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REPORT TO THE CONGRESS

Better Use Of Outpatient Services
And Nursing Care Bed Facilities
Could Improve Health Care
Delivery To Veterans B-167656

Veterans Administration

*BY THE COMPTROLLER GENERAL
OF THE UNITED STATES*

093483

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APRIL 11, 1973



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C 20548

B-167656

To the President of the Senate and the
Speaker of the House of Representatives

This is our report entitled "Better Use of Outpatient
Services and Nursing Care Bed Facilities Could Improve Health
Care Delivery to Veterans."

We made our review pursuant to the Budget and Accounting
Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of
1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office
of Management and Budget, and to the Administrator of Veterans
Affairs.

A handwritten signature in cursive script that reads "James B. Stacks".

Comptroller General
of the United States

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ABBREVIATIONS

GAO	General Accounting Office
VA	Veterans Administration

D I G E S T

WHY THE REVIEW WAS MADE

During the past several years the Veterans Administration (VA) outpatient program for medical and dental activities has expanded significantly. During fiscal year 1971, VA spent about \$311 million to operate its outpatient clinics.

The General Accounting Office (GAO) reviewed VA's health care delivery system to see if better use of outpatient clinics and nursing care bed facilities could improve care provided to veterans.

FINDINGS AND CONCLUSIONS

The VA medical outpatient program has expanded options available to deliver health care services to veterans. The number of veterans treated has increased substantially over the last decade, and the outpatient program has helped shorten the length of hospital stay. However, GAO believes opportunities exist to further improve the program.

Medical programs

To determine the potential for further reducing the length of hospitalization in acute care facilities, GAO selected a random sample of 420 patient medical records at 6 hospitals and had them reviewed by the

treating physicians who estimated that the length of hospital stay could have been reduced by

--832 days for 144 patients if diagnostic tests had been performed on an outpatient basis prior to hospital admission

--897 days for 79 patients if they could have been discharged earlier to nursing care bed facilities or outpatient treatment

--182 days for 47 patients if hospital admissions had been better coordinated with availability of surgical facilities

On this basis, GAO estimated that about 146,000, or 15 percent, of the 1 million hospital days furnished at these 6 hospitals during fiscal year 1971 could have been avoided. Data required for GAO to compute dollar savings was not available, however, GAO believes that savings could be substantial.

GAO found that

--Less than 10 percent of the patients admitted to each of the 6 hospitals received outpatient care for diagnostic testing before hospitalization. When such testing was performed, it was often duplicated when the patient was hospitalized, due to poor coordination between the outpatient and

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inpatient departments (See pp 12 and 14)

- Many patients could have been discharged earlier if greater use was made of outpatient facilities or had nursing care bed facilities been available. At certain hospitals, general and psychiatric beds were underutilized and could be converted to nursing care beds. (See pp. 15 and 17.)
- Poor planning and coordination of hospital admissions with available surgical facilities unnecessarily lengthened the hospitalization (See p. 21.)
- Utilization review committees placed most of their emphasis on determining the accuracy of medical records and relatively little on evaluating matters related to more efficient patient care. (See p 18)
- Outpatients often had to wait many hours to see a VA physician because an adequate appointment scheduling system was not in effect. The waiting period could be reduced and service to the veteran could be improved by making specific appointments or developing alternatives, such as block appointments. (See pp. 23 and 24)

Dental programs

Some VA dental clinics do not make extensive use of modern dentistry concepts to increase professional productivity. During fiscal year 1971, about 302,000 veterans applied for outpatient dental care and about \$55 million was spent on VA outpatient dental treatments. This level of activity is expected to continue or increase over the next 4 years.

GAO reviewed VA outpatient activities at eight dental clinics and found that operations could be improved at each location.

GAO found that

- Dental clinic productivity could be improved by using more para-dental personnel and using more than one chair per dentist where possible. (See pp 27 to 30.)
- At some clinics VA dentists performed administrative duties which reduced the amount of time they devoted to dental work. These duties could have been handled by clerical personnel (See pp 30 and 31.)
- Dental clinic efficiency could be improved if steps were taken to reduce the number of broken appointments (See p 33)
- The number of veterans referred to private dentists could be reduced if the coordination of dental resources among neighboring VA stations were improved. (See p. 34)

RECOMMENDATIONS OR SUGGESTIONS

To improve the medical outpatient program, the Administrator of Veterans Affairs should

- Require hospitals to revise their operating procedures so that inpatient physicians examine veterans on an outpatient basis before hospitalization.
- See that VA hospitals establish scheduling procedures to coordinate the patient's hospital admission date with the availability of surgical facilities.
- Require hospital review

committees to place greater emphasis on evaluating efficiency of patient care

- Take steps to insure that adequate funds are available to provide for additional nursing home beds
- Establish procedures to have the results of tests ordered by physicians at the outpatient clinics promptly filed in the patient's medical folder.
- Require all clinics to schedule specific appointments for outpatient visits or to develop other alternatives, such as block appointments

To improve the dental outpatient programs, the Administrator of Veterans Affairs should

- Evaluate dental activities at VA clinics and, if appropriate, take steps to improve productivity by requiring (1) increased use of parodontal personnel, (2) the use of more than one chair per dentist, (3) the use of administrative personnel, rather than dentists, to handle clerical duties,

and (4) implementation of an appointment reminder system to reduce the number of broken appointments.

- Insure that clinics' dental resources are coordinated to assist in meeting demands for VA outpatient dental care

AGENCY COMMENTS

VA was given an opportunity to review GAO's findings, conclusions, and recommendations and its views are included in this report. Generally, VA agreed with GAO's recommendations and said it had taken or would take the corrective actions needed. (See p. 36)

MATTERS FOR CONSIDERATION
BY THE CONGRESS

The Congress has considered several legislative proposals which would provide added medical benefits to veterans and their dependents at VA outpatient facilities. This report should be useful to the Congress in its future deliberations on such proposals.

CHAPTER 1

INTRODUCTION

Section 612 of title 38 of the United States Code provides that veterans who have medical disabilities--incurred or aggravated in the line of military duty--are entitled to all reasonable medical services necessary to treat the service-connected disabilities. This care may be delivered in a hospital or nursing home or on an outpatient basis.

Inpatient care may be provided to veterans for non-service-connected conditions, without regard to their ability to pay, who (1) were released or discharged from military service for disabilities incurred or aggravated in the line of duty, (2) have compensable service-connected disabilities, or (3) are 65 years of age or older. War veterans or veterans who were in military service after January 31, 1955, may be provided similar treatment if they certify their inability to pay. However, outpatient care may not be provided to those veterans unless it is (1) reasonably necessary in preparation for a scheduled hospital admission or (2) an extension of treatment received while hospitalized.

Dental care may be provided on an outpatient basis only to veterans for dental conditions or disabilities

--which are service-connected and qualify for disability compensation or

--which are service-connected and do not qualify for disability compensation, provided (1) they are shown to have existed at the time of discharge and (2) applications for treatment are made within 1 year of such discharge.

