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A STUDY OF THE CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM

AT KELLER ARMY COMMUNITY HOSPITAL

WEST POINT, NEW YORK 10996

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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

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By

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CHAPTER I

INTRODUCTION

In 1980 the Department of Defense established the Civilian-Military Contingency Hospital System (CMCHS) in an attempt to solicit the cooperation of civilian hospitals for meeting the nation's medical requirements during a short term conventional war or nationally declared emergency. This system's development stemmed from an extensive two year study of what the Department of Defense's capability would be for providing medical support for the United States' military forces given the current peacetime configuration of the medical departments for the three services. Recent accounts of armed conflict indicated that time for upgrading of the existing configuration would be practically non-existent. The exorbitant expense of enlarging the current system to meet the potential need, matched with the inefficient utilization of health care resources by having that enlarged system stand idle, required another alternative to be examined; CMCHS was that alternative.

In July 1982, United States Army Health Services Command was directed by the Department of Defense to begin implementing the CMCHS Program in the Greater New York Area. The Medical Department Activities at Ft. Monmouth, New Jersey and at West Point were subsequently alerted that their health care facilities would serve as regional coordination centers for the program.

The CMCHS Concept was introduced to the resident during May 1982. Members of Health Services Command's Staff in the area of medical planning and operations were queried as to what planning considerations might potentially involve the time and efforts of the staff at the West Point Medical Department Activity (MEDDAC), during the 1982-83 residency year.

In late July and early September of 1982 it became clearly evident that the CMCHS Program would require the coordinated efforts of not only the West Point Medical Department Activity, but of four regional Veterans Administration Health Care Facilities as well. Keller Army Community Hospital, serving as the regional coordination center would, therefore, be called upon to direct the effort. A tentative time-frame phasing plan for implementation was provided by Health Services Command and it became apparent that available staffing resources would be additionally strained in attempts to satisfy those time-framed deadlines. Hence, a clearly identifiable challenge of how to best satisfy the requirements set forth for implementing such a large scale planning effort existed for the West Point MEDDAC.

Statement of the Problem

The problem is to determine the optimal feasible method of implementing the Civilian-Military Contingency Hospital System Program at the United States Medical Department Activity, West Point, New York to include:

1. Analysis of existing disaster plans.
2. Identification of potential member civilian hospitals in the New York City area.
3. Consignment of hospital beds dedicated for support of the CMCHS Program.
4. Development of a CMCHS Operations Plan (CMCHS OPLAN, New York)
5. Establishment of a basic exercise test date of the CMCHS OPLAN, New York.

6. Design of feasible alternatives for the implementation and evaluation of those alternatives.

7. Selection of the optimal feasible method of implementation.

Study Restraints

Restraints to this study can be classified as limitations which serve to narrow the study's overall scope. The first such restraint is that no additional funding was programmed into the fiscal year 1983 operating budget of the West Point MEDDAC for program implementation. Therefore, all costs incurred will need to be locally absorbed from existing funds. A second restraint is that manpower support for program implementation will be placed on the current personnel assets of the West Point MEDDAC. Future relief from this situation may be possible if workload documentation for support of CMCHS in the succeeding years is accurately collected, processed, forwarded and approved by Health Services Command.

Limitation as to specific criteria set forth by the Department of Defense as to which civilian regional health care institutions are basically eligible to participate in the CMCHS Program additionally serves to limit the scope of this study. These criteria will be fully described as standards published by the Department of Defense along with other factors influential to the methodology of this study.

The scope of this project was not limited in the availability of research material from which to design, analyze and evaluate alternative causes of action for problem resolution.

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 to be expressed by civilian health care representatives as to what economic effects were likely to result from participation in CMCHS. Department of Defense spending under the Reagan Administration drew considerable attack by health care administrators who were tightly squeezed by cuts in social programs affecting the budgetary structure of their facilities.

From the historical point of view, the fact that West Point and Keller Army Community Hospital had for years tended to isolate themselves from involvement in programs of regional influence was a factor which could not be discounted as the study took place. Health care providers and administrators questioned the military's true interest in development of a contingency planning system. This factor, when considered with an added commitment by the current presidential administration to build up conventional and nuclear capabilities for national defense, resulted in a great deal of regional discord as to voluntary participation in CMCHS.

The hospital's unique mission for providing to the health care needs of the United States Corps of Cadets, in addition to regional medical coverage, has resulted in a rather parochialized view of what the MEDDAC's involvement in regional health care planning should be. This tendency to view the MEDDAC as a West Point support element to specific corps' matters also required some adjustment.

Standards established by the Department of Defense for active participation in the CMCHS Program were introduced as implementation was contemplated in the New York Region. The specific criteria which were used in other CMCHS Regions also served to influence how the study would be designed and conducted. Civilian hospitals to be eligible participants were required to have bed capacities of not less than approximately 150 beds and be willing to commit a minimum of 50 operational beds to the system. In addition, favorable accreditation granted by the Joint Commission on Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA) was established as a basic standard. Each potential participant was also required to have the following capabilities: post operative recovery, intensive care, blood bank support, respiration therapy, diagnostic X-ray services, laboratory services, an emergency department, physical therapy, and general support services, such as food services and logistic support. Strategic location of a potential participant was a required consideration and distances from airports and military hospitals established so as not to exceed fifty miles. Finally, a facility desiring to participate was required to have an adequate number of trained staff capable of supporting twenty-four hour patient care.¹ Hence, these established standards influenced conduct of the study since the kind of solution designed in feasible alternatives required addressing each specific standard published.

Literature Review

The literature available on the specific subject of the Department of Defense's Civilian-Military Contingency Hospital System is rather scarce, however, literature generally related to contingency planning, commonly

referred to as disaster planning, is rather abundant. By examining disaster planning, in general and specifically, CMCHS certain factors present themselves as common to each.

In the wake of such large scale disasters as the MGM Grand Hotel fire in Las Vegas,² the nuclear mishappenings of Three Mile Island,³ and the collapse of a skywalk at the Hyatt Regency Hotel in Kansas City,⁴ the need for a well coordinated and integrated disaster plan becomes readily apparent. Management of such disasters dictates reducing situational complexity. Traditional disaster planning efforts and manuals employed by numerous health care institutions have been expanded to meet new potential threats which reflect the environmental needs of our time. This expansion process contributes to the problem of reducing complexity. Individual health care facilities confronted with this paradox have shied away from multi-hospital, regionalized planning as a potential answer. Many facilities tend to view themselves as a total system rather than a sub-system component to a larger scale planning structure capable of better directing limited health related assets to alleviate disasters of great magnitude and complexity.

The Civilian-Military Contingency Hospital System is in fact such an attempt to reduce complexity when, and if, a regional or national disaster occurs. The system was established in 1980 by the Department of Defense as an attempt to solicit the cooperation of civilian hospitals to serve as a health care safety net for the current capabilities of the medical departments of the three services.⁵ When alternative means were being studied for how to best satisfy regional disaster needs, consideration was given to enlargement of the current military health care system. In addition

consideration was given to development of a system that would more efficiently utilize existing health resources. That system concept became known as CMCHS.

The primary objective of CMCHS was then, and is now, the development of an effective system for military casualty care in the United States utilizing the existing health care delivery capabilities of civilian hospitals in addition to those of the Armed Forces. The value of this system is for upgrading medical readiness which would certainly contribute to the nation's status of overall military preparedness.

A secondary result of equal value would be the potential such a multi-hospital system would have for management of civilian casualties during a peacetime national disaster. The coordinated employment of such health resources could make the distant dream of inter-community, state and national disaster planning a workable reality.

During the second session of the Ninety-Seventh Congress, Title 38 of the United States Code was amended calling for the sharing of health care resource management by the Department of Defense and the Veterans Administration so that the objectives set forth in the CMCHS Program could be undertaken in a purposeful manner. The United States Army Medical Department Activity at West Point, New York along with medical centers and medical department activities throughout the US Army Health Services Command have begun work with the Veterans Administration to make the contingency planning effort a successful one. Likewise, the US Air Force and Navy are implementing CMCHS in an attempt to improve the military medical profile for managing civilian and/or military casualties in time of need.

To date, forty-one CMCHS Programs have been initiated by the Department of Defense. Twenty-two of these areas have completed the implementation phase, five from the Army, thirteen from the Air Force, and four from the Navy. The total Army complement of the forty-one programs is sixteen and these are listed in Figure 1.⁶ Several programs have experienced remarkable success during implementation. For example, Scott Air Force Base at St. Louis, Missouri canvassed thirty-four civilian hospitals and all thirty-four decided to participate in CMCHS which resulted in a bed contribution of greater than four thousand. Similar successes were experienced at Great Lakes Naval Regional Medical Center where six thousand seven hundred beds were consigned and at Wright Patterson Air Force Base where three thousand four hundred beds were gained.⁷

Medical Centers - MEDCEN

Brooke Army Medical Center-Fort Sam Houston, Texas
 Dwight David Eisenhower Army Medical Center-Fort Gordon, Georgia
 Fitzsimons Army Medical Center-Aurora, Colorado
 Letterman Army Medical Center-Presidio of San Francisco, California
 Madigan Army Medical Center-Tacoma, Washington
 Tripler Army Medical Center-Honolulu, Hawaii
 William Beaumont Army Medical Center-El Paso, Texas
 Walter Reed Army Medical Center-Washington, DC

Medical Department Activities - MEDDAC

Fort Bragg-Womack Army Hospital, North Carolina
 Fort Devens-Cutler Army Hospital, Massachusetts
 Fort Dix-Walson Army Hospital, New Jersey
 Fort Jackson-Moncrief Army Hospital, South Carolina
 Fort Leavenworth-Munson Army Hospital, Kansas
 Fort Lee-Kenner Army Hospital, Virginia
 Fort Monmouth-Patterson Army Hospital, New Jersey
 West Point-Keller Army Community Hospital, New York

Figure 1 - Department of the Army
 CMCHS Programs

Such a contingency network of military, civilian and Veterans Administration health facilities is not a totally new idea for defining the need for a national emergency medical services system. The concept of CMCHS can be better described as a Department of Defense attempt to actively involve itself in planning that has occurred since The Highway Safety Act of 1966 (P.L. 89-564) and The Emergency Medical Services Act of 1973.⁸ Those planning efforts have resulted in a tremendous growth in the number of emergency medical services (EMS) during the period from 1966, where very little capability existed, to where in 1980 every state has some EMS network.

In a study prepared for the Department of Defense, Health Affairs it was determined that CMCHS could build upon the planning experience gained during development of EMS Systems throughout the country.⁹ It was also determined that establishment of cooperative planning linkage with current EMS Systems could add to the capability of CMCHS to realize its basic objectives for meeting the needs of the three services in time of war or national emergency.¹⁰ CMCHS, therefore, has been seen by the Office of the Assistant Secretary of Defense for Health Affairs as the central core around which formation of a true national scale disaster response system can be formed.

Endorsement by leaders in the health care community of this ambitious effort to enhance military and civilian medical readiness has been widespread. Support from organizations such as the Joint Commission on the Accreditation of Hospitals, the American Hospital Association, the American Medical Association and numerous others have enabled the initial bed goal for the program set at 50,000 to be reached as 1982 came to a close.¹¹ The path to that goal was, however, not without opposition by certain others in the health community.

As reported in the New England Journal of Medicine of March 25, 1982, CMCHS received criticism by the University of California, Sanford University, the American public Health Association, and an anti-nuclear war group of physicians known as the Physicians for Social Responsibility (PSR).¹² Pro and con arguments were discussed in detail, but the basic debate can be synopsisized by stating that the PSR feels that Department of Defense is planning for nuclear war. Advocates from the PSR state that such planning leads the American Public to believe that a nuclear war is in fact, survivable. Those representing the Department of Defense, in short, have stated that planning to treat servicemen and women beyond the current peacetime limits of military hospitals is, in fact, an asset to the prevention of war. Failure to plan, therefore, is seen as a failure to be prepared and a detriment to national security.

The literature indicates that debate between the representatives of the Department of Defense and the PSR continues. Others who represent various hospital systems tend not to be as extreme as the PSR's Executive Committee, but still voice concern. One such organization is the Catholic Health Association who professes a cautious examination of the CMCHS Program as a general guide for its members.¹³

Authors such as Leslie M. Kelly, Director of Public Affairs for the Kennestone Regional Health Care System in Marietta, Georgia summarize the views of many expressed in the literature.¹⁴ She emphasizes that only through the integrated and coordinated efforts with ambulance and rescue units, local government agencies, area public safety organizations, the regional military and the news media can a hospital respond to community needs during a county-wide disaster. Communication, which is of paramount importance for coordinating these types of groups, is echoed numerous times in the articles and reports that were reviewed.

Planning is built upon communication. Effective communication which is designed to control organizational activities provides the foundation on which planning can succeed. Analyses of the barriers to effective communication will, therefore, be critical in determining feasible methods of implementing the large scale planning effort that CMCHS represents to the Medical Department Activity at West Point, New York.

Study Approach

The planned method of the research project will be to first analyze the CMCHS Programs that were established during the period 1980-1982, at not less than seven of the fourteen Army sites. Specific interest will be focused on the methods of implementation used, cost of that implementation effort and the benefit in terms of beds committed. Then alternatives designed from experiences reported at more effective program sites with consideration for the unique aspects in the New York area will be developed and evaluated so as to maximize the benefits of past practices to facilitate actual implementation.

In acquiring the necessary research data each CMCHS coordinator will be identified by US Army Health Services Command. By random selection at least seven active Army coordinators will be contacted and interviewed as to what methods of implementation were considered, selected and finally utilized in their specific geographic area. Concurrently, US Army Health Services Command will forward copies of status reports that are available in their files which were submitted by MEDCEN's and MEDDAC's during and following their implementation phases. Implementation methods employed by the Air Force and Navy will also be obtained utilizing the respective liaisons from the Department of Defense CMCHS Program Office.

Data from the Veterans Administration Medical Centers in both the
 Portland and Atlanta areas will also be obtained by interview to determine
 what their newly appointed support role is to the program. These specific
 geographic areas have most recently experienced implementation of CMCHS
 since the Veterans Administration (VA) has come into full participation
 with the program.

Following the data acquisition phase of the research effort, analysis
 of common variables exhibited in successful programs will be evaluated by
 use of a non-parametric, alternative to the Chi-Square Test of Independence,
 known as, Fishers Exact Test. Those variables appearing as primary
 contributors to program success will then be employed in conjunction with
 the restraints and factors mentioned earlier in designing feasible
 alternatives for problem resolution. The specific criteria set forth by
 the Department of Defense governing participation will be used to assign
 relative weights when using the Churchman Ackoff Value Assignment Technique
 for determining potential benefit of each alternative.

military uses;
health care facilities - military medicine;
medical services; disaster; wars; (N7/SES) ←

FOOTNOTES

¹Maximus, Inc, In Combat, In the Community-Saving Lives... Together, July 1980. p. 8.

²Karl Manninger and Otto Ravenholt, "Lessons from Las Vegas: The MGM Hotel Fire", Journal of Emergency Medical Service 6:2 (February 1981), pp 37-40.

³Christopher Maxwell, "Hospital Organizational Response to the Nuclear Accident at Three Mile Island: Implications for Future-Oriented Disaster Planning," American Journal of Public Health 72 (March 1982), pp 275-279.

⁴"Emotional Aftershock Takes Its Toll: Kansas City, Disaster Haunts the Survivors, Hospitals (October 16, 1981), p 26.

⁵US Department of the Army, Health Services Command, Information Paper, "Civilian-Military Contingency Hospital System CMCHS," HSOP-SP, 26 July 1982.

⁶Interview with Major Walter Wells, Plans Officer, Office of the Surgeon General of the Army, Medical Plans and Operations, Washington, D.C., January 27, 1983.

⁷Ibid.

⁸Maximus, Inc., "The Role of Emergency Medical Services Programs in Support of DOD During Periods of National Emergency", Contract No.: MDA 903-79-C-0089, July 1, 1980, p II-2.

⁹Ibid, p. IV-11.

¹⁰Ibid, p. IV-12.

¹¹American Hospital Association, "Civilian-Military Plan Bed Count Up", Hospital Week 18:43 (October 29, 1982), p. 4.

¹²"The Civilian-Military Contingency Hospital System: Medical Planning for War", The New England Journal of Medicine 307:12 (September 16, 1982), pp. 751-752.

¹³"CHA Board Acts on Bylaws and Civilian-Military Contingency Issue," Hospital Progress 63.6 (June 1982), pp 18-20.

¹⁴Leslie M. Kelly, "A County-Wide Disaster Drill," Hospital Topics 58.5 (September-October 1980), p. 12.

CHAPTER II

DISCUSSION

Background

On July 27, 1982, representatives from The Office of the Surgeon General's Directorate of Health Care Operations, the Office of the Assistant Secretary of Defense for Health Affairs, the American Hospital Association, United States Army Health Services Command (HSC), and Executive Officers from five HSC Hospitals met at room 2C524 at the Pentagon, Washington, D.C.¹ One of those representatives was Lieutenant Colonel (LTC) A. Gordon Hennessy, Executive Officer of Keller Army Community Hospital (KACH) at West Point, New York.

The purpose of the meeting was to discuss the Civilian-Military Contingency Hospital System (CMCHS) and how that system would be introduced into the areas of Portland, Atlanta, and New York. Specifics relative to implementation were outlined as were the responsibilities of the Department of Defense (DOD), MAXIMUS Incorporated from McLean, Virginia² and Headquarters, HSC. In addition, Public Law (P.L.) 97-174 describing the newly legislated assistance role of the Veterans Administration (VA) was discussed.³

Plans regarding CMCHS implementation in the aforementioned areas were designed as completion activities to the initial CMCHS programs introduced starting in September 1980, when Madigan Army Medical Center introduced CMCHS to the communities of Seattle and Tacoma, Washington.⁴ HSC's involvement grew during the subsequent two years to a level of activity where eight medical centers and eight medical department activities were expending resources to develop and exercise CMCHS by the close of 1982.

The New York Area was therefore, a planned late arrival to the overall DOD effort for CMCHS implementation. There were two reasons for delaying the introduction of CMCHS to the area. The first reason centered around the simple logistics of not having a large military hospital to oversee the complex planning, consignment and exercise testing efforts that would be required for coordinating activities of the civilian hospitals in the region. Two small Army Medical Department Hospitals at West Point, New York and Fort Monmouth, New Jersey were not staffed to independently confront an operation of such magnitude. There was however, after the passage of P.L. 97-174 the possibility of obtaining assistance from eight Veterans Administration Medical Centers (VAMC) in the area. In addition, the area of responsibility for the Fort Dix CMCHS Program was able to be expanded to better support the New York City implementation effort. The problem of a logistical deficit, therefore, appeared to have been resolved.

The second reason for delaying introduction of CMCHS was an anticipated concern as to open resistance on behalf of physicians and administrators working at area hospitals.

In August 1981, the Boston, Massachusetts area was introduced to CMCHS. Resistance to implementation from an anti-nuclear group known as the Physicians for Social Responsibility (PSR) gained national acclaim in journals such as the New England Journal of Medicine⁵. Impact of that resistance was of little real consequence to implementation efforts in Boston; however, concern over such resistance as an undermining factor in the New York City area could not be discounted.

In July 1982, conditions appeared to be right for moving ahead with plans to include New York as a CMCHS region. On July 29, 1982, just two days following the meeting in Washington, D.C., a second planning session was held. Military Hospital Commanders, Executive Officers and staffs from Fort Dix, New Jersey, Fort Monmouth, New Jersey, and West Point, New York met along with eight VAMC Directors and Assistant Directors at room 2154AE of the Manhattan VAMC.⁶ The Commander and Executive Officer from the West Point Hospital met with the VAMC Representatives from Manhattan, The Bronx, Castle Point, and Montrose, New York to form the VA-DOD Leadership Group for Northern New York City.

It was from this beginning that a new mission of health care contingency planning for nine counties in and north of New York City evolved. The hospital at West Point, Keller Army Community Hospital (KACH), was designated to represent the DOD in the implementation of the duties and responsibilities inherent in that mission.

As a result of the July 29, 1982 meeting, the initial breakdown of local civilian facilities was accomplished. The local hospitals were then assigned to a coordinating VAMC. Each coordinating VAMC was provided a complete listing of eligible participants geographically as an attempt to assist the West Point Hospital in canvassing for their participation. This initial breakdown is provided at Appendix A. Formulation of the lists was accomplished using a DOD printout and conferring with the four VA representatives as to geographic factors of consideration.

Sixty-three hospitals from the surrounding counties were then invited to attend a CMCHS Implementation Meeting scheduled at the Westchester Marriott in Tarrytown, New York. This September 21, 1982 meeting was presented by Lieutenant Colonel (LTC) Podge M. Reed, CMCHS Project Officer-Army, stationed at the Pentagon. The purpose of this meeting was to introduce hospital executives to the "CMCHS Concept" and to provide representatives from KACH and the VAMC's an opportunity to initially meet with those executives. LTC Robert Collins, HSC Representative for Operations was also present at the meeting. Area health care executives were provided an excellent presentation and an information booklet entitled "CMCHS-In Combat, In the Community-Savings Lives...Together".⁷ This booklet provided answers to the questions: what is CMCHS; how will it operate; what are the benefits to you, the hospital; what are the hospital's expected functions; and how does the hospital wishing to participate become enrolled? Registration at the meeting indicated that attendees numbered fifty with thirty-two civilian hospitals, the four VAMC's and two health care groups being represented. The list of attendees is provided as Appendix B.

The success of this meeting was for a large part predetermined by events from the previous day.

On Monday, September 20, 1982, a similar meeting was conducted at the Marriott's Essex House in Manhattan.⁸ Anti-nuclear war advocates created a disturbance at that meeting and media coverage by major news affiliates made the most of the situation. At Appendix C is a representative

article which appeared as a result of that meeting. The mood of the encounter indicated to the representatives of the Office of the Assistant Secretary of Defense for Health Affairs that perhaps the time selected to begin New York CMCHS Implementation might not be as favorable as previously considered.

That timing question affected all supporters of the program, both military and non-military on September 21, 1982 in Tarrytown. The prevailing mood of that day was one of caution, caused by uncertainty. Despite the excellent presentation delivered by LTC Reed, a doubting mood persisted.

Events from July through August resulted in the establishment of a new and complex mission that would challenge the leadership of KACH for not just 1982, but for years to come. Design of methods required to meet the challenge will be systematically investigated.

The Challenge

Preparing to manage the regional contingency planning requirements for the northern counties of and adjacent to New York City would be classified as a formidable challenge for any health care planner. The heterogeneous composition of the sixty-three health care facilities assigned to such a region would be identified as a contributory factor amplifying the complexity of that challenge. The series of maps provided as Appendix D graphically depicts the pure magnitude of the regional planning effort. In addition, assigning such a challenge to a hospital that is smaller than any one of the sixty-three would further add to the difficulty of the task at hand.

The sixty-five bed hospital at West Point, New York, KACH, recognized the sheer magnitude of this challenge. What was not as clearly discernible was how such a task could be managed in an attempt to bring the designated region on line with previously established CMCHS programs throughout the nation.

Passage of a Congressional Act on January 25, 1982 which amended Title 38 of the United States Code paved the way for active participation by regional VAMC's.⁹ Understanding how to best employ the talents of the VA in addressing the challenge of CMCHS was identified early by not only members of the West Point Hospital, but the Department of Defense (DOD) and Health Services Command (HSC) as well, to be a key in determining the success of overall implementation.

The challenge of implementation was clearly identified by HSC. The establishment of milestones, outlined in Figure 1, was provided at the September 21, 1982 coordination meeting held at Tarrytown, New York by the HSC representative LTC Collins.¹⁰ How to meet the challenge of managing to satisfy those milestones while formulating a viable contingency system of civilian, military and VA health facilities was an undertaking that would require considerable research of existing systems and design of area specific alternatives.

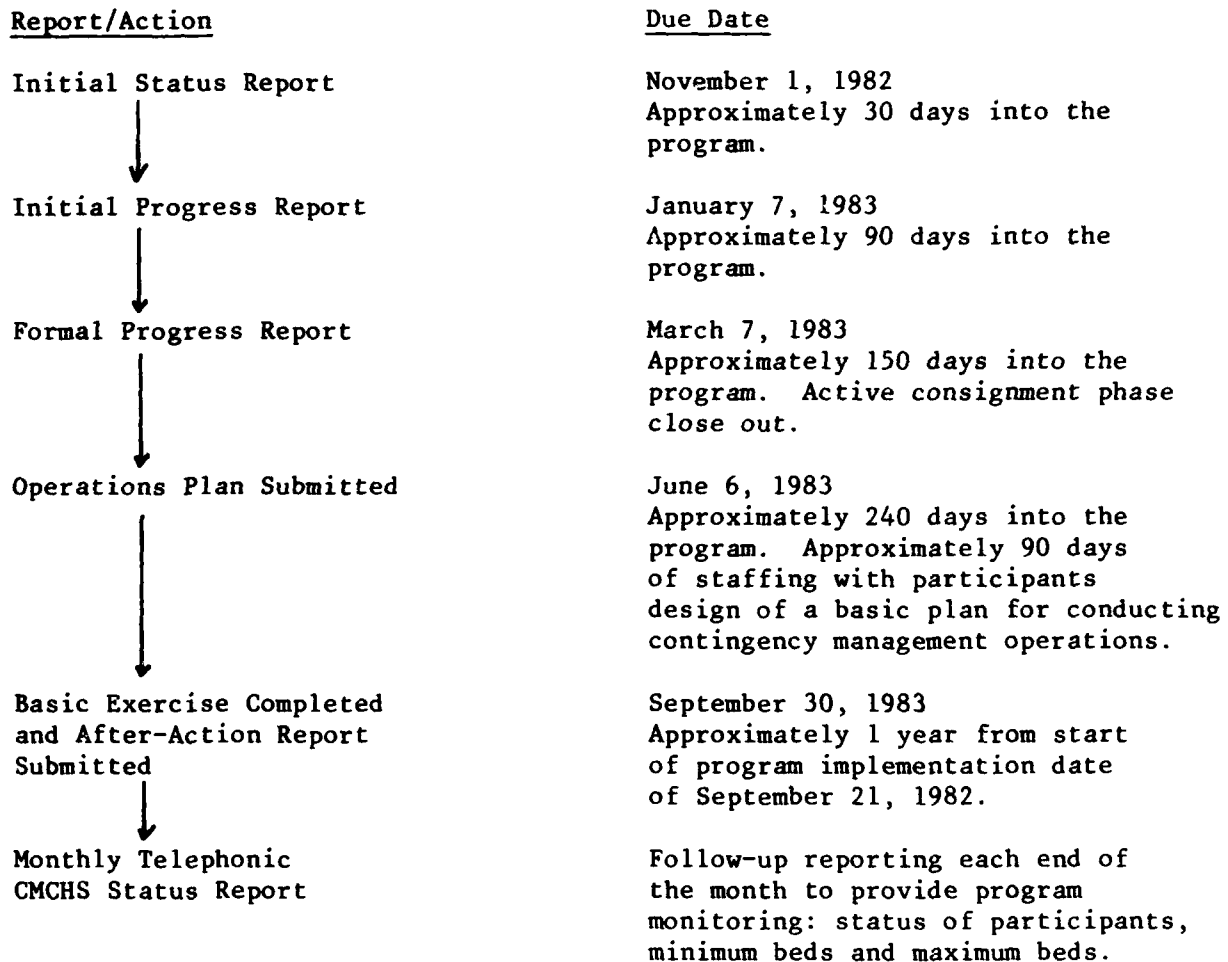


Figure 1-HSC Milestones for New York City
CMCHS Implementation

PRELIMINARY ANALYSIS OF EXISTING SYSTEMS

(Organization Framework Design)

By August 1982, any questions regarding KACH's involvement in the CMCHS program were answered. In short, the West Point Hospital that for years had kept its operations limited to the grounds of the United States Military Academy (USMA) was now committed to serve as a CMCHS coordinating agent for the Department of Defense (DOD). The newly acquired mission did not, however, provide for any complement of assets to assist KACH in meeting the additional workload requirement inherent in that mission.

Therefore, a decision regarding the best method of employing the current staff assets in the management of the new mission had to be made. Such a decision required analysis of what type arrangements were in operation at other military hospitals assigned a CMCHS mission.

Nine CMCHS programs were evaluated in an attempt to determine what types of organizational frameworks were being utilized to manage regional CMCHS requirements. The nine facilities selected had for the most part been involved in CHCMS for more than one year. Major J. Broach, the CMCHS Project Officer at HSC, provided the names and telephone numbers of the Army facilities.¹¹ To obtain a complete tri-service picture of how CMCHS was being structurally supported, project officer identification of Navy and Air Force coordinators was provided by the respective DOD Project Managers¹². Input by the action officers resulted in a representative cross sample of CMCHS programs which could be used to evaluate organizational support frameworks.

