SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

AD-A220 213

1a. REPORT SECURITY CLASSIFICATION
Unclassified

1b. RESTRICTIVE MARKINGS

2a. SECURITY CLASSIFICATION AUTHORITY

3. DISTRIBUTION/AVAILABILITY OF REPORT
Approved for public release;
Distribution unlimited

2b. DECLASSIFICATION/DOWNGRADING SCHEDULE

4. PERFORMING ORGANIZATION REPORT NUMBER(S)
5-89

5. MONITORING ORGANIZATION REPORT NUMBER(S)

6a. NAME OF PERFORMING ORGANIZATION
US Army-Baylor University
Graduate Program in Health Care

6b. OFFICE SYMBOL (If applicable)
Admin/HSHA-IHC

7a. NAME OF MONITORING ORGANIZATION

6c. ADDRESS (City, State, and ZIP Code)
Ft. Sam Houston, TX 78234-6100

7b. ADDRESS (City, State, and ZIP Code)

DTIC
ELECTE
AUG 05 1990
S E

8a. NAME OF FUNDING/SPONSORING ORGANIZATION

8b. OFFICE SYMBOL (If applicable)

9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER

8c. ADDRESS (City, State, and ZIP Code)

10. SOURCE OF FUNDING NUMBERS

PROGRAM ELEMENT NO.	PROJECT NO.	TASK NO.	WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A STUDY OF VETERANS ADMINISTRATION/DEPARTMENT OF DEFENSE HEALTH CARE RESOURCES SHARING AT KELLER ARMY COMMUNITY HOSPITAL, WEST POINT, NEW YORK

12. PERSONAL AUTHOR(S)
MAJ Darwin E. Fine

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Study	FROM Jul 83 TO Jul 84	Apr 84	285

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	Health Care; Medical Resource Sharing

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

This study was conducted to develop a model for implementing a Veterans Administration and Department of Defense Health Care Resource Sharing Agreement. Both health care facilities were examined to identify the abilities and deficiencies that could be shared. The specifics of construction of the written agreement and standards were examined in this study. The author emphasized the importance of a mutual agreement of services to be shared.

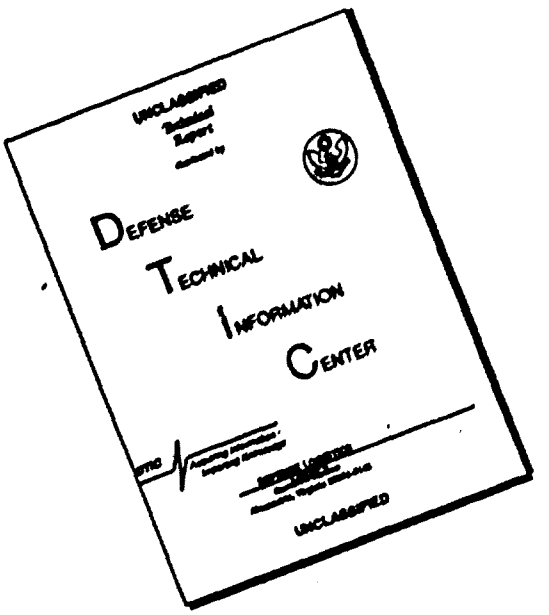
20. DISTRIBUTION/AVAILABILITY OF ABSTRACT
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS

21. ABSTRACT SECURITY CLASSIFICATION

22a. NAME OF RESPONSIBLE INDIVIDUAL	22b. TELEPHONE (Include Area Code)	22c. OFFICE SYMBOL
Lawrence M. Leahy, MAJ, MS	(512) 221-6345/2324	HSHA-IHC

DD Form 1473, JUN 86 Previous editions are obsolete. SECURITY CLASSIFICATION OF THIS PAGE

DISCLAIMER NOTICE



THIS DOCUMENT IS BEST QUALITY AVAILABLE. THE COPY FURNISHED TO DTIC CONTAINED A SIGNIFICANT NUMBER OF PAGES WHICH DO NOT REPRODUCE LEGIBLY.

A STUDY OF VETERANS ADMINISTRATION/DEPARTMENT OF DEFENSE HEALTH CARE RESOURCES SHARING AT KELLER ARMY COMMUNITY HOSPITAL WEST POINT, NEW YORK 10996

A Graduate Research Project
Submitted to the Faculty of Baylor
University in Partial Fulfillment of
the Requirements for the degree of
Master of Health Care Administration

By

Major Darwin E. Fine, MSC

April 1984

ACKNOWLEDGMENTS

The writer wishes to express his sincere gratitude to Mrs Alice Duffy for her untiring devotion to providing typing support not only for this manuscript, but for the numerous other requirements that were generated during the residency training.

Further acknowledgment is extended to Mr. C. F. Heard, Director, Franklin Delano Roosevelt VA Medical Center for allowing the writer to access his facility, records and reports and staff members. Also, the cooperation and assistance of Ms Mary Farrell, Quality Assurance Coordinator, Franklin Delano Roosevelt VA Medical Center, throughout the course of this study, is to be commended.

Final acknowledment is extended to Mr. Richard Droske, Director, Castle Point VA Medical Center for his personal interest in supporting the research effort. His commitment to resource sharing contributed immeasurably to the success of the project.

TABLE OF CONTENTS

APPENDIX

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER I

INTRODUCTION

Conditions Prompting the Study

The cost of health care in the United States soared to $286.6 billion in FY 81, an average of $1,225 per person. During the past 15 years, personal health care expenditures increased sixfold of which almost three-fifths resulted from price inflation.[1] The cost of health care in the United States surpasses the total of the entire defense budget, the United States sales of all foreign and domestic cars and the profits of the 41 largest international oil companies.[2] Such statistical data as these have developed an increased awareness and concern in consumers, politicians and health care critics which previously did not exist. This increased awareness, combined with the apparent inability of the health care industry to contain these costs from within, has resulted in an increasing demand for mandated cost containment with a concomitant improvement in the quality of care provided.

The concept of multi-institutional systems or inter-organizational arrangements as a means to provide comprehensive, quality care and contain costs dates back at least 50 years. Shared service arrangements have primarily gained popularity in the last 10 years and constitute one practical option available to the American health care industry to use in its effort to meet increasing demands without adding unreasonably to an already over-burdened cost structure. Rising costs, difficulty in obtaining financing, scarce resources, obsolete equipment and employee skills, changing as well as, increasing consumer needs, increasingly competitive pressures and expanding governmental demands and regulations have functioned to coerce non-Federal health care agencies to cooperate

and share resources with survival as the major incentive.

The Federal health care system received little pressure to consider sharing resources as a cost containment measure. Some Federal resource sharing did occur, but this was usually between facilities of the same Federal agency or between a Federal facility and a civilian facility. In FY 79, of the $20 million that the Veterans Administration (VA) spent on shared services, only $17,000 was for services shared with the Department of Defense (DOD).[3] The signing of Public Law 97-174 (Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act) on May 4, 1982, however, served notice to the Federal health care sector that it would no longer be permitted to avoid its cost containment responsibilities and that, if necessary, initiatives could (and would) be legislated.

The primary objective of PL 97-174 is to reduce the tremendous cost of Federal health care by minimizing underused and duplicated resources. A secondary objective is to maximize the sharing of resources between Federal facilities with the goal of improving the level of care provided. The final objective of PL 97-174 is to monitor capital equipment acquisition with the intent of terminating services which may adversely impact on patient care or which increase government costs to provide this care in Federal facilities.

Legislation in the past several years should have served notice to Federal health agencies that without self-initiated actions to effect cost containment, the government would become progressively more involved

in the delivery of health care. The Federal health care sector elected, however, to almost completely ignore these legislative attempts to encourage Federal interagency cooperative initiatives. PL 97-174 is the latest major legislation directed at the Federal health care sector and appears to be a reaction by Congress to the relatively minimal cost containment efforts initiated between Federal health care agencies and the perception that increased cooperative efforts would not be realized in the future without legislative intervention.

The Federal health care sector, if it wishes to avoid having cost containment mandated by Congress, must become proactive in the arena of cost containment. Congress, in passing PL 97-174, identified three significant findings: (1) opportunities exist for shared services between the VA and DOD which, if achieved, could reduce costs to the government by minimizing duplication and underuse of health care resources; (2) present incentives to encourage shared services are inadequate; and (3) such sharing of resources can be effected without a detrimental impact on VA and DOD beneficiaries. Any action taken to implement the resource sharing portion of PL 97-174 must, necessarily, address these findings.

PL 97-174 provides the authority for VA and DOD facilities to enter sharing agreements. It is not a mandate, the Federal health sector can elect to ignore this legislation completely. It is probable, however, that if managers of Federal facilities fail to develop and implement shared resource programs in support of PL 97-174, cost containment measures will be mandated in the near future.

With the intent of allowing maximum flexibility at the organization level, the VA Central Office and the DOD have provided limited guidance on how to implement the resource sharing provisions of PL 97-174. Without the clear guidance required to accomplish this task, a clearly identifiable challenge of how best to develop and implement a VA/DOD resource sharing agreement existed for the West Point MEDDAC. It became evident that Keller Army Community Hospital (KACH) could demonstrate active support of the government's efforts to contain Federal Health Care costs. by systematically developing and implementing a resource sharing agreement with one of the VA Medical Centers in the West Point area.

Statement of the Problem

The problem is to develop a model for implementing a Veterans Administration and Department of Defense (VA/DOD) Health Care Resource Sharing Agreement between Keller Army Community Hospital (KACH) and a VA Medical Center in the West Point area. to include the following:

1. Analysis of existing literature.

2. Examination of the historical environment which formed the basis for PL 97-174

3. Identification of barriers to effective implementation of PL 97-174.

4. Identification of medical resource requirements currently being contracted out by each participating facility.

5. Identification of excess capacity in those resources identified in each facility as having sharing potential.

6. Development of a cost analysis to compare the cost of resources acquired under the provisions of the sharing agreement with the cost associated with acquiring these resources from local civilian facilities.

7. Preparation of a model health care resources sharing agreement between Keller Army Community Hospital and a VA Medical Center in the West Point area.

Criteria

The solution to the problem should:

1. Be accomplished within the resource constraints of participating facilities.

2. Comply with the provisions of PL 97-174.

3. Avoid interfering with routine patient care provided to beneficiaries of each facility.

4. Demonstrate the potential to reduce the number of services being contracted out with civilian facilities.

5. Demonstrate the potential to reduce the excess capacity of participating facilities.

6. Provide a mechanism for notifying participating facilities that the purchase of additional equipment, new facility construction, or initiation/ discontinuance of services which may impact on resources available for sharing is imminent.

7. Provide a mechanism for addressing joint acquisition of major equipment/services.

8. Demonstrate a potential cost savings for resources acquired under the provisions of the agreement over the current civilian cost for these resources.

Study Restraints

Restraints to the study can be categorized into limitations which narrow the problem solving options, obstacles to optimum research and limitations which would narrow the scope of the study. Options available for the solution to the problem are reduced by the study criteria of complying with PL 97-174, cost effectiveness and resource constraints. A solution which was not bound by these criteria could, in actuality, be optimal but not feasible. In this regard, a driving concern in the development of a shared resources model is to meet the health care needs of the beneficiaries of the participating facilities while, at the same time, reducing the costs of providing this care. A second restraint which limited the problem solving options was the decision by the Commander, KACH and the Directors of the local VA hospitals not to consider sharing inpatient resources at this time.

The only major obstacle to optimum research was the physical distance separating KACH from the local VA Medical Centers. Coordination efforts were frequently delayed because of weather, road conditions and the time associated with commuting between facilities. The scope of the study was not limited in that sources of research material were available.

Other Factors

Additional factors which influenced the study were environmental, historical and mission related in nature. The environmental factor of the national economic picture, in general, and the health care industry's growth relative to that picture, specifically, caused increased awareness

and concern by management in both VA and DOD facilities as to what economic effects were likely to result from participation in a sharing agreement and what, if any, reprisals would occur to a facility that elected not to participate. Federal spending under the Reagan Administration has received increasing attacks from civilian health care officials, as well as Congressional sources, directed at what appears to them as inconsistencies in cost containment efforts. Whereas the non-Federal health care sector has been under constant pressure during the past decade to contain health care costs, little overt pressure has been exerted on the Federal health care sector to control spending. The result of this disproportionate cost containment pressure is an increasing consensus among non-Federal health care providers, as well as many members of Congress, that it is past time for the Federal health care sector to assume a more proportional share of the responsibility for containing Federal spending.

From the historical point of view, the fact that West Point and KACH, because of their unique mission requirements which limited the scope of operations to West Point only, had for years tended to isolate themselves from involvement in programs with organizations, or institutions, outside of the installation boundary was a factor which could not be discounted as the study took place. Health care providers and administrators from the local VA Medical Centers and KACH had become so accustomed to this isolationist policy that any proposed change would require overcoming the resistance which always accompanies changing what is "traditional."

The MEDDAC's unique mission of providing for the health care needs of the United States Corps of Cadets and the West Point military community, has resulted in a rather parochialized view of how, and to whom, this care should be provided. This mission, coupled with the different

beneficiary populations served by VA and DOD facilities, further served to challenge implementing the resource sharing provisions of PL 97-174 at the United States Army MEDDAC, West Point.

Literature Review

The concept of sharing hospital services to achieve a better quality of care and more economical operation is not new to the health care field. In the late 1940's, the Commission on Hospital Care submitted a report with several recommendations targeted at improving efficiency through increased cooperation among hospitals.[4] The President's Commission on the Health Needs of the Nation also considered, in great detail, the subject of regional hospital systems.[5] In 1959, Milton I. Roemer and Robert C. Morris presented a paper titled, "Hospital Regionalization in Perspective", which provided an excellent review of hospital regionalization and the potential benefits associated with shared services.[6]

It was not, however, until Mark Blumberg's 1966 study for the American Hospital Association that the potential impact of resource sharing in the health care industry was fully realized.[7] External pressures for greater efficiency in resource utilization continued to be exerted on hospital management through government programs, third party payers and even community officials. The contention was, based on the conclusions of Blumberg's study, that by appropriately pooling and sharing services, facilities and manpower, hospitals could substantially improve patient care, add services, and reduce costs through economies of scale and other economic theory principles.

It was this growing concern from both within and outside the health care field which prompted the American College of Hospital Administrators to establish, in 1971 and 1972, several task forces to examine the critical issues facing the field of hospital administration. One of these task forces examined the sensitive area of shared services. This task force was comprised of full-time hospital administrators, each involved in a merger or a sharing of services venture in his/her institution. Results of this task force were published in a 1974 report which provided guidance on why shared services were economically viable and answers to key questions on implementing shared services.[8]

Congress recognized early the utility of the sharing concept for the VA medical care system by enacting Public Law 89-785 in November 1966.[9] This law gave the VA specific statutory authority to enter into agreements to receive from, and share with, medical schools, hospitals and research centers throughout the country. The intent of this authority was to improve the quality of hospital care and other medical services provided to veterans by authorizing the VA Administrator to receive and share specialized medical resources wihtout diminution of services to veterans. Congress also gave the Secretaries of the military services and the VA Administrator, with certain exceptions, authority to enter agreements for the mutual use or exchange of use of hospital and domiciliary facilities, equipment and supplies and for the transfer among them of these items without reimbursement.[10] This authority, however, was seldom, if ever, invoked.

Congressional desire for greater sharing of health care resources was demonstrated in the Heart Disease, Cancer and Stroke Amendments of 1967[11] and the Public Health Service Amendments of 1966.[12] This same desire was reflected in 1974 with enactment of the National Health Planning and Resources Development Act, Public Law 93-641.[13] Such legislation required non-Federal hospitals to coordinate and plan the use of their medical resources in order to improve quality of care and avoid duplication of resources. Although the VA's participation in local health planning was provided for in the law, the other Federal agencies were included in advisory capacities only, no interaction between the VA and DOD was required and little occurred. PL 93-641 was, however, the first major legislation which impacted on shared services. At least two of the ten national health priorities in the law related directly to shared services and were identified as national goals.[14]

There were several laws that permitted Federal interagency sharing, but none of these clearly required sharing. The Economy Act[15] authorized a Federal hospital to request the services of another Federal hospital. The Economy Act was designed to allow Federal agency resources to be used to capacity and avoid unnecessary duplication and overlap of activities. DOD hospitals were authorized to share facilities and equipment with the VA under the 38 US Code.[16] In addition, they could provide medical services to certain veterans under contract with the VA and emergency services to non-military personnel. Congress also gave the VA specific authority to share "specialized medical resources" with other hospitals and clinics (Federal, state, local) and medical schools.[17]

For more than 30 years, reports and studies discussed the proper type of management needed by the DOD and VA to more effectively operate their medical facilities. In 1947 and 1953, Congress established two Commissions to determine changes needed to promote economy, efficiency and improve service in Federal health care agencies, these were known as the First and Second Hoover Commissions.[18] In 1949, the DOD Committee on Medical and Hospital Services of the Armed Forces examined the organizational structures for the tri-services and, while rejecting any form of a single medical service, recommended that coordination and policy guidance be provided at the Secretary of Defense level.[19] The Coller Report of 1958 was in response to President Eisenhower's request that Dr. Frederick Coller examine the advantages of a single manager for military health services.[20] In 1976, a Report on the Feasibility of Sharing Medical Facilities was provided to the Chairman, Senate Appropriations Committee, which emphasized the need for sharing between VA and DOD, but cautioned that the achievable level of sharing was limited by the uniqueness of the beneficiary populations served, locations of facilities and the short supply of ambulatory care services in Federal facilities.[21] In mid-1977, at the request of the Assistant Secretary of Defense for Health Affairs, representatives from DOD, VA and Health Education and Welfare (HEW) met to initiate plans for increasing inter-agency planning. As a result of this initiative, an inter-agency Federal Health Resources Sharing Committee was established.[22] This Committee was effective in identifying numerous opportunities for increased inter-agency sharing, however, recommendations by the Committee were either not adopted by the agencies, or, when adopted, they were not supported.

The Comptroller General's Report to the Congress on June 14, 1978,[23] emphasized many obstacles which contributed to the inability to effect meaningful inter-agency sharing between the VA and DOD: (1) the absence of a specific legislative mandate for inter-agency sharing and a lack of adequate headquarters guidance on how to share; (2) restrictive agency regulations, policies and procedures; and (3) inconsistent and unequal reimbursements. The Government Accounting Office (GAO) recommended that Congress chart legislation to establish a greatly expanded and cost effective interagency sharing program.

It would appear that the efforts of the GAO resulted in delayed, but positive, Congressional action. However, while Congress was finally initiating legislation to contain costs through resource sharing in the Federal health care sector, the non-Federal health care sector had been involved in cost containment efforts for many years. Studies with Diagnosis Related Groups (DRGs) in New Jersey,[24] along with legislation implementing the use of DRGs for reimbursement of Medicare and Medicaid, was only one of the many non-Federal cost containment efforts. The trend toward multi-institutional systems, Preferred Provider Organizations, hospital chains, emphasis on marketing, hospital alliances and employee cost sharing are a few of the more recent non-Federal health care sector's cost containment efforts.

An American Hospital Survey conducted in 1979[25] reported that while shared services among non-Federal facilities had increased by more than 20 percent over the previous year, the Federal sector reflected an increase of less than 10 percent and, of this 10 percent, shared services were almost exclusively between a Federal facility and a non-Federal facility.

Schwartz and Joskow[26] attempted to evaluate the potential savings that would result from eiiminating duplicative hospital facilities. however, after evaluating the results of their studies they had to conclude that indirect costs would offset any savings and that, therefore, any solution to cost containment must be through sharing services, not by eliminating facilities.

In 1980, Litman and Johnson[27] conducted a study on the feasibility of hospital sharing, the purpose of which was to elicit the attitudes and opinions of participants in the Sharing of Hospital Services (SOS) Project in the MinneapolisSt Paul area. Both tangible and intangible benefits were identified: more than $100,000 was saved in one year by the Pharmacy Service alone; quality of service improved; there was a greater willingness to work together; and there developed an atmosphere that was conducive to more extensive consolidation. This study was followed by the DiPaolos Study[28] which reflected that shared services business rose by 31 percent in 1980. Less than one year later, Punch[29] reported that shared service contracts rose by 22 percent in 1981. This trend toward increased shared service arrangements slowed noticeably in 1982, the result, according to Kuntz,[30] of uncertainty over the impact of prospective reimbursement, he forecasted, however, a "spurt" in shared service activity in 1983. This prediction was supported by a report from Johnson[31] which indicated a 16.7 percent increase in shared service contracts in 1983. Active participation by non-Federal hospitals in resource sharing was further documented by Smith and Cobb[32] who concluded

that, although there was a slight decrease in the overall number of hospitals participating in shared services activities between 1978 and 1982, 75.4 percent of non-Federal hospitals were participating in shared services activities in 1982. Weinstein[33] and Plant[34] have addressed the overall success of shared services and its potential for increased utilization in the 1980s. Shared services, according to these authors, have been initiated for three reasons: cost containment. quality control and creation of a product not available in the marketplace. As competition in health care becomes more pronounced, it is anticipated that arbitrary territorial boundaries will erode, that hospitals will diversify and the need for shared services, referred to as hospital ventures, will continue to impact significantly on the non-Federal health care sector.

The proliferation of health care cost containment literature through the 1970's was directed primarily at the non-Federal sector. This trend may be changing, as indicated in an uncomplimentary article by Davidson[35] that attacked the VA for planning to build a new 400 bed facility in downtown Baltimore, where a surplus of hospital beds already existed. The author went on to propose implementation of a voucher system which would authorize VA beneficiaries access to whatever hospital they desired, rather than build additional facilities. An article by Demkovich[36] echoed the sentiments of Davidson and further denounced both the VA and the White House for appearing not to care. Wallace[37] states that the VA is under competitive pressure of losing autonomy as the nation's largest integrated medical system. She states that pressure for the VA

to change is coming both from the private sector and from within. Pressure from the private sector comes from hospitals and physicians who advocate "mainstreaming" the VA system into the commercial health care system. Pressure from within is in the form of a Presidential Commission pushing for a single Federal system under the auspices of the military.

While the Federal health care system has lagged behind its civilian counterpart in cost containment initiatives, activity has recently increased. Motivated by the 1978 GAO Report to Congress and six additional GAO reports between 1979 and 1980,[38] a bill to establish a Federal Interagency Medical Resources Committee was introduced by Senator Charles Percy of Illinois before the 97th Congress during the summer of 1981.[39] Senator Percy argued in favor of a VA/DOD Medical Sharing Act which he felt would: clear away legal and administrative barriers to interagency sharing; create incentives at the local level; and encourage the agencies to begin assessing money-saving opportunities for sharing. On May 4, 1982, Congress enacted Public Law 97-174 which authorized VA and DOD agencies to enter into health resources sharing agreements.[40] A task force was organized under the Assistant Secretary of Defense for Health Affairs in Washington, DC to assist Federal facilities desiring to enter into these sharing agreements. In October and November 1983, this task force visited each region in the United States to discuss resource sharing, answer questions and solicit support.

The VA Central Office, Washington, D.C. published and distributed VA Circular 10-83-150 on September 7, 1983.[41] This Circular was published

as a guide only,[42] with the intent of allowing maximum flexibility by individual facility Directors in tailoring sharing agreements to meet their facility's specific needs. In late October 1983, DOD prepared a draft Directive on VA/DOD Resource Sharing,[43] but as of the date of this study had not provided official guidelines to Comanders of DOD health care facilities on how to implement the resource sharing provisions of PL 97-174. Increased discussions and reference to resource sharing in the past two or three years would indicate that considerable interest exists at the highest levels of both agencies and that increased initiatives on implementing resource sharing agreements can be expected in the future.

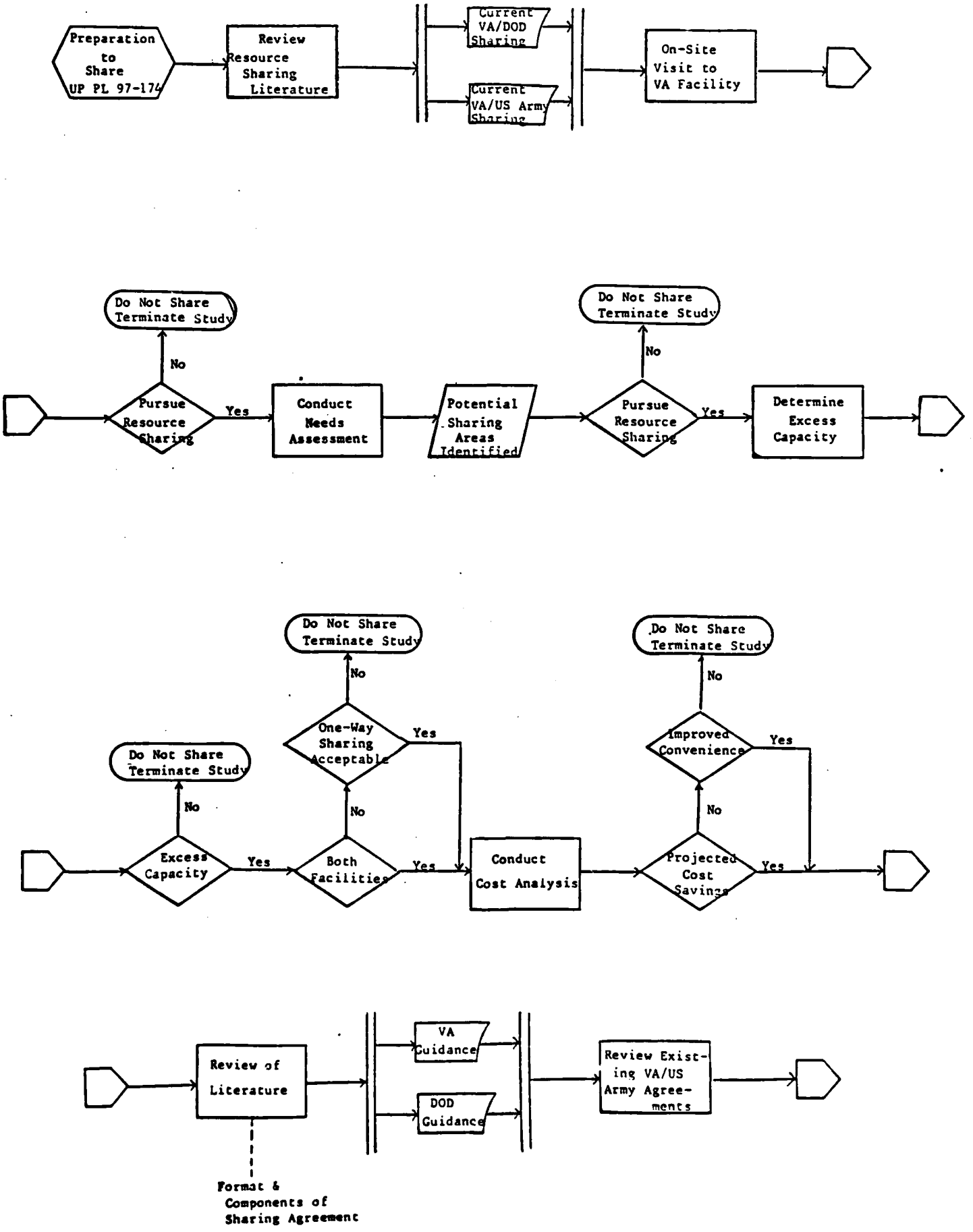
The literature indicates that the Federal health care sector has only recently begun to seriously consider interagency resource sharing as a viable alternative to containing health care costs while, on the other hand, resource sharing has been practiced by the civilian health care sector for more than two decades. Extensive documentation exists on administrative and ancillary resource sharing, however. documented sharing of direct patient care services was noticeably absent from the literature.

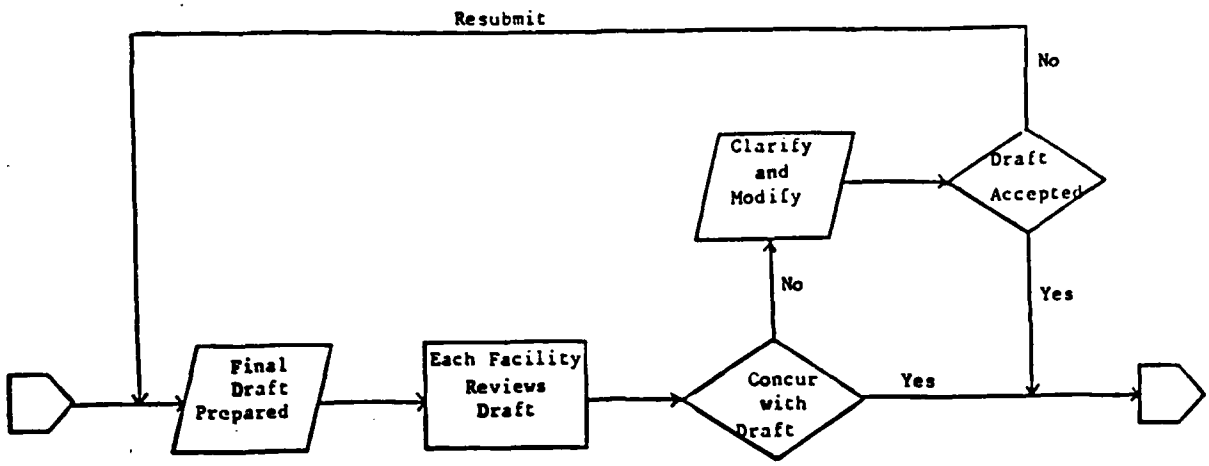
Effective implementation of the resource sharing provisions of PL 97-174 will require extensive planning, planning which is built upon communication. Effective communication, necessary to coordinate and control organizational activities, provides the foundation on which planning can succeed. Analysis of barriers to effective communication will, therefore, be an important aspect in determining an acceptable model to implement the resource sharing provisions of PL 97-174 at the Medical Department Activity, West Point.

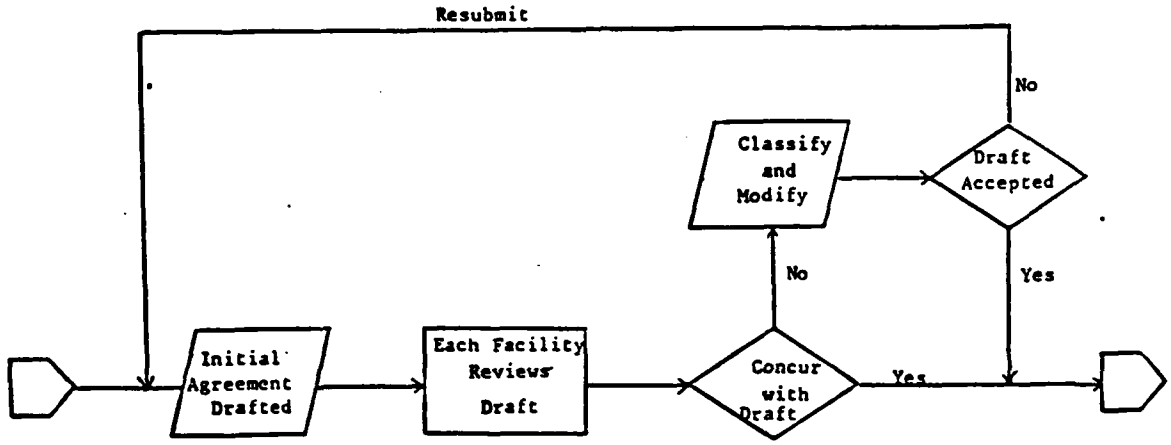
Study Approach

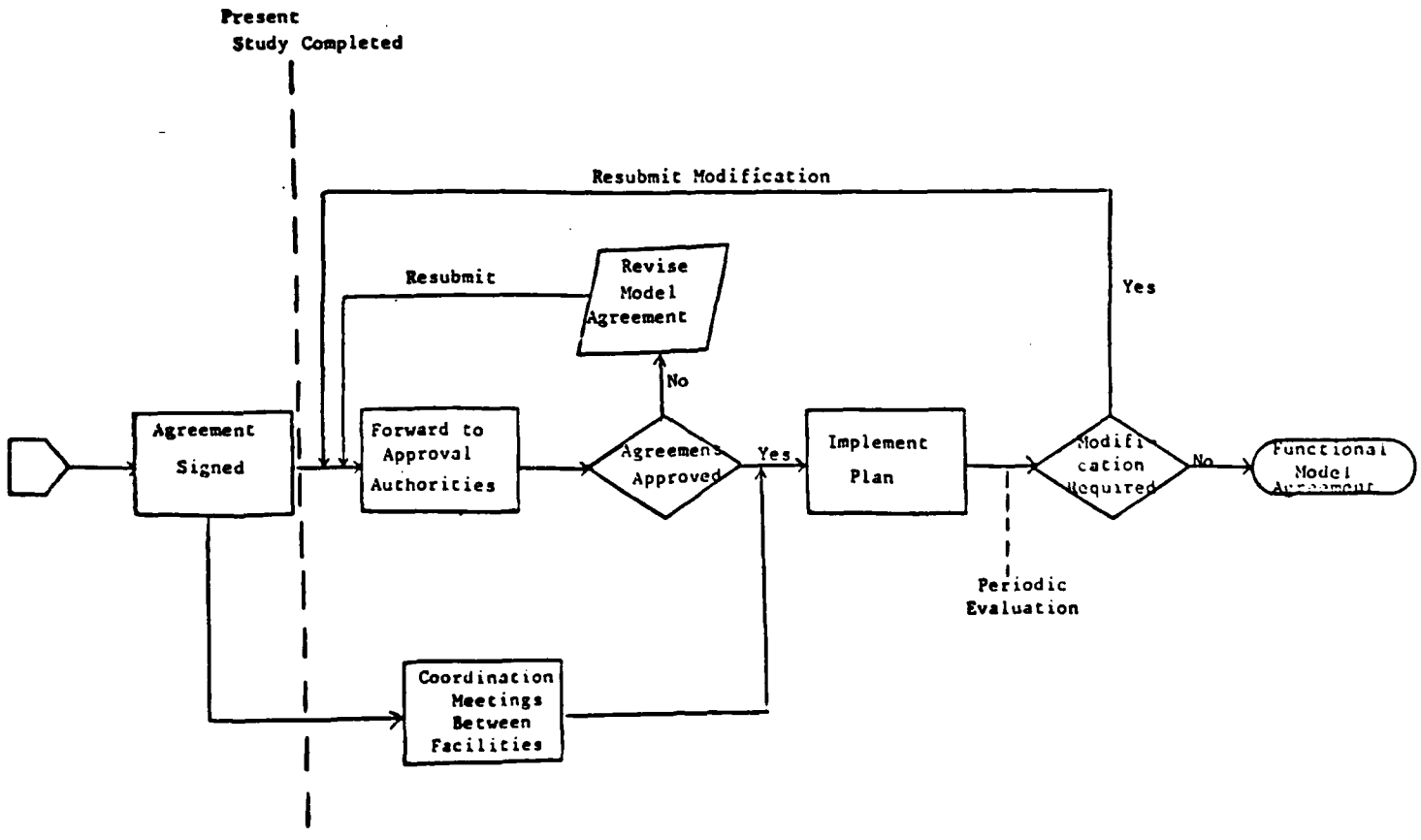
The planned method for implementation of the resource sharing provisions of PL 97-174 at KACH is diagrammed in Figure 1. This study will address the implementation process through development of the model resource sharing agreement and its signature by the authorized representatives of participating facilities. A segmented line has been drawn through the diagram to identify the point at which this study will be completed. An extensive literature review will be an ongoing process throughout the research effort, but is considered especially critical to the information gathering portion of the study to avoid early mistakes which may delay completion of the project, or challenge the ultimate success of the project. Coordination with the Office of the Assistant Secretary of Defense for Health Affairs, the Health Resource Sharing Committee and the VA Central Office. Washington, D.C. will be effected to provide general background data and statistical information on Federal resource sharing. The Deputy Chief of Staff, Operations at Health Services Command will be contacted next to identify the extent of known participation by Army Medical Activities (MEDDACS) and Medical Centers (MEDCENS). Informal telephonic contact with a minimum of four Army MEDDAC and two Army MEDCEN Comptrollers will be made to ascertain if their facility is presently negotiating a resource sharing agreement with a VA, or anticipates doing so. A copy of any agreements which have been completed will be requested for review, analysis and possible incorporation of significant components into the model to be developed for KACH. On-site visits with a local

Figure 1 - Implementation Process For
A VA/DOD Health Care Resource Sharing Agreement




Resubmit
No
Clarify and Modify
Draft Accepted
No
Yes
Final Draft Prepared
Each Facility Reviews Draft
Concur with Draft
Yes


Resubmit
No
Classify and Modify
Draft Accepted
No
Yes
Initial Agreement Drafted
Each Facility Reviews Draft
Concur with Draft
Yes


Present
Study Completed
Resubmit Modification
Resubmit
Revise Model Agreement
No
Yes
Agreement Signed
Forward to Approval Authorities
Agreement Approved
Yes
Implement Plan
Modification Required
No
Functional Model
Periodic Evaluation
Coordination Meetings Between Facilities

VA Medical Center in the West Point area will be made to: identify barriers to resource sharing; identify potential advantages to resource sharing; identify a single point of contact at the facility; request information on current sharing agreements on contracts in effect; and request a list of services provided by the facility. KACH will furnish the VA facility with a copy of services provided to its beneficiary population. Each facility will then conduct a needs assessment to determine those resources or services not available to, but required by, their particular facility and which is identified as being provided by the other facility. Extensive use of interviews with individuals from VA and DOD health care facilities who have been identified as personally involved in the implementation of VA/DOD resource sharing, and the managerial staffs of each participating facility, will be employed throughout the research effort.