VA has established four medical regions headed by Regional Medical Directors who report to the Director of the Department of Medicine and Surgery. The Regional Medical Directors, who are in Washington, D.C., have overall responsibility for all medical facilities in their regions

As part of its health delivery system, VA operates 192 outpatient clinics which are associated with its 168 hospitals and 9 independent clinics, 3 of which are overseas. Certain of these outpatient clinics (called "clinics of jurisdiction") are responsible for overseeing programs which provide for medical care to veterans by private physicians and dentists. With few exceptions, there is only one clinic of jurisdiction for each State.

During fiscal year 1971, VA spent about \$1.9 billion for its health care programs, including \$311 million for outpatient service. Of the latter amount, \$44 million was for fees for private dentists' services and \$11 million for VA dentists' services. During this same period, there were about 7.5 million outpatient visits to VA facilities and private physicians and dentists for medical services and about 900,000 visits for dental services.

The act of July 12, 1960 (38 U.S.C. 612), extended outpatient care to veterans for non-service-connected medical conditions. The House and Senate committees' reports accompanying this legislation stated that extending such care would (1) reduce the length of hospitalization, (2) decrease the cost per patient treated, and (3) decrease the number of patients waiting to be hospitalized.

VA data shows that these benefits have been achieved.

- Medical outpatient visits to VA facilities increased from about 2.4 million in 1961 to 6.2 million in 1971.
- Patients treated in VA hospitals increased from about 664,000 to about 819,000.
- Patients occupying hospital beds on any given day decreased from about 111,000 to about 84,000.
- Patients waiting to be admitted to VA hospitals decreased from about 19,000 to about 6,500.

In 1964 VA was initially authorized to operate a nursing home care program for veterans who had obtained maximum hospital benefits but still needed skilled nursing care. In fiscal year 1972 the average daily patient census in

VA-operated nursing home facilities was about 5,000. At the time of our review, VA was planning to increase the census to about 8,000.

Since the 1960 legislation was enacted, the cost per patient day in VA hospitals has increased 125 percent but the average total cost of treating each patient has increased only 38 percent. We believe that the reduction in the average length of stay per patient in VA hospitals has been a major factor in holding down the total cost of treating patients while hospital costs have been rising sharply over the past 10 years.

SCOPE OF REVIEW

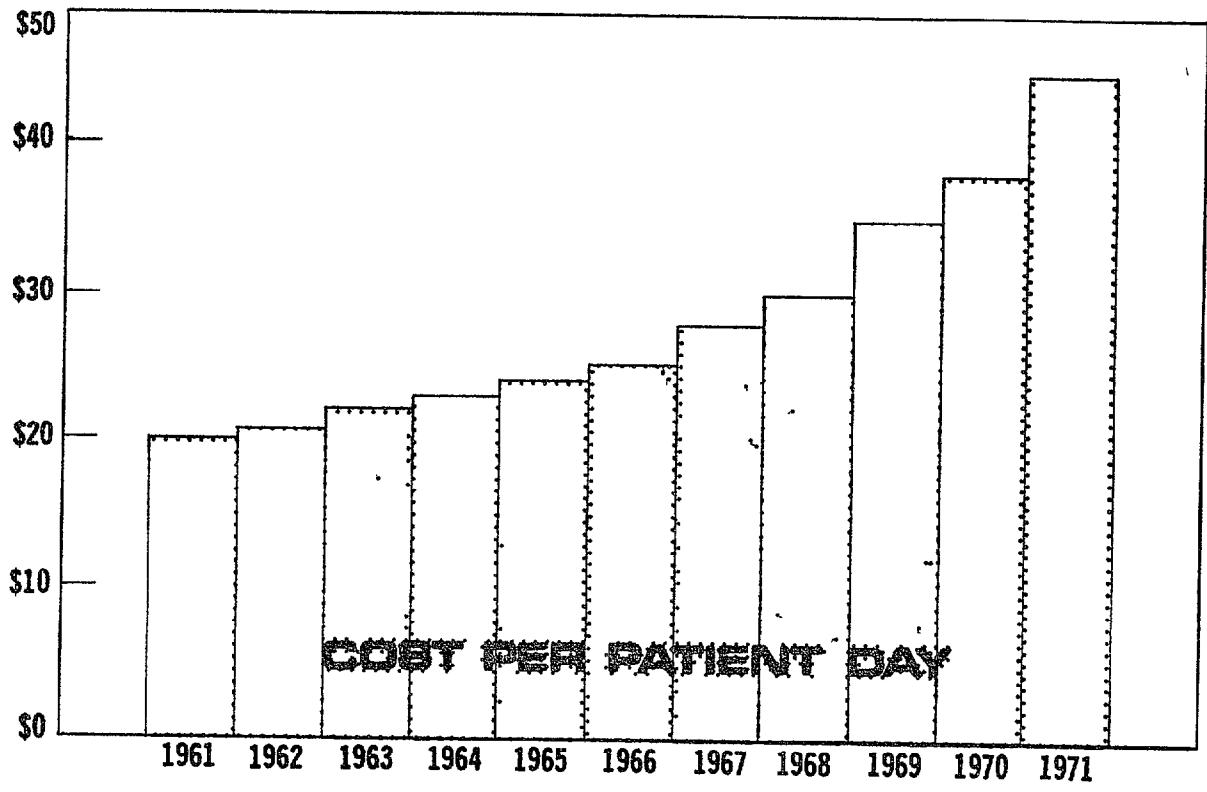
We performed our review at six selected VA hospitals and three outpatient clinics in California, New York, Missouri, and Oklahoma (see app. II) and at the VA Central Office in Washington, D.C. At each hospital we selected, on a random sample basis, medical care records for veterans hospitalized during fiscal year 1971. We asked the VA physicians responsible for treating the veterans to analyze each record sampled and to comment on how outpatient care reduced the hospitalization period and whether there were additional opportunities for further reductions.

We also reviewed the activities of eight VA dental clinics to determine whether productivity could be improved through more effective use of professional dental personnel and greater dental clinic efficiency.

We examined the history of the legislation authorizing VA to furnish outpatient care to veterans and the agency's related regulations, policies, and procedures.

