The original documents are located in Box 40, folder "Transition Reports (1977) - Veterans Administration: Draft (4)" of the John Marsh Files at the Gerald R. Ford Presidential Library.

TRANSITION OF THE PRESIDENCY

DM&S SECTION

NOVEMBER 1976

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DEPARTMENT OF MEDICINE AND SURGERY

Mission

The Veterans Administration Department of Medicine and Surgery functions to provide complete medical and hospital services for the care and treatment of veterans. Secondary and supporting missions include education and training of health care personnel to assist in providing an adequate supply of health manpower for the nation, and medical research to advance the level of health care for everyone including veterans.

History

Veterans benefit laws began in America with a Plymouth Colony Enactment of 1636 and progressed to the creation of the Veterans Administration (VA) in 1930. This new agency combined functions of three previous offices -- the Veterans' Bureau arising in 1921 from Treasury's Bureau of War Risk Insurance, Interior's Bureau of Pensions (1849), and the National Home for Disabled Soldiers (1865). Medical care to those eligible in a 1930 population of some 4.7 million veterans was coordinated professionally in 54 hospitals by a Medical Director responsible to a non-physician Assistant Administrator. This Assistant Administrator himself managed all non-clinical aspects of the program. Though some very competent physicians were procured via normal civil service channels, most available doctors were of

limited ability. During the World War II, shortage of personnel and the inadequate expertise of the professional staff required that Army and Navy physicians be detailed to the VA hospital system to meet the increasing needs for medical care of returning veterans.

A most significant event concerning the VA medical care system occurred in 1946 when President Harry S. Truman signed into law P.L. 79-293 which created a semi-autonomous Department of Medicine and Surgery (DM&S) under a Chief Medical Director who was responsible only to the Administrator of Veterans Affairs. Recognizing the unique needs of returning World War II veterans and the professional recruitment opportunities provided by release of many excellent young physicians from military service, Congress had the foresight to provide for unhampered recruiting practices by which physicians, dentists, and nurses could be appointed and compensated bsed upon their individual qualifications rather than upon the specific duties assigned. In addition to acquiring temporarily some military hospitals a large hospital construction program was begun to provide modern facilities. Many of these new VA hospitals were located adjacent to the nation's leading medical centers where formal medical school affiliations could be utilized to provide quality care to veteran patients while furnishing the much needed additional clinical base for the education of physicians and other health care personnel who were returning from the war.

VA MEDICAL CARE SYSTEM

The VA system is the largest centrally directed health care system in the nation, comprised of 172 hospitals and their associated outpatient departments, 42 additional outpatient clinics, 86 nursing homes, and 18 domiciliaries. These facilities are staffed with over 173,300 employees. In fiscal year (FY) 1975, this system provided complete care for 1,220,107 inpatients. Outpatient medical services given by VA staff at VA facilities during FY 1976, is expected to exceed 14,200,000 visits. Veterans are also provided care in non-VA hospitals, community nursing homes, and from community physicians and dentists under VA auspices. In addition, VA provides financial assistance for construction of facilities and for the care of veterans to 31 states which operate a total of 8 hospitals, 31 nursing homes, and 36 domiciliaries. The geographic dispersion of VA health care facilities generally parallels the nation's population distribution. There are one or more hospitals in each of the contiguous states and in the Commonwealth of Puerto Rico. In Hawaii and Alaska, the VA operates outpatient facilities and provides for hospitalization under contract with non-VA institutions.

VA experienced an unparalleled expansion during FY 1976 in its health care services, as well as in the demand for these services. More than 2,250,000 applications for care were received from veterans during the year. The number of inpatients treated (episodes of care)

incresed to almost 1.3 million, or 65,000 more than in FY 1975. More than 92 percent of these were in VA hospitals. Outpatient care provided also reached new highs. Visits for outpatient medical care amounted to 16 million, including 14 million visits to VA staff and 2.2 million visits to private physicians on a fee for service basis. On any single day, on the average, almost 180,000 individuals received care from the Veterans Administration.

It was evident that VA could not meet the total outpatient demand; hence, in 1976 P.L. 94-581 formulated a system of patient priorities for ambulatory care as follows:

(1) Treatment of a service-connected disability (SCD);

(2) Veterans having a 50% or greater SCD;

(3) Veterans having a less than 50% SCD;

(4) A nonservice-connected (NSC) patient receiving housebound or aid and attendance allowances.

Unspecified in this list, but eligible under former laws as facilities were available, are NSC patients who cannot otherwise afford needed medical care. On "humanitarian" basis until transfer to non-VA facility is medically safe, any patient may be given emergency care.

Such priorities naturally influences inpatient care also. Discharged patients during FY'75 were found to be 27% with an SCD and 16% NSC patients over age 65. A study of all admission during the week of 3/23/75 revealed that 35% had any health insurance (17% had medicare and 18% had some non-public health insurance). Applying these values (35%)

to the 57% remaining above as NSC under age 65, only 20% of all patients would be both under age 65 and have any form of health insurance apart from VA care.

The medical care provided by the VA can also be expressed in perhaps a more meaningful way in terms of the type of service provided the number of individuals treated. The following table presents the data for FY '75:

Program or Combination	Individuals Treated
A. Single Modality of Treatment	
VA Hospital Only	65,107
VA Domiciliary Only	4,909
VA Nursing Home Only	3,212
Community Nursing Home Only	1,347
Outpatient Staff Only	1,475,944
Outpatient Fee Only	83,095
B. More Than One Modality of Treatment	
VA Hospital and Outpatient Staff	606,785
VA Hospital and Outpatient Fee	1,422
Outpatient Staff and Fee	56,120
VA Hospital, Outpatient Staff and Fee	32,958
Other	57,439
Total All Programs	2,388,338

These are mutually exclusive groups. No patient is counted more than once either for different groups or for multiple episodes of treatment of like types. However, such repeated episodes of like type care (as multiple hospital admissions) do explain the apparent discrepancy between the daily load of 180,00 episodes and the annual load of nearly 2.4 million different individuals.

In a continuing effort to provide access to VA health care services, the VA has opened 13 new clinics since 1972 and 10 additional clinics are scheduled to be activated during fiscal years 1977 and 1978. Others are being relocated or renovated to improve their accessibility to veterans as well as to modernize their physical plant. Many VA hospitals are also scheduled to upgrade their ambulatory care activities as a result of new space criteria which permit a more modern and progressive approach to clinic design and to accommodate the expanding patient need. Emphasis on outpatient care and rapid intensive treatment with shorter periods of hospital stay for psychiatric patients has resulted in an increase in the number of veterans treated by VA's 122 mental hygiene clinics (32 of which were activated during the year), 40 day hospitals, and 52 day treatment centers.

ORGANIZATION

The Department of Medicine and Surgery is a highly decentralized organization. It is designed to permit the individual health care facilities and medical districts to adapt medical care programs to local needs and most effectively to utilize available resources.

Central management control is maintained through formulation of uniform general policies and monitoring activities by means of automated and other reporting systems. Central Office staff represents only 0.5% of the total DM&S employment.

The basic organizational unit for delivery of health care is the VA hospital (or other health care facility). Typically this is managed by a triad of Director (non-physician or physician/dentist) having line authority for the entire facility operation, an Assistant Director (non-physician) coordinating administrative services, and an Chief of Staff (physician) coordinating clinical services. Each service is headed by a service chief who is expert in his particular field of endeavor. In affiliated hospitals, a Dean's Committee advises the Director on the quality of patient care and the education and research programs, but has no control authority.

VA REGIONALIZATION CONCEPT

The primary objective of regionalization in the VA health care system is to improve patient care through effective, efficient, and economical use of available resources while minimizing the need to replicate services. Paramount in the organization design is the consideration of providing ready access to the required multitudinous resources of a complete health

care system. The patient may enter the system through any VA health care facility and is then granted easy access to all resources required for his diagnosis and treatment. Centain specialized medical services are therefore not required at every facility; however, these are usually available within the medical district organization and can be provided through a simplified referral method. Referrals are also expedited whenever unique services are required that are not available within the medical district. The regionalization concept, in addition, facilitates a flow of specialized consultative service among adjacent health care facilities and, thereby, often obviates the need for physical transfer of the patient.

A secondary objective of regionalization is improved utilization of VA and community health resources and facilities, making possible a more timely delivery of health services, faster pace of care, decreased length of stay, better bed occupancy rates, and appropriate placement to meet required levels of care for each patient's needs. This systems seeks also to avoid unnecessary duplication of specialized equipment, facilities, and personnel.

The present regionalization structure is made up of 28 geographic medical districts, one Hospital Director in each district is assigned as District Directror and regulates activity of all VA health care facilities within that area. He is aided by a small (no more than 4 people) administrative staff for this function.

VA Central Office

The Chief Medical Director is aided by a Deputy Chief Medical Director and an Associate Deputy Chief Medical Director for Operations. The Operations Office is organized on a functional rather than geographic basis and is in direct line authority between the Chief Medical Director and Medical District Directors in the field.

