

**DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE
CONTINGENCY PLAN**

- 1. REASON FOR ISSUE:** This revised Veterans Health Administration (VHA) Handbook defines VHA's role in the Department of Veterans Affairs (VA)-Department of Defense (DOD) Contingency Plan.
- 2. SUMMARY OF MAJOR CHANGES:** This revised VHA Handbook provides technical updates to guidance for the activation and operation of the VA-DOD Contingency Plan.
- 3. RELATED ISSUES:** VHA Directive 0320.
- 4. RESPONSIBLE OFFICE:** The Director, VHA Office of Emergency Management (10NA1) is responsible for the contents of this Handbook. Questions may be addressed to 304-264-4800.
- 5. RESCISSIONS:** VHA Handbook 0320.04, dated December 26, 2007, is rescinded.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of May 2019.

Robert A. Petzel, M.D.
Under Secretary for Health

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CONTENTS

**DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE
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PARAGRAPH	PAGE
1. Purpose	1
2. Background	1
3. Scope	1
4. Definitions	2
5. Responsibilities	4
6. Procedures	7
7. References	8

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

2. BACKGROUND:

a. The Department of Veterans Affairs (VA) - DOD Health Resources Sharing and Emergency Operations Act (Public Law 97-174) was enacted on May 4, 1982. Under this statute, VA serves as a principal health care backup to DOD during and immediately following a period of war or a period of national emergency declared by the President or Congress that involves the use of Armed Forces in armed conflict.

b. In response to Public Law 97-174, a Memorandum of Understanding was established in 1982 to specify each agency's responsibilities. It was revised as a Memorandum of Agreement (MOA) in November 2006, signed by the Secretaries of Defense and VA. The MOA establishes a "VA-DOD Contingency Plan" which was originally published as Appendix A to the MOA. The VA-DOD Contingency Plan is subject to annual review and change, and it provides the current list of VA assets which constitute VA contingency support to DOD.

3. SCOPE:

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

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

c. Patients could arrive at Primary Receiving Centers (PRCs) within 24 hours of activation of the VA-DOD Contingency Plan. Patients may be routed directly from a wartime theater to a civilian or military airport near the destination PRC, or may be transported from other DOD Continental United States (CONUS) medical facilities to the PRC.

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

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

(2) Nearest to home or unit of record.

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

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

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

4. DEFINITIONS:

a. **Available Beds.** Available beds are the beds that are vacant as of 12:00 midnight on the day previous to the day of the report, to which the DOD Theater Patient Movement Requirements Center - Americas (TPMRC-A) can regulate and to which patients can immediately be transported. They must be in a functioning military treatment facility set up and ready for all aspects of care of a patient. Available beds must include supporting space, equipment, medical material, ancillary and support services and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. Beds are reported in contingency medical regulating categories as instructed by TPMRC-A.

b. **Bed Report.** The bed report is the submission of a medical facility's real-time capacity to receive, admit, and treat patients from a disaster or war.

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

d. **Category.** Category is a specific discipline of medical care, used to identify the nature of a patient's illness or injury, as well as to identify the capability and capacity of a VA medical facility, used to match patients' needs with VA medical facility capabilities and regulate the movement of patients. The seven contingency categories used by the DOD TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) are:

- (1) Critical Care.
- (2) Medical and Surgery.
- (3) Psychiatry.
- (4) Burn.
- (5) Pediatric.
- (6) Pediatric Critical Care.
- (7) Negative Pressure / Isolation.

e. **Critical Care.** Critical care is a category of adult patients requiring sophisticated intervention to restore or maintain life processes. This involves the requirement to provide immediate and continuous attention and monitoring using specialized facilities, equipment and personnel. Critical Care beds are generally defined as those in licensed intensive care units.

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

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

h. **Medical/Surgery**. Medical/surgery is a category of patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. Medical/surgery beds are generally defined as those licensed, certified, or otherwise authorized, with adequate space, equipment, medical materiel, and ancillary support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

i. **Negative Pressure/Isolation**. Negative pressure/isolation is a category of patients requiring a separate room or area provided with negative airflow and respiratory isolation. Negative pressure/isolation beds are generally defined as those providing negative airflow and respiratory isolation.

j. **Patient Movement Items (PMI)**. PMI are select and standardized medical equipment and supplies used by DOD to support patients during evacuation operations. PMI must be certified for use in DOD aircraft by DOD testing agencies.

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

l. **Pediatric Critical Care**. Pediatric critical care is a category of patients critically ill or injured, aged 17 years or younger, including those requiring ventilator support. Pediatric Critical Care beds are generally defined as those in licensed intensive care units that can support critically ill or injured patients, aged 17 years or younger, including those requiring ventilator support.

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

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

(2) **Primary Receiving Center (PRC) Coordinator**. The PRC Coordinator is a DOD, VA, or other principal staff officer responsible for the readiness and operation of the PRC program.

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

o. **Pediatric**. Pediatric is a category of patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.

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

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

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

5. RESPONSIBILITIES:

a. Deputy Under Secretary for Health for Operations and Management.

(1) Provide policy direction to ensure the successful implementation of VA-DOD Contingency Plan.

(2) Provide program implementation guidance and technical assistance to VA Central Office and to the Veterans Integrated Service Networks (VISNs).

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

b. VISN Directors.

(1) Provide operational and policy direction to VA medical facilities to ensure the successful implementation of the VA-DOD Contingency Plan.

(2) Monitor implementation of VISN and VA medical facility contingency plans and implement corrective actions as necessary.

c. **Director, VHA Office of Emergency Management (OEM).**

(1) Serve as principal advisor in developing and maintaining the VA-DOD Contingency Plan.