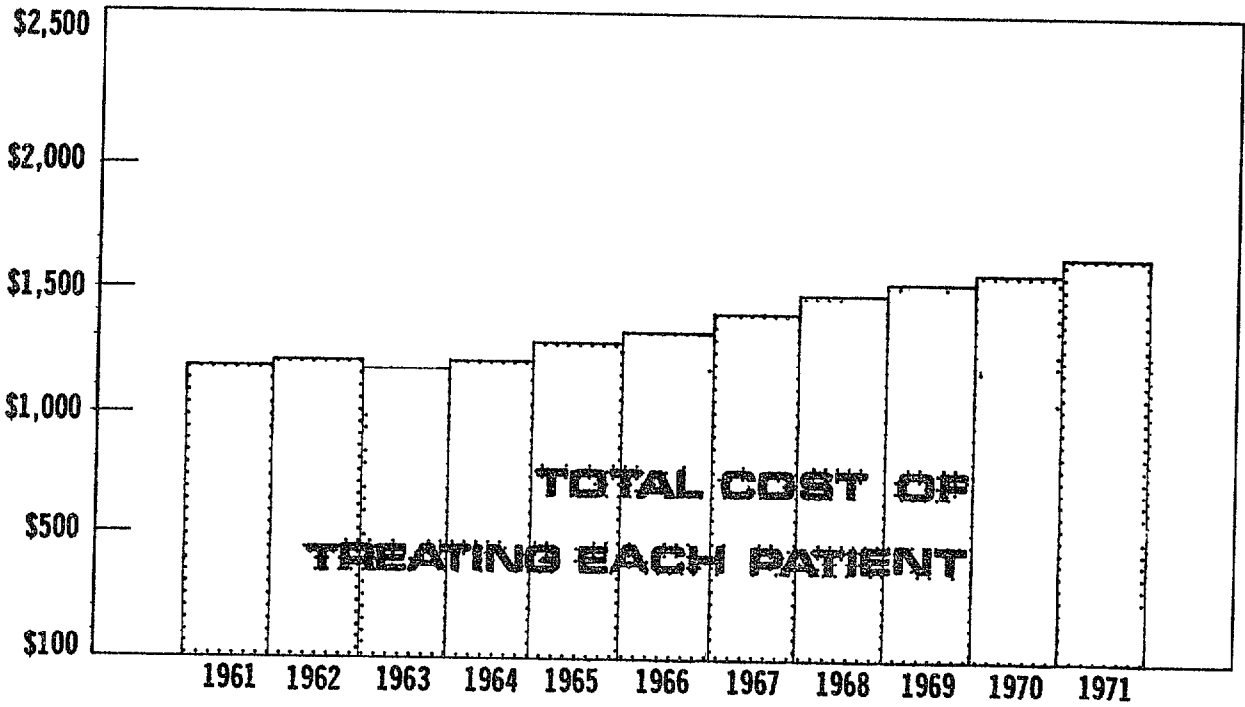
(Dollars)

TRENDS IN COST OF MEDICAL TREATMENT IN VA HOSPITALS



(Fiscal Years 1961- 1971)

(Thousands)



(Fiscal Years 1961- 1971)

CHAPTER 2

OPPORTUNITIES TO IMPROVE THE EFFECTIVENESS OF DELIVERING HEALTH CARE

Outpatient care has (1) shortened the period that patients were required to stay in VA hospitals, (2) increased hospital patient turnover and (3) treated more veterans with existing hospital facilities.

The number of outpatients has increased substantially during the past 10 years. However, after reviewing a random sample of medical case folders for patients they had treated, physicians at the six VA hospitals stated that more patients could be treated as outpatients. They advised us that, in about 60 percent of the cases, patients had spent more time in the hospital than necessary. These physicians said that greater use could be made of outpatient clinics for diagnostic testing and other preadmission medical preparation. The physicians also stated that earlier discharge from hospitals could be achieved by providing more post-hospital care at outpatient clinics or by transferring patients to nursing care facilities.

We estimated that during fiscal year 1971 patients at the 6 VA hospitals were hospitalized for about 130,000 days for treatment that could have been provided on an outpatient basis or in nursing care facilities. To better utilize its acute care hospital facilities, VA needs to (1) revise operating techniques to encourage treating physicians to see patients on an outpatient basis before hospitalization, (2) provide for additional nursing care beds, and (3) have hospital review committees place greater emphasis on evaluating the length of hospital stay.

Improvements in scheduling the admissions of surgery patients could reduce the length of hospital stay by these patients. During fiscal year 1971, surgery patients spent about 15,000 unnecessary days in the 6 hospitals because admissions were not well coordinated with the availability of surgery facilities.

Our estimates were based on a random sample of 30 prebed cases and 40 direct admission cases at each of the

6 hospitals At each of the hospitals we defined two groups of veterans hospitalized during fiscal year 1971 (1) veterans who were hospitalized after they had received medical workup on an outpatient basis in the prebed care program, and (2) veterans who were admitted directly to the hospital without prebed care. The results of our review are shown below

Cases Reviewed

	<u>Hospital admissions</u>		
	<u>Received prebed care</u>	<u>Admitted directly</u>	<u>Total admissions</u>
Total number of medical cases	2,823	36,323	39,146
Cases reviewed by GAO (sample)	180	240	420

Results of Review

	<u>Estimated number of days</u>	
	<u>Sample</u>	<u>Total</u>
Greater use could have been made of preadmission hospital workups	832	44,128 ^a
Patients could have been discharged earlier	897	<u>86,334</u> ^b
Subtotal		130,462
Better coordination of admissions could have been made with availability of surgical facilities	<u>182</u>	<u>15,504</u> ^c
Total	<u>1,911</u>	<u>145,966</u>

^aBased on a 90-percent confidence level plus or minus 10,476 days.

^bBased on a 90-percent confidence level plus or minus 21,154 days.

^cBased on a 90-percent confidence level plus or minus 7,293 days

It costs less to treat a patient on an outpatient basis than it does to treat him as a patient in the hospital because dietary, housekeeping, and other hospital service costs are eliminated. VA officials said that most of the cost of a hospital stay is incurred during the earlier days of hospitalization rather than in the latter days which are usually for recuperation.

The VA accounting system does not provide data showing the average costs incurred during the early part versus the latter part of hospitalization, and information is not available to show the average number of outpatient visits required by patients after they are released and placed on the post-hospital care program. Therefore we cannot estimate a dollar savings for each day that the hospital stay could be shortened by more extensive use of outpatient facilities. Nevertheless, we believe the savings could be substantial.

OPPORTUNITIES TO SHORTEN LENGTH OF HOSPITALIZATION

We selected a random sample of 420 medical case records for veterans hospitalized during fiscal year 1971 at the 6 hospitals. To determine if outpatient care could have been used more effectively to shorten the hospitalization period, we interviewed the physician who treated the patient or, if he was not available, the chief of the applicable medical service. In most cases, we were able to meet with the treating physician.

We asked the physicians to review the medical case records and to determine if the medical care provided in the hospital could have been provided on an outpatient basis without sacrificing the quality of treatment giving consideration to such matters as the need for emergency care and the feasibility of the patient traveling to the clinic for such care. We also asked them to estimate the number of hospital days which could have been avoided if such care were provided and to comment on the obstacles, if any, which precluded effective use of the outpatient alternative.

The physicians estimated that 832 days of hospitalization could have been avoided in 144 cases where tests or other procedures could have been performed on an outpatient basis before hospital admission. They also estimated that 897 days of hospitalization could have been avoided in 79 cases where the patients could have been discharged earlier and transferred to nursing care bed facilities or treated as outpatients.

Preadmission outpatient care

About 3 percent of all patients admitted during 1971 at 1 hospital received preadmission outpatient care. The percent of patients receiving preadmission outpatient care at the other 5 hospitals was slightly higher, the highest being about 9 percent.¹

¹These percentages compare closely with the national average for VA's general hospitals which was a 6.5-percent use of preadmission outpatient care during fiscal year 1971.