Following the data acquisition phase of the research effort, analysis of the needs of each facility, identified as having the potential to be shared, will be made using a cost comparison of the resource if purchased from a civilian facility and the same resource cost under a sharing agreement. Interviews with the staffs of participating facilities and coordinating personnel at the DOD, HSC and VA Central Office, review of current literature and, finally, analysis and review of existing VA/US Army sharing agreements will be effected to identify the format and components of a resource sharing agreement model.

The final phase for completing the research effort will consist of drafting a resource sharing agreement between KACH and a VA Medical

Center in the West Point area. The draft agreement will derive from the model developed during Phase II of the research methodology portion of the research project. This phase will conclude when the Director of the participating VA Medical Center and the Commander, KACH have both signed the Resource Sharing Agreement.

Footnotes

[1]U.S. Department of Health and Human Services, DHHS Publishing No. (PHS) 83-1232, "Health, United States 1982" (Hyattsville, MD: Public Health Service, December 1982), pp 2-3.

[2]Augustin Hedberg, "Health Care: Getting the Best Value" MONEY (September 19820, pp 55-58.

[3]Charles H. Percy, US Senator from Illinois, report from the Committee on Governmental Affairs to the 97th Congress in "VA/DOD Health-Care Resources Sharing Act: Hearing Before the Committee on Veterans' Affairs, United States Senate" (Washington, D.C.: US Govt Printing Office, 1982), p 278.

[4]The Commmission on Hospital Care, Hospital Care in the United States (Cambridge, Massachusettes: Harvard University Press, 1947), Chapter 27.

[5]President's Commission on the Health Needs of the Nation. Building America's Health (5 Vols) (Washington, D.C.: GPO, 1952), Vol 2.

[6]Milton I. Roemer and Robert C. Morris "Hospital Regionalization in Perspective" Public Health Reports 74: 916 October 1959.

[7]Mark S. Blumberg, Shared Services for Hospitals (Chicago, IL: American Hospital Association, 1966).

[8]American College of Hospital Administrators Task Force X, An Examination of Shared Services (Chicago, IL: American College of Hospital Administrators, 1974).

[9]Public Law 89-785, "Comprehensive Health Planning and Public Health Service Amendments" (42 USC 246), 1966.

[10]38 USC 5003.

[11]42 USC 299-299J, "Heart Disease, Cancer and Stroke Amendments," 1965.

[12]42 USC 246.

[13]Public Law 93-641, "National Health Planning and Resources Development Act" (42 USC 300 et seg.), 1974.

[14]Health Services Research Center, Services Shared by Health Care Organizations Volume 1 "A National Focus" (Chicago, IL: Health Services Research Center, 1977).

[15]31 USC 686 (Economy Act).

[16]38 USC 5003.

[17]38 USC 5053.

[18]Comptroller General "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" Report to the Congress-HRD-78-54 (Washington, D.C.: General Accounting Oficer, June 14, 1978), pp 44-45.

[19]Ibid, p 46.

[20]Ibid, p 47.

[21]Ibid, pp 48-49.

[22]"The White Paper" Federal Health Resources Sharing Committee, 1977.

[23]Comptroller General, p ii.

[24]"All New Jersey Hospitals Swith to Diagnosis-Related Reimbursements" Medical World News 23:3 (February 1, 1982) pp 30, 37-8.

[25]Elworth Taylor, "Survey Shows Who is Sharing Which Services" Hospitals (September 16, 1979), pp 147-152.

[26]William B. Schwartz and Paul L. Joskow, "Duplicated Hospital Facilities How Much Can We Save by Consolidating Them?" The New England Journal of Medicine (December 18, 1980) pp 1449-57.

[27]Theodor Litman and George Johnson, "Sharing Services: The Dynamics of Institutional and Administrative Behavior" Hospital and Health Services Administration (Fall 1980) pp 7-22.

[28]Vince DiPaolo, "Shared Service Business Soars 31%" Modern Healthcare (October 1981), pp 68-74.

[29]Linda Punch, "Shared Services Pacts Up 22%" Modern Healthcare (July 1982), pp 128-34.

[30]Esther F. Kuntz. "Shared Service Activity Might Spurt in '83 After Sluggish '82" Modern Healthcare (August 1983) pp 106-30.

[31]Donald E. L. Johnson, "Use of Management Contracts Climbs 16.7%; Clients Up 7.1%" Modern Healthcare (August 1983) pp 89-95.

[32]Ellworth Smith and Dorothy Cobb, "AHA Surveys Show That Fewer Hospitals are Participating in Shared Services" Hospitals (September 1, 1983), pp 67-70.

[33]Alan Weinstein, "Shared Services May Provide Hospitals With a Competitive Edge" Hospitals (September 1, 1983), pp 60-64.

[34]Janet Plant, "Shared Service Organizations Evolve Into Multi-facet Businesses" Hospitals (September 1, 1983), pp 71-76.

[35]Richard J. Davidson, "MHA Supports Voucher System, Not New VA Hospital" Hospital Progress (July 1980), pp 8-10.

[36]Linda E. Demkovich, "When it Comes to Planning Hospitals, the VA Marches to its Own Beat" National Journal (August 30, 1980), pp 1428-33.

[37]Cynthia Wallace, "VA Not Immune From Competition" Modern Healthcare (May 1983), pp 154-5.

[38]Percy, p 64.

[39]Ibid, pp 4-12.

[40]Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act" (38 USC 5011) May 4, 1982.

[41]VA Circular 10-83-150, "Instructions for Implementing the Sharing Provisions of Public Law 97-174" Office of the Department of Medicine and Surgery, Washington, D.C. September 7, 1983.

[42]Interview with LTC Steven Arnt, Project Officer for Shared Resources, Office of the Assistant Secretary of Defense, Health Affairs, Washington, D.C. September 14, 1983.

[43]Department of Defense Directive (Unnumbered Draft) "VA/DOD Healthcare Reosurces Sharing Guidelines" Washington, D.C., undated.

CHAPTER II

DISCUSSION

Background

In the spring of 1979, Mr. Corydon F. Heard, Director of the Franklin Delano Roosevelt VA Medical Center, Montrose, New York (Montrose VA) first expressed a desire to share medical resources with Keller Army Community Hospital (KACH), West Point, New York.[1] The mechanics of Federal interagency resource sharing were unfamiliar to both facilities and the issue was only briefly discussed before being dropped from consideration. The Government Accounting Office (GAO) had predicted only one year earlier, that disincentives to resource sharing between Federal facilities would result in reluctance to share by Federal facilities.[2] This 1978 GAO report identified the following Federal interagency sharing disincentives:

1. The absence of specific legislative authority and adequate headquarters guidance on how to share. As of April 1978, the DOD had no fewer than three laws authorizing resource sharing with the VA[3], including 31 USC 686, 38 USC 5003 and 38 USC 616. The VA had four laws authorizing resource sharing with the DOD[4]: 31 USC 686, 38 USC 5053, 38 USC 5003 and 10 USC 1074 (b). Each law contained its own reimbursement mechanism and was subject to different interpretation by each agency, consequently the extent of resource sharing being conducted was minimal in terms of the total medical resources controlled by the DOD and the VA.

2. There were restrictive regulations, policies and procedures. Army Regulation 40-3 imposed restrictions on providing services to VA

beneficiaries under authority of the Economy Act (31 USC 686).[5] Paragraph 4-30, AR 40-3 limited routine VA beneficiary care to Army facilities "where beds have been allocated" by prior agreement. Admission to an Army facility in the United States in which bed allocations had not been made would be authorized only in emergencies. The Economy Act permitted resource sharing, but was interpreted narrowly and inconsistently by the VA.[6] The GAO study further discovered that several opportunities to share had been unsuccessful because of the VA's inability to budget for the care of another agency's beneficiaries.[7]

3. Inconsistent and unequal reimbursement methods were being employed. The final obstacle to interagency resource sharing identified by the GAO was that no standard reimbursement mechanism existed for resource sharing between Federal facilities, reimbursement rates differed between the two agencies and no policy existed for allocating reimbursement back to the providing facility. This finding was reinforced by the discovery that the VA required full cost reimbursement, while the DOD used interagency reimbursement rates.[8]

These obstacles functioned as disincentives to resource sharing and it was, therefore, little surprise that the initial attempt at resource sharing between KACH and the Montrose VA proved unsuccessful. At Appendix B is a copy of Public Law 97-174 which was directed at removing the obstacles to resource sharing that were addressed by the 1978 GAO report. PL 97-174 established a Health Care Resources Sharing Committee (HRSC) to implement the law (a copy of the HRSC Charter is at Appendix C), but

implementation guidance was slow in arriving to facilities in the field. When, on March 29, 1983, Mr. Heard, once again, expressed a desire to share resources with KACH,[9] guidance had not been provided to either facility, and the request received no action by the KACH management.

On July 1, 1983, Harry N. Walters, VA Administrator, signed the official Memorandum of Understanding between the VA and DOD, Caspar Weinberger signed the Memorandum on July 29, 1983, thus providing the first implementation guidance to VA and DOD facilities. At Appendix D is a copy of the signed VA/DOD Memorandum of Understanding. Receipt of this document stimulated increased interest in resource sharing at KACH so that shortly after the arrival of the resident at West Point. the issue of resource sharing with the local VA Medical Centers had been discussed by staff members at KACH.

There had been sufficient interest generated at KACH on resource sharing by September 1983, that the resident scheduled a visit to the Office of the Assistant Secretary of Defense, Health Affairs during the period 14-16 September 1983. Sufficient background information and direction on resource sharing was received during the visit that the Deputy Commander for Administration (DCA) and Commander, KACH decided to initiate a concerted effort to implement the resource sharing provisions of PL 97-174 at KACH.[10] Development of the strategy to design a resource sharing model and draft agreement that would be acceptable to the Commander, KACH and a VA Medical Center Director was now ready for systematic investigation. The Montrose VA was selected to pursue development of a resource sharing agreement based on their expressed interest and proximity to KACH.

The Challenge

The effort required to implement a resource sharing agreement between health care facilities would be classified as a formidable challenge for any health care planner, but with the historical disincentives to VA/DOD sharing and the tradition of practiced isolationism characteristic of the United States Military Academy and KACH, the magnitude of the challenge became even more disquieting. Previous attempts by the Montrose VA to share resources with KACH had been unsuccessful and, therefore, the sudden interest in resource sharing by KACH was received, by the staff at the Montrose VA, with a degree of suspicion.[11] The 17 mile distance between KACH and the Montose VA, connected by a winding mountain road that was subject to coverage by snow and ice during the winter months, would hinder the continuous coordination that would be required to complete the project. With only 65 beds, KACH was significantly smaller than the 1403 bed Montrose VA, with proportionately less resources available to be shared. How this size and resource availability differential would affect the resident's ability to accomplish the study objectives was unknown as the research effort began.

Even though the staff at KACH was aware of the magnitude of the undertaking, what was unknown was how such a task could be managed to arrive at the desired resource sharing agreement.[12] A list of project milestones was developed by the resident to accomplish the project in a timely manner. These milestones, reflected in Figure 2, would function to give direction to the project while increasing the probability of completing the study prior to May 1984.

Milestone	Suspense Date
Initial Meeting with VA	1 Oct 84
Preliminary Analysis of Existing System	15 Oct 84
Needs Assessments Completed	1 Nov 84
Determine Billing Procedures	15 Nov 84
Identify Potential Areas for Resource Sharing	1 Dec 84
Determine Resources to be Shared	15 Dec 84
Complete Cost Analysis	1 Jan 84
Complete Model	10 Jan 84
Complete First Draft	20 Jan 84
Complete Staffing of First Draft	1 Feb 84
Complete Final Draft	10 Feb 84
Complete Staffing of Final Draft	20 Feb 84
Final Document Signed by Both Facilities	1 Mar 84

Figure 2 - Milestones For Developing a Resource Sharing Agreement

Preliminary Analysis of the Existing System

By October 1, 1983, any questions regarding KACH's intentions to support the resource sharing provisions of PL 97-174 had been answered. In short, the West Point Hospital that had for so long confined its operations to the boundaries of the USMA was now committed to supporting the development of a health care resource sharing agreement with the Montrose VA. The newly accepted mission did not, however, provide for a complement of assets to assist KACH in meeting the additional workload required by the new mission.

Expertise to implement the sharing agreement would have to be developed using existing resources. Acquisition of the basic knowledge to begin a systematic attempt to develop a resource sharing agreement would require: communicating with the VA Central Office, office of the Assistant Secretary of Defense (Health Affairs) and members of the HRSC; communicating with the Deputy Chief of Staff, Operations at Health Services Command; informal telephone communication with US Army MEDDACS and MEDCENS to obtain an impression of the present level of US Army participation in interagency sharing agreements; analyzing categories of shared services; and examining advantages and disadvantages of resource sharing.

Mr. Jim Simmons of the VA Central Office was contacted on October 10, 1983, and asked to provide an update on VA/DOD resource sharing.[13] During this conversation, he stated that only four resource sharing agreements had been approved as of October 10, 1983, and that none of these were between VA and US Army facilities. He also provided information on the review and approval process for resource sharing agreements required

by the VA Central Office of subordinate VA Facilities who wished to enter into a sharing agreement under the provisions of PL 97-174. Figure 3 diagrams the process required for VA hospitals to obtain sharing agreement approval. Once the signed agreement is received by the Regional

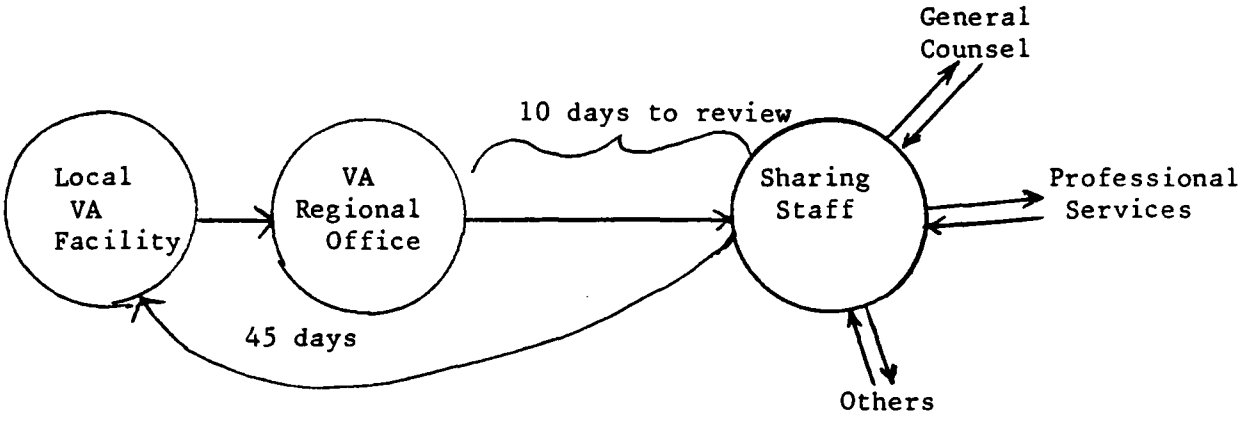


Figure 3 - VA Review/Approval Process

Office it must be approved, or disapproved within 45 days, or the agreement automatically goes into effect. Once the agreement is in effect it may only be terminated by a participating facility. Disapprovals must be fully justified, in writing, and arrive back at the originating facility prior to the end of the 45 days. or the agreement may be put into effect as though it had been approved. According to Mr. Simmons, the VA historically has spent close to 10 percent of its annual health care budget on civilian care for its beneficiaries. The many disincentives to interagency sharing, however, had placed sharing with the DOD as a low priority alternative

to containing these costs. The fact that reimbursement funds did not accrue to the providing facility, but rather were funneled to a central repository for redistribution and the lengthy, complicated review/approval process had, very simply, not encouraged interagency sharing. Mr Simmons expressed extreme optimism over the potential of PL 97-174 to overcome these disincentives and anticipated a significant increase in interagency sharing during 1984.

Lieutenant Colonel Stephen Arnt, Office of the Assistant Secretary of Defense, Health Affairs and present chairman of the HRSC was contacted next.[14] He stated, that at present no US Army facilities had resource sharing agreements under PL 97-174, but that he had been contacted by Munson Army Hospital, Fort Leavenworth and they had initiated one. He further stated that the DOD spends more of its total health care budget on civilian care for beneficiaries than the VA, but was unable to quote a specific percentage of the budget involved. He discussed the US Army review and approval process for resource sharing agreement requests under PL 97-174 as reflected in Figure 4. The medical treatment facility submits the signed agreement to Health Services Command (HSC) who has approval/disapproval authority. As with the VA, approval or disapproval

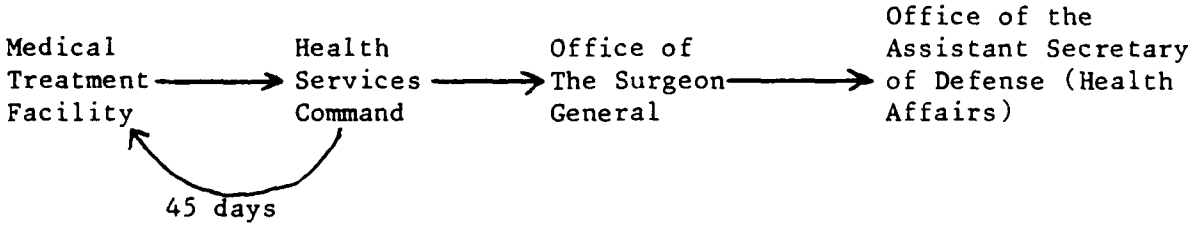


Figure 4 - DOD Review/Approval Process

(justified in writing) must be provided the requesting facility within 45 days, or the agreement automatically goes into effect. HSC provides a copy of the agreement, with their approval or disapproval. to the Office of The Surgeon General (OTSG) who, in turn, provides a copy to the Office of the Assistant Secretary of Defense, Health affairs. He went on to state that the driving force behind PL 97-174 was cost containment. When asked when official DOD guidelines on resource sharing could be expected, he stated that draft guidelines had been published, but that official guidelines would not be available to individual facilities before May 1984.

The review and approval processes for both the VA and DOD have two built-in mechanisms to reduce the time required to process sharing agreements: (1) the entire process must not exceed 45 days from the date that the approving authority receives the proposed agreement, or it automatically goes into effect; and (2) if disapproved, a full written justification must be provided to the facility submitting the agreement.

Lieutenant Colonel James Moa, Project Officer for VA/US Army resource sharing agreements, in the Office of the Deputy Chief of Staff, Operations at HSC, was contacted next to determine if his office was aware of any additional participation by US Army facilities.[15] He stated that he was aware of efforts by the MEDDAC at Fort Leavenworth, but had knowledge of no other resource sharing activities among US Army facilities.

PL 97-174 was signed into law in May of 1982, yet as late as November 1983, it appeared that there was only one Army medical facility seriously pursuing interagency resource sharing. In an attempt to obtain further information on participation by US Army facilities, the resident made informal telephone contact with the Comptrollers at five MEDDACS and two MEDCENS. These facilities were selected at random and the results of the conversations are reflected in Figure 5. Results indicated that not only was there little participation in resource sharing among the facilities contacted, but at two facilities the Comptroller was unaware of the existence of PL 97-174. Only one facility, Munson Army Hospital, was actually negotiating an agreement. Kenner Army Hospital indicated that resource sharing would be pursued as soon as the local VA Medical Center completed the construction project which was underway. The results of this telephone survey would appear to be attributable to poor publicity by the VA and the DOD of PL 97-174, the fact that resource sharing was not mandated under this law and the failure by the DOD to provide official implementation guidelines to military facilities.

Medical Facility	Aware of PL 97-174	Negotiating an Agreement	Considering an Agreement
1. Wm Beaumont AMC	Yes	No	No
2. Madigan AMC	Yes	No	No
3. Kenner Army Hospital	Yes	No	Yes
4. Martin Army Hospital	No	No	No
5. Womack Army Hospital	Yes	No	No
6. Dewitt Army Hospital	No	No	No
7. Munson Army Hospital	Yes	Yes	N/A

Figure 5 - Informal Telephonic Participation Survey Results

The one hospital that indicated negotiations with a VA facility were underway was Munson Army Hospital. The Comptroller at Munson agreed to forward a copy of the agreement when it was completed, but cautioned that all they were doing was converting an existing contract into the format recommended by the VA.[16] At Appendix E is a copy of the agreement between Munson Army Hospital and the Leavenworth VA. The format and components of the agreement were evaluated by the resident for possible application in an agreement at KACH. The use of contract terminology and components required by 38 USC 5053, but eliminated by PL 97-174, such as the inclusion of a disputes clause, an equal opportunity clause and even the insertion of the contract number in block 1A, reduced the value of the document as a resource to assist the resident in solving the research problem. Anticipated savings to Munson Army Hospital through resource sharing were, however, identified and further supported the potential benefits that could accrue through interagency sharing.

Delays by the VA and the DOD in providing guidelines to facilities for implementing PL 97-174 contributed to the year-long hiatus between enactment of the law and a response by US Army medical facilities. In September of 1983, the VA published guidelines on implementing the sharing provisions of PL 97-174, but as late as December 1983, the DOD still had not published official guidelines. Without official guidelines, and before further pursuing resource sharing, the resident felt compelled to review existing literature to identify categories of shared services and potential advantages/disadvantages to resource sharing.

Categories of Shared Services: A literature review, combined with telephonic interviews with staff members at the VA Central Office[17] and the Chairman of the HRSC,[18] successfully identified a number of methods available for organizing and operating shared services. Major distinctions between these methods related primarily to the physical location of the service, who would use the service and legal agreements of participants. In 1972, DHEW classified institutions into four categories based upon the extent of control and responsibility for the resource to be shared:[19]

1. Referred service - A service maintained by one member of a group of health care institutions and patients from all member institutions are referred to the institution providing the care.

2. Purchased service - A service for which an institution pays directly to the provider for the care desired. The institution obtaining the service does not own or operate it, but acts as an intermediary between the supplier and patient.

3. Multiple-sponsored service - A group of institutions jointly control and operate a service.

4. Regional association service - A service sponsored by an association of institutions, formed for a specific purpose.

From these four categories it was evident that a resources sharing agreement between KACH and the Montrose VA would most appropriately result in resource sharing categorized as purchased services under the above categorization scheme. Each facility would purchase needed resources from the other facility and reimburse that facility directly for providing the service.

Advantages and Disadvantages: Schweiker,[20] Griffin[21] and Smith and Cobb[22] have all authored articles addressing the advantages and disadvantages of resource sharing. Each author has produced a list of advantages and disadvantages with some comparative variability, but they all have concluded that the advantages of resource sharing outweigh the disadvantages. A review of the resource sharing literature, combined with interviews at the Montrose VA[22] and with the Deputy Commander for Administration (DCA) at KACH,[23] along with information obtained from the VA Central Office and the HRSC discussed earlier in this study, was used to identify the following potential advantages of resource sharing between the Montrose VA and KACH:

1. Affordability - If Federal beneficiaries expect to share the benefits of costly new technology, they will also have to share accessibility to this technology to keep health care affordable. Federal health care has enjoyed relatively little cost containment pressure in the past, however, indications are that this may not be the case in the future as increased attention is focused on spiraling Federal health care costs. Resource sharing between the Montrose VA and KACH would be a voluntary, proactive measure to contain costs, while at the same time, increasing accessibility to Federal health care for beneficiaries in the West Point, New York area.

2. Reduced Reliance on CHAMPUS and CHAMPVA: A resource sharing agreement between the Montrose VA and KACH would assist the Government in reducing a growing reliance on external health care delivery, such as DOD's CHAMPUS and the VA's CHAMPVA, which provide care to beneficiary populations when care is not available, or inconvenient, from the

Federal direct health care providers. Such an agreement would further reduce the costs to beneficiaries required to pay the deductible associated with care received under CHAMPUS and CHAMPVA.

3. Increased Efficiency: KACH and the Montrose VA should experience increased staff efficiency and improved patient care capabilities by consolidating workloads and resources.

4. Reduced Capital Outlay: Supplemental care costs for KACH in FY 83 were $169.2 thousand, an increase of $89.2 thousand over the FY 81 total.[24] Halting this trend toward increased supplemental care costs would be a positive action to contain Federal health care costs on the part of KACH.

5. Improved Patient Convenience: KACH presently refers patients to facilities as far away as 40 miles from West Point for diagnostic testing not available at KACH. The Montrose VA transports patients. on a weekly basis, to the Bronx VA, approximately 50 miles away. KACH is located 17 miles from the Montrose VA and, therefore, resource sharing between these facilities should improve the convenience of accessing the health care system for both facility's beneficiary populations.

6. Funds Received are Retained: Prior to PL 97-174, all funds received by a Federal facility for services provided to another Federal facility were funneled back to a central fund in Washington, DC. Under this arrangement, there was little incentive to develop and implement resource sharing programs between Federal facilities. PL 97-174 acknowledged this disincentive and authorized the providing facility to credit funds received as reimbursement from another Federal facility directly to the providing facility's local account. Additional unprogrammed money to purchase equipment should improve the quality of care available at both practicipating facilities.

7. Improved Communication: The practice of isolationism at West Point has already been discussed. A resource sharing agreement between the Montrose VA and KACH would have the potential benefit of establishing a working relationship between the two facilities which should facilitate responding to the medical needs of the Federal beneficiary population in the West Point area. By establishing a working relationship with the Montrose VA, the isolationist tradition of KACH would be visibly broken and may improve lines of communication. between KACH and other health care facilities in the local area.

8. Anticipates Mandate: Health care cost containment has received increased emphasis during the past few years. A resource sharing agreement at this time anticipates a Congressional cost containment mandate directed at Federal facilities which would appear imminent in view of the relatively minimal voluntary cost containment efforts. Proactive involvement by KACH with the Montrose VA may further encourage other Federal facilities to follow this lead, thereby decreasing the need for mandated legislation and reducing the impact of such legislation, if enacted, on those facilities participating.

The potential disadvantages of entering a resource sharing agreement at West Point were identified as:

1. Beneficiary Eligibility: There has still been no clarification by the VA Central Office. or the DOD, on the eligibility of each beneficiary population at the other agency's facility. This is of particular interest to KACH as the VA has always held that dependents of active duty military would not be provided care at VA facilities. Failure to resolve this issue could result in confusion. as well as, resentment by staffs and beneficiaries of both facilities.

2. Outyear Resource Acquisition: A resource sharing agreement could result in reduced funding to participating facilities that is directly proportional to the facility's identified savings through resource sharing. Increased savings through sharing would decrease future funding with the potential that a facility could eventually reach a point where it could no longer operate independently.

3. Standardization: Innovation has been a valuable asset for medical facilities through the years. A sharing agreement has the potential to stifle this innovation by standardizing operations.

4. Loss of Antonomy: The potential exists for a participating facility to experience a loss of autonomy as a result of resource sharing. This may be manifested through a loss of self-image, each facility must give up something as a participant, or as a loss of flexibility in terms of decreased control over the health care provided and the quality of the care.

The potential advantages and disadvantages of a resource sharing agreement at KACH were discussed with the DCA, KACH.[26] The determination, at the conclusion of this discussion, was that the advantages far outweighed the disadvantages and the decision was made to pursue implementation of a resource sharing agreement between KACH and the Montrose VA.

Design of the Implementation Strategy

Implementation of the resource sharing provisions of PL 97-174 at KACH can best be explained as a four phase process. The first three phases would be accomplished as a part of this study, the final phase would extend beyond the deadline for project completion and would, therefore, not be included in the present study. The first phase would be termed,

"The Data Acquisition Period," during which time initial meetings between participating facilities would occur, needs assessments would be completed and identification of potential resource sharing areas would be accomplished. The second phase would take over from the data acquisition period and analyze the data acquired during the first phase. A model that identified key components of a resource sharing agreement would be developed as the final objective of this, "The Data Analysis" period of the study. Phase three would apply the model developed in Phase two, the result of this application would be a draft resource sharing agreement between the Montrose VA and KACH. For this study, implementation will end when the authorized signatories from each participating facility have signed the agreement. The final phase will implement the resource sharing agreement once it has been approved by the VA Central Office and HSC. Once implemented, periodic evaluations of the resource sharing process will be required, along with modifications, as appropriate, to maximize the potential success of the agreement.

The research project objectives of conducting an in-depth literature review, examining the historical environment that formed the basis for PL 97-174 and identifying barriers to effective implementation of a sharing agreement were accomplished earlier in the study. The challenge of Phases I-III of the implementation strategy would be how to take the information gathered from meeting these objectives and apply it to fit the organizational uniqueness and individual facility needs of KACH and the Montrose VA.

Implementation Strategy - Phase I

The period from September through November 1983, was required for development of an initial strategy to govern implementing the resource sharing provisions of PL 97-174 at KACH. Several objectives were chosen for this period and were designed to provide a solid working foundation for the ultimate development of a functional resource sharing agreement. The objectives were: to open communication channels between KACH and the Montrose VA; to identify services provided by each participating facility; to identify medical services contracted for with civilian facilities; to conduct a needs assessment of each participating facility; and, to identify potential resource sharing areas. These five objectives were integrated, but they represented specific interim tasks required to accomplish the purpose of the study. Each objective would have to be met before the study could proceed to the next phase.

On September 29, 1983, the resident met with the Director and primary staff members of the Montrose VA.[27] This meeting opened formal communication lines between KACH and the Montrose VA. Members present agreed that opportunities for resource sharing between the two facilities had existed for a long time and that it was time to take advantage of these opportunities. Identification of Ms Mary Farrell, Quality Assurance Coordinator at the Montrose VA, as a single point of contact to assist in developing the resource sharing agreement, served to enhance project continuity and reduce the overall coordination effort. At this initial coordination meeting, the resident provided a list of critical milestones to be accomplished in arriving at the desired agreement. Figure 6 is a copy of the milestones that were presented. It was agreed by all attendees that the milestones,

and their corresponding target dates for completion, would provide acceptable direction to the effort ahead.

Milestone	Completion Date
List of Services Provided	Oct 15, 1983
Needs Assessments	Nov 15, 1983
Negotiate Services to be Shared	Jan 1, 1984
Draft Agreement	Feb 1, 1984
Agreement Signed	Mar 1, 1984
Agreement Approved by VA and HSC	Apr 15, 1984
Implementation	May 1, 1984

Figure 6 - Milestones for Implementing the Resource Sharing Agreement

The initial milestone was for each participating facility to identify the services which their facility provided, this list would later be used to assist in identifying potential resource sharing areas. At Appendix F is a copy of the list of services provided at KACH and at Appendix G is the list for the Montrose VA. The consideration of potential resource sharing areas that would occur later in the agreement's development would be restricted to the services identified on these two lists.

Joint acquisition of a Computed Tomography (CT) Scanner was also discussed at this initial meeting. KACH was purchasing CT Scans from civilian hospitals at a supplemental care cost in FY 1983 of approximately

$50,000.[28] The Montrose VA was transporting patients to the Bronx VA, approximately 50 miles distance, for their scans. Both cost and patient inconvenience were major concerns of the participating facilities. Each facility requested approximately 200 CT scans in FY 1983 and, although this number was expected to rise over the next few years, the demand fell significantly short of the state Certificate of Need (CON) compliance requirement of not less than 1500 scans per year.[29] Although Federal facilities are not bound by state CON requirements, attendees agreed that workload at this time, even when combined, could not justify acquisition of a CT Scanner and discussion on joint CT Scanner acquisition ended.