Appendix E contains the specific breakdown of medical facilities selected for preliminary evaluation. Telephonic contact with each facility and a plea for any and all supportive material that outlined lessons learned as a result of their implementation period were made. A follow-up letter, a sample of which is located at Appendix F, was then sent to each of the facilities queried by phone.

The results of the initial quest for data proved extremely successful. All nine facilities provided some form of input. For some this took the form of hand written working papers and fragmented status reports, while for others, a detailed accounting of problems encountered and actions taken was provided. Additional data from HSC and the Office of the Surgeon General also arrived following telephonic and written requests. Much of this data duplicated earlier input, however, some of the material was one of a kind and served to provide a more complete picture.

With the onslaught of data and no established system prepared to effectively receive and process that data, the question of local organizational structure again surfaced. A cursory analysis of the data indicated that three basic systems were in operation among the facilities reporting. These three have been classified as: Command Controlled, Staff Acquired and Staff Created. Figures 2, 3, and 4 graphically display each of these three systems respectively.

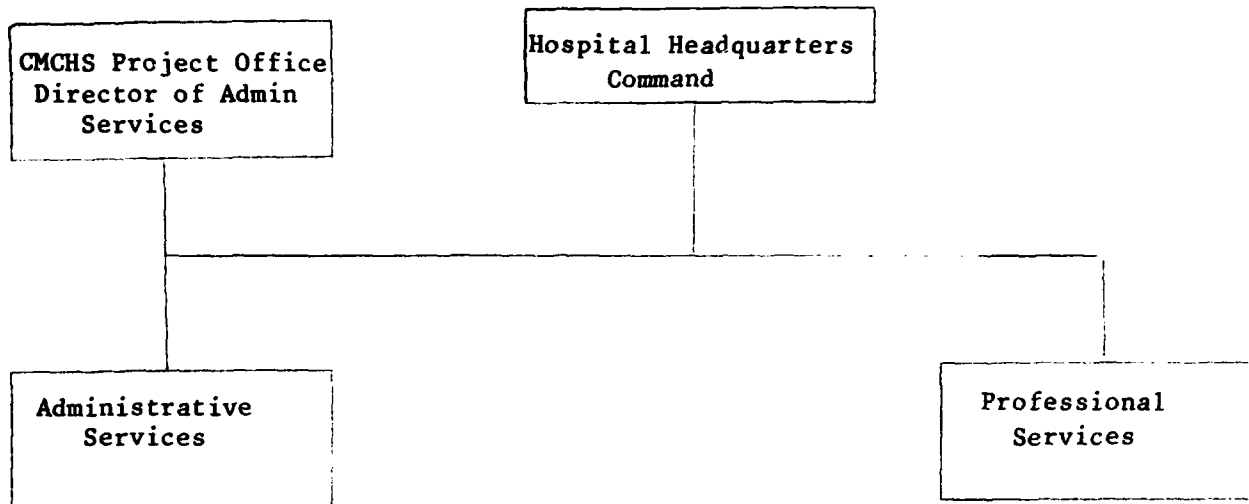


Figure 2

Local Organizational Structure - Command Controlled

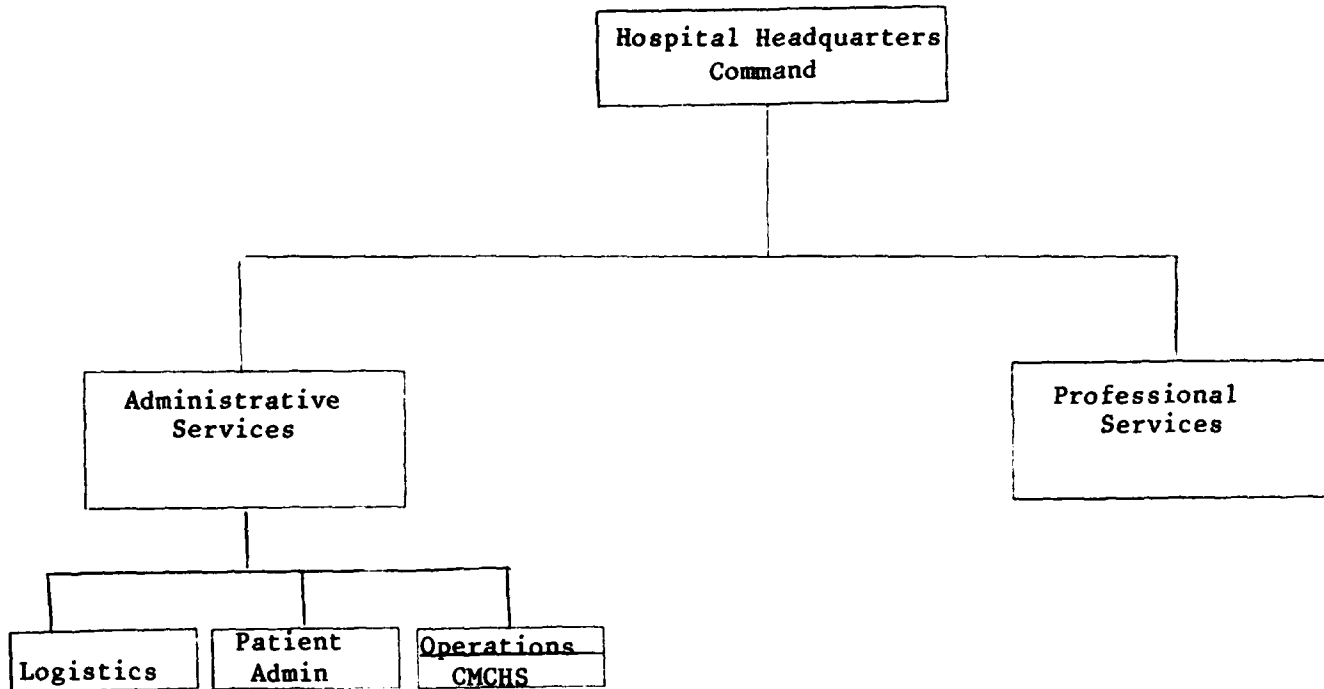


Figure 3

Local Organizational Structure - Staff Acquired

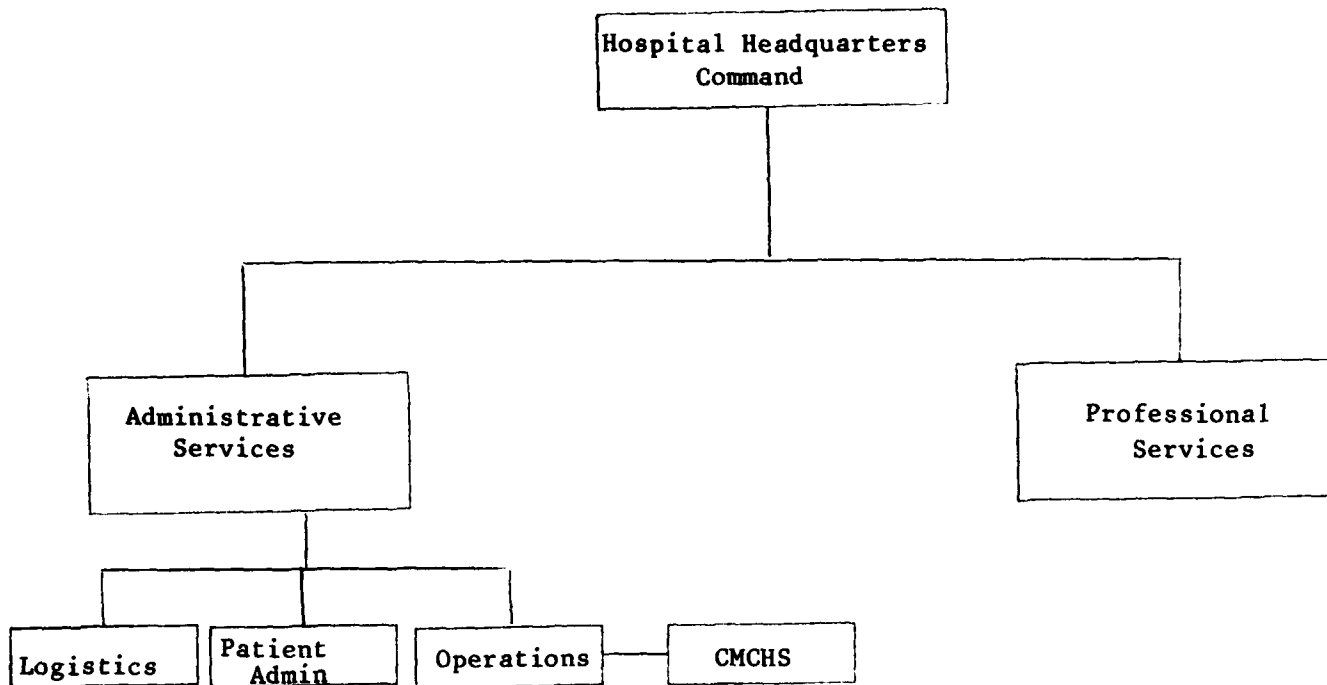


Figure 4

Local Organizational Structure - Staff Created

The command controlled system was established at the Regional Naval Medical Center at Great Lakes¹³. The Director of Administrative Services for that facility, Commander Jeffrey W. Baldwin, MSC, whose office is located in the medical center's hospital headquarters singularly directed the CMCHS implementation effort. There were 115 local civilian hospitals assigned as potential participants and 82 were consigned for a bed total contribution of 6700.¹⁴ Commander Baldwin not only directed operations, but personally became involved in each hospital's consignment. Where possible Commander Baldwin selected special staff officers of field grade rank and experience to follow through on initial contacts. In short, the headquarters' administrator personally dedicated his own time and years of managerial expertise to CMCHS. One factor that allowed for this was the competence and availability of his subordinate administrative staff members.

It became readily apparent that this approach did not lend itself to the West Point CMCHS Program. Colonel A. Gordon Hennessy did have the interest and expertise to do what his naval counterpart had done, yet he lacked the necessary time. This lack of time was caused by not having the depth of subordinate staff members in terms of pure numbers or experience.

The large majority of facilities surveyed operated under the staff acquired system of organization. All four Army Medical Department Activities and three of the Army Medical Centers reported using this duty expansion method. The Air Force Hospital at Scott Air Force Base also employed this approach. Selection of the appropriate staff element to task with

the CMCHS project was made along traditional staffing lines. In all the facilities using the staff acquired system the Plans, Operations and Training staff elements were the points of expansion. It became apparent by reviewing status reports from the Surgeon General's Office that successful CMCHS programs had an adequate number of personnel assigned to these staff elements. For example, the highly successful program at Madigan Army Medical Center had a degree of personnel depth by virtue of its assigned medical center operations mission.¹⁵ Conversely, the more shallow staffing of the operations section of a MEDDAC, such as Fort Leavenworth, was taxed more heavily to absorb the additional CMCHS mission.

Consideration of traditional placement of CMCHS to a shallow staffed Plans, Operations, and Training Division of three people at the West Point Hospital was not, therefore, viewed as a feasible alternative. The concern of the Executive Officer was how to dedicate all available staffing, while avoiding use of this already overextended staff element.

Use of the staff created approach was reported by Walter Reed Army Medical Center. First hand observation of this operation was also made during a two day visit in October 1982.¹⁶ Through reports and observation it appeared that Walter Reed had designed and created a "CMCHS Project Staff Element" as an added component to the medical center's operations division. This specifically designed staff element was formed to only manage the CMCHS project at Walter Reed by utilizing whatever personnel resources, full and part-time were available. As was true with the situation at Great Lakes, the largeness of the facility helped to provide the depth where administrative leadership was able to exercise a greater degree of flexibility than was available in smaller MEDDAC hospitals.

Keller Army Community Hospital (KACH) clearly being a small facility lacked the ability to pattern the pure staff created approach. KACH's Commander and Executive Officer recognized that operating within available personnel resource constraints would dictate a less structured organizational system than any of the three which were in established use. It was also recognized that careful consideration for the use of the personnel resources of the four VAMC's would be necessary in design of an overall CMCHS organizational framework.

Design of the West Point CMCHS

Organizational Structure

The staffing of administration at KACH, due to the limited size of the physical facility would be classified as being shallow in depth of numbers, yet heavily committed in service function. Therefore, placing the administrative workload that CMCHS would create on any one staff element was viewed as not being desirable on two accounts, first on the staff element itself and secondly on the potential for CMCHS success.

Command involvement from the hospital's headquarters was determined to be a necessary feature for facilitating coordination efforts with local hospital executives and governing boards. The ability of the headquarters to directly assume the centralized position of responsibility was however, seriously questioned. Since the operational staff elements of administration were already lacking depth in numbers, removal of headquarter's supervision by enhancing direct involvement in CMCHS was considered unfavorable. The traditional role of the hospital headquarters was that of meeting the intense demands of the United States Military

Academy and the West Point Community's health care needs. Redirecting that focus for direct management of CMCHS was also viewed as a compromise of that traditional role. Therefore, command involvement had to be added, yet not at the expense of operational and traditional demands inherent in the numerous other missions assigned KACH.

In evaluating what personnel assets would perhaps be available to administratively support CMCHS implementation, consideration had to be given as to linking those assets directly to the hospital's headquarters. The personnel asset that most closely fit the non-direct operational staff commitment, while also being closely aligned with the hospital's headquarters, was that of the administrative resident.

The use of the resident was seen as a beneficial compromise for both the hospital and the resident. From the hospital's position, the resident offered additional administrative expertise which was not being directed to satisfy daily operational requirements. For the resident, the CMCHS assignment offered a tremendous educational opportunity to meet with and learn from the local hospital executives in the geographic region. The natural link with the hospital headquarters would provide for the direct support needed by the resident, as well as, a direct information link to the headquarters. This approach of using the resident to administratively direct the mission would therefore maximize employment of the headquarter's staff in terms of both time and effort expended. Considerable attention was given, however, to assure that the resident's involvement in this mission would not limit his educational exposure to the learning aspects of the hospital acquired during scheduled rotations.

Additional personnel support was limited, yet a constant watch for available help persisted. The Executive Officer's commitment to free up two week reserve officers and overstrength personnel resulting from programmed overlap of primary staff assets was planned and executed.

Incorporation of the four VAMC's served to complement the limited staff support available at West Point. In early September 1982, all the VAMC's had signed memoranda of understanding with KACH which pledged cooperation in the regional planning effort. A copy of such an agreement is provided as Appendix G. Following the September 21, 1982 CMCHS introductory meeting held at Tarrytown an organizational meeting with the four VAMC's and KACH was scheduled for September 29, 1982.

On that Wednesday, all the regional participants tasked with implementation met at West Point's KACH to finalize the organizational structure that would lead them through implementation. The specific structure for both internal operation at KACH and a proposed regional coordinating structure were outlined and agreed to at that time. Figure 5 depicts KACH CMCHS Organizational Structure and Figure 6 outlines the approved regional concept. Following the development of the organizational structure all participants were then prepared to cooperate in the design of strategy to undertake actual implementation for CMCHS.

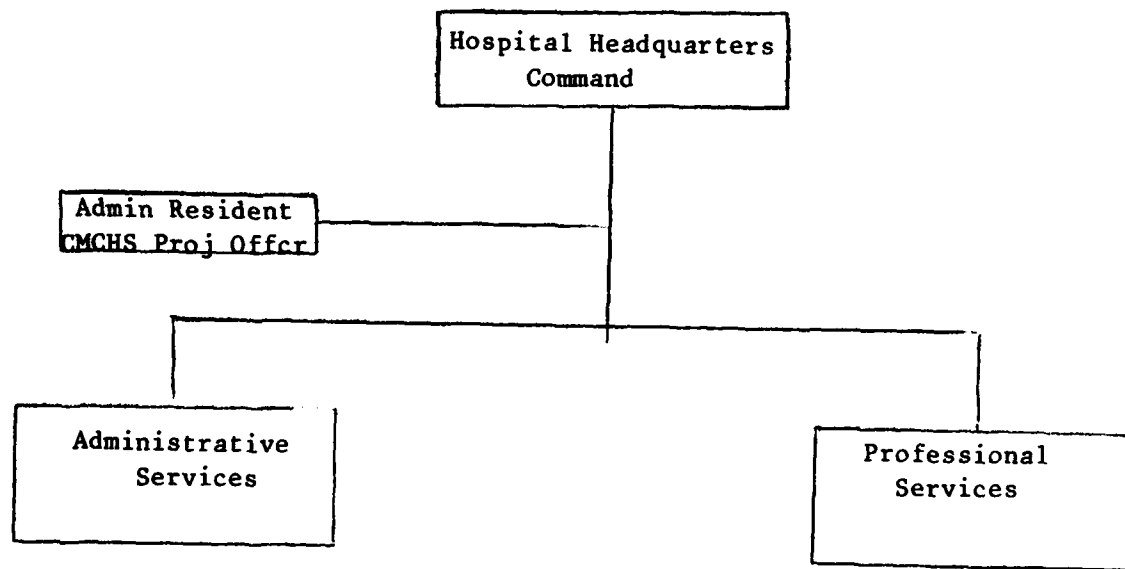


Figure 5

Keller Army Community Hospital
CMCHS Organizational Structure

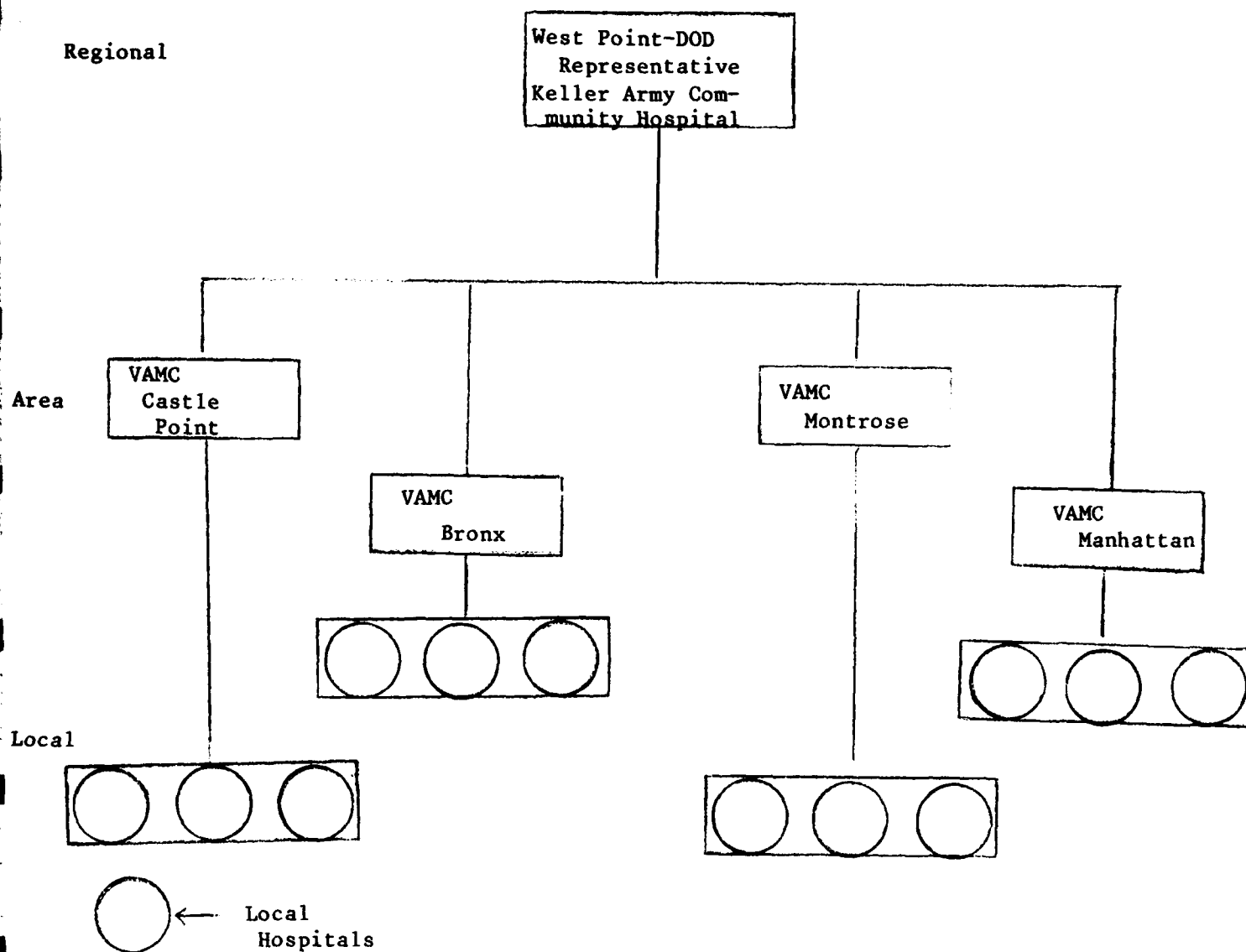


Figure 6

Northern New York CMCHS
Regional Organization

Design of Implementation Strategy

Implementation of CMCHS can perhaps be best explained as a three phase effort. The first phase would be termed, "The Learning Period", when the concepts of what the program is all about would be studied and tested by those tasked to manage the project. The second phase would take over from that learning period and place in motion the mechanics to exercise bed consignment to support CMCHS. Following the identification and signing of agreements of participants to the project, phase two would involve an active planning period for design and publication of a regional operations plan (OPLAN-N.Y.). Phase three would introduce an exercise test period. For the purpose of this study, implementation will end following the completion of the Basic Exercise of the CMCHS OPLAN-N.Y. scheduled for late September or early October 1983.¹⁷ Additional testing through the Intermediate and Advanced Exercises will take place however, during the 1984-1985 time period.¹⁸

Phase I

Time for development of an initial strategy to govern CMCHS implementation included the period from August through October 1982. Five basic objectives were chosen for the three month period and were designed to provide a solid working foundation for the program. These objectives were: to develop an operating knowledge of the CMCHS program to date; to establish an information sharing network with CMCHS program managers at other military hospitals; to develop a regional organizational framework to manage the program's requirements; to establish preliminary contact with all the local civilian hospitals eligible to participate; and to test and evaluate the DOD-VA relationships through active use.

All five objectives were integrated to the greatest extent possible. It became apparent that new and different demands would be created by involvement in CMCHS and that challenges, both foreseeable and unforeseeable, would likely result from that involvement. Those challenges would serve to test each facility's resourcefulness and persistence in the months ahead.

Learning was the common factor to meeting the challenges. First to learn, what CMCHS was, where it came from and why it was here? Once those answers were acquired, learning how to explain them in depth to doubting health care administrators would follow. Support in gaining the answers required learning where to search for information sources that would be both reliable and valid. How to apply that information to fit the organizational uniqueness of the regional DOD-VA representatives also had to be learned.

In short, the strategy was to meet the learning challenges. As the challenges were met, then clarity of the strategy for Phase I would improve. There were, however, several events that fostered the learning process and enabled all five objectives to be met.

Events previously discussed leading up through the Tarrytown meeting to the September 29, 1982, DOD-VA coordination meeting all contributed to the design of early implementation strategy. From that date on, however, events of added significance helped to bring clearer resolution to the strategy picture.

On October 4, 1982, Mr. Arthur E. Weintraub, President of the Northern Metropolitan Hospital Association (NMHA) extended an invitation to Colonels Howard and Hennessy to address a meeting of their membership on October 28, 1982¹⁹. Mr. Weintraub during his attendance at the September 21, 1982 Tarrytown meeting, expressed a tentative commitment to the general concepts upon which CMCHS was built. His graciousness in providing the fortuitous opportunity to formally introduce the CMCHS program to approximately sixty percent of all prospectively eligible hospitals in the region was too valuable to pass up. Efforts were immediately put in motion to obtain the service of Lieutenant General Willard S. Scott, The Superintendent of the United States Military Academy, to assist in welcoming the group and introducing CMCHS philosophy. In addition, coordination efforts to obtain a DOD video tape to support the presentation were aggressively pursued. Both efforts proved successful and indicated to the KACH CMCHS representatives that a great deal of personal effort and command attention would be required to support implementation of CMCHS. The scheduled presentation was a great success. Local chief executive officers were impressed with the presence of The Superintendent and the professional quality of the tape presentation. The question and answer session which followed was also very well received. Implementation was now truly underway.

On October 5, 1982, a formal request to obtain the services of an Army Reserve Medical Services Corps Officer from the 808th Station Hospital located at Hempstead, New York was initiated.²⁰ The request was designed to accommodate the officer, Captain John Craig White, as well as, the

KACH staff. Captain White's civilian position at the Hospital for Special Surgery in New York was viewed as a potentially valuable asset for developing a viable downtown, inner-city cooperation network among assistant administrators. His services were, therefore, scheduled for a two week period commencing on November 8, 1982 and terminating on November 19, 1982. Plans were designed to visit administrators at selected hospitals during his stay using the administrative resident from KACH, a VAMC representative and Captain White. This plan was executed with mixed results.

By the end of the initial strategy phase October 31, 1982, all sixty-three civilian hospitals had been contacted regarding enrollment in CMCHS. In addition, two local hospitals not meeting the bed size criteria established by DOD requested an exception to allow for participation. Bed acquisition realized by signed memoranda of understanding (MOU) for the Phase I period totaled 250 among five local hospitals.²¹ Specific hospital signing data by date and number of committed beds, as well as, a copy of one of the early MOU's are provided as Appendix H. Several other hospitals were also close to finalizing a positive response to participate as October came to a close.

All the news was not, however, positive. Several hospitals from the Bronx and Manhattan were reportedly being uncooperative with VA representatives. Resentment expressed by these hospitals was targeted against the DOD in general and CMCHS in particular. The extent of that resentment was not clearly measurable at that time.

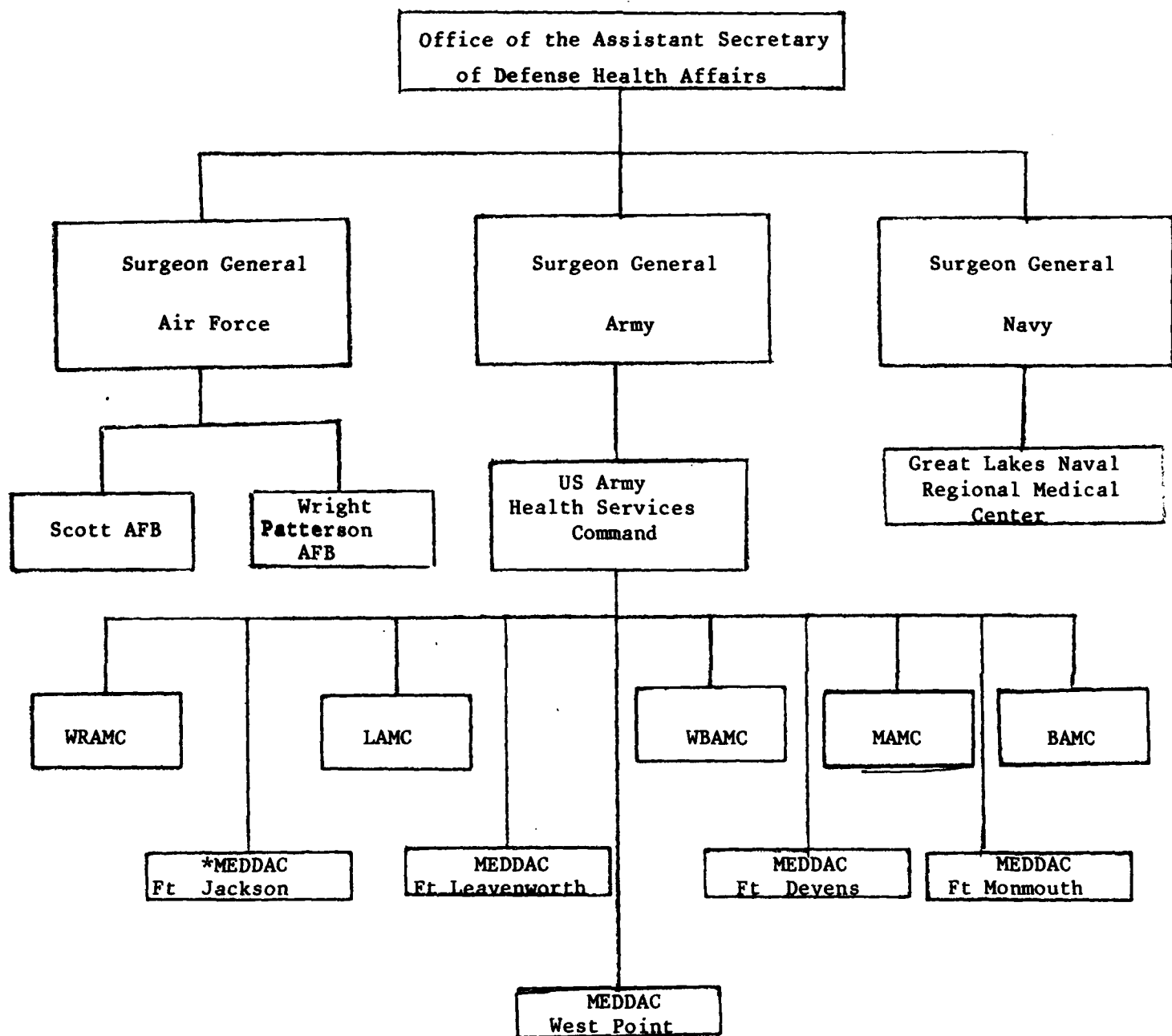
On November 8, 1982, initial status report was forwarded to Health Services Command. That report formally signified

the close of the initial strategy phase (Phase I) for CMCHS implementation in the Northern New York City area. All the objectives set forth were accomplished. Now the lessons learned needed to be applied so that a follow-up strategy for consigning additional beds and developing a regional operations plan could be formulated.

