The original documents are located in Box 40, folder "Transition Reports (1977) - Veterans Administration: Final (2)" of the John Marsh Files at the Gerald R. Ford Presidential Library.

III-A – DEPARTMENT OF VETERANS BENEFITS

DEPARTMENT OF VETERANS BENEFITS

CONTENTS

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DEPARTMENT OF VETERANS BENEFITS

I. PROGRAMS

1. COMPENSATION

a. Disability compensation is a monthly payment for a service-connected disability. Its purpose is to compensate a veteran for the loss of earning capacity due to a disease or injury which was incurred in or aggravated by active military, naval or air service. Compensable ratings range from 10 percent to 100 percent and financial payments are based upon the degree of disability established.

b. Under PL 94-433, effective October 1, 1976, compensation rates and statutory awards were increased by 8 percent. A new provision was inserted to pay increased additional compensation to the disabled veteran rated 50 percent to 100 percent who has a spouse who is a patient in a nursing home or who is so helpless as to need the regular aid and attendance of another person.

c. Dependency and Indemnity Compensation (DIC) is payable as a monthly benefit to eligible widows, widowers, and certain dependents surviving veterans who died on active duty or as a result of service connected disabilities.

Compensation Cases and Costs

	FY 1976	FY 1977 (Estimate)
Cases	2,593,508	2,613,045
Costs	$5,192,555,000	$5,719,228,000

2. PENSION

a. The nonservice-connected pension program is designed to provide a measure of financial assistance to needy disabled war veterans and their surviving dependents. It is intended for those veterans who are permanently and totally disabled from causes not related to their period of active service.

b. Effective January 1, 1977, PL 94-432 provides for a 7 percent increase in pension rates and income limitations. The new law also provides for payment of an aid and attendance allowance when income exceeds annual income limitations (to be reduced 16.6 percent for each $100 or fraction thereof that annual income exceeds the maximum limits but not beyond a $500 excess). In addition a 25 percent increase will be paid to those veterans who are age 78 or older.

Pension Cases and Costs

	FY 1976	FY 1977 (Estimate)
Cases	2,265,877	2,317,933
Costs	$2,890,416,000	$3,134,683,000

3. BURIAL PAYMENTS

a. The laws governing the payment of burial payments provide that when an eligible veteran dies, the Administrator of Veterans' Affairs may pay a sum not exceeding $250 to such persons as he prescribes to cover the burial and funeral expenses of the deceased veteran. In addition, if an eligible veteran is not buried in a National Cemetery or other cemetery under the jurisdiction of the United States, a sum not to exceed $150 may be paid as a plot or interment allowance.

b. If a veteran dies in a VA facility, the VA will pay the cost of transporting the body to the place of burial. Under PL 94-433, the VA may now also pay for the transportation of the remains of deceased veterans to a National Cemetery if the veteran died as the result of a service connected disability, or was in receipt of disability compensation, or but for the receipt of retirement pay or pension would have been entitled to compensation.

c. Payment of an amount not exceeding $800 as a burial allowance if the veteran's death is service-connected. This payment is in lieu of the $250 basic burial allowance and the $150 plot-interment allowance.

Burial Cases and Costs

	FY 1976	FY 1977 (Estimate)
Cases	* 312,487	* 330,000
Costs	** $143,585,000	** $155,372,000

**This figure only includes those persons receiving the basic $250 burial allowance. Many who received this benefit also received other benefits such as plot allowance, headstone marker, flags, transportation, etc.*

***Costs include payment of transportation, plot allowance, headstone marker, flags, etc.*

4. EDUCATION AND REHABILITATION

a. The program provides financial assistance to veterans, their dependents, and their survivors to aid them in obtaining education or training. The component activities are: vocational rehabilitation which provides assistance to disabled veterans to overcome the employment problems caused by their service-connected disabilities; educational assistance which provides financial benefits to veterans and other eligible persons to assist them in obtaining education. Additional programs provide tutorial assistance, education loans, and work study benefits to eligible persons. Vocational Counseling is furnished to veterans and dependents.

	1976	1977 Est.
Sons and Daughters	80,659	93,090
Wives and Widows	19,092	22,940
Voc. Rehab.	29,449	31,975
Readjustment	2,821,514	2,300,000
Total Costs ($1,000's)	$5,333,633	$4,793,178

5. HOUSING CREDIT ASSISTANCE

a. The Loan Guaranty Program provides housing credit assistance whereby mortgage credit needs of veterans and service personnel for the purchase of homes, condominium units and mobile homes may be satisfied by private capital on more liberal terms than generally available to non-veterans, without the assumption of undue risks by the Government.

b. Assistance is chiefly through substituting the Government's guaranty on loans in lieu of the substantial downpayments, relatively short terms and other investment safeguards applicable to conventional mortgage transactions.

c. In addition, a Direct Loan program is available which provides credit assistance to veterans living in rural and remote areas where private credit for guaranteed loans is not generally available and the Administrator has declared the area to be a "credit shortage area."

d. Following are the numbers and dollar amounts of loan origination activity for Fiscal Year 1976 and the projected figures for Fiscal Year 1977.

	Actual FY 1976	Estimated FY 1977
GI Loans Closed		
Number	327,133	338,500
Amount	$9,957,000,000	$10,482,000,000
Direct Loans Closed		
Number	2,782	2,650
Amount	$55,009,000	$54,108,000

e. Claim payments are made to lenders in accordance with the VA guaranty contract and represent the difference between the amount owed by the veteran on a defaulted loan and the value of the foreclosed property (as established by the VA).

f. In Fiscal Year 1976, VA experienced a total of 16,988 claims for which VA paid out $37,396,000. For Fiscal Year 1977, 17,000 claims are expected in the amount of $39,045,000.

g. Private lenders who have acquired property as a result of foreclosure on defaulted guaranteed or insured loans may elect to convey that property to the Veterans Administration. In Fiscal Year 1976, VA acquired 14,978 properties at a cost of $308,215,000. For Fiscal Year 1977, VA expects to acquire 14,700 properties for $305,760,000.

h. Properties acquired from lenders as a result of foreclosure are sold either for cash or on terms. In term sales, VA takes back a first mortgage or establishes an installment contract with the borrower. In fiscal year 1976, VA sold 17,273 properties and established 15,575 loans, called vendee accounts, in the amount of $310,700,000. In Fiscal Year 1977, VA expects to sell 16,700 properties and establish 15,000 vendee accounts in the amount of $318,000,000.

i. Cash sales of property and the sale to private lenders of vendee loans provide sources of funds for the payment of claims and other expenses.

6. SPECIALLY ADAPTED HOUSING GRANTS

a. This program was originally established by P.L. 80-702, approved June 19, 1948. It currently provides grants of up to $25,000 to aid certain permanently and totally disabled veterans in acquiring a specially adapted housing unit with such fixtures or moveable facilities as are necessary by the nature of the veterans' disabilities.

b. VA also assists these veterans in selecting an appropriate site and housing plans or existing property, provides for construction inspections and assists the veteran in obtaining conventional or VA guaranteed mortgage credit assistance or a direct loan to cover the nongrant portion of the cost or purchase price.

c. In FY 1976, 587 grants were made with the average grant amounting to $24,281 and in FY 1977 it is estimated that 620 grants will be made averaging $25,000 per grant.

7. INSURANCE PROGRAMS–VA ADMINISTERED

a. The VA is responsible for the administration of five separate life insurance programs for veterans. These include the United States Government Life Insurance program (USGLI) which was established in 1919 to handle the conversion of World War I War Risk Term Insurance. The largest program is the National Service Life Insurance program (NSLI) which was established on October 8, 1940 to meet the insurance needs of World War II servicemen. The Veterans Special Life Insurance program (VSLI) provided for the post-service insurance needs of Korean veterans. The Veterans Reopened Insurance program (VRI) gave certain disabled World War II and Korean veterans who were unable to obtain commercial insurance or could not obtain it at a reasonable cost the chance to obtain National Service Life Insurance. The program was open to new applications from May 1, 1965 to May 2, 1966. The only program now open to new issues is the Service-Disabled Veterans Insurance program (SDVI). This insurance is available to any veteran released from active duty with the military service on or after April 25, 1951, under other than dishonorable conditions, with service connected disability or disabilities for which compensation would be payable if 10 per centum or more in degree and except for which such person would be insurable according to the standards of good health established by the Administrator. Application must be made within one year from the date of notification of the VA rating to apply.

b. Effective July 1, 1972, NSLI policyholders may use dividends to buy more insurance protection as paid-up additions to their policy. For the first time this permitted policyholders to have more than $10,000 Government life insurance in force. A total of 993,775 policies have paid up additions with a face value of $665,139,787 as of June 30, 1976.

Insurance Programs VA Administered

	FY 1976	FY 1977*
Policies In Force	5,007,119	4,874,650
Value of Policies	$35,000,447,288	$34,301,727,000

**Estimated*

8. INSURANCE PROGRAMS–VA SUPERVISED

a. The VA supervises three additional insurance programs. The Servicemen's Group Life Insurance program (SGLI) provides coverage for active duty servicemen, Ready Reservists and certain members of the Retired Reserve. This coverage is provided by a group policy issued by the Prudential Insurance Company of America, who is the primary insurer, to the Veterans Administration. They are responsible for the administration of the program. The Veterans Group Life Insurance program (VGLI) provides post-service coverage for Vietnam era veterans separated on or after April 3, 1970. The coverage is provided for up to five years after separation from service and cannot be renewed beyond that time. It, too, is in the form of a group policy issued to the VA by the Prudential Insurance Company. The Veterans Mortgage Life Insurance (VMLI) provides mortgage protection life insurance to a maximum amount of $40,000 for veterans who have received a VA grant for specially adapted housing. The protection for this program is in the form of a group policy issued by Bankers Life Insurance Company of Lincoln, NE, who administers the program.

b. These three programs are unique in that the day-to-day operation is handled by a commercial company while the Veterans Administration assumes a supervisory role to insure that they are being administered in accordance with the law under which they are created.

Insurance Programs–VA Supervised

	FY 1976	FY 1977*
Policies in Force	3,445,385	3,416,725
Value of Policies	$68,826,787,000	$67,450,861,000

**Estimated*

9. VETERANS ASSISTANCE

a. Veterans Services Divisions in VA regional offices are the points established to which veterans, dependents, survivors and the public may go for information and assistance regarding veterans benefits. Under the law (38 USC 240-245) VA is also responsible to conduct a program of outreach and to have representatives on campuses of educational institutions. VA also provides personal service at all its hospitals. There are 58 regional office locations, 17 Veterans Assistance offices, 171 hospitals, 5 outpatient clinics, about 4,500 school campuses. The vast majority of campuses are served on a part-time itinerant basis. There are also 60 communities distant from VA locations to which service is provided on a scheduled itinerant basis.

b. In addition to the availability of personal interviews at the locations mentioned the Veterans Services Divisions at the regional offices are accessible by telephone. Over 90 percent of the continental U.S. population may reach VA regional offices for the cost of a local phone call. This is possible because VA provides an extensive network of toll-free lines.

c. In FY 1976 the following activity was recorded:

Toll-free Telephone Calls	3,893,276
Non-Toll-free (Local) Telephone Calls	15,268,380
Total	19,161,656

Personal Interviews at Office	5,252,819
Personal Interviews Away From Office	316,892
Interviews–Hospital and Domiciliary Patients	466,315
Total	6,036,026

Over 396,000 interviews were initial interviews with Vietnam era veterans.

d. **For Additional Veterans Assistance Activities, Also See:**

(1) **Significant Interagency Relationships**

- Benefit Assistance to Servicemen (Page III-A-11)
- United States Veterans Assistance Centers (Page III-A-11)
- Interagency Jobs for Veterans Advisory Committee (Page III-A-12)
- Information and Referral Services for Older People (Page III-A-12)
- Veterans Benefits Information Overseas (Page III-A-12)

10. BENEFIT ASSISTANCE TO VETERANS

a. In addition to the USVAC[1] concept, VA–through its Veterans Services Divisions–reaches out and makes itself available to veterans and other eligible persons in a number of ways enabling those persons eligible for benefits to obtain information and file applications with minimum inconvenience.

b. The VA maintains toll-free telephone service to Veterans Services Divisions in most of its regional offices. This service enables over 90 percent of the population of the continental United States to telephone VA on a local phone call basis regardless of the distance from the caller's location to the regional office. Almost 3.9 million calls were received over these facilities in FY 1976.

c. A fleet of mobile office vans is maintained. Currently five vans are in operation. Individual vans are rotated from regional office to regional office. The regional offices develop van itineraries to use the vans in remote and inner city areas where the availability of VA personnel will encourage eligible persons to inquire about and apply for veterans benefits. In FY 1976 the vans traveled 88,235 miles, visited 768 communities and conducted interviews with about 29,000 individuals.

d. Problems encountered by veteran-students in getting payments and information from VA led to stationing Veterans Services Division personnel on certain larger school campuses and making scheduled visits to smaller school campuses. The personnel recruited and trained to perform this mission were called Veterans Education and Training Representatives (Vet Reps) or Veterans Representatives on Campus (VROC's). The personnel went on duty in August 1974. Subsequently the program was authorized by law (38 U.S.C. 243). In FY 1976 service was provided at more than 4,400 campuses (about 3,100 at the college level). Full-time service was provided at 542 campuses with the remainder served on a scheduled itinerant basis. The Vet Reps assisted in expediting over 580,000 payments and conducted over 3.1 million interviews.

e. The VA receives from DoD copies of forms supplied to members being discharged or released from active duty in the various services and mails to each individual from the Data Processing Center in Austin, Texas complete information on benefits available including, where appropriate, certificates of eligibility for educational benefits and assistance in purchasing homes. Notice is sent to regional offices of those individuals who are educationally disadvantaged (less than high school education) and USVAC's attempt to contact these individuals personally. A reminder mailing is released six months following the date of separation or release.

[1] *U. S. Veterans Assistance Center.*

11. BENEFICIARIES UNDER LEGAL DISABILITY

a. The law (38 U.S.C. 3202) makes provision for payment of VA benefits to a third party (fiduciary) when the beneficiary entitled to payment is under a legal disability (minority or incompetency). In June 1973 there were 699,028 beneficiaries in this category of whom 115,495 were adults and 583,533 were minors. Field examinations were required to select fiduciaries, periodic accountings from fiduciaries were reviewed and field examinations were conducted from time to time to review the fiduciary's performance.

b. Through a study of the program and evaluation of experience it was determined in August 1973 that the procedures could be greatly improved especially in the case of beneficiaries, particularly minors, in the care of members of their immediate family. As a result, the number of beneficiaries for whom supervision was exercised was greatly reduced. It developed that in a small number of cases the new procedures did not accord some adult beneficiaries the benefits of due process of law and the procedures were changed accordingly. This will result in some increase in the number of adults for whom payment supervision is exercised.

c. As of October 31, 1976, beneficiaries for whom supervision was exercised were:

Adults	106,546
Minors	39,346
Total	145,892

II. SIGNIFICANT DVB INTERAGENCY RELATIONSHIPS

1. BUREAU OF SUPPLEMENTAL SOCIAL INCOME (Social Security Administration)

A relationship with BSSI was initiated with that agency in April 1976 and is maintained to implement the requirements of PL 92-603 which requires their consideration of an individual's income (including VA Compensation and Pension payments) in determining an individual's eligibility for SSI payments. Following development of the procedures for exchange of data by the technical staffs of both agencies in 1976, selected data from VA records was furnished to the BSSI in August and October 1976. Further exchanges are anticipated for subsequent years and will be furnished as requested.

2. FEDERAL INTERAGENCY COMMITTEE ON EDUCATION (FICE)

a. The purpose of FICE is to advise on matters dealing with Federal educational programs, policies and practices, particularly: to analyze the policies of various departments; to establish communications between agencies; to present leadership in resolving differences in Department practices; to establish subcommittees on special problems; to secure data for an overview of Federal educational activities.

Executive Director: Bernard Michael

Chairman: Dr. Virginia Y. Trotter, Asst. Secretary for Education, HEW

VA Representative: Andrew H. Thornton, Director, E&R Service

b. Education and Rehabilitation personnel are active on the following FICE subcommittees:

Educational Consumer Protection . . . . . H. Hugh Porter
Educational Technology . . . . . Dean E. Gallin
Minority Education . . . . . Ms. Jewell D. Chandler
Postsecondary Educational Definitions and Classifications . . . . . Donald K. Davis
Ad Hoc Committee on Racial and Ethnic Definitions . . . . . Marvin Diamond

3. FEDERAL TRADE COMMISSION

a. A formal agreement between the VA and FTC was entered into pursuant to the provisions of PL 93-508 for the purpose of investigating cases of alleged advertising, sales, or enrollment practices by institutions approved for veterans' education considered to be erroneous, deceptive or misleading. The VA refers documentary information to the Bureau of Consumer Protection, FTC for evaluation and investigation, and possibly cease and desist orders.

4. REHABILITATION SERVICES ADMINISTRATION–VETERANS REHABILITATION COORDINATING COMMITTEE

a. This interagency committee was established by the Department of Health, Education and Welfare pursuant to the sections of the Rehabilitation Act of 1973, as amended, that require the Department of Health, Education and Welfare to insure maximum coordination with the Administrator of Veterans Affairs and other agencies with respect to programs for and relating to the rehabilitation of disabled veterans. Membership includes, in addition to concerned Federal agencies, the major veterans service organizations. The VA, Department of Veterans Benefits representative to the Committee is Dr. Irene G. Cooperman.

5. SUBCOMMITTEE ON EMPLOYMENT, CABINET COMMITTEE ON DRUG ABUSE PREVENTION

a. This committee is one of five standing committees of the Cabinet Committee on Drug Abuse Prevention established by the President on May 12, 1976. Membership on the subcommittee includes the member organizations of the Cabinet Committee (HEW, DoD, DOL, VA) and other agencies. The subcommittee is responsible for developing government-wide action plans in the area of employment as an integral component of rehabilitation services for drug-addicted persons. Dr. Irene G. Cooperman is the VA, DVB representative.

6. TREASURY DEPARTMENT

a. Representatives from Education and Rehabilitation Service and Office of the Controller meet bi-monthly with Treasury representatives to discuss problem areas arising in the VA–Treasury benefits payment interface within the two months between meetings. Problem-solving sessions are concerned with ongoing program areas as well as questions involving implementation of new programs, and procedural changes. A typical agenda would involve, for example: inserts for enclosure with certain January pension checks, annual reporting fee payments, standard format for VA checks, interest forms and mailgrams, et cetera.

b. Controls the pricing and volume of loans to be sold to private investors.

7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

a. With HUD (together with the Department of Justice and the Commission on Civil Rights) on coordinated strategy and measures to assure fair housing practices and equal opportunity in housing.

b. With the Housing Assistance Administration to provide listings and make VA owned residential properties available for sale or lease to local housing authorities.

c. VA, together with FNMA and The Mortgage Corporation (FHLBB), is participating in a HUD led task force to draft uniform condominium requirements.

d. With FHA as respects:

Management, repair, rental and sale of Government owned residential properties.

Construction standards, land planning requirements, community water and sewer facilities, compliance inspections and appraisals.

Legal and other requirements for planned unit developments and condominiums.

Potential hazards, such as, geological and soil instability, water pollution and flood control.

Suspension of builders, lenders and brokers.

Determination of eligibility for FHA veteran's loan program.

Counseling of moderate-to-low income families on their housing needs.

Mobile Home and Mobile Home Park Standards, kickbacks and credit reporting contracts.

e. With HUD coordinating the need for implementation of Mortgage Relief Assistance for certain homeowners provided under the Emergency Homeowners Relief Act, PL 94-50.

f. With GNMA, coordination in the administration and liquidation of mortgage pools presently under the Federal Assets Liquidation Trust, the Government Mortgage Liquidation Trust, and the Federal Assets Financing Trust.

8. COUNCIL ON ENVIRONMENTAL QUALITY

a. As respects the Loan Guaranty Service of the Department of Veterans Benefits for implementation of environmental quality policies for improvement of the environment.

9. ENVIRONMENTAL PROTECTION AGENCY

a. As respects the Loan Guaranty Service of the Department of Veterans Benefits for effective agency action on behalf of the environment.

10. FEDERAL RESERVE BOARD

a. Furnish assistance based on VA's experience in housing in the development of Regulations to implement Equal Credit Opportunity Act.

b. Determining whether lenders applying for automatic lending status are supervised.

11. COMPTROLLER OF THE CURRENCY

a. Determining whether lenders applying for automatic lender status are supervised.

12. FEDERAL NATIONAL MORTGAGE ASSOCIATION

a. Servicing and liquidation on VA guaranteed loans which that corporation holds.

b. To assure the acceptability of VA guaranteed loans in the commercial secondary market, proposed changes in VA's security instruments are coordinated with FNMA.

13. FEDERAL HOME LOAN BANK BOARD

a. Servicing and accounting by Federal savings and loan associations in respect to VA guaranteed loans.

14. COUNCIL OF ECONOMIC ADVISORS

a. Together with HUD, FHLBB, FRB, Treasury and OMB, establishing maximum interest rates on VA guaranteed or insured and direct mortgage loans.

15. DEPARTMENT OF JUSTICE

a. Judicial foreclosures on VA acquired loans and other portfolio loans, including legal proceedings for eviction and deficiency judgments if required.

b. Possible criminal prosecution for fraud or civil action for damages under the false claims act.

16. DEPARTMENT OF DEFENSE

a. Assistance for certain home owners for losses sustained by base closing as required by PL 89-754, Section 1013.

b. Supplemental servicing to and counseling of obligors at military bases in respect to VA loan programs.

c. Determinations as to the suitability of housing in proximity to military air bases.

d. Rental and sale of VA owned properties for military personnel.

e. With the Office of the Chief of Engineers (Army), together with HUD, Commerce, Interior, GSA and other Federal agencies, identification of flood plan areas and establishment of guidelines for flood hazard evaluation to implement Executive Order 11296.

f. A close relationship is maintained with the Department of Defense by VA to implement the provision in the law which prohibits the duplication of benefits. Where a veteran has dual entitlement to disability retirement pay from a service department and VA disability compensation, he or she may elect the benefit which provides the greater advantage. Where retired pay is the greater benefit, the veteran may waive a portion of the retired pay equal in amount to the compensation in order to receive the compensation.

g. The Department of Defense also requires certain information from VA records before paying benefits under their Survivor Benefit Plan.

h. Eligibility for veterans benefits is based upon the veteran's military service. When processing applications for VA benefits and the veteran cannot provide proof of military service, it is necessary for VA to go to the service departments or military records centers to obtain verification of military service. Also, military medical records are needed in processing veterans' claims for service-connected disabilities. VA also furnishes information to the service departments and military records centers when requested. To reconstruct military records which were burned or damaged in the fire at the National Personnel Records Center in 1973, they request pertinent military documents and other information from veterans' claims folders.

i. PL 94-502 provides for a veterans matching funds Education program for all personnel entering service on or after January 1, 1977. Deductions from a service person's pay will be deposited with the VA by the Service Department which would be matched later by the VA on a 2-1 basis. The VA and DoD are defining the format, content and procedural functions for service persons' contributions to be sent to the VA beginning February 1977.

17. DEPARTMENT OF INTERIOR

a. With Geological Survey, determining areas subject to subsidence, earth slides, or other geological hazards preventing or restricting housing construction.

18. DEPARTMENT OF AGRICULTURE

a. With Farmers Home Administration (together with representatives of OMB and Federal Housing Administration), coordination on community water and sewer systems–standards and legal requirements of community facilities.

19. DEPARTMENT OF TRANSPORTATION

a. With the Bureau of Public Roads, procedures to make VA owned properties available to purchasers displaced by highway construction.

b. With Federal Aviation Administration, coordination on problems attributable to proximity of housing to airports–including safety factors, flight zones and noise level factors.