The final subject addressed at the September 29th meeting was current contracts of each facility for medical resources with civilian facilities. An acceptable resource sharing agreement should demonstrate an expected cost reduction to participating facilities over the cost of similar resources from civilian facilities. It was discovered, however, that neither KACH nor the Montrose VA had formal contracts with civilian facilities, civilian contracts were not an issue in developing this resource sharing agreement.

After the initial meeting with the Montrose VA, and before pursuing a resource sharing agreement any further, answers were required to the following questions:

1. Are certain services more efficient to share than others? The literature indicated that resource sharing has concentrated on the administrative services with an intentional avoidance of the direct patient care services.[30] This concentration on sharing administrative services was justified, according to the authors, on there being less risk and more efficiency than would be associated with sharing direct patient care services.

2. Can cost-saving expectations be defined for each type of service to be shared? Pivotal to an accurate response to this question is the requirement for the acquisition of reliable financial cost data to serve as a baseline for an objective judgment. Underlying all other considerations for entering, continuing, benefitting and creating similar programs are the economics of shared services. While the full range of benefits to resource sharing must be investigated, the one basic matter that most often sanctions or negates any shared service program is the financial cost to the participants.

Any consideration to enter into a resource sharing agreement should be evaluated in terms of the positive alternatives provided by such an agreement. This evaluation must consider two interdependent items: (1) service (for which the organization was created and now exists) and (2) cost (which makes the organization's programs of service possible). The following positive alternatives provided by a sharing agreement should be analyzed:

Same Service - Same Cost
Better Service - Same Cost
Same Service - Better Cost
New Service - New Cost

If one of the above alternatives does not result from an analysis of the potential sharing area, extreme care would be indicated to determine if the associated costs were outweighed by the benefits that would accrue. A decision to share when a negative alternative results would require considerable evaluation, analysis and necessary caution.

3. What guidelines should be followed? On October 20, 1983, the only official guidance on VA/DOD resource sharing was the Memorandum of Understanding between the heads of the two agencies and VA Circular 10-83-150, both addressed earlier in the study. The DOD had not published official guidelines for use in developing a resource sharing agreement and. for this reason, a delay in further development of a resource sharing agreement at KACH resulted.

The delay in developing the sharing agreement lasted until the HRSC Workshop at the Northport VA Medical Center, Long Island, New York on October 25, 1983.[31] The Draft DOD Directive on resource sharing was distributed to the attendees at the workshop with instructions that the Directive was not official, but could possibly assist in preparing an agreement. A copy of the draft DOD Directive is at Appendix H, and when combined with the VA Guidelines in Circular 10-83-150 at Appendix I, the VA/DOD Memorandum of Understanding, PL 97-174 and an extensive literature review, provided sufficient guidance to, once again, pursue the development of a resource sharing agreement at KACH.

Following the HRSC Workshop, the resident, with assistance from the Comptroller's Office and Patient Administration Division at KACH, conducted a needs assessment of KACH. Needs were defined as medical care. either services or resources, that are required by the DOD beneficiary population at West Point, but which are not provided at KACH. This care was available through CHAMPUS, TDY trips to Walter Reed Army Medical Center, or through the Supplemental Care Program. CHAMPUS is funded centrally, control of these funds is not with the Comptroller of KACH, and patients receiving

When the potential resource sharing areas had been identified for KACH, the data gathering effort for the Montrose VA began. The week of November 14-18, 1983 was used by the resident to assess the needs of the Montrose VA. With assistance from the Fiscal Officer and Deputy Director of the Montrose VA, and taking into consideration that the Director did not want services provided to the Montrose VA by other VA facilities identified as needs,[34] the needs of the Montrose VA were identified. Only two needs were identified: (1) OB/GYN care, and (2) Emergency Room outpatient care for VA beneficiaries with easier access to KACH than the Montrose VA. These needs were compared with the services provided at KACH to identify potential resource sharing areas as reflected in Figure 8.

Service/Resource Required	Estimated Monthly Demand
OB/GYN Outpatient Visit	1
OB/GYN Routine Exams by a DOD Physician at the Montrose VA Facility	10 (every visit-each two months)
ER/OPC Minor Outpatient Surgery	4
ER/OPC Setting Simple Fracture-Outpatient	2

Figure 8 - Potential Resource Sharing Areas Required by the Montrose VA

Implementation Strategy -

Phase II

Phase II of the implementation process began when the potential areas for resource sharing at each facility had been identified. The acquisition of data that had occupied Phase I transitioned into data analysis in Phase II. Phase II would consider: whether pursuit of a resource sharing agreement between the two facilities should be continued; the process of determining excess capacity for areas to be shared and the corresponding volume of demand to be supported; cost savings expectations; an analysis of costs for each potential sharing area; the components of a model resource sharing agreement.

The decision of whether to continue to pursue a resource sharing agreement after the data acquisition phase was considered necessary in view of the implications which would accompany such a decision. Resistance to changing the present system of providing health care to beneficiary populations was clearly evident from comments by staff members of both facilities. This resistance manifested itself most frequently in a series of "What If" questions. Bordering at times on making no sense, these questions appeared to be efforts by staff members to identify some reason, however shallow, to declare interagency sharing unacceptable. Unlike the Contingency Planning aspects of PL 97-174, the resource sharing provisions were not a mandate to Federal facilities and, therefore, efforts to complete a resource sharing agreement were frequently overcome by the daily operations of each facility. It was not until December 6, 1983 that the Commander, KACH made the final decision to continue efforts

to develop a resource sharing agreement.[35] With this final decision, negotiations to arrive at resources to be shared and corresponding levels of demand to be supported were now ready to begin.

Excess Capacity Determinations

Phase I had identified services provided, as well as the needs of each facility, it was now time to determine which of these potential sharing areas could be shared, along with the corresponding level of demand for the resource that could be supported. Determination of excess capacity at each facility for the potential sharing areas was required before a decision could be made to share a particular resource. At KACH excess capacity was determined through a two-step process: First, the latest Manpower Survey Report[36] was reviewed to obtain workload data that was used to recognize staffing level requirements. The current staffing levels of each potential sharing area, based on the Manpower Survey Report results, were then compared with actual FY 83 cummulative workload data reflected in the Uniform Chart of Accounts.[37] Comparisons were accomplished for each of the potential sharing areas that had been identified earlier. Second, the supervisor of each service with a potential resource to be shared was personally interviewed to (1) verify excess capacity results, and (2) solicit support for the resource sharing agreement, once implemented. Table 1 reflects the results of the excess capacity determinations for KACH.

Table 1 - Excess Capacity, KACH

Potential Sharing Area	Excess Capacity	Montrose VA Estimated Monthly Demand
OB/GYN - Walk-in Outpatient	6	1
OB/GYN - Routine Exams Provided at the Montrose VA	20 patients/visit	10 patients/visit
ER/OPC - Minor Outpatient Surgery	16	4
ER/OPC - Setting of Simple Fractures-Outpatient	8	2

KACH had sufficient excess capacity identified for each potential sharing area to support the estimated demand from the Montrose VA. Concern, however, was voiced by the Chief, ER/OPC[38] that because of no appointment system in these two outpatient clinics the patient workload fluctuates and actual excess capacity frequently changes. He was certain that there would, however, be no trouble absorbing the volume of increased demand that would be required to meet the needs identified for the Montrose VA.

In that the VA does not have a document comparable to the UCA, excess capacity for the Montrose VA was accomplished by going directly to the supervisor of the service providing the potential resource to be shared and asking how many of each diagnostic test needed by KACH could be provided, without disrupting routine care to the VA beneficiary population. Table 2 reflects the results of this information gathering process at the Montrose VA.

Table 2 - Excess Capacity, Montrose VA

Potential Sharing Area	Excess Capacity	KACH Estimated Monthly Demand
Thyroid Scan	4	2
Bone Scan	4	11
Liver/Spleen Scan	2	1
24 Hours Holter Monitor	2	3
Electro Encephalogram	3	4

Of particular disappointment to KACH was the lack of additional bone scan capacity at the Montrose VA. In FY 83, KACH expenditures for bone scans amounted to more than $32,000,[39] which represented approximately 19% of the total supplemental care costs for KACH, and with a civilian cost per scan of $245.25, KACH had hoped that the Montrose VA would have enough excess capacity to fully absorb KACH's nuclear medicine needs.

It was agreed, by representatives from both facilities, at a meeting on December 12, 1983,[40] that the excess capacity identified at each facility not be exceeded in the terms of the sharing agreement. This was considered essential to comply with the criteria that a model resource sharing agreement not interfere with routine care provided to the beneficiary populations of each facility. If the methodology used to determine excess capacity was sound, it was anticipated that each facility would experience a reduction in excess capacity through resource sharing.

Cost Analysis

After the resources to be shared had been identified, along with corresponding estimated monthly demand, it was time to conduct a cost analysis. The cost analysis consisted of comparing the cost of resources purchased from the local civilian health care community with the cost of the resource under the provisions of the sharing agreement. VA and DOD guidance had been that Federal facilities should not enter into resource sharing agreements unless a benefit. in terms of cost savings or convenience to the patient. would result.[41]

An exact methodology for costing out each resource to be shared at KACH was not readily available, but the HRSC members at the Northport VA workshop in October had stated that the latest cumulative UCA report, along with any adjustments which were needed, and DOD Directive 6010.10 should be used.[42] Paragraph 3-104 of the VA/DOD Memorandum of Understanding[43] further stated that reimbursement rates would not exceed the actual costs to the facility for providing the service. With these guidelines, the reimbursement rates for KACH were determined as presented at Appendix K.

Computation of reimbursement rates for the Montrose VA were slightly more complicated, in that the VA does not use a document which approximates the Army's UCA. The Fiscal Officer at the Montrose VA, Mr. Jerry Hussong, his staff and the resident had to take the annual funds provided each service involved in the agreement and determine a per procedure cost for each resource to be shared. At Appendix L are the reimbursement rate computations for the Montrose VA. Specifically prohibited by regulation

from being included in reimbursement rate computations were building depreciation, interest on net capital investment and central office overhead.[44] Actual costs considered were the cost of personal services, supplies, utilities, equipment depreciation and maintenance contracts.

Once the reimbursement rates had been computed for each facility, they were compared with the cost of purchasing the resource from the local civilian health care community. Data on costs for civilian purchased resources was provided by the Patient Administration Division, KACH.[45] The comparison was made by developing an Economic Impact Analysis (EIA) for each facility. At Appendix M is the EIA for the Montrose VA. By implementing the sharing agreement with KACH, the Montrose VA would realize an estimated annual cost savings of between $6,265 and $6,210 over the cost of purchasing the resources from the civilian sector. Cost comparisons indicated that each resource to be shared would provide an estimated cost savings to the Montrose VA. The advantages of resource sharing to the Montrose VA were further amplified by the fact that outpatient care not provided at the Montrose VA was being obtained by transporting patients to the Bronx VA in New York City.[46] Resource sharing with KACH should improve health care convenience to the VA beneficiary population.

At Appendix N is the EIA for KACH. Convenience to the military beneficiary population, although it should be improved through resource sharing, was considered less significant to KACH than to the Montrose VA. Cost savings, or rather containment of supplemental care costs

which had risen from $81,000 in FY 81 TO $169,200 in FY 83, was the primary motivation for resource sharing at KACH.[47] The EIA estimated an annual savings in excess of $12,000 would accrue to KACH through resource sharing with the Montrose VA. An estimated cost savings was identified for each resource that would be provided to KACH by the Montrose VA.

Results of the EIAs clearly identified the potential benefits available to each participating facility through resource sharing. It was now time to develop a model to serve as a blueprint for arriving at a mutually acceptable resource sharing agreement between KACH and the Montrose VA. The challenge of tailoring the components of the model to meet the specific needs of each participating facility was recognized as essential to the overall success of the effort.

Development of a Model

Format

At Appendix O is a copy of the VA recommended format for a resource sharing agreement. Paragraphs 1-8 of this format, which provide administrative data, were considered essential to a model agreement, however, the format was modified to a full page in an effort to provide adequate space for each entry (See Appendix P). Major headings (General Provisions, Other Provisions) and the signature block section were also adopted from the VA recommended format. Components under each of these major headings would require extensive modifications before an acceptable model could be arrived at, however.

Components

As was mentioned earlier in the study, paragraphs 1A through 8 were designed to address administrative requirements of the resource sharing agreement and would, therefore, need to: identify the Agreement, or Amendment Number (using local facility control numbers), address the period of the agreement; identify the facilities participating in the agreement; indicate the type of action being requested (i.e., new, amendment or renewal agreement); provide a brief description of resources to be shared; indicate the address to forward payments to for each facility; and address where to forward bills to, along with billing frequency. These components would constitute the first page of the resource sharing agreement model.

General Provisions: Paragraph 9 of the sharing agreement would address general requirements established in PL 97-174, by the Memorandum of Understanding between the VA and DOD and/or by the VA Central Office or the DOD. Paragraphs 9a-9f of the VA recommended format were, therefore, considered essential to a model agreement and should be a part of any proposed sharing agreement. Only one additional item should be addressed: that continuation of any agreement beyond the end of the Fiscal Year would be subject to the availability of funds. Paragraph 9e and g of the VA recommended format were considered guidance to be used for information purposes by facilities considering resource sharing and would therefore, not be included as components of a resource sharing agreement model.

Other Provisions: It was in paragraph 10 of the resource sharing agreement that the individual concerns of each facility had to be considered, along with extensive coordination between the staffs of each facility. Guidance from the HRSC had been to strive for simplicity in developing a resource sharing agreement.[48] They further advised that only critical issues be addressed in the agreement, yet guidance on what were to be considered critical issues was not provided by the HRSC, nor was it provided by any other source. Without more specific guidance, it was determined by the resident that every effort should be made to address those areas of resource sharing which would reduce the potential for confusion, or result in varying interpretations by the participating facilities, without developing a detailed contract-type agreement. Discussions were extensive between the resident and the staff at Montrose in an effort to identify which components should be included in a resource sharing agreement. It was finally agreed that, at a minimum, an acceptable resource sharing agreement would address the following:

1. Physician Qualifications - For the protection of each facility and its associated patient population, it was agreed that the physicians at a facility providing care under the terms of a sharing agreement, must be licensed in a state or territory of the United States.

2. Credentials: Credentials of physicians seeing patients at a participating facility other than the facility where they have staff privileges, would be forwarded to the facility where the care is to be provided for review and acceptance. Review of credentials would be required prior to patients being treated under the provisions of the sharing agreement.

3. Agreement Review - The HRSC had recommended that agreements not exceed one year in duration without being reviewed.[49] A resource sharing agreement must specifically address the frequency of agreement review to improve the possibility of a dynamic relationship between participating facilities.

4. Beneficiary Priority - An acceptable sharing agreement should benefit both facilities, not only through cost savings and/or convenience to the patient, but also by improving the quality of care provided. Resource sharing under PL 97-174 is not mandatory and should therefore only occur to the extent that it does not interfere with the range of services available, the quality of care to be provided, or the priority of care afforded primary beneficiaries of the respective facilities.[50]

5. Existing Contracts/Agreements - An acceptable resource sharing agreement should provide participating facilities an opportunity to reduce contracts with other facilities for resources that could be shared at a cost reduction under terms of the agreement. Resource sharing should not impact adversely on participating facilities, and should, therefore, not interfere with existing or anticipated contracts/agreements that are, or will be, benefiting the facilities. Resource sharing under PL 97-174 should occur in addition to other contracts or agreements a facility may have or desire to enter into, for resources not available or not considered as more beneficial to the facility under the PL 97-174 agreement.

6. Education Program - Very little sharing has occurred between VA and DOD facilities over the years. Referring a beneficiary of one agency for testing or medical treatment at the other agency has a potentially adverse psychological impact. The entire billing process and changing beneficiary populations may also impact adversely on participating facilities. Each facility, to improve the possibility of a successful agreement, must educate their individual patient populations, along with their staffs, before the provisions of the agreement are implemented. A reference to establishing an education program to accomplish this should be an essential component of any resource sharing agreement.

7. Billing Procedures - Complicated and misunderstood billing procedures had been identified as a major disincentive to VA/DOD resource sharing in the past.[51] In an effort to avoid confusion, a specific component of the sharing agreement should address, in detail, the billing procedures to be used by participating facilities.

8. Additional Care/Services - The potential exists for a patient receiving care under a sharing agreement to require additional care, or care beyond the scope of the agreement. An acceptable agreement would provide guidance on reimbursement for care required, but which was not addressed as a specific resource to be shared in the agreement.

DESCRIPTION OF SERVICES: Paragraph 11 of the sharing agreement would identify the resources to be shared by each facility, estimated demand and reimbursement rates.

Once the components had been identified, the initial model for a resource sharing agreement was complete. The third phase of the research effort would require applying this model to arrive at a resource sharing agreement between KACH and the Montrose VA.

Implementation Strategy - Phase III

Initial Draft

The initial resource sharing model would be used as a guide for preparing the draft resource sharing agreement between KACH and the Montrose VA. The first draft employed the format and components developed and discussed in Phase II of the study. A copy of this initial draft agreement is at Appendix Q.

Once the draft was completed it was simultaneously staffed at KACH and the Montrose VA for comments and recommendations. Comments from the Montrose VA are at Appendix R. The Montrose VA staff concurred with the agreement, with the exception that they felt a paragraph should be added requiring key organizational elements from each facility to meet, before actually implementing the agreement, to work out the finer details of the agreement and to increase the probability of both facilities fully understanding the provisions of the agreement.

Staff personnel at KACH concurred with the draft agreement, except the Chief, OB/GYN. His response to the draft ageement is at Appendix S. The support of the KACH OB/GYN Department was considered pivotal to the sharing agreement. According to the Director, Montrose VA, previous attempts at sharing between KACH and the Montrose VA had failed primarily because KACH had refused to provide the routine OB/GYN care to the inpatient female population at the Montrose VA.[52] The Director of the Montrose VA stated that he would not sign any agreement that did not provide for OB/GYN examinations by KACH physicians at his facility.

The first major threat to the success of the research effort had been encountered. A meeting was arranged for 1530 hours January 19, 1984, to discuss the objection of the Chief, OB/GYN and arrive at a decision of whether to continue with the resource sharing agreement, or stop negotiations. At 1430 hours, the day of the meeting, the Chief, Clinical Support Branch, informed the resident that the Chief, OB/GYN, would not attend the meeting, but had decided to support performing routine OB/GYN exams at the Montrose VA.[53] The anticipated confrontation had been averted, but the meeting would continue as previously scheduled. The meeting was attended by the Hospital Commander, Deputy Commander for Clinical Services, DCA, Chief, PAD, Chief, Clinical Support Branch, the Comptroller and the resident. Each component of the draft agreement was discussed, along with the comments from the Montrose VA. Attendees at the meeting agreed that the basic agreement would require slight modification before it would be acceptable for signature. Paragraph 9e of the initial draft was felt to be repetitious, in that in-depth billing procedures were also presented in paragraph 10g of the agreement. therefore. it was recommended that this paragraph be deleted. It was recommended that an additional paragraph be inserted under the GENERAL PROVISIONS heading referencing the fact that continuation of the agreement beyond the end of the fiscal year would be subject to the availability of funds.

Under the heading of OTHER PROVISIONS, the group made the following recommended changes:

1. A paragraph requiring coordination between key staff members of each facility should be added. The Montrose VA had expressed the desire to insert this paragraph in their comments back to the initial draft agreement. Staff members at KACH agreed that once the agreement had been signed, but prior to actual implementation, coordination meetings between staff members of each facility would be necessary to increase the likelihood of a successful sharing agreement. At a minimum, it was agreed that the following organizational elements from each facility should meet prior to implementing the agreement: (1) the Fiscal Officer from the VA facility with the Comptroller from the DOD facility; (2) the VA Medical Records Officer with the DOD facility's PAD Officer; and (3) other individuals whose areas of responsibility would be directly impacted on by the agreement, especially the physicians from each facility.

2. Add a paragraph to clarify the OB/GYN support responsibilities for care to be provided by KACH physicians at the Montrose VA. Specific support required from the Montrose VA should be addressed and the absolute necessity that prior coordination between key organizational elements of each facility occur before each scheduled patient visit.

3. A paragraph should be added to the effect that all patients, except walk-in emergencies, would be referred to the other facility on an appointment basis. Section 3(d)(3) of PL 97-174[54] provides that primary beneficiaries of one agency should be seen on a referral basis by the other agency. Through a mandatory referral system, expeditious

treatment of those patients cared for could be reasonably assured, problems which might develop from unexpected workload could be avoided and better monitoring of care being provided under the provisions of the agreement should result. A further advantage of inserting this paragraph in the model would be that the potential for the agreement to interfere with routine patient care at each facility would be decreased.

4. A paragraph should address adding or deleting services that may impact on the provisions of the sharing agreement. An acceptable sharing agreement should support paragraph 1-101 of the VA/DOD Memorandum of Understanding which emphasizes the need for Federal facilities to minimize duplication and underutilization of resources.[55] Prior to the purchase of major equipment, or adding or deleting services, a facility participating in the agreement should first inform the other facility(ies).

After each of the above changes had been discussed, the Hospital Commander directed that a final draft sharing agreement be prepared incorporating the recommended changes for his review and signature.[56]

Final Draft

The resident revised the components to the original resource sharing agreement model and prepared a final draft sharing agreement using this revised model. A copy of the resultant final draft sharing agreement is at Appendix T.

Each of the study's eight criteria were addressed by the final model used to develop the resource sharing agreement:

1. The resource sharing model provides for sharing only those resources where excess capacity has been identified. Applying the model to a resource sharing agreement should, therefore, be accomplished within the resource constraints of the participating facilities.

2. PL 97-174 requires that a resource sharing agreement have an emergency clause, identify the health care resources to be shared, not interfere with care provided to primary beneficiaries of the providing agency, provide for reimbursement to the providing facility at a rate not to exceed the cost of the care provided and be signed by both the Director of the participating VA facility and the Commander of the military facility. Each component of the resource sharing model was carefully chosen to avoid conflicting with these requirements. In addition, specific components of the resource sharing model were selected to address each of these requirements: paragraph 9c of the model addresses the emergency clause requirement; paragraph 11a and b of the model identify the specific resources to be shared; paragraph 10c of the model specifically addresses beneficiary priority; paragraph 7 of the model provides for reimbursement to be forwarded directly to the providing facility and Appendix B to the model derives the cost of the resource to the providing agency, an amount which also becomes the reimbursement rate; and, the last page of the basic agreement has separate approval blocks for each of the required signatories.

3. Paragraph 10c of the model provides a component to address the requirement that the resource sharing agreement avoid interference with routine patient care to the beneficiaries of each participating facility.

4. Paragraph 10d of the resource sharing model addresses the non-interference aspects of the resource sharing agreement. As was discussed early in the data acquisition phase of the research effort, neither KACH nor the Montrose VA had contracts with civilian health care facilities. The resource sharing model provides the potential to reduce services contracted out with civilian facilities, if the participating facilities would benefit more from acquiring resources under the provisions of the resource sharing agreement.

5. An essential aspect of the cost analysis portion of developing the resource sharing agreement model was to identify the excess capacity of each participating facility. Consideration of a resource as having the potential to be shared was dependent on an identified excess capacity by the service that would provide the desired resource. The potential to reduce excess capacity in participating facilities is therefore demonstrated by the fact that only resources from services with excess capacity would be shared.

6. Paragraph 10j of the resource sharing agreement model provides a specific component to address the need for each facility to notify the other prior to adding or deleting major equipment, or services which may impact on the provisions of the agreement.

7. Consideration of joint acquisition of a CT Scanner was discussed during the development of the resource sharing agreement between the Montrose VA and KACH. The resource sharing agreement model provides the mechanism through which participating facilities can address joint acquisition of equipment or services. An additional component specifying the procedure to follow to accomplish the joint acquisition would be required in paragraph 10 of the model. Determination of reimbursement rates and an ECI for the item(s) to be jointly acquired would be addressed in the two Appendixes to the model. Sufficient detail to avoid confusion would be required, in particular, if joint workload data were to be used, the standardization of data and its subsequent collection would have to be addressed. In addition, procedures for the joint control of payments would be required. Paragraph 3-102 of the VA/DOD Memorandum of Understanding provides authority to acquire or increase resources based on projected workload from a sharing agreement.[57] This paragraph was further expanded to include combining the workloads of more than one participating facility to realize economies of scale through joint acquisition.[58] The mechanism does, therefore, exist to allow facilities to jointly acquire equipment, facilities or services which they would singularly be unable to acquire because of insufficient workload data to justify the purchase, or prohibitive cost.

8. The resource sharing agreement model demonstrates the potential to reflect a cost savings because Section 3(d)(4) of PL 97-174 provides for reimbursement to the providing agency for the cost of the resource shared.[59] This was further amplified in paragraph 3-104 of the VA/DOD

Memorandum of Understanding, where the requirement was made that the reimbursement rate "may not be more than the actual cost to the providing facility."[60] Appendix B of the resource sharing model provides for reimbursement rate computations and Appendix A of the model provides a means to compare the reimbursement rates with the civilian cost for the resource. In that reimbursement rates may not exceed actual cost under PL 97-174, the potential to save money through resource sharing is apparent. Applying the resource sharing model to a resource sharing agreement between KACH and the Montrose VA demonstrated a potential cost savings of $12,309.50 for KACH and between $6,265,00 and $6,210.00 for the Montrose VA.

When the recommended changes had been made to the resource sharing model, a final draft sharing agreement was prepared and staffed for review and comment at both facilities. The concurrence of staff members from both facilities was received and the resource sharing agreement was ready to be signed by the Director of the Montrose VA and the Commander, KACH.

A signed resource sharing agreement between KACH and the Montrose VA would not take place, however. Prior to a date being established for the signing of the resource sharing agreement, the VA Central Office in Washington, DC conducted a formal investigation of the Montrose VA. The results of this investigation concluded that there were serious deficiencies in the ability of the Montrose VA to deliver quality patient care and further recommended that the Director and Chief of Staff be fired.[61]

In view of the findings of the investigation and the adverse local publicity (see Appendix U), the Commander, KACH felt that the political climate would not be acceptable for entering into a resource sharing agreement at this time.[62] This decision was based on the Commander's assessment that the best interests of the West Point beneficiary population, as well as the physicians and staff at KACH, would not be served by entering into the sharing agreement. The Commander's decision was relayed to the Montrose VA on February 14, 1984 and efforts to share resources were officially terminated.

If the methodology used to develop the resource sharing agreement model was correct, it should be equally effective when applied to any VA/DOD resource sharing situation. Using this logic, the resident effectively applied the model to an agreement between KACH and the Castle Point VA Medical Center (Castle Point VA), Castle Point, New York. Some tailoring of components was required to accommodate the different needs and services available at the Castle Point VA. Specifically, paragraph 10b, Credentials, and paragraph 10i, OB/GYN Support at the Montrose VA, were eliminated as they were not applicable to a resource sharing agreement with the Castle Point VA. Changes to accommodate the different VA Medical Center participating was required and new reimbursement rates and Economic Impact Analysis was required. Aside from these modifications, the same methodology that had been used with the Montrose VA proved effective when applied to the Castle Point VA.

The initial draft agreement with the Castle Point VA was concurred on by the staffs of both facilities, with no recommended changes, and a copy of the signed agreement is at Appendix V. Less than one third the time was required to finalize a resource sharing agreement for signature with the Castle Point VA as had been required with the Montrose VA. In addition, the initial draft agreement with the Castle Point VA required no redrafting. The successful application of the resource sharing agreement model to KACH and a second VA Medical Center, where different needs and services provided were available, strengthened the credibility of the resource sharing model and the methodology used to derive the model.

The final phase of implementing the resource sharing agreement would extend beyond the scope of the present study into the summer of 1984, and beyond. This final phase will consist of five subphases: (1) forwarding the signed agreement to the VA Central Office and HSC for review and approval/ disapproval; (2) coordination meetings between key organizational elements of each participating facility; (3) implementing the approved agreement or revising and resubmitting the agreement, if disapproved; (4) periodic evaluations of the agreement, once implemented; and (5) revising the resource sharing model, if required, once the agreement has been implemented.

FOOTNOTES

[1]Interview with Mr Corydon F. Heard, Director, Franklin Delano Roosevelt VA Medical Center, Montrose, New York, September 29, 1983.

[2]Comptroller General, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" 1978 Report to the Congress (Washington. D.C.: Government Accounting Office, MRD 78-54, June 14, 1978), pp 4-6.

[3]Ibid.

[4]Ibid.

[5]Ibid. p 15.

[6]Ibid. P 16.

[7]Ibid. p 19.

[8]Ibid. p 25.

[9]Interview with Mr Heard, September 29, 1983.

[10]Interview with Colonel Freeman I. Howard, Commander and Lieutenant Colonel Thad A. Krupka, *Deputy Commander* for Administration, Keller Army Community Hospital, West Point, New York, September 30, 1983.

[11]Interview with Mr Heard, September 29, 1983.

[12]Interview with Lieutenant Colonel Thad A. Krupka, Deputy Commander for Administration, Keller Army Community Hospital, September 22, 1983.

[13]Telephone interview with Mr Jim Simmons, member HRSC, VA Central Office, Washington, DC, October 10, 1983.

[14]Telephone interview with Lieutenant Colonel Stephen Arnt, Office of the Assistant Secretary of Defense, Health Affairs, Washington, DC, October 20, 1983.

[15]Telephone interview with Lieutenant Colonel James Moa. Project Officer, Office of the Deputy Chief of Staff, Operations, Health Services Command, Fort Sam Houston, Texas, October 20, 1983.

[16]Telephone interview with Ms Judity Morrison, Comptroller, Munson Army Community Hospital, Fort Leavenworth, Kansas, November 3, 1983.

[17]Telephone interview with Jim Simmons.

[18]Telephone interview with Lieutenant Colonel Arnt.

[19]US Department of Health, Education and Welfare, "Guidelines for Health Services R & D: Shared Services" (Rockville, MD: DHEW Publication 72-3023, 1972) pp 5-6.

[20]Richard S. Schweiker, "The Public Stake in Shared Services: Some Political Considerations", Hospital and Health Services Administration, (Fall 1979) pp 81-87.

[21]Adelaide Griffin, "Shared Services-A Recipe for Cost-Cutting in Hospitals" Long Range Planning (December 1981), pp 76-79.

[22]Elworth Smith and Dorothy Cobb, "Are Hospitals Still Sharing" Hospitals, (September 1, 1983), pp 67-70.

[23]Interview with Mr Heard.

[24]Interview with Lieutenant Colonel Krupka.

[25]Interview with Captain Michael Tate, Comptroller, Keller Army Community Hospital, West Point, New York, January 4, 1984.

[26]Interview with Lieutenant Colonel Krupka, October 12, 1983.

[27]Initial coordination meeting at the Montrose VA, attended by the Director, Deputy Direcotr, Chief of Staff, Fiscal Officer, Supply Officer and Quality Assurance Coordinator from the Montrose VA, September 29, 1983.

[28]Interview with Mr Heard, September 29, 1983 and Captain Tate, September 30, 1983.

[29]Meeting of the Northern Metropolitan Hospital Association, "Update on Topical Issues", Newburgh, New York, August 24, 1983.

[30]For example: Smith and Cobb; Alan Weinstein, "Shared Services May Provide Hospitals With a Competitive Advantage", Hospitals, (September 1, 1983), pp 60-64.

[31]Health Resources Sharing Committee Workshop on Public Law 97-174 (Sharing) Northport VA Medical Center, October 25, 1983.

[32]Interview with Captain Tate, November 3, 1983.

[33]Meeting with the Comptroller, Chief, Patient Adminsitration Division, Deputy Commander for Administration, Keller Army Community Hospital, November 4, 1983.

[34]Interview with Mr Heard, November 16, 1983.

[35]Colonel Freeman I. Howard, Commander, Keller Army Community Hospital, West Point, New York, December 6, 1983.

[36]Manpower Survey Report, TDA HSW2H8AA, 31 August 1981.

[37]Uniform Chart of Accounts, Keller Army Community Hospital, Third Quarter Cumulative Workload Data, FY 1983.

[38]Major James Busack, Chief, Emergency Room and Outpatient Clinic, Keller Army Community Hospital, West Point, New York, December 8, 1983.

[39]Dottie Farrar, Health Benefits Advisor, Patient Administration Division, Keller Army Community Hospital, West Point, New York, December 7, 1983.

[40]Mr Heard, December 1, 1983.

[41]HRSC Workshop, October 25, 1983.

[42]Ibid.

[43]Memorandum of Understanding between the Veterans Administration and the Department of Defense. "VA/DOD Health Care Resources Sharing Guidelines," July 29, 1983, paragraph 3-104, p 4.

[44]Veterans Administration, "Instructions for Implementing the Sharing Provisions of Public Law - 97-174" Circular 10-83-150, (Washington, DC: Department of Medicine and Surgery, September 7, 1983) p. 5.

[45]Dottie Farrar, December 7, 1983.

[46]Mr Heard, November 16, 1983.

[47]Captain Tate, January 4, 1984.

[48]HRSC Workshop, October 25, 1983.

[49]Ibid.

[50]Public Law 97-174 "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act" 97th Congress. Section 3(d)(3)(B), May 4, 1982.

[51]Comptroller General, pp 23-27.

[52]Mr Heard, February 1, 1984.

[53]Joseph Flannery, CPT, MSC, Chief, Clinical Support Branch, Keller Army Community Hospital, West Point, New York, January 19, 1984.

[54]PL 97-174, Section 3(d)(3)(A).

[55]Memorandum of Understanding, paragraph 1-101.

[56]Colonel Howard, January 19, 1984.

[57]Memorandum of Understanding, paragraph 3-102.

[58]HRSC, Northport VA, October 25, 1983.

[59]PL 97-174, Section 3(d)(4).

[60]Memorandum of Understanding, paragraph 3-104.

[61]"VA Demands Shake-up at Hospital in Montrose", The Times Hearald Record, (Middletown, NY: Newspaper Article. February 10, 1984) p 8.

[62]Colonel Howard, February 13, 1984.

CHAPTER III

CONCLUSION

Summary

As early as 1979, the Director of the Montrose VA had expressed a desire to participate in resource sharing with KACH. It was not, however, until the removal of disincentives to Federal interagency sharing were realized through PL 97-174 that the management of KACH expressed an interest in resource sharing. Rapidly escalating supplemental care costs also significantly impacted on the decision of the KACH's Commander to pursue resource sharing and thus undertake the present research effort.

The research effort began with a preliminary information gathering effort to include a detailed literature review, identification of barriers to resource sharing. determination of the present status of Federal interagency health care resource sharing, categorization of shared services and determination of advantages and disadvantages to resource sharing at KACH. This information provided a baseline level of understanding about resource sharing which allowed the research effort to proceed into the implementation strategy phases.