A veteran seeking medical care is seen by an admitting physician (a generalist in the outpatient service) who determines whether the veteran (1) needs to be hospitalized immediately, (2) needs to be hospitalized but is not an emergency case and could be a candidate for preadmission outpatient examination and care, or (3) does not need hospital care. The admitting physician is responsible for ordering any preadmission work. Once the patient is hospitalized, he is placed under the care of a treating physician--usually a specialist--who is responsible for the patient's care while he is hospitalized.

The work ordered by the admitting physicians in almost all cases was routine and included such items as chest X-rays, urinalysis, and blood tests. The physicians who reviewed the 420 medical case records selected by us identified 144 cases in which preadmission tests or other procedures could have been performed in outpatient clinics. These cases included patients admitted to the hospital directly who could have received preadmission outpatient workup and patients who had received some preadmission care on an outpatient basis.

The length of hospital stay for the 420 cases could have been reduced by 832 days, or an average of 2 days per case, if greater use of outpatient facilities had been made prior to admission. Projecting our sample results to all admissions during fiscal year 1971 at these 6 hospitals, we estimate that about 44,000 days of hospitalization could have been avoided.

The following is an example of the type of cases identified by the treating physicians

--A veteran was seen by the admitting physician who concluded that the patient had a hernia. The admitting physician placed the veteran on prebed care and took his pulse, temperature, respiration, and blood pressure. No other tests were performed on an outpatient basis. The day the patient was admitted to the hospital the treating physician performed a physical examination and took the patient's medical history. The next day a chest X-ray was performed. The treating physician advised us that, had he seen the patient prior to

admission, he could have performed the physical exam, taken the medical history, and ordered the X-ray and lab work on an outpatient basis. This would have avoided 2 days of hospitalization.

Because the treating physician generally does not see the patient until after he is hospitalized, the option to perform such tests on an outpatient basis is not available to him. However, officials at one of the largest prepaid group health organizations in the United States informed us that, except for emergencies, all patients receiving preadmission workup on an outpatient basis in their hospitals are examined by the same physicians that would treat them after admission.

In many instances in which the admitting physicians had ordered tests, the treating physician repeated them after the patient was hospitalized. Treating physicians said that the tests were repeated because the test results either were not in the patient's medical record or were too old to be of value.

On November 1, 1972, VA initiated a 1-year experiment with a new organization for admission services at 12 hospitals. The new organization will allow the chief of an inpatient service to have responsibility for the admitting function. Inpatient physicians will take part in the admitting function, and a single physician will prescribe tests and treatment for the patient both before and after hospital admission.

At three of the hospitals we examined the timeliness of the filing of test results in patients' medical records. We found that, on the average, the results remained unfiled for 30 days after the tests were completed. In one case the results remained unfiled for 181 days. In November 1972 VA informed us that they were rewriting their manual and that one of the revisions would specifically require prompt filing of test results.

No one had been assigned to follow up and file the results of tests ordered under the prebed care program at two of the three hospitals. The admitting physician--although responsible for ordering preadmission workup--has no particular reason to follow up on the results of the tests since

he may never see the patient again. However, the treating physician is either unaware that such tests have been ordered or, as indicated by one physician, unwilling to spend the time to find the results.

We discussed our findings with officials at the three hospitals, one hospital had already assigned a clerk to specifically follow up and file the prebed tests and the other two said they would study the matter to find a solution to the problem.

Earlier discharge of patient from
hospital beds to outpatient care
or nursing care bed facilities

Physicians told us that veterans often remained in the hospitals longer than necessary. They identified 79 cases from the 420 medical care records in which patients could have been discharged earlier by transferring them to nursing care facilities or by treating them as outpatients. They stated that 897 days of hospitalization would have been avoided by earlier discharges. Projecting the results of this sample to all admissions at the 6 hospitals during fiscal year 1971, we estimate that about 86,000 days of hospitalization could have been avoided if patients had been transferred to nursing care bed facilities (if available) or treated on an outpatient basis.

The following two cases identified by the treating physicians illustrate how the length of hospital stay could have been shortened.

--A veteran was admitted to the hospital on June 11, 1971, complaining of swollen ankles. The original diagnosis was heart trouble, but after tests were performed the next day, the problem was diagnosed as poor circulation in the lower extremities.

--The treating physician advised us that the patient could have been released for outpatient treatment after the first day, thereby avoiding 13 days of hospital care. This was not done because there was no administrative pressure to release patients to outpatient care. The physician decided to treat the patient in the

hospital rather than having him return for outpatient visits even though the veteran lived only 5 miles away.

--A veteran was hospitalized because of acute urinary retention diagnosed as a prostate problem. Surgery was performed to correct the problem, the veteran spent 70 days in the hospital. The treating physician stated that the patient could have been transferred to a nursing home 39 days earlier. This was not done, however, because (1) all the VA nursing care beds within that hospital were full and (2) money was not available to place the veteran in a private nursing home under the VA contract program

VA informed us that length of stay is not, in all cases, an accurate representation of the effectiveness of treatment. A short length of stay may be a sound measure of treatment effectiveness in acute care for younger patients but may be inappropriate for older patients with chronic diseases where maintenance rather than cure is the only obtainable goal.

Need for nursing care bed facilities

The act of August 19, 1964 (38 U.S.C. 620, 5001 and 5033) as amended, authorized VA to establish and operate nursing care beds--in facilities over which VA has direct and exclusive jurisdiction--to provide nursing home care to veterans. The law also authorized VA to transfer any hospitalized veteran to public or private community nursing homes for care at the expense of the United States, provided that (1) VA has determined that the veteran has received maximum benefits from hospital care but will require a protracted period of nursing home care and (2) the cost of such care will not exceed 40 percent of the cost of care furnished in a general VA hospital.¹

During fiscal year 1971 there were 5,119 nursing care beds available in VA facilities, these beds had an average occupancy of about 90 percent. On the average, there was a daily census of 3,377 VA patients in community nursing care beds during this period. The average daily cost of VA-operated nursing care beds averaged \$19.03 and purchased community nursing care beds averaged \$15.54. For all VA hospital beds, the average daily cost was \$44.92, and for VA general medical and surgical hospital beds, it was \$53.47.

At four of the six VA hospitals, the inadequate number of nursing care beds contributed significantly to longer than necessary hospital stays. VA officials at two of these hospitals stated that, although there was an abundant supply of community nursing care beds, they were able to contract for only a small number because of limited VA funding. They stated that, if funding were increased, it would have been possible to obtain the needed nursing care beds from the community at the fiscal year 1972 rate of \$18.50 per day. At the other two hospitals, we were advised that the VA maximum rate was inadequate to obtain nearby community nursing care beds. The prevailing rate was \$25 to \$30 a day.

