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REPORT OF THE VETERANS' ADMINISTRATION COMMITTTEE STUDYING PBC–PHC (PREBED AND POSTHOSPITAL CARE) ACTIVITY

AUGUST 16, 1966

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REPORT OF THE COMMITTEE STUDYING PBC–PHC ACTIVITY

Daniel R. Robinson, M.D., Chairman

MAY 1966

REPORT OF THE COMMITTEE STUDYING PBC–PHC ACTIVITY

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., August 8, 1966.

CHIEF MEDICAL DIRECTOR'S LETTER No. 66–32

To: Directors of VA hospitals, VA outpatient clinics and managers of regional offices with outpatient clinics.
Subject: Prebed program (PBC).

1. Interim issue 10–66–37, now being distributed, effects a major change in the criteria for placement of hospital applicants in the pre-bed care (PBC) program.

2. These changes, effective upon receipt of the interim issue, are being made after careful consideration of the findings resulting from a special study of both the pre-bed-care and post-hospital-care programs. This special study was initiated after receipt of a congressional inquiry about the results being attained with both programs.

3. Thirty-two hospitals were included in the study. It was found that the PHC program was accepted very well. On the other hand, the PBC program, on the average, was not fully accepted nor utilized to an acceptable degree. While there were many factors contributing to the nonacceptance and poor utilization of the PBC program, it was found that where top management and staff elements, particularly the Chief of Outpatient Service, were supporting this program, it was well utilized. It was also found that certain restrictive policies imposed by chapter 17, D.M. & S. manual, M–1, part I, were one of the chief impediments to utilization of the program. Therefore these policies were liberalized in the test hospitals, and improvement was noted with the change. In the hospitals where top management, the Chief of Outpatient Service, and other staff elements were contacted personally and a method for implementation of the program developed, still further improvement was noted.

4. The tested changes with certain modifications are now being effected VA-wide. It is expected that this will result in an increase in the use of PBC.

H. MARTIN ENGLE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., August 8, 1966.

INTERIM ISSUE 10–66–37

A. *Basic administrative issue affected.*—M–1, Part I, Chapter 17, Section II.

B. *Other issues affected.*—None.

C. *Reason for issue.*—To revise the criteria for placing admission applicants in the pre-hospital-care program (PBC).

D. *Text of issue.*—

1. *Page 17–3, paragraphs 17.09 and 17.10.* Delete these paragraphs and substitute the following:

"17.09 POLICY

"a. *Direct Placement on PBC*

"(1) Subject to the exception stated in subparagraph a(2) below, eligible applicants for hospital care will be placed in the prebed care program when all of the following conditions are met:

"(a) It has been established, as a result of initial examination by the admitting physician and the routine one or two tests included as part of that examination, that the patient requires hospital care. (The policy of resolving any doubt in favor of hospitalization will be applied.)

"(b) There is need for further workup (e.g., for substantiation of the diagnosis or in preparation for the admission) and such workup can be accomplished prior to the scheduled admission.

"(c) The patient can reasonably be expected to be admitted within 30 days. (This period may be extended for 15 additional days if the scheduled bed is not available.)

"(2) Applicants will not be placed in the PBC program if they are admitted on the same day that the initial examination occurs.

"(3) The hospital may provide some or all of the prebed care on the day that the initial examination by the admitting physician is done. Where this is not possible, or where necessary, the patient will be recalled for further tests, examinations or consultations.

"b. *Placement on PBC From the Waiting List.* Veterans scheduled for admission from the waiting list may be placed in the pre-bed-care program in preparation for admission within the same time limit specified in subparagraph a(1)(c) above.

"c. Medical services furnished PBC patients may include examination, treatment, medications and supplies, but must be limited to those necessary to prepare the patient for the scheduled episode of hospital care. Dental prostheses, wheelchairs, artificial limbs, trusses and similar appliances and clothing may not be furnished prior to admission.

"d. Generally, the admitting hospital will provide PBC. By agreement, however, between respective Directors, another VA hospital or clinic may provide prehospital care when the best interests of the veteran and the Government will be served. In this instance the hospital which is to admit the patient will forward all necessary records to the assisting hospital or clinic. After completion of PBC,

a station rendering services for another station will forward all medical records to the admitting hospital.

"e. PBC will not be authorized on a fee basis, except for essential services not available at an appropriate VA station.

"f. If it is determined at any time after placement in PBC status that hospital care is not necessary, the scheduled admission will be cancelled.

"g. The Chief, Outpatients Service, will have primary responsibility for placement of veterans in the PBC program. Consultation assistance will be provided as necessary by appropriate members of the staff.

"17.10 PROCEDURES

"a. When an applicant is to be placed in the PBC program, he will be scheduled for admission to the hospital and the intent of the program will be explained. (It is not necessary to specify the exact date of admission at this time, but adequate controls will be maintained to insure adherence to the established time limits.) Care will be exercised in making appointments for additional prescribed procedures so that diagnostic data will not be outdated at time of admission. Medical record forms will be initiated as necessary.

"b. VA Form 10–P–10 will be prominently stamped "PBC" and VA Form 10–2580, Locator Card, prepared for the master locator file. At the option of the station, a PBC folder may be initiated and a 4-line plate (if used locally) prepared containing name, identification number, claim number, date of birth and "PBC." SF 509, Clinical Record—Doctors Progress Notes, will be used by physicians to record any findings and comments made subsequent to the initial examination. During PBC status all completed reports will be returned to the reception activity for review and necessary action by a physician and then filed with the other PBC records of the patient.

"c. When the veteran is admitted for bed occupancy care, the 9-line plate (or VA Form 10–2750, Hospital Admission Stencil) will be prepared and routine admission procedures followed. Source of admission will be 'PBC.' Pages 1 and 2 of VA Form 10–P–10, and related administrative records will be filed in the patient's correspondence folder. Page 3 of VA Form 10–P–10 and other PBC medical record will be filed in the medical records folder.

"d. If the patient is not admitted, the PBC record will be appropriately annotated and filed with other rejected or cancelled VA Forms 10–P–10."

2. *Page 17–4, paragraph 17.11, line 7.* Delete "in the patient's PBC folder" and substitute "with the patient's PBC records."

H. Martin Engle, M.D.,
Chief Medical Director.

UNITED STATES GOVERNMENT MEMORANDUM

To: Chief Medical Director (10).
From: Special Assistant for Field Operations, Region 2 (10H).
Subject: Final Report of the Committee Studying PBC–PHC Activity.

In accordance with the Associate Deputy Chief Medical Director's memorandum dated August 25, 1966, the attached report is submitted for your consideration.

D. R. ROBINSON, M.D.

REPORT TO THE CHIEF MEDICAL DIRECTOR OF THE COMMITTEE STUDYING PBC–PHC ACTIVITY

Daniel R. Robinson, M.D., Chairman, H. J. Doben, A. A. Hosinski, P. A. Mavridis, May 16, 1966

1. INTRODUCTION

On July 16, 1965, the chairman of the House of Representatives Committee on Veterans' Affairs, Mr. Olin E. Teague, addressed a letter to the VA Administrator in which he commented on turnover rates and criticized the low usage of the pre-bed-care program by the Department of Medicine and Surgery. He used such words as "nothing short of a disgrace" and "shocking" in voicing the committee's concern over the administration of this program. In the conclusion of his letter the chairman stated:

> I hope it will be possible for you to inspire the Chief Medical Director's office to adopt for the first time a constructive and continuing approach to the PBC program so that the PBC admission rate for 1966 may be double that of 1965, which is at the ridiculous figure of 14,762 out of 602,545 admissions, or 2.4 percent. It seems to me that a doubling of this figure is the least which we should expect.

In a reply to Mr. Teague dated August 6, 1965, the VA Administrator stated that the Veterans' Administration was engaging in a study to determine, "what can and should be done with reference to this program."

It should be pointed out that the letter of Mr. Teague was but one in a series of letters, written by him, commencing January 17, 1962, which were critical of this program.

In accordance with Administrator's letter of August 6, 1965, on August 25, 1965, the Associate Deputy Chief Medical Director appointed a project team to study the use of VA pre-bed-care and post-hospital-care programs. Dr. Daniel R. Robinson was designated as the Project Director. The project team included Mr. H. J. Doben of the Reports and Statistics Service, and Mr. A. A. Hosinski of the Registar Service. Major assistance was also provided by Mr. P. A. Mavridis of the Reports and Statistics Service.

The project team developed a study protocol (see attachment 1) which involved a study of PBC activities at 34 VA hospitals including team visits to 12 of these hospitals.

The purpose of the study, as stated in the protocol, was "to survey selected hospitals for the purpose of obtaining data which will aid in evaluating the use of the pre-bed- and post-hospital-care programs."

Specifically, the following:

1. Recommendations for the future D.M. & S. position in the PBC and PHC programs.
2. Identification of the PBC potential including a realistic identification of the point in the examining procedures past which PBC may be rationally identified.
3. Recommendations on the relation between level of demand and the use of these programs.
4. Recommendations concerning the values of a "public relations" program to solicit the assistance of veterans organizations in overcoming potential patient resistance.
5. Recommendations concerning internal hospital organization and procedure for PBC and PHC.
6. Hospital resources necessary for these programs.

2. BACKGROUND

Public Law 86–639, July 12, 1960. authorized the Veterans' Administration to provide outpatient services to veterans for treatment of non-service-connected disabilities. under certain conditions. Prior to the passage of this law, the Veterans' Administration could legally provide outpatient medical treatment only to veterans for service-connected conditions, except for veterans who had service-connected conditions but required treatment for non-service-connected conditions (*a*) in order to complete VA-sponsored vocational retraining or (*b*) as an adjunct in the treatment of their service-connected disabilities. Otherwise, legally, the VA was required to limit the treatment of veterans with non-service-connected conditions to hospital (inpatient) care, and then only if such veterans certified their inability to pay for hospitalization and a bed in a VA hospital (in some cases, also in another Federal hospital) was available.