20. ADVISORY COUNCIL ON SERVICEMANS' GROUP LIFE INSURANCE

a. **Purpose:** To review operations and advise the Administrator on SGLI policy matters.

b. **VA Representatives:**

Richard L. Roudebush	Administrator
Rufus H. Wilson	Chief Benefits Director
Conrad R. Hoffman	Controller
S. W. Melidosian	Director VA Center Philadelphia, PA
Glenn C. Johnson	Assistant Director for Insurance VA Center Philadelphia, PA

c. **Membership:**

The Honorable William E. Simon (Chairman)
Secretary of the Treasury

c. **Membership:**—Continued

The Honorable Donald H. Rumsfeld
Secretary of Defense

The Honorable Elliot L. Richardson
Secretary of Commerce

The Honorable David Mathews
Secretary of Health, Education and Welfare

The Honorable William T. Coleman, Jr.
Secretary of Transportation

The Honorable James T. Lynn
Director, Office of Management and Budget

21. BENEFIT ASSISTANCE TO SERVICEMEN

a. The Veterans Assistance Service and Veterans Services Divisions on request provide training in veterans benefits subjects to personnel of Department of Defense components, who are responsible for orienting members about to be separated or released from active duty. On-call service is also provided to DoD hospitals and separation points.

22. UNITED STATES VETERANS ASSISTANCE CENTERS

a. These centers, referred to as USVAC's, were organized at the President's direction commencing in February 1968. The original concept was the creation of one-stop service centers, staffed by representatives of various agencies which would enable veterans to obtain information about all Federal benefits for veterans, in one visit to one location. They also included a departure from tradition in providing for positive outreach to locate veterans, inform them of entitlement and encourage them to avail themselves of those benefits.

b. As the years have passed, the concept has been modified. There are presently 72 USVAC's in all cases located in VA regional offices or Veterans Assistance offices. In areas of high unemployment one or more Veterans Employment Representatives participate in the USVAC to assist veterans with employment problems. Generally the USVAC activity is conducted by experienced VA Veterans Benefits Counselors who advise each veteran on the full range of benefits for veterans and assist the veteran in applying for those benefits in which he/she is interested. The outreach concept now directed by law (38 U.S.C. 240-245) continues.

c. The USVAC personnel maintain liaison with the Federal and state offices which can assist veterans and make necessary referrals. They also maintain liaison with community groups which may be resources for veterans and make necessary referrals. In some USVAC's a Community Service Specialist is employed to maintain liaison with and develop such resources.

d. In FY 1976 USVAC's assisted in placing 23,250 veterans in jobs. Of these 11,345 were arranged through State Employment Services, 4,404 were obtained through the Civil Service Commission, 4,198 were arranged by VA and 3,303 through other community resources.

e. The principal emphasis of USVAC's is in providing assistance to those veterans who are educationally disadvantaged in not having attained a high school education.

23. TITLE VI OF CIVIL RIGHTS ACT OF 1964

a. Veterans Services Divisions in all regional offices are responsible to perform compliance surveys of educational institutions and training establishments to assure compliance with the law and VA regulations. In this connection there is included in the compliance survey a review to assure compliance with the Civil Rights Act. The Civil Rights Review is performed only at proprietary schools and on job training and apprenticeship training establishments. The Department of Justice has primary responsibility for Civil Rights enforcement and VA reports on its activities to that Department. The VA has delegated to and the Department of Health, Education and Welfare has accepted responsibility for monitoring civil rights performance at institutions of higher learning,

public school systems, hospitals and other health facilities. VA is negotiating with the Department of Labor to avoid duplication of reviews in connection with apprenticeship programs because that Department's Bureau of Apprenticeship Training has similar responsibility.

24. COMMITTEE OF INTERAGENCY TERRITORIAL ASSISTANCE

a. The committee, under the Department of the Interior, coordinates Federal assistance to the territories and trust territories with current emphasis on the transition of the Marianas to commonwealth status.

b. The Director, Veterans Assistance Service, Department of Veterans Benefits, James J. Cox, represents VA.

25. INTERAGENCY JOBS FOR VETERANS ADVISORY COMMITTEE

a. A sub-group at the Assistant Secretary level of the Domestic Council Committee on Veterans Services.

b. Chairman–Assistant Secretary of Labor for Employment and Training.

c. Members–Departments of Commerce, Defense, Health, Education and Welfare, Labor, Civil Service Commission, Veterans Administration and National Alliance of Businessmen.

d. VA representative–Associate Deputy Administrator, A. J. Schultz.

e. VA representative–working group–Director, Veterans Assistance Service, Department of Veterans Benefits, James J. Cox.

f. The Committee's purpose is to promote the employment of veterans through coordinated interagency efforts.

26. INFORMATION AND REFERRAL SERVICES FOR OLDER PEOPLE

a. The VA is signatory to an agreement of December 21, 1974, involving fourteen Federal agencies to implement PL 93-29, Older Americans Comprehensive Services Amendments of 1973. The VA maintains liaison with and provides assistance to approximately 500 Area Agencies on the Aging (AAA's). Veterans Services Divisions in regional offices implement the information and referral service required under the agreement.

27. VETERANS BENEFITS INFORMATION OVERSEAS

a. The Veterans Assistance Service, DVB maintains close relationship with the Department of State to enable that Department through its embassies and consulates to be of assistance to veterans, dependents and survivors living in foreign countries. Training in veterans benefit matters is provided for employees of the Department whose duties involve providing benefits information to the public.

III. SIGNIFICANT INTERGOVERNMENTAL RELATIONSHIPS

1. ADMINISTRATOR'S EDUCATION AND REHABILITATION ADVISORY COMMITTEE

a. Furnishes advice and consultation to the VA Administrator with respect to the administration of education and training program. It may on its own initiative furnish reports to the Congress. The committee assists in evaluating existing programs and services and recommends needed new programs and services. It assists in long range planning and development. Recommendations may involve regulatory and administrative changes as well as legislative proposals.

b. **Chairman:**

Mr. William M. Detweiler
1370 Saratoga Building
212 Loyola Avenue
New Orleans, Louisiana 70112

c. **Members:**

Mr. Michael Gildea
Assistant to the Director
Department of Legislation

Mr. Glenn E. Heck
Chairman
Education Department
National College of Education

Mr. Jack H. Jones
Chairman, Board of Trustees
Jones College

Dr. James W. Mann
Professor of Education and
Chairman, Special Education Department
School of Education
University of Mississippi

Mr. Nelson M. Parkhurst
Registrar and Secretary of the Faculty
Purdue University

Mr. Walter J. Penrod
Executive Officer of the Indiana Rehabilitation Services Board

Mr. Theodore Shackelford, Jr.
Principal
Jardine Junior High School
Wichita Public Schools

d. **Ex-Officio Members:**

Mr. William H. Kolberg
Assistant Secretary for Manpower
Department of Labor

Dr. Edward Aguiree
Commissioner of Education
Office of Education
Department of Health, Education and Welfare

2. CENTRAL OFFICE EDUCATION AND TRAINING REVIEW PANEL

a. Reviews the actions of the field station committees on educational allowances and makes recommendations to the Director, Education and Rehabilitation Service to affirm, disapprove, or remand for further development the actions of the field station committees. The Review Panel receives evidence, hears testimony and reviews decisions made by the field station committees involving cases where a school may be in violation of any criteria of the law under chapters 34, 35, or 36, U.S. Code. Since such decisions could result in barring further enrollments in a school of veterans and other eligible persons, they are of vital importance to the school, and the review of these decisions by the Central Office Panel provides a source of administrative due process of law.

b. Central Office Education and Training Review Panel Membership Includes the Following:

George W. Smith, Registrar, University of Miami

Robert Gebhardtsbauer, Registrar, American University

Wilmer A. Sojourner, Howard University

Edward Bush, Dean of Liberal Arts, St. Clair County Community College

Marvin P. Busbee, Director, Division of Veterans Education, South Carolina Dept. of Education

James L. Reid, Maryland State Dept. of Education

George Arnstein, Executive Director, National Advisory Council on Education, Professions Development

Eugene W. Johnson, Comptroller, Hampton Institute

Paul S. Smelser, Director, Veterans Education, Missouri State Dept. of Education

E. R. Jeffers, Supervisor, Oklahoma State Accrediting Agency

3. STATE APPROVAL AGENCIES

a. In administering educational benefits under Chapters 34 and 35, Title 38, U.S.C., courses must be approved by State approving agencies. In accordance with Section 1771, Title 38, U.S.C., the governor of each State designates the State Department or agency to act as the "State approving agency."

b. Under Section 1774, Title 38, the Administrator of Veterans Affairs is authorized to enter into contracts with States to reimburse them for expense of salary and travel incurred in performing the functions of the State approving agency.

c. Contracts are negotiated with each State individually. The State agencies approve courses initially for training of veterans and servicemen under the Veterans Readjustment Assistance Act as amended. Problems concerning overall approval policies are also discussed with the National Association of the State Approval Agencies. Mr. Charles A. Shubat, Director, Program Education Section, Vocational Education, State Approving Agency is President and Mr. Marvin Busbee of South Carolina's State Approval Agency is Legislative Director.

d. VA contact is with Mr. Andrew H. Thornton, Director, Education and Rehabilitation Service.

4. STATE, COUNTY AND MUNICIPAL AUTHORITIES

a. The Loan Guaranty Service of the Department of Veterans Benefits has important relationships with State, county and municipal authorities, as respects:

(1) Approval of subdivisions, water and sewage disposal; zoning, building codes, flood control and other matters concerned with housing developments.

(2) Payments of real estate taxes and assessments on acquired properties and other properties securing loans owned by VA.

b. With States, as respects:

(1) Non-judicial foreclosures, recordation and applicable fees, and transfer taxes.

(2) Legislative consultation for appropriate statutes on instruments of conveyance, land sales agreements and other matters with direct bearing on the VA loan program.

(3) Condemnation of VA owned properties.

c. Veterans Services Divisions in regional offices work closely with the State Employment Service in their jurisdiction. In a number of cases Veterans Employment Representatives (VER's) of the Department of Labor's Veterans Employment Service are stationed at VA regional offices to provide liaison with State Employment Services and secure for veterans needing employment the preferences to which they are entitled.

5. VETERANS ADMINISTRATION ACTUARIAL ADVISORY COMMITTEE

a. **Purpose**: To advise on insurance matters in general, with particular emphasis on actuarial questions bearing on the solvency of the several insurance funds involving billions of dollars, and equity among the nearly five million policyholders in the Government-administered programs.

b. **Chairman**:

J. Edwin Matz, Chairman
President and Chief Administrative Officer
John Hancock Mutual Life Insurance Company

c. **Members**:

Joseph Sibiggroth, Senior Vice President and Chief Actuary, New York Life Insurance Company

Gathings Stewart, President, The Lincoln National Life Insurance Company

William A. Spare, Vice President and Actuary, Provident Mutual Life Insurance Company

Edward A. Lew, (Retired–Metropolitan Life Insurance Company)

d. **Insurance–VA Supervised**

(1) Each state has an official known as the State Director of Insurance (or Commissioner of Insurance, or some similar title). Supervising the program requires close surveillance of the conduct of business by those companies who resort to, or permit agents to carry on unethical practices. As a first step, corrective action calls for dealing through these state officials, keeping them informed, and soliciting their cooperative efforts.

(2) The preceding close surveillance on the conduct of unethical business practices may necessitate investigation by the FBI, and prosecution by a United States Attorney, both of whom are under the jurisdiction of the Attorney General.

6. STATE COURTS

a. The VA was instrumental in the enactment of legislation in virtually all of the 50 States constituting the VA as a party of interest, and a working partner with State courts in situations involving payment of VA benefits in behalf of the legally disabled. Implicit in the relationship is the reliance on the part of the courts that the VA will review the propriety of that which is submitted to them in guardianship matters involving VA beneficiaries, and in turn the courts grant the Agency's District Counsel special prerogatives which facilitate the transaction of Agency business before them.

IV. POLICY AND PROGRAM ISSUES: PRIORITIES

1. MATTERS COMING INTO FOCUS IN 12 MONTHS

a. **Congress has declared that the current pension program does not adequately provide for the needs of some eligible veterans and survivors.** Therefore under PL 94-432 the VA must undertake a comprehensive study of the pension program.

b. **PL 94-433 has mandated a DIC study** to measure and evaluate the adequacy of DIC benefits and determine whether, or to what extent, benefits should be based on the military pay grade of the deceased veteran.

c. **A study of vocational objective programs** with special attention directed towards the 50 percent employment criteria will be completed and submitted to the Congress and the President by April 1977.

d. **Public Law 94-502 added a 6-month normal completion time requirement for correspondence courses** and the correspondence portion of combination courses. These schools must now certify, based on actual records of all students who completed the course during the 24 months preceding the certification, the normal completion time of each correspondence course.

e. **Reforming the mortgage instrument.** The wild swings in interest rates and housing construction and inflation of the last ten years has increased the need to reform the present mortgage instrument. The Federal Home Loan Bank Board, with Congressional approval, has launched a study to help Congress decide just what kind of reforms the present home mortgage instrument needs. By next year some specially tailored varieties of mortgage instruments–attuned to present conditions–could emerge. The most discussed ideas are the variable rate mortgage and the graduated payment mortgage.

f. **Vet Rep service to schools will have to be reduced** as the result of declining enrollments and budgetary limitations. In many cases these employees are of significant assistance to the schools and some adverse reaction from the academic community may be expected.

2. MATTERS OF A LONG RANGE OR CONTINUING NATURE

a. **Termination of enrollments and reenrollments in PREP** under Chapter 34, effective November 1, 1976.

b. **Phasing out of Chapter 34 training** beginning with the elimination of training for persons entering service after December 31, 1976. Final cut-off date of December 31, 1989.

c. **The Post-Vietnam Veterans' Educational Assistance Act,** Chapter 32, a voluntary contributory matching-program for persons entering service after December 31, 1976.

d. **The assurance of a continuing funding of the Loan Guaranty Revolving Fund,** whether by sales of loans to private investors or by transfers from the Direct Loan Revolving Fund or a combination of both.

e. **The avoidance of any limitation on expenditures from the Loan Guaranty Revolving Fund** which disturbs effective operations and adversely affects the confidence of private lenders so necessary to a successful guaranteed loan program.

f. **The VA makes continuous efforts to alert term policy holders about the high premium rates if they retain their term policy to the older ages and encourages them to convert to a permanent plan of insurance.** Approximately 1.4 million or 37 percent of the 3.9 million NSLI policies are term insurance. These policies are renewed every five years at the current attained age and the premiums increase accordingly. As the policyholders grow older, the premiums can become prohibitive and many reduce the face amount of the policy.

g. **Under the Older American Comprehensive Services Amendments of 1973 (PL 93-29), VA is party to an interagency agreement of December 21, 1974.** This requires Veterans Services Divisions to assist Area Agencies on the Aging (AAA's) approximately 500 in number and provide improved information and referral service for older veterans and beneficiaries. Veterans and beneficiaries over 60 years of age number in the millions and the number will increase significantly every year. Providing essential service to older Americans will require increasing numbers of man-years as other program workloads decrease or by lessening emphasis on other programs.

h. **A CP&E Target System is currently under development.** The objective of the system is to automate the claims processing activities of the Compensation, Pension and Education Programs.

(1) The present CP&E claims processing system was designed and installed in the late 1950's; it is primarily a manual processing system with a batch-type ADP payment process. It is technically limited, people intensive, paper bound and is being redesigned to improve efficiency to take advantage of new ADP technology.

(2) The Target System will provide the capabilities for local regional offices to manipulate, store, and retrieve live claims file data from a readily accessible computer file. Exchange and modification of data through communications with other files containing original source data or master record information will be immediate. A central computer file and regional computer files will be available through various types of interactive communication devices in the regional offices. The system will maintain a work-in process file with automatic follow-up features, allow on-line award processing, provide answers to inquiries on benefit claims in a matter of seconds, and exercise greater control over accounts receivables, appropriation accounting and audit functions.

(3) The system should be completely developed and installed within the next several years. The on-line nature of the award processing activity will lead to the elimination of the present off-line batch input function with significant savings of hard dollars as well as improved service to the VA clientele.

i. **Education overpayments** increased 1,639.4 percent in FY 1976 over FY 1972. Comparison of this sharp increase with other indicators for the same periods show a 50.6 percent increase in trainees and a 177.2 percent increase in training costs. The increase in overpayments is due to a combination of reasons: 1) the greater number of trainees and legislation increasing benefit payments partially contributed to the increase, i.e., 2.9 million trainees in FY 1976 vs. 2.8 million in FY 1975, $5.3 billion training costs in FY 1976 vs. $4.4 billion in FY 1975. 2) Legislation authorizing prepayment (implemented November 1972) and advance payment of benefits (implemented September 1973). 3) Delays by students and training institutions in notifying the VA of changes in training status. 4) Relaxation of payment controls and expansion of special payments to insure timely receipt of benefit checks by students, and 5) VA Compliance Surveys have surfaced overpayments which have not previously been reported.

(1) VA is exploring ways to solve these problems and is implementing those which will not adversely impact payment of benefits; i.e., increasing compliance surveys at training institutions; periodically inserting notices with benefit payment checks to trainees pointing out their responsibilities for promptly notifying the VA of changes in training status and returning checks forwarded to them prior to receipt of their change in training status; and improving the recovery of overpayments by additional resources, expanding the use of automation and concentrating the recovery effort through centralization of the accounts receivable operations in the VA Center, St. Paul, Minn.

(2) Cathode Ray Tubes (CRT's) were installed in the Centralized Accounts Receivable Division at the St. Paul VA Center on October 26, 1976. These CRT's provide access to about 17 percent of the existing Compensation, Pension, and Education master records for fast response to inquiries in resolving accounts receivable problems.

(3) VA efforts to liquidate Education overpayments have shown positive results throughout the years, i.e., FY 1972 through FY 1976 the total overpayments amounted to $1,805.9 million—during this 5-year period dispositions were $1,376.0 million or 76.2 percent. Of the $1,376.0 million, $1,302.0 million were collected, the balance terminated or referred to GAO for further collection action.

j. **Due Process Procedures.** During the past year and a half, new due process procedures have been implemented in VA's field stations in the adjudication of compensation and pension claims. Principally these procedures require the giving of predetermination notices to claimants prior to taking final action in certain cases affecting entitlement or payment. Most of the due process requirements resulted from court cases, particularly Plato vs. Roudebush.

(1) Specifically the type of cases and class of beneficiaries covered under the new due process procedures are pensioners and DIC recipients whose payments are subject to suspension, reduction or termination based on information indicating, but not conclusively establishing, a change in entitlement. Due process by way of a predetermination notice is, also, required in those cases where the competency of a beneficiary is raised and in those cases where the veteran's character of discharge is in issue.

(2) The predetermination notice basically informs the claimant of the proposed action, of his or her right to submit evidence and to request a hearing.

(3) The major area of impact on the field offices is the increased workload and the additional time required to process a claim. There is also difficulty in scheduling the number of hearings required as a direct result of due process procedures.

(4) Due process also impacts Education processing, publications have been prepared to notify institutions of the requirements of PL 94-502. These requirements affect certifications of enrollment, standards of progress and attendance; measurement of courses; access to school records and accounts; two years operation rule; work study if enrollment changes to less than full-time; 6-month normal completion time for correspondence courses; and prohibition of assignment of educational benefits.

(5) To reconcile differences and to insure due process, VA Regulations provide for formal hearings before the field station Committee on Educational Allowances and an appeal before the Central Office Education and Training Review Panel. In addition, institutions are advised to submit information and arguments to VA regional offices to resolve questions without resort to the formal hearings.

k. **An increase in the number of school liability cases** can be anticipated. DVB Circular 20-76-84 and its appendices provide instructions for the implementation of the provisions of Public Law 94-502. The circular and its appendices require certifications by appropriate individuals and organizations concerning the six months or more completion time for a correspondence course, the two years of operation of courses offered by school extensions and branches, prohibition of assignment of VA educational benefits (powers of attorney). If it is discovered that erroneous certifications were made, awards will be terminated retroactively and school liability for the resulting overpayments will be considered under the existing procedures on the basis of false certifications.

DEPARTMENT OF MEDICINE AND SURGERY

CONTENTS

DEPARTMENT OF MEDICINE AND SURGERY

1. OVERVIEW

a. The health care delivery system of the VA, the Department of Medicine and Surgery, cannot be understood without recognition of the unique role it has played and continues to play with respect to the total health care system of this nation.

b. For 30 years this system has developed alongside and cooperating with, but administratively and economically separate from, the much larger private and State health systems.

c. Its strength and therefore its ability to be a partner of the non-federal system has derived in part from its singular mandate to care for veterans, in part from its extraordinarily successful policy of affiliation with the nation's medical schools, and in part from its productive research in areas of major and immediate importance to the nation.

d. In the care of veterans, the Department of Medicine and Surgery provides a complete medical, surgical and psychiatric system of care for more than 180,000 patients every day, and over 1.2 million episodes of inpatient care and 15 million outpatient visits every year. Through sharing of facilities and staff expertise, the Department of Medicine and Surgery contributes to meeting the health care needs of all citizens. Thus, the VA operates 20 percent of the renal dialysis (artificial kidney) capacity of the nation and a countrywide system of care and rehabilitation for the paraplegic, the blind, and the chronically disabled.

e. The VA's comprehensive program for the aged, with all levels of disease and disability, is unique in the nation and will be of rapidly increasing importance as the numbers of aged continue to increase over the next 25 years.

f. Department of Medicine and Surgery affiliations, first and most strongly with medical schools, but secondarily and more extensively, with over a thousand other schools and colleges have been accompanied by a major role in the training of health manpower to meet both VA and national needs. The number of students receiving a portion of their training in the VA system today exceeds 80,000 a year.

g. Department of Medicine and Surgery research efforts have had an immense impact on health care in the nation and the world. VA research on the therapy of tuberculosis led to the disappearance of this scourge as a leading cause of human disability and death. Most recently, VA studies in the treatment of high blood pressure promise a significant reduction in the late complications of cardiac disease, renal failure, and stroke.

h. We believe this system represents:

- The nation's only mechanism through which resource allocation to meet the medical needs of underserved areas can be effectively accomplished; such reallocation would include the provision of special medical services where other types of health facilities will not or cannot provide them;

- The nation's only health care system capable (and in the process) of economically distributing health services on the basis of geographic planning;

- The nation's largest trainer of health manpower, utilizing a system geared to meet specific occupational needs;

- The nation's only health care system that can test and evaluate new systems of health care delivery on a regional or national basis as required, *and* introduce successful new systems and procedures nationwide;

- The nation's only health care system that is capable of meeting the nation's critical socio-medical needs, such as those of alcohol and drug abuse.

i. In summary, the VA is the nation's largest and most comprehensive organization for the delivery of health care, health-related education, and research. It is inseparably entwined with the voluntary practice of medicine and with the educational institutions of the nation, and therefore provides the best informed Federal interface

with the pluralistic private health delivery system of the United States. As such, it constitutes a unique national resource for assessing the alternatives of how best to meet the health care needs of the nation.

2. BASIC ORGANIZATION AND FUNCTIONS

a. **Mission.** The VA 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 all citizens, including veterans.

b. **History**

(1) Veterans benefit laws began in America with a Plymouth Colony Enactment of 1636 and progressed to the creation of the Veterans Administration in 1930. This new agency combined functions of three previous offices–the Veterans' Bureau, which had arisen 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 the 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 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 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 medical needs of returning veterans.

(2) A major turning point for the VA medical care system was reached in 1946 when President Harry S. Truman signed into law P.L. 79-293 creating a semi-autonomous Department of Medicine and Surgery (DM&S) under a Chief Medical Director 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 on the basis of individual qualifications rather than assigned duties. The VA acquired some military hospitals for temporary use and also began a large hospital construction program to provide modern facilities. Many of the 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. In turn, the VA system furnished a much needed additional clinical base for the education of physicians and other health care personnel who were returning from the war.