Functional staff offices are headed by seven Assistant Chief Medical Directors, each responsible for one of the following areas:

Professional Services

Administration

Academic Affairs

Research and Development

Dental

Policy and Planning

Extended Care

The Chief Medical Director has, in addition, a Budget Staff. For furhter staff assistance, he can also call upon the VA's Personnel Office, General Counsel, Construction Office, Controller, and Planning and Education staffs.

OPERATING COSTS

The operating costs of VA's Department of Medicine and Surgery are shown below:

Activity	Fiscal Year 1976 (thousand $)	Fiscal Year 1975 (thousand $)	Percent Change
Total Medical Programs...	$3,974,849	$3,460,533	+ 14.9
Medical Care.....	3,838,833	3,328,230	+ 15.3
Inpatient Care.....	2,824,986	2,478,611	+ 14.0
Hospitals.....	2,564,674	2,253,636	+ 13.8
VA Hospitals.....	2,516,812	2,210,014	+ 13.9
Contract Hospitals.	43,774	39,597	+ 10.5
State Home Hospitals....	4,088	4,025	+ 1.6
Nursing Homes.....	188,609	161,890	+ 16.5
VA Nursing Homes...	122,279	105,247	+ 16.2
Community Nursing Homes....	56,718	47,272	+ 20.0
State Nursing Homes	9,612	9,371	2.6
Domiciliaries.....	71,703	63,085	+ 13.7
VA Domiciliaries...	61,923	53,010	+ 16.8
State Domiciliaries	9,780	10,075	- 2.9
Outpatient Care.....	709,913	593,776	+ 19.6
CHAMPVA.....	22,092	13,208	+ 67.3
Education & Training...	202,259	177,756	+ 13.8
Miscellaneous Benefits and Services.....	79,583	64,880	+ 22.7
Miscellaneous Operating Expenses.....	34,516	36,881	- 6.4
Medical Administration.	22,450	23,048	- 2.6
Post Graduate & Inservice Training..	9,952	10,484	- 5.1
Exchange of Medical Information....	2,114	3,349	- 36.9
Research in Health Care	101,500	95,422	+ 6.4
Medical Research.....	96,890	91,626	+ 5.7
Rehabilitative Research	3,334	3,796	- 12.2
Health Services Research	1,276	....	+100.0

FY 1976 were $3,974,849,000, an increase of 14.9 percent over FY 1975. The accompanying table shows the distribution of these costs by program.

Although much of this increase is the result of rising workload, a portion must be attributed to inflation and increased acuity of care. The accompanying table lists those categories which showed the most notable increases in FY 1976.

Item	Change (FY 1976 v. FY 1975)	
	Amount (thousand $)	Percent
Personnel Services	$ 334,715	+ 14.5
Beneficiary Travel	8,414	+ 19.1
Communications	5,818	+ 25.0
Utilities	10,720	+ 22.6
Outpatient Dental Fees	3,716	+ 7.2
Medical and Nursing Fees	11,570	+ 25.6
Community Nursing Homes	9,224	+ 19.9
Contract Hospitalization	3,946	+ 10.3
Other Contractual Services	11,204	+ 16.6
Provisions	4,413	+ 6.6
Drugs and Medicines	27,204	+ 22.9
Medical and Dental Supplies	18,726	+ 20.4
Fuels	1,176	+ 8.3
Operating Supplies	10,705	+ 22.9
Prosthetic Appliances	6,809	+ 22.2

These net increases have resulted in higher per diem costs, as shown in the accompanying table.

COST OF OPERATION OF MEDICAL INPATIENT FACILITIES FY 1976
($'s in thousands)
(VETERANS ADMINISTRATION FACILITIES ONLY)

Activity	Total	VA Hospital Care			VA Nursing Care	VA Domiciliari
		Medical Bed Section	Surgical Bed Section	Psychiatric Bed Section		
Total Costs	$2,703,390	$1,271,198	$664,735	$583,185	$122,300	$61,972
Professional and Ancillary:						
Medical Services 1/	654,940	322,935	183,646	123,917	14,140	10,302
Nursing Service	756,489	367,352	192,732	156,020	38,115	2,270
Chaplain Service	13,941	5,937	2,546	3,636	907	915
Dietetics Service	255,444	107,962	46,539	63,978	18,596	18,369
Dental Service	28,554	12,633	5,526	7,992	906	1,497
Audiology & Speech Pathology	3,493	2,225	646	231	276	115
Direct Care, Total	1,712,861	819,044	431,635	355,774	72,940	33,468
Administrative Support	334,334	157,696	83,531	72,169	13,208	7,730
Engineering Support	329,739	136,376	68,887	87,298	21,984	15,194
Building Management 2/	160,129	70,627	35,993	40,452	10,217	2,840
Research Support	49,790	29,332	13,597	6,407	260	194
Asset Acquisitions	116,537	58,123	31,092	21,085	3,691	2,546
Support, Total	990,529	452,154	233,100	227,411	49,360	28,504

1/ Professional medical services include laboratory, pharmacy, blind rehabilitation, clinical nuclear medicine, rehabilitation medicine, social service, clinical psychology, radiology, medical illustration and library.
2/ Includes operation of laundry.

PER DIEM COSTS BY BED PROGRAM

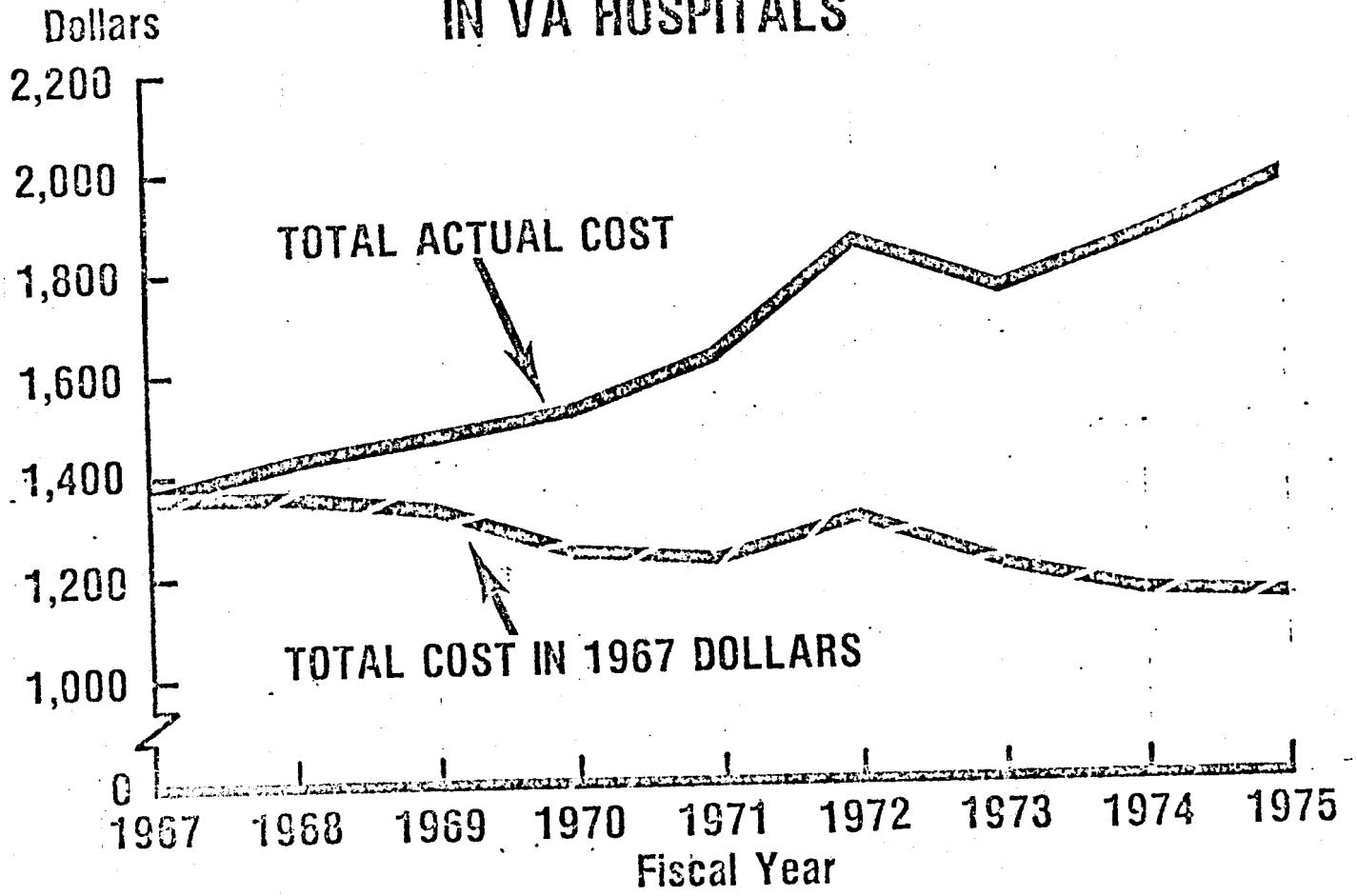
Type of VA Health Care Facility	Fiscal Year 1976	Fiscal Year 1975	Increase Amount	Increase Percent
Hospitals	$ 87.86	$75.71	$12.15	+ 16.0
Medical Bed Sections	91.36	79.49	11.87	+ 14.9
Surgical Bed Sections	117.52	102.45	15.07	+ 14.7
Psychiatric Bed Sections	64.08	54.12	9.96	+ 18.4
Domiciliaries	18.61	15.82	2.79	+ 17.6
Nursing Home Units	47.78	42.79	4.99	+ 11.7

The rising costs of medical supplies and materials, increased workload, and VA's efforts to deliver quality medical care are all contributing factors in the higher cost per patient day and cost per patient treated. Compared to FY 1975, the cost per patient day in VA hospitals increased by $12.15 to $87.86 in FY 1976, while the average cost per patient treated increased by $151 to $2,135 in FY 1976.