It was inferred by Congressmen and others who reviewed the VA's position, that the length of stay in VA hospitals could be reduced, with a consequent higher turnover of patients within existing beds, if the VA were authorized to provide certain pre-bed-care and post-bed-care outpatient services to non-service-connected veterans.

At the hearings on the VA program, held by the House Veterans' Affairs Committee in July and August of 1958, the chairman of the committee, Mr. Olin E. Teague, expressed his interest in providing such authorization, and the committee explored the possibility of legalizing non-service-connected outpatient care.

On June 24, 1959, Mr. Teague introduced H.R. 7965, 86th Congress. This bill sought to amend section 612, title 38, of the United States Code (which authorizes VA medical care to veterans) by adding:

> The Administrator may also furnish medical services for a non-service-connected disability under the following circumstances:
>
> (f)(1) Where such care is reasonably necessary in preparation for admission of a veteran for hospital care, or where such care is reasonably necessary in determining whether or not hospital care is needed.
>
> (f)(2) Where a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care.

Although the VA indicated some support for the bill in a letter to the Bureau of the Budget, dated October 10, 1959, the bill provided VA officials with some misgivings.

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On October 2, 1959, the Chief Medical Director addressed a memorandum to the VA Associate General Counsel for Legislative Services in which he recommended that the following wording be substituted for subsection (f)(1):

(f)(1) When such care is reasonably necessary in preparation for admission of a veteran who has been determined to need hospital care and who has been scheduled for admission.

Thus, he specifically recommended elimination of the words:

* * * or where such care is reasonably necessary in determining whether or not hospital care is needed.

The Chief Medical Director further stated that:

Unless the current language of subsection (f)(1) is changed as suggested, it could be interpreted to provide outpatient treatment for all applicants on our waiting lists. This would include veterans whose names may never be reached or whose applications are withdrawn, cancelled or rejected prior to being scheduled for admission for anyone of a number of good reasons. Such an interpretation in our opinion would not be consistent with the basic objectives of the bill and could be very costly.* * * Under our proposal, no treatment could be authorized in preparation for admission until such time as the veteran was actually scheduled for admission. Generally this covers a period of about 15 days from the time he is scheduled and the date he is actually admitted. This not only is sufficient time to permit completion of most of the procedure necessary for admission but it would also keep the costs of this bill to a minimum.

In other words, the Chief Medical Director feared that the bill as worded would make outpatient treatment available to any veteran with a non-service-connected disability merely by the expedient of permitting the veteran to apply for inpatient care. He therefore sought to limit prebed outpatient care to those veterans who genuinely required inpatient care.

In a letter dated March 16, 1960, the VA Deputy Administrator, Mr. Bradford Morse (now Congressman Morse) indicated VA's support of the bill, stating:

Some definite benefits that may be anticipated from enactment of this bill are:
1. An increased turnover of veterans hospitalized for treatment with the resulting effect of a reduction in the length of patient stay in the hospital;
2. A decrease in the cost per patient treated; and
3. A partial check on the development of longer waiting lists as the veteran population ages.

However, with an eye on the Bureau of the Budget's position, Mr. Morse also called attention to the "possible adverse effects" of the bill, stating:

This bill would for the first time mean that non-service-connected veterans would be receiving outpatient treatment even though we have endeavored to make revisions which would relate this only to hospital care. The outpatient treatment of the non-service-connected might be an opening wedge to a further extension of this type of medical treatment. Another consideration is that it has been the position of the present administration that other non-Federal governmental jurisdictions have a responsibility for providing medical assistance to all their citizens including veterans. This proposed legislation expands the number of non-service-connected veterans who would be cared for in our hospitals.

Mr. Teague amended his bill as requested by the VA and on April 21, 1960, the bill was reported out favorably by his committee. The Senate Committee on Labor and Public Welfare also took favorable action on June 22, 1960.

The bill was approved as a congressional act dated July 12, 1960, and became Public Law 86–639. (See attachment 2.)

Immediately following the passage of the bill, the VA prepared a supplemental appropriation request for fiscal year 1961 which was forwarded to the Bureau of the Budget on July 22, 1960. The request sought $5,170,000 to carry out the provisions of the new law. This amount was broken down as follows: $2 million for beneficiary travel, $734,000 for medical supplies, and $2,436,000 for an average employment of 400 increased personnel. The Bureau's response was to cut this requested appropriation in half. The Bureau permitted the VA to request $2,585,000 which was subsequently approved by the Congress. Of this amount $2,185,000 was allocated by the Bureau.

The initial funds were turned over to the seven area medical directors for distribution "where it would do the most good in increasing turnover." The area medical directors were also given responsibility for supervising the programs. This was in large part a "paper responsibility" since the area offices were not appropriately staffed to do an effective job of supervision.

The VA had planned to seek $11 million for this program for fiscal year 1962, but because the agency was also seeking additional funds to improve its medical care staffing pattern in the hospitals, it felt that a request of this size would not be politic. Consequently, less than one-half of this amount ($5,388,000) was sought, and even this amount was not specifically earmarked but was included as part of an overall line item, "Inpatient Care," in the budget.

The prebed and postbed programs continued as part of the inpatient program until fiscal year 1963 when they were transferred to the outpatient program and budget. However, at no time, following fiscal year 1961, was there any attempt made to provide specific budgets or realistic budgetary controls for these new programs. Instead the individual VA hospitals funded them as part of a larger program, and it was left up to the discretion of each hospital just how much pre-bed-care and post-bed-care activity would be accomplished. Dollarwise, these programs had to compete with other hospital programs.

The VA formally implemented the law by issuing directives to its hospitals (D.M. & S. Circular 10–203, Oct. 3, 1960, and D.M. & S. Circular 10–209, Oct. 25, 1960. This material was later published in VA Manual M–1, pt. I.)

3. STATISTICAL EXPERIENCE OF THE PROGRAM

The following table shows the statistical experience of the PBC and PHC programs at all VA hospitals.

The PBC program reached a peak of activity in fiscal year 1963 when 3.8 percent of all admissions were from PBC status. The program had steadily declined through fiscal year 1965, accounting for Mr. Teague's concern.

The PHC program has shown a steady increase in activity. The apparent statistical decline in fiscal year 1965 is really a paper loss due to a change in administrative procedures. Had this administra-

tive change not occurred, the program whould have continued to show an increase.

Fiscal year	Admissions from PBC		Discharges to PHC	
	Number	Percent of all admissions	Number	Percent of all regular discharges
1962	9,798	1.7	212,858	43.9
1963	22,478	3.8	225,459	47.1
1964	18,283	3.0	243,801	48.5
1965	14,767	2.5	[1] 237,039	47.3

[1] This number would have been approximately 248,000 (estimate) had the requirement that patients be readmitted to hospital after 1 year in PHC status in order to continue their PHC status not been rescinded.

As indicated above some of the benefits anticipated from Public Law 86–639 were an increase in patient turnover, a decrease in the cost per patient treated and a partial check on the development of longer waiting lists. The table below shows that generally such benefits have been attained during the period that the law has been in force. There has been a general increase in the number of patients treated and in the patient turnover rates and if we adjust the data to eliminate the effect of the annual increases in per diem costs (see line 3b of the table), there has been a decrease in the average cost per patient treated. The waiting list has fluctuated within a fairly constant range. However, there are factors, other than the law, which have contributed to these phenomena, such as the improvement in the hospital patient-staffing ratio, and for this reason it is impossible to determine the exact effect of the law in improving VA hospital operations.

	Experience of VA general hospitals in fiscal year—				
	1961	1962	1963	1964	1965
1. Patients treated (thousand):					
(*a*) As reported	558	575	593	613	608
(*b*) As adjusted [1]	548	566	583	603	608
2. Per diem cost	$25.82	$27.09	$28.33	$29.43	$30.99
3. Average cost per patient treated, as adjusted (line 1*b*):					
(*a*) On basis of anunal per diem cost	$1,007	$1,011	$989	$997	$1,047
(*b*) On basis of fiscal year 1961 per diem cost [2]	$1,007	$964	$901	$875	$872
4. Average monthly turnover rate:					
(*a*) As reported	70.8	74.3	79.8	82.8	81.3
(*b*) As adjusted [1]	69.6	73.0	78.3	81.3	81.3
5. Waiting list, June 30	6,926	6,984	8,447	7,572	7,250

[1] Adjusted to make 1961–64 data conform to the same definitions concerning PHC as were in effect in fiscal year 1965.

[2] Adjusted in terms of fiscal year 1961 per diem cost. In other words, these would have been the yearly costs per patient treated had the per diem cost remained the same as in fiscal year 1961.

5. METHODOLOGY

Thirty-four hospitals, including 32 general hospitals, 1 psychiatric hospital, and 1 tuberculosis hospital, were selected for study. The study team decided upon the following actions:

(*a*) *Pre-bed-care program*

1. Fourteen hospitals characterized by low PBC usage were selected for study of administrative changes in PBC procedure.

These 14 included hospitals located in both heavily populated and sparsely populated areas, with varying numbers of beds and patient loads, and with affiliated and nonaffiliated status.

2. Twelve hospitals equally distributed between "high" and "low" users of PBC, and paired off on the basis of beds, patients, affiliation, and metropolitan populations, were selected for visits by the study team. These stations were to be queried on the basis of a check list shown in attachment 3 to enable the team to develop an understanding of the environment, organizational structure, staff attitudes and other problems which appeared to affect the PBC and PHC program usage.