¹ VA makes an annual determination of the rates to be paid for community nursing home care within the 40 percent limitation. For fiscal year 1971 the rate was \$18.50 except in Alaska, Hawaii, and New York where the rate was \$21.20 because of higher costs. For fiscal year 1973 the rates are \$19.50 and \$24.50, respectively.

The demand also could be satisfied by converting existing VA hospital care beds (both general and psychiatric) to nursing care beds. During fiscal year 1971, the average occupancy rate of VA hospital care beds was about 83 percent and the occupancy of nursing care beds was about 90 percent. We were advised by VA officials that, since fiscal year 1971, they have converted most of the available underutilized hospital beds to nursing care beds, generally future expansion will require construction of new facilities. They stated also that, in planning new and replacement hospitals, VA is including space for nursing care beds.

VA advised us that, in a further effort to discharge chronic patients from the hospital earlier, it was exploring various other possibilities. For example, VA is developing a hospital-based home care program. This program, currently operating at several hospitals, places certain chronic patients into their own homes and brings medical services to them.

Independent evaluation of efficiency of patient care

By having an effective utilization review committee at each hospital, VA could determine whether the admissions of patients are necessary, treatments are prompt, and patients are discharged or transferred as soon as their conditions permit. VA regulations provide that such committees be established. We found at the hospitals we visited that the committees placed most of their emphasis on determining the accuracy of medical records and relatively little emphasis on evaluating matters related to more efficient patient care.

VA regulations also provide that each hospital director establish a medical records committee to insure that the patient care programs in the hospital meet standards of the Joint Commission on Accreditation of Hospitals--an independent body composed of representatives from the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association. To meet these standards, the hospital director is required to regularly conduct quality control and utilization review.

VA regulations further require that the medical records committee and the utilization review committee meet monthly to review a sampling of medical records of patients who are hospitalized and who have been discharged

The medical records and utilization review committees were combined into one committee at each of the six hospitals. We reviewed the minutes of committee meetings held during 1971 at two hospitals. Most comments were directed toward the accuracy of medical records rather than the efficiency of patient care. For example, most of the committee's comments concerned adequacy of medical history, length of medical summary, and legibility of handwriting. In the few cases where questions were raised concerning utilization, we found that action was usually taken to correct the problem identified only in the specific case. Efforts were not made to identify trends and patterns of utilization problems to make recommendations for correcting the causes of identified problems.

The Joint Commission on Accreditation of Hospitals has also identified the utilization review function as an area needing improvement at some VA hospitals. VA summaries of the major problems noted during 1970 and 1971 by the Commission in its independent examinations of VA hospitals also identified utilization review as an area in need of improvement. In its 1970 summary, VA noted that the Commission had stated that VA's utilization review procedures should be expanded to clearly determine whether the resources of the hospital--both plant and personnel--were appropriately utilized.

VA officials informed us that (1) in November 1972 they began testing systems for measuring quality of patient care in their hospitals and (2) VA Central Office officials are developing checklist criteria for specific diagnoses to be used by the individual hospitals in their utilization review programs.

- - - -

Greater use of outpatient or nursing home care to shorten the period of hospitalization can have far-reaching effects on VA's health care delivery system. We recognize that solutions to some problems discussed above are not

simple. Some of the more significant benefits and obstacles-- as we view them--are summarized below.

Benefits

- Improved use of outpatient care can shorten the period of hospitalization. The resulting increased hospital turnover rate will permit more veterans to be treated with existing resources.
- The cost of care would be reduced. Medical diagnostic and treatment costs would remain essentially the same, but shorter stays would lower dietary, housekeeping, and other hospital service costs incurred for each patient.
- Changes in the method of treating patients through greater use of its outpatient program could affect VA hospitals built in the future. This is particularly significant since the VA hospital system is aging--about one-third of VA's 167 hospitals are over 30 years old and may soon have to be replaced or modernized.

Obstacles

- Certain outpatient work has little appeal for the treating physicians since they are usually specialists. Treating physicians may not want to be involved in routine examinations to determine the degree of disability for veteran compensation purposes or in the treatment of chronic ailments. This is especially true for VA physicians in resident training programs who believe such work does not make full use of their special skills or provide them with the needed experience.
- Use of outpatient care prior to hospitalization may not be possible for patients who live long distances from a VA hospital or who require emergency care.

Need to coordinate surgical admissions
with availability of operating facilities

At the hospitals we visited, there were no procedures for coordinating a patient's admission with the availability of surgical facilities. The specific surgery date was not scheduled until after the patient was admitted. As a result, patients sometimes waited a week for available surgical facilities.

At one hospital, several surgery patients were admitted on Thursday or Friday which necessitated hospitalization over the weekend--ordinarily a time when no elective surgery is scheduled. In some cases, the operating room was made available only 1 day a week for certain specialized surgery. Thus, a patient admitted the day following the available surgery date would have to wait a week before the operation could be performed.

Surgical planning is hindered, in part, because of the lack of coordination and involvement of the treating physicians with the patient before admission. Time is lost waiting for test results because testing is usually done after the patient is hospitalized, and test results sometimes identify conditions which necessitate postponing surgery.

At the large prepaid group health organization (see p. 14), surgery dates are established before the patient is admitted and patients are operated on the day after admission. As previously mentioned, all patients are seen by the treating physician on an outpatient basis for pre-admission workup unless it is an emergency. The physician must have the test results before the patient is admitted, this allows a postponement if the test results indicate that surgery would be undesirable at the time.

Officials at most of the hospitals we visited stated that scheduling hospital admissions could be improved. Of the 420 cases reviewed, the treating physicians identified 47 cases in which better coordination of admission with surgical facilities could have avoided 182 days of hospitalization. For example

--A veteran was seen by the admitting physician on October 8, 1970, who determined that the patient had a hernia and needed surgery. He was admitted to

to the hospital on October 28, 1970. A specific surgery date was not scheduled before he was admitted. The veteran had to wait 9 days after admission for the hernia operation since surgical time was not available at an earlier date. The treating physician advised us that at least 7 days of hospitalization could have been avoided if the admission date had been coordinated with the availability for surgical time. This would have reduced the total hospital stay from 14 days to 7 days.

On the basis of statements made by VA physicians, we estimate that about 15,000 hospital days could have been avoided during fiscal year 1971 if surgical admissions were better coordinated with the availability of operating facilities.

IMPROVED SCHEDULING OF APPOINTMENTS
COULD REDUCE WAITING TIME
AT OUTPATIENT CLINICS

We noted that veterans often had to wait several hours at outpatient clinics before they were seen by a physician because an adequate appointment scheduling system had not been established. The outpatient scheduling practices at eight VA clinics showed that the problem was particularly acute for veterans receiving outpatient care at large VA hospitals in urban areas. The eight VA clinics we checked were located in two small hospitals (under 300 beds) in rural areas, two medium-sized hospitals (300 to 1,000 beds) in suburban areas, two large hospitals (over 1,000 beds) in urban areas, and two independent outpatient clinics in urban areas.

VA regulations provide that all outpatients be given advance appointments whenever possible. The VA clinics should use a daily appointment plan which should be divided into appropriate time intervals. The date and time selected should be agreeable with the patient, if possible.