COST PER PATIENT TREATED

While per diem costs have historically been utilized as cost guidelines for VA's health care system, the cost per patient treated is more indicative of the VA's attempt to hold down the costs per hospitalization episode, as the accompanying table illustrates.

MEDICAL CARE
COST PER PATIENT TREATED
IN VA HOSPITALS



HOSPITAL CARE

Purpose:

To provide the best possible inpatient, medical, surgical and neuro-psychiatric care and related medical and dental services to veterans.

Programs:

VA General Medical and Surgical Hospital and Neuro-psychiatric Hospitals Program. 171 hospitals have 93,077 operating beds. 1,100,000 patients are expected to be hospitalized this year. The hospitals are providing a broad spectrum of services for patient care and in an increasing degree, comprehensive care. Standards of medical practice and advancing medical technology require the system to make constant change. Many specialized modalities and facilities for care have become essential components of the hospital facilities, such as units for intensive care, respiratory care, coronary care, spinal cord injury, and other special diagnostic and treatment entities. Comprehensive and preventive care with appropriate treatment and counseling are included in the hospital programs for hypertensive screening and sickle cell screening. The hospital is a focal point of the three essential programs of DM&S; patient care, education and research. The hospitals and all employees, in the fulfillment of the mission, strive for a quality of care equating with excellence. Comprehensive hospital care is provided through numerous special services which are briefly described below.

A. Major Bed Services.

1. Medical Service:

a. Professional Manpower: 5,815 full-time and 3,080 part-time physicians in VAHCF's. Of these 1,718 are board-certified in internal medicine.

b. Patient Care Responsibilities: 160 VA Medical Services with a total of 39,441 beds, which include acute inpatient, outpatient and intermediate levels of care. The Medical Service is also responsible for the following Special Medical Programs: Hemodialysis, Cardiac Catheterization, Medical Intensive Care Units, Coronary Care Units, Respiratory Care Centers, Special Diagnostic and Treatment Units, Coronary Care Units, Respiratory Care Centers, Special Diagnostic and Treatment Units, Pulmonary Function Laboratory, Hypertension Screening Programs and Sickle Cell Screening.

2. Surgical Service:

a. Professional Manpower: 752 full-time and 1,013 part-time surgeons.

b. Patient Care Responsibilities: There are 143 VA Surgical Services with a total of 19,834 surgical beds. The staff provides health care in the area of general surgery and in 9 surgical subspecialties. Surgery has responsibility for Prosthetics and Sensory Aids Activities and for the following Special Medical Programs: Surgical Intensive Care Units, Open Heart Surgery and Renal Transplantation.

3. Mental Health and Behavioral Sciences:

a. Professional Manpower: 966 full-time and 604 part-time physicians and 1,238 full-time and 93 part-time psychologists.

b. Patient Care Responsibilities: 93 VA Psychiatry Services with 28,435 beds. The Service also has primary responsibility for the following Special Medical Programs: Alcohol and Drug Dependence Treatment Units, Day Hospitals, Day Treatment Programs and Mental Hygiene Clinics.

B. Minor Bed Services:

1. Neurology Service:

a. Professional Manpower: 146 full-time and 156 part-time physician neurologists.

b. Patient Care Responsibilities: 69 VA inpatient Neurology Services with 2,805 beds and responsibility for the system's Epilepsy Centers.

2. Rehabilitation Medicine Service:

a. Professional Manpower: 295 full-time and part-time physicians, 74 RMS coordinators, and 3,998 therapists representing six different rehabilitative disciplines.

b. Patient Care Responsibilities: RMS Services are established in all VA hospitals, with responsibility for 1,082 beds in 40 of these hospitals. The Service also supervises Blind Rehabilitation Service which operated four Blind Rehabilitation Centers and a system of eye/vision clinics throughout the VA system, and Audiology and Speech Pathology which operates programs in 87 VAF's.

3. Spinal Cord Injury Service:

a. Professional Manpower: 144 F.T.E. physicians and some 2,200 other F.T.E. in Nursing, Psychology, Social Work,

rehabilitative therapies and other related disciplines.

b. Patient Care Responsibilities: There are 18 SCI Services located in geographically dispersed VAHCF's which are responsible for a total of 1,430 beds.

C. Diagnostic Services.

1. Nuclear Medicine Service:

a. Professional Manpower: 78 full-time and 43 part-time physicians; 27 full-time and 4 part-time physicists, and 347 full-time and 7 part-time nuclear medicine technical personnel.

b. Patient Care Responsibilities: There are 114 Nuclear Medical Services currently operative in separate VAHCF's.

2. Pathology Service:

a. Professional Manpower: (FTEE) 495 physicians; 5,105 technical personnel and 205 scientists.

b. Patient Care Responsibilities: Laboratory Services exist at all VAHCF's. The Service is also responsible for the Special Medical Program in Electron Microscopy.

3. Radiology Service:

a. Professional Manpower: 340 full-time and 124 part-time radiologists. Of the full-time radiologists, 252 are board-certified.

b. Health Care Responsibilities: Provision of radiological diagnostic services in all VAHCF's; and radiation therapy in selected facilities.

D. Allied Health Services

1. Chaplain Service:

a. Professional Manpower: 378 full-time, 292 part-time and 226 intermittent chaplains representing the Protestant, Catholic and Jewish faiths.

b. Health Care Responsibilities: Formal Chaplain Services at all VAHCF's.

2. Dietetic Service:

a. Health Care Manpower: 969 full-time and 54 part-time dieticians, and 10,822 full-time and 3,487 part-time food service employees.

b. Health Care Responsibilities: The nutritional care of VA patients is provided through an organized Dietetic Service in each VAHCF.

3. Nursing Service:

a. Health Care Manpower: 24,207 full-time and 1,733 part-time professional nurses; 7,117 LPN's and 24,931 Nursing Assistants.

b. Health Care Responsibilities: In addition to providing basic nursing care at each VAHCF, Nursing Services also provide the staffing of VA's Nursing Home Care Units, Nurse Administered Wards and Nurse Clinics.

4. Pharmacy Service:

a. Health Care Manpower: 1,337 full-time Pharmacists and 824 Pharmacy Assistant Technicians.

b. Health Care Responsibilities: Provision of pharmacy services in all VAHCF's.

5. Social Work Service:

a. Health Care Manpower: 2,629 full-time social workers, 469 social associates and 37 social work assistants and aids.

b. Health Care Responsibilities: Provision of social work services at all VAHCF's, Nursing Home Care Units and Domiciliaries.

6. Voluntary Services:

a. Health Care Manpower: 191 full-time employees.

b. Health Care Responsibilities: Coordination and direction of volunteer activities throughout the VA system. There are 107,000 volunteers who contribute 10,891,000 hours, giving indirect support and assistance to patients and families.