3. Questionnaires (attachment 4) were sent to the 26 hospitals, indicated above, and also to 8 other hospitals which were selected as "average" users of the PBC program so that they could each provide data prospectively for a maximum of 200 consecutive admissions, within a specified period (October 18 through November 16, 1966). The questionnaire was designed to provide information concerning the proportions of patients who were suitable for placement on PBC. Information was also solicited concerning particular station and patient problems in the application of the PBC program.

(*b*) *Post-hospital-care program*

Each of the 34 study hospitals was also asked to survey 200 consecutive discharges and to report the number of such discharges who were placed on PHC, including data concerning the number who required medications for (1) less than 30 days and (2) more than 30 days following discharge. Also the hospitals were requested to review the length of stay of these patients to insure compliance with D.M. & S. Circular 10–64–110.

5. FINDINGS

(*a*) *Pre-bed-care program*

1. *Changes in administrative procedures.*—Of the 20 hospitals characterized as low users of PBC, 14 were employed in a test to determine the effect of administrative changes (see par D1 of the protocol and attachments 5, 6, and 7) and 6 continued on the basis of no change. A directive to these 14 stations (attachment 5) instructed them to place patients on PBC under the following conditions:

(*a*) When the workup procedures, or consultations with specialists ordered by the admitting physician, exceeded those required to determine actual need for hospitalization;

(*b*) When the need for hospitalization was not determined during the initial visit; and

(*c*) When an application was approved, and admission was deferred until a later date for any reason, and it was contemplated that the patient would again be seen by a physician prior to admission.

The directive further permitted the stations to exceed the 14-day limitation on PBC in those situations where beds were unavailable, and to cancel scheduled admissions in those cases where it was determined that hospitalization was no longer necessary.

Contact with a staff member of the House Veterans' Affairs Committee indicated that there would be committee objection to part of these provisions which appeared to be in violation of law. Consequently, the test conditions were changed effective November 1, 1965

(attachment 6) to eliminate provisions (b) and (c). Study stations were permitted to continue to exceed the 14-day limitation and to cancel scheduled admissions in those cases where it was determined that hospitalization was no longer necessary.

Effective December 20, all 34 stations in the study were placed into the test under the following conditions (attachment 7):

(*a*) Applicants could be placed in the PBC program on the same day that the 10–P–10 examination occurred, provided that the laboratory, X-ray, other diagnostic procedures or consultations with specialists ordered by the admitting physician exceeded those required to determine actual need for hospitalization and also provided that the applicant was not admitted on the same day that his 10–P–10 examination occurred;

(*b*) When necessary, because of unavailability of a bed, the 14-day limitation was to be exceeded provided that there was an intent to place the patient in bed occupancy status within 30 days. If at the end of 30 days, however, no bed was available for the patient, he was to be retained on the PBC rolls for an additional 15 days;

(*c*) If during the PBC period it was determined that hospitalization was not necessary, the scheduled admission could be canceled.

Table 1 compares the 32 general hospitals [1] in the PBC admission study showing the PBC admission rates during fiscal year 1965 and during the study period, and the net change during the study period as compared with fiscal year 1965. The table shows that during the first 5 months of the study period (October through February), largely because of the use of the test procedures, the PBC rate at the selected study hospitals tripled. On a monthly basis this was even more pronounced (see table 2). The "rippling" effect of the test was also felt by all 123 VA general hospitals, whose rate increased from 2.5 to 3.8 (table 1). There was a considerable amount of variation among the 32 hospitals insofar as the percentage increases or decreases in PBC activity were concerned. This was due in part to the fact that (*a*) not all of the stations were engaged in the test procedure prior to December 20; (*b*) stations in the study responded to the study procedure with differing degrees of implementation; (*c*) the extent to which PBC can be used differs among stations (cf. tables 3 through 7); and (*d*) some stations received special attention and stimulation from central office and the House Veterans Affairs Committee (see attachment 8). It is noted that while there was an increase in PBC activity at the study stations, from 2.7 percent to 8.1 percent of admissions (October through February), some study hospitals actually showed a decline, whereas others (like Brooklyn and Minneapolis) showed a tremendous increase.

Table 2 shows the monthly and cumulative results of these tests at all 32 general hospitals in the study.

Prior to the tests, the PBC rate for all general hospitals tended to be consistent ranging from 2.1 to 2.2 percent. The effect of instituting the test at the 12 study stations in October is shown by the fact the overall rate increased about 50 percent to 3.3. Since that date, it is

[1] The Baltimore TB hospital and the Tuskegee NP hospital are not included in this table since the PBC program has limited application at stations of these types.

obvious that steady progress has been made among the 32 general hospitals as the result of the test procedures.

There has been some question as to whether these test procedures save any patient days at the hospitals. This will have to be determined by means of follow-up study. It should be noted that PBC is but one of many factors that affect length-of-stay. The study team found that at some stations the use of PBC did apparently contribute to reducing length-of-stay.

2. *Visits to selected study hospitals.*—As indicated above, 12 VA hospitals were visited by the study team (Protocol—par. D3). A summary of the questions directed to these 12 stations and the answers provided by the field station personnel is shown in attachment 9.

It was observed that, at the stations with high PBC rates, the program was supported by top management staff and the program had the enthusiastic cooperation of all staff elements especially the chiefs of outpatient service (who at some stations review each application to determine suitability for PBC) and the chiefs of staff. At the stations with low occupancy rates the program received little consideration from the staff; top management provided no direction and felt that this situation was justified in view of what they considered to be a lack of aggressive leadership from central office in support of this program. Some stations attributed their low rate to the fact that they had empty beds, and that they had to cope with the supposition that a high occupancy rate was required by central office to insure strong budget support. Teaching hospitals with low rates tended to exhibit loose supervision over their residency programs. There was some feeling that if central office was really interested in this program, it would have provided meaningful financial support.

3. *Results of questionnaire—Survey.*—As indicated above, the 34 study hospitals were asked to provide individual data on a maximum of 200 admissions, exclusive of transfers (Protocol—paragraph D2).

Tables 3 through 14 show the results of this survey.

Table 3 is a summary of the reasons given by the stations for considering patients as "suitable" and "unsuitable" for PBC and for not placing "suitable" patients on PBC. The data are listed in separate columns to show the variation among the hospitals which are high users of PBC, average users and low users. The major groups of patients who were considered to be unsuitable for PBC were emergency cases and cases requiring immediate hospitalization; appropriately, two-thirds of the unsuitable patients fell into this category. Among the low users of PBC, the hospitals engaged in the test procedures reported a much lower percent in the emergency and immediate hospitalization category than those not in the test (58.1 as compared with 71.3).

Another important reason, accounting for approximately 11 percent of the patients as unsuitable, was distance of the patients' residence from the admitting hospital. It is interesting that, among stations with high use rates, distance was a factor of unsuitability for slightly more than 4 percent of all patients whereas among the hospitals with average and low use rates, this reason accounted for 10 to 16 percent of all patients.

Another important reason for not accepting patients on PBC was the fact that almost 10 percent of the admissions wer from PHC

status. Patients in PHC status of course are already receiving care on an outpatient basis. Therefore, there is no reason to place them in PBC status. The table also shows that among the low-use stations, the major reasons for not placing suitable patients into PBC were the availability of beds for immediate hospitalization and the preference of the physician.

The table indicates that if all patients judged suitable for PBC were placed on PBC, the rate of PBC admissions could be as high as follows:

	Percent
High PBC use hospitals	10. 6
Average PBC use hospitals	5. 1
Low PBC use hospitals:	
Not testing procedural change	8. 5
Testing procedural change	13. 2

In addition if distance is not considered as it is in this table, to be a factor of unsuitability for PBC then the percent of those suitable would be even higher as follows:

	Percent
High PBC use hospitals	15. 1
Average PBC use hospitals	20. 6
Low PBC use hospitals:	
Not testing procedural change	18. 6
Testing procedural change	27. 0

Tables 4, 5, 6, and 7 provide further detail concerning the information in table 3, on an individual hospital basis. These data indicate that there are difference among the individual stations concerning the types of admissions and that for this reason some hospitals cannot have a high PBC rate while others can accomplish a significantly higher rate than at present. However, even among those stations at which the PBC program appears to be impossible (e.g., the Hines Hospital where 99 percent of the admissions were classed as emergency or requiring immediate hospitalization or psychiatric) there is evidence that a PBC program can be instituted by changing the ground rules and encouraging the station to perform PBC on the same day as and immediately following the 10–P–10 examination (thus the Hines Hospital when placed into the test succeeded in raising its PBC rate to 11 percent (see table 2)).

Concerning the patients' attitude toward PBC, table 8 shows that PBC is generally accepted by patients at all stations. Concerning all study patients at the 34 hospitals, only 2 percent indicated that the program was not acceptable.

Table 9 shows the employment status of the patients in the study group. Approximately two-thirds of all these VA patients were not employed. As expected, there was a larger proportion of employed patients at the stations with high PBC rates than at the stations with lower rates.

Table 10 shows the distance of patients' residence from hospital. As expected, hospitals with high PBC rates served a larger proportion of patients living within 10 miles of the hospital and also a larger proportion of patients living within 20 miles of the hospital than did the stations with low or average PBC rates. At the hospitals with low or average PBC rates, over one-half of the patients lived more than 20 miles distant from the hospital.

Table 11 shows the marital status of the study patients. There was no significant difference in marital status among patients at hospitals with high, average, or low PBC rates.

Table 12 shows the eligibility status of the study patients. Again, there was no distinguishable difference concerning this item among the hospitals with high, average, or low PBC rates.

Table 13 shows the bed services to which patients were assigned. Hospitals with high PBC use rates assigned a larger proportion of PBC patients to surgical beds and a smaller proportion to medical beds in comparison with hospitals having average or low PBC rates.

Table 14 shows the age distribution of patients in the study. There appears to be a somewhat higher proportion of patients age 65 and over at hospitals with average and low PBC rates as compared with hospitals having high PBC rates.