3. MEDICAL CARE SYSTEM

a. The VA system is the largest centrally directed health care system in the nation, composed of 171 hospitals and their associated outpatient departments, 42 additional outpatient clinics, 86 nursing homes, and 18 domiciliaries. These facilities are staffed with over 177,000 employees. In Fiscal Year 1975, this system provided complete care for 1,220,107 inpatients. Outpatient medical services given by VA staff at VA facilities during FY 1976 exceeded 14,200,000 visits. Veterans are also given care in non-VA hospitals and community nursing homes, and from community physicians and dentists under VA auspices. In addition, VA provides financial assistance to 31 states which operate a total of eight hospitals, 31 nursing homes, and 36 domiciliaries. The VA supports both construction and care of veterans in these institutions. VA health care facilities are dispersed geographically paralleling 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.

b. 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) increased to almost 1.3 million, or 65,000 more than in FY 1975. More than 91 percent of this care was provided in VA hospitals. Outpatient medical care also reached new highs. Visits for outpatient care totaled 16.4 million, including 14.2 million visits to VA staff and 2.2 million visits to private physicians on a fee for service basis. On every day, on the average, almost 180,000 individuals received care from the Veterans Administration.

c. It was evident that VA could not continue to meet the growing 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 percent or greater SCD;

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

(4) Nonservice-connected (NSC) patients receiving housebound allowances or aid and attendance allowances.

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

e. Such priorities naturally influence inpatient care also. Discharged patients during FY 1975 included 27 percent with an SCD and 16 percent who were NSC patients over age 65. A study of all patients admitted during the week of March 23, 1975, revealed that only 35 percent had any health insurance (17 percent had medicare and 18 percent had some non-public health insurance). Applying this value (35 percent) to the remaining NSC patients under age 65, it is apparent only 20 percent of all patients were both under age 65 and have *any* form of health insurance.

f. The medical care provided by the VA also can be expressed in terms of the number treated in each type of service. The following table presents the data for FY 1975:

Program or Combination	**Individuals Treated**
(1) **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
(2) **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

g. These are mutually exclusive items. No patient was counted more than once either for different groups or for multiple episodes of treatment of like types. Repeated episodes of like care (as multiple hospital admissions) were counted, however, and this explains the apparent discrepancy between the daily load of 180,000 episodes and the annual load of nearly 2.4 million different individuals.

h. In an effort to provide access to health services, the VA has opened 12 new clinics since 1972 and plans to activate 13 additional clinics during Fiscal Years 1977 and 1978. Other clinics are being relocated or renovated to improve accessibility to veterans as well as to modernize physical plants. Many VA hospitals are scheduled to upgrade ambulatory care activities, also, as a result of new criteria for clinic design and to accommodate the expanding patient need. In particular, 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.

3.1 Organization

a. 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.

b. 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 percent of the total DM&S employment.

c. 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 a 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.

3.2 Regionalization Concept

a. 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. Certain 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.

b. 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.

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

3.3 Central Office Management

a. 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.

b. 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

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

3.4 Operating Costs

a. 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

b. Fiscal Year 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.

c. 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

d. 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 Domiciliaries
		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 Anciliary:						
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

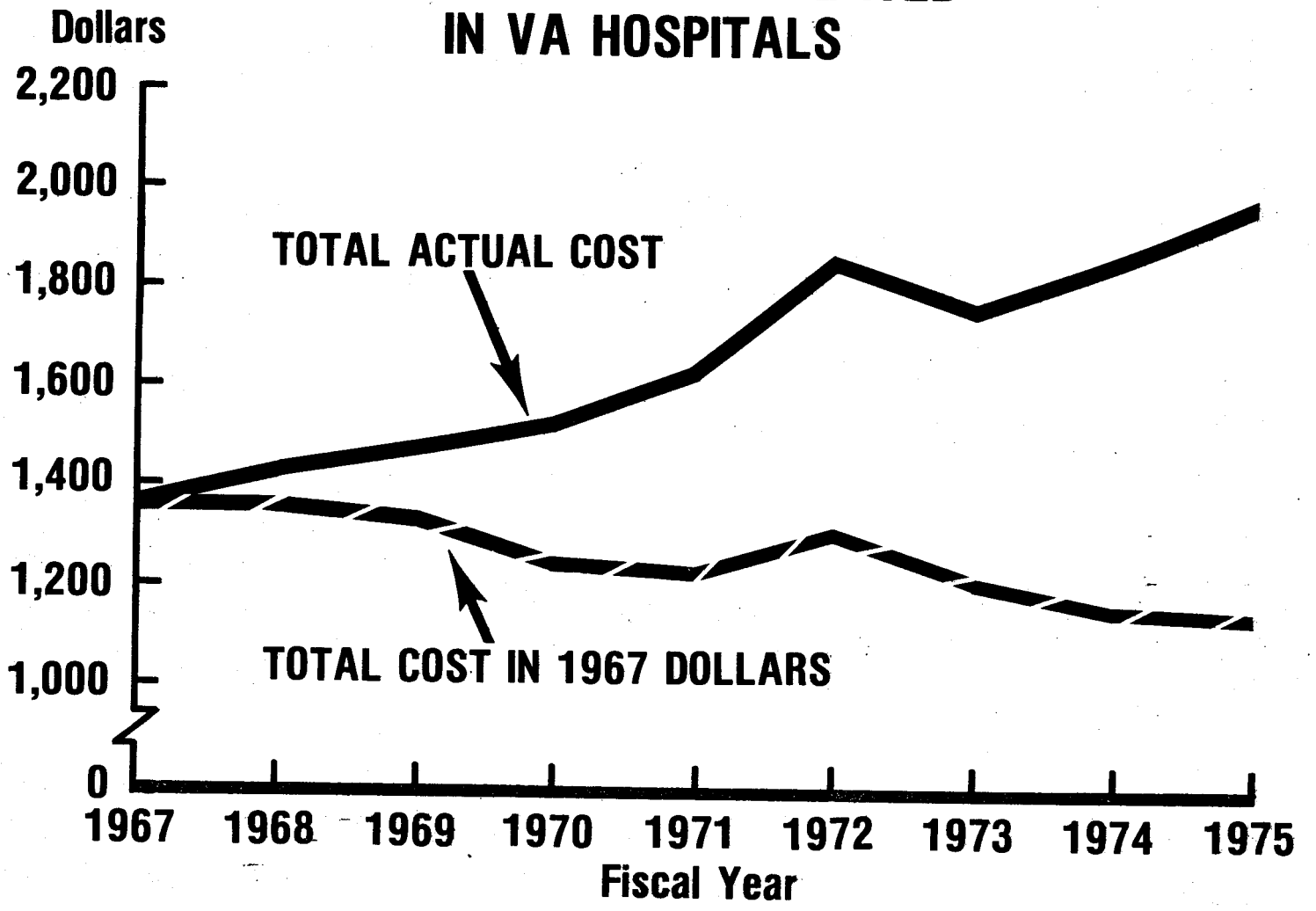
Type of VA Health Care Facility	Fiscal Year		Increase	
	1976	1975	Amount	Percent
Hospitals	$ 87.86	$ 75.71	$ 12.15	+16.0
Medical Bed Sections	91.36	79.49	11.87	+14.9
Surgical Bed Sections	117.52	102.45	15.07	+14.7
Psychiatric Bed Sections	64.08	54.12	9.96	+18.4
Domiciliaries	18.61	15.82	2.79	+17.6
Nursing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

e. 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

f. 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 chart illustrates.

MEDICAL CARE
COST PER PATIENT TREATED
IN VA HOSPITALS



4. HEALTH CARE DELIVERY

a. Hospital Care

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

(2) **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, 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 nine 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 FTE physicians and some 2,200 other FTE 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.** (FTE) 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 thereapy 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.

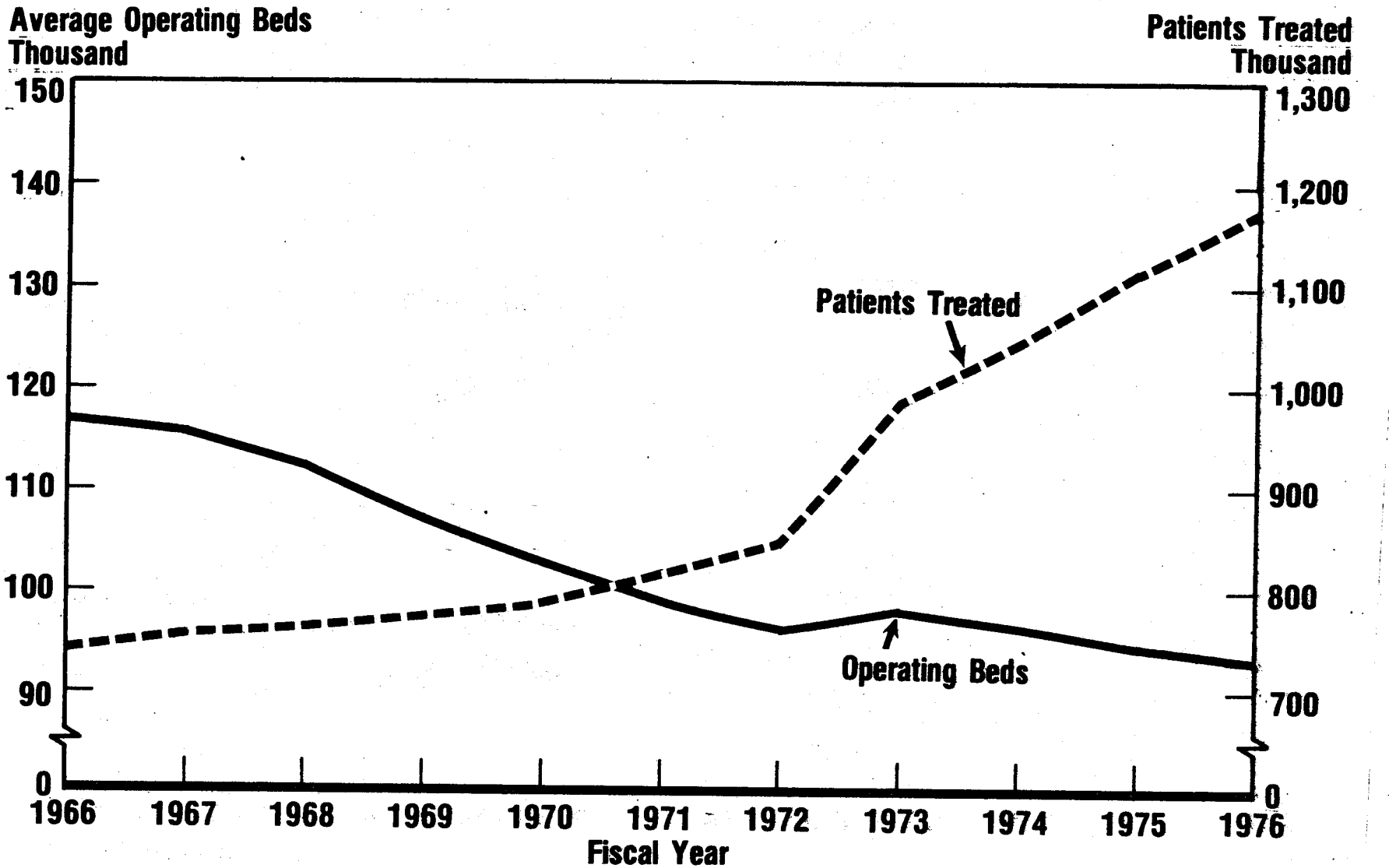
(3) **Hospital Beds**

(a) The VA operated, as of June 30, 1940, 86 hospitals with 59,637 beds. At the end of World War II an enormous expansion of VA health facilities became necessary due to the increase in the veteran population to 19 million and to liberalized veterans' benefits. This expansion was largely accomplished by acquisition of military hospitals, and in 1948 there were 126 hospitals in operation with 102,219 beds. Legislation enacted that year authorized construction to provide an overall total of 152,000 beds. On January 17, 1949, President Truman curtailed the number of beds to be added by new construction by approximately 16,000 beds.

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

(c) The 125,000 bed level included new beds under construction and beds out of service due to construction, staff shortages, etc., and therefore the 125,000 operating bed level was never attained. The bed level peaked in FY 1958 when the average operating level of 121,201 was recorded. Since then, even with progressively increasing hospital admissions, the level has steadily decreased to today's 93,077 beds. Significant bed reductions have been accomplished by increased emphasis on outpatient care, and improved performance effectiveness for certain categories of care. Additionally, a comprehensive study in 1969-70 determined there was gross overcrowding and many beds were not necessary to meet demand. Elimination of these beds contributed to a reduction of 28,000 operating beds in the past 19 years, although the dominant cause was the increased pace of care made possible by newer treatment techniques, use of ambulatory care and nursing home placements, and improved management of consolidating resources. The dynamic improvement in bed utilization and shortened length of stay is reflected in the following charts:

OPERATING BEDS AND PATIENTS TREATED IN VA HOSPITALS



b. **Ambulatory Care**

(1) **Fee Basis Care**

(a) **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.

(b) **Scope**

1. This policy grew from the practice in the 1930's of the VA 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.

2. 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 FY 1972 through FY 1976, hometown outpatient medical visits on fee basis increased by 37 percent while outpatient medical visits to VA staff increased by 79 percent. 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 percent 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 over $250,000,000 a year.

3. 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.

c. **Long-Term Care**

(1) **Purpose**

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

(b) Recognizing the rapidly expanding veteran population above the age of 60, an Office of Assistant Chief Medical Director for Extended Care was established in 1975. Its mission is to provide professional expertise and leadership for the following long-term care programs as alternatives to costly hospital care: 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). The Office also operates Geriatric Research, Education and Clinical Centers. Long-term care programs are intended to improve the quality of care for long-term patients, broaden the scope of our services, and make more effective use of manpower and resources.

(c) The Office works closely with the Administration on Aging (AOA) to initiate specialized services for elderly veterans. The VA is involved in the implementation of a working agreement with 13 other Federal agencies and AOA to improve information and referral services to older Americans.

(2) **Program Areas**

(a) **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 hospitalization but who require skilled nursing care.

(b) Nursing home care units provide skilled nursing care with related medical services, and individual adjustment services, including social, diversional, recreational and spiritual activities and opportunities. A typical veteran admitted to a VA nursing home care unit is chronically ill, has a permanent or residual disability, and is likely to require a long period of nursing care and rehabilitation. All the services required for the comprehensive care of a veteran in the nursing care unit who becomes acutely ill are available through the resources of the nearest VA hospital.

(c) Nursing home beds were increased during the past year to 7,585 nursing home care beds at 88 hospitals on June 30, 1976. An additional 1,360 beds were funded for design and/or construction through FY 1977. Current projection of nursing home bed needs is 14,500 by 1985, based upon statistical analysis of veteran population and the increased age-adjusted disease rate.

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

(3) **Community Nursing Home Care.** This program is also designed for veterans who require skilled nursing. The program aids the veteran and his family make the transition from a hospital to the community. Participating nursing homes must be licensed. VA hospital social workers, nurses, and other members of the treatment team make followup visits.

(a) Non-service-connected veterans may be placed in community facilities at VA expense for 6 months or less. Veterans requiring nursing home care for service-connected conditions may receive it indefinitely.

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

(4) **Personal Care Home Program.** This program provides personal care and supervision in the community to veterans who have no home or whose home is unable to provide 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 veteran pays for his own lodging. VA social workers make periodic followup visits to assist the veterans.

(5) **Hospital-Based Home Care Program.** This program allows veterans with chronic illnesses to be discharged to their own homes. The family provides necessary personal care under supervision of a hospital-based 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 provide home health care services. In FY 1976, 60,308 home visits were made by health professionals. Veterans were maintained in their homes for 255,190 days at an average per patient day cost of $16.96.

(6) **VA Domiciliary Care.** The VA domiciliary program provides 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 chronic disability, must be unable to earn a living, and have no adequate means of support.

(a) The domiciliary traditionally provided food, lodging, and limited medical care. During the period 1967-1975, emphasis changed from custodial care to a therapeutic community concept stressing more preventive health services, rehabilitation, and restoration.

(b) A modest construction effort has been initiated to counter inadequacies of existing domiciliaries so as to recognize the need for privacy and emphasize psychosocial aspects of congregate living. New domiciliaries have been designed to meet needs of aging veterans, and are capable of conversion to nursing home care at minimal

cost. Construction of a prototype 200-bed domiciliary will begin in FY 1977 at Wood, Wisconsin. Others will be built at Hampton, Virginia and at Dayton, Ohio, in the near future. Long-range plans envision one such domiciliary in each of the 28 Medical Districts. Many existing domiciliary buildings are economically infeasible to rehabilitate and will be razed; those judged suitable for rehabilitation to meet life safety codes will be brought up to standards.

(c) 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/members were treated. The average length of stay of patient/members discharged was 401.3 days. The average age of patient/members was 60 years, with 30.4 percent being 65 or over. Most (77.0 percent) receive compensation or pension from the VA.

(7) **State Home Program.** Through grants-in-aid, the VA assists 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 construction and remodeling of State home facilities.

(a) Under the Federal/State sharing legislation, VA has participated in 34 construction projects to add 4,587 State nursing home care beds, and 77 projects to remodel State nursing home, domiciliary, and hospital care facilities.

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

(8) **Geriatric Research Education and Clinical Centers.** As an adjunct to long-term treatment, the Geriatric Research, Education, and Clinical Center (GRECC) program was begun in 1974. Research into problems of aging is coupled with education about the aging process in a clinical setting. Eight GRECC's are now operating under the oversight of eminent scientists on the GRECC Federal Advisory Committee.

d. **Dental Program**

(1) **Purpose.** The mission of Dentistry in the Veterans Administration is to provide oral health care integrated with other medical care, to contribute to the training and continuing education of professional and paradental personnel, and to pursue research in oral biology.

(2) **Program Areas**

(a) **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 is consistent with overall patient care requirements.

(b) **Outpatient Dental Program.** Outpatient care is provided by both VA staff and private dentists. In FY 1976, 94,097 treatment cases were completed by VA staff and 121,956 treatment cases were completed by fee basis dentists at a cost of $57,218,202.

(c) **Special Medical Programs.** Dental service emphasizes prevention and conservative management of disease processes, and procedures to restore and preserve oral health and function. Special medical programs in preventive dentistry, team dentistry and dental auxiliary expanded functions enlarged the scope of basic service. Classification and qualification standards are now being developed for expanded functions dental auxiliaries (EFDA), and the first EFDAs will be employed in FY 1977.

(d) **Training and Continuing Education.** Affiliations with all 58 U. S. dental schools and 143 community colleges have led to an extensive VA involvement in postdoctoral residencies, clinical clerkships, and dental auxiliary training. The Dental Training Center at VAH Washington, D.C., is a major contributor to continuing education 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 video cassettes for use throughout the VA, in the private sector, and the academic community.

(e) **Facilities Improvement.** Significant progress in updating dental equipment has been achieved during the past few years. Modern equipment has facilitated the delivery of quality care. Every treatment facility now is equipped to enable professionals to practice team dentistry. Space criteria for dental clinics are being updated. Research–VA oral biology research recently has grown in size and excellence. In 1955, the first year of VA participation in the Annual Conference of the International Association of Dental Research, VA investigators presented two papers. In 1976, the Veterans Administration was 13th highest among contributing organizations in number of presentations.

e. **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 were initiated to provide Hemodialysis, Intensive/Coronary Care Units, Respiratory Care Centers, and other specialized resources involving a complexity of costs, planning, and construction. 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.

f. **Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)**

(1) The VA 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 VA is best equipped to provide may be provided in VA health care facilities when not needed for an eligible veteran.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(8) During FY 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.

5. EDUCATION AND TRAINING

a. **Affiliations.** In 1946, the VA 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.

(1) In the ensuing three decades there has evolved a truly remarkable symbiotic relationship between the VA 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.

(2) 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.

(3) Through this partnership in FY 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 VA.

(4) 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.

b. **Grants for Manpower Training**

(1) 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.

(2) 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.

(3) 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.

c. **Regional Medical Education Centers.** Existing efforts in continuing education must be expanded. In addition the VA has, under authority of 38 U.S.C., Section 4121, (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.

d. **Exchange of Medical Information**

(1) 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.

(2) 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.

(3) 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.

(4) 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 achievements 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.

(5) Since its inception in 1968, over 40 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 1977. Maximum funding authorized by legislation throughout FY 1979 is $4 million.

(6) 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.

(7) 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.

(8) 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 extension of the authority provided in Subchapter II and III.

6. **RESEARCH AND DEVELOPMENT**

a. **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 U.S.C. 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.

b. **Administration**

(1) **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.

(2) **Program Areas.** Research and development is conducted in three primary areas, each represented by a Service.

c. **Medical Research Service**

(1) 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.

(2) 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.

d. **Rehabilitative Engineering Research and Development**

(1) 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.

(2) 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).

e. **Health Services Research and Development**

(1) 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.

(2) 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.

f. **Role in National Health Care Research**

(1) VA research is broadly devoted to clinical excellence rather than to categorical disease entities but in the categorical areas, the VA plays an important role in translating laboratory findings into actual practice. The Veterans Administration research program is not only crucial in sustaining high level care for the veteran but provides the Nation's best resource for certain types of studies, such as multi-hospital clinical trials, 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 percent of the national effort in this area.

(2) 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 can lead to further strengthening of the flow of health care research from basic studies to everyday use in the practice of medicine in the entire country.

7. SUPPORTING SERVICES

a. Supply Service

(1) Purpose

(a) The VA Supply program, as the procurement arm 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 to 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.

(b) 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.

(2) **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 System.

(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 source of as much silver as the 18th largest silver mine in the country.

b. Veterans Canteen Service (VCS)

(1) Purpose

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

(b) The law further provides that canteen services may also be provided to personnel of the VA, 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.

(c) 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.

(d) 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 Injury, Nursing 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.

(2) **Scope**

(a) 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.

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

8. SUPPORTING ACTIVITIES

a. **Planning Process**

(1) 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.

(2) The many issues and problems are broad, complex and affected by directive legislation and interrelated legislation and Presidential initiatives, e.g., Federal-State-local interactions and budgetary controls. Public interests through long standing organizations, i.e., veterans organizations must be recognized.

(3) 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.

b. **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.

c. **Management by Objectives**

(1) The Department of Medicine and Surgery has found that Management by Objectives (MBO) is an effective 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.

(2) 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.

d. **Health Care Quality Control**

(1) **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.

(2) **Program Areas**

(a) 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.

(b) 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 structural 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.

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

e. **Facility Improvement for Quality Care**

(1) **Capital Improvements--VA Health Care Facilities**

(a) 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.

(b) 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.

(c) 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 an objective and integrated methodology. It will provide a standardized evaluation of individual health care facility deficiencies and needs.

(d) The 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. Objective comparison of relative needs in this system is a problem of obvious magnitude and complexity.

(2) **Patient Environment in VA Health Care Facilities**

(a) In recent years the Joint Commission on Accreditation of Hospitals has rasied its standards for patient privacy and improved environment and enforced them strictly. The evolving concepts of humane and modern health care incorporate the positive contribution of improved environment in patient treatment. This encompasses elimination of overcrowding, multiple occupancy in one room, privacy in toilets, bathing areas and bedrooms, and improved decor and personalization of the living environment. Lack of privacy which detracts from high quality patient care may jeopardize the accreditation of individual institutions. This factor has resulted in one year accreditation (rather than two year) to an increasing number of VA facilities.

(b) 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 to assist VA facilities in developing solutions to patient privacy requirements.