Hospital Beds

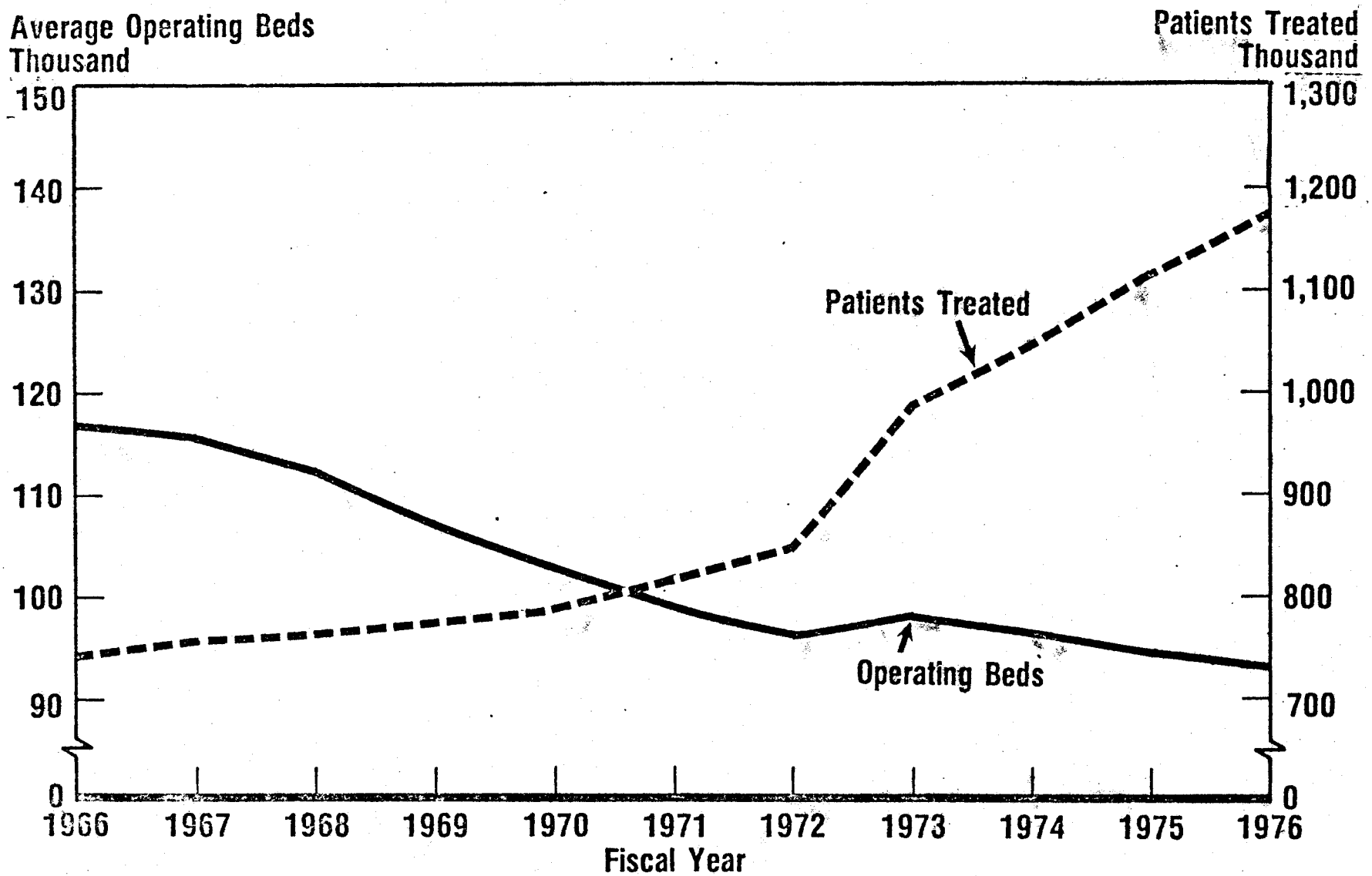
Prior to World War II, the VA reported as of June 30, 1940, 86 hospitals in operation with 59,637 beds. At the end of the war a gigantic expansion of VA health facilities became necessary due to the increase in veterans population to 19 million and liberalized veterans benefits. This expansion was largely accomplished by VA acquisition of military hospitals. Thus, in 1948 there were 126 hospitals in operation with 102,219 beds. Legislation was enacted that year for a construction program that would provide for an overall total of 152,000 beds. On January 17, 1949, President Truman curtained the total number of beds to be acquired by new construction by approximately 16,000 beds.

On February 29, 1959, President Eisenhower at the request of the VA Administrator, approved an authorized bed capacity for each VA hospital and a system-wide hospital bed authorization of 125,000.

The 125,000 authorized hospital bed level included new beds under construction and beds out of service due to construction, staff shortages, etc., thus, a 125,000 operating bed level was never attained. The VA's operating hospital bed level peaked in FY 1958 when an average operating level of 121,201 was attained. Since then, even with a progressively increasing number of hospital admissions, we have steadily decreased our hospital bed level to todays level of 93,077 beds. Significant bed reductions have been accomplished by means of increased emphasis on outpatient care, improved performanace effectiveness for care such as nursing homes. Additionally, as a result of a comprehensive study accomplished in 1969-70, it was

determined there were many hospital beds that were grossly overcrowded and not necessary to meet demand, while the elimination of these beds contributed significantly to the 28,000 operating bed reduction that has occurred in the past 19 years, the dominant cause was the increased pace of care made possible by newer treatment techniques. The use of ambulatory care and nursing home placements, and the improved management of consolidating resources brought to bear on the individual with the appropriate care at the proper time in the proper location. The dynamic improvement in bed utilization and shortened length of stay is reflected in the following chart.

OPERATING BEDS AND PATIENTS TREATED IN VA HOSPITALS



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Ambulatory Care
Fee Basis Care:

Purpose

The Veterans Administration provides medical care on a fee-for-service basis when such care is determined by the Administrator to be necessary or appropriate for the effective and economical treatment of a disability of a veteran, or a dependent or survivor of a veteran, who meets certain eligibility criteria.

Scope

This policy grew from the practice in the 1930's of the Veterans Administration using the services of private physicians to perform on a fee-for-services basis examinations for compensation and pension purposes. The Department of Medicine and Surgery instituted the "hometown" fee basis medical care program for the treatment of veterans with service-connected disabilities before the end of World War II when it became apparent that VA facilities could not provide all the care required for entitled veterans.

An unusually rapid rate of growth in workloads has also been experienced in recent years by staff at VA health care facilities as a result of the expanded eligibility and the increasing veteran population. From fiscal year 1972 through fiscal year 1976, hometown outpatient medical visits on fee basis increased by 37% while outpatient medical visits to VA staff increased by 79%. The current total outpatient workload for the VA is over 16,400,000 visits per year with almost 2,200,000 of these visits being conducted on a fee basis.

The private sector absorbs 13.3% of the total VA outpatient workload. The fee basis care program, which includes medical, dental, prescriptions, prosthetics, non-VA hospitalization, and community nursing home care now costs $2,242,000 a year.

On April 6, 1976, the Department of Medicine and Surgery established a task force to study all functions of the fee basis program. This group is charged with the responsibilities for (1) assessment of the present system so as to redefine and simplify its function requirements; (2) the investigation of existing alternate systems which may lead to the development of a centralized VA computerized system, purchase of an "off the shelf" software system, or lease of services to be provided by intermediaries; (3) the development of a conceptual design for a new system; (4) the development of feasibility and cost/benefit factors of the proposed new system; (5) the development of system specifications; and (6) the submission of summary of findings and recommendations. This project is progressing satisfactorily. Completion of the project is scheduled for not later than February 5, 1978.

LONG-TERM CARE

Purpose:

The program for long-term care constitutes a major contribution of the agency to the national effort to meet the growing health care needs of increasing numbers of older Americans. From now until the year 2000, barring armed conflict, a major thrust of the VA will be providing for the health care needs of the aging veterans. Program efforts de-emphasize institutional living and emphasize the humanistic approach to life.

Recognizing that the rapidly expanding veteran population above the age of 60 requires increased attention to patient care programs which provide alternatives to costly hospital care for patients requiring long-term care an Office of Assistant Chief Medical Director for Extended Care was established in 1975. The mission is to provide the necessary professional expertise and leadership for the following long-term care programs: VA Nursing Home Care, Community Nursing Home Care, Personal Care Home, Hospital-Based Home Care, Domiciliary Care, State Home Care (Nursing Home, Domiciliary, and Hospital), and Geriatric Research, Education and Clinical Centers. Through

increased emphasis upon long-term care programs, it is expected that the VA will improve the quality of care for long-term patients, broaden the scope of our services, and make more effective use of manpower and resources.

The VA has worked closely with the Administration on Aging (AOA) to initiate specialized services which will benefit the elderly veteran. For instance, the VA has been involved in the implementation of a working agreement with 13 other Federal agencies and AOA to improve information and referral services to older Americans.

Program Areas

VA Nursing Home Care -- This program, created in 1964 with the passage of P.L. 88-450, is designed for veterans, both convalescents and others, who are not acutely ill nor in need of hospital care but who require skilled nursing care and related medical services.

The primary purpose of a nursing home care unit is to provide skilled nursing care with related medical services, and individual adjustment services including social, diversional, recreational and spiritual activities and opportunities. Typically, a veteran admitted to a VA nursing home care unit is chronically

ill, has a permanent or residual disability, is expected to require a long period of nursing supervision, observation, and care, and requires special efferts of a long-term rehabilitative nature. All the services required for the comprehensive care of a veteran in the nursing care unit are available through the resources of the hospital.

Nursing home beds were increased during the course of the past year. On June 30, 1976, VA was operating 7,519 nursing home care beds at 88 hospitals with an additional 1,360 beds funded for design and/or construction through FY 1977. Our current projection of VA nursing home bed needs is 14,500 by 1985, based upon the statistical analysis of the aging veteran (and national citizenry) and the increased age-adjusted disease rate.

There were 10,979 veterans treated in this program in FY 1976 with an average daily census of 6,992. The average length of stay of patients discharged was 476 days. The average age of patients is 69 years, with 61.4 percent 65 or over.

Community Nursing Home Care -- This program is designed for veterans who are not acutely ill and not in need of hospital care, but who require skilled nursing home care and related medical services. The primary purpose is to aid the veteran and the family in making the transition from a hospital to the community by providing time to marshal resources for the veteran's continued care. Participating nursing homes must be licensed by their respective states. Follow-up visits are provided to the veteran in the nursing home by the hospital social worker, nurse, and other members of the treatment team.