(*b*) *Post-hospital-care program*

The 34 hospitals in the study each reviewed 200 consecutive discharges which occurred prior to September 30, 1965, to determine the number and percent placed on PHC and the number requiring medication for (*a*) less than 30 days and (*b*) 30 days or more. In addition these hospitals were asked to provide data on the number of patients readmitted to hospital within 48 hours following their discharge during September 1965.

Table 15 indicates that all of the study hospitals made a substantial use of PHC, the average rate being 46.7 percent of all hospital discharges. Patients on PHC ranged from 23 percent at Sioux Falls to 75.5 percent at St. Louis. Affiliated hospitals had a higher rate (54.4 percent) than nonaffiliated hospitals (37 percent). A sizable portion of the patients on PHC—62.1 percent—were described as requiring medication (about one-half of this group required medication in excess of 30 days). The group requiring medication ranged from 21.5 percent of the PHC cases at San Francisco to 100 percent at several hospitals.

Table 16 shows the number of patients discharged from bed status and readmitted to bed status within 48 hours following discharge, during September 1965. Only 2 percent of all discharges at the study hospitals fell within this category. However, at certain stations—Minneapolis, West Roxbury, Grand Island, and White River Junction—the percent ranged from 5.7 to 14.7.

The indication is that the PHC generally is being effectively used at all the study hospitals, but that medication requirements imposed a major problem.

6. ALTERNATIVES FOR ACTION CONCERNING THE PBC PROGRAM

A number of alternatives concerning the PBC program are provided for consideration. They are:

Alternative 1. Do not change the law but revise present manual instructions to incorporate special procedures as follows:

1. Applicants will be placed in the PBC program when the following three criteria are met:

(*a*) As a result of the 10–P–10 examination, and the routine one or two tests as part of this examination, it has been established that the patient is eligible for and requires

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hospitalization (based further on the supposition than when in doubt as to whether the patient requires hospital care, the patient will be given the benefit of the doubt),

(*b*) the patient can reasonably be expected to be admitted within 30 days of the 10–P–10 examination or recall from the waiting list (this period may be extended for 15 additional days if the scheduled bed is not available), and

(*c*) that there is need for further workup either for substantiation of the diagnosis or in preparation for the admission, and such workup can be accomplished prior to the scheduled admission.

2. The applicant for admission will not be placed in the PBC program if he is admitted on the same day that his 10–P–10 examination occurs.

3. Frequently, the VA facility will provide most or all of the PBC work (such as laboratory work, X-ray, EKG's, EEG's, consultations, dental examinations, etc.) on the same day that the 10–P–10 examination is done. Where this is not possible, or where necessary, the patient will be recalled for further tests, examinations, or consultations.

4. If during the PBC period it is determined that hospitalization is not necessary the scheduled admission may be canceled.

Comment. This alternative is essentially the same as the present study test procedure, except that it eliminates the phrase "* * * provided that the laboratory, X-ray, other diagnostic procedures or consultations with specialists ordered by the admitting physician exceed those required to determine actual need for hospitalization * * *." Adoption of the alternative is expected to result in a PBC admission rate in excess of 10 percent (the average experience of 32 test stations during the third quarter of fiscal year 1966) among the VA general hospitals. A copy of a proposed implementing station instruction that can be used to put this alternative into effect (based on one currently in use at a study hospital) is shown in attachment 10.

Alternative 2. Make no change in the present law or procedural instructions but seek to police the program through the method of individual station audit and insist that all patients who are suitable for PBC be placed in the program regardless whether beds are available. The indication (see table 3 through 7) is that the current overall PBC rate could at least be doubled if the policing were effective.

Comment. This alternative would require a large expenditure of time and effort by the SAFO's who would be required to proceed on an individual hospital basis. Such effort has proved ineffective in the past, and it is questionable whether any significant change in statistics or program would result from the adoption of this alternative.

Alternative 3. Make no change in the law or present procedure but permit the stations full latitude to use the program as they see fit.

Comment. This alternative may not satisfy the House Veterans' Affairs Committee in view of their letter of July 16, 1965, which asked that this program be implemented to its fullest extent. However, it would satisfy some VA hospital directors who feel that the program should not be forced upon them, especially when beds are available for the immediate hospitalization of patients; it would also satisfy some ward physicians and residents who prefer to have the patients in bed for their workup.

Alternative 4. Repeal that part of Public Law 86–639 which authorizes PBC.

Comment. Since PBC is administered primarily by the outpatient service but treatment is conducted on the inpatient wards, the system does not permit continuity of care by the same physician and therefore may not be serving the purpose for which it was intended—making VA care comparable with the care administered to patients in private practice. However, it is doubtful that this alternative would satisfy either the House Veterans' Affairs Committee or those VA hospital directors who do make effective use of PBC.

Alternative 5. Rewrite the law in accordance with H.R. 7965, 86th Congress, which was the original bill relating to PBC, to read as follows:

> The Administrator may also furnish medical services for a non-service-connected disability under the following circumstances:
>
> (f)(1) Where such care is reasonably necessary in preparation for admission of a veteran for hospital care, or where such care is reasonably necessary in determining whether or not hospital care is needed.

Comment. This would eliminate a number of problems of interpretation at the station level and include as PBC a certain amount of patient workup and outpatient treatment which is currently being done and for which the stations may be getting no credit.

There is a sizable number of applicants whose requirement for hospitalization cannot definitely be determined after routine examination. This group frequently requires extensive workup and recalls for consultation to confirm or rule out findings and to determine severity of the condition. From a realistic point of view, such procedures frequently go beyond the need to determine hospital care and constitute workup or treatment. In fact some hospitals, where the bed occupancy rate is low, actually admit such patients for this purpose.

The objection to this alternative in the past has been that its adoption would constitute an extension of outpatient services to non-service-connected cases, beyond the present mission of the Department. The American Medical Association and the Bureau of the Budget, among others, may be opposed to this alternative. However, if the change in law resulting from this alternative were adequately policed by the Veterans' Administration to prevent abuse, it is likely that the adoption of this alternative would enable the Veterans' Administration to parallel more exactly the procedures found in private medicine.

7. RECOMMENDATIONS

The Committee recommends:

(*a*) The adoption of alternative 1 (paragraph 6 above) in regard to the PBC program and the establishment of a small PBC–PHC Review Committee, composed of representatives from the offices of the SAFO's, who would be provided with monthly consultation by the D.M. & S. Reports and Statistics Service (which would provide information on an "exception basis").

(*b*) The continuation of the PHC program as it now exists but with the further development of standard station practices concerning drug usage and allowances.

(*c*) The development of PBC and PHC as separate line items in the station budget justifications with funds being specifically earmarked for these programs.

(*d*) That since the level of the demand and the use of these programs is determined primarily by individual hospital policies, the hospitals give primary consideration to the convenience of the veteran in using these programs. It is the Committee's impression that in some instances the PBC program is not being fully used because of inconvenience to the hospital staff.

(*e*) A "public relations" approach selling PBC be carried out among the VA hospital staffs. Such an approach is not required among veteran patients or veteran organizations since the latter appear to support the PBC–PHC programs.

(*f*) The chiefs of outpatient service and chiefs of staff be encouraged to develop close working relationships concerning acceptability of the PBC program, and that organizationally the chief of outpatient service be made responsible for reviewing (personally wherever possible) the record of examination of each applicant for hospital care to determine his suitability for PBC care and placement on PBC status.

Attachment 1

Study for Evaluation of Use of Prebed Care and Posthospital Care Programs

protocol

A. Purpose

To survey selected hospitals for the purpose of obtaining data which will aid in evaluating the use of the prebed and posthospital care programs.

Specifically, the following:

1. Recommendations for future D.M. & S. position in the PBC and PHC programs.
2. Identification of the PBC potential including a realistic identification of the point in the examining procedure past which PBC may be rationally identified.
3. Recommendations on the relation between level of demand and the use of these programs.
4. Recommendations concerning the values of a "public relations" program to solicit the assistance of veterans organizations in overcoming potential patient resistance.
5. Recommendations concerning internal hospital organization and procedure for PBC and PHC.
6. Hospital resources necessary for these programs.

B. Questions for study

1. *Questions relating to patient aspects.*—

(*a*) Analysis of the hospital's admission load to determine the proportion of patients suitable for inclusion in the program, i.e., identification of types of applicants (e.g., diagnostic categories) and effects of seasonal changes in demand.

(*b*) Hardship, i.e., travel to hospital, convenience and availability of transportation, time required for travel, distance, time off from work, age and ambulatory status.

(*c*) Attitude of veterans and service organizations.

2. *Questions relating to professional aspects.*—

(*a*) Appropriateness of present policy relating to PBC and PHC.

(*b*) Local implementation of policy by top management, chiefs of staffs, chiefs of services, admitting physicians (outpatient), residents.

(*c*) Impact of medical school relationship to the program.

(*d*) Adequacy of staffing, i.e., physicians, nurses, technicians and clerical personnel.

(*e*) Essentiality of coordination in regard to continuity of care, i.e., avoidance of unnecessary repetition.

(*f*) Suitability of procedures (e.g., routine blood tests, X-rays, etc.)—relationship of 10–P–10 examination to PBC.

3. *Questions relating to administrative aspects.*—

(*a*) Relationship of ADPL, length of stay, cost per patient treated and demand (eligibility rates and waiting lists) to PBC experience.

(*b*) Budgetary credit for PBC workload.

(*c*) Impact of present administrative restrictions, e.g., time limitations and commitment towards admission.

(*d*) Physical layout, i.e., adequacy of number of examining rooms, adjustment of space if necessary, administrative-patient flow.

(*e*) Impact of the internal hospital organization.

(*f*) Impact of scheduling and coordination, i.e., operating room, laboratory X-ray, etc.

(*g*) Effect of centralization of clinical activity versus dispersed clinical activity.