Implementation of resource sharing at KACH would consist of a four phase process: the first phase would require extensive data acquisition, culminating in the identification of potential areas for resource sharing; the second phase would transform the acquired data into a resource sharing agreement model; the third phase would apply the resource sharing agreement model and arrive at a resource sharing agreement between KACH and a VA Medical Center; the final phase would implement the resource sharing

agreement, evaluating the implementation process and modifying the resource sharing agreement, as required. Each phase would be built on the success of the preceding phase, thereby systematically developing a functional implementation strategy. The suspense for completing the research effort would only allow the study to address preliminary information gathering and the first three phases of the implementation strategy. The mutual signing of the resource sharing agreement would conclude the research effort.

The basic problem studied was to develop a model for implementing a resource sharing agreement between KACH and a VA Medical Center in the West Point area. Close and continuous coordination with the VA Central Office, the HRSC, the Office of the Assistant Secretary of Defense (Health Affairs), HSC, and staff members of the participating facilities was required to identify the format and components that would constitute the resource sharing agreement model. This model would then be used to prepare a resource sharing agreement between KACH and the Montrose VA. Routing the draft agreement through the staffs at each participating facility for comments and approval provided for mutual acceptance of the final agreement. A signed agreement between KACH and the Montrose VA would not be accomplished, however. Concern for the quality of patient care available, the image of KACH and the perceptions of the West Point patient population resulted from a formal investigation of the Montrose VA. This investigation concluded that the quality of care being provided by the Montrose VA was suspect and the Commander, KACH felt compelled not to enter a resource sharing agreement with the Montrose VA until a more acceptable patient care climate existed.

The decision by the KACH Commander would not preclude completion of the final implementation objective to the study-signing of the agreement by participating facilities. Employing the methodology developed during Phase I and II of the implementation strategy, the resource sharing agreement model was successfully applied in arriving at an agreement between KACH and the Castle Point VA. Application of the model required only slight modifications to account for the differences between the needs and available resources of the two VA Medical Centers, and resulted in a signed resource sharing agreement.

It was therefore concluded that the resource sharing agreement model that had been developed to implement resource sharing at KACH was successful when applied to two separate pairs of participating facilities. It was further concluded that the resource sharing model, by concentrating on those resources from services demonstrating excess capacity, could be accomplished without additional resource requirements of the participating facilities. The resource sharing model complies with PL 97-174 and specifically addresses the requirement that the agreement not interfere with routine patient care to the beneficiary populations of the participating facilities. The resource sharing agreement model demonstrates the potential to reduce services contracted out by Federal facilities with civilian facilities and the potential to benefit participating facilities through cost savings for resources shared. The model further provides the mechanism for notifying the other participating facility(ies) of anticipated increases or decreases in services available, which has the advantage of avoiding unnecessary duplication and/or underutilization of Federal health care resources in a given geographical region. The model also provides the

mechanism through which the participating facility(ies) may jointly acquire services or equipment. It was finally concluded that the resource sharing agreement, with slight modifications to accommodate facility-specific considerations, can be easily applied to arrive at interagency resource sharing agreements throughout the Federal health care sector.

Evaluating the Conclusion

Mutual acceptance of the resource sharing agreement by the participating faciiities did not provide assurances that either the VA Central Office, or HSC would approve the resource sharing agreement. If the methodology used to develop the resource sharing agreement model was faulty, the signed agreement would be returned disapproved, or implementation would indicate that the conclusions were not supported and that the model was inappropriate for implementing a resource sharing agreement. Disapproval of the signed agreement would require modifying the model. redrafting the agreement, restaffing the agreement, resigning the agreement and resubmitting the agreement to the approval authorities. This, of course, would require significant time thus delaying actual implementation of the agreement for several additional months. Delays in implementing the agreement would result in lost benefits anticipated by the participating facilities and have the potential to place the entire agreement in jeopardy.

The possibility also exists of a faulty agreement being erroneously approved. Implementation of a faulty agreement should be recognized early by the participating facilities and the agreement would then

require amending, or terminating, as provided for in paragraph 9b of the resource sharing model. At Appendix W are copies of the approval indorsements to the resource sharing agreement between KACH and the Castle Point VA. HSC approved the agreement with no contingencies while the VA Central Office requested that paragraph 10j reiterate that adding and deleting services must be pursuant to paragraph 9b of the agreement and that paragraph 10g(1) reflect what the "per procedure rate" is and that this rate may not exceed actual cost to the providing facility. With these minor revisions the final resource sharing agreement between KACH and the Castle Point VA (See Appendix X) was signed and copies forwarded to HSC and the VA Central Office.

Approval of the resource sharing agreement provided substantial support to the conclusions arrived at earlier in this Chapter. The careful review of the resource sharing agreement by the two separate approval authorities increased the significance of the resource sharing model developed during the research effort. Joint approval of the agreement increased confidence in the methodology that was used to derive the resource sharing model and emphasized the potential for increased application of the model.

The Problem in Retrospect

In reaching the conclusions to this research effort, seven intermediate objectives had to be satisfied. These objectives were included in the original problem statement and a retrospective review of how each was achieved is now warranted:

The first objective was to analyze existing resource sharing literature. During the extensive literature review in Chapter 1 of the study, considerable effort was expended analyzing the existing literature on resource sharing. Analysis of resource sharing literature extended beyond the literature review of Chapter 1. however, functioning as an ongoing process throughout the study. A review of the literature was not, however, sufficient to accomplish the objective of analysis; resources external to the researcher were used to provide expert insight for a better understanding and more meaningful analysis of the literature. Frequent contact with the DCA, KACH, the Director of the Montrose VA, the HRSC, the VA Central Office, the Office of the Assistant Secretary of Defense for Health Affairs, HSC and not less than eight MEDDAC and MEDCEN Comptrollers was required to accomplish this objective of the study and to arrive at a methodology for developing a resource sharing agreement model that could be applied successfully.

As a significant aspect of the information gathering portion of the study, an examination of the historical environment which formed the basis for PL 97-174, was required. A trip to Washington, DC during the period September 14-16, proved indispensable to the successful accomplishment of this objective. Lengthy interviews with members of the HRSC,[1] combined with a detailed review of the 1978 GAO Report to Congress[2] and the Senate Hearings Before the Committee on Veterans' Affairs[3] provided sufficient information to formulate an informed understanding of the historical environment that formed the impetus for PL 97-174.

Barriers to effective implementation of the resource sharing provisions of PL 97-174 were identified on a broad scale through existing literature.[4] Identification of barriers to effective implementation at KACH required extensive interviews with staff members from KACH and the VA Medical Centers. This process, although time-consuming, was considered by the researcher to be an essential task in the process of arriving at a comprehensive assessment of potential barriers to resource sharing at KACH.

Current resource sharing contracts with civilian health care facilities were not in effect at the participating facilities, however, the objective of identifying current medical resources being contracted out for each facility was still considered a valid requirement in the development of a resource sharing agreement. The importance of this information to a sharing agreement was determined to be two-fold: (1) one of the goals of resource sharing should be to reduce the number of resources being contracted out that could be purchased at less cost through a resource sharing agreement, and (2) resource sharing agreements should not interfere with existing contracts or agreements which benefit the facility politically, through added convenience to the patient population or through cost savings. Early identification of existing resource sharing contracts would allow for free discussion of facility needs, as well as the determination of which of the contracts should remain in effect and which should be closely reviewed for possible termination.

Identification of excess capacity was accomplished through a two-step process at KACH. First, the latest Manpower Survey Report was reviewed to obtain workload data that was used to recognize staffing level requirements and the current staffing levels of each potential

resource sharing area. based on the Manpower Survey Report results, was then compared with actual FY 83 cumulative workload data reflected in the latest UCA. The second step was to personally verify the results of this comparison of each service identified as containing resources needed by the VA facility. Excess capacity for VA facilities was accomplished without the first step used at KACH, the responsible individual of a service where a need had been identified by KACH was asked to indicate the additional volume he/she felt could be accepted without altering the present quality of care being provided to the beneficiary population.

The sixth element of the stated problem for the study was to conduct a cost analysis, to compare the cost of resources acquired under the provisions of the sharing agreement with costs associated with purchasing these resources from local civilian health care facilities. Accomplishment of this objective required the development of reimbursement rates for each participating facility. Use of the UCA facilitated this task for KACH, however, the VA facilities required a more extensive effort. Paragraph 7b of VA Circular 10-83-150[5] failed to provide sufficient guidance on how to arrive at a cost- per-procedure for a VA facility. The reimbusement rate was finally obtained by using the annual budget for each service that would be sharing resources with KACH, determining the components of associated costs for each item and finally computing the items of associated cost for each resource to be shared. This was both time consuming and laborious but essential to determining cost benefits associated with sharing resources under the terms of the agreement. Reimbursement rates were then compared with the cost associated with purchasing the resource

from the local civilian community through the use of an Economic Impact Analysis (EIA). Results revealed that a potential cost savings would accrue to KACH from entering into a sharing agreement with either the Montrose or Castle Point VAs.

The final objective of the study was to draft a resource sharing agreement between KACH and a VA Medical Center in the West Point area, by applying the model developed during the study. A resource sharing agreement between KACH and the Montrose VA was drafted, applying the format and components identified in Phase II of the implementation strategy. The development of a political atmosphere which the KACH Commander felt was not conducive to quality medical care, resulted in this agreement not being signed. Using the same methodology and resource sharing model, however, a second resource sharing agreement was drafted between KACH and the Castle Point VA, this time the agreement was signed by both authorized signatories. Approval by the VA Central Office and HSC supported the resource sharing agreement model developed during the study. The approved resource sharing agreement will now be implemented at KACH as the fourth, and final, phase of the implementation strategy.

Resolution of the basic research problem has, therefore. been accomplished. Like many solutions to complex issues, as the research effort concluded and was declared a success, it was evident that even a higher level of success could have been realized had the participants better understood the dynamics of the process so that problems could have been kept to a minimum. The following basic principles were derived during the course of the study:

1. Institutions cannot be compelled to share resources. If Federal interagency resource sharing is to maximize its potential benefits, participation must be voluntary. Success hinges on a commitment by participating facilities before actual implementation. Each institution must be willing to give up some of its autonomy and control, or the resource sharing effort will fail to accomplish its full potential.

2. There must be mutual trust and respect of the participants, both as individuals and as institutions. Early in the developmental stages of the resource sharing agreement there was evidence of suspicion directed at KACH by the Montrose VA, and a perceptive mind set, by the staff of KACH, that questioned the quality of care available at any VA facility. This mutual distrust and lack of respect delayed completion and narrowed the scope of services to be shared under the final agreement. Federal facilities can only expect to realize the potential benefits from resource sharing under PL 97-174 when these disruptive barriers have been removed. Adverse publicity from investigations such as that to which the Montrose VA was exposed, will continue to operate against the acceptance of the VA health care system by DOD health care providers.[6] The results of this investigation delayed implementation of valuable resource sharing between KACH and the Montrose VA by a minimum of six months, perhaps indefinitely.

3. Intense discussions, communication and coordination between staff members of participating institutions are essential to generate and maintain staff support. Frequent contact between facilities is required initially to draft the resource sharing agreement, but this

communication must not be allowed to stop. Coordination between key organizational elements from each participating facility to "fine-tune" the resource sharing agreement should be an on-going process if optimum results are desired.

4. Sharing services that involve the medical staff or clinical areas, using the resource sharing agreement developed for Federal interagency health care facilities as a part of this study, would appear to be no more complex or difficult than sharing administrative services. Implementation of the resource sharing agreement will be required for verification, but experience during the research effort in arriving at mutually agreed upon resource sharing of clinical services did not support the earlier findings of such authors as Litman and Johnson[7], who concluded that sharing in the professional areas was extremely difficult and should be avoided. The experience of this study would indicate that participating facilities should experience no appreciable difference in the level of difficulty between clinical and administrative resource sharing, if lines of communication remain open between the staffs of participating facilities and the resource sharing agreement model developed in this study is used.

Recommendations

It is recommended that the resource sharing agreement model developed during this study be adopted by KACH for use in implementing the resource sharing provisions of PL 97-174 at West Point. It is further recommended that the approved resource sharing agreement between KACH and the Castle

Point VA be expeditiously implemented. Further, it is recommended that KACH continue to pursue cost containment efforts through resource sharing by examining the potential benefits that would accrue from resource sharing with the three other VA Medical Centers in the West Point area. Finally, it is recommended that the results of this study be forwarded to Health Services Command, the Office of the Surgeon General and the Assistant Secretary of Defense for Health Affairs to perhaps be used to assist planners at other facilities in their efforts to implement VA/DOD resource sharing agreements.

A Final Word

The methodology used to develop the resource sharing agreement model proved successful in arriving at a resource sharing agreement between KACH and the Montrose VA. The soundness of the methodology was further supported when the researcher was able to successfully apply the model to arrive at a mutually acceptable sharing agreement between KACH and the Castle Point VA.

The ultimate test of the resource sharing model would not come, however, until the approved agreement was implemented. Implementation unfortunately was beyond the scope of the present study and, therefore, precluded assessment of the implementation process. Evaluation of the agreement, once implemented, must be a continual process. As a part of this evaluation process, the following questions should be asked:[8]

1. Is patient care being disrupted?

2. Will the administrative structure of the shared service be adequate?

3. Are employees, staff and physicians accepting the new system?

4. Are transportation and information flow mechanisms satisfactory?

5. Will operating costs be as expected?

6. Will anticipated cost savings be realized?

7. Is quality control acceptable?

Recognition of a negative response to any of the above questions could prove critical to the success or failure of the resource sharing agreement. Early recognition of a potential problem revealed by the evaluation should facilitate correcting the source, or modifying the model, if necessary. If the methodology was sound in developing the resource sharing agreement model, only minor modifications to the agreement should be required once it has been implemented.

This problem oriented research effort has addressed the question of how to implement a VA/DOD resource sharing agreement at West Point. The impact of that decision will be felt for years to come. Many traditional beliefs that West Point's Keller Army Community Hospital's only purpose is to provide for the health care needs of the Corps of Cadets and the community that exists to support the Corps have been questioned. That questioning of purpose which conflicts with time honored tradition will likewise be felt in future years.

Acceptance of the resource sharing concept among the staff and patients at KACH has not been overwhelming. Questions concerning the quality of care available at VA hospitals have surfaced on a recurring basis. Success or failure of the resource sharing agreement between KACH and the Castle Point VA may well depend on the experiences of the participants during the initial few months of the implementation process.

VA/DOD resource sharing has been slow to develop, however, it still offers a viable alternative for Federal cost containment efforts. PL 97-174 has been in effect since May 1982 and as of this date only a relatively few Federal facilities have indicated a desire to consider resource sharing. Will a mandated resource sharing policy be required to contain Federal health care spending? The answer to this question will come with time, however at the present rate of implementation, the probability of some form of mandated cost containment for the Federal health care sector would appear a realistic possibility.

FOOTNOTES

[1]Interview with Lieutenant Colonel Stephen Arnt, Office of the Assistant Secretary of Defense for Health Affairs and Mr Jim Simmons, VA Central Office, Washington, D.C., September 15, 1983.

[2]Comptroller General, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" 1978 Report to the Congress, (Washington, D.C.: Government Accounting Office, June 14, 1978).

[3]United States Senate, "Hearing Before the Committee on Veterans Affairs: VA/DOD Health-Care Resources Sharing Act", 5266 and Related Bills (Washington, D.C. US Government Printing Office, June 17, 1981).

[4]See, for example Comptroller General, pp 10-27; George O. Johnson and Theodor J. Litman, "Management of Shared Services", Topics in Health Care Financing (Summer 1976), pp 90-93; Richard S. Schweiker, "The Public Stake in Shared Services: Some Political Considerations" Hospital and Health Services Administration (Fall 1979), pp 81-87.

[5]Veterans Administration, "Instructions for Implementing the Sharing Provisions of Public Law 97-174" Circular 10-83-150 (September 7, 1983) para 7b, p 5.

[6]Associated Press, "VA Demands Shake-up at Hospital in Montrose", The Times Hearald Record (February 10, 1984), p 8.

[7]Theodor J. Litman and George O. Johnson, "Sharing Services: The Dynamics of Institutional and Administrative Behavior" Hospital and Health Services Administration (Fall 1980) pp 20-21.

[8]Health Services Research Center, "Guidelines for Health Services R & D: Shared Services" DHEW Pub No (HRA) 74-3023 (Chicago, IL: US Department of Health, education and Welfare, 1972) p 21.

APPENDIX A

DEFINITIONS

DEFINITIONS

1. Actual Cost - Funded costs directly associated with delivering a service. Salaries, communications, utilities, services, supplies and related expenses are included.

2. Beneficiary - Any individual who is entitled by law to direct health care furnished by the United States Government.

3. Direct Health Care - Any health care provided to a beneficiary in a facility operated by the Veterans' Administration or the Department of Defense.

4. Health Care Resource - Hospital care, medical services and rehabilitative services, as those terms are defined in Title 38 United States Code, Section (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.

5. Major Medical Resource - Equipment, service or technological advancement which is considered critical to providing state-of-the-art health care, but because of cost, legislated constraints or a lack of technical expertise may be inaccessible to some health care facilities.

6. Negotiated Cost - The cost determined on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the service(s) provided.

7. Primary Beneficiary -

a. With respect to the Veterans Administration: a person eligible under Title 38, United States Code or any other provision of law for care or services in Veterans Administration medical facilities.

b. With respect to the Department of Defense: A member or former member of the Armed Forces who is eligible for care under Section 1074 of Title 10 to direct health care in Department of Defense facilities.

8. Providing Agency - The Veterans Administration or Department of Defense, as appropriate.

9. Shared Resources - People, plant, equipment, services and/or expertise which belong to one health care facility and which are used by two or more health care facilities.

10. Sharing Agreement - A cooperative agreement (authorized by P.L. 97-174, Section 3, Stat. 70, 70-73 (1982) to share one or more health care resources. Such an agreement may involve buying, selling, or an exchange of services and/or resources between facilities or organizational elements.

APPENDIX B

PUBLIC LAW 97-174

APPENDIX C

HEALTH CARE RESOURCES

SHARING COMMITTEE

AGREEMENT AND CHARTER

VETERANS ADMINISTRATION
AND
DEPARTMENT OF DEFENSE
HEALTH CARE RESOURCES SHARING COMMITTEE
AGREEMENT AND CHARTER

This agreement between the Veterans Administration (VA) and the Department of Defense (DoD) establishes the policies, procedures and organization of the VA/DoD Health Resources Sharing Committee (hereafter referred to as the "Committee"). The Committee is established by the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (P.L. 97-174).

PREAMBLE

The Assistant Secretary of Defense (Health Affairs), and the Chief Medical Director of the Veterans Administration, affirm their common goal of providing high quality health care while delivering that care in a cost effective manner.

Public Law 97-174 finds that:

> "(1) there are opportunities for greater sharing of the health care resources of the Veterans Administration and the Department of Defense which would, if achieved, be beneficial to both veterans and members of the armed forces and could result in reduced cost to the government by minimizing duplication and underutilization of health care resources.
>
> (2) present incentives to encourage such sharing of health care resources are inadequate.
>
> (3) such sharing of health care resources can be achieved without a detrimental effect on the primary health care beneficiaries of the Veterans Administration and the Department of Defense.

PURPOSE.

The Committee is to implement the provisions of P.L. 97-174, the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act. It will serve to identify and promote opportunities for sharing of health care resources between the VA and DoD.

OBJECTIVES.

The Committee is required to accomplish the following objectives within the context of respective VA and DoD health care systems:

a. Maximize the cost effective utilization of VA and DoD health care resources through interagency sharing.

b. Improve the quality, availability, and accessibility of patient care, including patient comfort, convenience, and satisfaction.

c. Improve the efficiency with which patient care resources are expended.

d. Support attainment of the basic mission of agencies participating in the agreement.

e. Undertake sharing programs in a manner that supports training programs and enhances recruitment and retention of health care personnel.

f. Minimize disruption of existing patient care, training, and research programs. In no case shall such sharing reduce the capability of an agency to assure the provision of care to its primary beneficiaries.

AUTHORITY.

The Committee is established and vested with the authority to operate under the terms of this Charter by P.L. 97-174.

The basic authority for sharing among Federal health care providers is established in P.L. 97-174.

The Committee shall ensure compliance with such authorities in proposing joint programs or sharing activities.

ORGANIZATION.

a. Membership. The Committee shall be composed of the Chief Medical Director (CMD), the Deputy Chief Medical Director, the Director of Program Analysis and Development, from the VA; and the Assistant Secretary of Defense (Health Affairs) (ASD(HA)), the Principal Deputy Assistant Secretary of Defense (Health Affairs), and the Deputy Assistant Secretary of Defense (Medical Readiness), from DoD.

b. Chairmanship. During Fiscal Year 1982 and 1983, the CMD shall be the Chairman of the Committee. During Fiscal Year 1984, the ASD(HA) shall be Chairman of the Committee.Thereafter, the chairmanship of the Committee shall alternate each fiscal year between the CMD and the ASD(HA).

c. Meetings. Meetings shall be held at the behest of the Chairman at times and places designated by him.

d. Committee Staff. The Committee shall be supported by an Executive Secretary, who will be designated by the Chairman from the Chairman's agency. The position of Executive Secretary shall rotate annually with the chairmanship. The Executive Secretary shall be responsible for coordinating Committee staff, for all arrangements, announcements, and minutes of Committee meetings, and for maintaining committee files. Other staff from each agency shall be appointed in numbers sufficient to accomplish the stated purpose of the Committee.

e. Subcommittees. Subcommittees shall be constituted as required to accomplish necessary committee tasks. The ASD(HA) and the CMD shall designate subcommittee members from their respective agencies, prescribe and/or modify the scope and objectives, provide guidelines for the operation, and monitor the activities of subcommittees.

SCOPE OF ACTIVITIES

a. Review existing policies, procedures, and practices relating to the sharing of health-care resources between the agencies.

b. Identify and assess further opportunities for the sharing of health-care resources between the agencies that would not, in the judgment of the Committee, adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency.

c. Identify changes in policies, procedures, and practices that would, in the judgment of the Committee, promote such sharing of health-care resources between the agencies.

d. Monitor plans of the agencies for the acquisition of additional health-care resources, including the location of new facilties and the acquisition of major equipment, in order to assess the potential impact of such plans on further opportunities for sharing of health-care resources.

e. Monitor the implementation of activites designed to promote the sharing of health-care resouces between the agencies.

IMPLEMENTATION

All Committee recommendations will be sent to each agency for consideration and action. The recommendations will be implemented through existing agency procedures.

DONALD L. CUSTIS, M.D.
Chief Medical Director
Veterans Administration
15 Jan '85

JOHN F. BEARY, III, M.D.
Acting Assistant Secretary
(Health Affairs)
Department of Defense

APPENDIX D

MEMORANDUM OF UNDERSTANDING

BETWEEN THE VETERANS ADMINISTRATION

AND THE DEPARTMENT OF DEFENSE

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.

(Signature)

JUL 1 - 1983

(Signature)

29 JUL 1983

APPENDIX E

VA-DOD SHARING AGREEMENT

MUNSON ARMY HOSPITAL AND

THE LEAVENWORTH VA

HSOP-FF (18 Nov 83) 1st Ind
SUBJECT: VA-DOD Sharing Agreement

HQ, US Army Health Services Command, Fort Sam Houston, Texas 78234 05 DEC 1983

TO: Commander, US Army MEDDAC, ATTN: HSXN-CD, Fort Leavenworth, KS 66027

1. The sharing agreement with Veterans Administration Medical Center, Leavenworth, Kansas, is approved for enactment.

2. In future agreements/amendments/renewals, the terms "contract" in preference for "agreement" or "understanding" should be avoided. A contract number in block 1A should also not be assigned; your sequential numbers would be more appropriate. No additional funding is available for this action.

FOR THE COMMANDER:

wd all incl

R. O. GRAY
Colonel, AGC
Adjutant General

DEPARTMENT OF THE ARMY
MEDICAL DEPARTMENT ACTIVITIES
FORT LEAVENWORTH, KANSAS 66027

REPLY TO
ATTENTION OF

HSXN-CD

18 November 1983

SUBJECT: VA-DOD Sharing Agreement

Commander
USA Health Services Command
ATTN: HSOP-FF
Ft Sam Houston, TX 78234

1. Enclosed is copy of sharing agreement between Veterans Administration Medical Center, Leavenworth, KS and Munson Army Community Hospital for your approval.

2. Cost comparison of purchased is enclosed at Encl 2.

FOR THE COMMANDER:

STEPHEN T. BECK
CPT, MSC
Adjutant

2 Encl
as

DESCRIPTION OF SERVICES	ESTIMATED QUANTITY MONTHLY	VA REIMBURSEMENT RATE	RATES FROM C SOURCE
Lung Scan - Perfusion	1	$59.39	
Lung Scan - Ventillation	1	95.10	AVG 320.00
Liver & Spleen Scan	4	59.39	
Tomogram	1	73.10	175.00
Ultrasound of Liver & Gallbladder	1	59.75	160.00
Muga Scan	1	122.90	337.00
Bone Scan	8	63.16	210.00
Thyroid Uptake 6 hr & 24 hr	2	45.11	
Thyroid Scan Technetium	7	34.59	AVG 200.00
Thyroid Scan I-123	1	84.59	
Renal Scan	2	66.92	345.00
Thallium Scan	4	183.45	510.00
Brain Scan	1	49.82	
Brain Scan - Cerebral Blood Flow	1	37.07	245.00
Blood Flow Studies	1	55.64	
Venogram	1	63.16	500.00
Gallium Scan	2	133.84	235.00
Echocardiogram -2D & M-Mode	21	115.24	
Echocardiogram -2D	1	78.49	335.00
Echocardiogram -M-Mode	1	65.25	
Pulmonary Function	1	30.05	209.00
EEG & W/NP Leads	5	41.36	171.00
EMG W/Nerve Conduction	15	48.82	140-20
ENG	1	31.12	170.00
Sleep Study (Neurology Evaluation)	7	64.82	97.00
Pipida Study	1	133.84	260.00
Hida Scan	1	105.27	260.00
I-131 Whole Body Scan	1	152.62	370.00

ENCL 2

VA/DOD SHARING AGREEMENT

VETERANS ADMINISTRATION - DEPARTMENT OF DEFENSE SHARING AGREEMENT		PAGE 1 OF 5 PAGES
1A. AGREEMENT NO. Contract #V686P-1246	1B. AMENDMENT NO.	2. AGREEMENT PERIOD (Month & Year) 11/24/83 TO 11/23/84
3. VA FACILITY (Name & Address) Veterans Administration Medical Center Leavenworth, Kansas 66048		4. TYPE OF ACTION (Mark "X" as Appropriate X NEW AMENDMENT RENEWAL
5. DOD FACILITY (Name & Address) Munson Army Hospital (DOD) Fort Leavenworth, Kansas 66027		6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED (Lab Services, etc.) Clinical Services
7. DIRECT PAYMENTS TO: (Name & Address of VA and/or DOD Facility) Veterans Administration Medical Center, ATTN: Agent Cashier Leavenworth, Kansas 66048		
8. VA AND/OR DOD OFFICE TO BE BILLED & BILLING FREQUENCY (Name & Address) Munson Army Hospital (DOD) - Billing Frequency (MONTHLY) Fort Leavenworth, Kansas 66027		

9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DoD Health Care Resources Sharing Guidelines which are in th Memorandum of Understanding between VA and DoD, dated July 29, 1983.

b. Any amendments to this agreement shall be submitted for approval as a new sharing agreement pursuant to section 3-101 of the VA/DoD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty (30) days' notice in writing. To the extent that this contract is so terminated, each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. Agreements will go into effect 46 days after receipt of the agreements by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. Agreements will go into effect earlier than the 46-day period if approvals are obtained from both agency approving authorities.

e. If acquisition of additional resources is required to implement a proposed agreement, approval must be obtained for the additional resources prior to submitting the proposal.

f. The providing organization will prepare a SF-1080 and send it to the receiving organization's office to be billed. Documentation for audit purposes must accompany the SF-1080.

g. The addresses provided in boxes 7 and 8 may be used to provide special identification such as designated office correspondence symbols, and building numbers.

The Veterans Administration Medical Center, Leavenworth, Kansas (hereinafter called the Contractor) agrees, in accordance with the terms and conditions stated herein, to permit Munson Army Hospital (DOD), Fort Leavenworth, Kansas (hereinafter called Munson) to utilize the specialized medical resources listed in the appendixes to this contract at the prices specified therein. The initial listing of resources available to Munson shall be designated "Appendix B" and "Appendix C", and each succeeding appendix which either adds to or deletes from the resources available to Munson shall be designated as "Appendix D", "Appendix E", etc. Each appendix shall be attached to and become a part of this contract.

1. Resources. a. The resources listed in any of the attached appendixes may be modified or terminated. The amendment will be prepared by the VA Contracting Officer. Any amendments to this agreement shall be submitted for approval as a new sharing agreement.

b. The resources specified in the appendixes to this contract shall be made available to Munson subject to the limitations in Paragraph 6 hereof when requested by means of an individual written request, which has been authorized by hospital administrator or his authorized designee.

2. Period Covered: This contract when accepted by Munson and the Contractor shall be effective November 24, 1983 through November 23, 1984.

3. Extension of Time. Extension of time may be granted by the Contractor, with the concurrence of Munson. Notice of extension of time must be served in writing by the Contractor thirty (30) days prior to the scheduled expiration date. The extension will be granted subject to the availability of funds.

4. Termination. This contract will remain in force for the period stated herein unless terminated at the request of either party after thirty (30) days'

notice in writing. If this contract is so terminated, Munson shall be liable only for payment for the resources they have used from the date of last service for which they have been billed by the Contractor through the effective date of such termination.

5. Payment. Payment of sums due the Contractor will be paid monthly by Munson on submission of a properly prepared Standard Form 1080 by the Contractor. Payment will be made to the VA Medical Center, ATTN: Agent Cashier, Leavenworth, Kansas 66048.

6. Use of VA Resources. To preclude the possibility of denying or delaying the care and treatment of an eligible veteran, VA resources will be used by Munson only to the extent that there will be no reduction in service to a veteran. Furthermore, patients will be scheduled for diagnostic procedures in accordance with "Appendix A", Operating Procedures for the Scheduling and Processing of Medical and Nuclear Tests for (DOD) Munson Army Hospital.

7. Exchange of Data. Clinical or other medical records pertaining to the patients shall be exchanged.

8. Equal Opportunity. The resources of the Contractor covered by this contract shall be made available to Munson without regard to the race, color, religion, sex, or national origin of Munson's patients.

9. Disputed Matter - Equal Opportunity Program. Any dispute arising under this contract relating to matters pertaining to the equal opportunity program will be handled pursuant to the provisions of the Equal Opportunity clause of this contract (subcontract or agreement).

10. The geographical limitations on the medical community of this contract shall be the City of Leavenworth, Kansas, only.

11. Availability Of Funds. The portion of the contract period beginning October 1, 1984 through November 23, 1984 is subject to the availability of

Fiscal Year 1985 funds. No service will be performed by the Contractor after September 30, 1984 unless and until specifically authorized by the Contracting Officer.

10. OTHER PROVISIONS

11 DESCRIPTION OF SERVICES (PROVIDED BY VA)	ESTIMATED QUANTITY MONTHLY	REIMBURSEMENT RATE
Lung Scan - Perfusion	1	$59.39
Lung Scan - Ventillation	1	95.10
Liver & Spleen Scan	4	59.39
Tomogram	1	73.10
Ultrasound of Liver & Gallbladder	1	59.75
Muga Scan	1	122.90
Bone Scan	8	63.16
Thyroid Uptake 6 hr & 24 hr	2	45.11
Thyroid Scan Technetium	7	34.59
Thyroid Scan I-123	1	84.59
Renal Scan	2	66.92
Thallium Scan	4	183.45
Brain Scan	1	49.82
Brain Scan - Cerebral Blood Flow	1	37.07
Blood Flow Studies	1	55.64
Venogram	1	63.16
Gallium Scan	2	133.84
Echocardiogram -2D & M-Mode	21	115.24
Echocardiogram -2D	1	78.49
Echocardiogram -M-Mode	1	65.25
Pulmonary Function	1	30.05
EEG & W/NP Leads	5	41.36
EMG W/Nerve Conduction	15	48.82
ENG	1	31.12
Sleep Study (Neurology Evaluation)	7	64.82
Pipida Study	1	133.84
Hida Scan	1	105.27
I-131 Whole Body Scan	1	152.62

12. SIGNATURE & TITLE OF AUTHORIZING OFFICIAL OF PROVIDING ORGANIZATION

GERALD E. HINES
Acting Medical Center Director
Leavenworth, KS 66048

DATE 11-14-83

13. SIGNATURE & TITLE OF AUTHORIZING OFFICIAL OF RECEIVING ORGANIZATION

LOWMAN E. GOBER, Colonel, MC
Commander
Munson Army Hospital (DOD)
Fort Leavenworth, KS 66027

DATE 3/2-83

OPERATING PROCEDURES FOR THE SCHEDULING AND PROCESSING OF MEDICAL AND NUCLEAR TESTS FOR (DOD) MUNSON ARMY HOSPITAL

1. Munson Hospital (Champus Clerk) will contact Centralized Scheduling Unit (CSU), 682-2000, Ext. 534, giving name, ID Number and test requested.

2. CSU will contact appropriate Service for appointment time.

3. CSU will give appointment date and time to Champus Clerk. (Original call will be placed on hold or return call, whichever is appropriate.)

4. CSU will maintain a Munson Army Hospital Appointment Log, by service, test requested, name, date, and time.

5. Two (2) days before appointment, appointment schedule will be sent to the individual labs and one (1) copy of all appointments to Employee Health Clerk (EH), 136B4, Ginny Hattok.

6. On the day of the test, the Army patient will check in with the EH Clerk (Have patients park on the East side of the hopsital, using ambulance entry continue down the hall to the third door on the right), Room 39, Ambulatory Care, at least 15 minutes before test time. Patients will bring with him/her, Medical Records (if necessary), stamped gum labels (per test procedure card) and authorization, MAH Form Ltr 150 (R). EH Clerk will secure 150 (R), give VAF 10-2875-1, Routing Sheet, to patient, give direction; to the clinic location and to return Routing Sheet to clerk before leaving the hopsital. All test requests must have a provisional diagnosis relating to the test, and present medications if appropriate.

7. The EH Clerk will return the schedule sheets to CSU the morning following the appointment. Each appointment will be noted as a 'show' or 'no-show'. The 150 (R) will be sent to the Relief Clerk, AC&PS.

