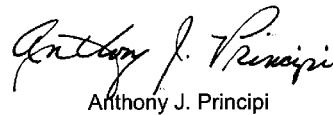
Page 2.

Ms. Cynthia A. Bascetta

- **Composite Health Care Systems/Veterans Information Systems and Technology Architecture (CHCA/VistA) Data Sharing Interface (DSI)** – This initiative allows for real time, bi-directional exchange of limited data for shared patients. For example, DSI will permit a military treatment facility to share clinical data, capable of computational actions, with any VA medical center when a patient presents for care.
- **VA/DoD Clinical Data Repository** – This initiative will develop an interface between VA's and DoD's health care data that will support real time bi-directional exchange of health data.
- **VA/DoD Joint Electronic Medical Records (JEMR)** – This comprehensive and coordinated electronic interface project management plan updates previous versions and is currently being reviewed by the Departments.
- **Security Policy** – Once the final technical architecture is identified, a security policy will be completed.

Thank you for the opportunity to review your draft report.

Sincerely yours,



Anthony J. Principi

**Appendix III: Comments from the Department
of Veterans Affairs and the Department of
Defense**



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

JUL 07 2004

Ms. Cynthia A. Bascetta
Director, Health Care-Veterans'
Health and Benefits Issues
U.S. General Accounting Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Bascetta:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report GAO-04-792, "VA AND DOD HEALTHCARE: Resource Sharing at Selected Sites," dated June 23, 2004 (GAO Code 290301/GAO-04-792).

The Department appreciates the opportunity to comment on the draft report and generally concurs with the GAO findings. The Department's response to the identified GAO issues is enclosed, along with overall comments and specific technical corrections for incorporation into the final report. Comments were requested from the Services' Surgeons General. However, due to the limited review time, only Army comments have been received. Army technical comments have been included as part of our response. A copy of the Army comments is enclosed.

Please direct any questions to my points of contact on this matter, Mr. Kenneth Cox (functional) at (703) 681-0039, ext. 3602 and Mr. Gunther J. Zimmerman (Audit Liaison) at (703) 681-3492, ext. 4065.

Sincerely,


William Winkenwerder, Jr., MD

Enclosures:

1. Overall Comments
2. Technical Comments
3. Additional Comments

Enclosure 1

**GAO DRAFT REPORT – DATED 23 JUNE 2004
(GAO CODE-290301/GAO-04-792)**

**“VA AND DOD HEALTH CARE: RESOURCE SHARING AT SELECTED
SITES”**

DEPARTMENT OF DEFENSE COMMENTS

The draft report provides a review of the Department’s resource sharing projects with the Department of Veterans’ Affairs. The Department’s comments on the GAO issues identified in the draft report follow:

Overall Comments:

- The Department of Defense appreciates the GAO’s review and assessment of the resource sharing activities and agreements in existence at the 16 identified sites, and believes that local health care demand differences as well as available assets account for most of the differences in the level of sharing occurring between the sharing partners.
- The Department of Defense acknowledges the findings of GAO regarding the increased time it takes for veterans to gain entry to military treatment facilities located on Air Force, Army, and Navy installations during periods of heightened security. While we work diligently to solve this problem, increased security has become a fact of life that is not likely to see early resolution.
- Comment on p.10-11 (last paragraph)--DoD and VA continue to play key roles as lead partners in the Consolidated Health Informatics (CHI) project, one of the 24 eGov initiatives in support of the President’s Management Initiative. CHI’s goal is to establish federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments. In March 2003, the CHI project announced the first set of standards to be adopted. They include four messaging and one vocabulary standard. In May 2004, 7 additional CHI standards were adopted. These standards apply to 20 of the 24 domains examined by CHI.
- Comment on P.13 (1st paragraph)—DoD and VA have implemented a joint project management structure for the DoD/VA Information Management/Information Technology initiatives that include oversight by the VA/DoD Health Executive Council and the VA/DoD Joint Executive Council, as needed. The Departments have

**Appendix III: Comments from the Department
of Veterans Affairs and the Department of
Defense**

Enclosure 1

effectively and consistently used this structure. The VA/DoD joint project management structure includes a single Program Manager and a single Deputy Program Manager with joint accountability and day-to-day responsibility for project implementation. They work with in the governance structure described above and follow sound project management and software development methodologies expressed by the Project Management Institute and federal guidelines.

Related GAO Products

Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management. [GAO-04-687](#). Washington, D.C.: June 7, 2004.

Computer-Based Patient Records: Improved Planning and Project Management Are Critical to Achieving Two-Way VA-DOD Health Data Exchange. [GAO-04-811T](#). Washington, D.C.: May 19, 2004.

Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data. [GAO-04-402T](#). Washington, D.C.: March 17, 2004.

DOD and VA Health Care: Incentives Program for Sharing Resources. [GAO-04-495R](#). Washington, D.C.: February 27, 2004.

Veterans Affairs: Post-hearing Questions Regarding the Departments of Defense and Veterans Affairs Providing Seamless Health Care Coverage to Transitioning Veterans. [GAO-04-294R](#). Washington, D.C.: November 25, 2003.

Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems. [GAO-04-271T](#). Washington, D.C.: November 19, 2003.

DOD and VA Health Care: Access for Dual Eligible Beneficiaries. [GAO-03-904R](#). Washington, D.C.: June 13, 2003.

VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients. [GAO-02-1017](#). Washington, D.C.: September 27, 2002.

VA and Defense Health Care: Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies. [GAO-02-872T](#). Washington, D.C.: June 26, 2002.

DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs. [GAO-01-588](#). Washington, D.C.: May 25, 2001.

Computer-Based Patient Records: Better Planning and Oversight By VA, DOD, and IHS Would Enhance Health Data Sharing. [GAO-01-459](#). Washington, D.C.: April 30, 2001.

Related GAO Products

VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies. [GAO/HEHS-00-52](#). Washington, D.C.: May 17, 2000.

VA and Defense Health Care: Rethinking of Resource Sharing Strategies is Needed. [GAO/T-HEHS-00-117](#). Washington, D.C.: May 17, 2000.

VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources. [GAO/HRD-88-51](#). Washington D.C.: March 1, 1988.

Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles To Interagency Sharing. [HRD-78-54](#). Washington D.C.: June 14, 1978.

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