C. Background

1. *Law.*—

Public Law 86–639, July 12, 1960, provided that the VA Administrator could furnish medical care for a non-service-connected disability "where such care is reasonably necessary in preparation for admission of a veteran who has been determined to need hospital care and who has been scheduled for admission", and "where a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care."

2. *Statistical experience.*—

Fiscal year	Admissions from PBC		Discharges to PHC	
	Number	Percent of all admissions	Number	Percent of all regular discharges
1962	9,798	1.7	212,858	43.9
1963	22,478	3.8	225,459	47.1
1964	18,283	3.0	243,801	48.5
1965	14,767	2.5	[1] 237,039	47.3

[1] This number would have been approximately 248,000 (estimate) had the requirement that patients be readmitted to hospital after 1 year in PHC status in order to continue their PHC status not been rescinded.

3. *Implementation.*—The PBC program, operating at 2.5 per 100 admissions to hospital in fiscal year 1965, has not achieved the level anticipated by the Veterans' Administration or the Congress. The PHC program has been more fully implemented to the point where almost one-half of all regular discharges from the VA hospitals are participating in the program.

D. Methodology

The memorandum of the Associate Deputy Chief Medical Director to the Chief Medical Director, subject: Use of pre- and post-hospital care programs by VA hospitals, dated July 29, 1965, provides for two methods of study (1) purposive and (2) randon.

The method of study selected here is purposive, since it is believed that a selection of stations known to have particular problems and stations that have developed particular solutions can more definitely contribute to the data and knowledge required for the accomplishment of study goals than stations selected on a random basis.

1. Certain revisions in procedure concerning the PHC program are being proposed by the Director of Clinics. The effect of these revisions will be tested as a pilot study by the project team. The following hospitals have been selected for such study:

Hospital	Number of operating beds, June 30, 1965	Admissions from PBC, fiscal year 1965
Affiliated:		
Baltimore (TB)	291	0
Boston	842	.1
Brooklyn	1,000	.7
Minneapolis	1,014	0
Pittsburgh (general)	703	0
St. Louis	513	.5
San Francisco	415	1.5
Nonaffiliated:		
Amarillo	156	.2
Beckley	196	.5
Dublin	500	.6
Grand Island	201	.1
Marion, Ill	184	0
Tuskegee (psychiatric)	1,789	0
White River Junction	188	.5

The above hospitals are all characterized by low PBC usage. They include both heavily populated and sparsely populated areas, and varying bed and patient loads.

The pilot study will be implemented by a proposed circular which sets forth the revisions. The proposed revisions are explained in Exhibit I.

2. A questionnaire will be sent to the above 14 hospitals, to the 12 hospitals listed in paragraph 3 below and to the following hospitals, i.e., "average" users of the PBC program.[1] See Exhibit II.

Hospital	Number of operating beds, June 30, 1965	Percent of admissions from PBC, fiscal year 1965
Affiliated:		
Houston	1,242	2.4
Madison	475	2.4
Omaha	486	2.6
West Roxbury	300	2.9
Nonaffiliated:		
Columbia	586	2.2
Martinez	498	3.2
Sioux Falls	270	2.4
Tucson	361	2.7

The questionnaire will be completed by each study hospital prospectively for 200 consecutive admissions, exclusive of transfers, or for all admissions within a specified 30-day period, whichever occurs first. It is expected that the results of the questionnaire will provide information concerning the proportions of patients who could be placed on PBC, should be placed on PBC, and are placed on PBC. Information will also be provided on particular station and patient problems in the application of the PBC program. Where the findings resulting from the questionnaire differ markedly from past station experience, the stations will be asked to explain the reasons therefor.

In addition, each study hospital will be asked to survey 200 consecutive discharges, occurring prior to a selected date, and report the numbers of such discharges who were placed on PHC and, concerning this latter group, the number who required medications for (a) less than 30 days and (b) more than 30 days. Also the length of stay of these patients will be reviewed to assure compliance with DM&S Circular 10–64–110.

[1] Thirty-three different hospitals will be engaged in the study. The VA hospital Brooklyn is listed in both paragraphs 1 and 3.

3. The project team will visit the following hospitals:

Hospital	Number of operating beds, June 30, 1965	Percent of admissions from PBC, fiscal year 1965
High users:		
Altoona	200	5.2
Chicago (West Side) [1]	505	7.7
Coral Gables [1]	450	6.3
Dearborn [1]	846	4.4
Fresno	250	8.0
New York [1]	1,218	12.6
Low users:		
Brooklyn [1]	1,000	.7
Buffalo [1]	951	.2
Erie	204	.1
Denver [1]	528	1.2
Hines [1]	2,079	2.0
Phoenix	192	.9

[1] Affiliated.

These hospitals with some exceptions were selected and paired on the basis of high and low PBC usage, number of operating beds, affiliation status, and metropolitan populations, as follows:

Low	*High*
Brooklyn*	New York*
Erie	Altoona
Hines*	Chicago (WS)*
Phoenix	Fresno
Buffalo*	Dearborn*
Denver*	Coral Gables*

*Affiliated.

These stations will be queried by the project team on the basis of the checklist shown in exhibit III to enable the team to develop an understanding of the environment, organizational structure, problems, and staff attitudes which affect PBC and PHC program usage; in other words an analysis of the conditions which must be understood and overcome if the PBC and PHC programs are to be used to their maximum potential.

E. Analyses and conclusions

Appropriate analyses will be made of the data referred to above. Conclusions developed from the analyses will be used to develop the recommendations required by paragraph 6 of the Associate Deputy Chief Medical Director's memorandum, subject: Use of Pre- and Post-Hospital-Care Programs by VA Hospitals, dated August 25, 1965.

ATTACHMENT 2

PUBLIC LAW 86–639

"(f) The Administrator may also furnish medical services for a non-service-connected disability under the following circumstances:

"(1) Where such care is reasonably necessary in preparation for admission of a veteran who has been determined to need hospital care and who has been scheduled for admission.

"(2) Where a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care."

ATTACHMENT 3

Station

1. What type of organization does O/P service have?
2. Where is PBC and PHC done?
3. Who is in charge of these programs? Who controls them?
4. Are clinics centralized or dispersed?
5. What are the physical facilities and layout like? Is there sufficient space?
6. What is staffing pattern in PBC and PHC (*a*) doctors, (*b*) nurses, R.N., (*c*) nurses' aids, (*d*) secretarial help, (*e*) registrar help?
7. Is a bed service physician (in medicine, surgery, etc.) called for consultation in PBC program, or is it all handled by the O/P physician?
8. What has been the impact on laboratory or radiology? Have they complained about extra work?
9. What are the criteria for admission to PBC? For PHC?
10. Are patients scheduled for the operating room prior to admission, if they are in the PBC program?
11. If scheduled prior to admission, are they operated upon when scheduled or delayed for further tests?
12. Method of scheduling? Who schedules procedure (PBC and PHC)?
13. What is the demand? Turnover rates by type? The average waiting list by type? Have active clinics affected the waiting list? What is the effect on ADPL? On length of stay?
14. Are clinics held at predesignated times? Where? How many times per week?
15. How are patients' visits recorded and who does it?
16. What is the effect of affiliation and residents? Are they used in the program?
17. What is the effect without residents?
18. What has been the reaction, if any, of patients to this program? Other groups, if any?
19. How many patients scheduled for PBC do not return for tests?
20. How many patients scheduled for PHC do not return for treatment?
21. Follow a case actively through the procedure.
22. Review the last 10 cases for procedure and follow through on what happens after admission.
23. What are the problems? Query the—
    (*a*) Admitting physician.
    (*b*) Service chiefs (medicine, surgery, etc.).
    (*c*) Chief of staff.
    (*d*) Director.
    (*e*) Registrar.
24. Are they identifying the PBC program? Are all 10–P–10's put in PBC program which have more than ordinary procedures to determine need for hospitalization? Are there any routine rules for this? What is the problem? Is it the 14-day limitation on admitting time? Or other?
25. Are there any hospital bulletins or orientation to the program?
26. Does staff go along with PBC? PHC? If not, why not?
27. Does chief of staff back up program and support it—and sell it to the staff? How many meetings in the past 6 weeks re these programs?
28. Does management support this program in funding? If not, why not?
29. Opinion of investigator:
    Why is this program active; or why is this program inactive at this hospital?

ATTACHMENT 4

CIRCULAR 10–65–285

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., October 13, 1965.

Subject: Nonrecurring report, RCS 10–95–658, pre-bed-care status of patients admitted to VA hospitals, VA form 10–20290(NR), and post-hospital-care data.

To: Staff assistants to the chief medical director, and directors of selected hospitals.

1. Central office is conducting a special study of the use of pre-bed-care and post-hospital-care programs. Your station has been selected to participate in this study.

2. Concerning prebed care, you will complete one copy of VA form 10–20290(NR) for either (*a*) or (*b*) below, whichever occurs first:

(*a*) Two hundred consecutive admissions, exclusive of transfers; or

(*b*) All admissions, exclusive of transfers, within the 30-day period, October 18, through November 16, 1965.

Since parts of this report will be processed by automation, uniform entries will be necessary. The following are examples of the block entries for dates and diagnostic codes.

Question 2: Year of birth (1899) /9/9/

Question 3: Date of admission to hospital (September 12, 1965) /0/9/1/2/6/5/

Question 7: Admission diagnoses:

(1) Hernia, inguinal, direct /0/5/6/0/0/

A supply of forms is being forwarded to your station by first-class mail for this purpose.

(Circular expires February 28, 1966.)

3. Concerning posthospital care (formerly referred to as CBOC), you will survey the last 200 consecutive discharges prior to September 30, 1965, and report:

(*a*) The number of such patients who were placed on PHC.