(3) **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 have 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.

f. **Approved Replacement Hospitals Not Under Construction**

(1) 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 analyses 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

(2) 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.

(3) 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.

(4) 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.

(5) 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).

9. INTERGOVERNMENTAL COUNCILS AND COMMITTEES AND DM&S ADVISORY COMMITTEES

a. 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.

b. 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.

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

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

d. 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.

e. 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

f. 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.

10. CONSUMER AND VETERANS ORGANIZATION PARTICIPATION

a. Unquestionably, the most significant consumer participation in policy and program planning is through the recipients 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.

b. More formal mechanisms for consumer participation at the local level include veterans' organizations, VA'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.

DEPARTMENT OF DATA MANAGEMENT

1. OVERVIEW

a. The Department of Data Management (DDM) supports the mission-oriented programs of the VA by providing systems development, programing and ADP production services.

b. In addition, the Department also provides technical support and assistance, equipment evaluation, ADP equipment procurement, systems audit, telecommunications and ADP planning services.

c. ADP production is accomplished at six (6) VA Data Processing Centers which are under managerial and operational control of DDM. (See Map, Appendix 1.)

2. VA DATA PROCESSING FACILITIES

a. In 1963, the VA had five Data Processing Centers and 103 station locations with electrical accounting machine equipment. In 1966, a major reorganization of computer resources was accomplished and the systematic VA information processing requirements were serviced by ten geographically dispersed Data Processing Centers. As a result of gains in efficiency, one Data Processing Center was closed and three others were closed based upon cost/benefit evaluations. Presently, VA systematic information processing requirements are serviced by six geographically dispersed Data Processing Centers under the operational management of the Department of Data Management.

3. MAJOR OPERATIONAL SYSTEMS

a. At the present time the VA has an impressive array of operational computer systems which might be termed "bread and butter" operations. The VA currently employs a variety of modern information processing techniques in providing a computer-based capability for 1) the authorization, processing and disbursement of disability compensation, pension, and educational benefits; 2) the processing of such insurance transactions as premium payments, regular and special dividends, and policy awards; 3) the processing of all systematized personnel data and the issuance of regular and/or special salary payments for all agency employees; 4) the processing of fiscal information concerning the VA-wide operating appropriations; 5) the processing of management information for project and fiscal control in support of the VA construction program; 6) the systematic compilation of operational data for management planning and evaluation purposes; and 7) a broad range of other programs and administrative information processing requirements.

4. SYSTEMS DEVELOPMENT EFFORTS

a. In 1972 data processing within the VA was decentralized, transferring the authority and responsibility, along with data processing personnel, from the Department of Data Management to using organizational units. In 1976, the Department of Data Management was restructured to provide a more meaningful relationship for the accomplishment of data processing functional responsibilities within the VA.

b. Since the last "Presidential transition" briefing some non-medical systems were developed and installed such as the CALM (Centralized Accounting for Local Management); BIRLS (Beneficiary Identification and Records Locator); and CARS (Centralized Accounts Receivable Systems). In the next few years the VA will continue systems development work on several non-medical systems, the most important of which will be the development of an on-line inquiry and claims processing system (TARGET) for administering the Compensation, Pension, and Education financial benefits.

c. The most significant area with potential for development of automated systems lies in the patient care area. Within the last few years some efforts have been initiated toward automating VA medical facilities. Automated systems in support of the Drug Dependency Treatment Centers (DDTC); Clinical Laboratories (CLINLAB); and on-line Automated Prescription Processing, Labeling, Editing and Storage (APPLES) Systems have been developed and installed, but major development work remains for each system. It is still very early in terms of our developmental efforts to bring useful automated systems to VA Hospitals and it is essential that a major commitment of ADP resources be continued to the area of medical activities.

5. RELATIONSHIP WITH OTHER AGENCIES HAVING BASIC AUTHORITY

a. **Acquisition of Automatic Data Processing Equipment.** Public Law 80-306, October 30, 1965 (commonly referred to as the Brooks Bill) vested in the General Services Administration the authority to coordinate and provide for the economic and efficient purchase, lease, and maintenance of automatic data processing equipment by Federal agencies. This Bill gives the General Services Administration jurisdiction over all Government agencies in the acquisition of ADP equipment and related supplies. The Veterans Administration works very closely with GSA in these areas and coordinates appropriate ADP procurement and maintenance actions with that agency.

b. **Telecommunications.** The Federal Property and Administrative Services Act of 1949, as amended, gives the General Services Administration the responsibility for prescribing policies for the management of public utilities services for executive agencies and representing those agencies in rate matters before regulatory bodies. Pursuant to GSA directives implementing this act, VA is required to secure approval of GSA through appropriate Federal Property Management Regulations, for installation of, and major changes in certain telecommunications systems i.e., private branch exchanges (PBX's), Wide Area Telecommunications Service (WATS), foreign exchange lines, facsimile, Centrex Service, etc. to be procured and operated by VA. This requires VA management and technical support to GSA in the coordination of VA's telecommunications equipment, systems and/or network including designing, engineering and acceptance. In addition, since most VA stations receive long distance voice service from the Federal Telecommunications System (FTS) and all VA stations receive record/data telecommunications service from the Advanced Record System (ARS), both of which are procured and operated by GSA, we are charged with several interactive management and technical responsibilities on matters relating to system engineering, realignment, operations and acceptance.

6. MEMBERSHIP ON INTERAGENCY COMMITTEES

a. Interagency Telecommunications Committee (ITC)

(1) **Authority**: Letter to Administrator from Acting Commissioner of Transportation and Communications Service, General Services Administration, September 15, 1966.

(2) **Purpose**: To advise GSA of using agency viewpoints regarding forecasting of requirements, system operation, cost reduction and FTS usage controls.

(3) **VA Membership**: Matthew C. Dillon (GS-15), Department of Data Management, Director, Telecommunications Service.

b. Interdepartment Radio Advisory Committee (IRAC)

(1) **Authority**: Reorganization Plan No. 1 of 1970, Executive Order 11556.

(2) **Purpose**: To assist the Director, Office of Telecommunications Policy, in the utilization of the radio frequency spectrum for telecommunications.

(3) **VA Membership**: R. D. Holt (GS-13), Department of Data Management, Telecommunications Service.

c. Frequency Assignment Subcommittee (FAS)

(1) **Authority**: Section 305 of the Communications Act of 1934 as amended, Executive Order 11556.

(2) **Purpose**: In accordance with the Act, the FAS shall provide radio frequency assignments for all radio stations "belonging to and operated by the United States."

(3) **VA Membership**: R. D. Holt (GS-13), Department of Data Management, Telecommunications Service.

d. **Spectrum Planning Subcommittee (SPS)**

(1) **Authority**: Reorganization Plan No. 1 of 1970, Executive Order 11556.

(2) **Purpose**: Responsible for planning for the use of the electromagnetic spectrum including the apportionment of spectrum space for established or anticipated radio services.

(3) **VA Membership**: R. D. Holt (GS-13), Department of Data Management, Telecommunications Service.

e. **Interagency Committee on Emergency Medical Services, EMS Communications Interagency Work Group**

(1) **Authority**: Letter dated June 9, 1975, from the Administrator, Richard L. Roudebush, to the Acting Administrator, Health Services Administration, Department of Health, Education and Welfare.

(2) **Purpose**: To provide national policy and planning to implement EMS communications standards to all federally funded EMS programs.

(3) **VA Membership**: R. D. Holt (GS-13), Department of Data Management, Telecommunications Service.

f. **Interagency Committee on Automatic Data Processing**

(1) **Authority**: Letter to the Administrator from W. F. Finan, Assistant Director for Management and Organization, Bureau of the Budget, May 29, 1957.

(2) **Purpose**: To attain optimum exchange of experience, skills, and facilities among all Government agencies and to deal with problems facing both present and future ADP users.

(3) **VA Membership**: H. J. Clarke (GS-15), Department of Data Management, Director, Systems Audit Staff.

g. **ADP AD HOC Committee**

(1) **Authority**: Public Law 89-306.

(2) **Purpose**: To study implementation of Public Law 89-306 (Brooks Bill).

(3) **VA Membership**: William R. Martin (GS-18), Chief Data Management Director.

h. **Federal Information Processing Standards Coordinating and Advisory Committee (FIPSCAC)**

(1) **Authority**: Letter to the Administrator from the Assistant Secretary of Commerce for Science and Technology, December 19, 1973.

(2) **Purpose**: Acts as an advisory body to the National Bureau of Standards with respect to the scope and program of work of Federal Information Processing Standards (FIPS) task groups and coordinates the activity of those groups in their efforts to develop or refine government-wide standards for automated information processing.

(3) **VA Membership**: William R. Martin (GS-18), Chief Data Management Director.

i. **Various Federal Information Processing Standards (FIPS) Task Groups**

a. The Federal Property and Administrative Service Act of 1949, as amended, Public Law 89-306 (Brooks Bill) as implemented by Executive Order 11717 and Part 6 of Title 15, CFR, gives the Secretary of Commerce

responsibility for development and implementation of government-wide information processing standards. Accordingly, the National Bureau of Standards manages the Federal Information Processing Standards (FIPS) program which develops ADP standards through a number of FIPS interagency task groups and public advisory groups. The Veterans Administration participates on seven (7) of these task groups which are involved in the development or refinement of standards in the areas of hardware, software, documentation, data and computer security. The VA members of these task groups are various employees of the Department of Data Management and are all GS-13 and above.

NATIONAL CEMETERY SYSTEM

a. The National Cemetery System program was transferred from the Department of the Army to the VA on September 1, 1973, by Act of Congress, Public Law 93-43. This legislation was the result of the pressures of the veterans groups to expand the System and provide additional cemeteries. The Administration was directed by this law to make a study of the National Cemetery System and make proposals to Congress for the future of the System. This study was completed in January 1974 and submitted to Congress.

b. The study made two significant recommendations. The first was to expand the present system by providing a cemetery in each of the standard Federal regions. The policy now is to provide new cemeteries in those areas where the need is the greatest. The second recommendation was to provide a 50 percent grant-in-aid for veterans' cemeteries developed by States and interment in those cemeteries. Legislation to implement the latter recommendation has not passed the Congress.

c. Five new national cemeteries are in the process of being established. Land has been transferred to the VA in three instances and the cemeteries have been dedicated. Transfer of the land at the other two sites is pending. The land at the five sites is either excess Government land or was donated by the State. Following is a table showing the location of the sites and pertinent information.

Location	Acres	Gravesites	Status
VA National Cemetery Riverside, California	740.28	309,000	Site dedicated on June 27, 1976. Scheduled to open in early 1978.
VA National Cemetery, Indiantown Gap, PA	676.8	360,000	Site dedicated on October 30, 1976. Scheduled to open in mid 1979.
VA National Cemetery of Massachusetts	749	360,000	Site dedicated on October 31, 1976. Scheduled to open in late 1978.
District of Columbia Area	726.58	300,000	Land is being transferred from the Department of Defense.
Calverton, Long Island, New York	902	480,000	Land is being transferred from the Department of Defense.

d. The National Cemetery System now consists of 106 cemeteries, containing 6,599 acres and 1,378,323 interments. A total of 38,632 interments were made in FY 1976. Burial is available to any deceased veteran who was discharged under conditions other than dishonorable, the veteran's spouse, minor children and, under certain conditions, to unremarried adult children.

e. Full time employment within the System for FY 1977 is 1,041. Of this, 148 positions are located in VA Central Office and the balance in the Field. The funding program for national cemeteries for FY 1977 is $25,543,000 for General Operating Expenses and $13,464,000 for national cemetery construction.

f. **Headstone and Marker Program**

(1) Public Law 93-43, dated June 18, 1973, provides that an appropriate Government headstone or marker may be furnished for unmarked graves of the following:

(a) Any individual buried in a national cemetery or in a post cemetery.

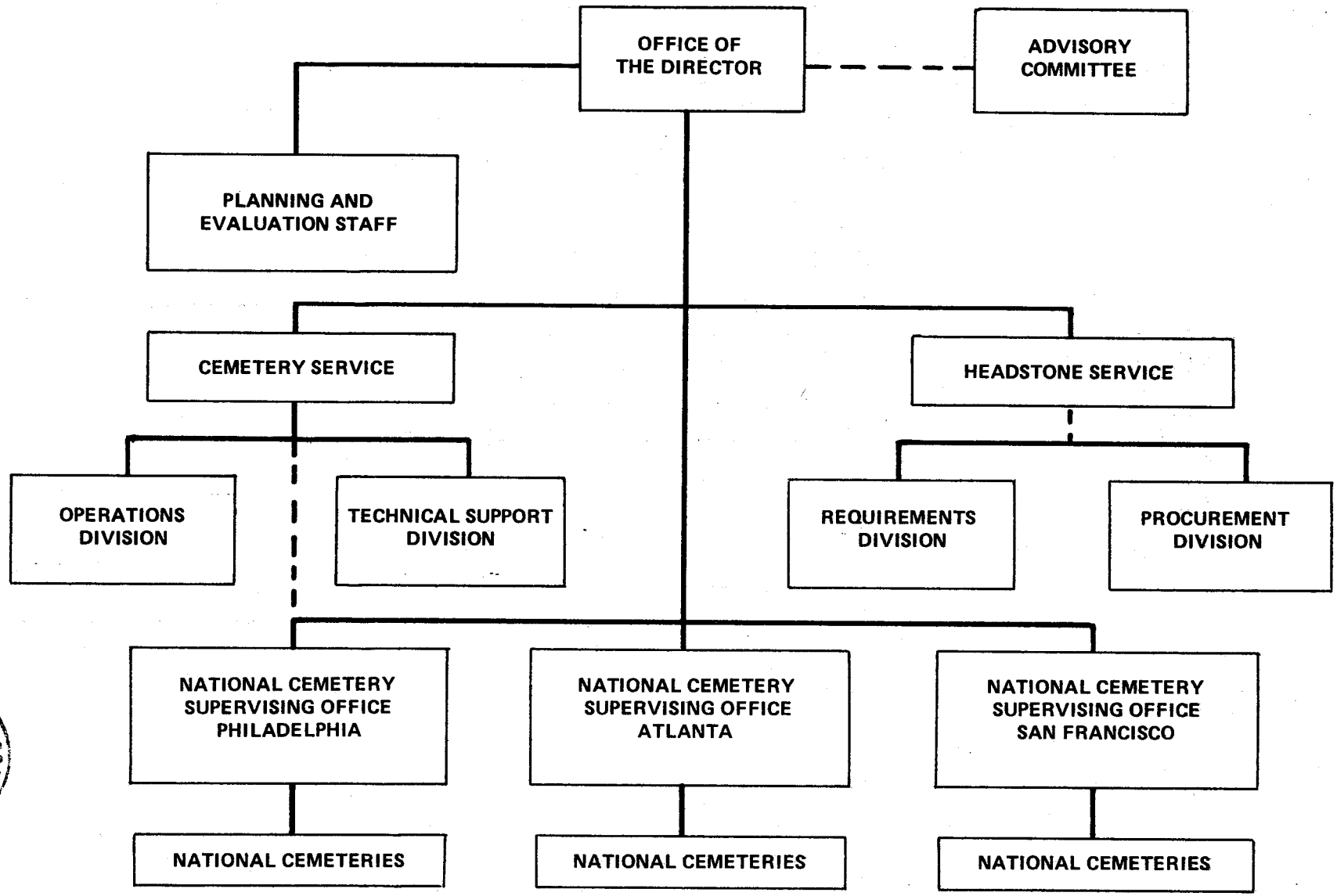
(b) Any veteran having an other than dishonorable discharge.

(c) Soldiers of the Union and Confederate Armies of the Civil War.

(2) The Administrator is also authorized to furnish an appropriate memorial headstone or marker to commemorate any veteran dying in the service, and whose remains have not been recovered or identified or were buried at sea, for placement in a national cemetery or in any private or local cemetery.

(3) Four basic types of headstones and markers are procured; an upright marble, flat marble, flat granite and a flat bronze marker. During FY 1976, a total of 229,331 headstones and markers were procured and issued at a cost of $8,965,878. The processing of the applications was accomplished with a staff of 80 personnel assigned to the National Cemetery System, VA Central Office.

NATIONAL CEMETERY SYSTEM



Veterans Administration
ADVISORY COMMITTEE
on
CEMETERIES and MEMORIALS

CHAIRMAN
Admiral John S. McCain, Jr. U.S.N. (Ret.)

MEMBERS

William (Bill) Baldwin	World War II Correspondent
Major General John R. Blandford	USMC
Leroy S. Demanes	Memorial Consultants, Inc.
Leslie M. Fry	Past National Commander, Veterans of Foreign Wars
Joe L. Mathews	Past National Commander, The American Legion
John C. Metzler	Retired Superintendent, Arlington National Cemetery
Stuart J. Satullo	Past National Commander, American Veterans of World War II, Korea & Vietnam
Meyer Sokolow	Past Department Commander (Maryland) Jewish War Veterans
James E. Van Zandt	Rear Admiral USNR (Ret.) Past National Commander, Veterans of Foreign Wars
Louis F. Zaruba	National Commander, Veterans of World War I

BOARD OF VETERANS APPEALS

1. GENERAL

a. The Board of Veterans Appeals (BVA) is established under the authority of 38 U.S.C., Chapter 71. Its mission is to decide appeals on claims involving benefits administered by the VA. In each case a claimant files an appeal with the field office that took the action in question. If that office is not able to resolve the matter to the satisfaction of the claimant, the case is certified to the Board for review of the entire record and for final decision.

b. A Chairman, directly responsible to the Administrator, controls and supervises the Board.

2. ORGANIZATION

a. The Board consists of a Chairman, Vice Chairman, a number of associate members (not to exceed 50), and other professional, administrative, and support personnel required to conduct hearings and consider and decide appeals properly before it.

b. Under the FY 1977 Budget, BVA is organized around the Office of the Chairman and 14 sections of three members each–a chief member (attorney), a medical member, and a legal member.

- There are 98 attorney advisers to perform necessary research and prepare tentative decisions for review and approval by board sections.

- Four additional physicians serve as principal medical advisers to the Chairman and, in their specialities, to board sections and attorney advisers on individual cases.

- Administrative support–keeping the docket, scheduling hearings, transcribing decisions and hearings, and related tasks–includes 145 employees.

3. APPELLATE WORKLOADS

a. BVA receives about 55 to 57 percent of all appeals filed in the field stations. The remainder are either allowed in the field or withdrawn or closed by claimants or their representatives.

b. Appeals reaching the Board cover a very broad range of legal, medical, and technical problems. Issues on appeal involve entitlement to and compensation for service-connected disabilities, pension, education, insurance, eligibility for medical treatment, home loans, waivers of indebtedness and overpayments, specially adapted homes and autos for certain disabled veterans, and payment for unauthorized medical care. Within these categories, the vast majority of appeals are in the following areas:

Categories of Appeals	Percent of Total
Service connection	48
Increased rating	25
Death benefits	8
Pension	7

c. Appeals filings reached 54,200 in FY 1972. There was a drop to 43,200 by FY 1974 followed by an upturn to 45,600 in FY 1975. Then, apparently the result of increased emphasis on due process consideration, appeals rose sharply to 53,000 in FY 1976.

d. Based on appeals filed during the Transition Quarter (July - September 1976)–15,600–it appears that the total for FY 1977 may approach 60,000.

e. The Board's budget for FY 1977 is based on a projection of 28,000 case receipts. At this time it appears that a more realistic estimate of appeals reaching BVA in FY 1977 is 33,000.

f. BVA considers the desirable number of appeals on the docket to be in the 5,000 to 6,000 range. The shifts in number of appeals filed in recent years is reflected in the size of the docket. At the end of FY 1974 the docket carried 3,900 cases. This rose to 4,900 by end FY 1975. As a result of the sharp upswing of appeals, it reached 6,500 at the end of FY 1976; 8,000 by September 30, 1976; and 9,000 by November 15, 1976.

g. Because case receipts are far outstripping the Board's ability to produce decisions, overtime on three Saturdays in November and December 1976, has been scheduled. After Christmas considerations will be given to additional overtime and other alternatives to meet the demands of the pending caseloads.

OFFICE OF CONSTRUCTION

CONTENTS

VA CONSTRUCTION PROGRAM

1. INTRODUCTION

a. The Office of Construction is responsible for the design and supervision of construction of new buildings, additions, alterations, and major repairs of existing buildings and structures at nearly 170 hospitals domiciliary facilities, and nursing homes, and 104 cemeteries located throughout the United States. In the field of hospital and health care facilities construction, the VA is and has been a leader for many years. Highly diversified types of medical and scientific equipment used in connection with patient care and research activities have been introduced, and an integrated professional staff of architects, engineering specialists and generalists, construction management officials, and administrative personnel together perform the variety of functions necessary to implement the VA's $500 million annual construction program.

b. In the last decade, 13 replacement or relocation hospitals were constructed at a total cost of $297.1 million; 75 Nursing Home Care unit projects were completed at a total cost of $24.7 million; five new hospitals are currently under construction at a total anticipated cost of $369.6 million.

2. PROGRAM DATA FOR FY 1977

a. Significant steps were taken during FY 1977 to replace eight VA Hospitals. Architect-Engineer Consultants were contacted to assemble and correlate information relating to the continued use, renovation, or total replacement of the eight hospitals. Master Plan Studies were subsequently formulated and presented to the Department of Medicine and Surgery and the Administrator for analysis and recommendation, and then forwarded to OMB and the President for final consideration. Design funds were appropriated for all eight hospitals, as well as construction funds for the first two hospitals to be built in Richmond, Virginia and Bay Pines, Florida, and construction funds for the remaining six (Martinsburg, West Virginia; Portland, Oregon; Seattle, Washington; Little Rock, Arkansas; Baltimore, Maryland; and Camden, New Jersey) were promised, to be developed at a rate of two a year. The total anticipated cost for the eight new hospitals is $826.4 million.

b. The total budget appropriation for FY 1977 totals $497.7 million: Sixty percent will be appropriated for the replacement and modernization of health care facilities; 27 percent will be appropriated for other Health Care Facilities improvements; 5 percent will go for Nursing Home Care and Domiciliaries; 2 percent for a Computer Center; 3 percent for Cemeteries, and 3 percent for administration.

3. HISTORY

A Staff Office to administer the VA Construction program as a major independent organizational unit has been in existence since 1946. However the functions it performs have been established for approximately 52 years and have passed through several major reorganizations. On January 17, 1924, a plan of organization was adopted by the Veterans Bureau which established the first Supply Service. Included in this Supply Service was the Construction Division, assigned responsibility for design and supervision of hospital construction. This organization was in response to a major hospital construction program to provide medical care for the veterans of WWI. No further change in organization occurred until after the Veterans Administration was established in 1930. In July 1930 both Supply and Construction were set up as separate services within the newly created Office of the Assistant Administrator for Medical and Domiciliary Care, Construction and Supplies. From 1930 until the end of World War II the number of VA Hospitals increased from 46 to 94. Although it was known that a great expansion of facilities would be necessary as soon as the war ended, the continuation of the war prevented substantial progress in this area. The great concern for providing veterans with adequate facilities was demonstrated in the Congressionally approved 1947 and 1948 Construction program, better known as the 90 New Hospital Construction Program. This great effort coincided with the decision to establish a new Office of Assistant Administrator for Construction, Supply and Real Estate. This reporting relationship continued until a major VA-wide reorganization in 1953 which set up the Office of the Assistant Administrator for Construction. In 1966 the name of this staff element was officially changed to the Office of Construction.