It was the application of those lessons that presented the problem for this study, how to determine the optimal method for implementing CMCHS at the Medical Department Activity at West Point, New York.

Data Collection Methodology - Comparative
Analysis of Existing Systems-Continued

Throughout Phase I of the implementation process the objective of establishing an information sharing network with other CMCHS program managers was fully satisfied. From the initial comparative analysis evolved an operational framework to manage the program for the region. The networking used for the development of that framework was again exercised for evaluating what methodologies, past and present, were being employed nationwide to conduct implementation of CMCHS. Figure 7 graphically depicts the network and Appendix I further details specific use of that network.



Direct contact by the researcher was established with every organization within the network.

WRAMC-Walter Reed Army Medical Center
WBAMC-William Beaumont Army Medical Center
BAMC-Brooke Army Medical Center

LAMC-Letterman Army Medical Center
MAMC-Madigan Army Medical Center
*MEDDAC-Medical Department Activity

Figure 7 - Information Sharing Network Established by West Point to Evaluate CMCHS Methodologies

While KACH was designing its communications network for formulation of organizational structure, additional data collection relative to CMCHS support methodologies was also in progress.

During the early stages of Phase I, Health Services Command (HSC) assisted in the identification of US Army CMCHS coordinators. Interviews were conducted with nine of these coordinators to determine what methods of implementation were considered, selected and employed for their specific geographic areas. In addition, HSC provided copies of status reports which had been provided by each coordinator throughout the implementation phases of all Army CMCHS Programs. Input was also obtained from Air Force and Navy project coordinators. In an attempt to better understand the newly devised role of the VA, interviews were again conducted, this time with the VAMC's in Portland, Oregon, and Atlanta, Georgia.

Appendix J outlines the full range of CMCHS related activities that were surveyed during Phase I. The adequacy of the available data was excellent. What had to be determined was the relevance of that data to regional CMCHS implementation for New York.

While processing the data it appeared that seven general data classifications could be clearly established. The potential for successful movement from Phase I of the implementation effort through Phases II and III was viewed to be contingent on utilization of what experience had proven to be most successful elsewhere. The seven classifications are outlined in Figure 8 and each will be discussed in turn.

- I Command Support for CMCHS
- II Profile of the Project's Management Structure
- III Use of Local Health Care Associations
- IV Veterans Administration (VA) Support
- V Community Acceptance of the Military
- VI Size of the Coordinating Facility vs Size of the Mission
- VII Personal Visits to Civilian Facilities

Figure 8
General Data Classifications
for CMCHS Implementation

Command Support

In 1980, CMCHS was introduced to each of the three Surgeon Generals as a means to enhance the nation's medical readiness capabilities which had eroded since the end of World War II.²² Each Surgeon General determined what degree of priority CMCHS would receive for his respective branch of service. That attitude of priority was then communicated to the field. If one were to consider bed acquisition alone as the measure of success in the 73 programs nationwide, then priorities established and carried out during the past three years might convince one that the message was better received by the Navy and the Air Force.²³ Of the beds consigned as of December 31, 1982, 55,512, a by service breakdown indicates that 23,742 beds, or 43% were obtained by the Air Force; 17,978 beds, or 32% from the Navy; and 14,045 beds, or 25% from the Army.²⁴ It would be

unfair to conclude, however, that command support for the CMCHS effort was lacking among all commanders of Army Medical Department MEDCENS and MEDDACs. What might appear to be a fairer assumption is that personal involvement by commanders or their deputies was a determining factor for producing successful programs.

Project Management Structure

Closely associated with the issue of command support is the issue of what staff agency was given CMCHS responsibility and how were assets made available to that agency for satisfying program responsibilities. As mentioned earlier, when KACH attempted to design a management structure for CMCHS, the analysis of existing systems indicated that three primary systems were in use. Data collected subsequently did not tend to support any specific placement of that responsibility, but it did support providing available staff personnel and resources to manage the additional workload CMCHS would create.

The program at Fort Devens (Cutler Army Community Hospital) illustrated that such support in terms of additional assets was of critical importance²⁵. During the implementation period at Fort Devens officer personnel in an overstrength category were available. Problems in obtaining a graduate school start date and management of overlap time for scheduled reassignments resulted in the additional assistance. This additional assistance permitted a full time officer to be made available exclusively for CMCHS. That condition persisted for eleven months and for three of those months two full time officers worked on the implementation of CMCHS.²⁶ Such availability of staff allowed for normal routine operational requirements to be satisfied, as well as the added workload produced by CMCHS.

Use of Local Associations

All the project officers surveyed were asked if they utilized local health associations to facilitate implementation. For some areas, use of these associations was quite extensive and viewed as a major contributing factor to program success. Conversely, several areas totally ignored the use of associations, or had no true access to associations. For those areas such a planned strategy for reaching local decision makers was seen as inconsequential.

Veterans Administration (VA) Support

With the passage of current legislation (P.L. 97-174) formally calling for the support of the VA it appeared that the support might prove significant for CMCHS success. Programs which had started and completed implementation during the early days of CMCHS worked as solo agents. More recent entries to the program, however, have developed partnerships with their area VA health facilities in an attempt to better manage the requirements of CMCHS. Madigan Army Medical Center's (MAMC) early involvement in the Tacoma, Washington geographic area and Portland, Oregon's more recent CMCHS Project, also sharing MAMC's past experience provided a contrast of both support positions.²⁷ Support agreements during the early days of CMCHS between VA and DOD were not formalized. Today, programs which are more heavily dependent on VA assistance seem to attach a great deal of value to the new partnership approach. Jointly, all CMCHS project officers appear ready to welcome the added assistance the VA can provide for planning and conducting regional contingency exercises.

Community Acceptance

The ease of entering the civilian health care community for the purpose of introducing CMCHS was for many project managers a simple and welcomed task, yet for others, entering was complex and highly unwelcomed. Discussion during telephone interviews always made specific reference to community acceptance of the military's role in the joint civilian-military effort. Results indicated that programs which had begun early, prior to late summer of 1981, generally were well received. The national mood with the new administration's defense initiatives of 1980 might have had a great deal of influence on that acceptance.²⁸ Along with the fact that most of the early CMCHS efforts were planned and developed in the Midwest and Northwest, where military acceptance traditionally runs high; early successes were perhaps highly predictable. With the later development of CMCHS in the Far West in early 1981, organized resistance began to emerge.²⁹ Coincidental readjustment of society's attitudes toward defense spending and nuclear arms upgrading, along with a deepening economic reason proved that the CMCHS and military image could become tarnished. When potential cuts in social programs were first being discussed as a means to fuel defense spending, concerns among health care planners turned to more immediate matters such as fiscal survivability.³⁰ Groups of physicians and others also began speaking out on the dangers of competing in a new arms race which was viewed as not a deterrent to war, but a potential course towards armed nuclear conflict. With such an environment the Physicians for Social Responsibility (PSR) mobilized its forces to resist CMCMS. Communities around Letterman Army Medical Center (LAMC), California and Fort Devens, Massachusetts experienced and continue to experience, PSR resistance which served to further tarnish civilian and military relations.³¹

For late arrivals to the CMCHS program resistance was better organized and the PSR had developed into a coherent voice which could seriously damage CMCHS implementation planning efforts for the New York City area. Both the coordinating agents at Fort Monmouth and West Point were confronted with the resistance as public support of the military lessened even further in 1982.

Size-Facility vs Mission

As mentioned earlier, when the issue of command support was addressed, commitment of support was seen as a critical element in CMCHS success. One related element that was now preceived as highly important was the issue of evaluating the size of a given CMCHS coordinating facility with the size of the area's assigned CMCHS mission. Each facility was assigned a mission by the Department of Defense through its service's respective Office of the Surgeon General. In the case of the Army, Health Services Command (HSC) also was informed as the major medical command. Geographic areas were at first designed around the major medical centers and later around military hospitals of various size and capabilities.³² Distribution of the medical facilities for the three services does not support an even geographic distribution of the nation's civilian health care institutions. For example, in the San Francisco, California area, Letterman Army Medical Center, a 366 bed teaching complex, was assigned the CMCHS mission to seek participation from 20 civilian hospitals.³³ In the Boston, Massachusetts area a much smaller hospital at Fort Devens of 68 beds was assigned a 59 hospital mission.³⁴

Along with coordinating agency size goes a comparable degree of military and civilian staffing designed to manage mission requirements. This area was specifically questioned during interviews and the data evaluated.

Personal Visits

The last of the seven general data classifications for CMCHS implementation success was the influence of personal visits to civilian facilities. Each project manager was asked to report the frequency at which visits were made. This proved difficult for several managers since they were not directly involved in all the visits. In addition, several managers had arrived during, or after, the implementation visits and others were not able to accurately account for multiple visits made. Each project manager was, however, able to report the general trend of either all or most potential hospitals visited, or few if any visited. This breakdown by trend also helped to avoid confusion when accounting for visits made to administrators through local associations.

The data which was gathered is displayed by the seven general classifications at Appendix K. Each of the seven was then analyzed by use of the Fishers Exact Test, a non-parametric alternative to the Chi-Square Test of Independence. Program success ratings based on bed acquisition and satisfaction of established DOD objectives is provided as Appendix L. Performance of the analysis itself is outlined in Appendix M.

Results of the Analyses

Of the seven data classifications analyzed none proved statistically significant when compared to CMCHS success. Interpretation of that result does, however, suggest several interesting possibilities. First, is the question of sample size used in the study. Twelve total samples were gathered with only eleven being used in the actual analysis. This small number would make it difficult to achieve significance at the .05 level. A second possibility for the result might be that segregation of the data classifications produced a false picture of how CMCHS programs in reality functioned. For example, several of the data classifications, such as: command support, personal visits, community acceptance and use of associations, if viewed collectively could have had a systemic impact on CMCHS success. By allowing total segregation, true impact on success might have therefore been attenuated. Another possibility could be that the classifications identified were too specific in scope. This possibility is closely associated with the second, yet goes one step further. Perhaps, limiting the scope by dividing responses from the surveyed CMCHS project managers resulted in an oversight in the design of broader based data classes. Therefore, the results might be a reflection of classification design and not of relationship to overall CMCHS success.

Several data classifications did show a tendency toward significance and are worthy of note. Community acceptance, size versus mission and personal visits all tended to polarize when compared to the established success score. Perhaps the relationship of those classifications supports one of the later two possibilities for more statistical proof.

The data classifications which tended to show the smallest relationship to CMCHS success were command support, management structure and use of local associations. VA support appeared inconclusive due to the delayed formal agreement achieved between DOD and the VA. Most of the programs evaluated had been in operation long before that agreement was signed and had little, if any, experience base on which to judge VA support.

As alluded to earlier, when each data classification was briefly introduced, measurement of data used in this study was based on experience and personal judgment. Attempts to oversimplify or quantify all such judgment for the purpose of attaining statistical proof of various hypotheses would therefore, be impractical. The statistical tool employed was an attempt to augment the overall evaluation process of the data collected for designing alternative courses of action. That objective was achieved.

Implementation Strategy

Phase II

The lessons which were learned as a result of Phase I indicated to the regional planners at Keller Army Community Hospital (KACH) and the four VAMC's that Phases II and III would require a considerable commitment in terms of time and resource expenditure. The transitional months of November and December 1982 were only moderately active for recruitment of hospitals due to the seasonal lull of the holidays. While Phase II approached it became apparent that defining duties and responsibilities would in a large part determine the future viability of CMCHS in Northern New York.

Establishment of the basic organizational framework to manage the arrival of CMCHS related data for Phase I appeared to be working quite well. In addition, the accomplishment of simply contacting all the eligible hospitals indicated that the framework was able to support information dissemination throughout the region; a challenge that was considered during the framework's design. Phase II, which would last throughout the first nine months of 1983, would either fail or succeed based on the strength of the organizational framework. That strength would in a part come from the framework's capability to adjust. Such an adjustment capability would need to be not only reactive in nature, but also able to anticipate which factors would likely produce situational change.

Specifically, Phase II would cover the period December 31, 1982 to September 1983. The major objectives of this phase of implementation would be twofold. First, Phase II would provide the time to complete the active consignment of hospital beds for the region. February and March 1983, would serve as the planned close out period for active consignment, while it would be anticipated that additional beds would be added throughout the spring months of April through early June.

Actual contingency planning for the region would serve as the second major objective of Phase II. The scheduling of meetings with participants and support agencies would be conducted concurrently with the consignment efforts mentioned above. In addition, KACH would conduct a small scale area exercise during the month of March 1983, so that basic planning and implementation efforts to that stage might be evaluated. The immediate goal of this second objective would be to publish a Regional Operations Plan for Northern New York, to be known as OPLAN-New York.

Once the active regional consignment process subsides and area hospitals desirable of participation are identified, then planning for the development of a regional contingency health care network will take over. Phase II is therefore, the planning stage for operational employment of CMCHS. Each hospital's external disaster plan will be considered for integration in the design process for development of an area plan around each VAMC and an overall regional plan (OPLAN-New York) around KACH. That planning process is what will consume the resources of the VAMC's and the West Point Hospital. The more successful consignment efforts are throughout Phases I and II, the greater the planning challenge itself is likely to be.

Implementation Strategy

Phase III

The actual design and redesign of a regional operations plan will undoubtedly consume the talents of many health care planners in the New York area. Publication of OPLAN-New York will not signify the end of implementation, but will only mark the beginning of a two year testing phase. This test period will serve to evaluate the planning product developed as a result of the earlier implementation phases. Therefore, Phase III will, through a series of exercises, simulate circumstances which would permit rehearsal of the region operations plan.³⁵ Such rehearsal will provide a means to identify planning shortfalls and other overall considerations necessary for upgrading regional responsiveness.

There will be three basic formats for conducting CMCHS exercises: The Basic, The Intermediate, and The Advanced Exercises.³⁶ Actual CMCHS implementation will be considered complete when The Basic Exercise is conducted, during October 1983. Phase III, however, will continue beyond 1983, until The Intermediate and The Advanced Exercises are carried out and their results evaluated. Specifics as to what constitutes each type exercise is provided in Appendix N.

Three principal objectives have been established for conducting each type of CMCHS exercise. These are to motivate and train personnel of the planned role; to assess the adequacy of plans to accomplish assigned missions and to adjust those plans as circumstances may dictate; and to assess the ability of personnel to perform in accordance with plans and to correct noted deficiencies.³⁷ In order to satisfy those objectives, duties and responsibilities, as mentioned earlier, will need to be clearly defined and executed.

CMCHS implementation strategy will, therefore, be a growing challenge that will attempt to promote a shared approach to civilian-military cooperative planning. From the basic establishment of an operational framework for processing CMCHS related data; to exercising that framework for introducing the CMCHS concept of consigning beds, design area and regional plans; to finally exercising those plans for assessing preparedness, implementation will test the cooperative spirit within the region. If the framework is strong and capable of meeting the challenge of adjusting to necessary change, then success in the CMCHS mission will result for all.

Design of Alternatives

The headquarters element of the West Point Medical Department Activity and Keller Army Community Hospital (KACH) understands the critical importance of successfully developing a regional CMCHS program that could effectively be mobilized to support a civilian or military emergency mission. Feasible alternatives designed to determine how best to implement CMCHS, so that such a regional response system could be effected, were formulated based on the analysis of data collected. That data when applied to the unique features of the region resulted in three alternatives that warrant consideration. Those three alternatives are outlined below:

1. Strategic Regional Planner - Keller Army Community Hospital to serve as the strategic planner allowing operational management of implementation for prearranged areas by each Veterans Administration Medical Center. (VAMC).

2. Regional Implementation Agent - Keller Army Community Hospital and each VAMC to determine area-specific strategy.

3. Regional Planning and Implementation Partner - Keller Army Community Hospital and each VAMC would jointly determine specific area needs for both planning and implementation of CMCHS.

Each alternative will be discussed in turn.

Alternative 1 - Strategic Regional Planner

Planning and actual implementation under this alternative would be segregated to the greatest degree possible. KACH would strategically

manage the plans for actual implementation by communicating with higher headquarters from Health Services Command, The Office of the Surgeon General and the Department of Defense. Operational implementation of CMCHS would be managed primarily through each area VAMC. Therefore, the vast majority of contact with local hospitals would be the direct responsibility of the VA.

Programs developed in the Portland and Atlanta areas have tended to follow this basic design for overall regional implementation.³⁸ The Houston area however, relied very heavily on VA operational initiative, yet the Department of Defense influence was not simply isolated to planning.³⁹

Under this alternative KACH would, in conjunction with the Department of Defense, identify potential member civilian hospitals and assign each to a specific VAMC area. In addition, the planning responsibility for KACH would include: analysis of existing disaster plans for the region, development of a CMCHS Operations Plan for New York and establishment of the Basic Exercise test date. Consignment of hospital beds dedicated for support of CMCHS would become the primary responsibility of the VAMC's. Each VAMC would be expected to utilize their resources to meet operational demands of the consignment process.

One advantage of this alternative for KACH would be retainment of the historical perspective that the West Point health care facility is in fact the medical support element for the Corps of Cadets and that regional or community involvement should be kept to the bare minimum. Segregation of the planning and implementation responsibilities might be viewed as an advantage for the enforcement of the standards established

by the Department of Defense for participation in CMCHS. Bed capacities, accreditation, capabilities, and strategic location of a potential hospital could be more objectively screened by the regional planner who has no direct involvement in the consignment process.

The apparent lack of direct involvement by KACH in identifying local and regional needs is a disadvantage of this alternative. By detaching planning from operational implementation, acquisition of an honest appreciation for what problems are confronting local hospitals would be lost, or appear lost. The Department of Defense's image as a large and impersonal arm of the government would be reinforced under this alternative. In addition, direct control of expenditures might appear to be an advantage of the strategic regional planner approach, yet with little direct involvement in operational affairs, awareness of what planning resources would be actually called for would likely suffer.

Alternative 2 - Regional Implementation Agent

Planning and implementation under this alternative would be totally integrated to the greatest extent possible. KACH would not only provide strategic management as the planning aspects for CMCHS, but would also involve itself totally with operational requirements. Direct coordination with local hospitals under this alternative would be highly encouraged.

Implementation from initial planning, to include design of a strategy to maximize consignment of beds, through development of the CMCHS OPLAN-New York, to the set-up and conduct of the three levels of CMCHS exercises would all be the primary responsibility of KACH. The four VAMC's would

for the most part provide passive support on an as required basis only.

This alternative would be a KACH attempt at total implementation. The role of the VA would be viewed as it was in earlier developed programs. Several of those earlier CMCHS programs utilized this type approach and were able to produce highly successful results.

The CMCHS Program at Scott Air Force Base, Saint Louis, Missouri was one such example of total federal hospital management of both planning and implementation. This 175 bed facility was assigned the mission to invite 34 hospitals to participate in CMCHS. An operations plan was drafted and exercises were scheduled with minimum support from the Saint Louis VAMC.⁴⁰ This effort at Scott was successfully completed without additional augmentation to the hospital's staff.

Advantages of this alternative are command and control related to the enforcement of established DOD standards and management of available personnel and fiscal assets. Direct involvement in regional planning is also an advantage which would likely be seen by potential hospitals of as outward sign of commitment to CMCHS. Problem awareness as to what situations are impacting on the civilian sector would also likely be enhanced.

Depth of available staff assets when this alternative is considered for KACH is a noticeable disadvantage. Successes at places like Scott Air Force Base and Great Lakes Naval Regional Medical Center which independently managed CMCHS implementation exhibited staff profiles of far greater depth than available at KACH. Operation of a small MEDDAC with a well defined, yet diversified mission as is present at West Point

does not allow for the necessary flexibility to readily commit its limited assets to aggressively canvass 63 hospitals over a seven county area.

Alternative 3 - Regional Planning and Implementation Partner

Under this alternative KACH and each VAMC would determine overall regional strategy and specific area direction for the planning of and carrying out of implementation. Direct coordination with local health care agencies and hospitals would be mutually shared and specific support agreements established. To attempt improved return on resource expenditure, the internal and external organizational structure outlined earlier would be fully exercised.

Historically, VA support of the Department of Defense has been limited due to a difference in mission relative to active duty versus disabled military treatment for the military forces. Following the Second World War however, conceptual differences were put aside so that a more supportive role for the VA could be established in the event of a national or international emergency. In 1965, a memorandum of understanding was established which set in place a contingency planning framework for overseas conflicts.⁴¹ In 1978, the VA-Department of Defense agreement was tested under the Nifty Nugget National Mobilization Exercise.⁴² Contingency planning between the VA and the Defense Department continued throughout the early years of the CMCHS and in May of 1982, Public Law 94-174 entitled, "VA-DOD Health Resources and Emergency Operations Act" was enacted.⁴³ This alternative attempts to take full advantage of the VA-DOD Partnership Concept.

Early CMCHS programs did not have the benefit of PL 94-174 and agreements with area VA representatives ranged from moderately strong to miserably weak. The two newest CMCHS programs in New York have the opportunity to fully exploit the designed purposes of the memorandum of understanding of December 1982, which outlines interpretation of PL 94-174 (Appendix O).

Advantages of this alternative are expansion of available assets and improved involvement in regional planning. The limited staff and resource base of KACH could be extended through partnership programs with much VAMC's, which have a much larger operational base. In addition, each VAMC has developed functional networks with hospitals and health care support agencies within their area. The partnership approach would take advantages of those relationships. KACH's involvement in regional planning would logically benefit similarly, due to the established networks. Time and effort could be saved through use of existing associations.

Disadvantages result due to a lessening of command and control over enforcement of established Department of Defense standards. Consideration would need to be given to altering those standards to meet interpretational differences of program managers with each VAMC. Negotiations between the VAMC and a prospective participant might lead to new and different situational problems for the region. Such problems could affect the design of the regional operations plan or the conduct of various exercises.

Alternative Summary

Three alternatives have been formulated and will be evaluated independently against the criteria set forth as study constraints and those additional factors which were discussed as having an influence on the overall study. In addition, the analyses of the data classifications were integrated throughout the evaluation process. The Churchman-Ackoff Value Assignment Technique⁴⁴ for evaluating each of the alternatives is fully developed in Appendix P. A summary of the results from performing the technique is provided in Figure 9.

Alternatives

- I Strategic Regional Planner
- II Regional Implementation Agent
- III Regional Planning and Implementations Partner

Decision Matrix Summary

Alternatives	Criteria						Total
	1	2	3	4	5	6	
1	.6	.8	.6	.4	.4	.6	.5840
2	.3	.3	.8	.5	.6	.7	.5220
3	.7	.7	.5	.8	.8	.7	.6740

Figure 9

Summary of Churchman-Ackoff Technique

Optimal Feasible Solution

The optimal feasible solution based upon the analyses made is Alternative III, Regional Planning and Implementation Partner.

FOOTNOTES

¹Agenda, Army-Veterans Administration Joint CMCHS Planning Meeting, Pentagon, Washington, DC, July 27, 1982.

²Maximus Inc., In Combat, In the Community-Saving Lives..., Together, July 1980.

³Congress of the United States, "VA-DOD Health Resources Sharing and Emergency Operations Act", Section 5011A of Title 38, US Code, Washington, DC, May 4, 1982.

⁴Interview with Lieutenant Colonel Harry A. Wisdom, Chief, Plans, Operations, and Training Division, Madigan Army Medical Center, Tacoma, Washington, February 14, 1983.

⁵"The Civilian-Military Contingency Hospital System: Medical Planning for War," The New England Journal of Medicine 307:12 (September 16, 1982), pp 751-752.

⁶Proposed Agenda, VA-DOD Contingency Planning for the New York City Area, Manhattan, New York, July 29, 1982.

⁷Maximus, Inc. In Combat, In the Community-Saving Lives..., Together, July 1980.

⁸Agenda, CMCHS Implementation Schedule, New York City, Marriott's Essex House, Manhattan, New York, September 20, 1982.

⁹Congress of the United States "VA-DOD Health Resources Sharing and Emergency Operations Act, Introduced to the Ninety-Seventh Congress on January 25, 1982.

¹⁰Agenda, CMCHS Implementation Schedule-Upper New York City Area, Westchester Marriott, Tarrytown, New York, September 21, 1982.

¹¹Interview with Major J.C. Broach, Training Officer/CMCHS Project Officer, Health Services Command, San Antonio, Texas, September 14, 1982.

¹²Interview with LCDR William Lambert, USN, Deputy Director CMCHS, OASD(HA), Pentagon, Washington, D.C., September 16, 1982.

¹³Interview with CDR Jeffrey W. Baldwin, USN, Director of Administrative Services, Great Lakes Naval Regional Medical Center, Great Lakes, Illinois, January 21, 1983.

¹⁴Ibid.

¹⁵Interview with Lieutenant Colonel Harry A. Wisdom, February 14, 1983.

¹⁶Interviews with Major G.S. Mobley, CMCHS Project Manager, Walter Reed Army Medical Center, Washington, D.C., October 21-22, 1982.

¹⁷Maximus, Inc., Advanced Draft Working Papers CMCHS Exercise Manual, Contract No. MDA 903-79-C-0089, January 7, 1982, p II-2.

¹⁸Ibid, pp II-3 - II-6.

¹⁹Northern Metropolitan Hospital Association, Letter of Invitation to Address CMCHS at the October 28, 1982, Board/Membership Meeting, September 23, 1982.

²⁰Keller Army Community Hospital Letter to Commander, 808th Station Hospital, Subject: Request for Change in AT Site for CPT John C. White, October 5, 1982.

²¹Keller Army Community Hospital, CMCHS Status Report Number 1, October 29, 1982.

²²U.S. Department of the Army, Health Services Command, Information Paper, "Civilian-Military Contingency Hospital System CMCHS," HSOP, July 26, 1982.

²³Interview with Major Walter Wells, Plans Officer, Office of the Surgeon General of the Army, Medical Plans and Operations, Washington, DC, January 27, 1983.

²⁴Department of Defense CMCHS Status Report for the period ending December 31, 1982, Washington, DC, February 16, 1983.

²⁵Interview with Captain Michael DeCesare, Chief, Plans, Operations, and Training, Cutler Army Community Hospital, Fort Devens, Massachusetts, February 7, 1983.

²⁶Ibid.

²⁷Interview with Lieutenant Colonel Harry A. Wisdom, Chief, Plans, Operations, and Training, Madigan Army Medical Center, Tacoma, Washington, February 14, 1983.

²⁸John G. Eresian, "Reagan and Health Care: Strategic Questions for Hospitals," Hospitals 55:8 (April 16, 1981), pp. 45, 48-49.

²⁹Jennifer Leaning Link, M.D. "Physicians For Social Responsibility Statement on Civilian-Military Contingency Hospital System (CMCHS)" Published Paper for Massachusetts Chapter American College of Emergency Physicians, 1981.

³⁰Michael Lesparre, "Governors Balk at Medicaid Cuts in Reagan Plan," Hospitals 55:6 (March 16, 1981) pp. 30, 32.

³¹U. S. Department of Defense, Office of the Assistant Secretary of Defense Health Affairs Memorandum, "Background Information for CMCHS Coordinating Hospitals," December 7, 1981.

³²U.S. Department of the Army, Office of the Surgeon General, "CMCHS Status Report (As of December 31, 1982)," Washington, D.C., February 1983.

³⁴Interview with Captain Michael DeCesare, February 7, 1983.

³⁵Maximus, Inc, "Advanced Draft Working Papers CivilianMilitary Contingency Hospital System Exercise Manual," Contract No. MDA 903-79-C-0089, January 7, 1982, p. 11.

³⁶Ibid, pp. II2 - II6.

³⁷Ibid, p. 11.

³⁸Interview with Lieutenant Colonel Peter Mekkelson, Plans Officer, Office of the Surgeon General of the Army, Medical Plans and Operations, Washington DC, January 25, 1983.

³⁹Ibid.

⁴⁰Interview with Lieutenant Colonel Turk, Associate Administrator, Scott Air Force Base, Saint Louis, Missouri, February 21, 1983.

⁴¹Memorandum of Understanding Between Veterans Administration (VA) and the Department of Defense (DOD), "Regarding the Furnishing of Health Care Services to Members of the Armed Forces in the Event of a War or National Emergency," December 23, 1982.