(*b*) Of those placed on PHC, the number who required medication for:

(1) Less than 30 days;

(2) Thirty days or more.

4. Also furnish a list of all patients who were readmitted to your hospital during the period September 1 through September 30, as bed occupants from PHC status who, following such readmission were discharged again within 48 hours to PHC status. Identify each such patient by unit number and cite the reasons for his readmission.

5. The data requested in paragraphs 3 and 4 will be typed on letter-size white bond paper, identified by the name and address of the reporting station and the reports control symbol shown in the subject of this circular.

6. The completed forms, requested in paragraph 2, and the data requested in paragraphs 3 and 4 will be forwarded to reach central office (10F812) as soon as possible but not later than November 22, 1965.

By direction of the chief medical director:

M. J. MUSSER, M.D.,
Deputy Chief Medical Director.

PRE-BED-CARE STATUS OF PATIENTS ADMITTED TO VA HOSPITALS

REPORTS CONTROL SYMBOL—10–95–65S

Name of hospital (7-digit station number).

1. Patient's unit number _____

2. Year of birth: Month _____ Day _____ Year _____

3. Date of admission to hospital:

4. Approximate distance of patient's residence to hospital: Less than 10 miles (1) ____; 10 to 19 miles (2) ____; 20 miles or more (3) _____.

5. Marital status: Single (1) ____; Married (2) ____; Widowed (3) ____; Divorced (4) _____.

6. Eligibility status: SC (1) ____; SC with NSC (2) ____; NSC (3) _____.

7. Admission diagnoses (enter description and ICDA code):
(1) ----------
(2) ----------
(3) ----------
(4) ----------
(5) ----------
(6) ----------

8. Service to which patient is assigned for bed care: Surgical (1) ____; Medical (2) ____; Other (3) ____ Specify.

9.* Was patient suitable for placement on PBC? Yes (1) ____; No (2) ____.

10.* If patient was not suitable for placement on PBC, explain:

11.* If patient was suitable for placement on PBC, was he placed on PBC? Yes (1) ____; No (2) ____.

12.* If patient was suitable for placement on PBC but was not placed on PBC, explain why not placed:

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13. Was patient actively employed at time of admission? Yes (1) ____; No (2) ____.

14. If patient was placed on PBC, what was his attitude toward PBC program? Acceptable (1) ____; Not acceptable (2) ____.

15. If patient's attitude toward PBC program was not acceptable, explain:

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*These questions will be completed by the chief of staff.

(VA form 10-20290 (NR), October 1965.)

ATTACHMENT 5

OCTOBER 1, 1965.

Veterans' Administration, Central Office.
Staff assistants to the Chief Medical Director; directors of selected VA hospitals.
D.M. & S. Circular 10-65-281—Study of PBC Program.

Studies of the PBC program lead to the conclusion that there is a significant amount of activity now being classified purely as admission determination activity which could properly be classified as PBC activity. There appears to be a point in our admission examining procedure beyond which PBC may be rationally identified.

URSTA has been selected to participate in a test procedure for the purpose of attempting to identify this activity. Effective October 1, 1965, and continuing until further advised, admission applicants at URSTA will be placed in the PBC program when any of the following conditions exist:

(*a*) When the laboratory, X-ray, other diagnostic procedures, or consultation with specialists ordered by the admitting physician exceed those required to determine actual need for hospitalization;

(*b*) When the need for hospitalization is not determined during the initial visit. In such cases the policy of resolving doubt in favor of the veteran will be applied. Therefore, he will be automatically scheduled for admission and placed on PBC status for necessary further outpatient appointments, when necessary because of unavailability of a bed, the 14-day limitation imposed by paragraph 17.09A(3), M-1, part I, may be exceeded. This procedure will eliminate any pending file of applications awaiting medical determination of need for hospitalization. If during the PBC period it is determined that hospitalization is not necessary the scheduled admission will be canceled;

(*c*) When an application is approved and admission is deferred to a later date for any reason and it is contemplated that the patient will be seen again by a physician prior to admission.

In these cases the veteran will be placed on PBC status at the time he is scheduled for admission.

This circular expires March 31, 1966 (136A/10).

Signed and dispatched October 1, 1965, 12:25 p.m.—Communications and Records, D.M. & S.

ATTACHMENT 6

OCTOBER 26, 1965.

Veterans' Administration, Central Office.
Staff assistants to the Chief Medical Director; directors of selected VA hospitals.
D.M. & S. Circular 10–65–299—Revision of study of PBC program.

D.M. & S. Circular 10–65–281 provides for a study of the PBC program by a group of selected stations. The provisions of Circular 10–65–281 will be applied through October 31. Thereafter, the following study procedure will be observed. Effective November 1, 1965, and continuing until further advised, admission applicants at URSTA will be placed in the PBC program when the laboratory, X–ray, other diagnostic procedures, or consultations with specialist ordered by the admitting physician exceed those required to determine actual need for hospitalization. When necessary because of unavailability of a bed, the 14-day limitation imposed by paragraph 17.09A(3), M–1, part I, may be exceeded. If during the PBC period it is determined that hospitalization is not necessary the scheduled admission may be canceled.

Circular 10–65–281 is rescinded effective November 1, 1965.

This circular expires April 30, 1966 (10F81/10).

(Signed and dispatched October 26, 1965, 10:32 a.m.—Communications and Records, D. M. & S.)

ATTACHMENT 7

DECEMBER 20, 1965.

Veterans' Administration, Central Office.
Directors of selected VA hospitals.
D.M. & S. Circular 10–65–352—Revision of Study of PBC Program.

Your station has been participating in a study of the PBC program. Effective immediately for purposes of this study, and continuing until further advised, admission applicants at your station will be placed in the PBC program on the same day that the 10–P–10 examination occurs, provided that the laboratory, X-ray, other diagnostic procedures, or consultations with specialists ordered by the admitting physician exceed those required to determine actual need for hospitalization, and also provided that the applicant is not admitted on the same day that his 10–P–10 examination occurs. When necessary because of unavailability of a bed, the 14-day limitation imposed by paragraph 17.09A(3), M–1, part I, may be exceeded provided there is an intent to place the patient in bed occupancy status within 30 days. If at the end of 30 days, however, no bed is available for the patient, he may be retained on the PBC rolls for an additional 15 days. Note that the foregoing study procedure permits your station to do PBC workup (e.g., chest X-ray, dental examination) on the same day that the 10–P–10 examination occurs. In such cases there will be only one outpatient routing list, VA form 10–2875, prepared for each applicant and the purpose of visit (item F) to be checked will be purpose 3, 10–P–10. An additional entry, however, will be made in item H, routing, on the last line (code 53) where both the letters PBC and a checkmark will be entered. If during the PBC period it is determined that hospitalization is not necessary the scheduled admission may be canceled.

Circular 10–65–299 is rescinded.

This circular expires May 31, 1966 (10F812/10A).

(Signed and dispatched December 20, 1965, 3:09 p.m.—Communications and Records, D.M. & S.).

ATTACHMENT 8

WASHINGTON, D.C., *February 23, 1966.*

DIRECTOR,
Veterans' Hospital,
Dearborn, Mich.:

Chief Medical Director has advised me of your percentage of patients admitted for PBC care July through January. Please advise at once what steps you are taking at your station to increase your participation in this program and at least equal national average of 32 selected general hospitals.

OLIN E. TEAGUE,
Chairman, Veterans' Affairs Committee.

Attachment 9

Questions and Answers Concerning Field Station Visits

1. What type of organization does the outpatient service have?

The type of organization does not appear to be a factor in the use of PBC and PHC.

2. Where is PBC and PHC done?

Not a factor.

3. Who is in charge of these programs? Who controls them?

Generally, the chief of outpatient service and his admitting physician staff is in charge of the PBC and PHC programs, although the latter is under the actual control of the ward staff. The organizational setup does not appear to be a determining factor.

4. Are clinics centralized or dispersed?

Not a problem. In general most clinics are centralized.

5. What are the physical facilities and layout like? Is there sufficient space?

Generally space and facilities were adequate or fairly adequate at most of the hospitals. VAH Denver, a low PBC user, and VAH Dearborn a high PBC user were exceptions to this rule.

6. What is staffing pattern in PBC and PHC?

Staffing differences did not appear to vary greatly between low and high users, although there were slightly more physicians available for PBC among the high PBC stations.

7. Is a bed service physician (in medicine, surgery, etc.) called for consultation in PBC program or is it all handled by the outpatient physician?

Inmost cases the admitting physician handled the PBC, calling for consultation (mostly in surgery cases) as required.

8. What has been the impact on laboratory or radiology? Have they complained about extra work?

There appear to be no problems except at VAH Chicago (W.S.) (a high PBC station) and at VAH Brooklyn (a low PBC user).

9. What are the criteria for admission to PBC?

Agreed upon criteria for admission to PBC are that veterans (*a*) live within easy and cheap commuting distance, (*b*) be nonemergent cases (preferably elective surgery), and (*c*) be reasonably ambulatory. Low PBC users generally believed that the program was mainly applicable to stations with high turnover and high bed-occupancy rates.

10. Are patients scheduled for the operating room prior to admission, if they are in the PBC program?

Generally no. There is no set pattern for either the high or low PBC groups.

11. If scheduled prior to admission are they operated upon when scheduled or delayed for further tests?

Generally no for high PBC group but yes for low PBC group.

12. What is the method of scheduling? Who schedules the PBC and PHC procedures?

PBC is generally scheduled by the outpatient service or by the registrar. PHC is generally scheduled by the ward physicians or residents.

13. What is the demand? Turnover rates by type? The average waiting list by type? Have active clinics affected the waiting list? What is the effect on ADPL? On length of stay?

Statistically, there appears to be no definite relationship between use of the PBC and PHC outpatient programs and demand, turnover, waiting lists, bed occupancy, and ADPL. A review of folders did indicate some reduction in length of stay attributable to the PHC program.