4. THE ORGANIZATION

a. The Assistant Administrator for Construction formulates and recommends to the Administrator general policies and plans of VA-wide application pertaining to Medical facilities requirements for DM&S, the design and

construction of buildings and cemeteries, the management of real property, cemetery property acquisition, the coordination of technical services support for the National Cemetery system, and space management including agency negotiations with GSA and the consummation of all VA leases for space.

b. Under the AA/C, the Director of Planning and Development initiates all actions to secure departmental concurrence and agency and Presidential approval for all projects and the development of all facilities construction requirements, space criteria, and equipment guidelines. He supervises four services which together accomplish the early phase of project work: Health Care Facilities, Preliminary Planning, Land Management, and Estimating.

c. The Director of Architecture and Engineering handles the next phase of each construction project, and is responsible for architectural and engineering design, and for the adequacy of review of such work performed by contracted Architect-Engineers. He serves as Chairman, Construction Methods Determination Board and the Completion Items Review Board, and is responsible for the preparation of Master Specifications, and individual specifications for projects designed in-house. He supervises four services responsible for specifications and working drawing preparation and coordination: Architectural, Civil Engineering, Mechanical Engineering, and Electrical Engineering.

d. In conjunction with the Directors of Planning and Development and Architecture and Engineering, four Project Directors assure that the planning, design, and construction of projects are accomplished within established time frames and budgetary limitations.

e. The Project Directors serve as Contracting Officers and act as focal points for all project information and assure the provision of necessary architectural and engineering technical service throughout the life of each project. They issue necessary authorizations to the Director of Architecture and Engineering to proceed on projects. As A/E and construction contracting officers, they negotiate fees with Architect-Engineer firms, evaluate the bids for construction projects, and award, execute, and administer all contracts.

f. In addition, various staff offices provide special services and administrative support for the Assistant Administrator. The Research Staff plans and implements a research and development program on building technology for health care facilities construction. The Management Staff advises the AA/C on all administrative, managerial, and personnel-related matters, formulates and prepares the administrative budget, and supervises the O/C Resident Engineer Program in which approximately 100 professional employees relocate to oversee and administer the nationwide on-site contract construction activities. The Program Control and Analysis Staff reviews for the AA/C project submissions and other program proposals for the VA, OMB, Congressional, or Presidential approval of authorizations, and formulates and prepares the construction budget for the Office of Construction. If also operates the MIS and CPM systems.

5. SIGNIFICANT DEVELOPMENTS IN THE VA CONSTRUCTION PROGRAM

a. **Energy Conservation.** The VA is in the forefront among Government agencies in implementing a policy of energy conservation.

(1) Solar Energy, total energy, selective energy and incinerators using waste heat boilers are being investigated for possible use in hospitals. Several projects are currently under design and construction. Energy saving devices and existing hardware are used extensively.

(2) A computer software program is being developed in conjunction with the University of Pittsburgh specifically for the design of VA hospitals to provide the opportunity for analysis of over 30 different air conditioning systems for optimum energy conservation.

(3) In addition, an "Energy Bank" utilizing a modified annual cycle energy system is now under construction as part of the 60-bed nursing home care unit at Wilmington, Delaware as well as a demonstration solar energy system for their Research Building. A selective energy system will be investigated for use in one of the new hospitals so that it can generate its own electric power to run air conditioning systems. The heat recovery wheel first introduced to the VA in the hospital at Phoenix, Arizona, in 1969, is now standard practice. Heat pumps are now in operation at several facilities, and energy-management systems using mini-computers are being designed into all new hospitals.

b. **Advisory Committee on Structural Safety.** Public Law 93-82 requires that hospitals, domiciliaries, and other medical facilities, including nursing home facilities contracted for under Section 620, Title 38 U.S.C., are to be of fire, earthquake and other natural disaster resistant construction. To comply with this law, an Advisory Committee on Structural Safety of VA Facilities was appointed to advise the Administrator on all matters of structural safety in the construction and remodeling of VA facilities. The Committee's recommendations for fire, earthquake, and other natural disaster resistant construction are developed as Construction Standards by the VA staff.

c. **Construction Research.** The construction research and development program is a continuing effort comprised of a wide variety of architectural and engineering projects on hospital building technology. During FY 1976, 20 widely diversified research and development projects were undertaken on a budget of $630,000. A pioneering study was completed and a report published on seismic protection for hospital furniture, equipment and supplies. Also completed were a computerized data base for designing nursing homes, a test installation of plastic casework, and a Picturephone demonstration project. New projects which originated during FY 1976 included studies on hospital internal transportation systems, fire detection and engineering smoke control systems, directional graphics guidelines, computerized design analysis of mechanical utility systems for energy conservation, plumbing design criteria, and illumination of patient bed areas.

d. **Computer-Aided Design.** The Office of Construction Research Staff and the Preliminary Planning Service received training from the Boston-based firm of Perry, Dean, and Stewart in computer graphics. This served as preparation for the installation of the VA's own PDP 15/76 mini-computer now used in the Preliminary Planning Service with ARK-2 programs. This was a model installation for the Federal Government, and a VA first in Federal operation. It has received nationwide recognition and the ARK-2 program has the potential of becoming a prototype for future Federal agency and military users.

6. PARTICIPATION IN PROFESSIONAL ORGANIZATIONS

Members of the Office of Construction are members of many and varied professional organizations outside the agency for the mutual benefit of both. Among those major organizations and societies in which the VA personnel actively participate are: Federal Construction Council (Building Research Advisory Board), National Fire Protection Agency, Inter-Agency Committee for Information Exchange, the American Institute of Architects, National Society of Professional Engineers, Consulting Engineers Council, American Society of Landscape Architects, the American Society for Testing and Materials, the American Concrete Institute, and the President's Committee on Employment of the Handicapped, and the International Hospital Federation.

WASHINGTON, D. C. MONTHLY OCTOBER 30, 1976

SUMMARY

of

Large Construction Projects

REPORT NO. 2/08D11.2M

O/CONSTRUCTION VETERANS ADMINISTRATION

III-F-5

PROPOSED AND ACTIVE
RELOCATION AND REPLACEMENT HOSPITALS -- AS OF OCTOBER 31, 1976

Line No.	LOCATION (Alphabetically by City)	Project Number	BRIEF DESCRIPTION (Including Total Beds)	Est. Constr. Cost ($ Million)	FISCAL YEAR FUNDING PLAN		DESIGN BY		PROGRESS STEPS						REMARKS
					Technical Services	Construction	Architect Engineer	Veterans Administration	Requirements	Preliminary Development	Working Dwgs. & Specs. (% Complete)	Advertised for Construction	Construction (% Complete)	Supplies and Equip. (% Complete)	
1	Augusta, GA	510-001	Replacement Hospital PH-I	3.74	73/74	75/76	X		///	///	///	///	5		Contractor Installing Piling
2	Augusta, GA	510-001C	Replacement Hospital PH-II	33.49	71/73	75/76	X		///	///	U				2nd Wkg Dwg Rev Sched for 11/29-12/1/76
3	Baltimore, MD	511-001C	Replacement Hospital	76.67	71/73 77	FUTR	X		U						Design Funds FY 77
4	Bay Pines, FL	516-053	Replacement Hospital	102.30	70/79 77	FUTR	X		U						Design Funds FY 77
5	Bronx, NY	526-079	Replacement Hospital (642 MS& N & 60 Psy. Beds)	107.31	73	74/75	X		///	///	///	///	30		Phase I Complete 5/25/76 Est. Compl. Phases 2 thru 11 5/14/78
6	Camden, NJ	101-INT-001	New Hospital	62.32	73/77	FUTR	X		U						Design Funds Requested in FY 77
7	Little Rock, AR	598-016	Replacement Hospital	74.85	73/77	FUTR	X		U						Coordination of funds with Design and Constr. Project
8	Loma Linda, CA	605-001	Relocation Hospital PH-I	14.82	72	74	X		///	///	///	///	100		Physically Completed 1/76
9	Loma Linda, CA	605-001	Relocation Hospital PH II	46.40	73	75/76	X		///	///	///	///	73	70	Partial Final inspection for sub-phase I 11/76
10	Los Angeles, CA	691-072	Replacement Hospital PH I PH II	74.99	73	73/74 75	X		///	///	///	///	100 98		Phase 1 completed 3/21/75 Phase 2 Est. Compl. 2/11/77
11	Martinsburg, WV	613-012	Replacement Hospital	58.98	73/77	FUTR	X		U						CBD Ad for A/E issued 11/76
12	Portland, OR	101-INT-002	Replacement Hospital	144.11	73/77	FUTR	X		U						Recommendations to OMB 4/76 Part 1 of 8 Special Studies
13	Richmond, VA	651-001	Replacement Hospital	104.94	71/73 77	FUTR	X		U						Design Funds FY-77

LEGEND:
- ////. Action Completed Prior to Current Quarter.
- ■ Action Complete During Quarter.
- U Underway - Interim Progress Not Shown.
- 10 Underway - Interim Progress Percent Complete to Date.

*Figures in parenthesis ( ) denote space for constructed beds
(Total Beds = Constructed Beds + Receiving and Recovery Beds.)

PROPOSED AND ACTIVE
SELECTED MODERNIZATION AND OTHER IMPROVEMENTS PROJECTS – AS OF OCTOBER 31, 1976

Line No.	LOCATION (Alphabetically by City)	Project Number	BRIEF DESCRIPTION (Including Total Beds)	Est. Constr. Cost ($ Million)	FISCAL YEAR FUNDING PLAN		DESIGN BY		PROGRESS STEPS						REMARKS
					Technical Services	Construction	Architect Engineer	Veterans Administration	Requirements	Preliminary Development	Working Dwgs. & Specs. (% Complete)	Advertised for Construction	Construction (% Complete)	Supplies and Equip. (% Complete)	
1	Boise, ID	531-034	New Clinical Support Facility	5.47	71/72 73	74/75	X						32		Early Completion of 5 Months Anticipated
2	Buffalo, NY	528-022	Outpatient Clinic Expansion	6.16	73	FUTR	X				U				A/E contract modified
3	Columbia, SC	544-024B	New Bed Bldgs/Exist. Hosp. Bldg. & Boiler Plant Exp.	47.10	73	74/75 76		X					73		PH-I Awarded 12/75 PH-II Est. Dsgn Compl 6/76
4	Dallas, TX	549-014	Research & Education Addition	5.78	73	77	X					U			Pre Bid Conference held 10/76
5	Denver, CO	554-019	Clinical Support Wing & Air Conditioning	16.81	73	FUTR	X		U						Update Requirements. Correct Space Deficiencies.
6	Gainesville, FL	573-008	Clinical Improvements (Addition-Part 1)	6.60	74/75	76	X						31		Est. Constr. Compl.
7	Houston, TX	580-023	Research & Education (25,000 NSF-Res.-10,000 Educ.)	4.68	73	76	X						9		Constr. on Sched. Req. X-Ray Equip. Draw Delay
8	Jackson, MS	423-011	Research and Education	6.67	71/72	76	X	X					15		Existing Sewer Requires Reconstruction
9	Long Beach, CA	600-023	Research Addition (43,000NSF)	7.08	71	FUTR	X					U			Funds Deleted From Budget
10	Madison, WI	607-018	New Wing Addition	12.89	75	FUTR	X				U				Final Wkg. Dwg. Review Scheduled for 11/18/76
11	Miami, FL	546-004	Research, Education & Psy. Addition	8.34	71	73/ FUTR	X			U					Proj. Req. Submission by VACO & DM&S
12	Philadelphia, PA	642-014	Research Addition	3.68	71	73	X						97		Proj. will be ready for Final Inspection soon.
13	Phoenix, AZ	644-004	328 Bed Addition (206 MS&N and 122 Psy)	19.27	67	70/71 72	X						100		Est. Compl. Date 7/5/76
14	Phoenix, AZ	644-006	Modernization, Part 2	6.99	75	76	X						U		Est. Compl. date 1/78
15	Reno, NV	654-025	Clinical Improvements	11.64	74	76 FUTR	X			U					Proposal for wkg./dwg. Sub.
16	Salisbury, NC	659-005	Air Conditioning System	7.36	73	74/75	X						97		Final Inspection Anticipated Soon
17	St. Albans, NY (Brooklyn)	527-9AA-001	Modernization PH 1 PH 2	3.55	75	75/76		X					86		Outpatient Med Bldgs. 85, 86, 92 & 93
18	Seattle, WA	663-014	Bed Building	77.36	68/73 77	FUTR	X		U						Budget Cost Revised
19	West Roxbury, MA	690-024	Spinal Cord Rehabilitation Cntr & Mod. Bldg. 1 (PH 1)	11.63	72	74/75 FUTR	X						34		Est. Compl. Date 3/13/78

COMPLETED BED PROJECTS

July 1, 1945 to September 30, 1976

LINE	LOCATION	Type of Hosp.	Space for Beds: Constr	Space for Beds: Total**	F.Y. Prog	Assigned: Design	Assigned: Constr	Constr. Subst. Completed	Officially Opened
	NEW HOSPITALS								
1.	Tomah, Wisc.	NP	1,172	1,172	Pr	V	V	July 47	Mar 47
2.	Lebanon, Pa.	NP	479	479	Pr	V	V	Jun 47	Sept 47
	Sub-Total		1,651	1,651					
3.	Grand Jct., Colo.	GM	152	152	47	V	C	Feb 49	May 49
4.	Providence, R. I.	GM	393	393	47	V	C	Feb 49	June 49
5.	Sioux Falls, S.D. (C)	GM	283	283	47	V	C	Feb 49	July 49
6.	Buffalo, N.Y.	GM	997	1,009	47	C	C	Dec 49	Jan 50
7.	Brooklyn, N.Y.	GM	1,004	1,015	47	C	C	Feb 50	Feb 50
8.	Iron Mt., Mich.	GM	253	285	47	C	C	Jan 50	Mar 50
9.	Wilmington, Del.	GM	320	333	47	C	C	Feb 50	Mar 50
10.	Fresno, Calif.	GM	251	260	47	C	C	Dec 49	Mar 50
11.	Montrose, N.Y.	NP	1,960	1,968	47	V	C	May 50	May 50
12.	Ft. Wayne, Ind.	GM	199	204	47	C	C	Mar 50	May 50
13.	Manchester, N.H.	GM	153	158	47	C	C	May 50	Jun 50
14.	Minot, N.D.	GM	162	162	47	V	C	Apr 50	July 50
15.	Big Spring, Texas	GM	246	256	47	C	C	Apr 50	July 50
16.	Saginaw, Mich.	GM	193	206	47	V	V	Jun 50	Aug 50
17.	Grand Island, Nebr.	GM	197	206	47	C	C	Jun 50	Sept 50
18.	Altoona, Pa.	GM	204	213	47	C	C	July 50	Sept 50
19.	Little Rock, Ark.	GM	500	518	47	C	C	Aug 50	Oct 50
20.	Shreveport, La. (C)	GM	449	467	47	C	C	Sept 50	Oct 50
21.	Marlin, Texas	GM	193	206	48	V	V	Jun 50	Nov 50
22.	Spokane, Wash.	GM	200	208	47	C	C	Jun 50	Nov 50
23.	Wilkes-Barre, Pa.	GM	489	491	47	C	C	Aug 50	Nov 50
24.	Poplar Bluff, Mo.	GM	201	206	47	C	C	Oct 50	Jan 51
25.	Omaha, Nebr.	GM	486	494	47	C	C	Oct 50	Feb 51
26.	Beckley, W. Va.	GM	196	203	47	C	C	Oct 50	Mar 51
27.	Clarksburg, W. Va.	GM	200	205	47	C	C	Oct 50	Mar 51
28.	Erie, Pa.	GM	204	208	47	C	C	Feb 51	Mar 51
29.	Albany, N.Y.	GM	1,009	1,027	47	C	C	Feb 51	Apr 51
30.	Seattle, Wash.	GM	325	328	47	C	C	Mar 51	May 51
31.	Miles City, Mont.	GM	96	104	47	C	C	Feb 51	Aug 51
32.	Phoenix, Ariz. (7th St.)	GM	192	197	47	C	C	Jun 51	Aug 51
33.	Denver, Colo.	GM	485	493	48	V	V	July 51	Aug 51
34.	Madison, Wisc.	TB	486	498	47	C	C	July 51	Sept 51
35.	Bonham, Tex. (Dom. 291)	GM	52	52	47	C	C	Aug 51	Nov 51
36.	Indianapolis, Ind. (10th St. D)	GM	486	494	47	V	V	Nov 51	Feb 52
37.	Iowa City, Iowa	GM	480	488	47	C	C	Jan 52	Mar 52
38.	Louisville, Ky.	GM	486	496	47	V	V	Jan 52	Apr 52
39.	Boston, Mass.	GM	941	949	47	C	C	Apr 52	July 52
40.	Salt Lake City, Utah	NP	546	546	47	C	C	Jun 52	Sept 52
41.	New Orleans, La.	GM	492	492	47	C	C	July 52	Sept 52
42.	East Orange, N.J.	GM	951	971	47	C	C	Jun 52	Sept 52
43.	Kansas City, Mo.	GM	492	500	47	C	C	Jun 52	Oct 52
44.	Baltimore, Md.	TB	289	295	47	C	C	July 52	Oct 52
45.	Philadelphia, Pa.	GM	488	496	47	V	V	Aug 52	Jan 53
46.	Birmingham, Ala.	GM	479	487	47	C	C	Nov 52	Mar 53
47.	Durham, N.C.	GM	483	491	47	C	C	Jan 53	Apr 53
48.	W. Haven, Conn.	GM	872	891	47	C	C	May 53	Apr 53 a/
49.	Syracuse, N.Y.	GM	488	496	47	V	V	Feb 53	Jun 53
50.	Chicago, Ill. (W.S.)	GM	488	496	48	V	V	May 53	Sept 53
51.	Okla. City, Okla.	GM	488	496	48	V	V	Jun 53	Sept 53
52.	Ann Arbor, Mich.	GM	487	495	48	V	V	July 53	Oct 53
53.	Brockton, Mass.	NP	948	956	48	V	V	Oct 53	Oct 53
54.	Salisbury, N.C.	NP	973	981	48	C	V	Aug 53	Oct 53
55.	Pittsburgh, Pa. (L. F. R. D.)	NP	944	950	47	C	C	Aug 53	Nov 53
56.	Chicago, Ill. (Res.)	GM	516	524	47	A	V	Sept 53	Dec 53
	NEW HOSPITALS (Cont'd)								
57.	St. Louis, Mo.	GM	487	495	47	V	V	Nov 53	Mar 54
58.	Cincinnati, Ohio	GM	487	495	47	V	V	Mar 54	May 54
59.	Pittsburgh, Pa. (UN. DR. D)	GM	742	749	47	C	C	Mar 54	Sept 54
60.	New York, N.Y.	GM	1,238	1,252	47	C	C	Apr 54	Oct 54
61.	Sepulveda, Calif.	NP	956	961	48	V	V	Jan 55	Apr 55
62.	Topeka, Kans. b/	NP	1,011	1,014	48	V	V	May 58	Aug 58
63.	Palo Alto (SFBA), Calif.	NP	1,000	1,000	48	A	V	Mar 60	July 60
64.	Brecksville, Ohio	NP	994	994	48	X	V	May 61	Sept 61
65.	Cleveland, Ohio (WADE P.)	GM	800	800	48	A	V	Apr 64	June 64
66.	Washington, D.C. (Sd. Hom.)	GM	710	710	47	A	V	Jan 65	May 65
	Sub-Total		34,263	34,739					
	GRAND TOTAL		35,914	36,390					
	REPLACEMENT or RELOCATION								
1.	Lake City, Fla.	GM	229	234	52	X	V	June 55	Sept 55
2.	Long Bch, Calif. (Ph I)	GM	561	569	55	A	V	May 58	Oct 58
3.	Downey, Ill.	NP	818	821	56	V	V	Mar 61	May 61
4.	Jackson, Miss.	GM	498	505	57	A	V	Oct 61	Jan 62
5.	Nashville, Tenn.	GM	498	506	57	A	V	Jan 63	May 63
6.	Martinez, Calif.	GM	498	505	57	A	V	May 63	Aug 63
7.	Wood, Wisc.	GM	1,264	1,264	58	A	V	Sept 65	May 66
8.	Atlanta, Ga. (Emory)	GM	572	587	62	A	V	Mar 66	June 66
9.	Charleston, S. C.	GM	498	505	61	A	V	June 66	June 66
10.	Temple, Texas	GM	474	480	63	X	V	Nov 66	Apr 67
11.	Memphis, Tenn.	GM	984	993	59	A	V	Mar 67	Aug 67
12.	Gainesville, Fla.	GM	480	486	63	A	V	June 67	Sept 67
13.	Oteen, N.C.	GM	500	505	60	A	V	June 67	Oct 67
14.	Miami, Fla.	GM	1,054	1,066	59	A	V	Oct 67	Mar 68
15.	Long Beach, Calif.	GM	1,126	1,126	59	X	V	Oct 67	c/
16.	San Juan, P.R.	GM	698	710	64	A	V	July 69	Nov 69
17.	Hines, Ill.	GM	1,220	1,232	63	A	V	June 70	Sept 70
18.	Columbia, Mo.	GM	464	470	64	A	V	Oct 71	Apr 72
19.	San Diego, Calif.	GM	811	811	66	A	V	Dec 71	Feb 72
20.	Tampa, Fla.	GM	702	711	64	A	V	Mar 72	Aug 72
21.	Northport, N.Y.	GM	470	476	65	A	V	May 72	Aug 72
22.	Lexington, Ky. (U.D.)	GM	370	378	66	A	V	Feb 73	June 73
23.	San Antonio, Tex.	GM	760	773	66	A	V	July 73	Oct 73
24.	White River Jct., Vt.	GM	204	205	68	A	V	May 74	Jun 74
	San Francisco, Ca								Jan 76