Under this program, non-service-connected veterans may be placed in community facilities at VA expense for a period not to exceed six months. Veterans requiring nursing home care for service-connected conditions may receive such care at VA expense indefinitely.

A total of 22,998 veterans were treated in over 2,800 community nursing homes in the 50 States and Puerto Rico during FY 1976, with an average daily census of 6,646. The average age of veterans is 68 years, with 58 percent being 65 or over. Most (76.7%) receive compensation or pension from the VA.

Personal Care Home Program -- This program is designed to provide personal care and supervision in a homelike setting in the community to veterans who have no home or whose home is unable to provide the needed care. Approximately 35,000 veterans were placed in FY 1976. There is no financial support provided the proprietor of such homes by the VA. The charge is a liability of the veteran, comparable to renting a hotel or motel room or other lodging. VA social workers do make periodic follow-up visits to veterans to assist them in readjusting to the community.

Hospital-Based Home Care Program -- This program allows for an early discharge of veterans with chronic illnesses to their own homes. The family provides the necessary personal care under coordinated supervision of a hospital-based multidisciplinary treatment team. The team directs the medical, nursing, social, dietetic, and rehabilitation regimens as well as the training of family members and the patient. Thirty-one hospitals are providing home health care services. In FY 1976, 60,308 home visits were made by health professionals. By providing 259,827 days of care in the home, these veterans were maintained in their homes at

an average per patient day cost of $16.66, a cost-effective method of providing care while basic support is given by the family.

VA Domiciliary Care -- The VA domiciliary program is designed to provide necessary medical treatment and comprehensive professional care for eligible ambulatory veterans in a residential-type setting. To be entitled to domiciliary care, the veteran must have a disability chronic in nature, must be incapacitated from earning a living, and have no adequate means of support.

The primary focus of the domiciliary had traditionally been to provide food, lodging, and limited medical care in an institutionalized setting. During the time period 1967-1975, there was a change in emphasis from custodial care to a therapeutic community concept stressing more preventive health services, rehabilitation, and restoration.

A modest construction effort has been initiated to counter the inadequacies of existing domiciliaries while recognizing the need for emphasis on privacy and on the psychosocial aspects of congregate living. Design criteria have been developed which address the multiple needs of the aging veteran resident, and are capable of conversion to nursing

home care at minimal cost. Construction of the prototype for a new 200-bed domiciliary will begin in FY '77 at Wood, Wisconsin, with one at Hampton, Virginia and another at Dayton, Ohio scheduled in the near future. Long-range plans envision one such domiciliary in each of the 28 Medical Districts. Many of the aging domiciliary buildings are economically infeasible to rehabilitate and will be razed, while those judged suitable for rehabilitation to meet life safety codes will be brought up to standards.

On June 30, 1976, VA's 18 domiciliaries were operating 10,152 beds. During the year, the average daily census was 9,090 and 18,408 patient/menbers were treated. The average length of stay of patient/members discharged was 391.2 days. The average age of patient/members is 60 years, with 30.4 percent being 65 or over. Most (77.0%) receive compensation or pension from the VA.

State Home Program -- Through grants-in-aid, the VA assists the States in providing domiciliary, nursing home, and hospital care to veterans in State veteran homes. VA makes per diem payments for the care of eligible veterans and provides grants up to 65 percent of costs for the cost of construction and remodeling of State home facilities.

Under the Federal/State sharing legislation to construct or remodel nursing home care facilities and to modernize existing domiciliary or hospital facilities in State homes, VA has participated in 34 projects to construct 4,587 nursing home care beds, and 77 projects to remodel existing nursing home, domiciliary, and hospital care facilities.

Forty State homes in 31 states (including two annexes in Nebraska) provided care to veterans during FY 1976. Of these homes, 33 provided 8,125 veterans with nursing home care, 35 provided 11,544 veterans with domiciliary care, and eight provided 6,814 veterans with hospital care. The combined average daily census during the year was 10,829.

Geriatric Research Education and Clinical Centers -- As a corollary to VA long-term patient treatment programs, and consistent with our recognition of the increasing need for alternatives to care of the aged, the Geriatric Research, Education, and Clinical Center (GRECC) program was begus in 1974. This innovation placed the VA in the vanguard of developing integrated programs where research into problems of aging could be coupled with education about

the aging process in a clinical setting. Eight GRECC's now exist under the oversight of eminent scientists on the GRECC Federal Advisory Committee.

DENTAL PROGRAM

PURPOSE: The mission of Dentistry in the Veterans Administration is to provide oral health care integrated with other medical patient care, to contribute to the training and continuing education of professional and paradental personnel, and to pursue research in oral biology for the advancement of allied health sciences.

Program Areas

Inpatient Dental Program - A complete oral examination by a dentist is an integral part of the required physical examination for patients admitted for hospitalization. Treatment objectives are consistent with overall patient care requirements.

Outpatient Dental Program - These benefits are accomplished by both VA staff and private, hometown dentists. In FY 1976, 83,670 treatment cases were completed by VA staff and 123,419 treatment cases were completed through fee basis authorizations at a cost of $56,400,000.

Special Medical Programs - Continued efforts to upgrade the quality of dental services are reflected in an increase in the types of care which emphasizes prevention and conservative management of disease processes. Procedures to restore and preserve oral health and function gained further impetus. Implementation of special medical programs in preventive dentistry, team dentisty and dental auxiliary expanded functions enhances the scope of these objectives. Classification and qualification standards are now being develped for expanded functions dental auxiliaries (EFDA). It is anticipated that the initial employment of EFDA's under Title USC 38 will occur during calendar year 1977.

Training and Continuing Education - Affiliations with all U. S. dental schools and 143 community colleges have led to an extensive involvement in postdoctoral residencies, clinical clerkships, and dental auxiliary training. The Dental Training Center at VAH Washinton, D. C. is a major contributor to continuing education which is vitally important for professional advancement, relicensure requirements, and peer review evaluations. This Center conducts training courses for VA dental personnel; produces single concept films, a number of which have received national acclaim; and has distributed 30,000 single concept cassettes for use throughout the agency, the private sector, and the academic community.

Facilities Improvement - Significant progress in updating dental equipment has been realized during the past few years. The acquisition of essential modern-concept equipment items has facilitated the delivery of quality care as every treatment facility now possesses the capability for professionals to practice team dentistry. We are in the exploratory phase of updating health care facilities space criteria for dental clinics.

Research - The growth and excellence of oral biology research is easily demonstrated. In 1955, the first year of our participation in the International Association of Dental Research, two papers were presented by VA investigators. In 1976 the Veterans Administration was listed among the leading contributing organizations ranking thirteenth for the total number of dental research presentations and tenth for the number of times it was cited in the program.

AFFILIATIONS: In 1946 the Veterans Administration embarked upon a program of affiliations with the Nation's medical schools. This effort was initiated in order: a) to provide veterans with the highest quality of health care; b) to provide postgraduate study opportunities in medicine for veterans who had to forego this opportunity while serving their country; and, c) to raise the standard of medical practice in the United States by participation in the expansion of opportunities for graduate medical education.

In the ensuing three decades there has evolved a truly remarkable symbiotic relationship between the Veterans Administration and the Nation's academic community. The product of this relationship has been one of the most extensive education and training efforts for health manpower that currently exists in the Nation today. The beneficiaries of these efforts have been the veterans of this country whose quality of care has indeed been enhanced and a Nation whose health manpower pool would have been greatly diminished had the effort not been initiated and expanded to its present level.

The initial affiliations have grown to include 102 of 119 medical schools with 130 of the VA's facilities, and all 58 of the country's dental schools with 74 VA facilities. Also included as partners in the VA's education and training effort are 358 schools of nursing, 72 schools of pharmacy, 199 schools and departments of social work, 241 departments of psychology and more than one thousand other educational units in allied health in universities, colleges, junior and community colleges, and technical institutions.

Through this partnership in Fiscal Year 1976 over 87,000 students were involved in the VA's facilities for a portion of their training, including 28 percent of the medical students and 26 percent of the medical house staff of the country. Over 80 percent of these students are participating without pay from the Veterans Administration.

The VA has benefited from recruitment of many of these students to their facilities upon completion of training. Their very presence has enhanced the recruitment of other high quality staff to the VA. The veterans have benefited from this enhanced staffing, and increased quality of care has been a real and direct derivative. The Nation's health manpower pool has been expanded appreciably.

GRANTS FOR MANPOWER TRAINING

The importance of the VA as a resource in the Nation's manpower production was further acknowledged by the passage of the Veterans Administration Medical School Assistance and Health Manpower Training Act of 1972 (P.L. 92-541). It authorized the establishment of grants to academic institutions for education and training activities, to be conducted in affiliation with VA health care facilities, to assist in meeting the needs of the VA and of the Nation for manpower in the health professions and occupations. Under this law, support is being provided in the establishment of four new state medical schools. Also being supported are 18 additional established medical schools and 96 other health professions and occupations training programs.