8. CSU will notify Munson Champus Clerk if an individual was a no-show and give another appointment if authorized by Munson.

9. All test results will be sent to the Relief Clerk, 136B, Room 39 for mailing or pickup.

10. As the results are received the 150 (R) will be noted to show date of receipt, date of mailing or pickup and date forwarded to MIS, Billing Clerk, 135D. Receipt of 150 (R) indicates ready to bill.

11. Billing to Munson, Controller's Office will be on the 15th and last day of the month. Copy of the billings will be sent to Fiscal Service (04).

12. AC&PS, Relief Clerk will maintain a log showing Name, Date of Test, Date Test Results forwarded to Munson, Cost and Date sent to Billing.

APPENDIX C

TESTS

ECHOCARDIOGRAM - 2D

1. Can not be performed separately from M-Mode

ECHOCARDIOGRAM - 2D & M-Mode (unseperable)

1. Duplicate consult to Cardiac Lab.

2. No prep.

per Cardiac lab 1983

ECHOCARDIOGRAM - M-MODE

1. Can not be performed separately from 2D.

EEGs

1. Prepare EEG Request with two labels.

2. Mark routine or emergency.

3. Show the reason for the test, history, summary of PX, neuro findings and medications.

6. The patient should have no coffee or stimulants the day of the exam.

7. Patient's hair will be shampooed before test.

8. Patient will receive 500 mg Chloral Hydrate forty-five minutes before the EEG.

9. If adequate history is not given, the request will be returned.

EMG (ELECTROMYELOGRAM)

1. Duplicate consult for EEG Lab
2. No prep.

ENG

1. Send double consult to Neurology lab.
2. Send chart.

Per Neurology lab 1983

BONE SCAN

1. Done in Nuclear Medicine. (route to 115)
2. Duplicate consult.
3. No Prep.

1982

BLOOD FLOW STUDIES

1. Same as procedure for Brain Scan

BRAIN SCAN

1. Done in Nuclear Medicine.
2. Duplicate consult.
3. No prep.

1982

BRAIN SCAN-CEREBRAL BLOOD FLOW

1. Same as procedure for Brain Scan

GALLIUM SCAN

1. Duplicate consult to Nuclear Medicine - no labels. (Route to 115).

2. No prep is necessary.

3. Gallium must be ordered by Nuclear Medicine so test cannot be scheduled for same day as request.

July 1982

LIVER SCAN & SPLEEN SCAN

1. Done in Nuclear Medicine.
2. Duplicate consult and 2 labels are needed.
3. This test may also be done with the Spleen Scan but only one set of duplicate consults is needed .

1982

LUNG SCAN - PERFUSION

1. Done in Nuclear Medicine.
2. Duplicate consult and 2 labels are needed.

1982

LUNG SCAN - VENTILLATION

1. Done in Nuclear Medicine
2. Duplicate consult and 2 labels are needed

MUGA TEST

1. Done in Nuclear Medicine.
2. Duplicate consult (no labels).
3. No prep.

1982

RENAL SCAN

1. Duplicate consult to Nuclear Medicine.
2. No prep.

THALLIUM SCAN

1. Double consult to Nuclear Medicine.
2. Double consult to Cardiac lab.
3. NPO after midnight

per Cardiac lab 1983

TOMOGRAMS

1. X-ray request to Radiology.

2. No prep.

THYROID SCAN I-123

1. Duplicate consult and 2 labels to Nuclear Medicine
2. Need medical chart

THYROID SCAN TECHNETIUM

1. Duplicate consult and 2 labels to Nuclear Medicine
2. Need medical chart

THYROID UPTAKE 6 hr & 24 hr

1. Duplicate consult and 2 labels to Nuclear Medicine
2. Need medical chart

ULTRASOUND OF GALLBLADDER & LIVER

1. Double consult to Nuclear Medicine
2. Need Medical Chart
3. NPO after midnight

VENOGRAM

1. Double consult & 2 labels to Nuclear Medicine
2. Need medical Chart.

Nuclear Medicine 1983

SLEEP STUDIES

1. Same procedures as EEG
2. Patient should come in sleepy

PULMONARY FUNCTION TEST

1. Double consult to Inhallation Therapy.
2. Need patient's height, weight, and age.
3. Specify:
   a. Screening (FEV1, FVC & FEV1/FVC
   b. Before and after Bronchodilator
   c. FVC, FEV1, IC, FRC, ERV, RV, TLC, MMV

PIPIDA STUDY

HIDA SCAN

I-131 WHOLE BODY SCAN

APPENDIX F

SERVICES PROVIDED BY

KELLER ARMY COMMUNITY HOSPITAL

Inventory of Clinical Services
KACH West Point, New York

1. MEDICAL CLINIC (3 Internal Medicine MDs)

ECGs
Treadmill
Pulmonary Function Test
Allergy Service
EKG Clinic
Upper GI Endoscopies
Proctoscopies
Liver Biopsy
Bone Marrow
Chemotherapy Administration

2. DERMATOLOGY CLINIC (1 MD)

Full Services

3. IMMUNIZATION CLINIC

4. PEDIATRIC CLINIC (2 MD)

Full Services

5. SURGERY CLINIC (1 Surgeon)

Broncoscope
Proctoscope
Cystoscope
Gastroscope
Endoscope
Vasectomy

6. UROLOGY (1 Urologist)

Male Cysto
Female Cysto
Prostate Biopsy
Calibration
Delitation
Female Catheterization
Female Installation

7. OB/GYN (2 MDs)

Full Services

8. OPHTHALMOLOGIST (1 MD)

   Full Services except Fluorescein Angiogram

9. OPTOMETRY (3 Optometrists)

   Full Services

10. AUDIOLOGY CLINIC (1 Audiologist)

    Full Services

11. PHYSICAL THERAPY (3 PTs)

    Full Services

12. ORTHOPEDIC CLINIC (2 Surgeons, 1 GMO, 1 PA)

    Full Services
    Cast Room
    Brace Shop

13. PODIATRY (1 Podiatrist)

    Bunionectomies
    Metatarsal Osteotomies
    ORIF Pedal Fractures
    Arthroplastics
    Exostectomies
    Resection Septic Onychomytosis
    Chemical Cautery Onychoplasties

14. OUTPATIENT CLINIC

    Foleys Inserted
    Sutures
    Casting/Splints
    Minor Surgery
    Throat Cultures
    Antibiotic Prescriptions

15. RADIOLOGY (1 MD)

Diagnostic Only	Chest	Gall Bladder
Abdomen Series	Extremities	Small Bowel Series
Scanogram	Head/Sinus	Tomography
Portable Exams	Spine	IVP
UGI	Ultrasound	Berium Enema
Cystogram	Barium Swallow	KUB

16. PATHOLOGY (1 MD, 1 Lab Off)

Chemistry
Urinalysis
Parasitology
Microbiology
Spinal Fluid
Immunohematology
Transfusion
Cytology
Tissue Exam

17. NURSING

Community Health Nursing (1)
Nurse Anesthetists (2)
Inhalation Therapy
  IPPB Treatments
  Humidity Aerosol
  Chest Physiotherapy
  Arterial Blood Samples
OB/GYN Nursing
  Maternal/Fetal Monitor
  Pitocin
  Mag Sulfate
  Ritodrine

18. PHARMACY (1 Pharmacist)

1,000 Stocked Items

19. LOGISTICS (2 Officers)

Biomedical Equipment Repair
Custodial Services
Linen Control/Repair
Infectious/Contamianted Waster Disposal
Calibration/Verification
Silver Recovery

APPENDIX G

SERVICES PROVIDED BY

THE MONTROSE VA

INVENTORY OF CLINICAL SERVICES
F.D.R. VETERANS ADMINISTRATION HOSPITAL
MONTROSE, N.Y.

1. MEDICAL SERVICE (25 M.D.'S, 1 Epidemiologist)
   A. Medical evaluation and treatment for patients on the three acute medical units, acute pulmonary unit, medical intensive care unit, six intermediate medical units, and neurology unit.

   B. Outpatient care for:
      (1) General Internal Medicine
      (2) Dermatology
      (3) Allergy
      (4) Subspecialty clinics in:
         - Cardiology
         - Gastroenterology
         - Pulmonary
         - Neurology

   C. Complete laboratory work for all tests, including blood level for drugs.

   D. The following procedures are offered:
      (1) Nuclear scans for thyroid, spleen, liver, brain, heart.
      (2) Isotope studies for thyroid, digitalis blood level, etc.
      (3) Bronchoscopy and Biopsy
      (4) Pulmonary Function Tests and Arterial Blood Gases
      (5) Gastroduodenoscopy
      (6) E.R.C.P.
      (7) Colonoscopy and Polypectomy
      (8) EEG
      (9) Noninvasive Cardiac Procedures (Holter Monitoring, Echocardiography)
      (10) Invasive Procedures (Swan-Genz Catheterization)
      (11) Electroconvulsive Therapy (ECT)

2. PSYCHIATRY SERVICE (39 M.D's, 4 P.A.'s)

   A. Triage Unit - Screening and Evaluation.

   B. Inpatient Programs

      (1) Acute Psychiatric Admissions
      (2) Psychiatric Rehabilitation
      (3) Women's Unit
      (4) Intermediate Therapeutic Community
      (5) Intermediate Psychiatric Unit
      (6) Closed Psychiatric Unit
      (7) Halfway House
      (8) Behavior Therapy
      (9) Drug Free Treatment
      (10) Alcohol Treatment

(11) Comprehensive Alcohol Treatment for Continuing Health

(12) Psychiatric Intensive Care Unit

(13) Post-Traumatic Stress Unit

(14) Geriatric

C. Outpatient Program - Mental Hygiene Clinic

3. PSYCHOLOGY SERVICE (30 PhD's, Residents)
Psychologists are active members of the multidisciplinary treatment team in each of the above programs and are also involved on the medical units on a consultation basis. In addition, the Psychology Service coordinates:

A. Neuropsychology Clinic
B. Behavioral Medicine Program
C. Human Relations Training
D. Family Therapy Program
E. Ongoing Seminar Series
F. Psychology Internship Program
G. Research

4. SOCIAL WORK SERVICE (50 Social Workers - MSW's)
Social Workers are active members of the multidisciplinary treatment team in each of the programs listed under Psychiatry Service and also on the medical units and the Mental Hygiene Clinic. In addition, social workers provide treatment services to include:

A. Social casework, social group work and milieu therapy.
B. Supportive services through involvement in community activities and organizations and research activities.
C. Special counseling services to include psychotherapy, family therapy and behavior therapy.

5. NURSING SERVICE
The Nursing Service consists of a large professional staff of Registered Nurses, Licensed Practical Nurses, Nurse Instructors, Geriatric Consultant Nurse and a Clinical Specialist. Nursing Assistants provide technical assistance in patient care. The Nursing Service is actively represented is actively represented on each of the Psychiatric Treatment Teams. Nursing provides a full range of psychiatric and medical nursing services to every inpatient including those in the Nursing Home Care Unit and to all outpatients.

6. REHABILITATION MEDICINE SERVICES (3 M.D.'s, 48 Therapists)

Please refer to attached "Program Statement" of R.M.S.

7. PODIATRIC MEDICINE SERVICE (2 D.P.M.'s, Residents)
The P.M.S. provides all patient care services allowable under the New York State law governing podiatric medicine and surgery. The attached Memorandum of Affiliation between Keller Army Hospital and F.D.R. Hospital may be of interest.

8. RADIOLOGY SERVICE (1 M.D., 3 Technicians)

Diagnostic Roentgenology Examinations:

A. Skull, Including Sinus, Mastoid, Jaw, etc.
B. Chest, single view
C. Chest, multiple view
D. Cardiac Series
E. Abdomen - KUB
F. Obstructive Series
G. Skeletal - Spine and Sacroiliac
H. Gastrointestinal
I. Genitourinary
J. Cholecystogram, oral
K. Laminagram (Tomogram)
L. Ultrasound

9. LABORATORY SERVICE (.5 Pathologist (M.D.), 4 Med. Technologists, 7 Medical Technicians).
This service consists of the following sections with gross and microscopic analysis of appropriate specimens in each section:

A. Blood Bank
B. Chemistry
C. Hematology
D. Microbiology
E. Serology
F. Tissue Pathology (surgical, cytological, autopsy)
G. Urinalysis

10. NUCLEAR MEDICINE SERVICE (1 M.D., 2 Technologists, 1 Technician)

Please refer to attached "Routine Nuclear Medicine Examinations".

11. RESEARCH SERVICE

Please refer to attached "Approved Research Projects" at this facility.

12. CHAPLAIN SERVICE

Please refer to attached "Chaplain Service Bulletin" for description of services. In addition, Chaplains provide the following services to inpatients and outpatients:

A. Group meetings
B. Bedside Holy Communion, Confession
C. Ministry to Dying
D. Emergency Calls
E. Pastoral Visits
F. Consultation with Patients, Relatives, Staff.

13. PHARMACY SERVICE (5 Pharmacists, 2 Pharmacy Technicians)
Preparation of I.V. Admixtures, Dispensing Medications to eligible inpatients and outpatients, full range of clinical pharmaceutical services.

PROGRAM STATEMENT
REHABILITATION MEDICINE SERVICE
VA Medical Center, Montrose, New York
April, 1983

Rehabilitation Medicine Service is a medical specialty characterized by the utilization of physical agents and physical, occupational, educational and a vocational activities for the prevention and diagnosis of disease and treatment of the individual with a disability to prepare him for optimum adaptation to the community. R.M.S. is thus utilized for preventive, prognostic, diagnostic, therapeutic and rehabilitation purpose, R.M.S. provides treatment on a consultation basis, according to patient need, and has six component specialized therapies.

1. Corrective Therapy utilizes definitive and rehabilitative measures through the application of exercise, physical education, self-care and reconditioning activities comnlications, physical maintenance, and physical fitness activities for prevention of deconditioning and functional rehabilitation.

2. Educational Therapy uses educational techniques and materials to achieve evaluation, treatment, and rehabilitation measures designed to promote mental health.

3. Manual Arts Therapy supplies mechanical, technical, industrial, work-for-pay and creative activities of vocational significance for therapy and rehabilitation.

   a) Incentive Therapy: provides paid work assignments of vocational significance which are integrated within normal facility operations.

   b) Compensated Work Therapy: induce motivation, heighten self-esteem, create new interests, and break institutional patterns through the use of renumerative work with the expectation of either increasing the patients potential for adjustment to the community, or preventing regression from his present functional level.

4. Occupational Therapy provides definitive treatment and rehabilitation measures of a scientific, purposeful, and constructive nature to assist in promoting physical, mental health, and recovery.

5. Physical Therapy provides diagnostic procedures, definitive treatment and functional rehabilitation through the application of scientific and purposeful physical measures.

6. Recreation Therapy involves the use of activities to develop interpersonal relationships, socialization, relieve anxieties and tensions, and promote the patients ability to more fully participate in society.

In addition to consultative services to all patients, R.M.S. operates a Bed Service with a capacity of 49 beds, for the rehabilitation of patients who have the possibility of improving from additional intensive rehabilitation treatment. R.M.S. provides clinical training in Physical Therapy for students from three approved schools.

MEMORANDUM OF AFFILIATION
VETERANS ADMINISTRATION HOSPITAL, MONTROSE, NEW YORK
AND
KELLER ARMY HOSPITAL, U.S. MILITARY ACADEMY, WEST POINT, NEW YORK

1. It is mutually agreed by the Veterans Administration Hospital, Montrose, N.Y. and The Keller Army Hospital, U.S. Military Academy, West Point, New York that practical experience for residents in the Residency in Podiatric Medicine and Surgery will be provided at Keller Army Hospital, U.S. Military Academy, West Point, New York.

2. The residency program director will assume responsibility for the selection and assignment of residents to the learning experience. There will be coordinated planning between the Keller Army Hospital and the director of the residency program regarding scheduling and work assignments. While at the U.S. Military Academy, the residents will conduct themselves in accordance with the rules and regulations of the Keller Army Hospital, West Point, New York.

3. The Keller Army Hospital will retain full responsibility for the care of patients and will maintain administrative and professional supervision of residents insofar as their presence affects its operation and/or the direct or indirect care of the patients.

4. Residents will receive a thorough orientation to the Keller Army Hospital. The V.A. Hospital residency program director and the Army Keller Army Hospital staff supervisors will evaluate the residents performance by mutual consultation according to the guidelines of the residency program.

5. The Keller Army Hospital complies with title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, and title III of the Older Americans Amendments of 1975, and all related regulations, and assures that it does not and will not discriminate against any employe or applicant for employment or registration in the course of study because of race, color, sex, national origin, handicap or age.

6. Nothing in the agreement is intended to be contrary to State or Federal laws. In the event of conflict between terms of this agreement and any applicabable State or Federal law, that State Federal law will supersede the terms of this agreement. In the event of conflict between State and Federal laws, Federal laws will govern.

7. A periodic review of program and policies will be conducted under the auspices of the Office of Academic Affairs.

8. This Memorandum of Affiliation may be terminated by either party on written notice the other four weeks in advance of the next training experience.

Signature for Health Care Facility Keller Army Hospital — Peter D. Edgette — Name: PETER D. EDGETTE — Title: Chief, Clinical Support Div — 22 Apr 82 — Date Signed

Signature for V.A. Hospital — Name: — Title: — Feb 28, 1982 — Date Signed

ROUTINE NUCLEAR MEDICINE EXAMINATIONS

A - IMAGING PROCEDURES

a. Abdomen
b. Angiography (radionuclide)
   1. Arteriography
   2. Regional Perfusion
   3. Venography
c. Bladder
d. Bone
e. Bone Marrow
f. Brain (includes carotid flow)
~~g. Cisternography~~
h. Esophageal Transit/Reflux
i. Gall Bladder
j. Gallium Whole Body Survey
k. Gastric
l. G.I. Bleeding
m. Heart
   1. Blood Pool
   2. Myocardial Avid Infarct
   3. Myocardial Perfusion - including Stress Thallium Study
   4. MUGA (MUltiple Gated Acquisition)
      (i) Ventricular Ejection Fraction
      (ii) Wall Motion Studies
n. Joint
o. Kidney
p. Liver/Spleen (Kupffer Cells)
q. Liver (Parenchymal Cells)
r. Lung Perfusion
s. Lung Ventilation
t. Pancreas
u. Salivary Glands
v. Spleen
w. Testes
x. Thyroid

B - NON-IMAGING PROCEDURES

a. Bladder Residual Volume
b. Blood Volume - Plasma
c. Blood Volume - Red Cell Mass
d. Ferrokinetics
e. Kidney Function (Renogram)
f. Red Blood Cell Sequestration
g. Red Blood Cell Survival
h. Schilling Test
i. Thyroid Uptake

C - TESTS

a. Digoxin
b. HBsAG (Hepatitis-B Surface Antigen)
c. Iron Binding Capacity
d Prolactin
e. T-3 Uptake
f. T-4
g. TSH (Thyroid Stimulating Hormone)

APPROVED RESEARCH PROJECTS
V.A. Hospital
Montrose, NY
October 1983

PRINCIPAL INVESTIGATOR	TITLE
Butler, Marilyn, D.P.M.	"The Effects of Cyclospasmol and Nifedipine on Peripheral Vascular Disease"
Davis, Kenneth, M.D.	"Biological Basis of Relapse and Remission in Schizophrenia" (Bronx, VA)
Filippone, Richard, M.A.	"The Relationship of Alcohol and Opiate Abuse to Cognitive Deficits"
Goldfarb, Warren, Ph.D.	"Determination of Cognitive Style and its Ability to Predict When Combined with Individual Life Events One's Susceptibility to Depression"
Goldmeier, M.D., Ph.D.	"Korsakoff Amnesia: Essential Components of the Memory Defect"
Hartwig, William H., Ph.D.	"Noninvasive and Cost-Effective Approach to Diagnosing Normal Pressure Hydrocephalus in the Elderly"
Segal, Boris M., M.D.	"Apomorphine Therapy of Alcohol Dependence"
Segal, Boris M., M.D.	"Pattern of Change of Serum Prolactin Levels During Alcohol Withdrawal"
Smith, James G., M.A.	"Vocational Adaptation, Worker Personality and Supervisory Belief"
Stetson, David, M.A.	"The Effect of Alcohol Withdrawal on Smoking Behavior in an Alcohol-Dependent Population"
Thaler, Jerome S., O.D.	"The Relationship Between Ocular Pigmentation and Phenothiazine Intake: Quantification Procedures"

Chaplain Service Bulletin

Telephone Ext. 2706

FOR THE MONTH OF OCTOBER 1983

CATHOLIC SERVICES: Chaplains: Rev. John Borzuchowski
Rev. Daniel Lynch, O. Carm.
Rev. Hugh McGovern

Sunday	9:15 A. M.	Mass	Chapel
	10:00 A.M.	Mass	Bldg. 10
	11:00 A.M.	Mass	Bldg. 8
Weekdays	11:20 A.M.	Mass	Chapel

Confessions before mass and upon request. Blessed Sacrament Chapel open daily for prayer and meditation.

JEWISH SERVICES: Chaplain: RAbbi Abraham Sheingold

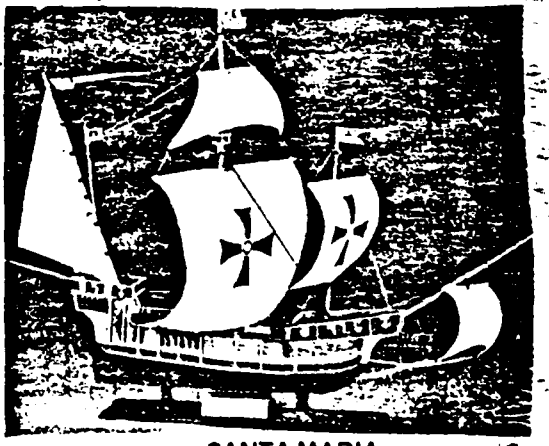
Friday	1:30 P.M.	Sabbath Eve Service	Chapel
	2:30 P.M.	Oneg Shabbat	Bldg. 8
Saturday	9:30 A.M.	Sabbath Service	Chapel

PROTESTANT SERVICES: Chaplains Rev. Robert A. Jones
Rev. Robert F. Dorer

Sunday	10:15 A.M.	Worship Service	Chapel
Monday	3:00 P.M.	Worship Service	Bldg. 9
Sunday Oct. 2	10:15 A.M.	Communion Service	Chapel

EASTERN ORTHODOX: Chaplain Fr. Constantine Eliades

AVAILABLE ALTERNATE WEDNESDAYS & SATURDAYS



SANTA MARIA

Outline Of Dental Procedures Performed

V.A. Hospital Montrose, N.Y. 10548

Oral Diagnosis

Comprehensive examinations with needed x-rays (panorex, periapical, bite wings, occlusal, extra oral studies); vitality tests, biopsy; all needed pathologic laboratory tests. Referrals to EENT, Neurology, Dermatology etc; as needed.

Operative Dentistry

All types of fillings - amalgam, composite etc; pin techniques, posts.

Prosthetics

Removable complete and partial dentures; fixed partial dentures, individual crowns, veneer crowns, porcelain jackets, post and cores; special dentures (immediate, over-dentures, dolber); relining, repairing dentures.

Periodontics

All phases of conservative and surgical periodontics.

Endodontics

All phases - multiple roots and canals, hemisections; apicoectomy; perio-endo cases.

Oral Surgery

Extractions, surgical removal teeth and roots, impactions; soft tissue surgery, neuroplasms, biopsy, repairs, flaps, oroantral closures, vestibuplasties; bone surgery - apicoectomy, cystectomies, bone neoplasms, tori reduction, alveoplasty; trauma, fractures.

Note - malignancies, cases requiring O.R. general anesthesia are referred to the VA Bronx under our VA policy.

Preventive Dentistry

All phases including prophylaxis by hygienist, application of fluorides.

Geriatric Dentistry

Modifications of standard dental procedures and use of special procedures to meet the needs of these patients.

Dentistry For Special Patients

Modifications of standard dental procedures and use of special procedures; adaptations of patient handling, to meet the needs of neuropsychiatric patients.

ROBERT E. CROWLEY, D.D.S.
Chief, Dental Service

Psychology Service

6. LIST OF CURRENT TESTS

16PF	Sixteen Personality Factor Test
ACL	Adjective Check List
AOR	Analysis of Relationships
BECK	Beck Depression Scale
BIPL	Bipolar Psychological Inventory
BRAS	Behavioral Type-A Scale
BPRS	Brief Psychiatric Rating Scale
BUSS	Buss-Durkee Anger Inventory
CES	Classroom Enviroment Scale
CMT	Concept Mastery Test
COPS	California Occupational Preference Survey
CORN	Cornell Index
CPI	California Psychological Inventory
EPPS	Edwards Personal Preference Schedule
EPQ	Eysenck Personality Questionnaire
EWI	Experiential World Inventory
EYSN	Eysenck Personality Inventory
FEAR	Fear Inventory
FES	Family Environment Scale

MEDH	Medical History
PAIN	Pain Questionnaire
PROB	Problem List
SEXH	Sexual Experiences
SEXS	Sex Problem Screening
SLEP	Sleep-Related Problems
SOCW	Demographic Information
SOMP	Somatic Problems
SURV	Post-Interview Survey
TENS	Tension Questionnaire
TRMT	Treatment Motivation and Past Care

APPENDIX H

DRAFT DEPARTMENT OF DEFENSE DIRECTIVE: VA/DOD HEALTH CARE RESOURCES SHARING GUIDELINES

NUMBER

Department of Defense Directive

SUBJECT: VA/DoD Health Care Resources Sharing Guidelines

References: (a) ASD(HA) as of 7 February 1983
(b) Public Law 97-174, Veterans Administration and Department of Defense "Health Resources Sharing and Emergency Operations Act," of May 4, 1982, (Encl 1)
(c) Memorandum of Understanding between the Veterans Administration and the Department of Defense of 29 July 1983, (Encl 2)

A. PURPOSE

In compliance with reference (a), this memorandum provides guidance for implementation of references (b) and (c) and establishes procedures to promote greater sharing of health care resources between the Veterans Administration (VA) and the Department of Defense (DoD).

B. APPLICABILITY

This memorandum applies to the Office of the Secretary of Defense (OSD) and the Military Departments. The term "Military Services§' refers to Army, Navy, Air Force, Marine Corps, and the Coast Guard (by agreement with the Department of Transportation).

C. DEFINITIONS

The terms used in this memorandum are defined in enclosure (3).

D. POLICY

It is DoD policy to pursue sharing agreements with VA medical facilities that result in increased quality of care, improved services to patients, and enhanced cost effectiveness.

E. RESPONSIBILITIES

1. The Secretaries of the Military Departments shall:

a. Be responsible for and have the authority to establish approval mechanisms for health care resource sharing agreements between the Veterans Administration and Organizations within their Departments consistent with the provisions of references (b) and (c) above.

b. A report shall be forwarded by 1 November of each year to the Assistant Secretary of Defense (Health Affairs) summarizing sharing agreements entered into during the preceding fiscal year. This report shall include workload accomplished and actual reimbursement data for each agreement.

2. The Commanders of Military Medical Treatment Facilities shall:

a. Enter into agreement with heads of Veterans Administration Medical facilities consistent with the approval process established by the particular services.

F. PROCEDURES

1. All DoD Agencies that are participating in sharing agreements with Veterans Administration Medical facilities shall follow the guidelines in the Memorandum of Understanding between the Veterans Administration and the Department of Defense (reference (c)) and enclosure 2.

2. Authority. The Secretaries of the Military Departments have the authority to publish implementing instructions.

3. Reimbursement and Rate Setting

a. All Military Treatment Facility (MTF) rates changed for services furnished to the VA under local health resources sharing agreements will be locally determined, facility-specific, actual cost and per procedure (i.e., UCA performance factor) rates.

b. The MTF's most recent fourth quarter cumulative report under the Uniform Chart of Accounts (UCA) cost accounting and performance reporting system (DoD Directive 6010.10) will be the primary source of data from which these per procedure rates will be derived.

c. Raw MTF costs will include the direct funded expenses, as cited in the UCA accounts and subaccounts related to the services furnished, by the work centers concerned, less depreciation.

d. To determine the MTF's current actual cost of the services to be provided, adjustment of the above UCA data (raw costs) may be necessary. These adjustments will be based on the best available local management information and include considerations such as inflation factors, cost trends, pay increases, workload changes, planned management actions, etc.

*Example: For pathology services, the maximum rate to be charged will be determined by reviewing the most recent fourth quarter cumulative "Detail Unit Cost Report" developed by the Expense Assignment System (EAS) during quarterly UCA report computation. It will show the total expenses assigned and the weighted workload procedures accomplished for each major pathology service function. Make the necessary management adjustments to the expense data. Then divide as follows:

Total Adjusted Expense Assigned = Cost per Weighted
Total Weighted Procedures Procedure

The number of weighted units will be determined by reviewing the weighted units for a particular test or procedure as reflected by the College of American Pathology. Then multiply this by the cost factor developed above. The result is the maximum charge which may be levied for that particular test or procedure.

Note: During the computation process, facilities should recognize proposed workload increases and their impact on per procedure rates.

e. Under no circumstances will the rates charged exceed the actual cost of providing the services to the VA. Nothing precludes local commanders from negotiating agreements which utilize less than actual cost rates. However, all local health resource sharing agreements will clearly reflect per procedure rates. Such agreements will specifically provide for the periodic review and updating of MTF/VA rates and other provisions of the agreements.

f. Pursuant to billing and reimbursement requirements, the MTF will specifically identify that portion of the actual cost which is attributable to non-accelerated direct military personnel costs based on current composite rate tables. Since the UCA does not identify costs by appropriation or element of expense, the MTF will have to use Service unique financial reports to determine the pro-rate share of military personnel expense.

g. Procedures for the internal and command review of facility-specific rates or proposed agreements will be established by the individual Services. As a minimum, such procedures will include a headquarters review to insure:

(1) The efficacy of proposed rates and agreements.

(2) That neither the range of services, quality of care, nor established priorities for MTF care are adversely affected. To facilitate review, proposed agreements will be accompanied by supporting documentation which includes rate computation formulae and data, and an economic impact analysis consistent with the level of detail cited in DoD 4000.19M, Defense Retail Interservice Support (DRIS).

4. Billing Procedures

a. MTF/VA billings will be submitted in a timely fashion. The specific frequency will be locally determined and stipulated in the agreement. All MTF/VA billings will be forwarded on Standard Form 1080 (Voucher for Transfers Between Appropriations and/or Funds) (sample furnished at Appendix B) with appropriate supporting documentation. The specific nature of such documentation will be locally determined and stipulated in the agreement. However, as a minimum the bill and/or supporting documents will cite:

(1) The specific MTF/VA facility agreement concerned and the time period it covers.

(2) The name and social security number of the military or VA beneficiary receiving the services.

(3) The date the services were furnished.

(4) The specific types of services rendered and the quantity of each such service.

(5) The MTF/VA per procedure rate for the service and the total costs.

(6) The specific appropriation reimbursement accounts to be credited (e.g., local O&M and MP appropriations) and the dollar amounts to be credited to each.

(7) The MTF/VA points of contact and telephone numbers of the offices responsible for SF 1080 preparation and related inquiries.

(8) Additional instructions related to billing procedures may be established in Service specific regulations.

b. The necessary appropriations and element of expense (EOE), to be placed on SF 1080, will be separately provided by each of the military Services prior to the onset of the fiscal year.

c. In order to verify billings, the MTF will establish suitable internal control mechanisms to validate services furnished or received.

5. Reimbursement for Additional Care or Services Beyond the Scope of the MTF/VA Agreement.

a. In certain instances, beneficiaries of the requesting facility, who are undergoing agreement-related servics at the providing facility, may unexpectedly require additional care or services beyond the scope of the agreement. Such care or services may even exceed the capabilities of the providing facility. In either event, the providing facility will immediately notify the requesting facility. The requesting facility will fund the additional care or services as follows:

(1) When the additional care or services are furnished by the providing facility, the requesting facility will be billed at the current inpatient or outpatient interagency per diem rate (established by OSD(C) or approved for the VA by the Office of Management and Budget) or the agreement's per procedure rate, which ever more closely approximates the actual cost of the services rendered.

(2) When the additional care or services are furnished by another Federal medical treatment facility, the requesting facility will be billed by that agency at its current inpatient or outpatient interagency rate.

(3) When the care must be furnished by a non-Federal health care source, the requesting facility will be billed for actual expenses by the non-Federal source.

b. In a (1) and (2) above, duplicate billing safeguards will be necessary (see paragraph 6 below). In a (2) or (3) above, the requesting facility will also be billed for the initial procedures furnished under the MTF/VA health resources sharing agreement.

6. Procedures for Handling Collections. All reimbursement will be forwarded via SF 1080 by the facility receiving the services to the facility furnishing the services. The manner and frequency of such reimbursements will be stipulated in the applicable sharing agreement. The appropriate military pay (MP) appropriation will be credited with that portion of reimbursements properly attributable to it. All remaining amounts will be credited to the MTF's operating funds.

7. Separation of Interagency and Facility-Specific Billings/Reimbursements. In addition to services exchanged locally under health resources sharing agreements, at facility-specific rates, the VA and military medical departments routinely, exchanged services on an interagency basis at per diem rates. These per diem rates are annually determined by OSD(C) or are approved for the VA by the Office of Management and Budget. The provision of both interagency and agreement-related services can occur at the MTF/VA facility level. Interagency services may or may not be the same type of services as those exchanged under local agreements. Interagency billings/reimbursements are

based on MTF/VA facility input. However, they may be centrally managed, thereby creating the potential for duplicate billings or reimbursements. Accordingly, all local agreements will contain specific provisions which require MTF/VA facilities, engaged in local sharing agreements, to establish a system of internal controls which precludes double billings/reimbursements at both the facility and interagency levels.

8. Incentives and Reapplication of Savings.

a. Before any agreement is negotiated, it must be demonstrated to be economically beneficial (i.e., reduce alternative care costs or use the facility's excess capacity). To maximize cost savings, MTF commanders will be afforded the greatest flexibility in accomodating local conditions and needs when developing their MTF/VA health resource sharing agreements.

b. In addition to retaining funds received through reimbursements in accordance with paragraph 5 above, savings realized in an activity's local funding may be reapplied at the installation level in the year of implementation to satisfy valid, unfunded requirements when:

(1) Such savings constitute a decrease in current year funding expenditures for a funded MTF program, project, or personnel end strengths, and

(2) Such savings are directly attributable to newly established or expanded sharing agreements developed in the current fiscal year.

c. Disposition and/or allocation of economies, achieved through continuation of MTF/VA health resources sharing agreements subsequent to the year of implementation, will be subject to guidance by the military department concerned.