⁴²Murray, G. Mitts, M.D., "VA-Department of Defense Contingency Planning," Draft Letter VA Program Analysis and Development (10CC), January 21, 1983, p. 12.

⁴³Ibid, p. 13.

⁴⁴C.W. Churchman and R.L. Ackoff, Introduction to Operations Research (New York: John Wiley and Sons, Inc.) (1967), pp. 138-143.

CHAPTER III

CONCLUSION

Summary

July 1982 was the month in which CMCHS and Keller Army Community Hospital (KACH) first crossed paths. From that point in time on, four Veterans Administration Medical Centers (VAMC's) and approximately 64 civilian health care facilities in Northern New York were influenced in some way by CMCHS.

At first, KACH and the VAMC's had to determine what type of basic organizational framework would best support the early management requirements of implementation. Following an initial comparative analysis of established CMCHS programs a workable framework was designed.

Next, CMCHS implementation was discussed as a three phased program; starting with an orientation phase; followed by an active consignment and plan development phase; and ending with an evaluation and redesign or refinement phase. Each phase was built to the success, or failure, of the basic operational framework and that framework's ability to adjust to changing factors that impacted on CMCHS.

The basic problem that was studied was to determine the optimal feasible method of implementing the three phased program, CMCHS, at the United States Medical Department Activity, West Point, New York. Three alternatives were designed to provide resolution to that problem. These alternative approaches were the strategic regional planner, regional implementation agent, and the regional planning and implementation partner. The last of the three proved to be the most feasible course of action.

Evaluating the Conclusion

While designing alternatives to resolve the problem at hand several situations presented themselves which allowed for practical evaluation of the feasibility and supportability of the optimal solution. Two of these situations are worthy of note.

The first of these occurred on 18 November 1982 while introducing CMCHS to the staff at The Kingston Hospital and Benedictine Hospital, both located in Kingston, New York.¹ A question that was surfaced to the CMCHS representatives from West Point and the Castle Point VAMC concerned what possible negative impact could result for a potential participant in the review of a new or pending certificate of need at the state planning level. It appeared that these and other area hospitals did not feel assured that participation in CMCHS would not adversely affect their future ability to grow or add services. This concern did not appear to present itself in other CMCHS areas which were surveyed.

Direct coordination with The State of New York Department of Health, Office of Health Systems Management helped to put the issue to rest. Letters between KACH and The New York State Bureau of Facility and Service Review are provided as Appendix Q.

The partnership approach of planning and implementing, during Phase I, proved that rapid resolution of issues of local concern could prove beneficial for acquiring regional support for CMCHS. This action was certainly instrumental in the decision reached by both hospitals to participate in CMCHS. That decision was reached in mid-March 1983.

As 1982 came to a close, CMCHS implementation was at a planning crossroad. Several inquiries to the Department of Defense (DOD) on common area issues were not being aggressively answered. Three specific areas were: reimbursement, medical liability, and Joint Commission on Accreditation of Hospitals (JCAH) support of the Basic Exercise as an approved external disaster drill.²

On January 13, a meeting of the four VAMC's and KACH CMCHS representatives was held at the Montrose VAMC.³ The purpose of that meeting was to plan entry into Phase II of implementation. The partnership approach at that time produced two valuable finds. First was that each VA Director was able to share tried and proven methods of attaining local hospital support. That sharing was most beneficial in planning for Phase II and for actual implementation of those plans to increase the bed acquisition rate for that period. Secondly, the problem of local credibility was raised in regards to Joint Commission recognition of the Basic Exercise.

In a letter sent to LTC Podge M. Reed, Jr, Director of CMCHS and Medical Readiness for the Army, the JCAH questioned the Basic Exercise's ability to satisfy the annual accreditation requirements of conducting a realistic drill of the hospital's external disaster plan.⁴ JCAH support for CMCHS and the specific approval of the three levels of exercises for satisfying the JCAH external disaster requirements were strong selling points that regional CMCHS representatives from West Point and the VAMC's exploited when discussing CMCHS benefits to local hospitals.

The issue of credibility was of serious concern to those in attendance on January 13, 1983 at the Montrose VAMC. The question was, what could be done to retain credibility with those local hospitals and regional representatives from the VA? Doubt as to the true commitment of the JCAH and of the DOD Agent (KACH) to the expressed purpose and benefit of CMCHS in New York had to, therefore, be addressed. The partnership approach again, was instrumental in the identification of the issue and the designed course of action to set aside all doubt of JCAH support.

KACH assumed the proactive stance of the strategic planner in the development of a proposed structural organization for the design of the regional CMCHS, OPLAN for New York, as well as, the proposed scenario for conducting a October 1983 Basic Exercise. Specific areas of concern surfaced by the JCAH as to the evidence of participation by the medical staff, administration and nursing, along with identification of "drill like" activity to permit realistic drill evaluation were addressed.⁵ The complete correspondence between the JCAH and KACH, which resulted in a favorable JCAH interpretation to be rendered, is provided as Appendix R.

Together, the partnership of the DOD Agent, KACH, and the VA proved capable of identifying planning requirements and designing positive actions to facilitate satisfying those requirements. KACH and the four VAMC's demonstrated that joint planning and implementation not only worked, but worked well toward attaining the goals and objectives of CMCHS implementation.

The Problem in Retrospect

The conclusion that has just previously been evaluated was determined to be the optimal feasible method of implementing CMCHS at the West Point MEDDAC. In reaching that conclusion, five intermediate objectives had to be satisfied. These objectives were included in the original problem statement and a retrospective evaluation of how each was achieved is now warranted.

The first objective was to analyze existing disaster plans. During the initial quest for information concerning CMCHS and during subsequent quests to aid in designing a regional operations plan, no less than 12 plans were reviewed. An indepth study of emergency preparedness planning at the West Point MEDDAC was conducted, during the period 26 July through 22 October 1982.⁶ In addition, analysis of existing disaster planning was conducted on site, during visits to the Montrose VAMC and to the Nassau County Medical Center, East Meadow, New York. Insight gained in the analysis process was of great value in designing alternative approaches to the study at hand.

In order to determine the magnitude of the problem a second objective, identification of potential member civilian hospitals in the area, had to be accomplished. Initially, this identification was provided by the Department of Defense (DOD). In cooperation with the American Hospital Association and the Joint Commission on Accreditation of Hospitals, DOD was able to identify those area hospitals that satisfied the guidelines set forth for participation in CMCHS. The 63 hospitals identified covered

a seven county area and provided little commonality as to size of facility or composition of specialties. As the study continued, several hospitals not previously identified by DOD were determined to be vital links in the establishment of area contingency systems. Three of these facilities were overlooked simply by virtue of their basic bed size. Unique features of the area and region did, however, allow for their inclusion in CMCHS. Therefore, just short of 70 local hospitals were identified as potential CMCHS members.

Consignment of hospital beds dedicated for support of the CMCHS program was the third objective. Phases I and II were designed to manage the planning and execution of methods for attaining signed memoranda of understanding. Success in satisfying this objective would be classified as clearly outstanding. As of the end of March 1983, eighteen local hospitals and the four VAMC had signed memoranda of understanding (MOU). The maximum number of beds represented by those MOU's exceeded 1000.⁷ In addition, seven hospitals were pending a final decision which appeared to be positive in nature.

Development of a CMCHS Operations Plan (CMCHS OPLAN, New York), which was the fourth element of the stated problem, was addressed in a rather interesting fashion. Once the question of JCAH support for the Basic Exercise surfaced, a proposed structural framework for the design of the OPLAN was developed (Appendix R). That basic framework, along with a proposed scenario subsequently approved by JCAH, served as the basic blueprint for the finalization of the OPLAN.⁸ While developing the correspondence, lessons learned from other CMCHS programs were used so

that the basic objectives for evaluation of the OPLAN could be incorporated. Those OPLANS, which had already been drafted elsewhere, proved most valuable in design of the basic OPLAN-New York's standard framework and provided ready material for confronting the JCAH.

On March 25, 1983, a mini-test of the structural framework for the regional OPLAN was conducted.⁹ Two civilian hospitals, the Castle Point VAMC and the KACH jointly conducted a small area test of the plan along with area-wide support agencies (ambulance corps, evacuation assets, and fire departments). This practical application of the plan's basic design proved useful for all concerned and surfaced issues that would facilitate modification to the plan's basic design.

Closely associated with the development of the regional OPLAN was a fifth problem consideration; that of establishment of a date to conduct the Basic Exercise. Again, while addressing the fundamental conduct of the exercise with the JCAH, an October 1983 test date was established. That date was included in the scenario as the period when large scale deployment of troops oversease, in fact, be conducted. Specific establishment of a single day was not made so that planning considerations could allow for a 48 to 72 hour time period to activate the regional OPLAN. Exactly how such activation would occur, or how time phase substitution would be managed, has yet to be determined. By selecting a given period time, flexibility as to the actual extent of the exercise play was maintained for further planning consideration.

The sixth objective, design of feasible alternatives and the seventh, that of selecting the optimal feasible method of implementation, were indeed addressed and have already been discussed in detail.

Resolution of the basic research problem has therefore, been accomplished. Like many solutions to complex problems new variations of different problems surface as a result. One fact that became quite clear was that CMCHS success during implementation and the amount of future work and resource expenditure were directly proportional. The greater the success early on during the consignment and planning phases, the larger the challenge of conducting the three levels of exercises. For a small hospital, such as the one at West Point, the management of those future challenges will present problems that will continue to affect the systems that were developed to resolve those problems identified and studied herein.

Recommendations

It is recommended that the conclusion outlined be used to implement CMCHS at the United States Military Academy at West Point. In addition, it is recommended that the results of this study be forwarded to Health Services Command, The Office of the Surgeon General, and The Department of Defense, Secretary of Defense for Health Affairs. Perhaps the information contained herein could serve to alert those planners of the impact that CMCHS has had to date and will continue to have on the West Point MEDDAC.

A Final Word

This problem oriented research effort has addressed the question of how CMCHS could be best implemented at West Point. The impact of that decision will be felt for years to follow. Many traditional beliefs that West Point's Keller Army Community Hospital's only purpose is for

providing to 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.

Community acceptance of CMCHS has not been overwhelming. The reactions reflected in the rate of acceptance will also be confronted for years to come. Valid questions surfaced by concerned community members as to the inner workings of CMCHS were not properly addressed (reimbursements and liability being two specific areas in question). Program credibility was affected by an inability to provide such answers. Again, this will be felt in future community interaction with the West Point MEDDAC.

CMCHS was in 1980, and remains today, a viable program to help identify community health care assets to augment those of the Department of Defense in time of need. Development of that program has been rapid and the basic bed acquisition goal of 50,000 beds has been surpassed. Questions, however, still exist. For example, can a central agency ever integrate those bed assets to achieve a true working network for delivery of health care to meet future wartime or peacetime needs? Regional programs are in place and those programs contain the numbers of beds called for, but where does the command and control for activation of CMCHS exist? Many have contributed to the development of CMCHS since 1980, but does anyone have planned for what the CMCHS role will be in 1985 or 1990? Will CMCHS die a slow death with member hospitals voluntarily disengaging to enter other planning endeavors, or will interest be maintained?

Answers to those questions must be energetically pursued so that CMCHS can survive the test of standing idle during years of non-utilization. If the answers are slow in coming CMCHS may not be effective when and if the need to activate the system should arise.

FOOTNOTES

¹Northern Metropolitan Hospital Association, Membership Directory: 1982-83, September 1982.

²Interview with Major Walter Wells, Plans Officer, Office of the Surgeon General of the Army, Medical Plans and Operations, Washington, DC, January 6, 1983.

³Freeman I. Howard, M.D., "CMCHS Planning", Memorandum for Record, January 17, 1983.

⁴Lawrence A. Hill, "CMCHS Exercise Manual Review," JCAH Letter, Chicago, Illinois, October 8, 1982.

⁵Interview with Mr. Harry Weir, Associate Director Hospital Accreditation Program, JCAH, Chicago, Illinois, January 17, 1983.

⁶Joseph G. Flannery, "Analysis of Emergency Preparedness Planning at West Point MEDDAC New York," Unpublished Quarterly Management Project, October 22, 1982.

⁷U.S. Department of the Army, MEDDAC West Point, "CMCHS Status Report Fact Sheet", March 23, 1983.

⁸Harry M. Weir, "Proposed Regional Disaster Exercise," JCAH Letter, Chicago, Illinois, February 16, 1983.

⁹A.G. Hennessy, "Mass Casualty Planning," Committee Minutes for March 23, 1983, March 30, 1983.

SELECTED BIBLIOGRAPHY

BIBLIOGRAPHY

Public Documents

Accreditation Manual for Hospitals. Functional Safety and Sanitation, Standard III. Joint Commission on Accreditation of Hospitals, 1981.

Comptroller General, General Accounting Office. DOD Needs Better Assessment of Military Hospital's Capabilities to Care for Wartime Casualties (HRD 81-56), May 19, 1981.

Comptroller General, General Accounting Office. The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System (HRD 80-76), June 26, 1980.

Congress of the United States. VA-DOD Health Resources Sharing and Emergency Operations Act. Section 5011A of Title 38, US Code, May 4, 1982.

Congress of the United States. VA-DOD Health Resources Sharing and Emergency Operations Act - Introduced. January 25, 1982.

Joint Commission on Accreditation of Hospitals. Letter: Entitled CMCHS Exercise Manual, October 8, 1982.

Joint Commission on Accreditation of Hospitals. Letter, Entitled Proposed Regional Disaster Exercise, February 16, 1983.

MAXIMUS Inc. Advanced Draft Working Papers CMCHS Exercise Manual. Contract No.: MDA 903-79-C-0089, January 7, 1982.

MAXIMUS Inc. In Combat, In the Community-Saving Lives..Together. July 1980.

MAXIMUS Inc. Medical Readiness Report: Medical Exercise for the Civilian-Military Contingency Hospital System. Contract No.: MDA 903-79-C-0089, November 30, 1982.

MAXIMUS Inc. The Role of Emergency Medical Services Programs in Support of DOD During Periods of National Emergency. Contract No.: MDA 903-79-C-0089, July 1, 1980.

Memorandum of Understanding Between Veterans Administration (VA) and Department of Defense (DOD). Furnishing of Health Care Services to Members of the Armed Forces in the Event of War or National Emergency, December 23, 1982.

Memorandum of Understanding Between Veterans Administration (VA) Montrose and Keller Army Community Hospital, West Point, New York 10996. The Civilian-Military Contingency Hospital System. September 10, 1982.

Northern Metropolitan Hospital Association. Membership Directory: 1982-83, September 1982.

U.S. Department of the Army. Army Treatment Facilities General Administration. AR 40-2, 15 July 1981.

U.S. Department of the Army, Health Services Command. Civilian-Military Contingency Hospital System (CMCHS), Information Paper, HSOP-SP, 26 July 1982.

U.S. Department of the Army, MEDDAC West Point. CMCHS Status Report Fact Sheet, March 23, 1983.

U.S. Department of the Army, Office of the Surgeon General. CMCHS Status Report (As of December 31, 1982), February 1983.

U.S. Department of Defense, Office of the Assistant Secretary of Defense, Health Affairs. The Civilian-Military Contingency Hospital System, Fact Sheet, June 1982.

U.S. Department of Defense, CMCHS Status Report for the Period Ending December 31, 1982, February 16, 1983.

U.S. Department of Defense, Office of the Assistant Secretary of Defense, Health Affairs. Memorandum for CMCHS Work Group Members, December 7, 1981.

U.S. Department of Defense, Office of the Assistant Secretary of Defense, Health Affairs. Memorandum for Under Secretaries of Defense Entitled, CMCHS Update, April 16, 1982.

U.S. Department of Defense, Office of the Assistant Secretary of Defense, Health Affairs. Memorandum for Assistant Secretary of the (Army, Navy, and Air Force) Entitled, Reserve CMCHS Coordinating Teams, April 22, 1982.

Veterans Administration, Office of Program Analysis and Development (locc) Draft Letter Entitled, VA-Department of Defense Contingency Planning, January 21, 1983.

Books

- American Academy of Orthopaedic Surgeons. Emergency Care and Transportation of the Sick and Injured. 2d. ed. Chicago: American Academy of Orthopaedic Surgeons, 1977.
- Brown, Montague and Lewis, Howard. Hospital Management Systems: Multi-Unit Organization and Delivery of Health Care. Germantown, Maryland: Aspen Systems Corporation, 1976.
- Butnam, Alexander M. Responding to the Mass Casualty Incident: A Guide for EMS Personnel. Westport, Connecticut: Educational Direction Inc, 1982.
- Churchman, C.W. and Ackoff, R.L. Introduction to Operations Research. New York: John Wiley and Sons, 1967.
- Everett, B.S. Analysis of Contingency Tables. New York: London Chapman and Hall, John Wiley and Sons, 1977.
- Pearson, E.S. and Hartley, H. Biometric Tables of Statisticians. New York: Cambridge University Press, 1970.
- Snook, I. Donald, Jr. Hospitals: What They Are and How They Work. Rockville, MD: Aspen, 1981.

Periodicals

- "AHA Cites Three Developers of Civilian-Military System". Hospitals 57:5 (March 1, 1983): 23.
- American Hospital Association, "Civilian-Military Plan Bed Count Up". Hospital Week 18:43 (October 29, 1982): 4.
- Billberry, George T. "Miami Fire Department's SWAT/Medic Program", Emergency Medical Services 10:2 (March-April 1982): 50-53.
- Bishop, Samuel D. "Team Work Between Two Hospitals". Hospital Topics 58:5 (September-October 1980): 13-16.
- "CHA Board Acts on Bylaws and Civilian-Military Contingency Issue". Hospital Progress 63:6 (June 1982): 18-20.
- deSaulles, J.B. "Proven: The Value of an Emergency Preplan". Emergency Medical Services 9:6 (November-December 1980): 114-115.

- DiPaolo, Vince. "Tragic Hotel Fires Trigger Disaster Plans; Fire Forces Hospital Evacuation." Modern Health Care 11:1 (January 1981): 18,22.
- Edlich, Richard F. "Response of a Regional Emergency Medical System to a Local Disaster: Derailment of the Southern Crescent." EMT Journal 4:3 (September 1980): 29-34.
- "Emotional Aftershock Takes Its Toll: Kansas City, Disaster Haunts the Survivors." Hospitals 55:20 (October 16, 1981): 26.
- Eresian, John G. "Reagan and Health Care: Strategic Questions for Hospitals." Hospitals 55:8 (April 16, 1981): 45, 48-49.
- Garvin, John M. "The Logistics of a Disaster Drill: Medex-78." Emergency Medical Services 10:1 (January-February 1981): 39-48.
- Goodman. "More on Medical Planning For War." The New England Journal of Medicine 307:25 (December 16, 1982) 1578-79.
- Kelly, Leslie M. "A County Wide Disaster Drill." Hospital Topics 58:5 (September-October 1980): 12.
- Kuntz, Ester. "Hospitals Mobilize as Volcano Chokes Pacific Northwest, Riots Rock Miami." Modern Health Care 10:7 (July 1980): 32-33.
- Lesparre, Michael. "Governors Balk at Medicaid Cuts in Reagan Plan." Hospitals 55:6 (March 16, 1981): 30, 32.
- Lowry, John W. "Responding to a Scheduled Disaster." Emergency Medical Services 9:5 (September-October 1980): 17-20.
- Maxwell, Christopher. "Hospital Organizational Response to the Nuclear Accident at Three Mile Island: Implications for Future-Prevented Disaster Planning." American Journal of Public Health 72 March 1982): 275-279.
- McCann, Jean. "Disaster Plan Set in Motion By Collision Off Florida Coast." Emergency Department News. 2:3 (March 1980): 1, 3.
- McCann, Jean. "Rock Concert Disaster Tests Emergency Plan." Emergency Department News. 2:1 (January 1980): 1, 23.

- Melton, Robert J. "Revising the Rural Hospital Disaster Plan: A Role for the EMS System in Managing the Multiple Casualty Incident." Annals of Emergency Medicine. 10:1 (January 1981): 39-44.
- Miller, P.J. "The Nuneaton Derailment." Inquiry 12:2 (September 1980): 130-138.
- Munninger, Karl and Ravenholt, Otto. "Lessons from Las Vegas: The MGM Hotel Fire." Journal of Emergency Medical Service 6:2 (February 1981): 37-40.
- "Sea-Land Disaster Drill Tests Regional Response to Emergency." Hospitals 55:20 (October 16, 1981): 76, 81.
- "The Civilian-Military Contingency Hospital System: Medical Planning for War." The New England Journal of Medicine 307: 12 September 16, 1982) 751-752.
- Wyman, Stanley M. "The Civilian-Military Contingency Hospital System (CMCHS)-Pro and Con, The New England Journal of Medicine 306: 12 (March 25, 1982): 738-742.

Newspaper Articles

- Beary, John. "Misguided Foes of Wartime Medical Readiness," New York Times, November 28, 1981, p. 2-E.
- Higham, Scott. "Some L.I. Hospitals Balk at Pentagon Request for Space," New York Times, January 30, 1983.
- King, Wayne. "Coast Doctors Rebuff Pentagon on a Plan for War," New York Times, October 27, 1981, p. A19.
- Nelson, Lars-Erik. "No Nuking, of Course (But Hospitals, Just In Case)," New York News, October 23, 1981, p. 16.
- Sullivan, Ronald. "City Area's Hospitals Urged to Allocate Beds In Wartime," New York Times, September 21, 1982.

Other Sources

Automobile Club of New York. Members' Guide to New York City and Vicinity, 1978.

Janke, Thomas A. How to Manage Practically Anything Systematically. GR 14-260-100-010. U.S. Army-Baylor Graduate Program in Health Care Administration, 1979.

Flannery, Joseph G. Analysis of Emergency Preparedness Planning at West Point MEDDAC, New York, Unpublished, Quarterly Management Project, October 22, 1982.

Hennessy, A.G. Mass Casualty Planning, Committee Minutes for March 23, 1983, March 30, 1983.

Howard, Freeman I. CMCHS Planning, Memorandum For Record, January 17, 1983.

Interviews

Badgett, Arthur, LTC, MSC, Associate Professor of Health Care Administration, Fort Sam Houston, Texas (Telephonic), March 7 & 9, 1983.

Baldwin, Jeffrey W., Commander, MSC, USN, Director of Administrative Services, Naval Regional Medical Center, Great Lakes, Illinois, (Telephonic), January 21, 1983.

Broach J., Major, MSC, Training Officer Health Services Command (HSOP-S), Fort Sam Houston, Texas (Telephonic), September 14, 1982, October 8 & 26, 1982, November 11 & 18, 1982, December 13, 1982, January 19, 1983, February 8, 1983.

Collins, Robert, LTC, MSC, Chief, Plans, Training, and History Branch, Health Services Command, (HSOP-S), Fort Sam Houston, Texas, September 21, 1982, (Telephonic), November 10, 1982.

Dainley, W., CPT, MSC, Chief, Plans, Operations and Training, MEDDAC Fort Leavenworth, Kansas, (Telephonic), February 11, 1983.

DeCesare, Michael, CPT, MSC, Chief, Plans, Operations, and Training, MEDDAC, Fort Devens, Massachusetts, (Telephonic), September 16, 1982, February 10, 1983.

- Erwin, J.L., Major, MSC, USAF, Associate Administrator, Wright-Patterson Air Force Base, Dayton, Ohio, (Telephonic), February 9, 1983.
- Fishback, James W., CPT, Armor Department of Mathematics, United States Military Academy, West Point, New York, March 3, 1983.
- Farbish, Bruce, Major, MSC, Chief, Plans, Operations, and Training, Letterman Army Medical Center, Presidio of San Francisco, California, (Telephonic), February 9, 1983.
- Hahn, R., LTC, MSC, Executive Officer, MEDDAC, Fort Monmouth, New Jersey, (Telephonic), November 10 & 24, 1982, February 7, 8, & 14, 1983.
- Jordan, Timothy J, CPT, MSC, Chief, Plans, Operations, and Training, MEDDAC, Fort Leavenworth (Departed December 1982), Kansas, (Telephonic), September 15 & 21, 1982.
- Kamenar, John M., LTC, MSC, Chief, Plans, Operations, and Training, Brooke Army Medical Center, Fort Sam Houston, Texas, (Telephonic), February 8, 1983.
- Krebs, Charles A., Major, MSC, Chief, Plans, Operations, and Training, MEDDAC, Fort Jackson, South Carolina, (Telephonic) February 7, 1983.
- Lambert, William, LCDR, MSC, USN, Deputy Director CMCHS, Office of the Secretary of Defense, Health Affairs (OASD/HA), Washington, D.C., (Telephonic), September 16, 1982, October 7, 1982, November 11, 1982.
- Matheson, William A., Major, MSC, Chief, Plans, Operations, and Training, William Beaumont Army Medical Center, El Paso, Texas, (Telephonic), February 7, 1983.
- Mekkelson, Peter, LTC, MSC, Plans Officer, Office of The Surgeon General, Medical Operations, Washington, D.C., (Telephonic) January 25, 1983.
- Mobley, G.S., Major, MSC, Project Officer CMCHS Walter Reed Army Medical Center, Washington, D.C., October 21-1982 (Telephonic), February 10, 1983.

Reed, Podge M., LTC, MSC, Director, CMCHS, Office of the Secretary of Defense Health Affairs (OASD/HA), Washington, D.C., September 21, 1982, (Telephonic) September 16, 1982.

Turk, LTC, MSC, USAF, Associate Administrator, Scott Air Force Base, Saint Louis, Missouri, (Telephonic) February 11, 1983.

Wells, Walter, Major, MSC, Plans Officer, Office of The Surgeon General, Medical Operations, Washington, D.C., (Telephonic) January 13 & 27, 1983.

Weir, Harry M., Associate Director Hospital Accreditation Program, Joint Commission on Accreditation of Hospitals, Chicago, Illinois, (Telephonic) January 17, 1983.

Wisdom, Harry A., LTC, MSC, Chief, Plans, Operations, and Training Madigan Army Medical Center, Tacoma, Washington, (Telephonic) February 14, 1983.