In addition to achieving the primary purposes of expanding enrollments and enhancing the educational programs of the grantee institutions, the grants now active have resulted in 14 VA hospitals being effectively affiliated with medical schools for the first time and experiencing greater availability of specialized services for their patients and access to a much broader base for recruitment and retention of professional staff. Under still other grants, enrichment of some 100 existing affiliations is having similar results for the VA partners.

The VA has an obligation not only to the development of new health manpower, but also in assuring the continued updating of its existing manpower. A portion of this critical need for awareness of new advances in biomedical knowledge is met as an important by-product of the educational milieu created by the academic affiliation mentioned above. With the rapid proliferation of new requirements for recertification and relicensure of all health professions comes the responsibility for specific efforts in continuing education of VA health personnel.

REGIONAL MEDICAL EDUCATION CENTERS

Existing efforts in continuing education must be expanded. In addition the VA has, under authority of Subchapter II of P.L. 92-541, commenced the establishment of Regional Medical Education Centers (RMEC). As of this date five RMECs, widely dispersed geographically, have been established. These regional centers are providing in-residence and related continuing education experiences for medical and health

personnel of the VA. In that each center must now serve over thirty other facilities there must be expansion of the existing centers as well as establishment of additional centers in the near future.

EXCHANGE OF MEDICAL INFORMATION

Underpinning these basic and continuing educational activities, is a learning resources effort made up of library support and networking, as well as significant medical media (audio visual) activities. Specific authority (P.L. 89-785 and succeeding continuing legislation) has made possible the establishment of the Exchange of Medical Information (EMI) program.

This program has the responsibility for developing and supporting pilot projects which have as their objectives the strengthening of those VA hospitals located remote from major medical centers, and promoting consultation and cooperation among clinicians and other members of the medical and health related professions who are within and outside the VA.

The operation of the VA's health care delivery system of 171 hospitals and 213 outpatient clinics carries with it a mandate to provide the most effective care to every eligible individual who comes to a VA facility regardless of its location.

In order to accomplish this, the agency must look to the latest scientific and technological developments to determine what impact each may have on the delivery of quality medical care and to determine how these achivements may be harnessed in ways that are cost-effective and in the interest of constantly improving medical care. The EMI Program is the vehicle through which this is accomplished.

Since its inception in 1968, over forty separate EMI projects have been approved and funded. The annual budget for the EMI program totaled $942,000 in FY 1968 and is at the level of $3,500,000 in FY 77. Maximum funding authorized by legislation throughout FY 77 is $4,000,000.

The educational and training programs in the VA have, since their inception in 1946, clearly established their worth. Over three decades they have enhanced the quality of care provided in the VA's facilities significantly. They have provided invaluable additions to the VA's and the Nation's health manpower pool.

In the decade ahead every effort should be made to sustain and enhance this remarkable alliance of the VA with the academic community. The health of our veterans is dependent upon it. Through the quality health manpower produced, the Nation is dependent upon it.

The authority provided by P.L. 92-541 (38 U.S.C. Chapter 82) will expire at the end of FY 1979. The Department of Medicine and Surgery will request extention of the authority provided in Sub-chapter II and III.

RESEARCH AND DEVELOPMENT

PURPOSE: To conduct and support research and development - including biomedical, rehabilitative engineering, and health services programs - that enable the VA and its Department of Medicine and Surgery to provide most effectively for the complete medical care of veterans (38 USC 4101(c) as amended by PL 94-581, Sec. 205). In addition to the direct improvement of care for veterans, the programs provide biomedical knowledge of benefit to all citizens making such results available without delay and facilitate the recruitment and retention of health care professionals for the Department of Medicine and Surgery.

NATURE OF PROGRAMS

Research and development are chiefly intramural with projects conducted by the professional staff of VA hospitals and clinics. Most programs are administered locally to ensure their relevance to the VA's patient care mission. Centralized control is maintained to a degree sufficient to guarantee quality, safeguard patients' welfare, and facilitate cooperative programs between two or more hospitals. Contracts and Interagency Agreements are used to secure services not available within VA, but the agency does not administer a grant program in research.

PROGRAM AREAS

Research and development is conducted in three primary areas, each represented by a Service.

Medical Research Service. Programs cover a wide range of biomedical projects directed by some 3,250 physicians, dentists, and other health care personnel. These projects numbering over 5,000 include laboratory and clinical research in 132 hospitals and clinics.

The biomedical research program has supported VA medical scientists recognized throughout the world, including winners of five Lasker Awards as well as those honored by the American Diabetes Association, the American Heart Association, and the American Cancer Society. VA Cooperative Clinical Studies, each involving many hospitals and hundreds of patients, have established the optimal treatment plan for hypertension, prostatic cancer, various mental diseases, and tuberculosis. Work is continuing on the evaluation of heart operations for coronary artery disease and of means for preventing hepatitis. VA investigators have given the world the widely used radioimmunoassay technique and the principle of the CAT scanner which is revolutionizing X-ray examinations.

Rehabilitative Engineering Research and Development. The prosthetics research program has been reorganized and renamed to reflect its growing importance in areas in addition to those of artificial extremities. Programs include the search for improved aids to the blind and deaf, better means for transporting the handicapped and for enabling the paralyzed to care for themselves. The goal is an improved quality of life including greater independence for the handicapped.

Since World War II, the VA prosthetics and orthotics program has been considered a world asset. The Service's accomplishments have been recognized by lay and professional organizations for leadership in such difficult areas as reading machines for the blind, development and evaluation of wheel chairs, and the continuing training of technicians and professionals in the use of new developments. It has set standards for and currently is involved in the development and evaluation of automotive conveyances for the paralyzed and adaptive equipment as mandated by Congress (PL 93-538).

Health Services Research and Development. Research, development, and evaluation are new activities as applied to systems for the delivery of health care. The Service, of recent origin, is as yet of limited scope. It is concerned with such problems as the optimal management of an information system in a health care facility, innovative schemes of patient care by multidisciplinary systems, the best way to use new medical equipment, and improved ways to evaluate the quality of patient care.

The Service has developed the system and many of the tools currently used by VA facilities to evaluate patient care. This evaluation is both episodic as conducted by an outside group and continuing as a program for the facility's staff. Present efforts include developing better automated management of hospital data. Attention is also being given to training research personnel for health care systems since this new field still lacks an adequate number of qualified investigators.

PROBLEMS

Despite these contributions, VA research has received relatively little recognition within the Federal government. Because such research is broadly devoted to clinical excellence rather than categorical disease entities, Congressional initiatives in these categorical areas sometimes overlook the important role the VA plays in translating laboratory findings into actual practice. Of even greater importance is the lack of complete appreciation within the Executive Branch of the fact that the Veterans Administration research program is not only crucial to the sustaining of high level care for the veteran, but that it provides the only resource the nation has for certain types of studies (such as multi-hospital clinical trials) and the best available resource for others (including health systems research and clinical research in Alcoholism and aging). Two examples can be cited: The commitment to alcohol-related research matches that of any Federal agency including the National Institute on Alcohol Abuse and Alcoholism. VA efforts in prosthetics research represent almost 50% of the national effort in this area even though the VA receives only 1/20 of the total federal health care research support.

Interagency cooperation, particularly with DHEW, is excellent and its effectiveness depends on the continuing support of the clinically directed research program of the VA. Recognition of this important fact outside the agency has often been lacking.

SPECIALIZED MEDICAL PROGRAMS

Specialized Medical Programs are critical to the VA's ability to assure every patient of modern medical care. In 1966, the VA determined that it was extremely important to provide for new technology and developments in the medical field. Programs such as Hemodialysis, Intensive/Coronary Care Units, and Respiratory Care Centers which required specialized resources and involved a complexity of costs, planning, and construction were initiated. At the end of FY 1967, the VA had established 18 specialized programs with a total of 401 units in operation. At the close of FY 1976, the VA had established 21 specialized medical programs with a total of 1,183 separate units in operation. Specialized Medical Program planning on a regionalized basis will continue in order to provide quality health service without unnecessary duplication of resources.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE VETERANS ADMINISTRATION (CHAMPVA)

The Veterans Administration provides medical care for: (a) The spouse or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability, or (b) The surviving spouse or child of a veteran who died as the result of a service-connected disability, and (c) The widow or child of a veteran who had a service-connected disability, total and permanent in nature at the time of death. The CHAMPVA care is usually rendered in non-VA facilities under the same or similar limitation as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Specialized care for which the Veterans Administration is best equipped to provide may be provided in VA health care facilities when not needed for an eligible veteran.

Persons who have attained age 65 and are eligible for Medicare and persons eligible for CHAMPUS benefits are precluded from eligibility for CHAMPVA. Children are eligible for CHAMPVA benefits through age 18. When a child is enrolled in an approved school, benefits are extended to age 23.

Public Law 93-83 provided the authority for the Veterans Administration to initiate the CHAMPVA program and Public Law 94-581 has extended those benefits to eligible survivors of veterans who had a total disability, permanent in nature, regardless of the cause of such veteran's death.