9. Reporting Requirements. Consistent with DoD Reports Control Symbol requirements, each military department will gather, maintain, and report the following agreement data by 1 November of each year:

a. The number of new agreements established during the fiscal year.

b. The number of agreements renewed during the year.

c. The number of agreements expanded during the year.

d. The quantity and type of services involved in a through c above.

e. The total amounts billed and received under a through c above.

f. The total amounts of cost savings achieved under a through c above during the year.

g. The total amount of earnings (under a through c above) credited to the military pay appropriation and the amount credited to local operating funds.

Note: This information will be transmitted to the Service headquarters in accordance with guidance isued in forthcoming Service specific implementing instructions.

10. Liability. The provision of direct health care to beneficiaries under this agreement is within the scope of duties or employment of employees of the providing agency. Claims for injury arising from such health care will be processed by the providing agency in accordance with its existing administrative claims regulations.

G. INFORMATION REQUIREMENTS

The reporting requirements in Section F.(9) have been assigned Report Control Symbol _____.

H. EFFECTIVE DATE AND IMPLEMENTATION

This Memorandum is effective immediately.

Enclosure - 3

1. Reference
2. Reference
3. Definitions

DEFINITIONS

1. "Actual Cost" are those funded costs directly associated with delivering the service. Salaries, communications, utilities, services, supplies, and related expenses are included.

2. "Beneficiary" means a person who is a primary beneficiary of the Veterans Administration or the Department of Defense.

3. "Direct Health Care" means health care provided to a beneficiary in a medical facility operated by the Veterans Administration or the Department of Defense.

4. "Heads of a Medical Facility"

a. With respect to a Veterans Administration medical facility, means the director of the facility.

b. With respect to a medical facility of the Department of Defense, means the commanding officer, officer in charge, or the contract surgeons in charge.

5. "Health Care Resource" includes hospital care, medical services, ambulatory services and rehabilitative services, as those terms are defined in Title 38 United States Code, Section 601 (5), (6), (8), any other health care services, and health care training, research, or other support, or administrative programs.

Enclosure 3

6. "Medical Facility"

a. With respect to the Veterans Administration, means facilities over which the Chief Medical Director has direct jurisdiction.

b. With respect to the Department of Defense, means medical and dental treatment facilities over which the Department of Defense or its organizational elements, the component Services, have direct jurisdiction.

7. "Providing Agency"

a. The Veterans Administration, in the case of care or services furnished by a facility or organizational element of the Veterans Administration.

b. The Department of Deense in the case of care or services furnished by a facility or organizational element of the Department of Defense or its component military services.

8. "Primary Beneficiary"

a. With respect to the Veterans Administration, means a person eligible under Title 38, United States Code (other than Section 611 (b), 613, or 5011 (d)) or any other provision of law for care or services in Veterans Administration medical facilities.

b. With respect to the Department of Defense, means a member or former member of the Armed Forces who is eligible for care under Section 1074 of Title 10.

9. "Savings"

a. Costing Savings - A decrease in current year funding expenditures due to a new or expanded support agreement (current year) in a funded program, project, or personnel end strength supported by a cost analysis and eligible to be reapplied at base level.

b. Other Savings - Savings that do not result in a decrease in current year funding expenditures as a result of a new or expanded support agreement (cost avoidance, also supported by cost analysis).

10. "Sharing Agreement/Agreement" means a cooperative agreement (authorized by P.L. 97-174, Section 3, Stat. 70, 70-73 (1982)) to share one or more health care resources. Such an agreement may involve buying, selling, or an exchange of services and/or resources between facilities or organizational elements.

APPENDIX I

VETERANS ADMINISTRATION

CIRCULAR 10-83-150:

INSTRUCTIONS FOR IMPLEMENTING

THE SHARING PROVISIONS OF

PUBLIC LAW 97-174

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-83-150

September 7, 1983

TO: Regional Directors; Medical District Directors; Directors, All DM&S Field Activities

SUBJ: Instructions for Implementing the Sharing Provisions of Public Law 97-174 (the "Veterans Administration/Department of Defense Health Resources Sharing and Emergency Operations Act"), enacted May 4, 1982

1. **BACKGROUND:**

Provisions of Public Law 97-174 provide new opportunities for sharing health care resources between the Department of Defense (DoD) and the Veterans Administration (VA). This law supplements, but does not supersede, existing legislative sharing authorities.

VA medical centers have engaged in sharing under three statutory bases: interagency "cross-servicing" agreements under the Economy Act of 1932, 31 U.S.C. § 1535, and agreements with medical schools, hospitals, and other medical installations under provisions of 38 U.S.C. §§ 5053 and 5054. Any of these authorities, or 38 U.S.C. § 5011, as amended by P.L. 97-174, may be used in accordance with their terms as a basis for a sharing agreement with DoD.

2. **OBJECTIVE:**

To provide guidance to medical facility directors in preparing sharing agreements and to elaborate on areas covered in the VA/DoD Health Care Resources Sharing Guidelines.

3. **POLICY:**

Medical facility directors are to pursue sharing arrangements with DoD medical facilities that would result in increased quality of care, improved services to patients, and enhanced cost effectiveness. Sharing arrangements under this law shall not reduce services or diminish the quality of care for veteran beneficiaries. All agreements will be in accord with the VA/DoD Health Care Resources Sharing Guidelines. These guidelines were agreed to on July 29, 1983 (VA Circular 00-83-30).

Both field-initiated and Central Office-initiated sharing agreements are anticipated. Field-initiated sharing will undoubtedly constitute the great bulk of new sharing activities. Sharing agreements, most frequently, will be consummated between facilities in close proximity. Various agreements, including sharing of data, may also be negotiated at the Central Office level.

4. **RESPONSIBILITIES:**

a. **Chief Medical Director**

Member of the VA/DoD Health Care Resource Sharing Committee and chairman of the Committee in alternating years beginning in Fiscal Year 1983.

b. **Associate Deputy Chief Medical Director (ADCMD)**

(1) Responsible to the CMD for VA/DoD sharing activities.

(2) Responsible for processing sharing agreements for approval within 45 calendar days of receipt by the appropriate Regional Director in VACO.

(3) Authority to approve or disapprove sharing agreements for the Chief Medical Director.

(4) Member of the VA/DoD Health Care Resources Sharing Committee.

c. **Regional Directors**

(1) Transmit, with comments and appropriate recommendations, proposed VA/DoD Sharing agreements referred by facility directors to Emergency Management and Resource Sharing Service (EMRSS) (10B/EMS).

(2) Assess sharing opportunities having a regional impact and initiate action when appropriate.

(3) Recommend changes to policies and procedures to the EMRSS for maximum VA/DoD sharing of health care resources.

(4) Keep ADCMD informed of the plans for the acquisition of additional health care resources in the region by VA and DoD, and advise the ADCMD on the potential impact of such plans on opportunities for sharing.

d. **Emergency Management and Resource Sharing Service (EMRSS)**

(1) Recommend approval or disapproval or other appropriate action on proposed agreements to the ADCMD.

(2) Maintain records of approved VA/DoD sharing agreements.

(3) Cooperate with DoD in preparing the annual joint VA/DoD report to Congress required by 38 U.S.C. § 5011 (f).

e. **Director, Program Analysis and Development**

(1) Relates sharing to the MEDIPP process.

(2) Serves as member of VA/DoD Health Care Resources Sharing Committee.

f. **Medical District Directors**

(1) Maintain liaison with DoD health care facilities in the Medical District and monitor plans for the acquisition of additional health care resources that might be shared with DoD.

(2) Assess opportunities for sharing of health care resources within the local Medical District and for initiating proposed agreements on a district-wide basis.

(3) Develop sharing policies and practices with respect to MEDIPP priorities.

g. **Facility Directors**

(1) Assess local VA and DoD opportunities for sharing of health care resources.

(2) Develop and submit proposed VA/DoD sharing agreements for approval to their Regional Director.

(3) Inform the Medical District Director of all proposals for sharing prior to submission to the Regional Director for review for consistency with MEDIPP plans. Comments should be directed to the Regional Director.

(4) Issue a station policy directive informing personnel that health care is to be provided to DoD primary beneficiaries only on a referral basis and that sharing agreements with DoD are not to adversely affect the range of services, quality of care, or priority for services provided to primary beneficiaries of the VA.

5. **RESOURCES TO BE SHARED:**

a. Agreements are authorized under provisions of 38 U.S.C. § 5011 for sharing any health care resources or services offered to eligible beneficiaries. A multitude of services may be covered in a single sharing agreement. Emphasis will be placed on the sharing of health care resources producing the most immediate benefits to patients. This may include inpatient and outpatient care, consultation, diagnostic services, and allied health services.

b. Sharing agreements may be negotiated with DoD facilities and organizations for ancillary services such as diagnostic laboratory tests and CT scans, research, education and training, communications, and such related resources as laundry, food services, and transportation.

c. Resources not currently available at either VA or DoD field facilities may be acquired by requesting the written approval of the Regional Director. Agreements will not be submitted to the Regional Director until written permission to increase existing resources or to acquire new resources has been obtained from the Resource Allocation Committee or a recommendation approving the request is received from the Resource Advisory Committee.

6. **ASSESSMENT OF OPPORTUNITIES:**

a. **National Agreements**

Arrangements for national sharing agreements will be made at Central Office following joint VA/DoD negotiations.

b. **Local Agreements**

Medical Center Directors will contact neighboring DoD health care facilities to explore sharing opportunities. Opportunities for sharing may be identified by reviewing the Clinical Inventory and a listing of specialized medical programs available at VA facilities. Further opportunities for sharing other hospital services (e.g., laundry and dietetics) should also be explored. The Medical District Directors will be responsible for

determining that appropriate VA facilities in their District have contacted DoD health care facilities to explore possibilities for sharing health care resources.

7. **DEVELOPMENT OF INITIAL AGREEMENTS:**

a. **Local Negotiations**

After potential areas for sharing have been identified, Medical Center staff should explore with their counterparts at DoD facilities projected costs, workload, and resources. Rates will be locally determined in accordance with the methodology described in the VA/DoD Health Care Resources Sharing Guidelines.

b. **Reimbursement Rate Determination Methodology**

Given the complexity of determining the reimbursement rate, no single source or method is mandated by this circular. The VA facility or organization should first carefully estimate its actual cost of providing the resource to DoD. Under the VA/DoD guidelines, actual costs to the providing facility include the cost of personal services, supplies, services, communications, utilities, and equipment depreciation. Building depreciation, interest on net capital investment, and Central Office overhead are excluded from both the actual cost to the local providing facility and from the reimbursement rate. (This exclusion applies only to agreements authorized under 38 USC § 5011). Actual cost to the providing facility or organization should then be considered along with local conditions and needs in determining a proposed reimbursement rate for use in negotiations with DoD. The setting of reimbursement rates at less than actual cost is permitted. For example, if a VA facility already has excess capacity, the reimbursement rate for the resource to be provided to DoD may be competitive with the price the DoD facility could obtain in the private sector. Facilities are strongly encouraged to exclude equipment depreciation from the reimbursement rate. Rates should neither exceed actual cost to the providing facility nor constitute a subsidy of the local DoD facility at the expense of our primary beneficiaries. Estimates of actual cost and worksheets used to estimate actual cost need not be forwarded to the Regional Director in VACO when submitting a proposal for approval (except when required by paragraph 7c of this circular).

c. **Exchange of Resources Without Billing**

The VA/DoD Guidelines permit the exchange of resources without billing. However, the actual cost of the resources being provided by one agency must be approximately equal to the actual cost of the resources to be provided by the other agency. Estimates of the actual costs should be specified in the agreement. Services to be provided and received will be documented.

d. **Additional Capacity**

VA/DoD Guidelines permit facility heads to request permission to acquire or increase health care resources that exceed the needs of the facility's primary beneficiary but serve the combined needs of both agencies. Such additional capacity must first be justified and approved in the normal budget process. The combined workload must be cited in the justification. Directors are encouraged to obtain multi-year commitments from the DoD facilities if new medical resources are to be obtained by the VA. No sharing agreement requiring additional capacity will be submitted until written permission to increase existing resources is obtained from the Resource Allocation Committee or a recommendation approving the request is received from the Resource Advisory Committee.

e. **Multi-Year Agreements**

Agreements extending into future fiscal years must be made subject to the availability of appropriated funds. Such agreements may provide for cost adjustment amendments each fiscal year.

f. **Preparation of Agreements**

A proposed agreement between the Medical Center Director and the Commanding Officer will be prepared. A model format is included at the end of this circular. The agreement will detail the resources to be provided, the cost per unit of those resources, the anticipated number of units, and performance and delivery requirements.

The agreement will also include any special arrangements such as transportation, meals, and required escorts.

8. **APPROVAL OF AGREEMENTS:**

a. **Time Limitation For Approval**

Each locally developed proposal for an agreement shall be submitted to the Regional Director in VACO, and shall be effective as an agreement in accordance with its terms forty-six calendar days after receipt of the proposal by the Regional Director (VACO) and the appropriate DoD component if not disapproved earlier; or, upon written approval of the ADCMD in the case of the VA and the designated DoD official within 45 calendar days after receipt by the Regional Director (VACO), and the approving DoD official.

b. **Submission of Proposed Agreements**

Original proposed local agreements and all appendices will be forwarded to the office of the appropriate Regional Director in VACO. After review, the agreement will then be forwarded to (10B/EMS). Agreements, national in scope, will be submitted directly to the EMRSS (10B/EMS).

c. **Review and Approval of Agreements**

Proposed agreements will be reviewed by appropriate VACO program elements. The VA Medical Center will be notified in writing by EMRSS through the Regional Office of approval or disapproval. Copies of fully executed agreements will be sent by the Medical Center Director to EMRSS (10B/EMS), within 15 days following an effective agreement. Copies of these agreements will be maintained in the Medical Center Director's files and in the files of EMRSS.

d. **Renewing Agreements**

(1) If the agreement in effect is to continue without changes and the reimbursement rate is not increased by more than 10 percent over the previous year, renewals can be approved by the District Director. The District Director will forward a copy of all agreements renewed as described above to EMRSS (10B/EMS) through the Regional Director for the annual report to Congress, Accession #00010-10-251.

(2) Agreements containing cost increases in excess of 10 percent over the previous year, or other substantive changes,will be processed as initial agreements as provided by paragraph 7 of this circular.

e. **Amending Existing Agreements**

Any amendments or changes to existing agreements will be forwarded to EMRSS (10B/EMS) through the Regional Director for approval subject to the 46 calendar day limitation mentioned in paragraph 8a.

9. **BILLING AND REIMBURSEMENT:**

a. **Billing Procedure**

The billing procedure is described in M-1, Part 1, Chapter 15, Section IV. Billing will be accomplished on an SF 1080. Generally, billing will be accomplished on a monthly basis. Agreements involving small numbers of beneficiaries or low costs may provide for quarterly billing. In agreements where each agency will provide some service for the other, consideration should be given to providing for billing by each facility of the gross amounts due but with payment made by one facility for the net amount only. No billing will be required if the approved agreement satisfies the criteria in paragraph 7(c) of this circular.

b. **Billing and Payment Locations**

Billings (or payments) made under the authority of 38 U.S.C. § 5011 should be directed to the DoD medical facility entering into the agreement and not to the centralized billing locations specified in paragraph 15.25(a) (4) of M-1, Part I. The manual is being revised to reflect this change.

c. **Reimbursement**

Funds received from DoD will be recorded by Fiscal Service as appropriation reimbursements in the normal manner. Medical facilities may request a like amount of funding from Central Office on line 9 of Section II Estimated Obligations and Status of Funds, in accordance with the DM&S Supplement to MP-4, Part VII, "Budgeting Policy and Administration," paragraph 3D.02e(2)(b)5. Prior to October 1, 1983, requests should be entered on line 7 of the October, 1981 revision of the form.

CIRCULAR 10-83-150
September 7, 1983

10. ANNUAL REPORT RCS 10-251:

An annual report on VA/DoD sharing activities will be submitted by facilities. VA Form 10-1245 will be completed in duplicate and forwarded to Central Office, Associate Deputy Chief Medical Director (722A), for agreements in effect during any quarter of the previous fiscal year. The report is due in Central Office ten workdays after September 30.

11. SHARED HEALTH CARE RESOURCES OVERSEAS:

All questions concerning sharing of health care resources in Alaska, Hawaii, Guam, and the Philippines should be referred to the Western Regional Director, 10BA6, VACO.

W. J. JACOBY, JR., M.D.
Deputy Chief Medical Director

Attachment

DISTRIBUTION: COB: (10) only
SS (10B) FLD: DMSFA-5 each; RD-2 each plus 200-8
FLD: MDD
EX: Box 44-6, Boxes 60, 54, 52-1 each & 63-5

SUGGESTED FORMAT
VA/DOD SHARING AGREEMENT

<table>
<tr><td colspan="3">VETERANS ADMINISTRATION - DEPARTMENT OF DEFENSE SHARING AGREEMENT</td><td>PAGE OF PAGES</td></tr>
<tr><td>1A. AGREEMENT NO.</td><td>1B. AMENDMENT NO.</td><td colspan="2">2. AGREEMENT PERIOD (Month & Year)
/ / TO / /</td></tr>
<tr><td colspan="2">3. VA FACILITY (Name & Address)</td><td colspan="2">4. TYPE OF ACTION (Mark "X" as Appropriate)
NEW
AMENDMENT
RENEWAL</td></tr>
<tr><td colspan="2">5. DOD FACILITY (Name & Address)</td><td colspan="2">6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED (Lab Services, etc.)</td></tr>
<tr><td colspan="4">7. DIRECT PAYMENTS TO: (Name & Address of VA and/or DOD Facility)</td></tr>
<tr><td colspan="4">8. VA AND/OR DOD OFFICE TO BE BILLED & BILLING FREQUENCY (Name & Address)</td></tr>
<tr><td colspan="4">9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DoD Health Care Resources Sharing Guidelines which are in the Memorandum of Understanding between VA and DoD, dated July 29, 1983.

b. Any amendments to this agreement shall be submitted for approval as a new sharing agreement pursuant to section 3-101 of the VA/DoD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty (30) days' notice in writing. To the extent that this contract is so terminated, each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. Agreements will go into effect 46 days after receipt of the agreements by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. Agreements will go into effect earlier than the 46-day period if approvals are obtained from both agency approving authorities.

e. If acquisition of additional resources is required to implement a proposed agreement, approval must be obtained for the additional resources prior to submitting the proposal.

f. The providing organization will prepare a SF-1080 and send it to the receiving organization's office to be billed. Documentation for audit purposes must accompany the SF-1080.

g. The addresses provided in boxes 7 and 8 may be used to provide special identification such as designated office correspondence symbols, and building numbers.</td></tr>
</table>

CIRCULAR 10-83-150
September 7, 1983

PAGE OF PAGES

10. OTHER PROVISIONS		
11A. DESCRIPTION OF SERVICES (PROVIDED BY VA)	ESTIMATED QUANTITY MONTHLY	REIMBURSEMENT RATE
11B. DESCRIPTION OF SERVICES (PROVIDED BY DoD)	ESTIMATED QUANTITY MONTHLY	REIMBURSEMENT RATE

12. SIGNATURE & TITLE OF VA MEDICAL CENTER DIRECTOR	DATE	13. SIGNATURE & TITLE OF AUTHORIZED DEPARTMENT OF DEFENSE OFFICIAL	DATE

APPENDIX J

NEEDS IDENTIFIED AT

KELLER ARMY COMMUNITY HOSPITAL

*IDENTIFIED NEEDS

Procedure	Total Demand 12 Months	Cost/ Proc	Annual Cost
Bone Scan	134	$245.25	$32,863.50
Thyroid Scan	22	107.00	2,354.00
Liver/Spleen Scan	10	195.00	1,950.00
MUGGA Scan	6	500.00	3,000.00
Gallium Scan	2	211.50	423.00
Meckels Scan	3	209.50	628.50
Xero Mammogram	125	100.00	12,500.00
Thallium Treadmill	6	600.00	3,600.00
EMG/NCU	120	150.00	18,000.00
24 Hr Holter	35	181.50	6,352.50
EEG	46	99.75	4,588.50
CT Scans:			
Brain	121	246.50	29,826.50
Body	57	323.00	18,411.00
Spine	16	323.00	5,168.00
Kidney	8	323.00	2,584.00
Fluorescein Angiogram	25	250.00	6,250.00
Carotid Flow w/OPG	5	197.00	985.00
Neurology Eval	24	75.00	1,800.00
Cardiology Eval	17	220.00	3,740.00

*Supplemental care demands-At least two demands in 12 month period.

APPENDIX K

REIMBURSEMENT RATES

FOR KELLER ARMY

COMMUNITY HOSPITAL

DOD Reimbursement Rate

The method used to arrive at the DOD reimbursement rate is indicated below for each resource to be shared, the latest cumulative UCA data was used:

1.a. OB/GYN
Walk-in Emergencies (duty hours):

Equipment Depreciation	$ .33
Supplies	.86
Salaries	20.12
Utilities & Administrative	17.37
Reimbursement Rate	$39.00

b. OB/GYN
Walk-in Emergencies (non-duty hours):

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	26.22
Utilities & Administrative	21.31
Reimbursement Rate	$ 50.00

2. OB/GYN
Routine Exams at VA:

These patients would be seen by an OB/GYN physician from Keller Army Community Hospital at the Franklin Delano Roosevelt VA Medical Center. Patients would be scheduled for exams during one, half day period, every two months. Routine exams at the VA Facility would be for female geriatric inpatients. Supplies would be provided by Franklin Delano Roosevelt VA Medical Center along with an exam room. Estimated costs/physician visit to the DOD for this care would be:

Travel	$ 8.00
Meal	10.00
Salaries	23.00
Reimbursement Rate	$ 41.00

3. ER/OPC-Minor Surgery Outpatient:

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	38.21
Utilities & Administrative	21.31
Reimbursement Rate	$62.00

4. ER/OPC-Setting of Simple Fractures-Outpatient:

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	38.21
Utilities & Administrative	21.31
Reimbursement Rate	$62.00

APPENDIX L

REIMBURSEMENT RATES FOR

THE MONTROSE VA

RATE COMPUTATIONS

VA Reimbursement Rate

The method used to arrive at the VA reimbursement rate is indicated below for each resource to be shared:

1. Thyroid Scan:

Equipment Depreciation	$10.25
Supplies	30.70
Salaries	22.40
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$96.00

2. Bone Scan:

Equipment Depreciation	$10.25
Supplies	22.50
Salaries	22.40
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$87.00

3. Liver/Spleen Scan:

Equipment Depreciation	$10.25
Supplies	20.50
Salaries	16.72
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$80.00

4. 24-Hour Holter Monitor:

Equipment Depreciation	$ 1.08
Supplies	12.00
Salaries	16.12
Utilities & Administrative	20.50
Maintenance Contracts	1.68
Reimbursement Rate	$51.00

5. Electro Encephalogram

Equipment Depreciation	$ .25
Supplies	6.00
Salaries	27.47
Utilities & Administrative	26.00
Maintenance Contracts	.32
Reimbursement Rate	$60.00

APPENDIX M

ECONOMIC IMPACT ANALYSIS

FOR THE MONTROSE VA

ECONOMIC IMPACT ANALYSIS
VA Facility

The following resources will be provided to Franklin Delano Roosevelt VA Hospital, Montrose, New York by Keller Army Community Hospital, West Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Visit	Estimated Annual Cost	DOD Reimbursement Rate/Visit	Estimate Annl Reim
OB/GYN Walk-in Emergencies	5 patients	$66.00	$330	$39.00 during duty hours ($50.00 during non-duty hrs)	$195.00 ($250.00
OB/GYN Routine Exams at VA Facility	60 patients	$66.00	$3,960	$41.00	$2460.0
ER/OPC Minor Surgery (sutures, cuts, bruises) Outpatient	50 patients	$115.00	$5,750	$62.00	$3,100.0
Setting of simple fractures-Outpatient	20 patients	$161.00	$3,220	$62.00	$1,240
	Annual Total		$13,260		$6,995 ($7,050)
	Annual Savings With Sharing Agreement		$6,265 ($6,210)		

APPENDIX N

ECONOMIC IMPACT ANALYSIS

FOR KELLER ARMY COMMUNITY HOSPITAL

ECONOMIC IMPACT ANALYSIS
DOD Facility

The following resources will be provided to Keller Army Community Hospital, West Point, New York by the Franklin Delano Roosevelt VA Hospital, Montrose, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Procedure	Estimated Annual Cost	VA Reimbursement Rate/Proced	Estimated Annl Reimb
Thyroid Scan	25 patients	$107.00	$2,675	$96.00	$2,400
Bone Scan	40 patients	$245.25	$9,810	$87.00	$3,480
Liver/Spleen Scan	12 patients	$195.00	$2,340	$80.00	$ 9[illegible]
24 Hr Holter Monitor	24 patients	$181.50	$4,356	$51.00	$1,224
Electro-Encephalogram	30 patients	$ 99.75	$2,992.50	$60.00	$1,800
	Annual Total		$22,173.50		$9,864
	Annual Savings With Sharing Agreement		$12,309.50		

APPENDIX O

VA RECOMMENDED

SHARING AGREEMENT FORMAT

SUGGESTED FORMAT
VA/DOD SHARING AGREEMENT

VETERANS ADMINISTRATION - DEPARTMENT OF DEFENSE SHARING AGREEMENT		PAGE OF PAGES
1A. AGREEMENT NO.	1B. AMENDMENT NO.	2. AGREEMENT PERIOD (Month & Year) / /. TO / /
3. VA FACILITY (Name & Address)		4. TYPE OF ACTION (Mark "X" as Appropriate) NEW AMENDMENT RENEWAL
5. DOD FACILITY (Name & Address)		6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED (Lab Services, etc.)
7. DIRECT PAYMENTS TO: (Name & Address of VA and/or DOD Facility)		
8. VA AND/OR DOD OFFICE TO BE BILLED & BILLING FREQUENCY (Name & Address)		

9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DoD Health Care Resources Sharing Guidelines which are in the Memorandum of Understanding between VA and DoD, dated July 29, 1983.

b. Any amendments to this agreement shall be submitted for approval as a new sharing agreement pursuant to section 3-101 of the VA/DoD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty (30) days' notice in writing. To the extent that this agreement is so terminated, each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. Agreements will go into effect 46 days after receipt of the agreements by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. Agreements will go into effect earlier than the 46-day period if approvals are obtained from both agency approving authorities.

e. If acquisition of additional resources is required to implement a proposed agreement, approval must be obtained for the additional resources prior to submitting the proposal.

f. The providing organization will prepare a SF-1080 and send it to the receiving organization's office to be billed. Documentation for audit purposes must accompany the SF-1080.

g. The addresses provided in boxes 7 and 8 may be used to provide special identification such as designated office correspondence symbols, and building numbers.

PAGE OF PAGES

10. OTHER PROVISIONS

11A. DESCRIPTION OF SERVICES (PROVIDED BY VA)	ESTIMATED QUANTITY MONTHLY	REIMBURSEMENT RATE

11B. DESCRIPTION OF SERVICES (PROVIDED BY DoD)	ESTIMATED QUANTITY MONTHLY	REIMBURSEMENT RATE

12. SIGNATURE & TITLE OF VA MEDICAL CENTER DIRECTOR	DATE	13. SIGNATURE & TITLE OF AUTHORIZED DEPARTMENT OF DEFENSE OFFICIAL	DATE

APPENDIX P

MODIFIED FORMAT

FOR PARAGRAPHS 1-8

OF RESOURCE SHARING AGREEMENT

VETERANS ADMINISTRATION-DEPARTMENT OF DEFENSE SHARING AGREEMENT	Page____ of ____ Pages

1A. AGREEMENT NO.	1B. AMENDMENT NO.	2. AGREEMENT PERIOD _____ TO _____ (Mo&Yr) (Mo&Yr)

3. VA FACILITY (Name & Address)	4. TYPE OF ACTION: NEW _____ AMENDMENT _____ RENEWAL _____
5. DOD FACILITY (Name & Address)	6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED:

7. DIRECT PAYMENTS TO:

VA DOD

8. VA AND/OR DOD OFFICE TO BE BILLED AND BILLING FREQUENCY:

VA DOD

APPENDIX Q

INITIAL DRAFT RESOURCE

SHARING AGREEMENT

VETERANS ADMINISTRATION-DEPARTMENT OF DEFENSE SHARING AGREEMENT	Page____of____Pages
1A. AGREEMENT NO. 1B. AMENDMENT NO.	2. AGREEMENT PERIOD _____ TO _____ (Mo&Yr) (Mo&Yr)
3. VA FACILITY (Name & Address)	4. TYPE OF ACTION: NEW_____ AMENDMENT_____ RENEWAL_____
5. DOD FACILITY (Name & Address)	6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED:
7. DIRECT PAYMENTS TO: VA DOD	
8. VA AND/OR DOD OFFICE TO BE BILLED AND BILLING FREQUENCY: VA DOD	

9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174,"Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DOD Health Care Resources Sharing Guidelines which are in the Memorandum of Understanding between VA and DOD, dated July 29, 1983.

b. Any amendment to this agreement shall be submitted for approval as a new sharing agreement pursuant to Section 3-101 of the VA/DOD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty days' notice in writing. To the extent that this agreement is so terminated, each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. This agreement will go into effect 46 days after receipt by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. This agreement will go into effect earlier than the 46 day period if approvals are obtained from both agency approving authorities.

e. The providing organization will prepare a SF-1080 and send it to the receiving organization's office to be billed. Documentation for audit purposes must accompany the SF-1080.

10. OTHER PROVISIONS:

a. Qualifications: The physicians furnished by the parties to this agreement must be licensed to practice in a state, territory or commonwealth of the United States or the District of Columbia.

b. Credentials: Credentials for OB/GYN physicians assigned to Keller Army Community Hospital will be provided to Franklin Delano Roosevelt VA Medical Center for review and acceptance before care is provided by one of these physicians at the Montrose, New York VA Medical Center.

c. Agreement Review: The provisions of this agreement will be reviewed and updated by the Director, Franklin Delano Roosevelt VA Medical Center and the Commander, Keller Army Community Hospital, on an as need basis, but at a minimum of once within six months after the date of the last signature to the agreement and at six month intervals after that date.

d. Beneficiary Priority: To preclude the possibility of denying or delaying the care and treatment of an eligible beneficiary of a facility, both parties agree that their facilities will be shared only to the extent that there will be no reduction in the range of services, quality of care, or established priorities of care provided to beneficiaries of the providing facility.

e. Existing Contracts/Agreements: This agreement is in addition to any existing contracts or agreements which the signing parties may currently have in effect and is not intended to affect existing contracts/ agreements which a facility may now be a party to, or future contracts/agreements which a party may desire to enter into.

f. Education Program: Each facility agrees to develop an internal education program to inform their beneficiaries, physicians and staff members on the provisions of this agreement.

g. Billing Procedures: All billings will be forwarded on Standard Form 1080 (Voucher for Transfers Between Appropriations and/or Funds) with appropriate supporting documentation. As a minimum the bill and/or supporting documents will include:

(1) The specific facility agreement concerned and the time period it covers.

(2) The name and social security number of the military or VA beneficiary receiving the services.

(3) The date the services were furnished.

(4) The specific types of services rendered and the quantity of such service.

(5) The per procedure rate for the service and the total costs.

(6) The specific appropriation reimbursement accounts to be credited and the dollar amounts to be credited to each.

(7) The points of contact and telephone numbers of the offices responsible for SF-1080 preparation and related inquiries.

h. Reimbursement for Additional Care or Services Beyond the Scope of Agreement: In certain instances, beneficiaries of the requesting facility, who are undergoing agreement related services at the providing facility, may unexpectedly require additional care or services beyond the scope of the agreement. In such an event, the providing facility agrees to immediately notify the requesting facility. The requesting facility will fund the additional care or services as follows:

(1) When the additional care or services are furnished by the providing facility, the requesting facility will be billed at the current inpatient or outpatient interagency per diem rate (established by OSD(C) or approved for the VA by the Office of Management and Budget), or the agreements per procedure rate, which ever more closely approximates the actual cost of the services rendered.

(2) When the additional care or services are furnished by another federal medical treatment facility, the requesting facility will be billed by that agency at its current inpatient or outpatient interagency rate.

(3) When the care must be furnished by a non-federal health care source, the requesting facility will be billed for actual expenses by the non-federal source.