APPENDIX A

THE INITIAL BREAKOUT OF HOSPITALS
WITHIN THE NORTHERN NEW YORK REGION
BY VA ASSIGNED AREA



DEPARTMENT OF THE ARMY
U. S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

REPLY TO
ATTENTION OF:

HSUD

MANHATTAN COORDINATING HOSPITAL

Manhattan Veteran's Administration
Medical Center
First Avenue at E. 24th Street
New York, New York 10010
(212) 686-7500

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Madeline A. Bohman Executive Director Bellevue Hospital Center First Avenue & 27th Street New York, New York 10016	1200	(212) 561-4141
Robert G. Newman, M.D. General Director Beth Israel Medical Center 10 Nathan D. Perlman Place New York, New York 10003	909	(212) 420-2000
Sister Josephone Tsuei President Cabrini Medical Center Columbus Hospital Division 227 East 19th Street New York, New York 10003	478	(212) 725-6000
John C. Donaher, Jr Executive Vice-President Doctor's Hospital 170 East End Avenue New York, New York 10028	263	(212) 535-3000
Robert J. Campbell, M.D. Director Gracie Square Hospital 420 East 76th Street New York, New York 10021	215	(212) 988-4400
Anthony Somers Executive Director Harlem Hospital Center 506 Lenox Avenue New York, New York 10037	819	(212) 694-1234

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Harvey Machaver Executive Director Hospital for Joint Diseases Orthopedic Institute 301 East 17th Street New York, New York 10003	230	(212) 561-2200
Donals S. Broas Executive Director & Vice President Hospital for Special Surgery 535 East 70th Street New York, New York 10021	200	(212) 535-5500
Charles Gellman President Jewish Memorial Hospital Broadway & 196th Street New York, New York 10040	197	(212) 569-4700
Allan C. Anderson President Lenox Hill Hospital 100 East 77th Street New York, New York 10021	696	(212) 794-4567
George A. Sarkar Executive Director Manhattan Eye, Ear, & Throat Hospital 210 East 64th Street New York, New York 10021	150	(212) 838-9200
Gabriel Koz, M.D. Director Manhattan Psychiatric Center 600 East 125th Street New York, New York 10035	1300	(212) 369-0500
Donald P. Teece Acting Vice-President- Administrator Memorial Hospital for Cancer & Allied Diseases 1275 York Avenue New York, New York 10021	565	(212) 794-7722
Carlos Loran Executive Director Metropolitan Hospital Center 1901 First Avenue New York, New York 10029	680	(212) 360-6262

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Gerald J. McCoy Executive Vice-President New York Eye & Ear Infirmary 310 East 14th Street New York, New York 10003	199	(212) 598-1313
Edward V. Grant Executive Vice-President New York Infirmary-Beeckman Downtown Hospital 170 William Street New York, New York 10038	508	(212) 233-5300
Irvin G. Wilmot Executive Vice-President New York University Medical Center 550 First Avenue New York, New York 10016	878	(212) 340-5111
F. E. Demartini, M.D. President Presbyterian Hospital in the City of New York 622 West 168th Street New York, New York 10032	1291	(212) 694-2500
David D. Thompson, M.D. Director Society of the New York Hospital 525 East 68th Street New York, New York 10021	1417	(212) 472-5454
Sister Gladys Sharkey Executive Director St Clare's Hospital & Health Center 415 West 51st Street New York, New York 10019	513	(212) 586-1500
Gary Gambuti President St. Luke's-Roosevelt Hospital Center Amsterdam Avenue and 114th Street New York, New York 10025	1363	(212) 870-6000
Sister Margaret Sweeney President St. Vincent's Hospital & Medical Center of New York 153 West 11th Street New York, New York 10011	891	(212) 790-7000

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
James S. Dooley Director Veteran's Administration Medical Center First Avenue at E. 24th Street New York, New York 10010	885	(212) 686-7500
Lorraine Tregoe Executive Director Bird S. Coler Memorial Hospital and Home Franklin d. Roosevelt Island 10044	1082	(212) 688-9400
Bernard Hirsch Executive Director Goldwater Memorial Hospital Franklin D. Roosevelt Island 10044	795	(212) 750-6512



REPLY TO
ATTENTION OF:

HSUD

86
DEPARTMENT OF THE ARMY
U. S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

BRONX COORDINATING HOSPITAL

Veteran's Administration Medical Center
130 West Kingsbridge Rd
Bronx, New York 10461
(212) 584-9000

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Barry Freedman Director Mount Sinai Hospital One Gustave L. Levy Place New York, New York 10029	1212	(212) 650-6500
Leonard R. Piccoli Executive Director Bronx Municipal Hospital Center Pelham Parkway South & Eastchester Rd Bronx, New York 10461	868	(212) 430-5000
Stephen Bender Director Bronx Psychiatric Center 1500 Waters Place Bronx, New York 10461	700	(212) 931-0600.
Fred Silverman President Bronx-Lebanon Hospital Center 1276 Fulton Avenue Bronx, New York 10456	568	(212) 588-7000
Joseph Citron Executive Director Lincoln Medical & Mental Health Center 234 East 149th Street Bronx, New York 10451	521	(212) 579-5000
Jorge L. Batista President Misericordia Hospital Medical Center 600 East 233rd Street Bronx, New York 10466	389	(212) 920-9575

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Carl Eisdorfer, M.D. President Montefiore Hospital & Medical Center 111 East 210th Street Bronx, New York 10467	1320	(212) 920-4321
Harold Fingeret Executive Director North Central Bronx Hospital 3424 Kossuth Avenue Bronx, New York 10467	400	(212) 920-7171
Albert V. DeCamillis Administrator Pelham Bay General Hospital 1870 Pelham Parkway South Bronx, New York 10461	183	(212) 430-6000
Arnold M. Freeman Administrator Prospect Hospital 730 Kelly Street Bronx, New York 10455	168	(212) 542-1500
Eugene Batterferd President St. Barnabas Hospital 183rd Street and Third Avenue Bronx, New York 10457	365	(212) 960-9000
Daniel S. Fruchter Administrator Union Hospital of the Bronx 260 East 188th Street Bronx, New York 10458	201	(212) 220-2020
Julius Wolf, M.D. Director Veterans Administration Medical Center 130 West Kingsbridge Road Bronx, New York 10468	702	(212) 584-5000
Ray Cubisino Administrator Westchester Square Hospital 2475 St. Raymond Avenue Bronx, New York 10461	205	(212) 430-9400



REPLY TO
ATTENTION OF:

HSUD

88

DEPARTMENT OF THE ARMY
U. S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

MONTROSE COORDINATING HOSPITAL

Franklin Delano Roosevelt
Veteran's Administration Hospital
Montrose, New York 10548
(914) 737-4400

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Roger G. Dvorak Executive Director Lawrence Hospital 55 Palmer Avenue Bronxville, New York 10708	281	(914) 337-7300
Corydon F. Heard, Jr. Director Franklin Delano Roosevelt Veterans Administration Hospital Montrose, New York 10548	1396	(914) 737-4400
Peter H. Wade President Northern Westchester Hospital Center East Main Street Mount Kisco, New York 10549	272	(914) 666-6777
George A. Vecchione Administrator New Rochelle Hospital Medical Center 16 Guion Place, Box 321 New Rochelle, New York 10802	320	(914) 632-5000
Edward C. Ackerman Executive Director Phelps Memorial Hospital North Broadway North Tarrytown, New York 10591	231	(914) 631-5100
Kenneth F. Adamec President United Hospital 406 Boston Post Road Port Chester, New York 10573	300	(914) 939-7000

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Bernard M. Weinstein Commissioner Westchester County Medical Center Grasslands Reservation Valhalla, New York 10595	422	(914) 347-7000
Fletcher H. McDowell, M.D. Executive Director Burke Rehabilitation Center 785 Mamaroneck Avenue White Plains, New York 10605	150	(914) 948-0050
Gerald R. Fitzgibbon Vice-President & Administrator St. Agnes Hospital North Street White Plains, New York 10605	195	(914) 682-3500
Jack H. Engelmohr Executive Director White Plains Hospital Medical Center Davis Avenue at E. Post Road White Plains, New York 10601	290	(914) 949-4500
Louis F. Parker Chief Executive Officer St. John's Riverside Hospital 967 North Broadway Yonkers, New York 10701	276	(914) 963-3535
Sister Mary Linehan President St. Joseph's Hospital 127 South Broadway Yonkers, New York 10701	185	(914) 965-6700
Bertram J. Oppenheimer, M.D. Administrator Yonkers General Hospital Two Park Avenue Yonkers, New York 10703	207	(914) 965-8200

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
James M. Dawson President Nyack Hospital North Midland Avenue Nyack, New York 10960	323	(914) 358-6200
Charlotte E. Oliver Director Rockland Psychiatric Center Orangeburg, New York 10962	1633	(914) 359-1000
Don Brown Administrator Helen Hayes Hospital Route 9W West Haverstraw, New York 10996	150	(914) 947-3000

<u>Hospital/Address</u>	<u>Beds</u>	<u>Telephone</u>
Edwin B. Bolz Executive Director Vassar Brothers Hospital Reade Place Poughkeepsie, New York 12601	330	(914) 454-8500
Wendy P. Acrish Director Harlem Valley Psychiatric Center Wingdale, New York 12594	470	(914) 832-6611
Sister Mary Charles McCarthy President Benedictine Hospital 105 Marys Avenue Kingston, New York 12401	282	(914) 338-2500
Anthony R. Triulzi Administrator Kingston Hospital 396 Broadway Kingston, New York 12401	206	(914) 331-3131

APPENDIX B

LIST OF HOSPITALS AND HEALTH CARE ORGANIZATIONS
IN ATTENDANCE AT THE CMCHS MEETING HELD IN
TARRYTOWN, NEW YORK - SEPTEMBER 21, 1982

List of Hospitals and Health Care Organizations that Attended
CMCHS Meeting, Tarrytown, New York - September 21, 1982

Arden Hill Hospital
Beth Israel Medical Center
Cabrini Medical Center
Hospital for Joint Diseases
Hospital for Special Surgery
Jewish Memorial Hospital
Lenox Hill Hospital
New York University Medical Center
Presbyterian Hospital in the City
of New York
Bronx Lebanon
Mount Sinai Hospital
Lincoln Medical and Health Center
Misericordia Hospital Medical Center
Montefiore Hospital and Medical Center
Middletown Psychiatric Center
St Barnabas Hospital

Lawrence Hospital
Northern Westchester Hospital Center
New Rochelle Hospital Medical Center
Phelps Memorial Hospital
United Hospital
Rockland Psychiatric Center
The New York Hospital-Cornell Medical Ctr
Horton Memorial Hospital
St. Francis Hospital
Vassar Brothers Hospital
Benedictine Hospital
Kingston Hospital
Westchester County Medical Center
St. John's Riverside Hospital
Burke Rehabilitation Center
Pelham Bay General Hospital

Northern Metropolitan Hospital Association
Bronx County Medical Society

Bronx Veterans Administration Medical Center
Castle Point Veterans Administration Medical Center
Manhattan Veterans Administration Medical center
Montrose Veterans Administration Medical Center

Keller Army Community Hospital-West Point

APPENDIX C

SAMPLE ARTICLE EXPLAINING THE MOOD OF THE
HEALTH CARE PUBLIC TO CMCHS AS IMPLEMENTATION
IS INTRODUCED TO NEW YORK

THE NEW YORK TIMES, TUESDAY, SEPTEMBER 21, 1982

City Area's Hospitals Urged To Allocate Beds in Wartime

By RONALD SULLIVAN

The Department of Defense asked hospitals in the New York area yesterday to allocate a percentage of their beds to the care of American military casualties in the event of a conventional, non-nuclear war overseas.

However, the president of the Greater New York Hospital Association, which represents public and private non-profit hospitals in the city, said each institution would have to decide for itself whether to allocate any beds for the system.

"But my personal view," said the group's president, Dr. S. David Pomrinne, "is that, in the event of a war and plane loads of military wounded begin arriving at Kennedy Airport, we have to have plans to take care of them."

Pentagon officials had saved the New York area as their final stop in a two-year nationwide effort to allocate about 50,000 hospital beds for military use under the voluntary Civilian-Military Contingency Hospital System.

Military Hospitals Lacking

One reason they kept this area for last, the officials said, was that it lacks large military hospitals and thus civilian institutions would have to play a larger role in the contingency system.

They said another reason New York had been kept for last was that the Pentagon expected even more opposition than in the Boston and San Francisco areas, where antiwar groups said the plan was a guise for preparing the country for the possibility of a nuclear war.

Dr. Jonathan Lorch, president of the New York chapter of Physicians for Social Responsibility, a group of physicians opposed to the spread of nuclear weapons, said there was "no way to

stop a conventional war from turning into a nuclear holocaust, and any plan that does not recognize that is irrelevant."

"We cannot support in any way any proposal which makes nuclear war a possibility or perpetuates the illusion of its survivability," the chapter said in a statement.

'A Propaganda Effort'

Speaking for seven medical colleges in the New York area, Dr. Ephraim Friedman, dean of Yeshiva University's Albert Einstein College of Medicine, said the Pentagon's plan had "no real meaning except as a propaganda effort that suggests we have the medical capability to deal with the millions of casualties that would result from a nuclear war."

"This is a dangerous attitude," Dr. Friedman said, "that could make it easier for the military to contemplate war."

Comdr. Richard J. Lambert of the Navy's Medical Service Corps and deputy director of the contingency system, said he recognized the "legitimate concerns" of protest groups. He conceded that no one could guarantee that a conventional conflict would not become a nuclear war.

Commander Lambert said that, with the support of the American Hospital Association and the American Medical Association, 560 hospitals in 44 areas across the country had allocated 48,000 beds to the program. Hospitals participating in the program are asked to take part in preparation drills once a year.

He said the New York area was important because it had 200 hospitals with a total of 85,000 beds.

THE NEW YORK TIMES, TUESDAY, SEPTEMBER 21, 1982

APPENDIX D

MAPS

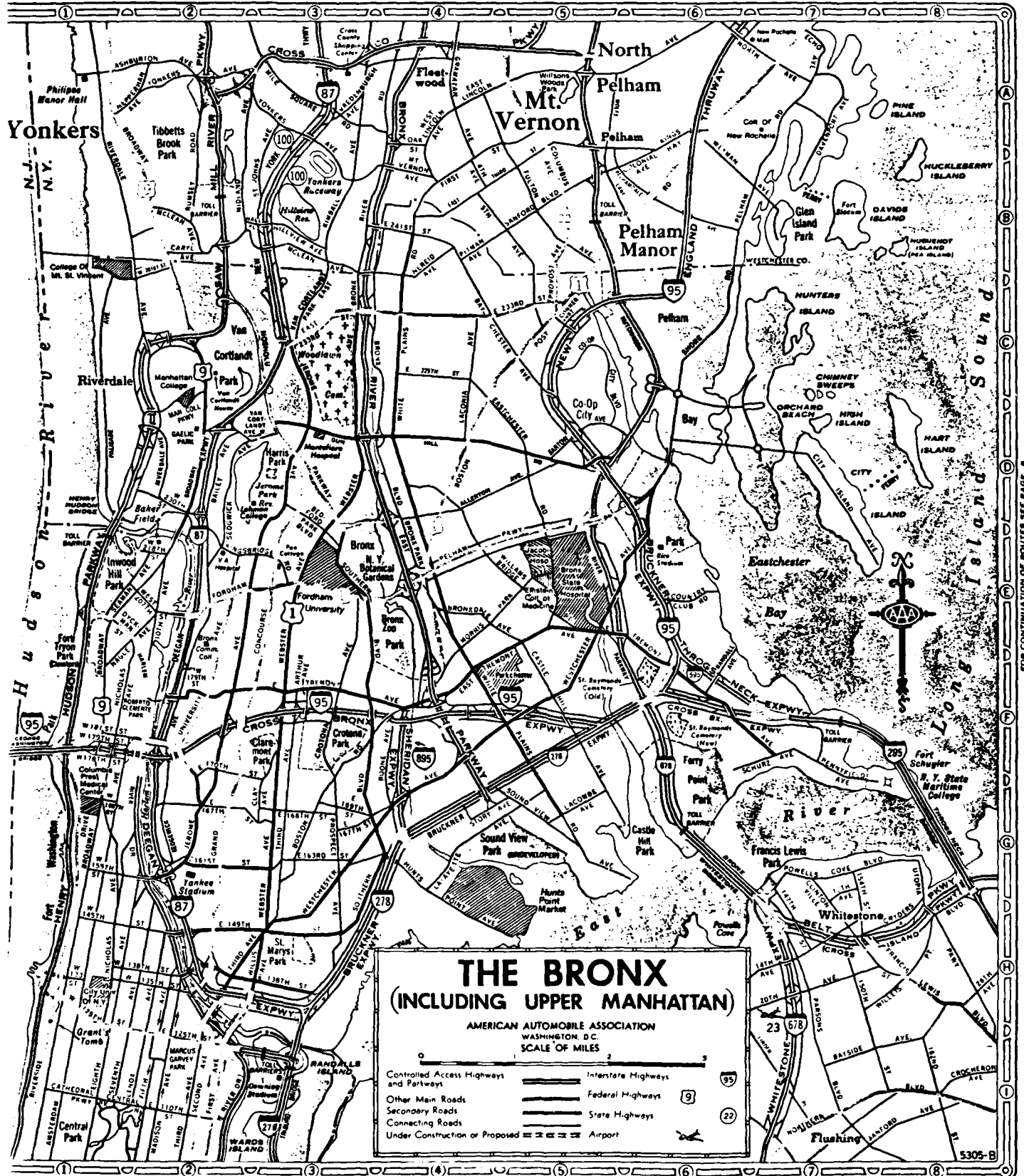
BRONX VAMC AREA

BRONX COUNTY

Bronx Lebanon
 Bronx Psychiatric Center
 Bronx Municipal Hospital Center
 Montefiore Hospital
 North Central Bronx Hospital
 Pelham Bay General
 Prospect Hospital
 Saint Barnabas Hospital
 Misericordia Hospital and Medical Center
 Union Hospital
 Westchester Square

MANHATTAN (Northern)

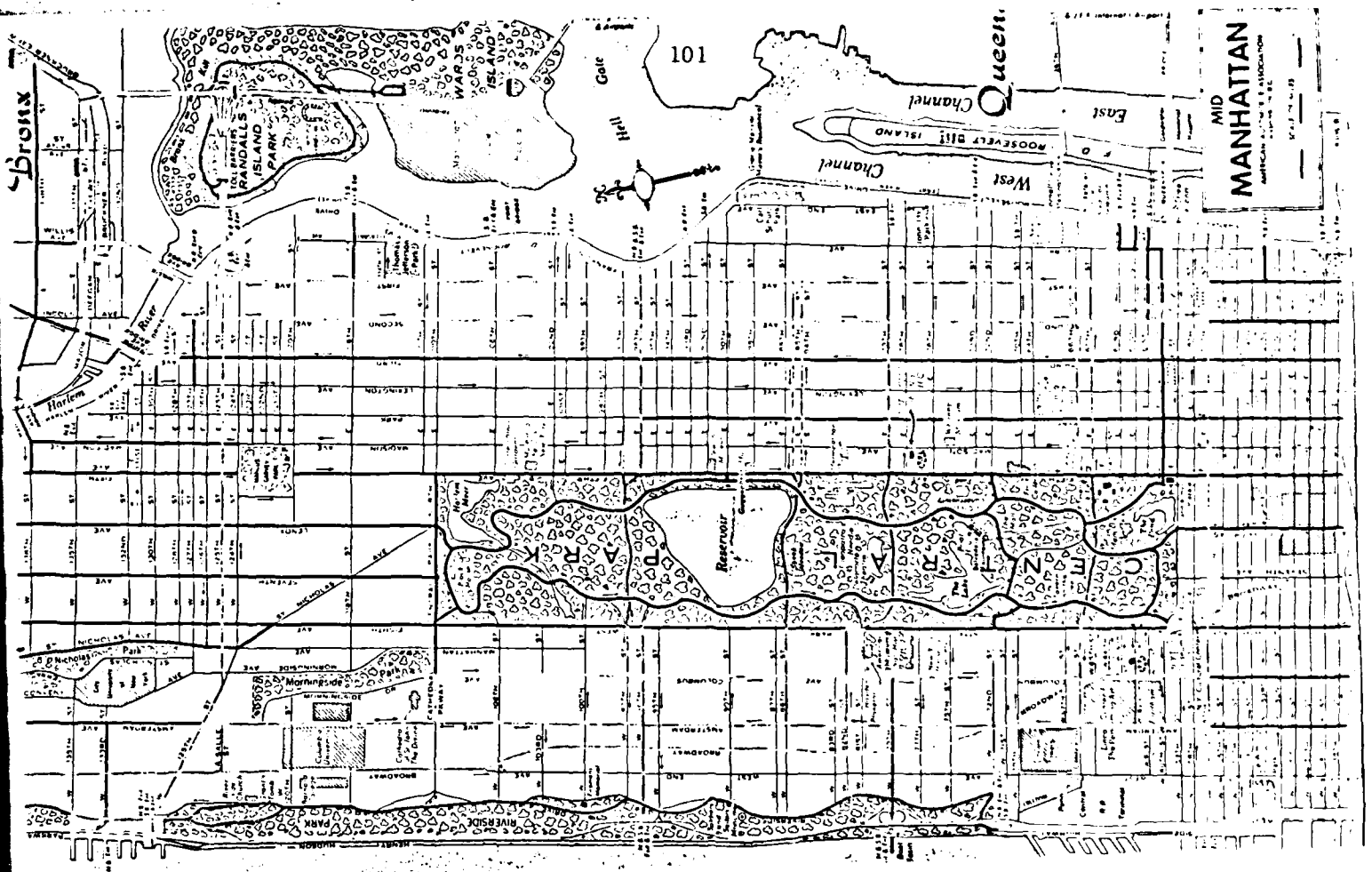
Mount Sinai Hospital (coordinate with Manhattan VAMC)



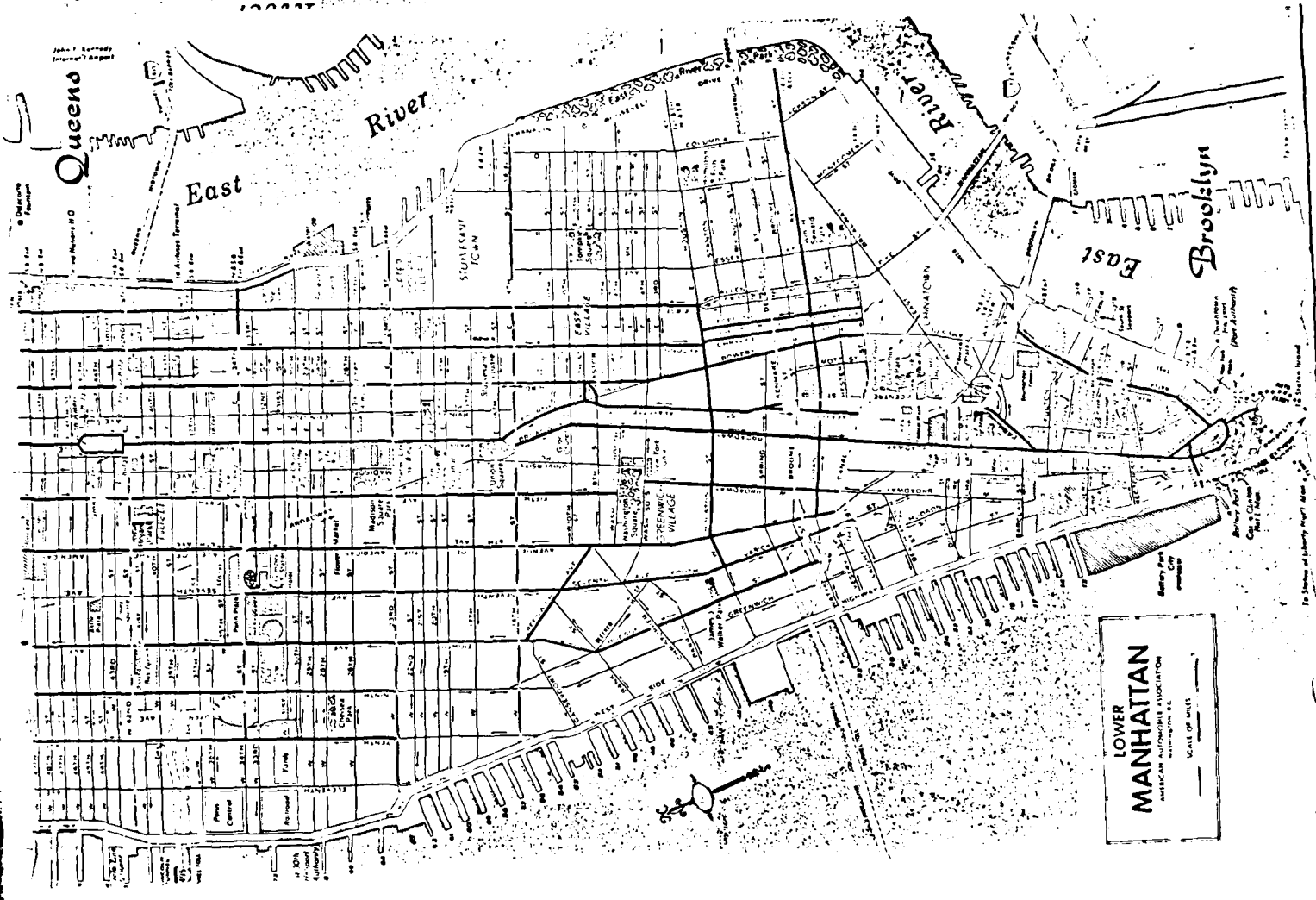
MANHATTAN VAMC AREA

MANHATTAN

Bellevue Hospital Center
Beth Israel Medical Center
Cabrini Medical Center
Doctors Hospital
Gracie Square Hospital
Harlem Hospital Center
Hospital for Joint Diseases
Hospital for Special Surgery
New York Infirmary-Beekmen Downtown Hospital
New York University Medical Center
Presbyterian Hospital
Society of New York Hospital
Saint Clare's Hospital and Medical Center
Saint Luke's-Roosevelt Hospital
Saint Vincent's Hospital and Medical Center
Jewish Memorial Hospital
Lenox Hill Hospital
Manhattan Eye, Ear, and Throat Hospital
Manhattan Psychiatric Center
Memorial Hospital
Metropolitan Hospital Center
Mount Sinai Hospital
New York Eye and Ear Infirmary
VAMC-Manhattan



MID
MANHATTAN
AMERICAN ASSOCIATION
OF GEOGRAPHERS
1947



LOWER
MANHATTAN
AMERICAN ASSOCIATION
OF GEOGRAPHERS
1947

CASTLE POINT VAMC AREA

ULSTER COUNTY

Kingston - Benedictine Hospital
Kingston Hospital

DUTCHESS COUNTY

Castle Point - Castle Point VAMC

Wingdale - Harlem Valley Psychiatric Center

Poughkeepsie - Saint Francis Hospital
Vassar Brothers Hospital

*Rhinebeck - Northern Dutchess Hospital - *Assigned to Montrose VAMC

ORANGE COUNTY

Cornwall - Cornwall Hospital

Goshen - Arden Hill Hospital

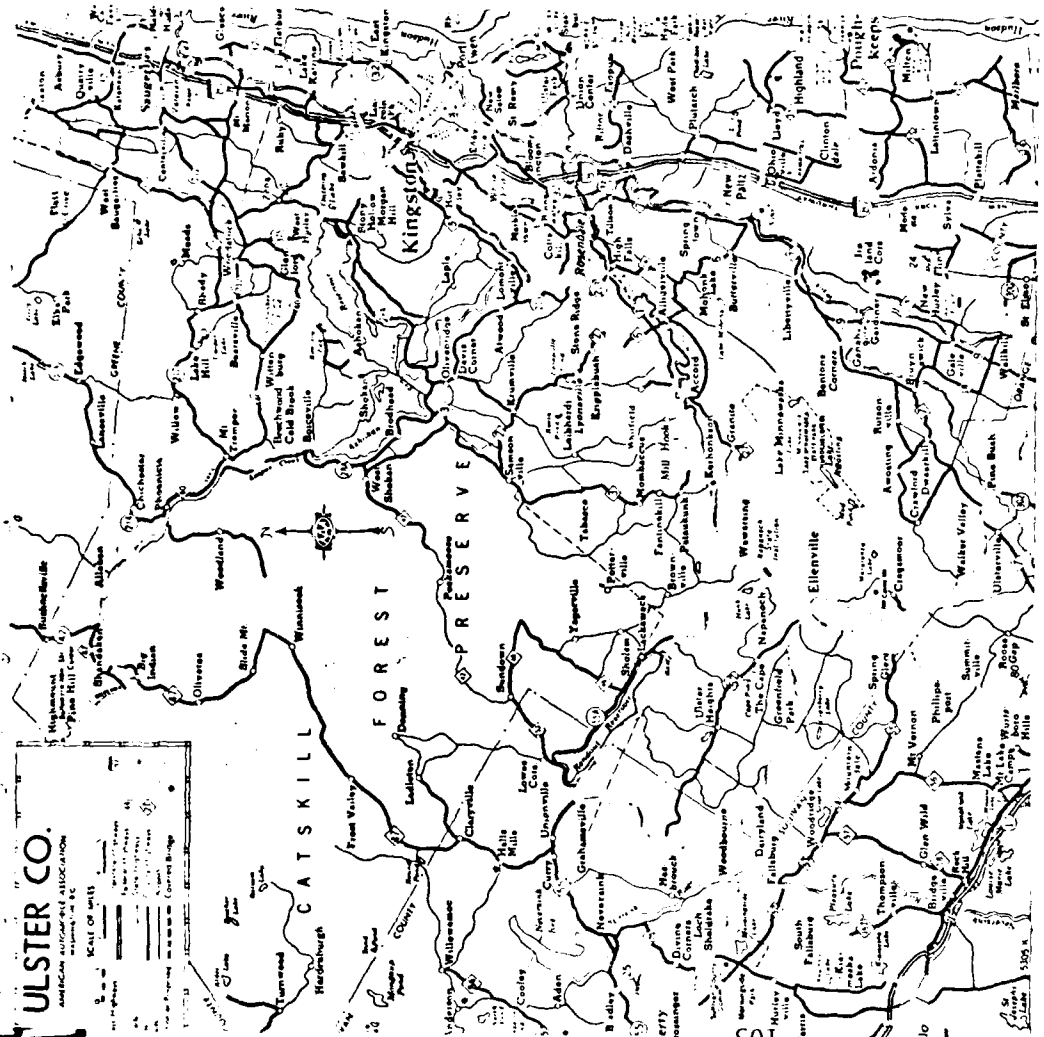
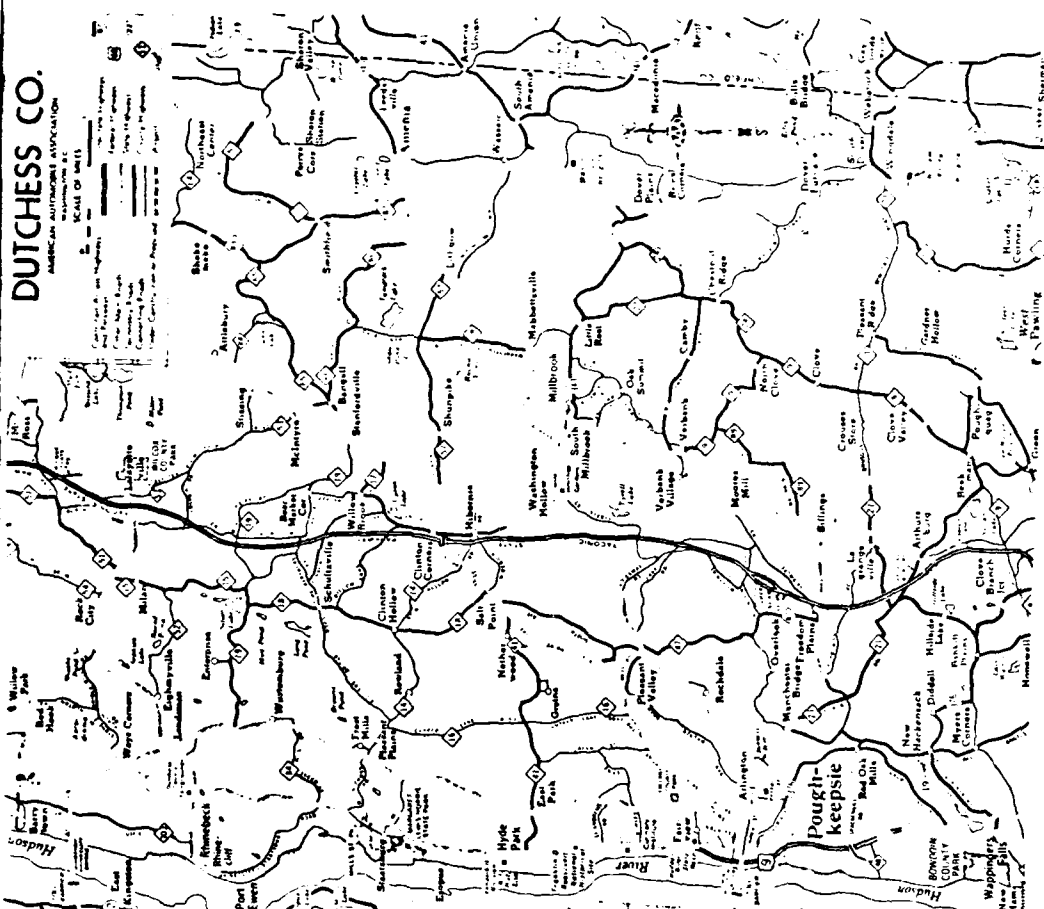
Middletown - Horton Hospital
Middletown Psychiatric Center

Newburgh - Saint Lukes Hospital

*West Point - DOD Coordinating Agent for Northern New York Region
Keller Army Community Hospital

DUTCHESS CO.