14. Are clinics held at predesignated times? Where? How many times per week?

Most stations conduct PBC and PHC activities on a scheduled basis; practically all PBC is done in the outpatient or admitting area; PHC is usually done on the wards or in the outpatient clinic by the ward physician. Schedules vary from once per week to more often for PHC.

15. How are outpatients' visits recorded and who does it?

In the prescribed manner, by use of the outpatient routing list.

16. What is the effect of affiliation and residents? Are they used in the program?

At hospitals with residency programs, it was found that the residents were generally used to provide care for patients in PHC status. However, only

the hospitals with high PBC rates oriented and made use of residents on the PBC program. Contrasting hospitals on this question were VAH New York and VAH Brooklyn. At VAH New York, the residents are oriented at least once each month on an individual basis by an enthusiastic Chief of Outpatient Service and their acceptance of the program is very high. At VAH Brooklyn there was a lack of such orientation and poor liaison between the Chief of Outpatient Service and the ward physicians. We believe that this situation is now remedied.

17. What is the effect without residents?

It is easier to conduct a PBC program without residents since the latter require constant supervision and orientation. PHC programs appear to work well with and without residents.

18. What has been the reaction, if any, of patients to this program? Other groups, if any?

Generally, both programs are well accepted by the patients and the public. A number of patients on PBC were interviewed. Almost all preferred the program with the most notable exceptions being two patients at VAH Hines, one of whom complained of the high transportation cost from Chicago to Hines and the other who complained about being kept out of a bed when he required bed treatment.

19. How many patients scheduled for PBC do not return for tests?

20. How many patients scheduled for PHC do not return for treatment?

Almost all patients in the PBC–PHC programs observe the scheduling requirements in these programs, with the exception of VAH Chicago (West Side) and VAH New York where one-third or more of those scheduled for PHC treatment fail to report.

21. Follow a case actively through the procedure.

22. Review the last 10 cases for procedure and follow through on what happens after admission.

In most cases where PBC and PHC were utilized, there was an indication of some reduction in length of stay. In a number of cases, the PBC examination requirements could have been used to greater advantage had the work-up tests been spelled out more completely by prearrangement with each service concerning specific types of diagnosis. Generally, tests were not unnecessarily repeated. At VAH Chicago (West Side), however, PBC did not tend to reduce stay since some tests were unnecessarily repeated.

At hospitals with low PBC rates, the uncertain scheduling for elective surgery appeared to be a major problem which contributed to increasing the length of stay. It was also our impression that some of these hospitals were issuing passes to patients excessively thereby contributing to an increased length of stay.

23. What are the problems? Query the: (*a*) Admitting physician.

Problems raised by the chiefs of admitting services generally concerned the need for additional personnel or space. In addition, insofar as PBC was concerned, there were problems concerning the time required to orient residents about the program, and the lack of coordination and weak liaison between the inpatient and outpatient services; affecting this situation seems to be an indication that the physicians assigned to outpatient duties have a somewhat lesser status than those assigned to the inpatient services. Notably, at VAH, New York, where the chief of outpatient service is a personality who demands and commands respect, there is an effective working relationship between the inpatient and outpatient staffs.

(*b*) Chief of medicine.

Problems raised by chiefs of medicine indicated a lack of orientation concerning the PBC program. Most chiefs felt that better workup could be achieved by placing the patient in bed and that PBC was not particularly applicable to medical cases. There was some thought that the use of PBC would result in an increase rather than a decrease in the length of stay where hospital staffs were insufficient to provide properly for both PBC and inpatient care. It was felt that PBC, since it was accomplished by the admitting rather than the treating service, could result in some unnecessary workup procedures and that residents resented PBC because of its interference with their treatment of bed patients. Also, in hospitals having large proportions of emergencies, PBC had limited application. One chief felt very strongly that the PBC program was hindered by the fact that the stations were forced to be ADPL conscious.

(*c*) Chief of surgery.

Chiefs of surgery were generally favorable to the PBC program but said that there was a need for direction and coordination by top management to effect good working relationships between the outpatient and surgical services. Some chiefs complained that there was a need for more beds, staff (not only surgeons but supporting laboratory and radiology staff), and operating rooms in order to make PBC effective, since the program applied only to elective cases, and it was very difficult to schedule elective surgery under overcrowded conditions. Several chiefs stressed that there was a need to eliminate the 14-day limitation since elective cases could not always be scheduled within that time. Some chiefs felt that the program was applicable primarily to stations with high bed occupancy, high waiting lists and high turnover. One chief felt that the program could not work well because most surgeons prefer to conduct their own patients' physical examination and histories. One high PBC station builds its operating room schedule around the PBC program, assuring good working relationships between the outpatient and bed services.

(*d*) Chief of staff.

Chiefs of staff believe that PBC has not been an impressive program because of the failure of higher VA echelons to exert proper emphasis. They believe the program refers primarily to elective surgery and state that there is a problem in scheduling elective surgery into operating rooms that are busy. Also, that the physicians including residents, dislike interference with their regular routines. They believe there is need for better field orientation and staffing concerning this program. Other obstacles listed include the fact that Congress may have been "oversold" as to the program's value, the 14-day limitation on admissions, the need to admit, and distance between the hospital and the patients' home.

(*e*) Director.

Remarks by most directors were noncommital. However, two directors indicated that the need to provide funds through ADPL discouraged stations from using PBC. Another director stressed the need to eliminate the 14-day limitation and the need to admit.

(*f*) Registrar.

Approximately 50 percent of the registrars cited the 14-day limitation as a major problem as well as the need to admit. Others individually cited that (a) there was no real interest on the part of hospital personnel in promoting this program, and (b) the call for additional administrative work required more personnel.

24. Are they identifying the PBC program? Are all 10–P–10's put in PBC program which have more than ordinary procedures to determine need for hospitalization? Are there any routine rules for this? What is the problem? Is it the 14-day limitation on admitting them? Or other?

Summarizing their problems the stations said that there was a need (*a*) for effective leadership and guidance and orientation by higher VA echelons, (*b*) to extend the 14-day limitation, (*c*) to eliminate the absolute requirement of admission, (*d*) to increase staffing, (*e*) to identify PBC work-up which presently is not being counted because it is administered to the patient as part of the 10–P–10 examination subsequent to a determination that the patient requires hospital care, and (*f*) to relate PBC with ADPL or to discount ADPL in the budget process. There is also a need that all 10–P–10's be reviewed by the chief admitting officer to determine whether the patient should be placed on PBC.

25. Are there any hospital bulletins or orientation to the program?

Five of the six stations with high PBC rates had written regulations and orientation concerning PBC. Of the six stations with low rates three had no written instructions at all and one very limited instructions.

26. Does staff go along with PBC and PHC? If not, why not?

All 12 stations indicated an enthusiatic acceptance by staff of PHC. All six stations with high PBC rates indicated acceptance by staff of PBC. The six stations with low PBC rates indicated that their staffs did not favor PBC.

27. Does chief of staff back up program and support it—and sell it to the staff? How many meetings in the past 6 weeks concerning this program?

At most of the stations with high PBC rates the chiefs of staff actively support the program and tend to hold frequent and regular meetings for purposes of support. At the low PBC stations, with the exception of one

station, the chiefs of staff have not indicated any support for PBC and have held no meetings in recent years concerning the subject.

28. Does management support this program in funding? If not, why not?

All the stations visited with the exception of three with low PBC rates indicated that they either do or would support the PBC program budget-wise, although several stations indicated that additional funds are needed for drugs and medicines in regard to PHC. Three stations with low PBC rates indicated that they do support this program, and one of these three stated that support of PBC would take away money from ADPL, despite the fact that ADPL was the key to securing budget funds from central office.

29. Opinion of investigator.

It was observed that at the stations with high PBC rates the program was supported by top management staff and the program had the enthusiastic cooperation of all staff elements especially the chief outpatient service (who at some stations review each application to determine suitability for PBC).

At the stations with low occupancy rates the program received little consideration from the staff; top management provided no direction, and felt that this situation was justified in view of what they considered to be a lack of aggressive leadership from central office in support of this program. Some stations attributed their low rate to the fact that they had empty beds, and a high occupancy rate was required by central office to insure strong budget support. Teaching hospitals with low rates tended to exhibit loose supervision over their residency programs. There was some feeling that if central office was really interested in this program, it would have provided meaningful financial support.

ATTACHMENT 10

VETERANS' ADMINISTRATION HOSPITAL

HOSPITAL MEMORANDUM NO. 136–2

APRIL 27, 1966.

Subject: The pre-bed-care (PBC) program.

1. PURPOSE

This memorandum outlines hospital policy and procedure to be followed with respect to the PBC program when certain medical care is reasonably necessary in preparation for admission of eligible patients to bed occupancy care.

2. POLICY

It is the policy of the VA to do PBC work-up (laboratory, X-ray, EKG, consultation, dental examination, etc.) limited to examinations appropriate to the pending episode of hospital care.

3. RESPONSIBILITIES

The chief, registrar division is responsible for the administrative aspects necessary for reporting and control of the PBC program.

4. PROCEDURES

A. Eligible veterans may be placed in the PBC program by the admitting physician if it has been established that the patient requires hospitalization and the following conditions pertain:

1. Laboratory work, X-rays, diagnostic procedures or other consultations performed by the VA, other than those required for actual admission, pertain to the work-up or treatment of the patient.

2. The patient can reasonably be expected to be admitted or scheduled for admission within 30 days of the date of his initial 10–P–10 examination. These cases may come from the waiting list. Cases transferred from the VA outpatient clinic are eligible for participation in the PBC program.

3. This may be extended for 15 days if the expected bed is not available.

NOTE.—The applicant for admission will not be placed in the PBC program if he is admitted on the same day that his 10–P–10 examination occurs.