Veterans at the two independent outpatient clinics and at one medium-sized and one small hospital were given specific time appointments for outpatient visits. At these four locations, veterans were usually seen by a physician within a half hour. At the other four locations, veterans usually did not receive specific time appointments and all patients were instructed to report when the clinic opened. For example, if the eye clinic physicians were to see outpatients between 8 a.m. and 12 noon, all patients were told to report at 8 a.m.

At the two large hospitals, the average waiting time was about 1-1/2 hours and some veterans waited as long as 4 hours. At the one medium-sized hospital and the one small hospital which did not schedule specific appointments, veterans did not have to wait as long because there were usually only a few patients at each clinic.

Officials at one of the large hospitals stated that having all outpatients report at the opening of the clinic maximized the physicians' time because physicians' time is wasted when specific time appointments are not kept.

However, they stated that they would implement a procedure for scheduling patients at time intervals. Officials at the other large hospital advised us that they did not plan to change their present scheduling practices.

In our opinion, there are satisfactory alternatives available which would conserve the physicians' time while shortening the patients' wait. For example, block appointments, where several patients are scheduled for each hour, or moderate overscheduling to cover no-shows could be used.

In November 1972 VA officials informed us that they were conducting a pilot study of a centralized scheduling system for veterans seeking medical care at one hospital's outpatient clinics, when the study is completed and evaluated, VA will consider implementing the system nationwide.

CONCLUSIONS

The substantial increase in the use of outpatient facilities since 1960 has helped shorten the length of time veterans are hospitalized. This has enabled VA to treat more veterans with existing medical facilities. VA hospitals treated about 819,000 veterans in fiscal year 1971 compared with 664,000 in fiscal year 1961. Moreover, the use of less costly outpatient facilities has helped VA to hold down the cost of treating patients. Although the average cost per patient day in VA hospitals rose 125 percent from \$19.93 in 1961 to \$44.92 in 1971, the average cost to treat a patient has only increased 38 percent--from \$1,219 to \$1,683 over the same period.

We believe that the length of stay in VA hospitals could be shortened further by

- Adopting an operational technique to encourage treating physicians to see veterans on an outpatient basis before hospitalization so that the use of preadmission testing and other medical preparation can be maximized
- Establishing scheduling procedures to coordinate a patient's hospital admission with availability of the required surgical facilities

- Improving utilization review committee procedures to place greater emphasis on evaluating whether a patient's hospital stay has reached a point where he should be transferred to a nursing home or discharged completely
- Increasing the availability of nursing home care facilities so that patients who no longer need acute care resources can be transferred

There is a need to insure that the results of tests ordered by the physicians at the outpatient clinics are filed promptly in the patient's medical records so that the benefits of such tests are available to the treating physician

Improvements are also needed in scheduling outpatient visits--particularly at large VA hospitals located in urban areas--to shorten the average waiting period. Specific time appointments or satisfactory alternatives, such as block appointments, should be used rather than having all veterans report at the same time.

RECOMMENDATIONS

We recommend that the Administrator of Veterans Affairs

- Require VA hospitals to revise their operating procedures so that treating physicians, as a general practice, examine veterans on an outpatient basis before hospitalization, which would maximize the use of preadmission testing and other medical preparation.
- Require that scheduling procedures be established at VA hospitals to coordinate the patient's hospital admission date with the availability of surgical facilities.
- Require utilization review committees to place greater emphasis on evaluating the efficiency of patient care.
- Take steps to insure that adequate funds are available to provide for additional nursing home beds

- Establish procedures to have the results of tests ordered by physicians at the outpatient clinics promptly filed in the patient's medical folder.
- Require all clinics to schedule appointments for outpatient visits at specific times or to develop other satisfactory alternatives, such as block appointments.

CHAPTER 3

INCREASED PRODUCTIVITY POSSIBLE

IN VA OUTPATIENT DENTAL CLINICS

We reviewed outpatient dental activities at eight VA clinics and found that their effectiveness and efficiency could be improved. The VA dental clinics generally did not make extensive use of modern concepts of dentistry to increase professional productivity. Studies reported by the American Dental Association and the Public Health Service show that a dentist can increase productivity and improve the quality of care by using such modern dental concepts as parodontal personnel (e.g. chairside dental assistants and hygienists) and by having more than one dental chair per dentist.

During fiscal year 1971, about 302,000 veterans applied for outpatient dental care and about \$55 million was expended on VA outpatient dental treatments. VA expects no decrease in the program during the next 4 years. To accommodate the workload, non-VA dentists are utilized extensively, on a fee-for-service basis, for both examination and treatment. Non-VA dentists received about \$44 million in fees during fiscal year 1971.

MORE EFFECTIVE USE OF PROFESSIONAL DENTAL PERSONNEL

Dental personnel at seven of the clinics stated that the effectiveness of their operations was impaired to some degree because dentists were performing tasks which could be performed by parodontal personnel or were not as productive as possible because they did not have adequate assistance from such personnel. At some clinics dentists were performing a substantial amount of clerical work at the expense of rendering patient care.

Use of parodontal personnel

We estimated that an additional 6,000 veterans could have been treated during fiscal year 1971 at the eight VA dental clinics if VA had made greater use of parodontal personnel. On the basis of the average cost per VA dental

treatment in fiscal year 1971, adjusted for the necessary additional personnel and materials, the cost of VA's dental program could have been reduced significantly if the number of cases sent to fee-for-service dentists were reduced.

Oral prophylaxis, or cleaning the teeth, was performed entirely by VA dentists at six clinics, a hygienist was used at two. Dentists at the clinics without a hygienist spent about 5,200 hours during fiscal year 1971 performing this one task which hygienists could have adequately performed. VA officials told us that the relatively low Federal pay scale for oral hygienists--from about \$7,300 to \$10,600 per year--virtually prohibited VA from employing these hygienists. According to information available from several employment agencies located in the same cities as the VA facilities, a hygienist with a comparable background could obtain from \$10,000 to \$15,000 annually working for a private dentist.

We estimated that, if dentists did not have to clean patients' teeth, they could have treated about 1,200 additional patients at an estimated savings of over \$250,000.

Dental assistants were available at all eight clinics, however, at five clinics there were more dentists than assistants. In some instances the dental assistants were used primarily for clerical tasks. As a result, dentists were required to perform tasks which could have been adequately performed by assistants.

The use of dental assistants--often referred to as four-handed dentistry--modifies the usual procedure of the dentist in providing care.

- The dentist can work from a seated position.
- Before the dentist takes his position on the operating stool, the assistant has prepared the patient for treatment by properly adjusting the chair and has provided the appropriate dental instrument setup.
- When dental care begins, the assistant hands the dentist the necessary instruments.
- When the cavity is prepared, the assistance isolates the tooth with cotton rolls and dries the cavity with cotton pellets and air.

- The assistant prepares the filling material and hands the dentist the necessary tools to complete the procedure.
- When the procedure is completed, the assistant performs the necessary cleanup work.