LINE	LOCATION	Space for Beds: No.	Space for Beds: Type	F.Y. Prog	Assigned: Design	Assigned: Constr	Constr. Subst. Completed	Equipped
	ADDITIONS							
1.	Waco, Texas	656	NP	Pr	V	V	Aug 1945	Aug 1945
2.	Los Angeles, Calif.	406	NP	Pr	V	V	Aug 1945	Aug 1945
3.	Waco, Texas	164	NP	Pr	V	V	Oct 1945	Oct 1945
4.	Tuskegee, Ala.	328	NP	Pr	V	V	Nov 1945	Nov 1945
5.	Canandaigua, N.Y.	492	NP	Pr	V	V	Dec 1945	Dec 1945
6.	Lyons, N.J.	498	NP	Pr	V	V	Dec 1945	Dec 1945
7.	Chillicothe, Ohio	518	NP	Pr	V	V	Jan 1946	Jan 1946
8.	Northampton, Mass.	104	NP	Pr	V	V	Feb 1946	Feb 1946
9.	Coatesville, Pa.	328	NP	Pr	V	V	Feb 1946	Feb 1946
10.	Ft. Howard, Md.	79	GM	Pr	V	V	Feb 1946	Feb 1946
11.	Salem (Roanoke), Va.	656	NP	Pr	V	V	Dec 1945	Feb 1946
12.	Battle Cr (Ft. Custer), Mich.	165	NP	Pr	V	V	Mar 1946	Mar 1946
13.	Ft. Lyon, Colo.	162	NP	Pr	V	V	Feb 1945	Mar 1946
14.	Sheridan, Wyo.	164	NP	Pr	V	V	Mar 1946	Mar 1946
15.	Los Angeles, Calif.	432	NP	Pr	V	V	June 1946	June 1946
16.	Biloxi (Gulfport), Miss.	164	NP	Pr	V	V	Aug 1946	Aug 1946
17.	Bedford, Mass.	89	NP	Pr	V	V	Nov 1946	Dec 1946
18.	Dwight, Ill.	90	GM	Pr	V	V	Nov 1946	Dec 1946
19.	Lexington, Ky.	492	NP	Pr	V	V	Mar 1947	Mar 1947
20.	Perry Point, Md.	328	NP	Pr	V	V	Apr 1947	June 1947
21.	Tuscaloosa, Ala.	328	NP	Pr	V	V	June 1947	June 1947
22.	Little Rock (N. Lit. Rk), Ark.	640	NP	Pr	V	V	Sept 1947	Sept 1947
23.	Battle Cr (Ft. Custer), Mich.	328	NP	Pr	V	V	Sept 1947	Oct 1947
24.	American L. Tacoma, Wash.	228	NP	Pr	V	V	Mar 1947	Dec 1947
25.	Reno, Nev.	166	GM	Pr	V	V	Sept 1947	Mar 1948
26.	Rutland Hts., Mass.	148	TB	Pr	V	V	Aug 1947	Mar 1948
27.	Fargo, N. D.	248	GM	Pr	V	V	Mar 1948	May 1948
28.	Fayetteville, N. C.	166	GM	Pr	V	V	Oct 1947	May 1948
29.	Murfreesboro, Tenn.	474	NP	Pr	V	V	June 1947	May 1948
30.	Allen Pk (Dearborn), Mich.	948	GM	Pr	V	V	Apr 194	Dec 1948
31.	Kerrville (Legion), Texas	373	TB	Pr	V	V	Nov 19-	ec 1948
	Sub-Total	10,362						
		**						
32.	Brecksville, Ohio	153	TB	48	V	V	June 1950	Sept 1950
33.	Livermore, Calif.	162	TB	48	V	V	Oct 1949	Sept 1950
34.	San Fernando, Calif.	132	TB	48	V	V	Oct 1949	Sept 1950
35.	Lebanon, Pa.	564	NP	48	V	V	Aug 1950	Nov 1950
36.	Portland, Oreg.	159	TB	48	V	V	June 1950	Feb 1951
37.	Alexandria, La. (Ph. 1) d/	251	TB	48	V	V	Jan 1951	May 1951
38.	Tuskegee, Ala. (Ph. 1) e/	102	GM	48	V	V	Dec 1950	June 1951
39.	Albuquerque, N. M.	267	TB	48	V	V	Apr 1951	July 1951
40.	Jefferson Brks., Mo.	544	NP	47	C	C	Oct 1952	Jan 1953
41.	Minneapolis, Minn. (Ph. 1) f/	464	GM	47	V	V	June 1953	June 1953
42.	Houston, Texas	200	NP	51	V	V	July 1953	Dec 1953
43.	Dallas, Texas (Ph. 1) g/	503	GM	47	V	V	Feb 1955	Aug 1955
44.	Houston, Texas	276	NP	54	X	V	June 1957	June 1957
	Sub-Total	3,777						
	GRAND TOTAL	14,139						
	CONVERSIONS							
1.	Downey (Camps Lawr. & McInt.) Ill.	1,100 GM-NP-TB		48	V	V	Apr 1949	Apr 1949
2.	Atlanta, Ga.	300 GM to 225 TB		48	V	V	Apr 1949	June 1949
3.	Brecksville, Ohio	269 GM to 169 TB		48	V	V	Dec 1951	Feb 1952
4.	Batavia, N. Y.	294 GM to 199 TB		48	V	V	June 1952	June 1952
5.	Memphis, Tenn.	300 GM to 249 TB		48	V	V	July 1952	July 1952
6.	Augusta, Ga. (annex) to h/	224 TB - 198 GM		51	V	V	Nov 1952	Nov 1952
7.	Atlanta, Ga. (North Atlanta)	225 TB to 300 GM		51	V	V	Jan 1953	Jan 1953
8.	Wadsworth, Kan.	328 GM to 200 TB		52	V	V	May 1953	July 1953
9.	Indianapolis, Ind. (C. S. R. D.)	347 GM to 241 TB		52	V	V	Aug 1953	Sept 1953
10.	West Roxbury, Mass.	316 GM to 153 Para, 151 GM		52	X	V	Aug 1953	Nov 1953
11.	Allen Pk (Dearborn), Mich.	538 GM to 362 TB		48	V	V	Nov 1954	Feb 1955
12.	Jefferson Barracks, Mo.	GM to 278 NP		47	X	V	July 1957	Sept 1957

** Bed capacities shown include Receiving and Recovery Beds in addition to Constructed Beds. (Figures represent capacities constructed from original project funds).

A- Design by private architectural firm.
C- Corps of Engineers
(C) Center - Hospital/Regional Office.
V- Veterans Administration
X- Design by VA and private architectural firm.

a/ Portion of TB Bldg. opened 4-8-53; entire hospital not turned over to Manager until 9-26-53.
b/ Air Conditioning completed July 1960.
c/ Bldgs #126 and #128 for 1,126 beds completed and dedicated 10-67, and balance of project substantially completed 4-69.
d/ Phase II Constructed, Activated and Equipped February 1957.
e/ Phase II substantially completed August 1958. (Convert to 478 NP Beds).
f/ Phase II Constructed, Activated and Equipped May 1956.
g/ Phase II substantially completed June 1958.
h/ Forest Hills Division.

CONTRACT COMPLIANCE PROGRAM

1. The Contract Compliance Service is a staff office which reports to the Administrator through the Associate Deputy Administrator and the Deputy Administrator.

2. The Service formulates and recommends general policies, plans and procedures of VA-wide application pertaining to the Federal Contract Compliance Programs under Executive Order 11246, as amended; conducts compliance reviews and takes enforcement actions to assure that VA supply and construction contractors are providing equal employment opportunity as required, and maintains liaison and acts in cooperation with officials of other agencies to further this objective.

3. The goal of the programs is to ensure that Federal contractors move toward full utilization of minorities and women.

4. In addition to the Contract Compliance Service staff located in Washington, D. C., there are seven field offices: Atlanta, Chicago, Dallas, New York, San Francisco, Philadelphia and Kansas City, Missouri. Resources allocated to the Service for Fiscal year 1977 consist of a budget of $1,206,200 and an average employment ceiling of 54.

5. The Construction Compliance Program is designed to ensure compliance with Executive Order 11246, as amended, and implementing rules and regulations of the Office of Federal Contract Compliance Programs, Department of Labor, in connection with VA construction contractors and subcontractors. Pre-award reviews are conducted for low bidders to provide orientation and to emphasize the EEO requirements of the VA should an award be made. Contractors, having been successful bidders on major projects ($500,000 or more), are given a more detailed description of their EEO obligations. Onsite conferences are held with individual contractors, with the prime contractor participating, to discuss contractors performance and to obtain commitments for corrective action where appropriate. The staff examines "Daily Logs," submitted by VA Resident Engineers, which are annotated with the appropriate minority group designations showing on a day-to-day basis exactly how many workers were on the job, what the jobs were, and how many were minority members. Data so collected are verified by periodic on-site compliance reviews. For construction contracts in areas covered by the Department of Labor's City Plans, conditions data are collected by means of monthly reports from the contractors and subcontractors which list all workers on the job that month with minority group workers so designated.

6. During FY 1976, there were 308 VA construction projects operating under "City Plans" administered by the Department of Labor and 123 VA construction projects ($100,000 or more) operating outside City Plan areas, for an overall total of 431 contracts (or 2,586 contractors, including subcontractors). The success attained in review activities is reflected in the fact that VA's major construction projects (those of approximately $500,000 or more) have averaged about 25 percent minority group workers throughout the year. Minority group workers accounted for almost one-fifth of the total skilled manhours worked and almost one-half of the total unskilled manhours worked.

7. The Industrial Compliance Program is designed to monitor the assigned non-construction industries to ensure their compliance with Executive Order 11246, as amended. The industries assigned to the VA are the pharmaceutical; soap, detergent and cosmetic; and wholesale drug industries. The monitoring is accomplished by onsite compliance reviews and desk audits of Affirmative Action Programs. Pre-award clearance reviews to determine contractor eligibility are conducted for all non-exempt supply and service contracts exceeding $10,000, as well as contracts of other Federal agencies totaling $1 million or more awarded to companies for which VA is the designated Compliance Agency. The staff also conducts onsite investigations of discrimination complaints involving pattern and practice. Priority program emphasis is placed on obtaining goals and timetables to achieve prompt and full utilization of minorities and women, and the corrections of situations where minorities and women continue to suffer the present effects of past discrimination.

8. During FY 1976, the compliance reviews conducted at the industrial facilities under VA jurisdiction reflected the following 12-month goals for their Affirmative Action Programs: Hiring goals - Minority 2725, Female 2810; Promotion goals - Minority 1350, Female 1557.

9. The Industrial Compliance staff also formally identified 20 cases in which protected employees were still suffering the effects of past discrimination (affected class situations). The staff settled 13 of the 20 identified contractor affected class situations, with the result that covered employees were to receive $262,805.00 in back pay or incentive bonuses. The remaining seven cases were still under negotiation at the close of the fiscal year. Remedies for inequality of pay for substantially equal work deficiencies at seven locations involved $10,179.00 in back pay and immediate promotions.

10. Other important results of the industrial compliance reviews included the equalization of employment benefits, the removal of invalid and non-job related selection criteria adversely affecting minorities and/or women, construction of a dressing room for women in a New Jersey production facility, training and incentive programs to assist in the movement of covered group members to non-traditional jobs, the revision of job ladders, and the awarding of retroactive seniority.

11. The highlight of program developments during the year was the extension of the industrial compliance program to Puerto Rico, where initially 118 facilities were identified as assigned to VA and 58 as Federal contractors and subcontractors. By year's end, three mandatory pre-award reviews had been conducted there. Also, a technical assistance conference was held in San Juan for four more firms who annually receive one million dollars or more in contract awards.

12. Twenty-three show cause notices were issued during FY 1976, and authority requested from OFCCP to issue 14-day notices of debarment in 6 cases. Of the 23 enforcement actions, 15 were still in conciliation stages at the end of FY 1976.

13. The staff also provided technical assistance to contractors on 132 occasions during FY 1976.

14. Workload projections for FY 1977 follows:

Construction Compliance Program

Compliance surveys	350
Reporting system desk reviews	8700
Pre-award clearances	415
City Plans (monitoring, reporting, enforcement)	70

Industrial Compliance Program

Facility compliance reviews	344
Corporate compliancr reviews	5
Pre-award clearances	4000
Technical assistance visits	140

LEGISLATIVE PROGRAM

1. THE LEGISLATIVE CLEARANCE FUNCTION

The legislative clearance function is intended to serve the needs of the President in carrying out his legislative responsibilities and is a joint activity of the Office of Management and Budget and the executive branch agencies. It can also be helpful to the Congress and the agencies in meeting their responsibilities. The purpose of this memorandum is to outline the origin and development of the clearance function, to describe briefly how it works, and to summarize its purposes.

a. **Background.** The basic rules for enactment of laws are set forth in Article I of the Constitution.

(1) A description of the congressional legislative process is contained in the pamphlet, "How Our Laws are Made," prepared by Charles Zinn for the House Judiciary Committee and revised and updated by Edward F. Willett, Jr., Law Revision Counsel, United States House of Representatives (House Document 94-509, 94th Congress, May 10, 1976).

(2) The President's legislative responsibilities are founded in his constitutional duties and powers to: 1) require the opinion in writing of the principal officer in each of the executive departments, 2) take care that the laws are faithfully executed, 3) give the Congress information on the state of the Union, 4) recommend to the Congress such measures as he judges necessary, 5) approve or disapprove bills passed by the Congress, and 6) convene either or both Houses of Congress.

(3) The legislative clearance function originated in the early 1920s in the Administration of President Harding. In its initial years, the clearance function was largely confined to bills involving expenditures, but it was later extended by President Roosevelt to all bills. A detailed description of the development of the legislative clearance function is contained in an article by Richard Neustadt, "The Growth of Central Clearance," in the *American Political Science Review* of September 1954.

(4) Office of Management and Budget Circular A-19, issued at the direction of the President, sets forth the basic guidelines and procedures for carrying out the function. These procedures have been substantially the same for the last 20 years.

b. **Description of Current Clearance Procedures.** The clearance function covers agency legislative proposals, agency reports and testimony on pending legislation, and enrolled bills.

(1) **Legislative Proposals.** All bills which agencies wish to transmit to the Congress are sent to the Office of Management and Budget for clearance. There they are reviewed and a determination is made on what additional data and information are needed and what other agencies have substantial interests and should be asked to comment.

(2) Agencies whose views are asked may favor a draft bill or have no objection. It is likely, however, that one or more of them will propose substantive or technical amendments, or perhaps a complete substitute. Divergent views may be reconciled by telephone or by letter. If appropriate, a meeting of the interested agencies will be arranged by OMB staff.

(3) In its review of draft bills, the Office of Management and Budget applies existing Presidential policies. If significant issues arise which are not covered by such policies, it seeks appropriate Presidential direction.

(4) After review, analysis, resolution of issues, and obtaining appropriate policy guidance, OMB advises the proposing agency that: 1) there is no objection from the standpoint of the Administration's program to the submission of the proposed draft bill to the Congress, 2) the proposed bill is consistent with the Administration's objectives, or 3) the proposed bill is in accord with the President's program. This "advice" is conveyed by the

submitting agency to the Congress in its transmittal letter. On the other hand, if the agency is advised that its proposed bill conflicts with an important Administration objective, or is not in accord with the President's program, it may not transmit the bill to the Congress.

(5) The above are simply illustrative of the the range of advice given, and there are many possible variations or qualifications, including suggested amendments to eliminate other agencies' objections.

(6) **Reports on Pending Legislation.** If agencies are asked by congressional committees to report or testify on pending legislation or wish to volunteer a report, similar clearance procedures are followed. Agencies are given "advice" which they transmit in their reports or include in their testimony.

(7) **Enrolled Bills.** After Congress has completed action on a bill, it is enrolled and sent to the President for his approval or disapproval. The Constitution provides that the President shall take action within 10 days after receipt of the bill, not including Sundays.

(8) To assist the President in deciding his course of action on a bill, the Office of Management and Budget requests each interested agency to submit within two working days its analysis and recommendation in a letter to OMB, signed by the head of the agency or other Presidential appointee. OMB prepares a memorandum to the President on the enrolled bill which transmits these views letters and summarizes the issues and various views and recommendations. If an agency recommends disapproval or a signing statement, it is responsible for preparing a draft of an appropriate statement for the President's consideration.

(9) **Volume of Activity.** During the 94th Congress, about 34,300 bills and joint resolutions were introduced in the two Houses. The 94th Congress enacted more than 700 public and private laws.

c. **Relationship to the President's Legislative Program**

(1) The legislative recommendations of the President in his three regular annual messages–State of the Union, Budget and the Economic Report–together with those in any special messages or other communications to the Congress generally constitute the President's legislative program. These recommendations have had their origin in many sources. One major source is the agencies themselves. Each year, along with their budgets, departments and agencies submit to the Office of Management and Budget proposed agency legislative programs for the coming session of Congress. The more important items are identified and referred to the White House for consideration. (See Appendix I of this section.)

(2) Other major sources include bills introduced in the Congress, and proposals of commissions, panels, and task forces established by law or by administrative order to examine and recommend on particular subjects.

(3) In conjunction with the legislative clearance function, OMB and the agencies assist the White House staff in the development of the President's program. Each President develops his legislative program, of course, through methods of his own choice; and the form and nature of OMB and agency assistance vary, depending on the President's wishes. Almost always, however, it has involved the application of clearance procedures to the draft bills which are prepared to carry out the President's legislative recommendations.

(4) The existence of the President's program gives the legislative clearance process coherence, a set of goals, and greater significance. It provides general guidance for the executive branch, both in shaping proposals which are not part of the President's program and in commenting on bills before the Congress.

d. **Purposes of the Clearance Function.** As noted earlier, the function is essentially a staff service for the President performed in accordance with his wishes and designed to assist him in carrying out his legislative responsibilities. It has several purposes, of which some assist the Congress and the executive branch agencies themselves, as well as the President:

- It provides a mechanism for bringing together and staffing out agency legislative proposals which the President may wish to include in his legislative program;

- It helps the executive agencies develop draft bills which are consistent with and which carry out the President's policy objectives;

- It is a means of keeping Congress informed (through the "advice" transmitted by the agencies) of which bills are part of the President's program and of what the relationship of other bills is to that program;

- It provides a mechanism of assuring that Congress gets coordinated and informative agency views on legislation which it has under consideration;

- It assures that bills submitted to Congress by one executive agency properly take into account the interests and concerns of other affected agencies and will therefore have the general support of such agencies;

- It provides a means whereby divergent agency views can be reconciled.

2. KEY ISSUES AND MATTERS CONCERNING VETERANS AFFAIRS LIKELY TO BE CONSIDERED IN THE 95TH CONGRESS

a. **Judicial Review.** For many years legislative proposals have been considered in the Congress which would subject the decisions of the Administrator to judicial review of Federal Courts as provided in chapter 7 of title 5 (the Administrative Procedure Act). Under current law the decisions of the Administrator on a claim for benefits are final. A commitment has been made in the Senate that such legislation will be considered in Committee during the 95th Congress.

b. **Repeal of Limitation on Attorneys' Fees.** For several years there have been attempts in Congress to repeal current law which limits to $10 the fee an attorney representing VA claimants for benefits before the agency can charge. This fee is currently paid from an award to a successful claimant. It is expected that the attempt in Congress to repeal this provision will be continued in the 95th Congress.

c. **Role of the VA Health Care Delivery System in Any Possible National Health Insurance Program.** The President-elect has indicated his intention to propose a National Health program. We do not have any indication as to the form such Administration proposal will take. We do hope that in formulating the new Administration position on the National Health program, the VA will be considered as a Health Care provider. Consideration must be given to the fact that the VA Health Care System is in existence, and is ongoing; it has a deep commitment towards improving health care for all Americans; it has a great training capability, and it has special capabilities under Special Medical Programs.

d. **Construction of VA Health Care Facilities.** During the past few Congresses legislation has been introduced to require VA to receive the approval of the Senate and House Committees on Veterans' Affairs on major construction or renovation projects prior to starting such projects. Under current law the Administrator, with the approval of the President, can locate VA health care facilities where he determines best. On May 11, 1976, the President approved the Administrator's plan to provide design funds for eight new VA hospitals. Two of those projects were assigned a priority and construction funds were requested for FY 1977. Those are Richmond, Virginia, and Bay Pines, Florida. The other funds will be sought at a rate of two a year for 3 years, for Martinsburg, West Virginai; Portland, Oregon; Seattle, Washington; Little Rock, Arkansas; Baltimore, Maryland; and Camden, New Jersey.

e. **Pension Reform.** The House has resisted efforts by the Senate to revise or reform the pension programs. Under Public Law 94-432 the Veterans Administration is required to study the current programs, supply information relative thereto and report to Congress and the President by October 1, 1977.

f. **Omnibus Medical Bill Remains.** There were several provisions of the Omnibus Medical Bill (Public Law 94-581) which were deleted by the House prior to enactment. It can be anticipated that the Senate Veterans' Affairs Committee will combine most of these provisions into a new 94th Congress bill. Some major provisions deleted by the House were: 1) a comprehensive program for the treatment of veterans with alcohol or drug abuse problems, 2) readjustment counseling, 3) preventive medicine, 4) direct admission to community nursing home care for nonservice-connected veterans, and 5) special pay for clinical researchers.

g. **Senate Proposal to Eliminate Committee on Veterans' Affairs.** The Senate will have before it a Senate Resolution to reorganize the committee system of the Senate. In the 94th Congress such a measure was designated as S. Res. 586. One provision would place legislative jurisdiction over veterans' measures, except housing, in a new Committee on Human Resources. Measures relating to veterans' housing would be handled by the Senate Committee on Banking, Housing, and Urban Affairs.

h. **VA Legislative Program.** The Legislative Program of the Veterans Administration for the First Session of the 95th Congress was submitted to the Office of Management and Budget in accordance with OMB Circular No. A-19, on September 15, 1976. An index of the items in that program is shown in Appendix 1 to this section. Where the purpose of any item was accomplished by an enactment subsequent to September 15, 1976, that fact is shown in the right column of that chart.

3. PROPOSED LEGISLATIVE PROGRAM FOR THE 1ST SESSION OF THE 95TH CONGRESS

(Items in each Part are listed in order of priority)

PART I–PRESIDENT'S PROGRAM PROPOSALS

No.	Subject	Enacted
95-1	Set a date beyond which individuals entering the military services may not accrue entitlement to G.I. Bill education benefits and set a final date beyond which such benefits may not be afforded anyone.	P.L. 94-502
95-2	Modification of eligibility requirements for hospital, domiciliary, nursing home care, and other medical services for the treatment of nonservice-connected conditions and related amendments to facilitate collection of reimbursement for these services from insurance carriers, employers, and other non-Federal sources from which the veteran may be entitled to complete or partial reimbursement for such medical expenses.	
95-3	Authorize a program of assistance to States for the establishment, expansion, improvement, and maintenance of veterans cemeteries and to provide transportation of bodies to a national cemetery.	P.L. 94-433
95-4	Terminate the authority for the pursuit of flight training by veterans and for the pursuit of correspondence training by veterans, spouses, and surviving spouses.	
95-5	Eliminate certain duplications in payment of Federal burial benefits, now payable for the same, or similar purposes.	
95-6	Terminate the predischarge education program (PREP).	P.L. 94-502

PART II–ALL OTHER PROPOSALS

No.	Subject	Enacted
95-7	To provide a new section in title 38 authorizing continued appropriation availability.	P.L. 94-424
95-8	Authorize an extension of the authority contained in Public Law 94-123, to pay a variable allowance on a permanent basis to assist in the recruitment and retention of certain physicians and dentists in the Department of Medicine and Surgery.	P.L. 94-581
95-9	Extension of current authority which expires June 30, 1978; to make grants to the Republic of the Philippines (38 U.S.C. 631-634) for hospital care, nursing home care, and medical treatment of certain Commonwealth Army veterans and New Philippine Scouts and to authorize outpatient care to veterans living in the Philippines.	