(2) Provide guidance and technical assistance to VA Central Office, VISNs, and medical facility staff on the preparation of supporting plans.

(3) Provide liaisons as required to the TPMRC-A.

d. **VA Facility Directors Designated as PRC Directors.**

(1) Develop plans to, train for, exercise, and maintain the capability to receive DOD patients from other regions by land, air, or sea.

(2) Provide health care services, and/or coordinate with other health care providers within their area for services for DOD patients received at the PRC.

(3) Appoint a PRC Coordinator responsible for the readiness and the operation of the PRC Program.

(4) Actively coordinate with associated SSCs to develop and maintain a PRC Plan. At a minimum, each PRC Plan should address the following areas:

- (a) Concept of Operations.
- (b) System Activation.
- (c) Alerting SSCs.
- (d) Bed Availability Reporting.
- (e) Patient Reception.
- (f) Patient Administration and Tracking.
- (g) Communications.
- (h) Transportation.
- (i) PMI.
- (j) Personnel Administration.
- (k) Exercise and Evaluation.

- (1) Public Relations and Media Information.
- (5) Review and update the PRC Plan annually.
- (6) Train appropriate staff to support and manage local patient reception and distribution operations (e.g., TRAC2ES contingency bed reporting).
- (7) Ensure that PRC staff, and other individuals designated to augment the PRC staff, annually receive detailed education and training on their specific duties.
- (8) Organize patient reception teams to receive military patients from local airfields, bus stations, and train depots.
- (9) Identify shortfalls and submit a request for any resources needed to rectify the shortfall(s) and to enhance their PRC Plan.
- (10) Coordinate with associated SSCs to ensure that reports on available beds and throughput capabilities are consolidated and reported when requested.
- (11) Participate in annual drills to evaluate the PRC Plan, and conduct a full-scale patient reception exercise at least once every 3 years.
- (12) Report available beds in accordance with instructions received from TPMRC-A during exercises and operations.
- (13) Designate an administrative point of contact (POC) and a clinical POC, to be available 24 hours a day, 7 days a week during PRC activations, to coordinate with TPMRC-A. POC contact information must be provided to TPMRC-A using TRAC2ES, and may be provided by telephone at (800) 303-9301 or at (618) 229-4200.

e. **VA Facility Directors Designated as SSC Directors.**

- (1) Coordinate with the designated PRC to develop a plan for providing additional beds, personnel, supplies, and equipment to assist in maximizing the number of DOD patients that can be received at the PRC.
- (2) Report to the supported PRC, when requested, the number of beds available for DOD patients.
- (3) Prepare to accept transfers of patients from PRCs, or to provide available resources to the PRC.
- (4) Identify shortfalls and submit a request for any resources needed to rectify the shortfall(s) and to enhance their PRC Plan.
- (5) Review and update plans annually.

f. **VA Facility Directors Designated as ISC Directors.** Each VA facility Director designated as an ISC Director is responsible for developing local plans to provide health care

services and other health care resource support, as required to local military forces in the event of armed conflict or national emergency.

6. PROCEDURES:

a. In accordance with 38 USC, Section 8111A, the Secretary of Veterans Affairs may unilaterally, or at the request of the Secretary of Defense, furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty during and immediately following a period of war, or a period of national emergency declared by the President or Congress that involves the use of the Armed Forces in armed conflict. The Secretary may give a higher priority to the furnishing of care and services under this section than to the furnishing of care and services to any other group of persons eligible for care and services in medical facilities of the Department with the exception of Veterans with service-connected disabilities.

b. Following the granting of higher priority access to members of the Armed Forces on active duty, select VA PRCs or all VA PRCs are activated by the Under Secretary for Health, or designee, and VA-DoD Contingency Plan activation notification is sent to the applicable PRCs through the VISN directors.

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

d. Detailed contingency bed availability reporting instructions are received by the PRCs from TPMRC-A.

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

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

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

(4) Regardless of the means of reporting, these reports must include two key elements: Categories of Available Beds and Throughput. The following Categories of Available Beds will be used: Critical Care, Medical and Surgery, Psychiatry, Burn, Pediatric, Pediatric Critical Care, and Negative Pressure/Isolation.

e. TPMRC-A medically regulates the movement of patients and coordinates individual patient movement missions directly with each receiving PRC.

f. Prior to the arrival of patients, the PRC Director ensures that patient reception personnel are alerted.

g. Upon the arrival of patients at the airfield, train station, or bus depot, the PRC Coordinator notifies the TPMRC-A. The PRC Coordinator, or other designated individual, then further regulates and coordinates the movement of the patients to the VA medical facility, the SSC, or to other local health care providers as required.

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

i. If available, TPMRC-A Liaisons may be dispatched to the PRC to assist in coordinating operations. TPMRC-A Liaisons:

(1) May be officers or senior enlisted medical administrative personnel under the operational control of the TPMRC-A.

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

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

j. PMI. When a patient requires evacuation, it is generally the originating MTF's responsibility to provide the PMI required to support the patient during evacuation. PMI often accompanies a patient through numerous stops and layovers from the originating medical facility to the destination medical facility. PMI is designed to support in-transit medical capability without removing equipment from patients, and without degrading originating MTF. Upon admission of the patient to a VA medical facility, the VA medical facility will contact the DOD PMI Center via the toll free number affixed to each piece of PMI and coordinate the timely return of the PMI to the DOD.

7. REFERENCES:

a. Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," 1982. Codified at Title 38 United States Code (U.S.C.) Section 8110 and 8011A, and implemented at Title 38 Code of Federal Regulations (CFR) 17.230.

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