AMERICAN AUTOMOBILE ASSOCIATION
 1934 EDITION
 SCALE OF MILES
 0 1 2 3 4 5 6 7 8 9 10



ULSTER CO.

AMERICAN AUTOMOBILE ASSOCIATION
 1934 EDITION
 SCALE OF MILES
 0 1 2 3 4 5 6 7 8 9 10

MONTROSE VAMC AREA

WESTCHESTER COUNTY

White Plains - Burke Rehabilitation Center
 New York Hospital
 Saint Agnes Hospital
 Lawrence Hospital

Yonkers - Saint John's Riverside Hospital
 Saint Joseph's Medical Center
 Yonkers General Hospital

Mount Vernon - New Rochelle
 Mount Vernon Hospital

Port Chester - United Hospital

Mount Kisco - Northern Westchester Hospital Center

Tarrytown - Phelps Memorial Hospital Center

Peekskill - Peekskill Memorial Hospital Center
 Peekskill Community Hospital

Montrose - Montrose VAMC

ROCKLAND COUNTY

Haverstraw - Helen Hayes Hospital

Suffern - Good Samaritan Hospital

Orangeburg - Rockland Community Hospital

Nyack - Nyack Hospital

PUTNAM COUNTY

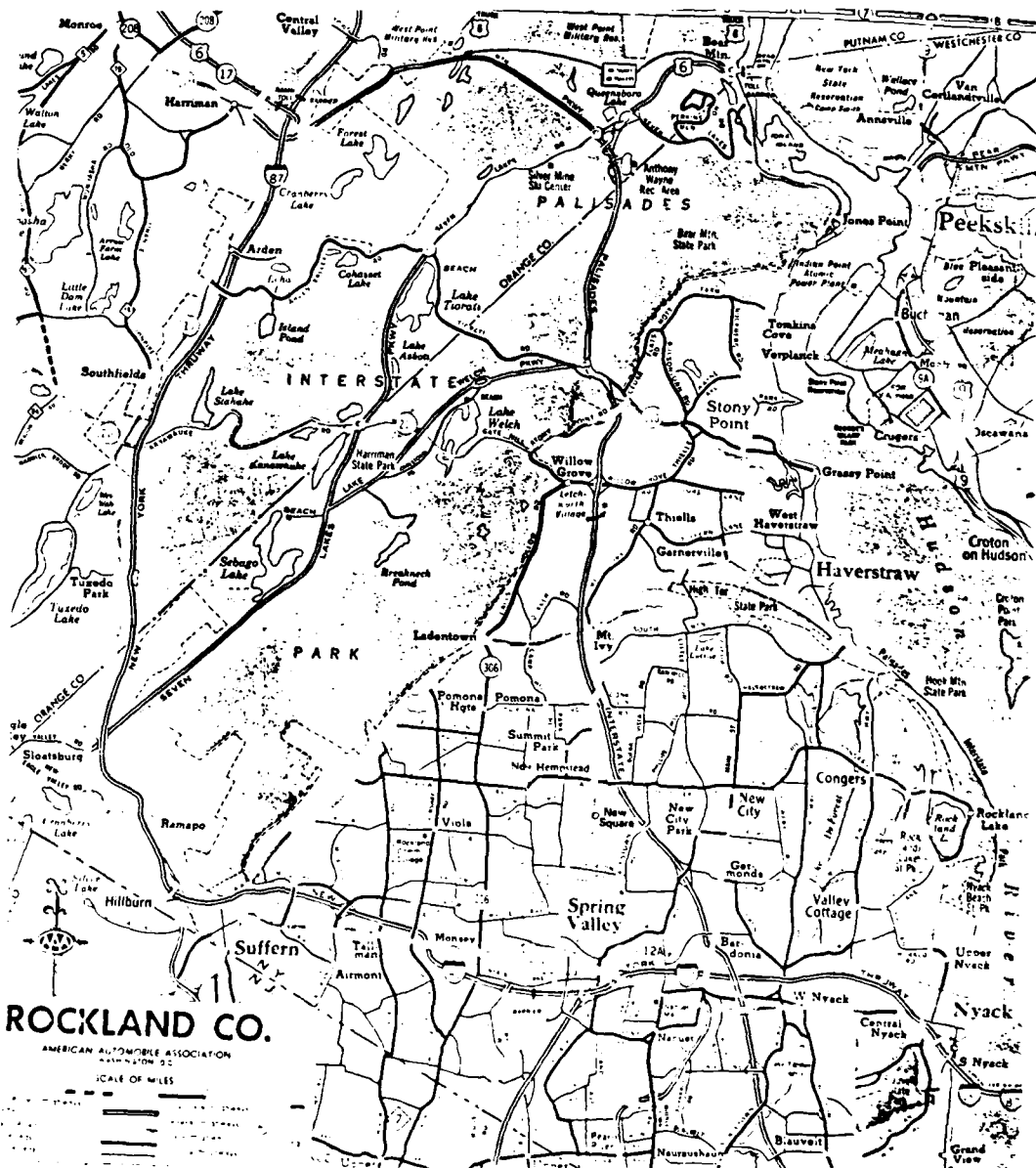
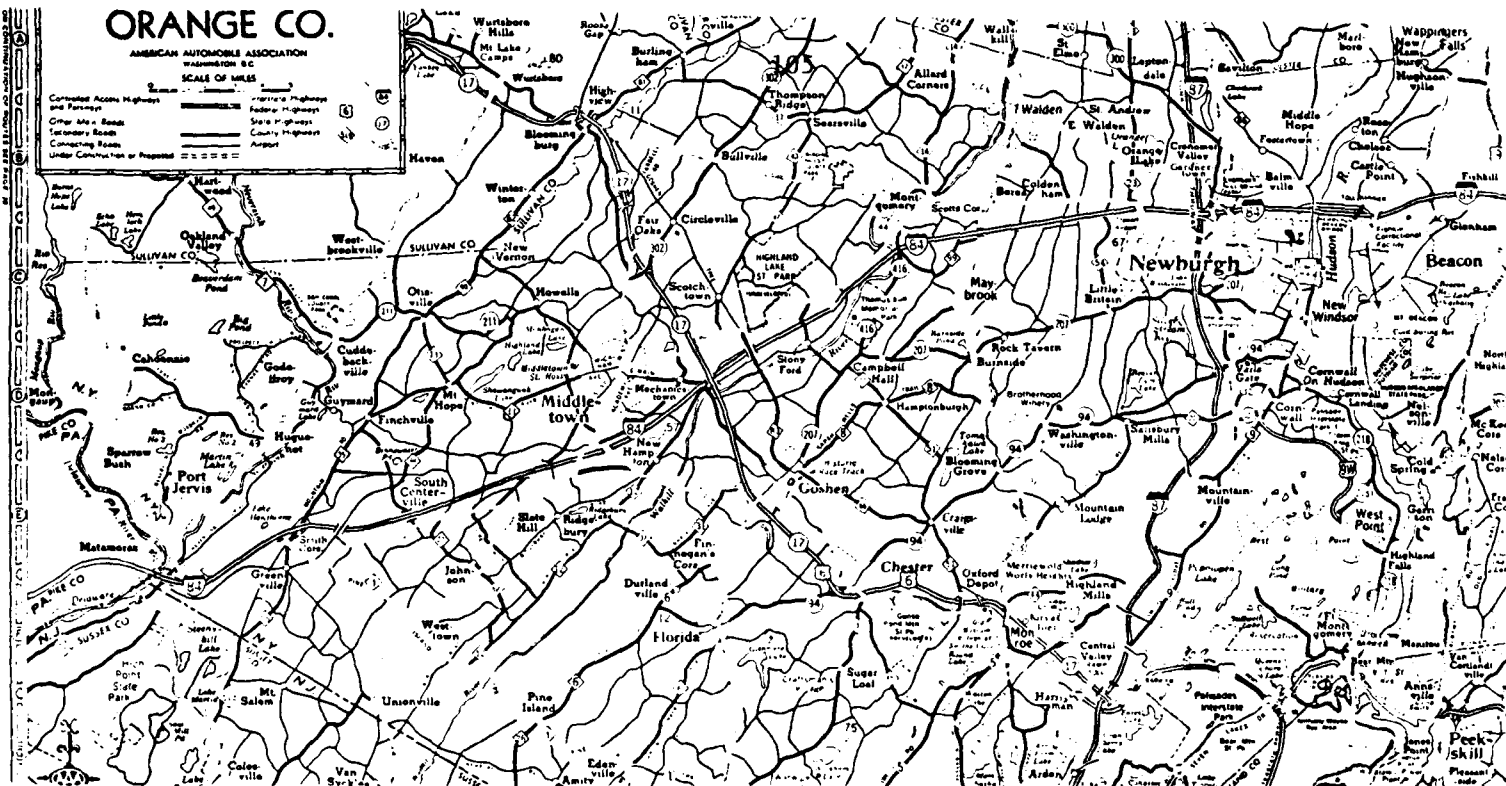
Carmel - Putnam Hospital Center

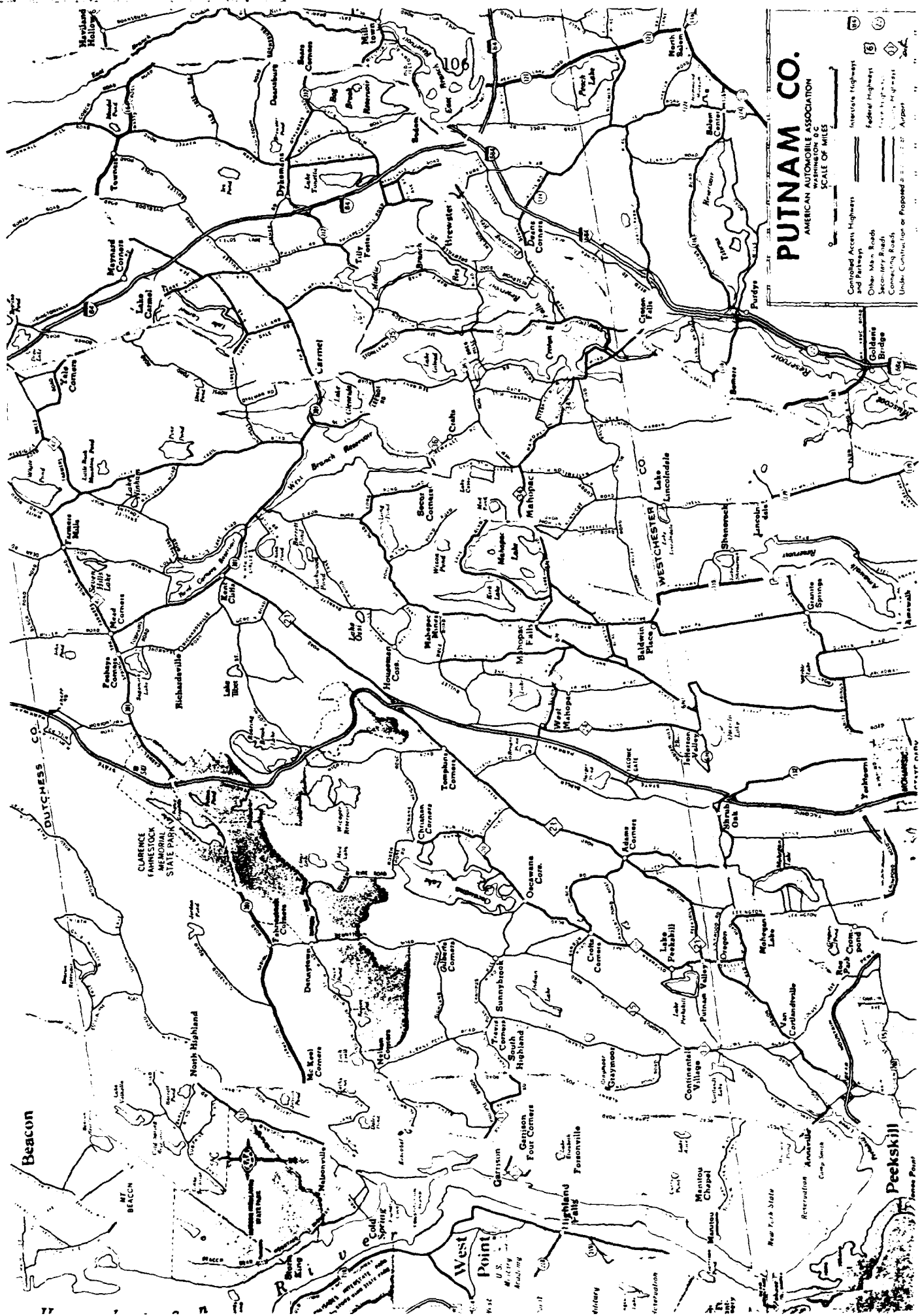
ORANGE CO.

AMERICAN AUTOMOBILE ASSOCIATION
WASHINGTON D.C.

SCALE OF MILES

Continental Access Highways
State Highways
County Highways
Under Construction or Proposed

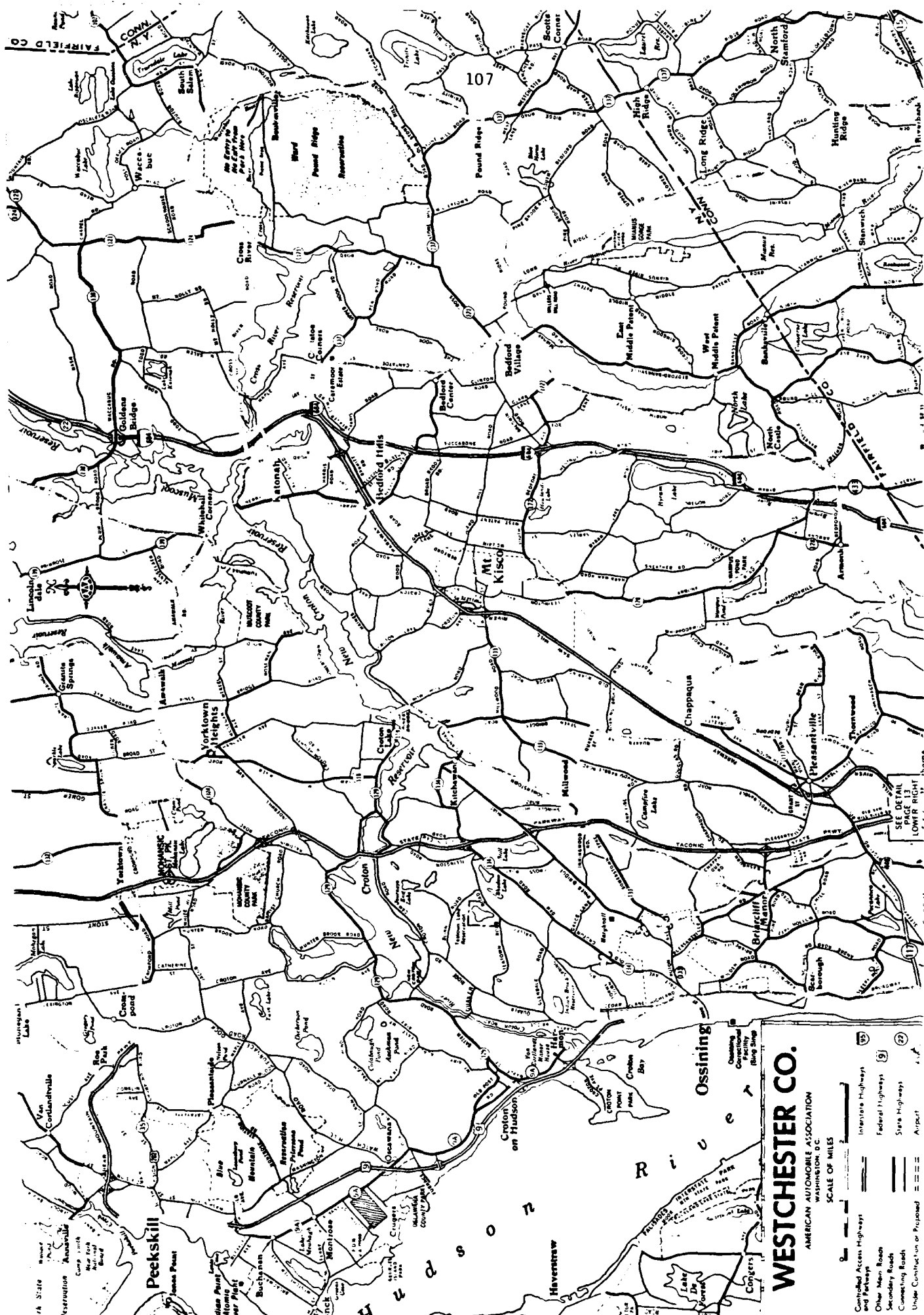




PUTNAM CO.

AMERICAN AUTOMOBILE ASSOCIATION
WASHINGTON, D. C.
SCALE OF MILES

- Controlled Access Highway
- Other Main Road
- Secondary Road
- Connecting Road
- Under Construction or Proposed
- Interstate Highway
- Federal Highway
- State Highway
- County Highway
- Airport

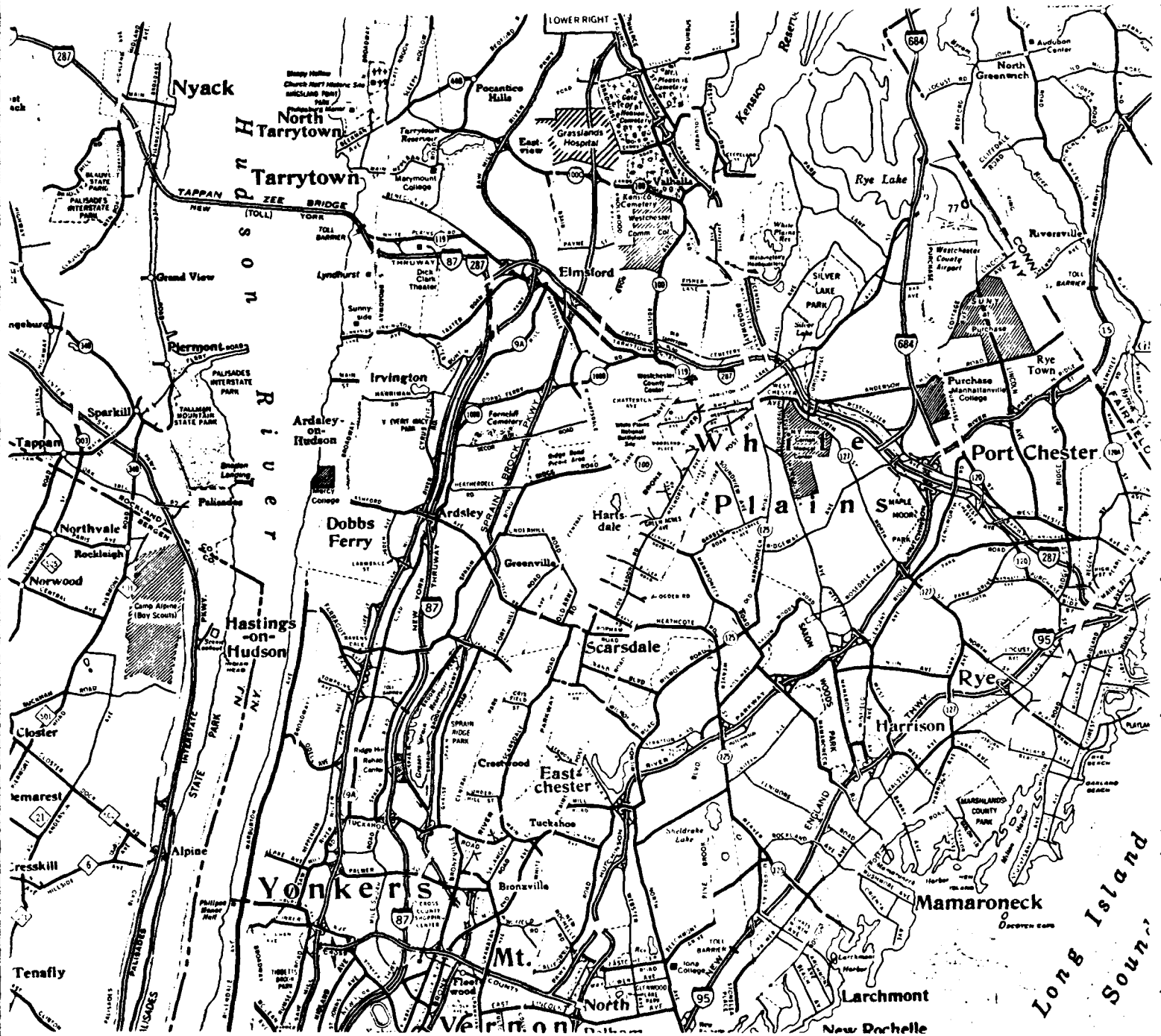


WESTCHESTER CO.

AMERICAN AUTOMOBILE ASSOCIATION
WASHINGTON, D.C.

SCALE OF MILES

- Controlled Access Highways
- Interstate Highways
- Federal Highways
- State Highways
- Airport
- Other Main Roads
- Secondary Roads
- Connecting Roads
- Under Construction or Proposed



APPENDIX E

DOD MEDICAL FACILITIES SURVEYED
TO DETERMINE ORGANIZATIONAL SUPPORT
STRUCTURE IN OPERATION FOR CMCHS
(PRELIMINARY COMPARISON OF PRESENT SYSTEMS)

DOD Medical Facilities Surveyed
To Determine Supportive Structure For CMCHS

Letterman Army Medical Center

Madigan Army Medical Center

Walter Reed Army Medical Center

William Beaumont Army Medical Center

MEDDAC - Fort Devens - Cutler Army Community Hospital

MEDDAC - Fort Jackson - Moncrief Army Community Hospital

MEDDAC - Fort Leavenworth - Munson Army Community Hospital

MEDDAC - Fort Monmouth - Patterson Army Community Hospital

Great Lakes Naval Regional Medical Center

Scott Air Force Base Hospital

APPENDIX F

SAMPLE FOLLOW-UP LETTER
FOR CMCHS RELATED DATA



DEPARTMENT OF THE ARMY
U. S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

REPLY TO
ATTENTION OF:

HSUD

8 September 1982

CPT Michael DeCesare
USA MEDDAC
ATTN: HSXF-0
Fort Devens, Massachusetts 01433

The purpose of this letter is to serve as a follow-up request for implementation data concerning the Civilian-Military Contingency Hospital System. During our recent telephonic conversation we discussed the potential value that status reports, memoranda of agreement and understanding, letters of solicitation, draft operations plans and personal recollections of lessons learned might have for assisting our program development in the New York area.

Cutler's success in identifying and consigning hospital beds has been accomplished through a great deal of work and perseverance. Your expressed willingness to share program experience with the West Point MEDDAC is deeply appreciated. We at West Point stand ready to reciprocate, so please do not hesitate to call on us in the future.

Thank you again for your support in helping us confront this complex and important mission of building a cooperative military-civilian safety net of quality medical care.

Sincerely,

JOSEPH G. FLANNERY
CPT, MSC
Administrative Resident

APPENDIX G

COPY OF A

MEMORANDUM OF UNDERSTANDING

BETWEEN AN AREA VA MEDICAL CENTER
AND KELLER ARMY COMMUNITY HOSPITAL

MEMORANDUM OF UNDERSTANDING
BETWEEN
VETERANS ADMINISTRATION MEDICAL CENTER, MONTROSE
AND
THE US KELLER ARMY COMMUNITY HOSPITAL, WEST POINT, NY 10996

SUBJECT: The Civilian Military Contingency Hospital System

1. PURPOSE: This Memorandum of Understanding (MOU) is to provide a basis for coordination between the Veterans Administration Medical Center, Montrose and the US Keller Army Community Hospital, West Point, New York in the execution of the Civilian Military Contingency Hospital System (CMCHS).

2. REFERENCES:

a. Section 266, title 38, US Code, Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, 25 Jan 82.

b. DOD Directive 5126.9, CMCHS, 2 Jan 80.

c. AR 1-35, Basic Policies and Principles for Interservice, Inter-Department and Interagency Support, June 73.

d. Health Services Command Regulation, 10-1, Organization and Functions.

3. SCOPE: This MOU applies to the signatory Army medical facility and the Veterans Administration Medical Center in the area of implementation and maintenance of the CMCHS during peacetime and after mobilization of US Army Forces.

4. Veterans Administration Responsibilities:

a. Appoint a staff member as CMCHS point of contact to maintain liaison with the West Point Army Hospital, represent the Veterans Administration Medical Center Montrose, and to coordinate with designated civilian hospitals, matters related to CMCHS.

b. Assist the West Point Army Hospital in the coordination of CMCHS agreements (MOU) with designated civilian hospitals.

c. Assist in obtaining MOU signatures and bed commitments from designated civilian hospitals. Maintain and update consolidated changes and forward to the West Point Army Hospital before the end of each month.

d. Conduct CMCHS briefings as requested by designated civilian hospitals to assist them in determining participation in the system.

e. In coordination with the West Point Army Hospital Public Affairs Officer, assist in the preparation of press releases and in the handling of publicity.

f. Assist with the development of the CMCHS educational program.

g. In conjunction with the West Point Army Hospital, assist in the development of a local area operation plan.

h. Conduct an annual CMCHS exercise with designated participating civilian hospitals and provide an after action report to the West Point Army Hospital. This report will be forwarded to HQ, Health Services Command and to the office of the Assistant Secretary of Defense (Health Affairs).

i. Absorb minor costs associated with local implementation of CMCHS (administration, travel, etc.).

j. If required, provide space and administrative assistance to active or reserve military CMCHS coordinator.

5. Keller Army Community Hospital, West Point, New York Responsibilities:

a. Serve as DOD Executive Agent for CMCHS in the local area. Plan, program, coordinate, and execute the implementation of and maintain the CMCHS program for the designated area.

b. Designate civilian hospitals and areas that the Veterans Administration Medical Center, Montrose, will be responsible for assisting.

c. Appoint a CMCHS coordinator to establish liaison with the Veterans Administration Medical Center, Montrose, point of contact.

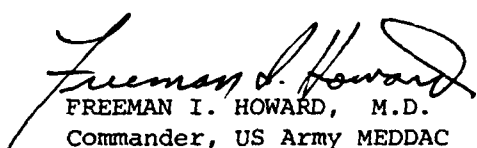
d. Provide technical guidance concerning the CMCHS program.

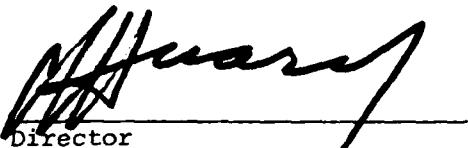
e. Maintain a complete consolidated list of bed commitments based on the Veterans Administration Medical Center, Montrose, input.

f. Coordinate with the Veteran Administration Medical Center Montrose, the release of information concerning CMCHS.

g. Write and maintain the area Operations Plan in conjunction with the Veterans Administration Medical Center, Montrose. The plan will include a coordinated effort in establishing procedures, to receive, sort and transport patients arriving in the designated area.