PART II—ALL OTHER PROPOSALS—Continued

No.	Subject	Enacted
95-10	Revise 38 U.S.C. 3301: To authorize the Administrator to approve the use of record systems of the VA for epidemiological and statistical research by researchers from outside the VA; names and addresses of subject and patients would be made releasable in conjunction with this research.	
95-11	Extend the period of time during which seriously disabled veterans may be afforded vocational rehabilitation training.	P.L. 94-502
95-12	Clarify eligibility requirements for VA domiciliary care.	
95-13	Revision of authority relating to sharing of medical resources, facilities and services with the surrounding medical community.	
95-14	To amend chapter 17, title 38, United States Code, to limit the payment for reimbursement for travel expenses of beneficiaries provided medical care for non-service-connected disabilities.	
95-15	Set minimum standards of progress for approval of accredited courses.	P.L. 94-502
95-16	To define unsatisfactory progress.	P.L. 94-502
95-17	Authorize a flexible interest rate for insurance settlement on installment basis.	
95-18	Exemption of the procurement of certain professional and ancillary services of the VA from the provisions of the Federal Property and Administrative Services Act.	
95-19	To define nursing home care to include intermediate nursing care.	P.L. 94-581
95-20	Extend entitlement to medical care to the widow or child of a totally and permanently disabled service-connected veteran who died of a non-service-connected disability.	P.L. 94-581
95-21	Technical and clarifying amendments to title 38.	P.L. 94-581
95-22	Amend the criteria for determining maximum rates to be applied in contracting for community nursing home care and to authorize the Administrator to establish such rates.	
95-23	Provide a single authorization for State construction grants; permit VA grants for new State construction for domiciliary care, increase the authorized amount; and make appropriations available on a no year basis.	
95-24	Extend the authority and increase the authorized appropriation for carrying out a program of exchange of medical information for the VA.	P.L. 94-424
95-25	Authorize the Administrator to establish rates of pay retroactively for residents and interns serving in the Department of Medicine and Surgery.	P.L. 94-581

PART II–ALL OTHER PROPOSALS–Continued

No.	Subject	Enacted
95-26	Authorize the furnishing of outpatient dental care for a dental condition or disability which is non-service-connected and subsequent to hospital care when it is considered necessary to complete treatment initiated during hospitalization.	P.L. 94-581
95-27	Permit payment of educational benefits when a veteran transfers from one approved educational institution to another educational institution.	P.L. 94-502
95-28	Permit eligible veterans to receive vocational rehabilitation training after they have had their discharge or release changed, corrected or modified, beyond the present delimiting period of eligibility.	
95-29	Permit completion of a work-study agreement when veteran ceases to be a full-time student.	P.L. 94-502
95-30	Permit eligible persons pursuing courses not leading to a standard college degree (excluding programs of apprenticeship and other on-job training) under chapter 35 to submit certifications of enrollment-attendance on a quarterly, rather than a monthly, basis.	
95-31	Provide for an adjustment of the provision concerning discontinuance of a veteran's or dependent's assistance allowance due to unsatisfactory progress.	P.L. 94-502
95-32	Limit approval of independent study program to one leading to a standard college degree.	P.L. 94-502
95-33	Extend the period of operation of a course for approval purposes.	P.L. 94-502
95-34	Extend the 85-15 veteran/nonveteran ratio requirement to all courses.	P.L. 94-502
95-35	Limit payment of educational assistance allowance.	P.L. 94-502
95-36	To allow the transfer of money from readjustment benefits appropriations to the vocational rehabilitation revolving fund.	
95-37	To provide substantive legislation authorizing amounts to be appropriated from time to time to finance the establishment, maintenance and operation of the revolving supply fund.	
95-38	Provide a retroactive effective date for initial awards of disability pension for veterans who continue to work after age 65.	P.L. 94-432
95-39	Equalize the effective date of termination or reduction of a veteran's benefits in annulment cases with the more liberal existing provisions relating to divorce and death of a spouse.	P.L. 94-433
95-40	Authorize realistic attorney's fees for litigation of National Service Life Insurance (NSLI) and United States Government Life Insurance (USGLI) claims.	

PART II–ALL OTHER PROPOSALS–Continued

No.	Subject	Enacted
95-41	Permit chapter 31 training in Federal facilities on an uncompensated basis.	P.L. 94-502
95-42	To make technical changes to chapter 35 of title 38, U.S.C.	P.L. 94-502
95-43	Define the terms "institution of higher learning" and "standard degree."	P.L. 94-502
95-44	Authorize compensated rehabilitation therapy for patients of VA hospitals or outpatients and members of VA domiciliaries.	P.L. 94-581
95-45	Remove the requirement to inspect the manufacturing process of mobile homes.	
95-46	Extend priority for training in VA Regional Medical Education Centers to VA career personnel.	
95-47	Extend the protection to VA special investigators of the statute requiring criminal penalties for assault on a Federal officer.	
95-48	Clarification of certain provisions of chapter 82 of title 38.	P.L. 94-581
95-49	Equalize criteria for the protection of an evaluation of less than total disability following 20 years with the criteria for protection of a rating of total disability or total permanent disability following 20 years.	
95-50	To clarify sections 4001 and 4002 of title 38, by deleting "associate" as it applies to members of the Board of Veterans Appeals.	
95-51	Redefine the term discharge or release to include a conditional discharge for the sole purpose of reenlistment after 24 consecutive months of service.	
95-52	Amend subchapter III of chapter 3 of title 38, in order to provide additional benefits to employees of the VA serving in offices in the Republic of the Philippines.	
95-53	Provide authorization for the Administrator to authorize the acceptance of payment in cash or in kind from non-Federal agencies and organizations for travel and subsistence expenses by officers and employees of the Veterans Administration.	
95-54	Authorize the Veterans Administration to furnish memorial markers to commemorate any veteran who dies and whose remains have not been recovered, have been determined to be nonrecoverable, cannot be identified, were buried at sea, or whose body has been donated to a medical school, with the result that there are no remains.	
95-55	Elimination of duplication of dependency and indemnity compensation (DIC) payments on behalf of a school child for the month of attainment of age 18.	

PART II–ALL OTHER PROPOSALS–Continued

No.	Subject	Enacted
95-56	Limit the recognition and definition of adopted children to those children adopted through courts of competent jurisdiction within the United States or, if adopted through courts in foreign countries, to children who reside in the adopting parent's household, receive a major portion of support from the adoptive parent, are not in the care and custody of a natural parent, and are under 18 years of age.	

UNDER CONSIDERATION

No.	Subject	Enacted
1.	Authorize payment of less than the statutorily provided rates of service-connected and non-service-connected monetary benefits to a dependent who establishes entitlement subsequent to the effective date of award of benefits to another dependent in the same class.	
2.	Permit payment of benefits to eligible veterans and persons to allow them to obtain educational credit by examination.	
3.	Extend the right to elect current pension law benefits to surviving spouses of Civil and Indian War veterans under same criteria as applies to surviving spouses of Spanish-American War veterans.	
4.	Authorize care in VA facilities for veterans not otherwise eligible for care under section 610 of title 38.	
5.	Equalize limitation on pension payments of a pensioner while in a domiciliary or during hospitalization as between those receiving pension under the protective provisions (old law) with those under the current pension law.	
6.	Authorize the Administrator to furnish hospital care and medical services to a veteran who was never a U.S. citizen, but otherwise eligible for care.	
7.	Provide that a claim for Social Security is also a claim for VA death benefits, only where an invitation to file a claim for death benefits was not initiated by the VA.	

EXPIRING LAWS

	Subject	Enacted
	Authority to enter into contracts for the exchange of medical information.	P.L. 94-424
	DM&S Physician and Dentist Special Pay program which was extended by P.L. 94-581, expires September 30, 1977.	

4. IDENTIFICATION OF KEY MEMBERS OF CONGRESS FOR VETERANS AFFAIRS

a. Budgetary and Appropriations

HOUSE BUDGET COMMITTEE
94th Congress

Majority Members:

Brock Adams, Wash. (Chairman)
Thomas P. O'Neill, Jr., Mass.
Jim Wright, Tex.
Thomas L. Ashley, Ohio
Robert L. Giaimo, Conn.
Neal Smith, Iowa
James G. O'Hara, Mich.
Robert L. Leggett, Calif.
Parren J. Mitchell, Md.
Omar Burleson, Tex.
Phil M. Landrum, Ga.
Sam Gibbons, Fla.
Patsy T. Mink, Hawaii
Louis Stokes, Ohio
Harold Runnels, N.M.
Elizabeth Holtzman, N.Y.
Butler Derrick, S.C.

Minority Members:

Delbert L. Latta, Ohio
Elford A. Cederberg, Mich.
Herman T. Schneebeli, Pa.
James T. Broyhill, N.C.
Del Clawson, Calif.
Garner E. Shriver, Kans.
Barber B. Conable, Jr., N.Y.
Marjorie S. Holt, Md.

SENATE BUDGET COMMITTEE
94th Congress

Majority Members:

Edmund S. Muskie, Maine (Chairman)
Warren G. Magnuson, Wash.
Frank E. Moss, Utah
Walter F. Mondale, Minn.
Ernest F. Hollings, S.C.
Alan Cranston, Calif.
Lawton Chiles, Fla.
James Abourezk, S.D.
Joseph R. Biden, Jr., Del.
Sam Nunn, Ga.

Minority Members:

Henry Bellmon, Okla.
Robert Dole, Kans.
J. Glenn Beall, Jr., Md.
James L. Buckley, N.Y.
James A. McClure, Idaho
Pete V. Domenici, N.M.

SENATE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON HUD AND INDEPENDENT AGENCIES
94th Congress

Majority Members:

William Proxmire, Wisc. (Chairman)
John O. Pastore, R.I.
John Stennis, Miss.
Mike Mansfield, Mont.
Birch Bayh, Ind.
Lawton Chiles, Fla.
J. Bennett Johnston, Jr., La.
Walter Huddleston, Ky.
John L. McClellan, Ark., ex officio

Minority Members:
Charles McC. Mathias, Jr., Md.
Clifford P. Case, N.J.
Hiram L. Fong, Hawaii
Edward W. Brooke, Mass.
Henry Bellmon, Okla.
Milton R. Young, N.D., ex officio

NOTE: The exact make-up of the Subcommittee will not be known until the Appropriations Committee is reorganized in January or February 1977. Members listed above were on the Subcommittee in the 94th Congress, and are returning for the 95th Congress.

HOUSE SUBCOMMITTEE ON HUD AND INDEPENDENT AGENCIES
94th Congress

Majority Members:

Edward P. Boland, Mass. (Chairman)
Joe L. Evins, Tenn.
George E. Shipley, Ill.
J. Edward Roush, Ind.
Bob Traxler, Mich.
Max S. Baucus, Mont.
Louis Stokes, Ohio
Yvonne Brathwaite Burke, Calif.

Minority Members:

Burt L. Talcott, Calif.
Joseph M. McDade, Pa.
C. W. Bill Young, Fla.

NOTE: The exact make-up of the Subcommittee will not be known until the Appropriations Committee is reorganized in January or February 1977. Members listed above were on the Subcommittee in the 94th Congress and are returning for the 95th Congress.

b. **Legislative.** Congressional Committees-key names, issues, and pending matters.

(1) **House of Representatives.** All veterans benefits legislation in the House is referred to the *Committee on Veterans' Affairs.* The membership of that Committee in the 94th Congress, Second Session, was composed of:

Majority Members:

Ray Roberts, Texas (Chairman)
Olin E. Teague, Texas
David E. Satterfield, III, Va.
Don Edwards, Calif.
G. V. (Sonny) Montgomery, Miss.
Charles J. Carney, Ohio
George E. Danielson, Calif.
Lester L. Wolff, N.Y.
Jack Brinkley, Ga.
Ronald M. Mottl, Ohio
Robert J. Cornell, Wisc.
W. G. (Bill) Hefner, N.C.
Mark W. Hannaford, Calif.
Edward P. Beard, R.I.
Robert W. Edgar, Pa.
Kenneth L. Holland, S.C.
Matthew F. McHugh, N.Y.
Clifford Allen, Tenn.
Sam B. Hall, Jr., Texas

Minority Members:

John Paul Hammerschmidt, Ark.
Margaret M. Heckler, Mass.
Chalmers P. Wylie, Ohio
Elwood Hillis, Ind.
James Abdnor, S.D.
William F. Walsh, N.Y.
Tennyson Guyer, Ohio
George Hansen, Idaho
George O'Brien, Ill.

The House Committee on Veterans' Affairs in the 94th Congress was divided into the following Subcommittees:

SUBCOMMITTEES

Chairman and Ranking Minority Member are Ex-Officio Subcommittee Members if not assigned regular membership.

COMPENSATION, PENSION, AND INSURANCE

G. V. (Sonny) Montgomery, Chairman

Majority Members	**Minority Members**
Olin E. Teague	Chalmers P. Wylie
Ray Roberts	John Paul Hammerschmidt
Jack Brinkley	Tennyson Guyer
W.G. (Bill) Hefner	
Ronald M. Mottl	

EDUCATION AND TRAINING

Olin E. Teague, Chairman

Majority Members	Minority Members
Lester L. Wolff	Margaret M. Heckler
Ronald M. Mottl	Chalmers P. Wylie
Robert J. Cornell	William F. Walsh
Mark W. Hannaford	
Robert W. Edgar	
Kenneth L. Holland	
Clifford Allen	

HOSPITALS

David E. Satterfield III, Chairman

Majority Members	Minority Members
Don Edwards	John Paul Hammerschmidt
G.V. (Sonny) Montgomery	Margaret M. Heckler
Charles J. Carney	Elwood Hillis
George Danielson	James Abdnor
Lester L. Wolff	Tennyson Guyer
Edward P. Beard	George Hansen
W.G. (Bill) Hefner	George M. O'Brien
Mark W. Hannaford	
Kenneth L. Holland	
Matthew F. McHugh	
Ronald M. Mottl	
Clifford Allen	

HOUSING

Jack Brinkley, Chairman

Majority Members	Minority Members
Charles J. Carney	James Abdnor
David E. Satterfield III	William F. Walsh
Don Edwards	
Robert J. Cornell	
Edward P. Beard	

CEMETERIES AND BURIAL BENEFITS

George Danielson, Chairman

Majority Members	Minority Members
Ray Roberts	Elwood Hillis
Robert W. Edgar	John Paul Hammerschmidt
Matthew F. McHugh	George Hansen
Robert J. Cornell	George M. O'Brien
W.G. (Bill) Hefner	
Mark W. Hannaford	
Edward P. Beard	
Clifford Allen	

Key members of the Committee staff with whom we work most closely are: A.M. Willis, Jr., Staff Director; Mack Flemming, Counsel; and John R. Holden of the minority staff.

As an administrative agency we are concerned with matters before other House Committees. The most important are:

Ways and Means (Chairman Al Ullman, Staff: John M. Martin, Jr.).

Committee on the Judiciary (Chairman Peter W. Rodino, Jr.; Staff: Garner J. Cline).

Post Office and Civil Service (Chairman David N. Henderson; Staff: John H. Marting).

Interstate and Foreign Commerce (Chairman Harley O. Staggers; Staff: W.E. Williamson).

Government Operations (Chairman Jack Brooks; Staff: William M. Jones).

Appropriations

(2) **Senate.** Jurisdiction over veterans benefits legislation in the Senate is referred to the Committee on Veterans Affairs. The membership of that Committee for the 94th Congress was:

Majority Members	Minority Members
Vance Hartke, Ind., Chairman	Clifford P. Hansen, Wyo.
Herman E. Talmadge, Ga.	Strom Thurmond, S. C.
Jennings Randolph, W. Va.	Robert T. Stafford, Vt.
Alan Cranston, Calif.	
Richard (Dick) Stone, Fla.	
John A. Durkin, N.H.	

NOTE: Senator Hartke was defeated in November, 1976 and will probably be replaced as Chairman by Senator Cranston in the 95th Congress.

'SUBCOMMITTEES

(Chairman and Ranking Minority Member are Ex-Officio Members of All Subcommittees)

COMPENSATION AND PENSIONS

Herman E. Talmadge, Georgia, Chairman

Majority Members	Minority Members
Jennings Randolph, West Va.	Clifford P. Hansen, Wyo.
Richard (Dick) Stone, Florida	Strom Thurmond, S. Carolina
Vance Hartke, Indiana	

HEALTH AND HOSPITALS

Alan Cranston, California, Chairman

Majority Members	Minority Members
Jennings Randolph, W. Va.	Strom Thurmond, S. Carolinia
Richard (Dick) Stone, Fla.	Clifford P. Hansen, Wyoming
John A. Durkin, N. Hampshire	

HOUSING AND INSURANCE

Richard (Dick) Stone, Florida, Chairman

Majority Members	Minority Members
Herman E. Talmadge, Georgia	Robert T. Stafford, Vermont
Alan Cranston, California	Clifford P. Hansen, Wyoming
Vance Hartke, Indiana	

READJUSTMENT, EDUCATION, AND EMPLOYMENT

Vance Hartke, Indiana, Chairman

Majority Members	Minority Members
Herman E. Talmadge, Georgia	Robert T. Stafford, Vermont
Alan Cranston, California	Strom Thurmond, S. Carolina
John A. Durkin, N. Hampshire	

CEMETERIES AND BURIAL BENEFITS

John A. Durkin, New Hampshire, Chairman

Majority Members	Minority Members
Vance Hartke, Indiana	Clifford P. Hansen, Wyoming
Herman E. Talmadge, Georgia	Robert T. Stafford, Vermont
Jennings Randolph, W. Virginia	

As an administrative agency we are also concerned with legislative matters before the following Senate Committes:

Committee on the Judiciary, Subcommittee on Administrative Practice and Procedure (Chairman Edward M. Kennedy; Staff: James Flug, Chief Counsel)

Committee on Government Operations, Subcommittee on Inter-governmental Relations (Chairman: Edmund S. Muskie; Staff: Edwin W. Webber, Staff Director)

Special Committee on Aging (Chairman Frank Church; Staff: William E. Oriol, Staff Director)

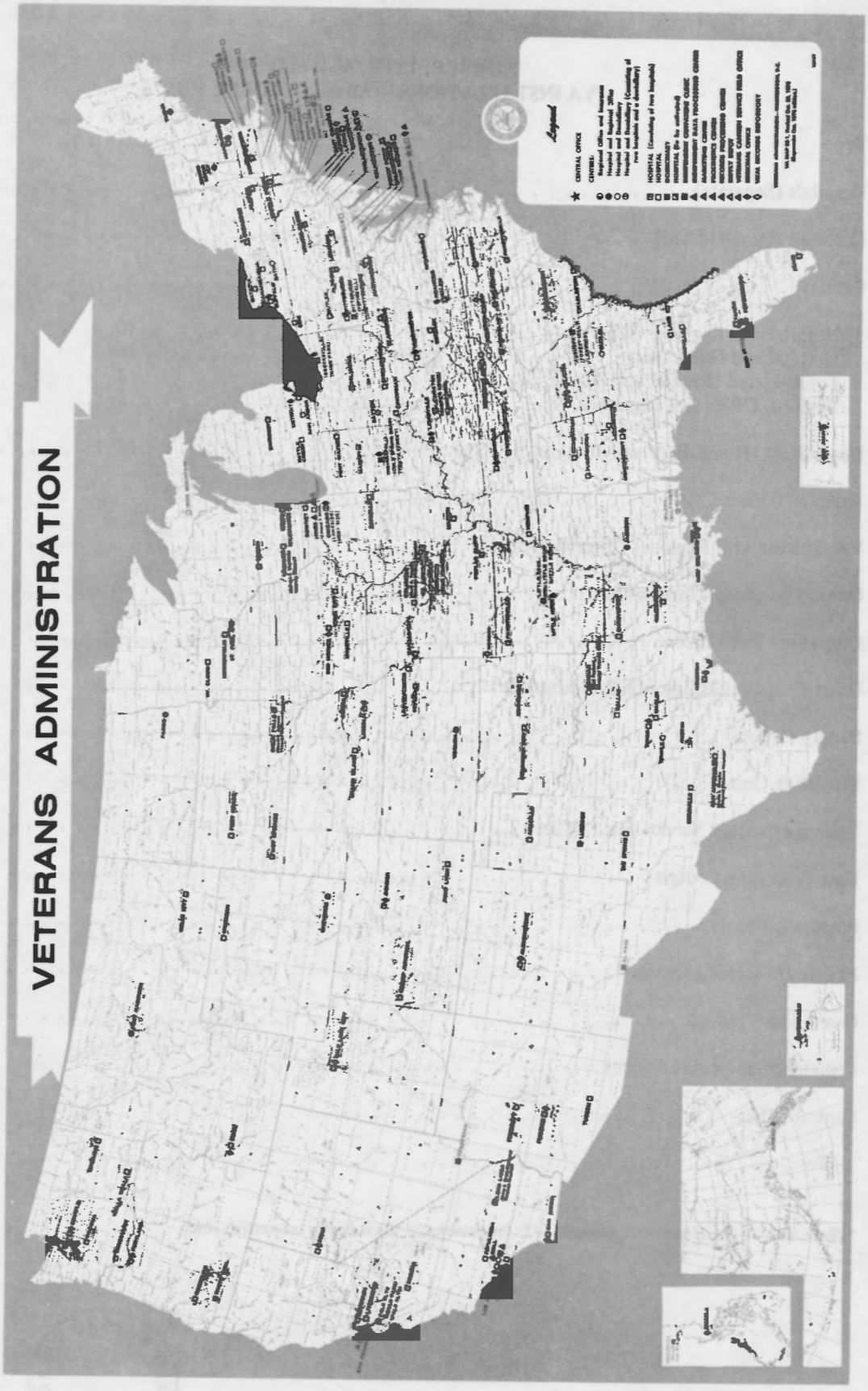
Appropriations - All members

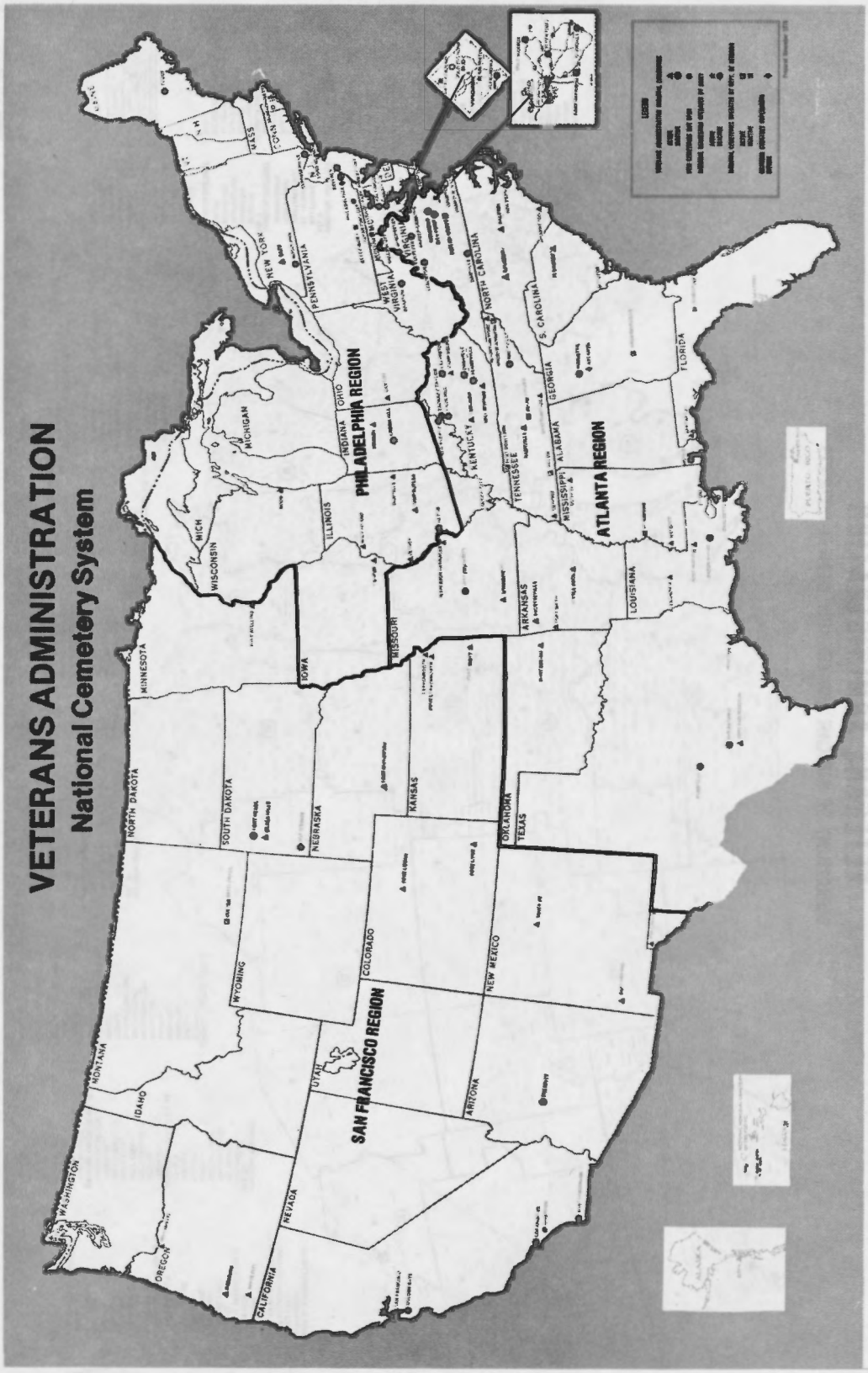
APPENDIXES

NUMBER, TYPE, AND MAPS OF VA INSTALLATIONS – AS OF OCTOBER 1, 1976

Type	Number
Hospitals (Separate)	*127
Hospitals (Consolidated)	* 9
Centers	27
Hospital and Regional Office	10
Hospital and Domiciliary	14
Consolidated Hospital and Dom.	1
Regional Office and Insurance	2
Domiciliary (Domiciliary activities only)	1
Regional Offices	48
VA Offices (with Regional Office Activities)	17
Outpatient clinics (Independent)	8
Outpatient Sub-Clinics	23
Other Outpatient Clinics (Not in hospitals)	15
Supply Depots	3
Marketing Center	1
Veterans Canteen Service Field Offices	5
Data Processing Centers	6
Prosthetic Center	1
Records Processing Center	1
Cemeteries	103
Cemetery Supervising Offices	3
Central Office	1
Total	399