11. DESCRIPTION OF SERVICES:

a. The Franklin Delano Roosevelt VA Medical Center agrees to provide the following services to eligible DOD beneficiaries on a referral basis from Keller Army Community Hospital in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. Thyroid Scan	2	$96.00/procedure
2. Bone Scan	4	$87.00/procedure
3. Liver/Spleen Scan	1	$80.00/procedure
4. 24 Hour Holter Monitor	2	$51.00/procedure
5. Electro Encephalogram	3	$60.00/procedure

b. Keller Army Community Hospital agrees to provide the following services to eligible VA beneficiaries from Franklin Delano Roosevelt VA Medical Center in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. OB/GYN: Outpatient Clinic Visit	1 patient	$39.00/Visit (normal duty hours) $50.00/Visit (non-duty hours)
2. OB/GYN: Routine exams by DOD physician at the VA facility	10 patients every two months	$41.00/Visit
3. ER/OPC-Minor Surgery (cuts, lacerations) Outpatient	4	$62.00/Visit
4. ER/OPC-Setting of simple fractures Outpatient	2	$62.00/Visit

Approved and accepted for Franklin Delano Roosevelt VA Medical Center

By_____ _____

_____ _____
(Title) (Date)

Approved and accepted for Keller Army Community Hospital

By_____

_____ _____
(Title) (Date)

APPENDIX A

ECONOMIC IMPACT ANALYSIS

ECONOMIC IMPACT ANALYSIS

DOD Facility

The following resources will be provided to Keller Army Community Hospital, West Point, New York by the Franklin Delano Roosevelt VA Medical Center, Montrose, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Procedure	Estimated Annual Cost	VA Reimbursement Rate/Proced	Estimated Annl Reimb
Thyroid Scan	25 patients	$107.00	$2,675	$96.00	$2,400
Bone Scan	40 patients	$245.25	$9,810	$87.00	$3,480
Liver/Spleen Scan	12 patients	$195.00	$2,340	$80.00	$ 960
24 Hr Holter Monitor	24 patients	$181.50	$4,356	$51.00	$1,224
Electro-Encephalogram	30 patients	$ 99.75	$2,992.50	$60.00	$1,800
		Annual Total	$22,173.50		$9,864

Annual Savings
With Sharing Agreement $12,309.50

VA Facility

The following resources will be provided to Franklin Delano Roosevelt VA Medical Center, Montrose, New York by Keller Army Community Hospital, West Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Visit	Estimated Annual Cost	DOD Reimbursement Rate/Visit	Estimated Annl Reimb
OB/GYN Walk-in Emergencies	5 patients	$66.00	$330	$39.00 during duty hours ($50.00 during non-duty hrs)	$195.00 ($250.00)
OB/GYN Routine Exams at VA Facility	60 patients	$66.00	$3,960	$41.00	$2,460.00
ER/OPC Minor Surgery(sutures, cuts, bruises) Outpatient	50 patients	$115.00	$5,750	$62.00	$3,100.00
Setting of simple fractures-Outpatient	20 patients	$161.00	$3,220	$62.00	$1,240
	Annual Total		$13,260		$6,995 ($7,050)
	Annual Savings With Sharing Agreement		$6,265 ($6,210)		

APPENDIX B

RATE COMPUTATIONS

RATE COMPUTATIONS

VA Reimbursement Rate

The method used to arrive at the VA reimbursement rate is indicated below for each resource to be shared:

1. Thyroid Scan:

Equipment Depreciation	$10.25
Supplies	30.70
Salaries	22.40
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$96.00

2. Bone Scan:

Equipment Depreciation	$10.25
Supplies	22.50
Salaries	22.40
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$87.00

3. Liver/Spleen Scan:

Equipment Depreciation	$10.25
Supplies	20.50
Salaries	16.72
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$80.00

4. 24-Hour Holter Monitor:

Equipment Depreciation	$ 1.08
Supplies	12.00
Salaries	16.12
Utilities & Administrative	20.50
Maintenance Contracts	1.68
Reimbursement Rate	$51.00

5. Electro Encephalogram

Equipment Depreciation	$ .25
Supplies	6.00
Salaries	27.47
Utilities & Administrative	26.00
Maintenance Contracts	.32
Reimbursement Rate	$60.00

DOD Reimbursement Rate

The method used to arrive at the DOD reimbursement rate is indicated below for each resource to be shared, the latest cumulative UCA data was used:

1.a. OB/GYN
Walk-in Emergencies (duty hours):

Equipment Depreciation	$ .33
Supplies	.86
Salaries	20.12
Utilities & Administrative	17.37
Reimbursement Rate	$39.00

b. OB/GYN
Walk-in Emergencies (non-duty hours):

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	26.22
Utilities & Administrative	21.31
Reimbursement Rate	$ 50.00

2. OB/GYN
Routine Exams at VA:

These patients would be seen by an OB/GYN physician from Keller Army Community Hospital at the Franklin Delano Roosevelt VA Medical Center. Patients would be scheduled for exams during one, half day period, every two months. Routine exams at the VA Facility would be for female geriatric inpatients. Supplies would be provided by Franklin Delano Roosevelt VA Medical Center along with an exam room. Estimated costs/physician visit to the DOD for this care would be:

Travel	$ 8.00
Meal	10.00
Salaries	23.00
Reimbursement Rate	$ 41.00

3. ER/OPC-Minor Surgery Outpatient:

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	38.21
Utilities & Administrative	21.31
Reimbursement Rate	$62.00

4. ER/OPC-Setting of Simple Fractures-Outpatient:

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	38.21
Utilities & Administrative	21.31
Reimbursement Rate	$62.00

APPENDIX R

COMMENTS FROM THE

MONTROSE VA ON THE

INITIAL DRAFT AGREEMENT

Franklin Delano
Roosevelt Hospital
Montrose NY 10548

Veterans
Administration

December 16, 1983

In Reply Refer To: 620/136/00

Lt. Col. Thad A. Krupka
Executive Officer
Keller Army Community Hospital
West Point, N.Y. 10996

SUBJ: Proposed Sharing Agreement Between Our Facilities

1. Concur in the proposed agreement with the addition of wording to the effect that "Mutually agreeable procedures will be established by both facilities to obtain services authorized herein."

2. It has been a pleasure for Ms. Farrell and the other members of our staff to work with Major Fine in this endeavor. We look forward to this new relationship.

C. F. HEARD, JR.
Director

APPENDIX S

NONCONCURRENCE TO INITIAL

DRAFT RESOURCE SHARING

AGREEMENT BY CHIEF, OB/GYN

KELLER ARMY COMMUNITY HOSPITAL

10 Dec 83

To Major Fine

In reviewing Gyne treatment, I feel that we cannot support the travel to the VA facility. We can see patients ~~me~~ as described in our facility if they are accompanied by appropriate supervisory personnel from the VA.

MICHAEL H POSNER
LTC, MC
123-34-6312
CHIEF, OB/GYN SVC

APPENDIX T

FINAL DRAFT RESOURCE

SHARING AGREEMENT

VETERANS ADMINISTRATION-DEPARTMENT OF DEFENSE SHARING AGREEMENT

Page 1 of 6 Pages

1A. AGREEMENT NO.	1B. AMENDMENT NO.	2. AGREEMENT PERIOD
1-84		May 1984 (Mo&Yr) TO May 1985 (Mo&Yr)

3. VA FACILITY (Name & Address)

Franklin Delano Roosevelt
VA Medical Center
Montrose, New York 10548

4. TYPE OF ACTION:

NEW X

AMENDMENT _____

RENEWAL _____

5. DOD FACILITY (Name & Address)

Keller Army Community Hospital
West Point, New York 10996

6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED:

Outpatient diagnostic tests, ER/OPC care and outpatient OB/GYN

7. DIRECT PAYMENTS TO:

VA	DOD
Franklin Delano Roosevelt VA Medical Center ATTN: 04 Montrose, New York 10548	Finance and Accounting Office USMA West Point, New York 10996

8. VA AND/OR DOD OFFICE TO BE BILLED AND BILLING FREQUENCY:

VA	DOD
Franklin Delano Roosevelt VA Medical Center ATTN: 04 Montrose, New York 10548 Frequency: Monthly	Keller Army Community Hospital West Point, New York 10996 Frequency: Monthly

9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174,"Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DOD Health Care Resources Sharing Guidelines which are in the Memorandum of Understanding between VA and DOD, dated July 29, 1983.

b. Any amendment to this agreement shall be submitted for approval as a new sharing agreement pursuant to Section 3-101 of the VA/DOD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty days' notice in writing. To the extent that this agreement is so terminated. each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. This agreement will go into effect 46 days after receipt by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. This agreement will go into effect earlier than the 46 day period if approvals are obtained from both agency approving authorities.

e. The provisions of this agreement are subject to the availability of funds after September 30, 1984.

10. OTHER PROVISIONS:

a. Qualifications: The physicians furnished by the parties to this agreement must be licensed to practice in a state, territory or commonwealth of the United States or the District of Columbia.

b. Credentials: Credentials for OB/GYN Physicians assigned to Keller Army Community Hospital will be provided to Franklin Delano Roosevelt VA Medical Center for review and acceptance before care is provided by one of these physicians at the Montrose, New York VA Medical Center.

c. Agreement Review: The provisions of this agreement will be reviewed and updated by the Director, Franklin Delano Roosevelt VA Medical Center and the Commander, Keller Army Community Hospital, on an as needed basis, but at a minimum of once within six months after the date of the last signature to the agreement and at six month intervals after that date.

d. Beneficiary Priority: To preclude the possibility of denying or delaying the care and treatment of an eligible beneficiary of a facility, both parties agree that their facilities will be shared only to the extent that there will be no reduction in the range of services, quality of care, or established priorities of care provided to beneficiaries of the providing facility.

e. Existing Contracts/Agreements: This agreement is in addition to any existing contracts or agreements which the signing parties may currently have in effect and is not intended to affect existing contracts/agreements which a facility may now be a party to, or future contracts/agreements which a party may desire to enter into.

f. Education Program: Each facility agrees to develop an internal education program to inform their beneficiaries, physicians and staff members on the provisions of this agreement.

g. Billing Procedures: All billings will be forwarded on Standard Form 1080 (Voucher for Transfers Between Appropriations and/or Funds) with appropriate supporting documentation. As a minimum, the bill and/or supporting documents will include:

(1) The specific facility agreement concerned and the time period it covers.

(2) The name and social security number of the military or VA beneficiary receiving the services.

(3) The date the services were furnished.

(4) The specific types of services rendered and the quantity of such service.

(5) The per procedure rate for the service and the total costs.

(6) The specific appropriation reimbursement accounts to be credited and the dollar amounts to be credited to each.

(7) The points of contact and telephone numbers of the offices responsible for SF-1080 preparation and related inquiries.

h. Reimbursement for Additional Care or Services Beyond the Scope of Agreement: In certain instances, beneficiaries of the requesting facility, who are undergoing agreement related services at the providing facility, may unexpectedly require additional care or services beyond the scope of the agreement. In such an event, the providing facility agrees to immediately notify the requesting facility. The requesting facility will fund the additional care or services as follows:

(1) When the additional care or services are furnished by the providing facility, the requesting facility will be billed at the current inpatient or outpatient interagency per diem rate (established by OSD(C) or approved for the VA by the Office of Management and Budget), or the agreements per procedure rate, whichever more closely approximates the actual cost of the services rendered.

(2) When the additional care or services are furnished by another federal medical treatment facility, the requesting facility will be billed by that agency at its current inpatient or outpatient interagency rate.

(3) When the care must be furnished by a non-federal health care source, the requesting facility will be billed for actual expenses by the non-federal source.

i. Coordination Meetings: It is agreed that coordination meetings between selected representatives from Keller Army Community Hospital and Montrose VA Medical Center will occur prior to implementing this agreement. The purpose of these meetings will be to address specific questions and define implementation procedures for each area of shared service. Meetings between representatives will take place at mutually agreed upon locations and times, but in no instance will occur later than the anticipated date for implementing this agreement. Specific organizational elements with a need to coordinate include, but are not limited to, the following:

(1) Comptroller Keller Army Community Hospital and the Fiscal Office Montrose VA.

(2) Patient Administration Division, Keller Army Community Hospital and Medical Records. Montrose VA.

(3) Chief, Clinical Support Division, Keller Army Community Hospital and the Administrative Assistant to the Chief of Staff. Montrose VA.

(4) Physician to physician coordination as determined by each facility.

(5) Meetings between additional organizational elements may be requested by either facility on an as needed basis.

j. OB/GYN Support At the Montrose VA:

The Franklin Delano Roosevelt VA agrees to provide an examination room, nurse support, a chaperone and specific equipment needs of the OB/GYN physician from KACH during bi-monthly visits. Specific equipment needs will be identified and relayed to the Administrative Assistant to the Chief of Staff at the Montrose VA during the coordination meeting with C, Clinical Support Branch, Keller Army Community Hospital. During this same meeting, the location of the examination room at the Montrose VA will be identified, along with where the physician is to report, times of the visits and a designated parking space for the OB/GYN physician.

Keller Army Community Hospital agrees to place one OB/GYN physician on TDY orders for one half day every other month as specified by the Montrose VA. Transportation to the Montrose VA will be either by POV or government vehicle obtained from the West Point motor pool. Small instruments for conducting routine gynecology examinations, as deemed necessary by the OB/GYN physician, will accompany the physician on his/her visits. The OB/GYN physician will report at a time and location specified by the Montrose VA.

k. Patient Referral:

Keller Army Community Hospital agrees that DOD beneficiaries, to receive care under this agreement at Franklin Delano Roosevelt VA Medical Center, will be referred to that facility to be seen on an appointment basis.

Franklin Delano Roosevelt VA Medical Center agrees that, except for walk-in emergencies, VA beneficiaries, to receive care under this agreement, will be referred to Keller Army Community Hospital to be seen on an appointment basis.

l. Adding/Deleting Services:

It is agreed by both parties that prior to adding or deleting services. or purchasing major equipment that may impact on the provisions of this agreement, the other party to the agreement will be informed.

11. DESCRIPTION OF SERVICES:

a. The Franklin Delano Roosevelt VA Medical Center agrees to provide the following services to eligible DOD beneficiaries, on a referral basis, from Keller Army Community Hospital in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. Thyroid Scan	2	$96.00/procedure
2. Bone Scan	4	$87.00/procedure
3. Liver/Spleen Scan	1	$80.00/procedure
4. 24 Hour Holter Monitor	2	$51.00/procedure
5. Electro Encephalogram	3	$60.00/procedure

b. Keller Army Community Hospital agrees to provide the following services to eligible VA beneficiaries from Franklin Delano Roosevelt VA Medical Center in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. OB/GYN: Outpatient Clinic Visit	1 patient	$39.00/Visit (normal duty hours) $50.00/Visit (non-duty hours)
2. OB/GYN: Routine exams by DOD physician at the VA facility	10 patients every two months	$41.00/Visit
3. ER/OPC-Minor Surgery (cuts. lacerations) Outpatient	4	$62.00/Visit
4. ER/OPC-Setting of simple fractures Outpatient	2	$62.00/Visit

Approved and accepted for Franklin Delano Roosevelt VA Medical Center

By_____

Director
(Title) (Date)

Approved and accepted for Keller Army Community Hospital

By_____

Commander
(Title) (Date)

APPENDIX A

ECONOMIC IMPACT ANALYSIS

ECONOMIC IMPACT ANALYSIS

DOD Facility

The following resources wlll be provided to Keller Army Community Hospital, West Point, New York by the Franklin Delano Roosevelt VA Medical Center, Montrose, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Procedure	Estimated Annual Cost	VA Reimbursement Rate/Proced	Estimated Annl Reimb
Thyroid Scan	25 patients	$107.00	$2,675	$96.00	$2,400
Bone Scan	40 patients	$245.25	$9,810	$87.00	$3,480
Liver/Spleen Scan	12 patients	$195.00	$2,340	$80.00	$ 960
24 Hr Holter Monitor	24 patients	$181.50	$4,356	$51.00	$1,224
Electro-Encephalogram	30 patients	$ 99.75	$2,992.50	$60.00	$1,800
	Annual Total		$22,173.50		$9,864
	Annual Savings With Sharing Agreement		$12,309.50		

VA Facility

The following resources will be provided to Franklin Delano Roosevelt VA Medical Center, Montrose, New York by Keller Army Community Hospital, West Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Visit	Estimated Annual Cost	DOD Reimbursement Rate/Visit	Estimat Annl Reir
OB/GYN Walk-in Emergencies	5 patients	$66.00	$330	$39.00 during duty hours ($50.00 during non-duty hrs)	$195.0(($250.0(
OB/GYN Routine Exams at VA Facility	60 patients	$66.00	$3,960	$41.00	$2460.(
ER/OPC Minor Surgery (sutures, cuts, bruises) Outpatient	50 patients	$115.00	$5,750	$62.00	$3,100.(
Setting of simple fractures-Outpatient	20 patients	$161.00	$3,220	$62.00	$1,240
	Annual Total		$13,260		$6,995 ($7,050)
	Annual Savings With Sharing Agreement		$6,265 ($6,210)		

APPENDIX B

RATE COMPUTATIONS

RATE COMPUTATIONS

VA Reimbursement Rate

The method used to arrive at the VA reimbursement rate is indicated below for each resource to be shared:

1. Thyroid Scan:

Equipment Depreciation	$10.25
Supplies	30.70
Salaries	22.40
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$96.00

2. Bone Scan:

Equipment Depreciation	$10.25
Supplies	22.50
Salaries	22.40
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$87.00

3. Liver/Spleen Scan:

Equipment Depreciation	$10.25
Supplies	20.50
Salaries	16.72
Utilities & Administrative	22.00
Maintenance Contracts	10.23
Reimbursement Rate	$80.00

4. 24-Hour Holter Monitor:

Equipment Depreciation	$ 1.08
Supplies	12.00
Salaries	16.12
Utilities & Administrative	20.50
Maintenance Contracts	1.68
Reimbursement Rate	$51.00

5. Electro Encephalogram

Equipment Depreciation	$ .25
Supplies	6.00
Salaries	27.47
Utilities & Administrative	26.00
Maintenance Contracts	.32
Reimbursement Rate	$60.00

DOD Reimbursement Rate

The method used to arrive at the DOD reimbursement rate is indicated below for each resource to be shared, the latest cumulative UCA data was used:

1.a. OB/GYN
Walk-in Emergencies (duty hours):

Equipment Depreciation	$ .33
Supplies	.86
Salaries	20.12
Utilities & Administrative	17.37
Reimbursement Rate	$39.00

b. OB/GYN
Walk-in Emergencies (non-duty hours):

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	26.22
Utilities & Administrative	21.31
Reimbursement Rate	$50.00

2. OB/GYN
Routine Exams at VA:

These patients would be seen by an OB/GYN physician from Keller Army Community Hospital at the Franklin Delano Roosevelt VA Medical Center. Patients would be scheduled for exams during one, half day period, every two months. Routine exams at the VA Facility would be primarily for psychiatric and geriatric inpatients. Supplies would be provided by Franklin Delano Roosevelt VA Medical Center along with an exam room. Estimated costs/ physician visit to the DOD for this care would be:

Travel	$ 8.00
Meal	10.00
Salaries	23.00
Reimbursement Rate	$41.00

3. ER/OPC-Minor Surgery Outpatient:

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	38.21
Utilities & Administrative	21.31
Reimbursement Rate	$62.00

4. ER/OPC-Setting of Simple Fractures-Outpatient:

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	38.21
Utilities & Administrative	21.31
Reimbursement Rate	$62.00

APPENDIX U

NEWSPAPER ARTICLES

ADDRESSING INVESTIGATION

OF THE MONTROSE VA

8 Friday, February 10, 1984 THE TIMES HERALD RECORD

VA demands shake-up at hospital in Montrose

WASHINGTON — The Veterans Administration (VA) has found such overwhelming problems at its hospital in Montrose that its investigating team has recommended a shake-up and high-level staff dismissals.

A report released yesterday details acute shortcomings in administration, staffing and patient care and even faults the "dismal physical surroundings" at the Franklin Delano Roosevelt Veterans Hospital in Montrose.

The report was prepared by five VA officials who went there after the suicide of Vietnam veteran Karl Lerchenmueller of Saugerties last December.

The report supports charges made by the Ulster County unit of the Vietnam Veterans of America (VVA) and praises what it calls their "grave concern." The VVA's complaint that the hospital's post traumatic stress unit is in serious difficulty led to congressional calls for the VA investigation.

The Veterans Administration report on its Montrose hospital calls for the firing of Director Corydon F. Heard Jr. and Gaston Trigos, the chief of staff, and orders the chiefs of both the psychiatric and nursing services to correct deficiencies in staffing and patient care in six to nine months.

The report agrees with the veterans group and also endorses the findings of the private Joint Commission on Accreditation of Hospitals (JCAH), which found "serious deficiencies in the hospital's ability to deliver quality patient care" when it visited Montrose in July.

Vernon K. Clayton, deputy VA medical director for the Northeast and head of the January investigating team, said the VA is working on changes recommended by JCAH and by the report.

Among those changes are:

— "Relieving the medical director of his position" (Corydon F. Heard Jr., the director, announced recently that he plans to retire).

— "Relieving the chief of staff (Gaston Trigos) of his position."

— Ordering the chiefs of both the psychiatric and nursing services to correct deficiencies in staffing and patient care in six to nine months; and

— Ordering the hospital's management to "begin immediate efforts to establish active and open relationships with community leaders" and veterans groups.

It also recommends that the VA send another team to the hospital in six to nine months to check on its progress.

Another top hospital official, Frank Gold, the chief of psychiatry services, will be put on probation, according to VA spokesman John Scholzen.

Reached at his home, the 67-year-old Heard said he had not seen the report, but already had sent in a letter of retirement. He linked many of the problems with inadequate budgets.

"I sound real sour, but I'm not. I'm more disgusted," Heard said.

"They (critics) don't talk about the good things the hospital is doing," he said. "It (criticism) is all built around the stress unit. We have eight patients there today. The most we ever had at one time was 15."

Gold said he had not seen the report and he declined to comment. Trigos is out of the country, Heard said.

The report says "top leadership has been unresponsive to attempts to deal with issues raised by veterans groups and local officials."

The 36-year-old veteran hung himself in a Peekskill City Jail cell following his arrest for disorderly conduct when he was out on a pass from the hospital's post traumatic stress disorder unit.

The report agrees with the JCAH that "ineffective medical leadership" is to blame for recurring and longstanding deficiencies.

Rep. Hamilton Fish Jr. of Millbrook, R-C-21, said he would use the VA report to push for money for needed staff at Montrose.

John Catterson of Huntington Station on Long Island, chairman of the New York State Council of the Vietnam Veterans of America, praised the VA report on Montrose. "I think it confirms everything the VVA has been saying for years. It's a tragedy that Lerchenmueller had to die for attention to be focused on this program."

The report says the stress unit has "substantial internal problems," and "an unclear authority structure."

According to patients on the stress unit, the latest example of this unclear authority structure occurred Monday morning when Dr. Joel Brende was transferred out of the unit to work at Building 3. The patients said there had been "a power struggle" between Brende, who was a recent staff addition, and Dr. Sigmund Gers, who has been there since the unit was started.

Brende has been working with Vietnam veterans for more than 12 years, primarily in Topeka, Kan. The patients said they "trusted" Brende and "believe in him." Several said they believed Gers "failed" Lerchenmuller, who was his patient.

Their distress at the removal of Brende from the ward is compounded by what they perceive as the difficulties of reaching him. They said they can only consult him once a week until the end of the month, then they have to have outpatient status to see him.

"This means we have to check out of here so we can see a man we trust," one of the vets said.

Vincent Crawford, assistant director at Montrose, would not discuss the patients' complaints, nor would the two doctors.

The patients are all decorated heroes of Vietnam, including one Silver Star winner who was wounded four different times who returned to combat after each recovery.

The critical report says several staff doctors at the unit did not know much about its inpatient programs.

But the stress unit's difficulties are intertwined with those of the entire hospital, which has more than 1,100 patients and 3,500 outpatients.

The report says one problem at the stress unit is "the permissive attitude by the staff toward patients' use of drugs, while one primary rule was that no patient would be admitted or retained in the unit unless drug and alcohol free."

Information for this story was compiled by Times Herald-Record staffers Bill Lowry and Chris Fariello, Ottaway News Service staffer Mark Greenberg and the Associated Press.

8 • Saturday, February 11, 1984 THE TIMES HERALD RECORD

Record photo by Mike Carey

Ditch effort

Dissatisfied with the Army Corps of Engineers' project to prevent flooding of the Wallkill River, the Sobiech, Mikulski and Gerczak farms banded together to have a 4,000 foot dike and drainage ditch built to separate their Black Dirt fields from the Pochuck Creek and flood damage this spring.

Vets praise VA report on hospital

By BILL LOWRY
Walden Bureau Chief

Vietnam veterans in the mid-Hudson area yesterday praised a Veterans Administration (VA) report blasting administrators at the VA hospital in Montrose where Karl Lerchenmueller of Saugerties was a patient at the time of his suicide in December.

"Fantastic," said Stanley Chandler Jr. of Kingston, who heads the Ulster County chapter of the Vietnam Veterans of America (VVA).

"All good things come to those who wait," commented Robert Duncan, who heads the mid-Hudson VVA, based in Poughkeepsie.

At the same time, Lerchenmueller's father, also named Karl, said he was "relieved" to know that changes would be made at the Franklin Delano Roosevelt Veterans Administration Hospital at Montrose. But he said the report did not lighten the burden of his son's death.

The report, based on an investigation following Lerchenmueller's suicide, called for the removal of the hospital's director, Corydon F. Heard Jr., and its chief of staff, Gaston Trigos. It recommended that the hospital's chief of psychiatric services, Frank Gold, be put on probation.

A VA spokesman in Washington said yesterday that the recommendations have been approved by the VA's Department of Medicine and Surgery, which has jurisdiction in the case.

Though the report did not comment on the Lerchenmueller case, it called for extensive changes and additions in staffing at the hospital, many of which had been sought by Vietnam veterans groups after Lerchenmueller's death.

Lerchenmueller, 37, a veteran of Vietnam combat who had a history of suicide attempts, hanged himself in a Peekskill jail cell after being arrested for fighting while out on pass from the Vietnam Veteran Stress Unit in the hospital, which has the nation's largest VA psychiatric center.

The results of a state investigation into the case, ordered by Gov. Mario M. Cuomo, are expected to be announced next week.

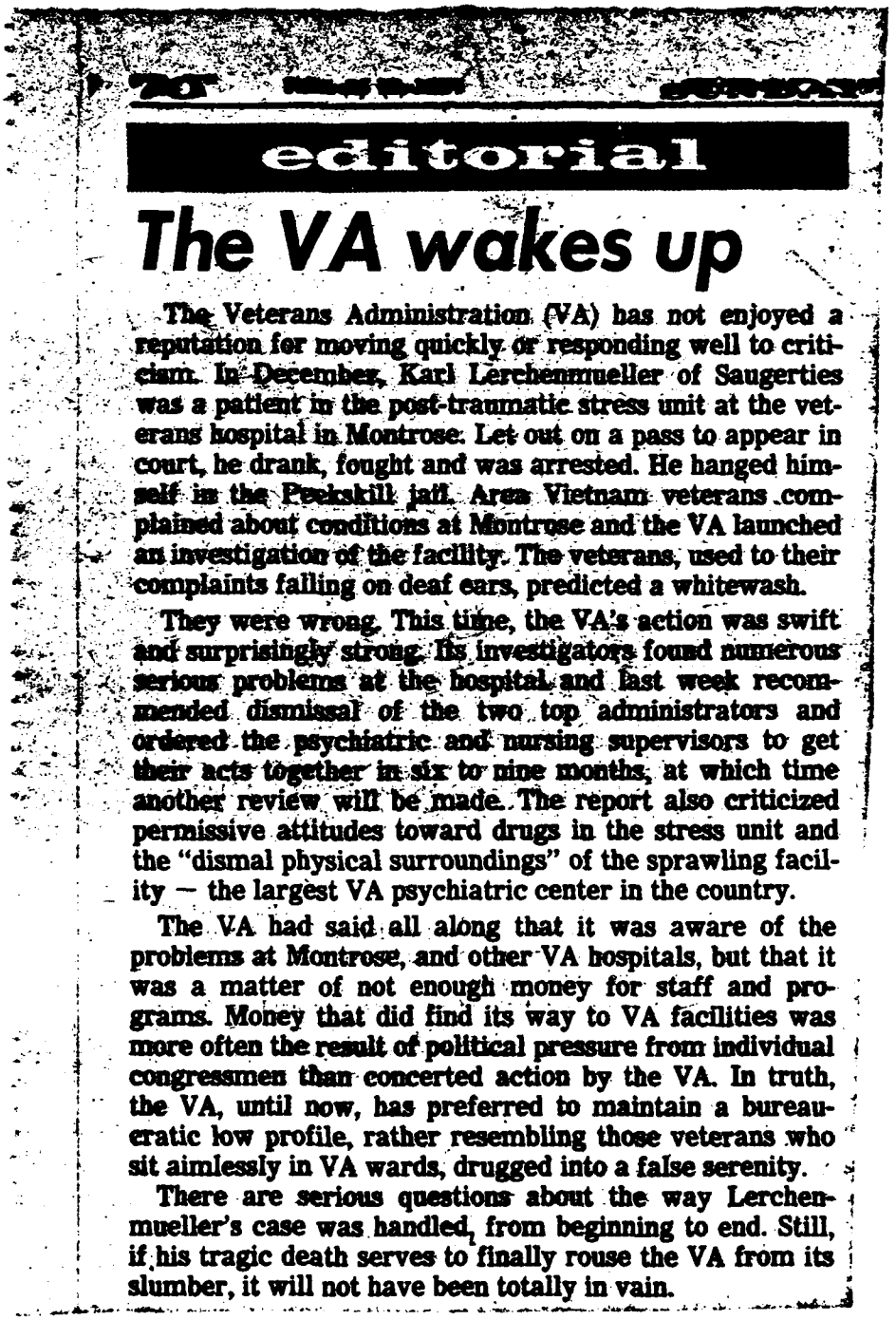
In the meantime, however, Chandler and Duncan, the local VVA leaders, said their groups and the national office of the VVA are still pushing for a congressional inquiry into the operation of other Vietnam veteran stress units around the country. They said they are not content with the VA's plan for a study of psychiatric and other problems afflicting Vietnam veterans. The study is scheduled for completion in 1986 when it is to be submitted to Congress.

Despite his satisfaction with the VA's report on Montrose, the elder Lerchenmueller said he was still disturbed over the circumstances of his son's death. "It sticks in my craw," he said.

Especially galling was "the pettiness of it all," he said, referring to his son's arrest for taking milk, bread and some cutlery from the hospital's cafeteria during the night. The younger Lerchenmueller was caught in the act by the hospital's security guard, then turned over to State Police, who arrested him.

He killed himself after being arrested a second time for fighting while on a pass from the hospital to appear in court in the pilfering case. In its report this week, the VA was critical of the hospital's policy to involve State Police "in disturbances on the hospital grounds."

The elder Lerchenmueller said he is scheduled to be interviewed today in the state investigation of the incident, which is also expected to deal with allegations that police hit the younger Lerchenmueller shortly before he was found hanging by his shirt in his cell.



editorial

The VA wakes up

The Veterans Administration (VA) has not enjoyed a reputation for moving quickly or responding well to criticism. In December, Karl Lerchenmueller of Saugerties was a patient in the post-traumatic stress unit at the veterans hospital in Montrose. Let out on a pass to appear in court, he drank, fought and was arrested. He hanged himself in the Peekskill jail. Area Vietnam veterans complained about conditions at Montrose and the VA launched an investigation of the facility. The veterans, used to their complaints falling on deaf ears, predicted a whitewash.

They were wrong. This time, the VA's action was swift and surprisingly strong. Its investigators found numerous serious problems at the hospital and last week recommended dismissal of the two top administrators and ordered the psychiatric and nursing supervisors to get their acts together in six to nine months, at which time another review will be made. The report also criticized permissive attitudes toward drugs in the stress unit and the "dismal physical surroundings" of the sprawling facility — the largest VA psychiatric center in the country.

The VA had said all along that it was aware of the problems at Montrose, and other VA hospitals, but that it was a matter of not enough money for staff and programs. Money that did find its way to VA facilities was more often the result of political pressure from individual congressmen than concerted action by the VA. In truth, the VA, until now, has preferred to maintain a bureaucratic low profile, rather resembling those veterans who sit aimlessly in VA wards, drugged into a false serenity.

There are serious questions about the way Lerchenmueller's case was handled, from beginning to end. Still, if his tragic death serves to finally rouse the VA from its slumber, it will not have been totally in vain.

APPENDIX V

SIGNED RESOURCE SHARING AGREEMENT BETWEEN KELLER ARMY HOSPITAL AND THE CASTLE POINT VA

DEPARTMENT OF THE ARMY
U. S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

REPLY TO
ATTENTION OF:

HSUD

1 March 1984

SUBJECT: VA-DOD Resource Sharing Agreement

Commander
USA Health Services Command
ATTN: HSOP-FF
Ft Sam Houston, TX 78234

1. Inclosed is a copy of the Resource Sharing Agreement between the Castle Point VA Medical Center, Castle Point, New York and Keller Army Community Hospital, west Point, New York for your approval.

2. POC at Keller Army Community Hospital is Major Fine, AV 688-4300/2511.

FOR THE COMMANDER:

Michael G. Tate

MICHAEL G. TATE
CPT, MSC
Acting Adjutant

1 Incl
as

VETERANS ADMINISTRATION-DEPARTMENT OF DEFENSE SHARING AGREEMENT

Page 1 of 6 Pages

1A. AGREEMENT NO.	1B. AMENDMENT NO.	2. AGREEMENT PERIOD
2-84		May 1984 (Mo&Yr) TO May 1985 (Mo&Yr)

3. VA FACILITY (Name & Address)

Castle Point
VA Medical Center
Castle Point, New York 12511

4. TYPE OF ACTION:

NEW X

AMENDMENT _____

RENEWAL _____

5. DOD FACILITY (Name & Address)

Keller Army Community Hospital
West Point, New York 10996

6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED:

Outpatient Diagnostic Tests, Podiatry and Ophthalmology

7. DIRECT PAYMENTS TO:

VA	DOD
Castle Point VA Medical Center c/o Agent Cashier Castle Point, New York 12511	Finance and Accounting Office USMA West Point, New York 10996

8. VA AND/OR DOD OFFICE TO BE BILLED AND BILLING FREQUENCY:

VA	DOD
Castle Point VA Medical Center ATTN: Chief, Fiscal Service Castle Point, New York 12511	Keller Army Community Hospital West Point, New York 10996
Frequency: Monthly	Frequency: Monthly

9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174,"Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DOD Health Care Resources Sharing Guidelines which are in the Memorandum of Understanding between VA and DOD, dated July 29, 1983.

b. Any amendment to this agreement shall be submitted for approval as a new sharing agreement pursuant to Section 3-101 of the VA/DOD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty days' notice in writing. To the extent that this agreement is so terminated, each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. This agreement will go into effect 46 days after receipt by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. This agreement will go into effect earlier than the 46 day period if approvals are obtained from both agency approving authorities.

e. This agreement is subject to the availability of resources after 30 September 1984.

10. OTHER PROVISIONS:

a. Qualifications: The physicians furnished by the parties to this agreement must be licensed to practice in a state, territory or commonwealth of the United States or the District of Columbia.

b. Agreement Review: The provisions of this agreement will be reviewed and updated by the Director, Castle Point Va Medical Center and the Commander, Keller Army Community Hospital, on an as need basis, but at a minimum of once within six months after the date of the last signature to the agreement and at six month intervals after that date.

c. Beneficiary Priority: To preclude the possibility of denying or delaying the care and treatment of an eligible beneficiary of a facility, both parties agree that their facilities will be shared only to the extent that there will be no reduction in the range of services, quality of care, or established priorities of care provided to beneficiaries of the providing facility.

d. Existing Contracts/Agreements: This agreement is in addition to any existing contracts or agreements which the signing parties may currently have in effect and is not intended to affect existing contracts/agreements which a facility may now be a party to, or future contracts/agreements which a party may desire to enter into.

e. Education Program:: Each facility agrees to develop an internal education program to inform their beneficiaries, physicians and staff members on the provisions of this agreement.

f. Billing Procedures: All billings will be forwarded on Standard Form 1080 (Voucher for Transfers Between Appropriations and/or Funds) with appropriate supporting documentation, As a minimum the bill and/or supporting documents will include:

(1) The specific facility agreement concerned and the time period it covers.

(2) The name and social security number of the military or VA beneficiary receiving the services.

(3) The date the services were furnished.

(4) The specific types of services rendered and the quantity of such service.