- h. Coordinate the development of the CMCHS educational program.
- i. Plan and conduct an annual CMCHS exercise in conjunction with the Veterans Administration Medical Center, Montrose.
- j. Absorb costs associated with implementation of the CMCHS program.
- k. Assist the civilian providers with the billing procedures and patient and personnel administration requirements.


FREEMAN I. HOWARD, M.D.
Commander, US Army MEDDAC
West Point, New York
Keller Army Community Hospital


Director
Veterans Administration
Medical Center, Montrose

APPENDIX H

HOSPITAL SIGNING DATA AND A SAMPLE MOU
FOR PHASE I OF CMCHS IMPLEMENTATION

Agreements Received During the
Initial Strategy Phase of CMCHS

<u>Hospital</u>	<u>Date Signed</u>	<u>Minimum Beds</u>
New Rochelle Medical Center	Oct 2, 1982	50
Arden Hill Hospital	Oct 18, 1982	50
Pelham Bay General Hospital	Oct 20, 1982	50
Cabrini Medical Center	Oct 22, 1982	50
Manhattan Psychiatric Center	Oct 27, 1982	50
	Total	250

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE DEPARTMENT OF DEFENSE, THE VETERANS ADMINISTRATION
AND
NEW ROCHELLE MEDICAL CENTER

The United States has long prided itself on being able to care for its sick and wounded Armed Services personnel at all times and particularly in times of war. In recognition of this National goal, the Department of Defense must continually seek to maintain a sufficient medical resource in reserve to care for its sick and wounded. The weapons of modern warfare may now create heretofore unknown numbers of American casualties in a zone of war. This potential medical demand makes it imperative that the Secretary of Defense seek additional sources of medical care for U.S. servicemen and servicewomen in the time of a conflict.

While no doubts exist about the response which could be expected from the medical community of the United States during a time of war, the possibility of short warning times and the need for unusually complex transportation, treatment, and hospitalization linkages require development of a comprehensive plan whereby some sick and wounded Service personnel would receive definitive treatment in civilian hospitals located throughout the United States.

New Rochelle Medical Center agrees that upon notification during a state of national emergency as declared by the President it will make available to the Department of Defense 50 beds with all necessary treatment and administrative processing as may be required for the patients hospitalized therein; and, for its part, the Department of Defense agrees to compensate at the hospital's regular charges New Rochelle Medical Center for its patient care services at the time said services are provided.

By this Memorandum of Understanding, the Department of Defense, the Veterans Administration and New Rochelle Medical Center mutually agree to jointly plan for the admission, treatment, hospitalization and discharge of all active duty military patients transferred to New Rochelle Medical Center under the Department of Defense Civilian-Military Contingency Hospital System (CMCHS). In addition, New Rochelle Medical Center agrees to participate in a joint annual exercise of CMCHS which will be approved by the Joint Commission of the Accreditation of Hospitals.

For the purpose of facilitating the Department of Defense Civilian-Military Contingency Hospital System, the Commander,

Keller US Army Community Hospital, West Point, New York, will represent the Department of Defense. The Veterans Administration will be represented by Corydon F. Heard, Jr.

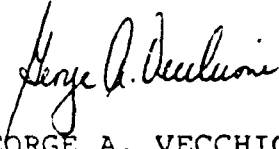
This agreement can be cancelled by either party by written notice.

FOR THE DEPARTMENT OF DEFENSE:


FREEMAN I. HOWARD, M.D.
Colonel, Medical Corps
Commander, Keller Army Hospital
DoD Executive Agent

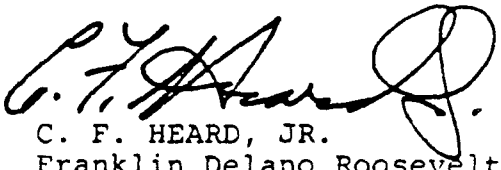
Date: 15 Oct 1982

FOR NEW ROCHELLE MEDICAL CENTER:


GEORGE A. VECCHIONE
Administrator
New Rochelle Medical Center
16 Guion Place
New Rochelle, N.Y.

Date: 11/1/82

FOR THE VETERANS ADMINISTRATION


C. F. HEARD, JR.
Franklin Delano Roosevelt VA Hospital
Montrose, N.Y.

Date: Oct 5, 1982

APPENDIX I

SPECIFIC EMPLOYMENT OF THE DATA COLLECTION
AND SHARING NETWORK

Use of Data Collection Network
Graphically Depicted in Figure 7

The data collection and information network employed by West Point to evaluate ongoing CMCHS programs nationwide included all three services; Army, Navy, and Air Force, and was highly active during the period September 15, 1982 to February 14, 1983. Specifics as to personnel contacted and dates of interviews are provided below:

- I. Office of the Assistant Secretary of Defense Health Affairs
 - A. LTC Podge M. Reed, Jr., Director, CMCHS, OASD(HA)
September 14, 1982, September 21, 1982
 - B. LCDR William Lambert, Deputy Director, CMCHS, OASD(HA)
September 16, 1982, October 7, 1982, November 11, 1982
- II. Office of The Surgeon General Army
 - A. Major Walter Wells, Plans Officer, OTSG, Medical Operations
January 13, 1983
 - B. LTC Peter Mekkelson, Plans Officer OTSG, Medical Operations
January 25, 1983
- III. US Army Health Services Command
 - A. LTC Robert Collins, HSC, HSOP-S, Chief Plans, Training and History Branch
September 21, 1982, November 10, 1982
 - B. Major J. Broach, HSC, HSOP-S, Training Officer
September 14, 1982, October 8, 1982, October 26, 1982
November 11, 1982, November 18, 1982, December 13, 1982
January 19, 1983, February 8, 1983
- IV. Army CMCHS Programs
 - A. Brooke Army Medical Center

LTC John M. Kamenar Jr, C, Plans, Operations, and Training (PO&T)
February 8, 1983
 - B. Letterman Army Medical Center

Major Bruce Furbish, C, PO&T
February 9, 1983

C. Madigan Army Medical Center

LTC Harry A. Wisdom, C, PO&T
February 14, 1983

D. William Beaumont Army Medical Center

Major William A. Matheson, C, PO&T
February 7, 1983

E. Walter Reed Army Medical Center

Major G.S. Mobley, Project Offficer CMCHS
October 21-22, 1982, February 10, 1983

F. Fort Devens MEDDAC

CPT Michael DeCesare, C, PO&T
September 16, 1982, February 10, 1983

G. Fort Jackson MEDDAC

Major Charles A. Krebs Jr., C, PO&T
February 7, 1983

H. Fort Leavenworth MEDDAC

CPT Timothy J. Jordan, C, PO&T
September 15, 1982, September 21, 1982 (Departed Dec 82)
CPT Dainley, C, PO&T
February 11, 1983

I. Fort Monmouth MEDDAC

LTC R. Hahn, Executive Officer
November 10, 1982, November 23, 1982, February 7-8, 1983
February 14, 1983

V. Air Force CMCHS Programs

A. Scott Air Force Base, St. Louis, Missouri

LTC Turk, Associate Administrator
February 11, 1983

B. Wright Patterson Air Force Base, Dayton, Ohio

Major J.L. Erwin, Associate Administrator
February 9, 1983

VI. Navy CMCHS Programs

Great Lakes Naval Regional Medical Center, Great Lakes, Illinois
CDR Jeffrey W. Baldwin, USN, Director of Administrative Services
January 21, 1983

APPENDIX J

FULL RANGE OF CMCHS RELATED ACTIVITIES

SURVEYED DURING PHASE I

OF CMCHS IMPLEMENTATION

CMCHS Related Activities Surveyed
During Phase I

- I. Department of Defense - Office of the Assistant Secretary of Defense (Health Affairs)
- II. The Office of The Surgeon General - US Army - Medical Operations
- III. US Army Health Services Command - Operations (HSOP)
- IV. Federal Hospitals
 - a. Army
 - 1. Brooke Army Medical Center
 - 2. Letterman Army Medical Center
 - 3. Madigan Army Medical Center
 - 4. Walter Reed Army Medical Center
 - 5. William Beaumont Army Medical Center
 - 6. Cutler Army Community Hospital-Fort Devens
 - 7. Moncrief Army Community Hospital-Fort Jackson
 - 8. Munson Army Community Hospital-Fort Leavenworth
 - 9. Patterson Army Community Hospital-Fort Monmouth
 - b. Navy
 - Great Lakes Naval Regional Medical Center
 - c. Air Force
 - 1. Scott Air Force Base
 - 2. Wright Patterson Air Force Base
- V. Veterans Administration
 - 1. Atlanta, Georgia
 - 2. Houston, Texas
 - 3. Portland, Oregon

APPENDIX K

DATA GATHERED AS A RESULT OF REPORTS
AND INTERVIEWS (SEVEN DATA CATEGORIES)
SEPTEMBER 15, 1982 - FEBRUARY 14, 1983

Data Gathered As A Result of Reports
And Telephonic Interviews
September 15, 1982 - February 14, 1983

General Classification of Data

Federal Hospital	Command Support	Management Structure	Use of Local Associations	VA Support	Community Acceptance	Auth Size vs Beds	Size of Mission # of Area Hospitals	Personal Visits
MEDCEN or MEDDAC								
<u>ARMY</u>								
Walter Reed Army Medical Center Baltimore	Excellent	Separate Project Office	Yes	Yes	Positive	980	29	All or Most
Letterman Army Medical Center San Francisco	Excellent	Additional Function, PO&T	Yes	No	Negative	366	20	All or Most
William Beaumont Army Medical Center El Paso	Excellent	Additional Function, PO&T	No	No	Positive	483	7	All or Most
Madigan Army Medical Center Tacoma/Seattle	Excellent	Additional Function, PO&T	No	No	Weak Negative	411	23	Few if Any
Brooke Army Medical Center San Antonio	Excellent	Additional Function, PO&T	Yes	No	Positive	691	6	All or Most
Fort Jackson Moncrief Army Hospital Columbia, SC	Fair	Additional Function, PO&T	Yes	Yes	Negative	209	14	Few if Any
Fort Leavenworth Munson Army Hospital Kansas City	Fair	Additional Function, PO&T	Yes	No	Positive	99	24	All or Most

MEDCEN or MEDDAC	Command Support	Management Structure	Use of Local Associations	VA Support	Community Acceptance	Auth Size vs Beds	Size of Mission # of Area Hospitals	Personal Visits
Fort Devens Cutler Army Hospital Boston	Excellent	Reinforced Project Office	Yes	No	Negative	68	59	All or Most
*Fort Monmouth Patterson Army Hospital Lower NY	Excellent	Executive Officer Directed	No	Yes	Negative	34	72	Few if Any
* Not to be included for evaluating success score								
<u>NAVY</u>								
Great Lakes Naval Regional Medical Center - Chicago	Excellent	Executive Officer Directed	Yes	No	Positive	136	115	All or Most
<u>AIR FORCE</u>								
Scott Air Force Base - St Louis	Excellent	Associate Administrator Directed	Yes	No	Positive	175	34	All or Most
Wright Patterson Air Force Base Dayton/Columbus/ Cincinnati	Excellent	Associate Administrator Directed	Yes	Yes	Negative	285	32	All or Most

APPENDIX L

EVALUATION OF CMCHS SUCCESS
IN ESTABLISHED PROGRAMS

Evaluation of CMCHS Program Success

Federal Hospital	Hospitals Eligible and Invited to Participate	Hospitals Electing Participation	Maximum Bed Consignment	DOD Directives Met
<u>ARMY</u>				
Walter Reed Army MEDCEN-WRAMC	29	19	1525	Yes
Letterman Army MEDCEN-LAMC	20	11	1035	No
William Beaumont Army MEDCEN-WBAMC	7	7	405	Yes
Madigan Army MEDCEN MAMC	23	14	914	Yes
Brooke Army MEDCEN-BAMC	6	4	200	Yes
Fort Jackson MEDDAC-Ft Jackson	14	8	550	Yes
Fort Leavenworth MEDDAC-Ft Leavenworth	24	16	1407	Yes
Fort Devens Ft Devens	59	35	2125	Yes
<u>NAVY</u>				
Great Lakes Naval Regional Medical Center-GLNRMHC	115	85	6855	Yes
<u>AIR FORCE</u>				
Scott Air Force Base Scott AFB	34	34	4100	Yes
Wright Patterson Air Force Base-W/PAFB	32	34	3409	Yes

Evaluation based on percent of eligible hospitals signed and average bed contribution achieved. In addition, satisfaction of DOD directives achieved to date (Basic exercise completed) was considered. Weighing of the evaluation criteria was as indicated below:

Percent of eligible hospitals signed	.5
Average bed contribution - 100	.3
Satisfaction of DOD directives	.2
	Yes .3
	No .1

	% Signed x .5	+ Average Bed Contribution x .3	+ Directives x .2	= Total
WRAMC	.66 x .5 (.33)	+ .80 x .3 (.24)	+ .3 x .2 (.06)	= .63
LAMC	.55 x .5 (.28)	+ .94 x .3 (.28)	+ .1 x .2 (.02)	= .58
WBAMC	1.00 x .5 (.50)	+ .58 x .3 (.17)	+ .3 x .2 (.06)	= .73
MAMC	.61 x .5 (.31)	+ .65 x .3 (.20)	+ .3 x .2 (.06)	= .57
BAMC	.67 x .5 (.33)	+ .50 x .3 (.15)	+ .1 x .2 (.02)	= .50
Ft Jackson	.57 x .5 (.29)	+ .69 x .3 (.21)	+ .3 x .2 (.06)	= .56
Ft Leavenworth	.67 x .5 (.33)	+ .88 x .3 (.26)	+ .3 x .2 (.06)	= .65
Ft Devens	.59 x .5 (.30)	+ .61 x .3 (.18)	+ .3 x .2 (.06)	= .54
GLNRMC	.74 x .5 (.37)	+ .81 x .3 (.24)	+ .3 x .2 (.06)	= .67
Scott AFB	1.00 x .5 (.50)	+ 1.21 x .3 (.36)	+ .3 x .2 (.06)	= .92
W/PAFB	1.06 x .5 (.53)	+ 1.00 x .3 (.30)	+ .3 x .2 (.06)	= .89

Average Success Score = .66 -----> Cut-off Success Score Set At .60

Input from Fort Monmouth was considered but not included in the evaluation process due to the newness of that CMCHS effort.

Above Cut-off Score in Rank Order (High - Low)	Below Cut-off Score in Rank Order (High - Low)
---	---

Scott AFB

LAMC

W/P AFB

MAMC

WBAMC

Ft Jackson

Great Lakes

Ft Devens

Fort Leavenworth

BAMC

WRAMC

APPENDIX M

FISHERS EXACT TEST ANALYSIS
OF THE SEVEN DATA CATEGORIES

Fishers Exact Test
Analysis by Data Classification

Significance Level Set At .05

I. Command Support

Ho: Command support for the CMCHS program is independent of a CMCHS success score $\geq .60$

Ha: Not Independent

		Success		
		$\geq .60$	$< .60$	
Command Support	a		c	Excellent
	4		5	
	b		d	Fair
	1		1	

A = a + c 9 Use of Table A=9 B=2

B = b + d 2 Probability = .018
a=5, b=1
Probability $< .018+$

Result - Accept the Ho - Command Support for the CMCHS Program is independent of a CMCHS success score $\geq .60$

II. Management Structure

Ho: Management structure for the CMCHS program is independent of a CMCHS success score $\geq .60$

Ha: Not Independent

		Success		
		$\geq .60$	$< .60$	
Management Structure	a 2	c 4		PO&T
	b 4			
	d 1			Other

A = a + c 6 Use of Table A=6 B=5

B = b + d 5 Probability = .045+
a=2, b=4
Probability $< .045+$

Result - Accept the H_0 - Management structure for the CMCHS program is independent of CMCHS success score. $> .60$

III. Use of Local Associations

H_0 : The use of local health care associations for implementation of CMCHS is independent of a CMCHS success score $> .60$

H_a : Not Independent

		Success		
		$> .60$	$< .60$	
Use of Associations	a		c	Yes
	5		4	
	b		d	
	1		1	No

$$A = a + c \quad 9 \quad \text{Use of Table } A=9 \quad B=2$$

$$B = b + d \quad 2 \quad \text{Probability} = .018$$

$$a=5, b=1$$

$$\text{Probability} < .018$$

Result - Accept the H_0 - The use of local health care associations for implementation of CMCHS is independent of a CMCHS success score $> .60$.

IV. VA Support

H_0 : The active use of the VA is independent of CMCHS implementation success at a score $> .60$.

H_a : Not Independent

		Success		
		> .60	< .60	
Active VA Support	a	2	c	Yes
	b	4	d	
		4	4	No

$$A = a + c \quad 3 \quad \text{Use of Table } A=3 \quad B=8$$

$$B = b + d \quad 8 \quad \text{Probability} = .050$$

$$a=2, b=4 \quad .050$$

$$\text{Probability} < .050$$

Result - Accept the Ho - The active use of the VA is independent of CMCHS implementation success at a score $\geq .60$.

V. Community Acceptance

Ho: That community acceptance of the military is independent of CMCHS success at a score $\geq .60$.

Ha: Not Independent

		Success		
		$\geq .60$	$< .60$	
Community Acceptance	a	5	c	2
	b	1	d	3
				Positive
				Negative

A = a + c 7 Use of Table A=7 B=4

B = b + d 4
 Probability = .045+
 a=5, b=1
 Probability $< .045+$

Result - Accept the Ho - That community acceptance of the military is independent of CMCHS implementation success at a score $\geq .60$.

VI. Size vs Mission

Ho: That the relationship between DOD Facility Size and Assigned Mission is independent of CMCHS success at a score $\geq .60$.

Ha: Not Independent

		Success		
		$\geq .60$	$< .60$	
Size vs Mission (Beds to Hospitals Authorized in the Area)	a	4	c	2
	b	2	d	3
				< 16 to 1
				> 16 to 1

A = a + c 6 Use of Table A=6 B=5

B = b + d 5
 Probability = .015+
 a=5, b=1
 Probability .013+

Result - Accept the Ho - That the relationship between DOD Facility Size and Assigned Mission is independent at a score $< .60$.

VII. Personal Visits

Ho: That personal visits to eligible hospitals are independent of CMCHS success at a score $< .60$.

Ha: Not Independent

		Success	
		$> .60$	$< .60$
Personal Visits	a	c	All or Most
	6	3	
	b	d	Few if Any
	0	2	

A = a + c 9 Use of Table A=9 B=2

B = b + d 2 Probability = .018
 a=6, b=0
 Probability $< .018$

Result - Accept the Ho - That the personal visits to eligible hospitals are independent of CMCHS success at a score $> .60$.

APPENDIX N

EXERCISE SPECIFICS FOR THE THREE TYPES
OF CMCHS EXERCISES

Specifics of What Constitutes
CMCHS Exercises³⁶

I. The Basic Exercise

Basic objective - To familiarize key players with the CMCHS OPLAN's main elements. Should accomplish the following:

- A. Test Command and Control - Communication - System-Wide
- B. Test personnel alert and notification
- C. Assess establishment of emergency operations centers (EOC)
- D. Evaluate transportation requirements and capabilities
- E. Assess mechanisms for patient regulating (patient reception sorting and reporting bed availability)
- F. Evaluate systems for press management (electronic and print media)

II. The Intermediate Exercise

Basic objective - To implement (execute) the elements of the CMCHS OPLAN. Should accomplish those elements outlined above (Basic Exercise) plus the following:

- A. Evaluate EOC Operations to include staffing, locations, and ability to carry out command and control responsibilities.
- B. Assess the effectiveness and efficiency of the patient reception facility(s) to include assets required to conduct patient movement.
- C. Evaluate the receipt and processing of patient data through a reporting system.

III. The Advanced Exercise

Basic objective - To evaluate the overall CMCHS OPLAN in a realistic manner to the fullest possible extent. All elements of the plan should be addressed in designing the plan for executing the level of exercise. Realism is a key feature, therefore, a one week minimum should be set for conduct of the exercise.

APPENDIX O

MEMORANDUM OF UNDERSTANDING
BETWEEN THE VETERANS ADMINISTRATION (VA)
AND THE DEPARTMENT OF DEFENSE (DA),
ALONG WITH THE VA'S GENERAL GUIDANCE TO
VA MEDICAL CENTER DIRECTORS

MEMORANDUM OF UNDERSTANDING
BETWEEN THE
VETERANS ADMINISTRATION (VA)
AND THE
DEPARTMENT OF DEFENSE (DoD)

**REGARDING THE FURNISHING OF HEALTH-CARE SERVICES TO MEMBERS OF THE
ARMED FORCES IN THE EVENT OF A WAR OR NATIONAL EMERGENCY**

Recognizing that the VA's extensive and comprehensive health-care system could assist DoD in the event of a war, or a national emergency involving the use of U.S. Armed Forces in armed conflict, and that in such a situation DoD might not have adequate health-care resources to care for military personnel wounded in combat and other active-duty military personnel, the Administrator of Veterans Affairs and the Secretary of Defense agree to this Memorandum of Understanding.

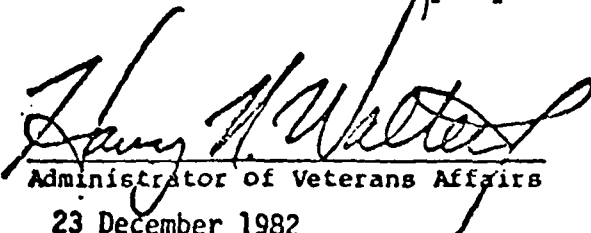
- I. PURPOSE. The purpose of this Memorandum is to establish procedures and guidelines for planning and implementing the VA's role as the principal backup to the military health-care system in the event of war or national emergency.
- II. AUTHORITY. This Memorandum of Understanding is entered into pursuant to the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Public Law 97-174, Section 4(a), 96 Stat. 70, 74 (1982) (codified at 38 U.S.C. Section 5011a).
- III. WAR OR NATIONAL EMERGENCY OPERATIONS. During and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict:
 - A. Facilities of the VA health-care system will be available as the principal support to the military health-care system in furnishing health-care services to active-duty members of the Armed Forces when DoD does not have adequate medical resources under its own jurisdiction to meet medical contingencies. Throughout such period, the medical centers and other facilities of the VA will continue to be managed and operated under the direction of the VA.

- B. Upon request of the Secretary of Defense, the Administrator of Veterans Affairs will furnish hospital care, nursing home care, and medical services in facilities under VA jurisdiction to members of the Armed Forces on active duty in accordance with plans which shall be developed and periodically updated.
- C. In providing for care to active-duty personnel outside of DoD facilities, the Secretary of Defense may refer active-duty personnel to the local civilian (non-VA) health care facilities if the local VA health-care facility designated to provide contingency support cannot furnish the required care.
- D. In the event of an attack on the United States (i.e., an attack within the geographic limits), the use of VA health-care resources may be affected by other Executive Orders and Memoranda of Understanding between the VA and other Federal (non-DoD) departments or agencies.

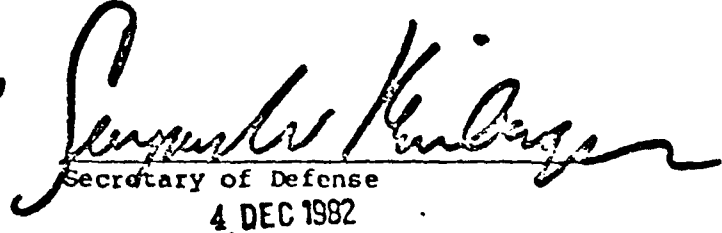
IV. PLANNING FOR WAR OR NATIONAL EMERGENCY OPERATIONS

- A. The Chief Medical Director of the Department of Medicine and Surgery will represent VA in coordinating with DoD the planning and implementation of VA's contingency role under this Memorandum.
- B. The Assistant Secretary of Defense for Health Affairs will represent DoD in coordinating with VA the development of VA-DoD contingency plans.
- C. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) shall initiate DoD's planning for the VA's support of the military health-care system by developing a plan for the use of military medical facilities located in the United States which have a contingency planning mission. This plan shall be submitted annually to the Secretary of Defense or his designee for approval. After being approved, the plan will be forwarded to the Administrator for review.
- D. Based on the DoD plan for its military medical facilities, the Chief Medical Director will develop a VA Contingency Plan in support of military medical facilities. The VA contingency plan will be based on a bed availability assessment projecting the number, type, and location of VA beds which could be made available to support the treatment of military personnel in the event of war or national emergency. This bed availability assessment will take into account the impact upon VA operations of a call-up to active-duty (mobilization) of VA employees who are members of the Ready Reserves. The Chief Medical Director will annually submit the proposed VA contingency plan to the Administrator for approval. After approving the plan, the plan will be forwarded to the Secretary of Defense or his designee for review.

- E. Following the annual reviews of the VA and DoD plans by the Administrator and Secretary of Defense, any modification in such plans shall be reported within thirty days to the Committees on Veterans' Affairs and on Armed Services of the Senate and House of Representatives.
- F. The Chief Medical Director and the Assistant Secretary of Defense for Health Affairs will coordinate the publication of directives on the VA and DoD plans.
- G. The Chief Medical Director, or his designee, at the request of the Assistant Secretary of Defense for Health Affairs or his designee, may authorize DoD to use VA medical facility resources including office space and supplies and administrative support services. DoD shall use any such resources to carry out various responsibilities and functions relating to the implementation of VA-DoD contingency plans in a designated area. These responsibilities and functions may include, among other activities, developing local VA-military-civilian contingency plans and coordinating planning efforts with local emergency preparedness organizations. DoD shall assist VA in carrying out the VA's contingency planning responsibilities under this article. The parties contemplate that, in many cases, DoD officials who are charged with developing local contingency plans for the Department will be in the best position to assist in developing local VA contingency plans.
- V. REIMBURSEMENT. DoD will reimburse VA in accordance with rates agreed upon by the Administrator and the Secretary of Defense based on the cost of care and services provided and in accordance with existing laws, policies and procedures.
- VI. REVOCATION. The March 30, 1965, Memorandum of Understanding between the VA and DoD regarding the utilization of beds in VA hospitals for military patients in support of a national emergency when the United States is not under attack is hereby revoked.
- VII. EFFECTIVE DATE, MODIFICATION, AND TERMINATION. This Memorandum becomes effective on the date of the last signature. Either party may amend or terminate this Memorandum upon thirty days written notice to the other party.


Administrator of Veterans Affairs

23 December 1982


Secretary of Defense

4 DEC 1982

JAN 21 1983

DRAFT

JAN 21 1983

TO: Director, VA Medical

Center Activities,
Domiciliary, Outpatient,
Clinics, Regional
Offices Medical District
Directors (00)

SUBJ: VA - Department of
Defense Contingency
Planning

1. Purpose. This letter is to encourage VA contingency planning with DoD and to provide information to DM&S field personnel on the status of VA-Department of Defense (DoD) Contingency Planning. Specific information is provided on the proposed VAMC's that will have initial responsibility for receiving casualties in the event of an overseas war. This letter does not address VA-DoD sharing of resources.

2. Distribution. This information letter is directed to Medical District Directors, Facility Directors, Chiefs of Staff, ACOS/Education, District Coordinators and Planners,

Medical Center Emergency Coordinators. A copy of this letter has also been sent to DoD hospitals that have been designated to participate as primary receiving centers in the contingency hospital system.

3. Action Required. Since this letter is non-directive, no specific response (i.e. response to VA Central Office) is required; however, directors of VAMC's listed on the attachment are encouraged to participate in local DoD contingency planning that is currently underway. VA participation is based on the enactment of PL 97-174, the "VA-DoD Health Resources Sharing and Emergency Operations Act" of May 1982 and the VA-DoD Memorandum of Understanding signed by the Administrator of Veterans Affairs and the Secretary of Defense in December, 1982. VA actions are encouraged in the following ways:

a. Directors of designated VAMC's should initiate and/or maintain close communications with the local Federal Coordinating Center. A list of the VAMCs, their corresponding Federal Coordinating Center and point of contact is attached.

b. Directors of designated VAMC's should participate fully with their local military point of contact in

the development of contingency plans and in testing the operation of the plan in the community.

c. Directors should designate a Contingency Planning Coordinator to represent the VAMC in developing local plans. The selection of a Coordinator should consider personnel who have: high level positions (Associate or Assistant Director; Service Chief, etc.); knowledge of emergency preparedness planning such as the medical center's emergency planning coordinator; and/or knowledge and experience in military medical care.

The designated medical centers listed on Attachment I will have initial responsibility for implementation of a contingency planning system. Other VA medical centers in the Medical District will support the designated hospital by accepting transfers and/or sharing resources so as to maximize the availability of VA beds. At this time, however, DM&S efforts are focusing on implementing a network of primary receiving centers for treating returning battlefield casualties.