The effective use of dental assistants, as outlined above, relieves the dentist of many tasks he would have to perform when rendering dental care unassisted.

Dental personnel at each of the clinics agreed that four-handed dentistry would increase the efficiency of dental operations. However, officials at several of the VA dental clinics stated that they were precluded from using this technique because of obsolete dental equipment and space limitations. Two clinics also mentioned the reluctance of older dentists to change their traditional methods of dentistry

At one clinic, the need for modern equipment was justified on the basis that four-handed dentistry could be used and would increase the clinic's efficiency. Once the equipment was purchased, however, the dentists continued to use the equipment in the traditional method because there were only 5 dental assistants available to the 10 dentists. We estimated that about 2,300 additional patient visits could be handled annually at this clinic if four-handed dentistry were used. By hiring additional assistants and treating more patients at the VA facility rather than having the work done on a fee-for-service basis by private dentists, VA would save about \$31,000 annually. VA officials at this clinic agreed with our estimate of savings but stated that they were unable to obtain the necessary authority to hire the additional assistants.

Multiple-chair operations

Almost 90 percent of private dentists surveyed in a 1968 study by the American Dental Association used two or more chairs. Under this technique, a dentist can treat one patient while a dental assistant prepares the next. This increases the dentist's overall productivity, since time is not lost in preparing the patient for treatment or in cleaning up after the treatment is completed. The 1968 study showed

that the mean net income of dentists with two chairs was 42 percent higher than those with one chair and that the average income of dentists with three chairs was 26 percent higher than those with two chairs.

None of the eight VA dental clinics included in our review had two or more chairs per dentist.

Less involvement of VA dentists
in clerical matters

Five of the eight VA clinics were designated as clinics of jurisdiction and, as such, were responsible for administering the fee-for-service dental program. During fiscal year 1971, these five clinics authorized payments of about \$5 million to private dentists for examining and treating veterans. VA regulations require that all treatment recommended by non-VA dentists under the fee-for-service program receive prior approval by a VA dentist

At two of the five clinics the veterans were examined by a VA dentist who prescribed the necessary treatment and determined the applicable fee before the veteran was sent to a private dentist. After the dentist completed the treatment and submitted the bill, clerical personnel reviewed the bill and approved payment, except in cases where there was a significant deviation from the originally determined fee. These bills were sent to the Chief of the Dental Service for review. At another clinic, clerical personnel reviewed recommended plans by non-VA dentists for appropriateness of the fees requested, except for the complex cases which were sent to the VA dentist for his review. At this clinic we were advised by the Chief of the Dental Service that he spent about 25 percent of this time reviewing the complex cases and the remainder providing dental care to veterans.

At the remaining two clinics we found that the VA dentists were spending a significant portion of their time reviewing treatment plans recommended by non-VA dentists with a corresponding reduction in their dental effort. There were 15 VA dentists at these clinics--5 at one and 10 at the other. Four of these dentists were involved in this review work, and three of them spent 70 percent or more of their time in this function.

We selected a random sample of 50 fee-for-service cases authorized in fiscal year 1971 at each of these 2 clinics. Private dentists requested fees totaling \$30,411 for the 100 cases sampled. Reductions made as a result of the VA review totaled \$5,410. However,

--38 of the 100 treatment plans recommended by the private dentists were not changed in any manner

--53 of the treatment plans were changed to reflect the maximum scheduled fees allowed by VA or were changes relating to the veteran's eligibility for proposed treatment, these could be resolved by clerical personnel.

--9 of the treatment plans involved changes to the type of treatment prescribed that could only be identified by a dentist. These changes involved dental work costing \$659

At both clinics VA officials stated that trained clerical personnel could adequately handle many of the recommended treatment plans, which would free the professional staff for dental care. On the basis of the average number of dental cases completed in fiscal year 1971 by the VA dentists at these two clinics, we estimated that 470 additional veterans could be treated annually if these dentists devoted at least 75 percent of their time to dental treatment. This would reduce the cost of the fee-for-service program by about \$130,000. Because of their interpretation of VA regulations, officials at these clinics were not transferring the responsibility for reviewing any portion of fee cases to clerical personnel.

On the basis of the type of changes made to treatment plans by dentists at the two clinics, we believe VA should require VA dentists to become involved only in those cases identified by clerical personnel as complex or expensive on the basis of preestablished criteria. A dentist usually is not needed to reduce fees to preestablished levels or to resolve issues relating to veteran eligibility. Most authorizations for dental treatment could be handled by properly trained clerical personnel. On a sample basis, VA dentists could check the decisions to insure adequate control.

VA was made aware of the need to eliminate the involvement of VA dentists in clerical matters in December 1971 by a report prepared by its Internal Audit Service, Office of Management and Evaluation. The internal audit report proposed that medical administrative personnel handle communications with fee-basis dentists and, within certain limitations, process and approve treatment plans.

POSSIBLE IMPROVEMENTS IN CLINIC EFFICIENCY

During our review we also noted areas where efficiency could be improved at the dental clinics.

Scheduling appointments

In December 1968 the VA Chief Medical Director issued a letter to all dental clinics requesting that the backlog of outpatient dental treatments be reduced. He suggested that reducing the number of broken appointments would help and that phoning the veteran a few days in advance of his appointment should be considered

Broken appointments continued to be a significant problem at the eight dental clinics during fiscal year 1971. Our analysis of dental activities during a 5-day period in fiscal year 1971 showed that 6 of the 8 clinics had more than 10 percent of their scheduled outpatient appointments broken, 1 clinic averaged 34 percent. Another clinic reported that, of the 10,141 dental appointments which were scheduled during fiscal year 1970, 2,539, or about 25 percent, were broken. The Chief of this dental clinic stated that the veteran was usually advised of his appointment by mail and was not consulted as to the convenience of the date or time.

None of the clinics had developed a reminder system to notify the veteran a few days in advance of his scheduled visit either by letter or by phone call

Use of available dental resources at nearby VA clinics

Private dentists can provide dental care on a fee-for-service basis if (1) the veteran resides some distance from a VA facility or (2) the demand for dental services cannot be met by VA facilities. To maximize the use of VA dental resources, each clinic is supposed to maintain current information regarding dental resources available at other nearby VA clinics.

None of the clinics we visited had a systematic approach to periodically obtain information on the availability of dental resources at other clinics. VA officials at these clinics informed us that this information was usually obtained informally during telephone conversations.

At one of the eight clinics a large number of cases had to be sent to private dentists because it was unable to handle the heavy workload. At the same time, a VA dental clinic located about 30 minutes away had the capability to treat some of the other clinic's patients. We informed officials of both VA clinics about this situation and arrangements were made to transfer part of the workload which would otherwise have been sent to private dentists. On the basis of the number of cases transferred to the nearby clinic during a 5-month period after these arrangements were made, we estimate that VA's fee-for-service dental program will be reduced by about \$90,000 annually at this 1 clinic

Similar situations were not identified at the other VA clinics. However, the lack of a systematic approach to identify available resources at other clinics suggests that it could happen if dental demands at one location exceeded available resources.