**There are 171 VA Hospitals: General-142; Psychiatric-29. Each has an outpatient clinic.*


VETERANS ADMINISTRATION


VETERANS ADMINISTRATION
National Cemetery System
PHILADELPHIA REGION
ATLANTA REGION
SAN FRANCISCO REGION
WASHINGTON
OREGON
CALIFORNIA
IDAHO
NEVADA
MONTANA
WYOMING
UTAH
COLORADO
ARIZONA
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICHIGAN
INDIANA
OHIO
KENTUCKY
TENNESSEE
MISSISSIPPI
ALABAMA
GEORGIA
FLORIDA
S. CAROLINA
NORTH CAROLINA
VIRGINIA
WEST VIRGINIA
PENNSYLVANIA
NEW YORK
MASS
CONN
LEGEND

ON-GOING ADP APPLICATIONS

JULY 1976

(WESTERN REGION)

CENTRALIZED SERVICES
- Automated Management Information System (AMIS)
- Beneficiary Identification and Records Locator System (BIRLS)
- Census (CEN)--Annual Patient Sample
- Centralized Accounting for Local Management (CALM)
- Centralized Accounting System for Construction Appropriation (CASCA)
- Liquidation Claim System (LCS)
- Medical Facility Planning System (MFPS)
- Patient Treatment File (PTF)
- Personnel and Accounting Integrated Data Pay System (PAID)
- Portfolio Loan Accounting (LGY)
- Procurement, Storage and Distribution (LOG 1)
- Prosthetics and Sensory Aids
- Veterans Assistance Discharge System (VADS)

NON-CENTRALIZED SERVICES
- Adjudication End Products 5
- [1] Automated Clinical Laboratory System
- Automated Diary and Index System (ADIS) 5
- Engineering Management Information System (EMIS) 20
- Fee Basis Medical 10
- Property Management 1
- Records Management 3
- Retirement Annuity Estimating 27
- Social Work Service and Voluntary Service Reporting 3
- Trial Balance--General Ledger Accounts 7

[1] *Birmingham and Houston VA Hospitals*

CENTRALIZED SERVICES
- Annual Pharmacy Inventory

NON-CENTRALIZED SERVICES
- Adjudication End Products 19
- [1] Automated Clinical Laboratory System
- Automated Diary and Index System (ADIS) 17
- Automated Loan Guaranty Geographic File System 1
- Automated Pharmacy Prescription Labeling Editing System (On-Line APPLES) 5
- Diabetic Clinical Evaluation System 1
- Engineering Management Information System (EMIS) 44
- Fee Basis Medical 36
- Hearing Aid 1
- Infectious Diseases Information System (IDIS) 3
- Property Management 1
- Retirement Annuity Estimating 60
- Social Work Service and Voluntary Service Reporting 5
- Supply and Prosthetics 17
- Trial Balance--General Ledger Accounts 18

[1] *Long Beach and Wadsworth VA Hospitals*

Centralized Services: *Applications processed VA-wide and/or Central Office approved applications dedicated to one DPC.*

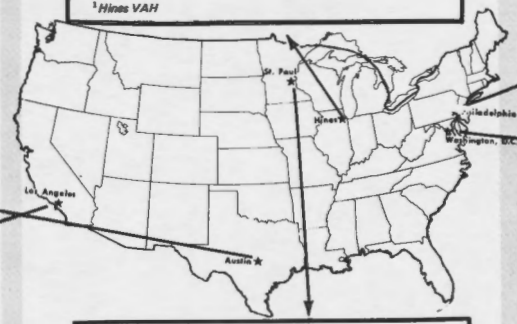
Non-Centralized Services: *Applications processed within the DPCs geographic servicing jurisdiction for Central Office approved applications. Figure used as a suffix to each application listed, indicates the number of stations serviced.*

(CENTRAL REGION)

CENTRALIZED SERVICES
- Compensation and Pension
- Consultant and Attendings
- Education
- Income Questionnaire
- Receivables and Payables System
- Services and Reclamation System
- Vocational Rehabilitation and Education

NON-CENTRALIZED SERVICES
- Adjudication End Products 2
- [1] Automated Clinical Laboratory System
- Automated Diary and Index System (ADIS) 2
- Automated Pharmacy Prescription Labeling Editing System (APPLES) 1
- Engineering Management Information System (EMIS) 12
- Fee Basis Medical 2
- Hospital Service and Clinic Reports 1
- Patient Data and Supply Reports 1
- Pharmaceutical Manufacturing Reports 1
- Retirement Annuity Estimating 16
- Trial Balance--General Ledger Accounts 4

[1] *Hines VAH*



CENTRALIZED SERVICES
- Administrative Issues System
- Centralized Accounts Receivable System (CARS)
- Certificates of Pursuit--IHL
- DM&S Entitlement Notices
- EAM Utilization
- Guaranteed and Insured Loans (GIL)
- Hypertension Screening
- Insurance (includes VMLI)
- Management Personnel Inventory (MPI)
- Nutritive Analysis
- Outpatient Staff and Fee
- Special C.O. Reports--Engineering (DM&S)
- Special C.O. Reports--R&S (Controller)
- VA Voluntary Service (VAVS)
- VR&E (Chapter 31)
- War Orphans (Chapter 35)

NON-CENTRALIZED SERVICES
- Adjudication End Products 15
- [1] Admissions Data Medical Information Needs (ADMIN)
- [1] Automated Clinical Laboratory System
- Automated Diary and Index System (ADIS) 15
- Automated Pharmacy Information System (APIS) 9
- Automated Pharmacy Presc. Labeling Editing Sys. (APPLES) 1
- Engineering Management Information System (EMIS) 51
- Fee Basis Medical 18
- [1] Health Oriented Patient System (HOPS)
- Minnesota Multiphasic Personality Inventory (MMPI) 77
- Property Management 1
- Radiology Service & Social Work Service 11
- Retirement Annuity Estimating 24
- Summary Hospital Information Processing System (SHIPS) 6
- Trial Balance--General Ledger Accounts 16

[1] *Minneapolis VAH*

(EASTERN REGION)

***CENTRALIZED SERVICES**
- Books and Periodicals Control
- Card and Paper Orders
- Computer Utilization
- Income Questionnaire
- Inpatient Discharge Data System (IDDS)
- Insurance
- Insurance Awards
- Motion Picture Schedules
- Supply Fund--Management Inventory/Analysis

NON-CENTRALIZED SERVICES
- Adjudication End Products 13
- [1] Automated Clinical Laboratory System
- Automated Diary and Index System (ADIS) 13
- Engineering Management Information System (EMIS) 38
- Fee Basis Medical 24
- Retirement Annuity Estimating 44
- Social Work Service and Voluntary Service Reporting 7
- Supply and Dietetic 3
- Trial Balance--General Ledger Accounts 16

**CPB&E Pilot/Target Test Site*
[1] *Boston VAH*

CENTRALIZED SERVICES
- Architect and Engineering Library System (AELS)
- BIRLS--Folder Relocation Processing
- Civilian Health and Medical Program (CHAMPVA)
- Conservation of Energy Program (CEP)
- Construction History Information System (CHIS)
- Construction Management Information System (CMIS)
- Critical Path Method (CPM)
- Drug Dependency Treatment System (DDTS)
- Health Service Training Reports
- Hospital Transport System (HTS)
- Hypertension Screening and Treatment System (HSTS)
- Log/Supply Extract for Catalogue Printing
- Management Information System for Construction Scheduling (MISC)
- Medical Administration Quality Control Report (MADQ)
- Medical Cost Distribution Reporting (RCS 14-4)
- National Cemetery System (NCS)
- Paylist for Veterans Representative (EDUPAY)
- Recruitment Clearing House
- Wage Survey System

NON-CENTRALIZED SERVICES
- Adjudication End Products 4
- [1] Automated Clinical Laboratory System
- Automated Diary and Index System (ADIS) 4
- [2] Automated Hospital Information System (AHIS)
- BVA Decisions System 1
- Central Office Finance 3
- Engineering Management Information System (EMIS) 14
- Fee Basis Medical 6
- Retirement Annuity Estimating 19
- Trial Balance--General Ledger Accounts 4

[1] *Durham and Miami VA Hospitals*
[2] *Washington VAH*

LIST OF RECOGNIZED ORGANIZATIONS

By virtue of authority contained in title 38, United States Code, the organizations listed below have been granted recognition in the presentation of claims under the statutes administered by the VA:

1. National Service Organizations Listed in Title 38, United States Code, Section 3402, or Chartered by Congress:

	Headquarters
American Legion	Indianapolis, Indiana 46206
American National Red Cross	Washington, D.C. 20006
AMVETS	Washington, D.C. 20036
Blinded Veterans Association	Washington, D.C. 20037
Congressional Medal of Honor Society of the U.S.A.	Braintree, Massachusetts 02184
Disabled American Veterans	Cincinnati, Ohio 45214
Legion of Valor of the United States of America, Inc.	Arlington, Virginia 22204
Marine Corps League	Arlington, Virginia 22201
Military Order of the Purple Heart	Washington, D.C. 20013
Paralyzed Veterans of America, Inc.	Washington, D.C. 20420
United Spanish War Veterans	Washington, D.C. 20420
Veterans of Foreign Wars of the United States	Kansas City, Missouri 64111
Veterans of World War I of the U.S.A. Inc.	Alexandria, Virginia 22314

2. Other National Service Organizations Recogized by the VA:

Air Force Sergeants Association	Marlow Heights, Md. 20031
American Veterans Committee	Washington, D.C. 20036
Army and Navy Union, U.S.A.	Lakemore, Ohio 44250
Army Mutual Aid Association	Arlington, Virginia 22211
Catholic War Veterans of the U.S.A.	Washington, D.C. 20001
Disabled Officers Association	Washington, D.C. 20006
Fleet Reserve Association	Washington, D.C. 20036
Jewish War Veterans of the United States	Washington, D.C. 20009
Military Order of the World Wars	Washington, D.C. 20006
National Jewish Welfare Board	New York, New York 10010
National Tribune	Washington, D.C. 20013
Navy Mutual Aid Association	Washington, D.C. 20370
Regular Veterans Association	Washington, D.C. 20015
United Indian War Veterans, U.S.A.	San Francisco, California 94103

3. State Organizations Recognized by VA:

Alabama Department of Veterans Affairs	Montgomery, Alabama 36102
Alaska Division of Veterans Affairs	Juneau, Alaska 99811
American Samoa-Veterans Affairs Office	Pago Pago, American Samoa 96920
Arizona-Department of Economic Security	Phoenix, Arizona 85007
Arkansas-Veterans Service Office	Little Rock, Arkansas 72201
California-Department of Veterans Affairs	Sacramento, California 95807
Colorado-Department of Social Services	Denver, Colorado 80203
Connecticut-Soldiers, Sailors, and Marine Fund	Hartford, Connecticut 06115
District of Columbia-Office of Veterans' Affairs	Washington, D.C. 20004
Florida-Division of Veterans Affairs	St. Petersburg, Florida 33731
Georgia-Department of Veterans Service	Atlanta, Georgia 30334
Guam-Office of Veterans Affairs	Agana, Guam 96910
Hawaii-Department of Social Services	Honolulu, Hawaii 96809

3. State Organizations Recognized by VA—Continued

	Headquarters
Idaho-Division of Veterans Services	Boise, Idaho 83707
Illinois-Department of Veterans Affairs	Springfield, Illinois 62705
Kansas-Veterans Commission	Topeka, Kansas 66612
Kentucky-Center for Veterans Affairs	Louisville, Kentucky 40203
Louisiana-Department of Veterans Affairs	Baton Rouge, Louisiana 70801
Maine-Bureau of Veterans' Services	Augusta, Maine 04330
Maryland-Veterans' Service Commission	Baltimore, Maryland 21201
Massachusetts-Office of Commissioner of Veterans' Services	Boston, Massachusetts 02202
Minnesota-Department of Veterans Affairs	St. Paul, Minnesota 55101
Mississippi-Veterans Affairs Commission	Jackson, Mississippi 39205
Missouri-Division of Veterans Affairs	Jefferson City, Missouri 65101
Montana-Veterans Affairs Division	Helena, Montana 59601
Nebraska-Department of Veterans' Affairs	Lincoln, Nebraska 65809
Nevada-Commission for Veterans Affairs	Reno, Nevada 89502
New Hampshire-State Veterans Council	Concord, New Hampshire 03306
New Jersey-Division of Veterans' Service	Trenton, New Jersey 08625
New Mexico-Veterans' Service Commission	Santa Fe, New Mexico 87501
New York-Division of Veterans Affairs	New York, New York 10047
North Carolina-Division of Veterans Affairs	Raleigh, North Carolina 27601
North Dakota-Department of Veterans Affairs	Fargo, North Dakota 58102
Ohio-Division of Soldiers' Claims and Veterans' Affairs	Columbus, Ohio 43215
Oklahoma-Department of Veterans Affairs	Oklahoma City, Oklahoma 73105
Oregon-Department of Veterans Affairs	Salem, Oregon 97310
Pennsylvania-Department of Military Affairs	Harrisburg, Pennsylvania 17108
Puerto Rico-Department of Labor, Veterans Office	Hato Rey, Puerto Rico 00917
Rhode Island-Veterans Affairs	Providence, Rhode Island 02903
South Carolina-Department of Veterans Affairs	Columbia, South Carolina 29201
South Dakota-Division of Veterans Affairs	Pierre, South Dakota 57501
Tennessee-Department of Veterans' Affairs	Nashville, Tennessee 37203
Texas-Veterans Affairs Commission	Austin, Texas 78711
Utah-Office of Veterans Services	Salt Lake City, Utah 84111
Vermont-Veterans Affairs Section, Military Department	Montpelier, Vermont 05602
Virginia-Division of War Veterans' Claims	Roanoke, Virginia 24011
Virgin Islands-Department of Veterans Affairs	Christiansted, St. Croix, Virgin Islands 00820
Washington-Department of Veterans Services	Olympia, Washington 98501
West Virginia-Department of Veterans Affairs	Charleston, West Virginia 25305
Wisconsin-Department of Veterans Affairs	Madison, Wisconsin 53702

4. Correspondence relative to the recognition of any organization should be addressed to the General Counsel, Veterans Administration, Central Office.

OTHER SIGNIFICANT INTERAGENCY AND INTERGOVERNMENTAL RELATIONSHIPS

1. FEDERAL EXECUTIVE BOARDS

a. **Authority**: Memorandum from the President, October 1961

b. **Purpose**: The FEB provides a structure for focusing creative Federal leadership in the field towards implementation of Presidential policies and initiatives and the mechanism for sharing responsibility for this venture among all Federal field executives.

c. Proposed objectives for FY 1977 are grouped under three broad activities:

(1) **Community Betterment and Community Relations**

- Combined Federal Campaign, blood and savings bond drives.
- Volunteer community service participation by Federal employees.
- Special Projects with local government, academia, etc.
- Public relations for Jobs for Vets.

(2) **Internal Federal Management Improvement**

- Personnel management.
- Economy in government.
- Consumer representation.
- Energy conservation.

(3) **Delivery of Services and Programs to People**

- Minority business opportunity.
- Assistance to the aging.
- Preventive health measures.

d. **Membership**: FEB's were established in 1961 as associations of representatives of Federal agencies located in ten metropolitan areas. These boards have been increased to 25 and are presently located in Albuquerque, Atlanta, Baltimore, Boston, Buffalo, Chicago, Cincinnati, Cleveland, Dallas-Ft. Worth, Denver, Detroit, Honolulu, Kansas City, Los Angeles, Miami, Minneapolis-St. Paul, Newark, New Orleans, New York, Philadelphia, Pittsburgh, Portland, San Francisco, Seattle, and St. Louis. They are made up of top Federal executives in each community. VA members total 86 and consist chiefly of Directors of VA field stations. Many have served as the annually elected Chairman of their Board. Four serve in this capacity for FY 1977. The Office of Management and Budget provides general policy direction to and liaison with FEB's.

2. FEDERAL RECORDS COUNCIL

a. **Authority**: PL 754, 81st Congress, Section 504

b. **Purpose**: To consult with, advise and assist the Administrator, GSA in carrying out his responsibilities for records management activities of the Government.

c. **Membership**: Drawn from representatives of the Legislative, Executive, and Judicial branches.

d. **Name of Person in Central Office**: Edwin L. Arnold, Assistant Administrator for Planning and Evaluation (VA Representative).

3. INTER-DEPARTMENTAL COMMITTEE ON MINORITY BUSINESS ENTERPRISE

a. **Authority**: Executive Order 11458, March 3, 1969

b. **Purpose**: To coordinate the operations of the Federal Government which may affect the establishment, preservation and strengthening of minority business enterprise.

c. **Membership**: Representatives of "appropriate departments and agencies" as determined by the Secretary of Commerce.

d. **Name of Person in VA**: Odell W. Vaughn, Deputy Administrator

4. ADMINISTRATIVE CONFERENCE

a. **Authority**: Public Law 88-499, 5 U.S.C. 571-6.

b. **Purpose**: To work on a continuing basis toward the development of improvements in the Federal administrative process.

c. **Membership**: Consists of 34 agencies plus 32 persons from private life who are named by the Chairman of the Conference and the Council of 10 members, five from Government and five from private life.

d. **Person to contact in Central Office**: The General Counsel, Mr. John Corcoran.

VA LINES OF AUTHORITY AND COMMUNICATIONS

1. LINE DEPARTMENTS

a. There are three line Departments to carry out the major purposes of the Veterans Administration.

(1) **The Department of Medicine and Surgery (DM&S).** The Chief Medical Director, as head of this Department, has jurisdiction over and is responsible to the Administrator for the proper conduct of the activities of the Department of Medicine and Surgery. Insures complete medical and hospital service for the medical care and treatment of veterans, and directs the safety and fire protection programs, as prescribed by the Administrator of Veterans Affairs pursuant to statutory authority and regulations.

(2) **The Department of Veterans Benefits (DVB).** The Chief Benefits Director, as head of this Department, has jurisdiction over and is responsible to the Administrator for the conduct of the activities of the Department of Veterans Benefits. Administers an integrated program of veterans benefits consisting of Compensation, Pension and Education, Insurance, Loan Guaranty, Guardianship, and Contact activities of the VA.

(3) **The Department of Data Management (DDM).** The Chief Data Management Director, as head of this Department, has jurisdiction over and is responsible to the Administrator for the conduct of activities of the Department of Data Management. Insures the effective support of the mission of the VA through the use of data processing, data management process control, and electronic communications systems.

b. Each of the first two Departments has its own field organization where service is actually provided to veterans and their dependents.

c. The Department Heads are responsible to the Administrator and receive their orders from him or from the Deputy Administrator.

d. Authority to issue orders to field stations is restricted to the Administrator or Deputy Administrator and, within their respective departments, to the Chief Medical Director, the Chief Benefits Director, and the Chief Data Management Director.

e. Staff offices have no authority over–or responsibility for–major operating programs, but do have a responsibility to the Administrator to keep him informed, to advise him, and to appraise for him the effectiveness and economy of operations. For reasons of economy and efficiency certain staff officers, notably the Assistant Administrator for Personnel and the Controller, provide staff services to the department heads. In providing these services, the staff office head acts in the role of staff officer to the department head, and his channels of communication within the department are prescribed by the department head.

f. In the field station, the Director or Manager is the only official "in the line" relationship to Central Office–through the Area Director, for the Department of Veterans Benefits, and through the Regional Medical Director, for the Department of Medicine and Surgery.

TYPES AND METHODS OF INTERNAL COMMUNICATIONS

1. ADMINISTRATIVE ISSUES–OFFICE OF THE ADMINISTRATOR

Media	Approving Officials* and Description
VA Regulations.	These are basic rules of general applicability which implement laws and Executive Orders administered by or pertaining to VA. Given legal effect by publication in the Federal Register.
VA Procurement Regulations.	Contain VA policies and procedures pertaining to procurement of supplies and nonpersonal services (including construction) which implement, supplement or provide for deviation from the Federal Procurement Regulations. Those of interest to the public are published in the Federal Register.
Administrator's Decisions.	Precedent decisions which the Administrator desires published. Prepared by the General Counsel.
VA Manuals.	Issued by direction of the Administrator to communicate policies, procedures and delegations of authority.
VA Organization Manual.	Contains charts and narrative descriptions showing the major organizational relationships and functional responsibilities which have been established VA-wide.
VA Circulars.	May contain: 1) general announcements; 2) policies and instructions of limited duration or which cannot be incorporated in other permanent media; 3) policies and instructions which will be added later to permanent media provided there are sound reasons for not publishing immediately in a permanent media; or 4) rescissions of administrative issues of the Administrator's office.
Numbered Memorandums, Office of the Administrator.	Used in Central Office for one-time or limited information.
Central Office Operating Instructions (OI-1)	Used to establish standing Central Office instructions of an interdepartmental/staff office nature in the field of administration, management, supply, building service, budget, finance, reports, personnel, and top management reporting.

2. ADMINISTRATIVE ISSUES–DEPARTMENTS

Media	Approving Officials and Description
Department supplements to VA manuals, department manuals, department circulars, etc.	Approved by department heads or their designees. Authorized to issue these and other appropriate directives to implement programs under their jurisdiction.

**Administrator's Decisions are approved by the Administrator. Certain chapters of the Central Office Operating Instructions are approved by designated staff office heads. All other issues listed are approved by the Administrator, or by the Deputy Administrator or Associate Deputy Administrator, signing "By direction of the Administrator."*

3. COMMUNICATIONS FOR SIGNATURE BY THE ADMINISTRATOR

The Administrator (or the Deputy Administrator acting for him) signs:

a. All communications to the President and Vice President of the United States;

b. Communications to the following officials concerning new or changed VA policy: officials of the Executive Office of the President, Congressmen, Supreme Court Justices, heads of executive departments and independent agencies, officials of Territories and other regions administered by the United States, State officials, and heads of service organizations;

c. Communications giving information to the Secretary of State for transmittal to diplomatic officials and officials of foreign governments.

4. COMMUNICATIONS FOR SIGNATURE BY OTHER TOP MANAGEMENT OFFICIALS

Members of the Administrator's immediate staff, and department staff office and field station heads or their designees sign all other correspondence to outside addresses on matters under their jurisdiction.

5. WEEKLY REPORT FROM DEPARTMENT AND STAFF OFFICE HEADS

A weekly report of policy and operating problems, and other important highlights of interest to the Administrator, prepared by department and staff office heads and submitted no later than 11:00 a.m. each Monday to the Office of the Administrator. Items of significant interest and importance are placed on the Agenda of the Administrator's Staff Meeting held weekly.

6. ADMINISTRATOR'S WEEKLY STAFF MEETING

A weekly staff meeting is held each Wednesday at 10:00 a.m. and attended by all department and staff office heads and designated officials in the Office of the Administrator.

7. ADMINISTRATOR'S PROGRAM REVIEW BRIEFING SCHEDULE

Administrator's program briefings are held at 3:00 p.m. on Tuesday of each week. Sessions are limited to 1 hour. Briefing officials (departments and staff offices) limit their presentation to 45 minutes to allow others to participate.