4. How the Contingency Hospital System is Designed.

Defining the configuration and linking system for hospitals was a central issue in the development of the system.

In preparing for emergency situations, it is considered

advantageous to have the flexibility of both VA and civilian resources as a backup to the military health system. By establishing a multi-hospital system of VA and civilian hospitals in a geographic area, the returning casualties may be distributed directly from the airport (or rail station, harbor) to various hospitals rather than transferring them only to a VA hospital. This distribution would utilize the entire capacity of the area's medical resources and avoid delays in patient treatment which could result from the time-consuming processing of casualties.

Recognizing that a military casualty in a VA or civilian hospital presents unusual health care and administrative situations, a system was designed so that VA and civilian hospitals in a specific geographical area could be linked to a specific hospital, usually a military hospital but in some areas a VA medical center. These Federal hospitals, working in cooperation with the civilian medical community, develop local plans, implement education and training programs, conduct exercises of the system and, if the system is activated in a wartime situation, coordinate the care of military casualties.

Therefore, a VA-Military-Civilian Contingency Hospital System is being established, consisting of forty-eight (48) local "systems" in selected metropolitan areas. Only areas that have a concentration of hospital beds, a jet airport or

deepwater harbor, and a designated Federal medical facility are being selected.

Additional information on the historical background of contingency planning is contained in Attachment II of this letter.

5. VA-Military Civilian Relationships.

The VA-Military-Civilian Contingency Hospital System is an integrated multi-hospital system composed of VA and civilian components under DoD guidance for the purpose of planning, preparedness for, and delivery of medical care to returning sick and wounded military personnel in a designated geographic area. The system includes, in addition to hospitals, other services such as ambulances, communications, and information.

a. The civilian component is known as the Civilian-Military Contingency Hospital System (CMCHS) and it was initiated in August, 1980 for the purpose of providing health care backup to DoD in the event of an overseas conventional war. This program calls for civilian hospitals in specific areas to be voluntarily linked to a designated Federal Coordinating Center. Based on an analysis of each hospital's capabilities, civilian hospitals are invited to participate in the system. Those hospitals desiring to participate complete a memorandum of understanding with the Department of

Defense that specifies the minimum and maximum number of beds that could be made available for casualty treatment. For its part DoD agrees to reimburse the hospital and individual providers of care. Participating hospitals also agree to plan with local military representatives for the admission of casualties and to participate in an annual exercise of the plan.

The initial implementation phase of CMCHS was completed in the 48 metropolitan areas in September 1982. At this time DoD has gained pledges of over 50,000 beds from participating civilian hospitals. In the coming months, each of the 48 areas will be completing its individual CMCHS operations plans and scheduling exercises to test the operation of the system in the community.

b. A VA-DoD Contingency Planning Program was officially initiated in May, 1982 with the enactment of Public Law 97-174. It was determined that the civilian-military program, CMCHS, could be expanded into a VA-Military-Civilian Contingency Hospital System.

CMCHS is different from VA-DoD Contingency Planning program in several ways including: the VA-DoD program is mandated by law and CMCHS is not; the VA is the primary backup to DoD with civilian hospitals providing additional backup if needed; the VA must focus on linking dissimilar institutions - acute care hospitals, long term hospitals, nursing homes, rehabilitation centers, etc; the VA will support the military medical system with administrative and logistical support; etc.

The relationship between VA, Military, and Civilian resources may be graphically illustrated with two examples. The first exemplifies the priorities for utilization of resources:

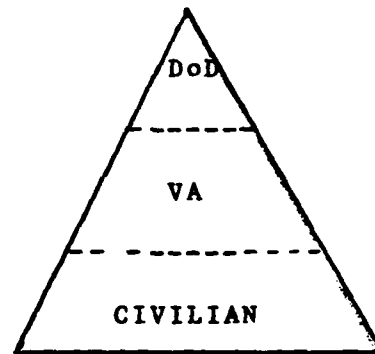


FIGURE 1: Priorities for use of resources in a VA-Military-Civilian Contingency Hospital System

The next illustration depicts the concepts of a VA-Military-Civilian Contingency Hospital System which is composed of a VA and a civilian program:

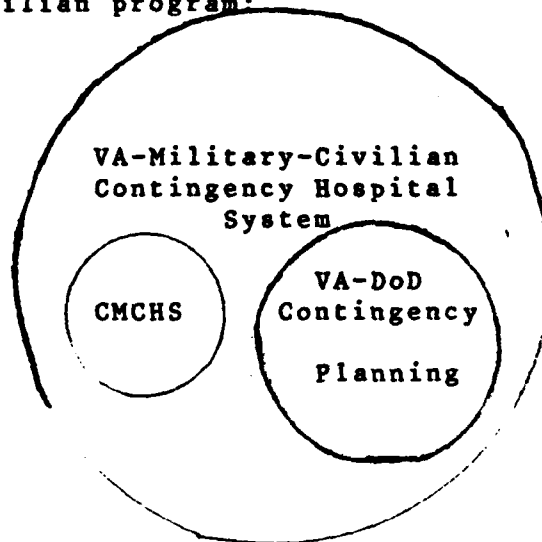


FIGURE 2: Organizational Elements of a VA-Military-Civilian Contingency Hospital System

6. Implementation of VA-DoD Contingency Planning. Currently several actions are being undertaken to implement VA-DoD Contingency planning which will be integrated with CMCHS. The following describes the current status of these actions.

a. VA-DoD Memorandum of Understanding.

This interagency agreement signed by the Administrator of the VA and the Secretary of Defense establishes overall policy guidance for VA-DoD contingency planning. *A copy of this agreement is included as Attachment III.*

b. Field Guidance

To help implement the VA's contingency planning, a DM&S Task Force, made up of field personnel and a DoD representative, was established in August 1982. The Task Force is writing a program guide to be used by field personnel for developing VA medical center and medical district contingency plans in support of the military system. This program guide is expected to be completed in the Spring, 1983.

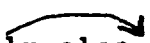
The Task Force is composed of a multi-disciplinary group chaired by H. Turner Edmondson, M.D., Chief of Staff, VAMC Augusta, Georgia. Other members are: Michael Norman, Medical District 23 Coordinator; Don Earle, Chief, Medical Administration Service, VAMC Palo Alto, California; Dennis Eliason, Chief, Engineering Service, VAMC New Orleans, Louisiana; Frankie Manning, RN, Chief, Nursing Service, VAMC Seattle, Washington; David Berg, Assistant to the Director, VAMC Philadelphia, Pennsylvania; Clarence Stirewalt, Assistant to Director, VAMC Augusta, Georgia; and Major Michael Vojtasko, USAF, Office of the Assistant Secretary of Defense for Health Affairs, the Pentagon.

c. Regulations.

Proposed regulations are being circulated within the Agency for concurrence and are expected to appear in the Federal Register prior to May, 1983.

d. Education Program.

An education program is being developed jointly by DoD and VA for the training of health professionals in treating sick and wounded personnel returning from an overseas war. In addition a symposium is being planned for June 1983 for the presentation of papers relating to treatment of returning casualties.

Robert Laning, M.D., Director, Surgical Service, Central Office and John F. Stremple, M.D., Chief of Surgery, VAMC Pittsburgh are coordinating the VA's role. Nursing Service and the Office of Academic Affairs are actively  also involved.

7. Inquiries. Questions relating to VA-DoD contingency planning should be directed to Richard Citron, DM&S Emergency Preparedness Planning Officer, Office of the Director, Program Analysis and Development (10CC), VA Central Office, Washington, D.C. 20420. Mr. Citron's telephone number is (FTS) 389-2322.

MURRAY G. MITTS, M.D.

Director

Program Analysis and Development (10CC)

Attachment

APPENDIX P

CHURCHMAN-ACKOFF VALUE
ASSIGNMENT TECHNIQUE FOR
EVALUATING THE THREE FEASIBLE
ALTERNATIVES

Churchman-Ackoff Technique For
Assignment of Values To
Decision Making Criteria

Criteria were evaluated by the Chief Executive Officer, Keller Army Community Hospital and the Analyst in the following rank order of importance.

Step 1

C-1 To be cost effective in terms of programmed funding and manpower utilization. Data classifications considered include: a profile of project management structure, use of local health care associations, the degree of VA support available, and personal visits to civilian facilities.

C-2 To enhance the contingency capabilities of all participants without adversely effecting performance of routine health care mission. Data classification considered was the size of the coordinating facility versus the size of the assigned mission.

C-3 To satisfy the criteria set forth by the Department of Defense (DOD) relative to bed capacity, accreditation, available capabilities, strategic location and twenty-four hour staffing. Data classification considered was command support for the CMCHS program.

C-4 To obtain signed memoranda of understanding with local hospitals, the area VAMC, and the DOD agent.

C-5 To remain aware of the potential conflict with anti-nuclear and anti-military agencies. Data classification considered was community acceptance of the military.

C-6 To address the essential objectives and elements of the CMCHS program to obtain an approved CMCHS Operations Plan for the region.

Step 2

Criteria	Value	Value Normalized
C1	14	.23
C2	12	.20
C3	10	.17
C4	9	.15
C5	8	.13
C6	7	.12

Step 3

Criteria	Alternative		
	1	2	3
C1	.6	.3	.7
C2	.8	.4	.6
C3	.6	.8	.5
C4	.4	.5	.8
C5	.4	.6	.8
C6	.6	.7	.7

Step 4

Alternatives	Criteria					
	1	2	3	4	5	6
Strategic Planner I	(.6x.23)	(.8x.20)	(.6x.17)	(.4x.15)	(.4x.13)	(.6x.12)
	Total .5840					
Regional Implementa- tion Agent II	(.3x.23)	(.4x.20)	(.8x.17)	(.5x.15)	(.6x.13)	(.7x.12)
	Total .5220					
Regional Planning and Implementation Partner III	(.7x.23)	(.6x.20)	(.5x.17)	(.8x.15)	(.8x.13)	(.7x.12)
	Total .6740					

Alternative III, which is regional planning and implementation partner, is the optimal feasible solution according the Churchman-Ackoff Technique.

APPENDIX Q

CORRESPONDENCE ADDRESSING THE
ISSUE OF CMCHS INVOLVEMENT RELATIVE TO
CERTIFICATE OF NEED APPLICATIONS
IN NEW YORK STATE

STATE OF NEW YORK

160

DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS MANAGEMENT

TOWER BUILDING • THE GOVERNOR NELSON A. ROCKEFELLER EMPIRE STATE PLAZA • ALBANY, N.Y. 12237

DAVID AXELROD, M.D.
Commissioner

ROBERT M. CRANE
Director

December 9, 1982

Joseph G. Flannery
CPT(F), MSC
Administrative Resident
Department of the Army
U.S. Army Medical Department Activity
West Point, New York 10986

Dear CPT Flannery:

Thank you for your letter of November 29, 1982 concerning the Contingency Medical Program being undertaken by the Army's Medical Department.

As I understand the Program from our recent conversation, the Army is requesting Hospitals in the West Point vicinity to allocate a relatively small number of beds for victims of unforeseen calamities. This is to advise that participation by area Hospitals in this Program will not cause the Department to discriminate against or negatively review Certificate of Need applications submitted by the Hospitals for modernization and/or expansion.

I trust this statement satisfactorily replies to your inquiry.

Very truly yours,



Dominick F. Testo
Director
Bureau of Facility and Service Review

st

Joe Flannery

November 29, 1982

HSUD

Mr. Dominic F. Testo
Director Bureau of Facilities and Services Review
New York State Health Department
Empire State Plaza Tower Bldg Rm 1603
Albany, NY 12237

Dear Mr. Testo:

Reference our phone conversation this date concerning the CMCHS Program and pending certificate of need action on behalf of potential members, I wish to formally request policy determination.

The concern expressed by several Chief Executive Officers over the possible misunderstanding your office might have if they participated in the contingency planning effort has caused generation of this request. To them participation might be highly desirable, yet when weighed against the possibility of discrimination on CON requests those desirable features are negated. A word from your office that such discrimination, neither positive or negative, will not result from voluntary participation would put to rest this real or perceived problem area.

Thank you for your cooperation and willingness to assist the Department of Defense in clarification of this potential conflict issue. If additional information or clarification is necessary, please contact the undersigned at (914) 938-4459.

Sincerely,

JOSEPH G. FLANNERY
CPT(P), MSC
Administrative Resident

APPENDIX R

CORRESPONDENCE WITH THE
JOINT COMMISSION ON ACCREDITATION OF HOSPITALS
REGARDING RECOGNITION OF THE BASIC EXERCISE (CMCHS)
FOR THE NORTHERN NEW YORK REGION

Joint Commission on Accreditation of Hospitals

875 North Michigan Avenue
Chicago, Illinois 60611
312.542-6061

John E. Affeldt, MD
President

February 16, 1983

Freeman I. Howard, M.D.
Colonel, Medical Corps
Commanding
Department of the Army
U.S. Army Medical Department Activity
West Point, New York 10996

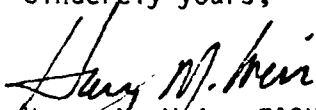
Dear Colonel Howard:

Thank you for submitting your plan for the proposed regional basic disaster exercise.

The enclosed format would appear to meet the intent of the JCAH standard which recommends a cooperative community effort in conducting a realistic external drill. As you know, however, the standards do require two realistic drills per year. The second drill can be conducted by the individual hospital and should be of sufficient depth to adequately permit an evaluation of all segments of the hospital's disaster plan including the response of participants.

We appreciate your sharing your format with us and if we can be of any further assistance, please do not hesitate to contact us.

Sincerely yours,



Harry M. Weir, FACHA
Associate Director
Hospital Accreditation Program

HMW:cat



DEPARTMENT OF THE ARMY
U. S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

REPLY TO
ATTENTION OF:

February 2, 1983

Mr. Harry Weir
Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Mr. Weir:

During your recent telephone conversation with CPT Joseph Flannery, on January 17, 1983, you discussed the Joint Commission's position regarding validity of the Civilian-Military Contingency Hospital Systems' (CMCHS) basic exercise as a measure of our participating hospital's ability to meet external disaster needs. At that time we agreed that exercise specifics would be required if a final decision was to be made.

The purpose of this letter is twofold; first to provide some of those specifics and second to ask for help and assistance in making our regional basic exercise effort meaningful to hospitals that voluntarily selected participation in the Civilian-Military Contingency Hospital Systems'. In our recruitment of local hospitals, we, representing the Department of Defense, based on the September 12, 1980 letter from Doctor Affeldt have committed ourselves by stating that such exercises would "count towards satisfaction of the JCAH requirement for the conduct of external disaster exercises". Our intent is to honor that commitment.

Completion of the implementation phase which involves consigning of hospitals is currently set for mid February 1983. From that point on, until mid-summer, the West Point Hospital (Keller Army Community Hospital), four Veteran Administration Medical Centers/Hospitals and local civilian hospitals which have agreed to participate, will jointly design and refine an area-wide CMCHS Operations Plan (CMCHS, OPLAN-NY). This document will serve as the basic planning tool for coordinating available health care resources to satisfy the demands of a regionalized disaster. The basic format as to specific subject coverage of this document is provided as inclosure 1.

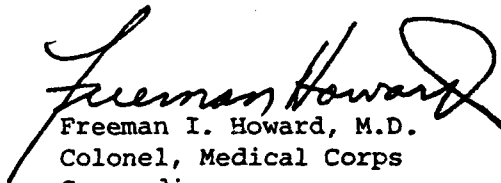
After this plan is developed and further refined to meet the needs of all within the scope of the region, testing the plan's ability to accomplish its desired objective will take place. The first step in this evaluation process will be the basic exercise. A proposed structural organization and scenario for this analysis of the OPLAN is provided as inclosure 2. The target timing for this exercise will be early to mid-Fall 1983, preferably during October.

-2-

As can be decerned from this basic exercise format, each participant will be committed to involve medical, nursing and administrative staff assets in a pre-arranged manner so that patient care capabilities of the region can be accurately assessed. Coordination and integration of disaster response assets will be tested individually by each facility and collectively, by the area managers of the Veterans Administration and the regional manager, the West Point Hospital.

The willingness expressed by JCAH in assisting CMCHS in September 1980 has contributed to the program's success to date. Approval of the concepts expressed herein as valid, for established disaster exercise standards of the Joint Commission will go a long way to enhance even further the CMCHS effort in the New York area. We stand ready to alter such concepts so that our exercises, now and in the future, are of the quality that JCAH fully accredits.

Sincerely,



Freeman I. Howard, M.D.
Colonel, Medical Corps
Commanding

2 Inclosures

Subject Format for
CMCHS Operations Plan for New York

1. Throughout the planning and conduct of community level medical exercises the following major functional areas will be addressed:

a. Exercise Program Design and Control:

(1) To provide the overall concept of the exercise to include preparation of the scenario and sequencing of events.

(2) Assignment of an Exercise Management Team with a central planning coordinator to manage exercise specifics such as appointment of support personnel and exercise controllers.

(3) This area will also coordinate post-exercise corrective action.

b. Medical Operations and Patient Management:

(1) Arrangement for use of a patient reception area and organization of sorting and emergency treatment concepts and methods at that area.

(2) Establish methods for moving patients from aircraft to reception area and sorting facility at the patient reception site.

(3) Identify and alert members selected to serve on sorting teams.

(4) Conduct liaison with CMCHS participants and other medically oriented groups in the area.

c. Communications:

(1) Design and publication of an alert notification procedure (regional directory).

(2) Establish and test communications capabilities in the patient sorting area and command and control network.

(3) Make maximum use of locally available communication system to include EMS and Hospital Emergency Administrative Radio (HEAR).

d. Transportation:

(1) Arrange for plane side patient transport in and around the sorting and emergency treatment area.

(2) Movement from sorting and emergency patient treatment site to CMCHS Hospital.

(3) Movement of additional personal support assets, equipment and supplies.

e. Logistics:

(1) Procure necessary items and manage all contracting and reimbursement actions governing material requirements.

(2) Arrange for food and/or refreshments for VIP's, press, representatives, observers, volunteer patients and others.

(3) Arrange for site clean-up.

f. Patient Volunteers:

(1) Recruitment of patient volunteers from sources provided below:

- (a) Military personnel
- (b) Hospital personnel
- (c) Student groups
- (d) Church groups
- (e) Scout groups
- (f) Red Cross

(2) Management of a system designed to provide patient accountability and control.

(3) Coordination of transportation with the transport manager.

g. Traffic Control:

(1) Provide police with accurate information as to routes selected for emergency vehicles and other transport.

(2) Provide for crowd control and necessary personnel for arranging parking for:

- (a) Ambulances
- (b) Patient volunteers
- (c) Press representatives and observers
- (d) VIP's

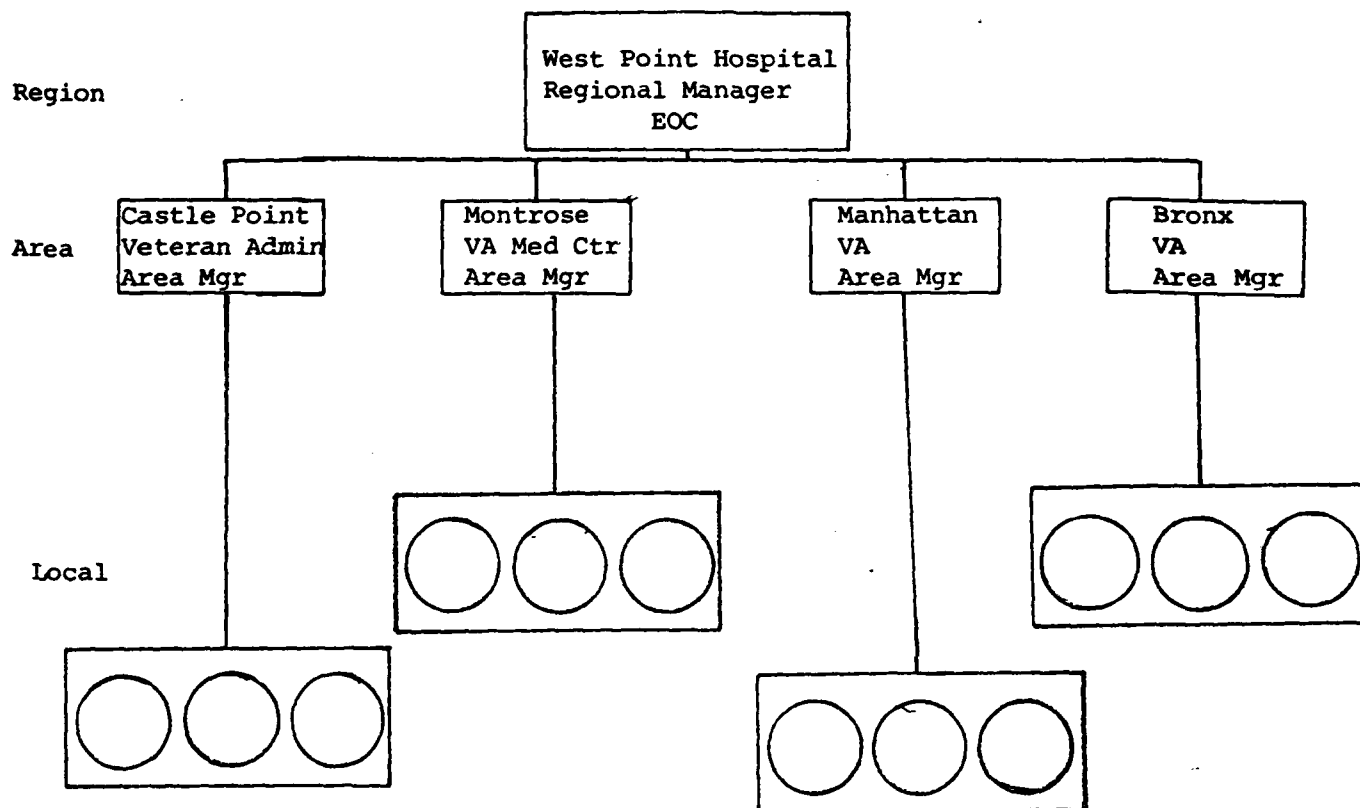
(3) Coordinate police material and agreements as necessary.

h. Public Information:

- (a) Prepare press releases and manage electronic and print media representatives.
- (b) Provide information packets and prepare mailing out of invitations to designated VIP's.
- (c) Provide escorts for VIP's and provide area spokespersons.

Structural Organization and Scenario for The Basic Exercise of CMCHS Operations Plan

I. Organizational Framework



ECC

Represents a local hospital participant such as Arden Hill Hospital. This hospital's external disaster plan will be re-designed, if necessary, to include coordination with other participating health care services and hospitals throughout a given area. The area management will be provided by the Veteran Administration. For example, the Castle Point VA Medical Center will assist local hospitals such as Arden Hill in establishing working relations with disaster related services of the county and state. The regional manager, West Point, will coordinate the activities of area managers to reduce duplication of effort. As the regional manager, West Point will operate the disaster drill's Emergency Operations Center. Veterans Administration Medical Centers will in turn staff an area management team and local hospitals will employ its current command and control structure for disasters in the form of an emergency coordination center. The operational design of these organizations are outlined below.

II. Emergency Operations Center - The West Point Hospital will serve as the EOC Coordination Agent for the basic exercise.

a. Staffing of EOC

(1) Exercise Director - West Point Hospital Commander, Medical Corps.

(2) Operational Deputy Director - Executive Officer - Administrative staff.

(a) Logistics (Supplies, Services and Transportation of Materials

(b) Patient Regulating - Bed availability and patient transport.

(c) Plans and Training - Plan execution and

(d) Personnel - Manpower evaluation

(3) Deputy for Nursing - Chief Nurse

(4) Medical Staff Coordinator Work with patient regulating and triage teams for site evaluation.

b. Area Management Teams - VA Staffed

(1) Area Director - VA Facility Director (or designee)

(2) Operational Manager

(a) Logistics

(b) Patient Regulating - EMS Networking

(c) Personnel - Manpower

(d) Plans and Training

(3) Nursing Manager

(4) Medical Staff Manager

c. Local Facility - Staffed Emergency Coordination Center utilizing current external disaster plans but reporting information provided below to the area manager. Each staff to manage requirements set forth in the exercise scenario to fit the local situation and area demands.

III. Information Reporting

a. Each facility participating in the basic exercise will report initially:

(1) Bed Status Report to patient regulating within 20 minutes real time.

(2) Personnel Status Report to - Personnel Manager within 20 minutes real time.

(3) Supplies Report To logistics Manager within

- (a) Medical - 30 minutes
- (b) Non medical - 40 minutes
- (c) Special Blood Report - each 30 minutes during exercise.
- (d) Equipment Status - On hand/Operational Status within

30 minutes.

b. Follow-up Reporting

(1) Bed Status - One hour into exercise; three hours into exercise; six hours into exercise; eight hours into exercise; (etc. as required).

(2) Personnel Status 40 minutes into exercise; one hour; 90 minutes, as required.

(3) Supplies Report:

- (a) Medical One hour and as required.
- (b) Non Medical - One hour and as required.
- (c) Blood Report - Each 30 minutes
- (d) Equipment Status - Upon change to status.

NOTE: As required is either generated by the EOC, Area Manager, or ECC of the local facility.

IV. Scerario for Basic Exercise of CMCHS OPLAN - NY, October 1983.

a. Military units from the United States traveling to the Federal Republic of Germany for the purpose of participating in the Annual Reforger Exercise are involved in a major disaster during arrival at Rhein Main Airport. Three C141 troop transport plans are involved in a landing mishap resulting in large numbers of civilian and military casualties.

b. A decision is made to evaluate the casualties numbering in excess of 300 back to the Continental United States. One factor in this decision was that families of the injured patients would be closer which might facilitate casualty notification and ease of hospitalization. The point of survivor return is pinpointed as the New York Area due to its ideal location and public transportation network. Two specific air field locations are announced to be John F. Kennedy and Stewart Airports.

c. The Department of Defense for Health Affairs notifies State Authorities to prepare for the influx of casualties. At the same time they notify US Army Health Services Command to alert the MEDDAC at West Point to put into action its Civilian-Military Contingency Hospital System. The official word received at West Point is that a triage team at each airfield will be provided from area resources and that patients are scheduled to arrive in approximately ten hours.

d. Reports to be rendered within the first 5 hours by the West Point EOC will determine if additional assets are necessary regionally or if employment of the Walter Reed Army Medical Center CMCHS OPLAN for Washington DC will require activation to help manage the projected workload.

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611
312/642-6061

John E. Alleidi, MD
President

October 8, 1982

LtCol Podge M. Reed, Jr.
Director
Civilian-Military Contingency
Hospital System
ASD/HA (Medical Readiness)
The Pentagon
Washington, D.C. 20301

Dear Colonel Reed:

Please refer to your letter of September 16, 1982 which seeks our views on whether the Draft Civilian-Military Contingency Hospital System (CMCHS) Exercise Manual meets the accreditation requirements for external disaster exercises.

We have reviewed the draft CMCHS Exercise Manual and believe there may be a question as to whether "The Basic Exercise" described therein would satisfy JCAH accreditation requirements for one of the two annual exercises of a hospital's external disaster plan.

With respect to rehearsal of a hospital's external disaster plan JCAH surveyors are charged to answer the following questions:

- Is the (an) external disaster plan rehearsed at least twice per year?
- Is there evidence of participation by
 - The medical staff?
 - The administration?
 - The nursing department/service?
- Is there a written evaluation of each drill (emphasis added) held?

JCAH

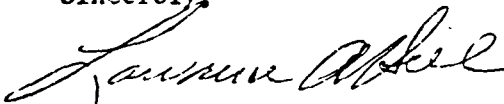
LtCol Podge M. Reed, Jr.
Washington, D.C. 20301
October 8, 1982
Page Two

As with nearly everything in this world, nothing is black or white. We could for example envision a scenario wherein a hospital in carrying out your "Basic" exercise could provide evidence of participation by medical staff, administration and nursing and included sufficient elements of "drill like" activity to enable the rendering of a realistic drill evaluation. On the other hand we are persuaded that there is an unacceptable risk that a hospital could carry out the rudiments of the "Basic" exercise described in a fashion you might find acceptable but which would be found unsatisfactory to our surveyors. In this regard you may wish to caveat your draft manual with a note that JCAH is unlikely to be satisfied that the "Basic" exercise meets its requirements. We understand that this "Basic" exercise only applies to the hospital's initial exercise.

It is our conviction that hospitals which carry out either the "intermediate" or "advanced" exercise in the fashion outlined in your draft manual will have satisfied the JCAH requirement for a rehearsal of its external disaster plan.

Thank you for the courtesy of providing us an opportunity to review and comment on this matter. We believe this draft plan represents a thoroughly professional and splendid piece of work.

Sincerely,



Lawrence A. Hill
Vice President

cc: James S. Roberts, M.D.
Donald W. Avant
John E. Milton

PEM:LAH:amf