CONCLUSIONS

We believe that fewer veterans would have to be sent to fee-for-service dentists and that, as a result, substantial savings could be achieved if dental clinic operations were improved by (1) increasing the use of parodontal personnel, such as oral hygienists and chairside dental assistants, (2) using more than one chair per dentist where possible, and (3) eliminating the involvement of VA dentists in clerical matters to the greatest extent possible. The dental clinics could be operated more efficiently if the number of broken appointments were reduced and if VA dentists made greater use of available dental resources at nearby VA clinics.

RECOMMENDATIONS

We recommend that the Administrator of Veterans Affairs

- Evaluate dental care at VA clinics and, if appropriate, increase or substitute the use of parodontal personnel. The Administrator should determine if higher salaries are needed to recruit hygienists, particularly in urban areas.

- Take steps to improve the productivity of VA dentists by requiring the use of (1) four-handed dentistry, (2) more than one chair per dentist, (3) administrative personnel, rather than dentists, to handle clerical duties, and (4) a reminder system which would notify the veteran, by phone or mail, of scheduled appointments a few days in advance.

- Insure that clinics' dental resources are coordinated to assist in meeting demands for outpatient dental care.

CHAPTER 4

AGENCY COMMENTS

After reviewing our findings, conclusions, and recommendations, VA advised us that it agreed with our conclusions and, in line with our recommendations, had taken or would take the corrective actions needed. (See app. I.)



VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D C 20420

FEBRUARY 9 1973

Mr. Frank M. Mikus
Assistant Director
Manpower and Welfare Division (801)
U. S. General Accounting Office
Room 137, Lafayette Building
Washington, D. C. 20420

Dear Mr. Mikus:

We have reviewed your draft report, "Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans," dated September 21, 1972, as revised following our joint meeting on November 6, 1972. We appreciate the opportunity to comment on your report. Generally, we agree with the report content and recommendations. Our comments relating to each recommendation are stated in the following paragraphs.

We agree that inpatient physicians should be involved in the admitting function. We have always encouraged this. Recently we established an organizational model for this purpose which is being tested at twelve VA stations.

Coordination of hospital admissions with the availability of surgical facilities can be accomplished by appropriately using pre-bed care procedures. We will reemphasize this matter to our VA field stations.

We agree that evaluation of the efficiency of patient care should be emphasized. A VA policy statement is being published clarifying review committee structure and functions.

Regarding the need to expand the nursing home care program, we have sharply increased the number of VA-operated nursing home care beds. Our average census increased from 3,760 in FY 1970 to 5,440 in FY 1972. We have since been

APPENDIX I

Mr. Frank M. Mikus
Assistant Director
Manpower and Welfare Division (801)
U. S. General Accounting Office

authorized to increase the bed level from 6,000 to 8,000. For the most part we have converted available underutilized hospital beds for this purpose, but future expansion will require construction of some new facilities. The program of community nursing home care has been expanded from 3,581 average census for FY 1970 to 4,700 in FY 1973.

Although current requirements imply that results of tests be filed promptly, we will issue a specific policy regarding this.

Current VA policy requires that a centralized scheduling system be established at each station to indicate times of outpatient visits. Additionally, we are conducting a pilot study which provides for the type of scheduling recommended and will consider it for nationwide implementation if it is successful.

We agree that increased usage of parodontal personnel would improve the dentists' efficiency and productivity. Staffing improvements have been budgeted for and implemented in 1971 and 1973 resulting in increased parodontal personnel. Our current budget submission provides for additional parodontal positions. We have exerted considerable effort to obtain a higher grade and salary level for hygienists and special salary rates have been established in three geographical locations. However, the resultant salaries are still not truly competitive with the private sector.

Productivity of VA dentists can be improved by the recommended actions. The VA supports the use of four-handed dentistry and is steadily progressing in providing adequate facilities and training for this purpose. Use of more than one chair per dentist directly relates to the availability of space and ancillary personnel. Although some flexibility is now attained, consideration will also

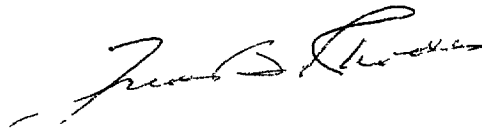
Mr. Frank M. Mikus
Assistant Director
Manpower and Welfare Division (801)
U. S. General Accounting Office

be given to reviewing our current space criteria. A new position is being considered which would relieve dentists of clerical duties in the fee-for-service program. Additionally a policy change is being made which permits non-dentists to review fee-dentist examination and treatment plans. We will make every effort to assure conformance to existing policy on the appointment reminder system.

We fully agree that the resources of clinics should be systematically coordinated to meet the demands for outpatient care. Recently, the establishment of Regional Medical Districts has provided the basis for a systematic review and exchange of workloads between stations.

It should be noted that with respect to greater use of outpatient care, the VA has exerted its resources to the limit prescribed by statutory boundaries in an effort to accomplish the objectives pointed out in this report.

Sincerely,



FRED B. RHODES
Deputy Administrator

APPENDIX II

VA FACILITIES AT WHICH REVIEW
WAS PERFORMED

<u>Organization</u>	<u>Location</u>	<u>Description</u>
VA Central Office	Washington, D C	
Wadsworth Hospital	Los Angeles, California	791-bed general hospital
Sepulveda Hospital	Sepulveda, California	821-bed hospital (385 general medical and surgical and 436 psychiatric) Our review was limited to general medical and surgical operations
Independent outpatient clinic	Los Angeles, California	Clinic of jurisdiction covering Southern California and Clark and Lincoln Counties, Nevada
Kansas City Hospital	Kansas City, Missouri	476-bed general hospital Clinic of jurisdiction covering western Missouri and eastern Kansas
Muskogee Hospital	Muskogee, Oklahoma	262-bed general hospital Clinic of jurisdiction for Oklahoma
New York Hospital	New York, New York	1,108-bed general hospital
Outpatient clinic	New York, New York	Clinic of jurisdiction covering 10 counties of southern New York Under the administrative direction of the New York Hospital
Outpatient clinic	Brooklyn, New York	Clinic of jurisdiction covering the Brooklyn area
Castle Point Hospital	Castle Point, New York	258-bed general hospital

PRINCIPAL OFFICIALS OF
THE VETERANS ADMINISTRATION
RESPONSIBLE FOR THE ADMINISTRATION OF
ACTIVITIES DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
ADMINISTRATOR OF VETERANS AFFAIRS· D. E. Johnson	June 1969	Present
DEPUTY ADMINISTRATOR F B. Rhodes	May 1969	Present
CHIEF MEDICAL DIRECTOR M. J. Musser, M.D.	Jan. 1970	Present
DIRECTOR, EXTENDED CARE SERVICE· W. F. Klein, M.D	June 1972	Present
J. F. Connor, M D.	Feb. 1971	June 1972
Vacant	Dec. 1970	Jan. 1971
P. A. Haber, M.D	Feb. 1964	Dec. 1970

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