Benefits authorized under CHAMPVA are limited to medical benefits and include treatment on an inpatient or outpatient basis for medical, surgical or psychiatric conditions, necessary supplies, drugs and medicines, when administered as a part of hospital care or by a physician, oxygen or insulin, ambulance or family planning services, dental care as necessary adjunct to medical and surgical treatment, orthopedic braces, crutches, artificial limbs, artificial eyes, and rental of durable medical equipment.

The following medical benefits are excluded from CHAMPVA: Domiciliary and custodial care, physical examinations and immunizations which are not for diagnostic or treatment purposes, well-baby care, perceptual and visual training, eyeglasses or examinations for correction of ordinary refractive error, hearing aids, orthopedic shoes and

prosthetic appliances (other than artificial limbs or eyes) and routine dental care and orthodontia care.

CHAMPVA may be provided not only to residents of the United States, but also to eligible U.S. citizens who are residing in foreign countries.

The CHAMPVA program was enacted into law September 1, 1973. During FY 1975, $17,428,679 was expended for medical benefits to 152.264 CHAMPVA beneficiaries.

During Fiscal Year 1976 expenditures for CHAMPVA medical benefits were $24,588,902. As of September 30, 1976, 102,186 applications had been approved which involved 187,737 CHAMPVA beneficiaries.

HEALTH CARE QUALITY CONTROL

Purpose

To ensure that the health care provided to veteran beneficiaries in VA health care facilities is of optimal quality, DM&S has developed a health care quality control program, the Health Services Review Organization (HSRO). Within the DM&S, the HSRO is coordinated and controlled by the Health Care Review Service (HCRS). Each VA health care facility is required to develop its own HSRO quality control program, with guidelines and consultation provided by the HCRS.

Program Areas

The quality control program consists essentially of two complementary sets of activities: quality assurance and quality review. Quality assurance activities relate to those organizational and clinical components of the facility that are established, in accordance with standards and criteria, to provide care of the highest quality. Quality review comprises the evaluative procedures systematically undertaken by the facility to ensure its organizational and clinical components continue to meet established standards. By means of these continuing evaluative programs, the quality control program is constantly modified, refined and improved.

The organizational components covered by the facility's quality assurance activities include, for example, the facility's environment, top management, relations between its clinical and support services, fire safety and other structual systems; and the clinical components include multi-level care, management by clinical algorithms and procedures designed to ensure that each patient entering the facility receives care that is timely and forms an integrated logical sequence.

On a biennial basis, the HCRS evaluates, by means of a multidisciplinary survey team, the effectiveness of each VA facility's quality control program.

FACILITY IMPROVEMENT FOR QUALITY CARE

Capital Improvements - VA Health Care Facilities

A number of our 171 health care facilities are old and approaching obsolescence. Over the years our capital investment resources have not kept pace with the physical facility needs of our health care system. Thus, many of our facilities are in urgent need of replacement, modernization, expansion or significant improvement projects.

Several years ago DM&S, in recognition of the system-wide gross space deficiencies and functional inadequacies, initiated a 5-year facility planning process for each of the 171 VA health care facilities. The objectives of the program are to maximize the benefit of every physical move or alteration accomplished; to have a complete and up-to-date inventory of health care facility deficiencies and facility improvement needs in priority order and a fiscal year plan for accomplishment; and lastly, to provide an orderly base which can be used to objectively recommend annual expenditure of resources for capital improvements. This 5-year facility planning process has been implemented and is being maintained by an annual revision process.

In order to supplement this 5-year facility planning system so that annual construction programs of facility replacement, modernization and other improvement construction projects can be objectively prioritized, DM&S has recently developed a "Space and Functional Deficiency Identification System" (SFDI). This system provides identification of

space and functional deficiencies at health care facilities utilizing a standardized, objective and integrated methodology. It will provide a standardized evaluation of individual health care facility deficiencies and needs and permit objective comparisons of facilities for priority programming purposes. To appreciate the magnitude of the facilities, DM&S system now includes 17,586 acres of land, 5,284 buildings having 60 million square feet of floor space and 1,638,000 items of major equipment with a replacement value of approximately $6,700,000,000.

Patient Environment in VA Health Care Facilities

In recent years the JCAH has examined more closely and set higher standards for patient privacy and improved environment. The evolving concepts of humane and modern health care recognizes the positive contribution of improved environment in patient treatment. This problem encompasses overcrowding, multiple occupancy in one room, privacy in toilets, bathing areas and bedrooms, decor and the personalization of one's living environment. A lack of privacy not only detracts from high quality patient care, but also jeopardizes the accreditation of individual institutions. This has resulted in one year accreditation to an increasing number of VA facilities.

A recent DM&S study determined that provision of required privacy in all VA facilities, utilizing permanent correction solutions, will require additional expenditures. Further, it is apparent that some bed loss will occur in the correction of these deficiencies. DM&S has completed a revised criteria standards and guidebook which has been published to assist individual VA facilities in developing their solutions to patient privacy requirements.

Fire and Safety Deficiency Identification and Correction

Correction of fire and safety deficiencies has long been a major concern of the VA and corrective action has been taken to the extent deficiencies have been identified and budgeted funds would permit. The Joint Commission on Accreditation of Hospitals (JCAH) has placed increased emphasis on fire and safety aspects in their hospital surveys. Numerous citations by the JCAH in recent surveys and requirements of the Occupational Health and Safety Act has prompted the VA to engage professional fire and occupational safety surveys of each VA health care bed facility. Primary deficiencies cited by JCAH and anticipated in the professional surveys are: deadend corridor conditions, lack of sprinkler systems in key areas, need for improvement of compartmentation and smoke containment capabilities, improved smoke and fire detection and alarm systems, and improvement of occupational safety. With review of the professional surveys just commencing, magnitude of correction for fire and safety deficiencies will be major. Additionally, it is apparent that bed losses will occur in the correction of these deficiencies.

PLANNING PROCESS

The Chief Medical Director reviews and acts on the options and alternatives of short, intermediate, and long-range plans for DM&S through a formalized organizational structure of a Planning Service reporting to the Assistant Chief Medical Director for Policy and Planning and in turn to the ACMD reporting to the CMD. This process involves all segments of DM&S in the development and coordination of the planning process.

The many issues and problems are broad, complex and affected by directive legislation and interrelated legislation and Presidential iniatives, e.g., federal-state-local interactions and budgetary controls. Public interests through long standing organizations, i.e., veterans organizations must be recognized.

The primary planning issue for the future is the role of the VA under the concept of partial or full national health insurance coverage. Our system can and should be a major contributor to that effort.

COORDINATION OF PLANS - NON-VA

VA health care planning and development is coordinated with State and community representatives in two ways. VA officials participate in local Health System Agencies and State Health Coordinating Councils established by the National Health Planning and Resources Development Act of 1974 (PL 93-641). These planning groups located throughout the nation are responsible for health planning in their respective areas. The VA participates to the greatest extent compatible with fulfilling the agency's statutory mission. The VA through the OMB Circular A-95 notification process, provides the area and statewide clearinghouses an opportunity to review and comment on the agency's appropriate construction and program plans. This mechanism enables state and area Clearinghouses to insure community interests are represented in the VA planning process, and protects against unnecessary duplication of services. During the recent review of the VA system to determine the need and possible locations for placement of computerized axial tomography (C.A.T.) x-ray units, each hospital which wished to be considered was required by DM&S policy to submit a "certificate of need" letter from the local planning agency.

Management by Objectives

The Department of Medicine and Surgery has found that Management by Objectives (MBO) is an effctive tool in the planning and managing of its health care delivery system. The MBO technique, which is well accepted in the field of management, defines clearly what is to be accomplished, sets specific objectives, establishes target dates for accomplishment, and monitors the progress. VA objectives deal with new programs, expansion of programs, problem areas in existing activities, and significant modification of on-going programs.

This participative management concept allows for the best input from all staff on important issues facing the health field. A comprehensive view of each issue is achieved and an informed decision can be reached to assure the most appropriate allocation of resources available to support high quality comprehensive health services.

SUPPLY SERVICE

PURPOSE: The VA Supply program, as the procurement are of the agency, renders supply support to the most extensive medical program in the Federal Government. A Marketing Center, three Supply Depots and 171 Supply Services in health care facilities furnish support about 250 VA installations, and about 400 installations of other Government agencies throughout the United States, the Republic of the Philippines, the Commonwealth of Puerto Rico, and Trust Territories.

Based on data submitted for the Fiscal Year 1976, VA Supply Service workload approximated $900 million. About $870 million of this figure represent expenditures for supplies, equipment and services for VA activities; and the remaining $30 million represent the volume of supplies and equipment furnished other Government agencies. In addition, VA Supply Service awards term contracts for nonperishable subsistence, drugs, and x-ray film, which are used by Federal civilian agencies, in the amount of approximately $67 million.