(5) The per procedure rate for the service and the total costs.

(6) The specific appropriation reimbursement accounts to be credited and the dollar amounts to be credited to each.

(7) The points of contact and telephone numbers of the offices responsible for SF-1080 preparation and related inquiries.

g. Reimbursement for Additional Care or Services Beyond the Scope of Agreement: In certain instances, beneficiaries of the requesting facility, who are undergoing agreement related services at the providing facility, may unexpectedly require additional care or services beyond the scope of the agreement. In such an event, the providing facility agrees to immediately notify the requesting facility. The requesting facility will fund the additional care or services as follows:

(1) When the additional care or services are furnished by the providing facility, the requesting facility will be billed at the current inpatient or outpatient interagency per diem rate (established by OSD(C or approved for the VA by the Office of Management and Budget), or the agreements per procedure rate, which ever more closely approximates the actual cost of the services rendered.

(2) When the additional care or services are furnished by another federal medical treatment facility, the requesting facility will be billed by that agency at its current inpatient or outpatient interagency rate.

(3) When the care must be furnished by a non-federal health care source, the requesting facility will be billed for actual expenses by the non-federal source.

h. Coordination Meetings: It is agreed that coordination meetings between selected representatives from Keller Army Community Hospital and the Castle Point VA Medical Center will occur prior to implementing this agreement, as well as, during each year of sharing. The purpose of these meetings will be to address specific questions, establish specific procedures for each area of shared service and facilitate physician to physician contact between participating facilities. Meetings between representatives will take place at mutually agreed upon locations and times, but in no instance will the first meeting occur later than the anticipated date for implementing this agreement. Specific organizational elements with a need to coordinate include, but are not limited to. the following:

(1) Comptroller Keller Army Community Hospital and the Fiscal Office Castle Point VA Medical Center.

(2) Patient Administration Division, Keller Army Community Hospital and Medical Records, Castle Point VA Medical Center.

(3) Chief, Clinical Support Branch, Keller Army Community Hospital and the Adminsitrative Assistant to the Chief of Staff, Castle Point VA Medical Center.

(4) Physician to physician coordination as determined necessary by each participating facility.

(5) Meetings between additional organizational elements may be requested by either facility on an as needed basis.

i. Patient Referral:

Keller Army Community Hospital agrees that DOD beneficiaries, to receive care under this agreement at the Castle Point VA Medical Center, will be referred to that facility to be seen on an appointment basis.

Castle Point VA Medical Center agrees that VA beneficiaries, to receive care under this agreement, will be referred to Keller Army Community Hospital to be seen on an appointment basis.

j. Adding/Deleting Services: It is agreed by both parties that prior to adding or deleting services, or purchasing major equipment that may impact on the provisions of this agreement, the other party to the agreement will be informed.

11. DESCRIPTION OF SERVICES:

a. The Castle Point VA Medical Center agrees to provide the following services to eligible DOD beneficiaries on a referral basis from Keller Army Community Hospital in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. Electromyography/ Nerve Conduction Velocity (EMG/NCV)	10	$120.00/procedure
2. Electro Encephalogram	2	$ 78.00/procedure
3. Neurological Evaluation	2	$ 72.00/procedure

b. Keller Army Community Hospital agrees to provide the following services to eligible VA beneficiaries from Castle Point VA Medical Center in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. OB/GYN: Walk-in Emergencies	2	$39.00/visit (normal duty hours) $50.00/visit (non-duty hours)
2. PODIATRY: Outpatient Podiatric Procedure	3	$31.00/visit
3. OPHTHALMOLOGY: Minor Outpatient Surgery	2	$47.00/visit

Approved and accepted
for Castle Point VA Medical
Roosevelt VA Medical
Center

By Richard A Wade

Director 1 MARCH 84
(Title) (Date)

Approved and accepted
for Keller Army
Community Hospital

By Truman Howard

Commander 1 March 84
(Title) (Date)

APPENDIX A

ECONOMIC IMPACT ANALYSIS

ECONOMIC IMPACT ANALYSIS

DOD Facility

The following resources will be provided to Keller Army Community Hospital, West Point, New York by Castle Point VA Medical Center, Castle Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Procedure	Estimated Annual Cost	VA Reimbursement Rate/Proced	Estimated Annl Reimb
EMG/NCV	120	$150.00	$18,000	$120.00	$14,400
EEG	24	$ 99.75	$ 2,394	$ 78.00	$ 1,872
Neurological Evaluation	24	$ 90.00	$ 2,160	$ 72.00	$ 1,728
	Annual Total		$22,554		$18,000
	Annual Savings With Sharing Agreement		$ 4,554		

VA Facility

The following resources will be provided Castle Point VA Medical Center, Castle Point, New York by Keller Army Community Hospital, West Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Visit	Estimated Annual Cost	DOD Reimbursement Rate/Visit	Estimated Annl Reimb
OB/GYN: Walk-in Emergencies	24	$ 66.00	$1,584	$39.00 during duty hours ($50.00 during non-duty hrs	$ 936.00 ($1,200.00
PODIATRY: Outpatient Procedure	36	$ 70.00	$2,520	$31.00	$1,116
OPHTHALMOLOGY: Outpatient Surgery	24	$120.00	$2,880	$47.00	$1,128
	Annual Total		$6,984		$3,180 ($3,444)
	Annual Savings With Sharing Agreement		$3,804 ($3,540)		

APPENDIX B

RATE COMPUTATIONS

RATE COMPUTATIONS

VA Reimbursement Rate

The method used to arrive at the VA reimbursement rate is indicated below for each resource to be shared:

1. Electromyography/Nerve Conduction Velocity:

Equipment Depreciation	$12.81
Supplies	38.38
Salaries	30.50
Utilities & Administrative	28.70
Maintenance Contracts	12.79
Reimbursement Rate	$120.00

2. Electro Encephalogram:

Equipment Depreciation	$ 8.35
Supplies	24.96
Salaries	18.72
Utilities & Administrative	17.86
Maintenance Contracts	8.35
Reimbursement Rate	$78.00

3. Neurological Evaluation:

Equipment Depreciation	$ 7.70
Supplies	23.04
Salaries	17.28
Utilities & Administrative	16.49
Maintenance Contracts	7.70
Reimbursement Rate	$72.00

DOD Reimbursement Rate

The method used to arrive at the DOD reimbursement rate is indicated below for each resource to be shared, the latest cumulative UCA data was used:

1.a. OB/GYN
Walk-in Emergencies (duty hours):

Equipment Depreciation	$ .33
Supplies	.86
Salaries	20.12
Utilities & Administrative	17.37
Reimbursement Rate	$39.00

b. OB/GYN
Walk-in Emergencies (non-duty hours):

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	26.22
Utilities & Administrative	21.31
Reimbursement Rate	$ 50.00

2. PODIATRY
Outpatient Podiatric Procedure:

Equipment Depreciation	$ .26
Supplies	1.86
Salaries	10.50
Utilities & Administrative	18.10
Reimbursement Rate	$ 31.00

3. OPHTHALMOLOGY
Minor Outpatient Surgery:

Equipment Depreciation	$ .39
Supplies	2.04
Salaries	28.52
Utilities & Administrative	15.90
Reimbursement Rate	$ 47.00

APPENDIX W

APPROVAL OF THE RESOURCE

SHARING AGREEMENT BETWEEN

KACH AND THE CASTLE POINT VA

S: 15 May 84

HSOP-FF (1 Mar 84) 1st Ind
SUBJECT: VA-DOD Resource Sharing Agreement

HQ, US Army Health Services Command, Fort Sam Houston, TX 78234 06 APR 1984

TO: Commander, US Army MEDDAC, ATTN: HSUD, West Point, NY 10996

1. Your sharing agreement is approved. All further correspondence regarding this action should address VA Sharing Agreement 4-84.

2. A DD Form 1144, Support Agreement must be initiated to document estimated savings in the first year and support provided to and from the VA. Your completed DD Form 1144 should be provided to HSCO-C, NLT 15 May 84.

FOR THE COMMANDER:

1 Incl
nc

R. O. GRAY
Colonel, AGC
Adjutant General

Department of Medicine and Surgery Washington D.C. 20420

Veterans Administration

MAR 30 1984

In Reply Refer To: 10BEMS

Director (00/134)
VA Medical Center
Castle Point, NY 12511

SUBJ: VA/DoD Resource Sharing

1. We have reviewed the proposed sharing agreement pursuant to 38 U.S.C. Section 5011 between the Castle Point, NY VAMC and Keller Army Community Hospital, West Point, NY. This sharing agreement is approved contingent upon:

a. Revision of paragraph 10j of the agreement on (page 5) so that it is clear that any additions or deletions of services from this agreement are also submitted for approval pursuant to the agreement paragraph 9b.

b. Revision of paragraph 10g(1) so that it is clear what "the agreement's per procedure rate" is. The reimbursement rate may not exceed the actual cost to the providing facility.

2. Please furnish this office with a revised copy of this agreement within 15 days after acceptance by both parties.

D. EARL BROWN, JR., M.D.
Associate Deputy Chief Medical Director

Enclosure

APPENDIX X

FINAL APPROVED RESOURCE SHARING AGREEMENT - KACH AND THE CASTLE POINT VA

VETERANS ADMINISTRATION-DEPARTMENT OF DEFENSE SHARING AGREEMENT		Page 1 of 6 Pages
1A. AGREEMENT NO. 2-84	1B. AMENDMENT NO.	2. AGREEMENT PERIOD May 1984 (Mo&Yr) TO May 1985 (Mo&Yr)
3. VA FACILITY (Name & Address) Castle Point VA Medical Center Castle Point, New York 12511		4. TYPE OF ACTION: NEW X AMENDMENT RENEWAL
5. DOD FACILITY (Name & Address) Keller Army Community Hospital West Point, New York 10996		6. GENERAL DESCRIPTION OF RESOURCES TO BE PROVIDED: Outpatient Diagnostic Tests, Podiatry and Ophthalmology

7. DIRECT PAYMENTS TO:

VA	DOD
Castle Point VA Medical Center c/o Agent Cashier Castle Point, New York 12511	Finance and Accounting Office USMA West Point, New York 10996

8. VA AND/OR DOD OFFICE TO BE BILLED AND BILLING FREQUENCY:

VA	DOD
Castle Point VA Medical Center ATTN: Chief, Fiscal Service Castle Point, New York 12511 Frequency: Monthly	Keller Army Community Hospital West Point, New York 10996 Frequency: Monthly

9. GENERAL PROVISIONS:

a. The authority for this agreement is Public Law 97-174,"Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 38 U.S.C. 5011 and the VA/DOD Health Care Resources Sharing Guidelines which are in the Memorandum of Understanding between VA and DOD, dated July 29, 1983.

b. Any amendment to this agreement shall be submitted for approval as a new sharing agreement pursuant to Section 3-101 of the VA/DOD Sharing Guidelines. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty days' notice in writing. To the extent that this agreement is so terminated, each party will be liable only for payment in accordance with provisions of this contract for resources provided prior to the effective termination date.

c. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

d. This proposed agreement must be signed by both parties and submitted to the approving authorities in each agency. This agreement will go into effect 46 days after receipt by the approving authorities provided no disapproval has been transmitted in writing to one or both parties signing the agreement. This agreement will go into effect earlier than the 46 day period if approvals are obtained from both agency approving authorities.

e. This agreement is subject to the availability of resources after 30 September 1984.

10. OTHER PROVISIONS:

a. Qualifications: The physicians furnished by the parties to this agreement must be licensed to practice in a state, territory or commonwealth of the United States or the District of Columbia.

b. Agreement Review: The provisions of this agreement will be reviewed and updated by the Director, Castle Point Va Medical Center and the Commander, Keller Army Community Hospital, on an as need basis, but at a minimum of once within six months after the date of the last signature to the agreement and at six month intervals after that date.

c. Beneficiary Priority: To preclude the possibility of denying or delaying the care and treatment of an eligible beneficiary of a facility, both parties agree that their facilities will be shared only to the extent that there will be no reduction in the range of services, quality of care or established priorities of care provided to beneficiaries of the providing facility.

d. Existing Contracts/Agreements: This agreement is in addition to any existing contracts or agreements which the signing parties may currently have in effect and is not intended to affect existing contracts/agreements which a facility may now be a party to, or future contracts/agreements which a party may desire to enter into.

e. Education Program:: Each facility agrees to develop an internal education program to inform their beneficiaries, physicians and staff members on the provisions of this agreement.

f. Billing Procedures: All billings will be forwarded on Standard Form 1080 (Voucher for Transfers Between Appropriations and/or Funds) with appropriate supporting documentation, As a minimum the bill and/or supporting documents will include:

(1) The specific facility agreement concerned and the time period it covers.

(2) The name and social security number of the military or VA beneficiary receiving the services.

(3) The date the services were furnished.

(4) The specific types of services rendered and the quantity of such service.

(5) The per procedure rate for the service and the total costs.

(6) The specific appropriation reimbursement accounts to be credited and the dollar amounts to be credited to each.

(7) The points of contact and telephone numbers of the offices responsible for SF-1080 preparation and related inquiries.

g. Reimbursement for Additional Care or Services Beyond the Scope of Agreement: In certain instances, beneficiaries of the requesting facility, who are undergoing agreement related services at the providing facility, may unexpectedly require additional care or services beyond the scope of the agreement. In such an event, the providing facility agrees to immediately notify the requesting facility. The requesting facility will fund the additional care or services as follows:

(1) When the additional care or services are furnished by the providing facility, the requesting facility will be billed at the current inpatient or outpatient interagency per diem rate (established by OSD(C) or approved for the VA by the Office of Management and Budget), or the agreement's per-procedure rate. as reflected in Appendix B, which ever most closely approximates the actual cost of the services rendered. In any case, the reimbursement rate may not exceed the actual cost to the providing facility.

(2) When the additional care or services are furnished by another federal medical treatment facility, the requesting facility will be billed by that agency at its current inpatient or outpatient interagency rate.

(3) When the care must be furnished by a non-federal health care source, the requesting facility will be billed for actual expenses by the non-federal source.

h. Coordination Meetings: It is agreed that coordination meetings between selected representatives from Keller Army Community Hospital and the Castle Point VA Medical Center will occur prior to implementing this agreement, as well as, during each year of sharing. The purpose of these meetings will be to address specific questions, establish specific procedures for each area of shared service and facilitate physician to physician contact between participating facilities. Meetings between representatives will take place at mutually agreed upon locations and times, but in no instance will the first meeting occur later than the anticipated date for implementing this agreement. Specific organizational elements with a need to coordinate include, but are not limited to, the following:

(1) Comptroller Keller Army Community Hospital and the Fiscal Office Castle Point VA Medical Center.

(2) Patient Administration Division, Keller Army Community Hospital and Medical Records, Castle Point VA Medical Center.

(3) Chief. Clinical Support Branch, Keller Army Community Hospital and the Adminsitrative Assistant to the Chief of Staff, Castle Point VA Medical Center.

(4) Physician to physician coordination as determined necessary by each participating facility.

(5) Meetings between additional organizational elements may be requested by either facility on an as needed basis.

i. Patient Referral:

Keller Army Community Hospital agrees that DOD beneficiaries, to receive care under this agreement at the Castle Point VA Medical Center, will be referred to that facility to be seen on an appointment basis.

Castle Point VA Medical Center agrees that VA beneficiaries, to receive care under this agreement, will be referred to Keller Army Community Hospital to be seen on an appointment basis.

j. Adding/Deleting Services: It is agreed by both parties that prior to adding or deleting services, or purchasing major equipment that may impact on the provisions of this agreement, the other party to the agreement will be informed. Additions or deletions of services will be submitted pursuant to paragraph 9b of this agreement.

11. DESCRIPTION OF SERVICES:

a. The Castle Point VA Medical Center agrees to provide the following services to eligible DOD beneficiaries on a referral basis from Keller Army Community Hospital in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. Electromyography/ Nerve Conduction Velocity (EMG/NCV)	10	$120.00/procedure
2. Electro Encephalogram	2	$ 78.00/procedure
3. Neurological Evaluation	2	$ 72.00/procedure

b. Keller Army Community Hospital agrees to provide the following services to eligible VA beneficiaries from Castle Point VA Medical Center in the estimated quantity and at the reimbursement rates indicated:

Service Provided	Estimated Monthly Quantity	Reimbursement Rate
1. OB/GYN: Walk-in Emergencies	2	$39.00/visit (normal duty hours) $50.00/visit (non-duty hours)
2. PODIATRY: Outpatient Podiatric Procedure	3	$31.00/visit
3. OPHTHALMOLOGY: Minor Outpatient Surgery	2	$47.00/visit

Approved and accepted
for Castle Point VA Medical
Center

By Richard S Dunbe

Director 18 APR 84
(Title) (Date)

Approved and accepted
for Keller Army
Community Hospital

By Freeman Howard

Commander 17 Apr '84
(Title) (Date)

APPENDIX A

ECONOMIC IMPACT ANALYSIS

ECONOMIC IMPACT ANALYSIS

DOD Facility

The following resources will be provided to Keller Army Community Hospital, West Point, New York by Castle Point VA Medical Center, Castle Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Procedure	Estimated Annual Cost	VA Reimbursement Rate/Proced	Estimated Annl Reimb
EMG/NCV	120	$150.00	$18,000	$120.00	$14,400
EEG	24	$ 99.75	$ 2,394	$ 78.00	$ 1,872
Neurological Evaluation	24	$ 90.00	$ 2,160	$ 72.00	$ 1,728
		Annual Total	$22,554		$18,000
		Annual Savings With Sharing Agreement	$ 4,554		

VA Facility

The following resources will be provided Castle Point VA Medical Center, Castle Point, New York by Keller Army Community Hospital, West Point, New York:

Resource	Estimated Annual Requirement	Non-Federal Cost/Visit	Estimated Annual Cost	DOD Reimbursement Rate/Visit	Estimated Annl Reimb
OB/GYN: Walk-in Emergencies	24	$ 66.00	$1,584	$39.00 during duty hours ($50.00 during non-duty hrs	$ 936.00 ($1,200.00
PODIATRY: Outpatient Procedure	36	$ 70.00	$2,520	$31.00	$1,116
OPHTHALMOLOGY: Outpatient Surgery	24	$120.00	$2,880	$47.00	$1,128
	Annual Total		$6,984		$3,180 ($3,444)
	Annual Savings With Sharing Agreement		$3,804 ($3,540)		

APPENDIX B

RATE COMPUTATIONS

RATE COMPUTATIONS

VA Reimbursement Rate

The method used to arrive at the VA reimbursement rate is indicated below for each resource to be shared:

1. Electromyography/Nerve Conduction Velocity:

Equipment Depreciation	$12.81
Supplies	38.38
Salaries	30.50
Utilities & Administrative	28.70
Maintenance Contracts	12.79
Reimbursement Rate	$120.00

2. Electro Encephalogram:

Equipment Depreciation	$ 8.35
Supplies	24.96
Salaries	18.72
Utilities & Administrative	17.86
Maintenance Contracts	8.35
Reimbursement Rate	$78.00

3. Neurological Evaluation:

Equipment Depreciation	$ 7.70
Supplies	23.04
Salaries	17.28
Utilities & Administrative	16.49
Maintenance Contracts	7.70
Reimbursement Rate	$72.00

DOD Reimbursement Rate

The method used to arrive at the DOD reimbursement rate is indicated below for each resource to be shared, the latest cumulative UCA data was used:

1.a. OB/GYN
Walk-in Emergencies (duty hours):

Equipment Depreciation	$ .33
Supplies	.86
Salaries	20.12
Utilities & Administrative	17.37
Reimbursement Rate	$39.00

b. OB/GYN
Walk-in Emergencies (non-duty hours):

Equipment Depreciation	$ .33
Supplies	1.81
Salaries	26.22
Utilities & Administrative	21.31
Reimbursement Rate	$ 50.00

2. PODIATRY
Outpatient Podiatric Procedure:

Equipment Depreciation	$ .26
Supplies	1.86
Salaries	10.50
Utilities & Administrative	18.10
Reimbursement Rate	$ 31.00

3. OPHTHALMOLOGY
Minor Outpatient Surgery:

Equipment Depreciation	$ .39
Supplies	2.04
Salaries	28.52
Utilities & Administrative	15.90
Reimbursement Rate	$ 47.00

SELECTED BIBLIOGRAPHY

SELECTED BIBLIOGRAPHY

U.S. Documents

Comptroller General, General Accounting Office. "Congressional Policy Guidance Should Improve Military Hospital Planning". (HRD-77-5), November 18, 1976.

Comptroller General, General Accounting Office. "Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Control Needed." (HRD-76-168), Feb 28, 1977.

Comptroller General, General Accounting Office. "Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Rescue Costs." (HRD-78-14). Nov 17, 1977.

Comptroller General, General Accounting Office. "Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions." (HRD-78-41), Jan 30, 1978.

Comptroller General, General Accounting Office. "Constructing New VA Hospital in Camden, New Jersey, Unjustified." (HRD-78-51), Feb 6, 1978.

Comptroller General, General Accounting Office. "Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals." (HRD-78-102), May 17, 1978.

Comptroller General, General Accounting Office. Better Coordination Could Improve Provision of Federal Health Care in Hawaii. (HRD-78-99), May 22, 1978.

Comptroller General, General Accounting Office. Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing. (HRD-78-54), June 14, 1978.

Comptroller General, General Accounting Office. Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing. (HRD-79-42), Feb 7, 1979.

Comptroller General, General Accounting Office. Military Medicine Is in Trouble: Complete Reassessment Needed. (HRD-79-107),Aug 16, 1979.

Comptroller General, General Accounting Office. Health Costs Can Be Reduced By Millions of Dollars If Federal Agencies Fully, Carry Out GAO Recommendations. (HRD-80-6), Nov 13, 1979.

Congress of the United States. Comprehensive Health Planning and Public Health Service Amendments, PL 89-785 (42 USC 246), 1966.

Congress of the United States. 38 US Code 5003, 5053.

Congress of the United States. Health Disease, Cancer and Stroke Amendments, (42 USC 299-299j), 1965.

Congress of the United States, 42 US Code 246.

Congress of the United States, 42 US Code 299-299J, "Heart Disease, Cander and Stroke Amendments" 1965.

Congress of the United States. The Economy Act, (31 USC 686), 1932.

Congress of the United States. VA/DOD Health Care Resources Sharing Act. Hearing Before the Committee on Veterans Affairs, June 17, 1981.

Congress of the United States. VA-DOD Health Resources Sharing and Emergency Operations Act - Introduced January 25, 1982.

Congress of the United States. VA-DOD Health Resources Sharing and Emergency Operations Act. Section 5011A, Title 38, U.S.C., May 4, 1982.

Congress of the United States. Military Construction Appropriation Bill-1984. July 11, 1983.

Department of Defense, unnumbered Draft Directive, "VA/DOD Health Care Resources Sharing Guidelines", Washington, D.C. undated.

Department of Health and Human Services Publication No. 83-1232. Health United States 1982. Hyattsville, Maryland, December 1982.

Manpower Survey Report, TDA HSW 2H8AA, 31 August 1981.

Memorandum for the Secretary of Defense. Proposed DOD-VA Joint Report to Congress. February 28, 1983.

Memorandum of Understanding Between the Veterans Administration and the Department of Defence. VA-DOD Health Care Resources Sharing Guidelines. July 1, 1983.

Office of the Surgeon General. Information Paper: DOD-VA Contingency Planning, February 15, 1983.

Uniform Chart of Accounts, Keller Army Community Hospital, Third Quarter Cumulative Workload Data, FY 1983.

US Department of Health, Education and Welfare, "Guidelines for Health Services R&D: Shared Services" (Rockvill MD: DHEW Publication 72-3023, 1972) pp 5-6.

U.S. Department of the Army. Army Treatment Facilities General Administration, AR 40-2, 15 July 1981.

Veterans Administration. Instructions for Implementing the Sharing Provisions of Public Law 97-174. Circular 10-83-150. September 7, 1983.

Veterans Administration and Department of Defense. Health Care Resources Sharing Committee Agreement and Charter. February 15, 1983.

Books

Altman, Stuart H. and Sapolsky, Harvey M., Federal Health Programs. Lexington, Mass: D.C. Heath and Co., 1981.

American College of Hospital Administrators. An Examination of Shared Services. Chicago, Ill.: American College of Hospital Administrators, 1974.

American Hospital Association. Shared Services in Health Care Institutions Chicago, Ill.: American Hospital Association, 1975.

Blumberg, Mark. Shared Services for Hospitals. Chicago Ill: American Hospital Association, 1966.

Brown, Montague and Lewis, Howard. Hospital Management Systems: Multi-Unit Organization and Delivery of Health Care. Germantown, Maryland: Aspen Systems Corporation, 1976.

Health Services Research Center. Services Shared by Health Care Organizations: An Annotated Bibliography. Chicago, Ill: Health Serrvices Research Center, 1977.

Health Services Research Center. Services Shared by Health Care Organizations. Volume 4: Economic Impact of Shared Services Arrangements. Chicago, Ill: Health Services Research Center, 1977.

Health Services Research Center. Services Shared by Health Care Organizations. Volume 3: Methodologies. Chicago, Ill: Health Services Research Center, 1977.

Health Services Research Center. Services Shared by Health Care Organizations. Volume 2: Case Studies. Chicago, Ill: Health Services Research Center, 1977.

Health Services Research Center. Services Shared by Health Care Organizations. Volume 1: A National Focus Chicago, Ill: Health Services Research Center, 1977.

Hepner, James O., Ed. Health Planning for Emerging Multi-Hospital Systems.

Lindsay, Cotton M. Veterans Administration Hospitals. Washington, DC: American Enterprise for Public Policy Research, November 1975.

President's Commission on the Health Needs of the Nation. Building America's Health (5 Vols) (Washington, D.C.: GPO, 1952), Vol. 2.

Snook, I. Donald, Jr. Hospitals: What They Are and How They Work. Rockville, MD: Aspen, 1981.

The Commission on Hospital Care. Hospital Care in the United States (Cambridge, MA: Harvard University Press, 1947), Chapter 27.

Periodicals

"All New Jersey Hospitals Switch to Diagnosis-Related Reimbursements" Medical World News 23:3 (February 1, 1982) pp 30, 37-8.

Barrett, Diana "The Trend Line for Multi-Institutional Systems Can Only go Up" Hospitals (April 1, 1982): 81-4.

Bennett, James and Ahrendt, K. "Achieving Economies of Scale Through Shared Ancillary and Support Services", Topics in Health Care Financing 7 No 3 (Spring 1981) pp 25-34.

Bennett, James E. and Baxter, John W. "Program Consolidation and Hospital Merger: Beware the Conventional Wisdom" Topics in Health Care Financing 7 No 3 (Spring 1981) pp 35-45.

Brown, Montague. "Multi-Hospital Systems: Implications for Physicians" The Hospital Medical Staff 8, No. 8 (August 1979): 2-11.

_____; "Multi-Institutional Arrangements: Shared Services Gain Support" Hospitals 52 No 7 (April 1, 1978): pp 131-2, 134, 136-7.

_____; Enright, Michael; and Wood, Jack C. "Shared Services" Topics in Health Care Financing 2, No. 4 (Summer 1976).

Cogne. Joseph S. "Multi-Hospital System Types: Comparing Costs and Occupancy" Hospital Progress 61, No. 1 (January 1980): 50-53.

Custis, Donald "The Question of Regionalization and Sharing of Health Services" Military Medicine 146, No 2 (February 1981) pp 114-5, 119.

Davidson, Richard J. "MHA Supports Voucher System, Not New VA Hospital" Hospital Progress (July 1980): 8-10.

Demkovich, Linda E. "When It Comes to Planning Hospitals, the VA Marches to Its Own Beat" National Journal (August 30, 1980): 1428-33.

DiPolo, Vince "Shared Service Business Soars 31%" Modern Health Care October 1981): 68-74.

Dorenfest, Sheldon I. "Hospital Chain Became Impatient Providers" Modern Health Care (November 1981): 77.

Finkler, Steven A "Cost-Effectiveness of Regionalization: The Heart Surgery Example" Inquiry (Fall 1979): 264-70.

Foley, G. "The Ultimate Shared Service For Hospitals: Political Synergy" Hospital Health Services Administration 25 No. 2 (Speical Issue 1980) pp 35-42.

Friedman, Bernard; Pierskalla, William; Beazoglow, Tryfon. "Sharing Arrangements in the Non-profit Hospital Industry Health Services Research (Summer 1979): 150-9.

Griffin, Adelaide. "Shared Services-A Recipe for Cost-Cutting in Hospitals" Long Range Planning (December 1981) pp 76-79.

Griffin, Adelaide and Adams, S. "Shared Services: A Long Term Commitment or a Short Term Fad?" Hospital Topics 58 No 1 (Jan-Feb 1980): pp 38-43.

Hedberg, Augustin "Health Care: Getting the Best Value" MONEY (September 1982), pp 55-58.

Hillestad, Steven G. and Berkowitz, Eric N. "Hospital Executives Need Marketing Tools To Meet Competition Challenges" Modern Health Care (January 1982): 84-6.

"Hospital Leads Way In Employee Cost-Sharing" Hospitals (September 1, 1983): 40.

Johnson, Donald E.L. "Multi-Unit Systems Grow 11% in '79" Modern Health Care (April 1980): 57-8, 60, 64.

_____. "Use of Management Contracts Climbs 16.7%; Clients Up 7.1%" Modern Health Care (August 1983): 89-95.

_____ and Diapaolo, Vince "Multi-Hospital Systems: $1.7 Billion Kaiser on Top" Modern Health Care (April 1981): 79-82.

Katz, Gerald (Ed) "Multi-Institutional System and Regionalization" Journal of Ambulatory Care Management (August 1980): 1-111.

Kraus, Shirley "How Corporate Hospital Chains Have Blossomed" RN (July 1982): 25, 99.

Kruegel, David and Evans, Carleton "The Organizaiton of Health Services Research in the Veterans Administration", Journal of Medical Systems Vol 5 Nos 1/2 (1981) pp 157-62.

Kuntz, Esther Fritz "Shared Service Activity Might Spurt in '83 After Sluggish '82" Modern Health Care (August 1983): 106-30.

Litman, Theodor and Johnson, George "Sharing Services: The Dynamics of Institutional and Administrative Behavior" Hospital and Health Services Administration (Fall 1980): 7-22.

Mason, S.A. "The Multi-Hospital Movement Defined" Public Health Reports (September/October 1979): 446-53.

Melum, Martha M. "10 'Lessons' Point the Way Toward Successful Hospital Planning" Hospitals (December 1, 1981) pp 58-62.

Plant, Janet. "Share Service Organizations Evolve Into Multi-faceted Businesses" Hospitals (September 1, 1983): 71-6.

Punch, Linda. "Hospital Alliance Forays Widen the Realm of Shared Services" Modern Health Care (August 1983): 136-8.

_____. "Shared Services Pacts up 22%" Modern Health Care (July 1982): 128-34.

Roemer, Milton I and Morris, Robert C. "Hospital Regionalization in Perspective" Public Health Reports 74: 916 October 1959.

Schwartz, William B. and Joskow, Paul L. "Duplicated Hospital Facilities, How Much Can We Save By Consolidating Them?" The New England Journal of Medicine (December 18, 1980): 1449-57.

Schweiker, Richard S. "The Public Stake in Shared Services: Some Political Considerations" Hospital and Health Services Administration, (Fall 1979) pp 81-87.

Smith, Elworth and Cobb, Dorothy. "AHA Surveys Show That Fewer Hospitals Are Participating in Shared Services" Hospitals (September 1, 1983): 67-70.

Taylor, Elworth. "Survey Shows Who Is Sharing Which Services" Hospitals, (September 16, 1979): 147-52.

Thies. James B. "Shared Modular Hospital Information Systems" Hospital and Health Services Administration (Spring 1977): 23-9.

Wallace, Cynthia. "VA Not Immune From Competition" Modern Health Care (May 1983): 154-5.

Wallace, Cynthia, "Shared Services Hold Antitrust Risk" Modern Health Care 12 No. 7 (July 1982) p. 136.

Weinstein, Alan. "Shared Services May Provide Hospitals With A Competitive Advantage" Hospitals (September 1, 1983): 60-4.

Zuckerman, Howard S. "Multi-Institutional Systems: Adaptive Strategy For Growth, Survival" Hospital Progress. (May 1981): 43-6.

Newspaper Articles

Lowry, Bill, "Vets Praise VA Report On Hospital" The Times Herald Record, February 11, 1984.

Lowry, Bill and Farlekas, Chris "VA Demands Shake-Up at Hospital in Montrose" The Times Herald Record, February 10, 1984.

"The VA Wakes Up", Editorial The Times Herald Record, February 12, 1984.

Other Sources

Coordination Meeting, Franklin Delano Roosevelt VA Medical Center, Montrose, New York, September 29, 1983.

Coordination Meeting with the Staff, Keller Army Community Hospital, November 4, 1983.

Federal Health Resources Sharing Committee, "The White Paper", 1977.

Health Resources Sharing Committee Workshop, Northport VA Medical Center. Long Island, New York, October 25, 1983.

Northern Metropolitan Hospital Association, General Membership Meeting, "Update on Topical Issues", Newburgh, New York, August 24, 1983.

Interviews

Arnt, Stephen, LTC, MSC, Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C. September 14, 1983; October 20, 1983 (telephonic).

Busack. James, MAJ, MC, Chief, ER/OPC, Keller Army Community Hospital, West Point, New York, December 8, 1983.

Farrar, Dottie, Health Benefits Advisor, Patient Administration Division, Keller Army Community Hospital, West Point, New York, December 7, 1983.

Heard, Corydon F., Director, Franklin Delano Roosevelt VA Medical Center. Montrose, New York, September 29, 1983, November 16, 1983, December 1, 1983, February 1, 1984.

Howard, Freeman I, COL, MC, Commander, Keller Army Community Hospital, West Point, New York, September 30, 1983, December 6, 1983, January 19, 1984, February 13, 1984.

Krupka, Thad, LTC, MSC, Deputy Commander for Administration, Keller Army Community Hospital, September 22 & 30; October 12, 1983.

Moa, James, LTC, MSC. Project Officer, Office of the Deputy Chief of Staff. Operations, Health Services Command, Fort Sam Houston, Texas, October 20, 1983.

Morrison, Judith, Comptroller, Munson Army Hospital, Fort Leavenworth, Kansas. November 3, 1983.

Simmons, James. Veterans Administration Central Office, Washington, D.C., October 10, 1983 (telephonic).

Tate, Michael, CPT, MSC, Comptroller, Keller Army Community Hospital, West Point, New York. September 30, 1983, November 3, 1983, January 4, 1984.