PROGRAM AREAS

Supply Service is responsible for supply support to all elements of the Veterans Administration. This involves implementing all statutory and executive directives relating to procurement and property management processes, as well as initiating new supply policies and procedures within the constraints of applicable statutes and directives. In addition, Supply Service participates in the following special activities:

(a) Implementing OMB directives on a single-manager concept for subsistence and drugs for the Federal Government, procurement of commercial/industrial products and services, use of commercial distribution facilities, and the Federal Procurement Data Sytesm.

(b) Assisting in the development of the Federal Procurement Institute.

(c) Participating in interagency studies on the Federal Quality Assurance program for food, and on marketing information for food procurement

(d) Continuing to operate the most successful silver recovery program in the Federal Government, which makes VA the equivalent of the 18th largest of the 80 silver mines in the country.

VETERANS CANTEEN SERVICE (VCS)

Purpose

On August 7, 1946, Public Law 636, 79th Congress, was passed establishing the Veterans Canteen Service as an instrumentality within the Veterans Administration with the primary purpose of making available at reasonable prices to veterans of the Armed Forces who are hospitalized or domiciled in hospitals and home of the Veterans Administration, articles of merchandise and services essential to their comfort and well-being.

The law further provides that canteen services may also be provided to personnel of the Veterans Administration, recognized veterans, organizations employed at VA facilities, families of the foregoing who reside on the VA grounds, and to relatives and other persons while visiting the aforementioned authorized customers - with the provision that sale of merchandise or services to visitors be limited to those items which are consumed or used on the premises.

VCS is self-sustaining and is financed by a revolving fund. VCS management annually budgets the Service to net only as much income as necessary to maintain current operations and needs for the ensuing fiscal year. Any balance in the revolving fund at the close of the fiscal year in excess of the estimated requirements for the ensuing fiscal year shall be sent to the Treasury as miscellaneous receipts.

Canteens are planned in size, equipment, staff and merchandise to meet the particular needs of the health care facility. Patient mix

(General Medical, Psychiatric, Spinal Cord Injuiry, Nurtsing Care and Domiciliary) has a strong influence on the canteen makeup. Although the degree of service may vary, the pattern of services provided remains uniform.

Scope

While a canteen typically includes a retail store, cafeteria, barber shop, and vending room, most canteens also provide additional services such as dry cleaning and laundry, repair, and photo services. Since the program is oriented toward patients, many canteens use ward carts which make regular rounds bringing merchandise and services to non-ambulatory patients.

In addition to providing merchandise and services, canteens also provide some relief from the confinement of hospital life and helps build morale. Confined psychiatric patients are brought into the canteens for supervised shopping trips, which includes selection of their own clothing. This therapy encouraged decision-making and interest in personal appearance and helps prepare the patient for return to society.

APPROVED REPLACEMENT HOSPITALS NOT UNDER CONSTRUCTION

During FY 1976 the Department of Medicine and Surgery completed a series of analytical studies of eight geographical locations where planned replacement or new hospitals were under consideration. The purpose of these analysis was to project the supply of medical services necessary to meet the estimated future demand at each location. The areas studied were:

Bay Pines, Florida
Baltimore, Maryland
Little Rock, Arkansas
Martinsburg, West Virginia
Philadelphia/Southern, New Jersey
Portland, Oregon/Vancouver, Washington
Richmond, Virginia
Seattle, Washington

These analyses were furnished to health care consulting firms hired by the VA to conduct a comprehensive study which included an evaluation of our existing facilities; the consideration of the availability and utilization of health service resources in the area; a review of potential sites; an analysis of the necessary size, composition, and cost of recommended construction; and an environmental assessment.

The VA analyzed the consultants' reports, recommendations, and alternate solutions for the eight major construction projects and developed recommendations and priorities for each project and submitted the results to the President.

On May 11, 1976, the President announced his decision for construction of the eight hospitals. He amended the FY 1977 Presidential Budget to the Congress to provide design funds in FY 1977 for the eight hospitals and to provide in FY 1977 construction funds for a replacement hospital in Bay Pines, Florida; and Richmond, Virginia. The President further indicated he would seek construction funds for the other six hospitals at the rate of two per year in subsequent budget years in the following priority: Martinsburg, Portland, Seattle, Little Rock, Baltimore, and Camden.

On May 20, 1976, the Subcommittee on Hospitals of the Committee on Veterans' Affairs, House of Representatives held hearings on these eight major hospital projects (Report of Hearings, page 2157-2253).

INTERGOVERNMENTAL COUNCILS AND COMMITTEES

AND DM&S ADVISORY COMMITTEES

DM&S participates in a wide range of councils and committees established by other federal agencies. Some are statutory in nature and name the Chief Medical Director as a member. Other committees are non-statutory, but are established by the President or a federal officer, including a committee which was authorized, but not established by a federal statute. Additional committees are not statutory but DM&S representation or liaison is desired because of the common efforts of the two or more agencies.

Public Law 92-463, the Federal Advisory Committee Act, enacted October 6, 1972, authorized a system for the establishment of advisory committees and delineated the responsibilities, purpose, procedures and other rules governing their activity.

The Chief Medical Director is ex-officio member of the following interagency councils or committees:

National Advisory Counsel on Aging
Allergy and Infectious Diseases
Armed Forces Institute of Pathology
National Arthritis Advisory Board
Cancer Advisory Board
National Advisory Council on Arthritis, Metabolism, & Digestive Diseases
National Advisory Dental Research Council
Commission on Digestive Diseases
National Advisory Eye Council
National Advisory Council on General Medical Sciences
National Advisory Council on Health and Lung
Board of Regents, Library of Medicine
National Advisory Neurological and Communicative Disorders and Stroke Council
National Advisory Research Resources Council
Sickle Cell Disease Advisory Committee

Arthritis Coordinating
National Diabetes Advisory Board
Health Data Policy Committee (DHEW)
National Council of Health Planning, P.L. 93-641
Science & Technology Policy Organization and Priorities Act of 1976
VA Committee (DOD-DHEW)

Other DM&S officials are members of additional councils and committees under the auspices of National Institutes of Health, General Services, Administration, Department of Health, Education and Welfare, Department of Agriculture, National Institute on Drug Abuse, Food and Drug Administration, Executive Branch of the President, American National Standards Institute, National Institute of Mental Health, American Dental Association, Department of Defense, National Institute on Alcohol and Drug Abuse, Civil Service Commission, Office of Management and Budget, Commerce Department, National Science Foundation, American Hospital Association, Environmental Protection Agency, Small Business Administration and others.

In addition, there are 22 chartered DM&S Advisory Committees covered by Public Law 92-463, Executive Order 11686 (October 7, 1972) and the revised draft of OMB Circular A-63 (December 26, 1972). The sole function of these committees is to provide advice to the VA on specific subjects.

Career Development
Cooperative Studies
Geriatric Research & Clinical Centers
Health Manpower Training Assistance
Medical School Assistance Review
Special Medical Advisory Group
Spinal Cord Injury
Voluntary Service

Merit Review Boards:
Alcoholism & Drug Dependence
Basic Sciences
Behavioral Sciences
Cardiovascular Studies
Endocrinology
Gastroenterology
Hematology
Immunology
Infectious Diseases
Nephrology
Neurobiology
Oncology
Respiration
Surgery

The Special Medical Advisory Group is required by Section 4112(a) of Title 38 U.S.C. It is comprised of members of the medical, dental, and allied scientific professions who, through advice and counsel, assist in the advancement of the functions of DM&S. The scope of the Group's activity includes review of and recommendations covering medical care and treatment of veterans, medical research, and education and training of health manpower.

CONSUMER AND VETERANS ORGANIZATION PARTICIPATION

Unquestionably, the most significant consumer participation in policy and program planning is through the receipients of medical care. There are mechanisms, both formal and informal, whereby information is channeled to the appropriate management level. There is extensive personal contact involved in medical care and the concerns of the patient (consumer) are relayed rapidly to local management through normal organizational channels. This input is reflected also in planning and policy decisions. The hospital and clinic staff members providing treatment are perhaps the most effective advocates of the consumer on the local level.

More formal mechanisms for consumer participation at the local level include veterans' organizations, Veterans Administration's Voluntary Service, patient satisfaction surveys, and local advisory committees. The close relationship between the VA and veterans' organizations has been especially helpful. Service officers of major veterans' organizations are provided office space in VA hospitals and serve as effective consumer representatives for both individuals and consumer groups. Top officials of the hospital meet regularly with these representatives with the objective of obtaining their advice relating to planning and policy decisions. The major veterans' organizations also employ national service officers who conduct surveys of hospitals and make formal reports with recommendations for action at both local and national levels. Further, these organizations

are a major source of consumer representation in policy and planning decisions at the Central Office level. As a routine practice, all proposed changes in regulations and other administrative issues having significant impact on the VA medical program are furnished the veterans' organizations in advance, and their comments and recommendations always are given full considerations. Some organizations, such as the Paralyzed Veterans of America, represent specific groups with common problems and maintain close contact with appropriate program officials in the VA Central Office.

MATERIAL FOR SECTION III-B DM&S

WILL BE HAND DELIVERED THIS

AFTERNOON, NOVEMBER 19, 1976.