B. The foregoing procedure permits our hospital to do PBC work-up on the same day that the 10–P–10 examination occurs, provided that the patient is not admitted on the same day of the 10–P–10 examination. In such cases there will be only one outpatient routing list, VA form 10–2875, prepared for each applicant and the purpose of visit (item F) to be checked will be purpose 3, 10–P–10. An additional entry however, will be made in item H, of the routing list on the last line (code 53) where both the letters PBC and a check mark will be entered. If during the PBC period it is determined that hospitalization is not necessary the scheduled admission may be canceled.

C. The results of all PBC examinations will be incorporated with the basic 10–P–10 and retained in the patients control section until the patient is admitted. Laboratory and radiographic reports will be stapled along the left margin of clinical record forms SF–513 and SF–519 respectively.

D. The patients control section will attach over-printed standard form 507—clinical record continuation sheet (exhibit 1) to the medical certificate of form 10–P–10 when the patient's clinical record is sent to the ward on admission. The continuation sheet will reflect the type of PBC work ordered and the date. The continuation sheet is an integral part of the new clinical record folder developed for the patient on admission. The medical certificate of the form 10–P–10, will also be marked with a rubber stamp reading "PBC case" to alert personnel in the admitting and ward areas.

E. Applications of veterans who receive pre-bed-care treatment of any kind and which are withdrawn thereafter for any reason will be retained in the 10–P–10 reject file in the same manner as other rejected 10–P–10s.

CLINICAL RECORD

Report on _____
or
Continuation of S.F. _____

(Strike out one line) (Specify type of examination or data)

(Sign and date)

PRE-BED-CARE WORK ORDER

(Type and date)

X-ray _____
Lab _____
Consult _____
Other (EKG) _____

Patient's identification (for typed or written entries give: Name, last, first, middle; grade; date; hospital or medical facility.)

Register No. _____
Ward No. _____
Report on _____or continuation of _____

TABLE 1.—*Percent of patients admitted to all VA general hospitals and 32 selected VA hospitals from pre-bed-care status*

VA hospital	Fiscal year 1965	July through February of fiscal year—			October through February of fiscal year—		
		1965	1966	Difference (1966 versus 1965)	1965	1966	Difference (1966 versus 1965)
All general hospitals	2.6	2.7	3.4	0.7	2.5	3.8	1.3
32 selected general hospitals	2.6	2.8	5.7	2.9	2.7	8.1	5.4
Altoona, Pa	5.2	4.9	2.0	−2.9	5.2	3.1	−2.4
Amarillo, Tex	.2	.3	1.6	1.3	----	2.4	2.4
Beckley, W. Va	.5	.3	1.6	1.3	.2	2.4	2.2
Boston, Mass	.1	.2	8.2	8.0	.1	12.8	12.7
Brooklyn, N.Y	.7	.9	22.8	21.9	.4	36.3	35.9
Buffalo, N.Y	.2	.1	2.7	2.6	.2	4.4	4.2
Chicago, Ill. (West Side)	7.7	7.7	8.4	.7	7.9	8.6	.7
Columbia, S.C	2.2	2.0	2.7	.7	2.0	3.2	1.2
Coral Gables, Fla	6.3	8.8	2.5	−6.3	9.6	3.8	−5.8
Dearborn, Mich	4.4	3.7	5.4	1.7	4.2	5.4	1.2
Denver, Colo	1.2	1.1	2.3	1.2	1.2	3.2	2.0
Dublin, Ga	.6	.8	1.2	.4	.6	2.4	1.8
Erie, Pa	.1	.2	.2	----	----	.3	.3
Fresno, Calif	8.0	8.0	7.5	−.5	6.7	7.5	.8
Grand Island, Nebr	.1	.2	3.9	3.7	----	6.4	6.4
Hines, Ill	2.0	2.0	5.3	3.3	1.9	7.8	5.9
Houston, Tex	2.4	3.1	2.4	−.7	2.4	2.0	−.4
Los Angeles, Calif	1.8	2.4	3.5	1.1	2.4	5.7	3.3
Madison, Wis	2.4	2.7	2.3	−.4	2.1	2.7	.6
Marion, Ill	----	.1	5.8	5.7	----	9.2	9.2
Martinez, Calif	3.2	3.3	5.7	2.4	2.8	7.3	4.5
Minneapolis, Minn	----	----	17.9	17.9	----	28.9	28.9
New York, N.Y	12.6	13.2	9.2	−4.0	14.0	9.3	−4.7
Omaha, Nebr	2.6	3.1	2.1	−1.0	2.5	2.5	----
Phoenix, Ariz	.9	1.0	.7	−.3	.5	1.0	.5
Pittsburgh, Pa	----	.1	.5	.4	----	.7	.7
San Francisco, Calif	1.0	.7	3.0	2.3	.4	3.7	3.3
Sioux Falls, S. Dak	2.4	3.0	2.0	−1.0	2.2	2.9	.7
St. Louis, Mo	.5	.4	3.4	3.0	.4	5.3	4.9
Tucson, Ariz	2.7	2.4	5.4	3.0	3.1	6.8	3.7
West Roxbury, Mass	2.9	2.7	4.9	2.2	2.6	6.7	4.1
White River Junction, Vt	.5	.5	1.8	1.3	.3	2.7	2.4

TABLE 2.—*Percent of patients admitted to all VA general hospitals and 32 selected VA hospitals from pre-bed-care status, July 1965 through March 1966*

Hospitals	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Cumulative, July–Mar.
All general hospitals	2.2	2.1	2.1	3.3	3.6	3.7	4.8	5.7	5.9	3.7
All nonselected VA general hospitals	2.2	2.3	2.2	2.2	2.2	2.1	2.5	2.6	2.4	2.3
32 selected VA general hospitals	2.2	1.8	1.9	6.2	6.8	7.2	10.3	12.9	13.5	6.8
Altoona, Pa	3.7	-----	-----	-----	1.6	2.0	1.0	8.2	13.8	3.3
Amarillo, Tex	-----	-----	-----	3.5	4.6	2.3	2.7	-----	7.5	2.3
Beckley, W. Va	-----	-----	.5	-----	3.6	2.5	2.3	3.2	1.9	1.6
Boston, Mass	-----	.1	-----	7.9	1.3	.3	20.0	28.7	32.2	11.3
Brooklyn, N.Y	.7	.3	.5	31.9	38.5	41.4	32.9	36.5	35.4	24.4
Buffalo, N.Y	-----	-----	-----	-----	-----	3.8	9.2	7.5	11.2	3.8
Chicago (West Side), Ill	8.0	7.0	9.6	7.6	7.5	6.7	9.4	11.4	11.7	8.9
Columbia, S.C	1.6	1.8	2.8	3.4	3.2	3.0	2.8	3.3	3.0	2.8
Coral Gables, Fla	1.5	.2	-----	.4	-----	1.4	5.3	10.9	12.3	3.7
Dearborn, Mich	6.2	5.3	4.9	6.5	6.3	7.0	2.7	4.3	3.9	5.2
Denver, Colo	.4	1.4	1.2	1.5	6.4	3.8	2.0	1.5	10.4	3.4
Dublin, Ga	.4	-----	-----	-----	1.9	1.0	4.8	3.2	1.7	1.5
Erie, Pa	-----	-----	-----	-----	-----	-----	.6	.7	2.5	.5
Fresno, Calif	6.9	10.1	5.5	11.1	7.6	4.3	5.2	9.6	7.3	7.5
Grand Island, Nebr	-----	-----	-----	1.5	2.0	6.8	10.0	10.1	6.8	4.2
Hines, Ill	.9	1.2	1.2	1.7	10.8	8.2	7.1	11.0	10.7	5.9
Houston, Tex	4.1	2.4	2.7	2.1	1.3	1.3	.8	4.5	7.0	3.0
Los Angeles, Calif	-----	-----	-----	.2	.2	.1	9.1	17.8	14.1	4.7
Madison, Wis	1.4	1.9	1.4	3.5	1.3	1.8	3.0	3.9	6.4	2.9
Marion, Ill	-----	-----	-----	9.3	12.4	5.9	10.3	6.9	12.6	6.6
Martinez, Calif	2.9	3.3	2.9	2.4	4.6	2.8	10.2	14.4	21.0	7.6
Minneapolis, Minn	-----	-----	-----	-----	16.6	37.2	34.1	47.4	43.3	21.2
New York, N.Y	11.7	6.8	8.7	10.6	10.4	7.5	7.7	10.0	11.8	9.5
Omaha, Nebr	1.0	2.1	.5	1.6	5.3	2.7	1.5	2.0	2.9	2.2
Phoenix, Ariz	.5	-----	-----	-----	.9	1.3	2.0	.9	1.1	.8
Pittsburgh, Pa	-----	-----	-----	-----	.4	.4	.7	1.9	1.7	.6
St. Louis, Mo	-----	.2	.6	5.6	9.2	2.6	4.3	2.6	5.6	3.6
San Francisco, Calif	2.0	1.6	1.8	1.9	1.3	1.0	1.1	12.2	18.3	4.9
Sioux Falls, S. Dak	1.6	-----	-----	.4	5.8	3.1	.8	4.4	7.8	2.7
Tucson, Ariz	1.9	3.1	2.5	2.8	7.1	7.6	5.5	10.1	7.3	5.7
West Roxbury, Mass	5.1	-----	1.0	.5	4.1	1.8	8.6	14.2	14.0	6.2
White River Junction, Vt	.4	-----	-----	1.6	1.3	1.6	4.3	4.3	1.7	1.8

TABLE 3.—*PBC–PHC study*

	Hospitals with PBC rates that are—			
	High	Average	Low	
			Not testing procedural changes	Testing procedural changes
	Number [1]	*Number* [1]	*Number* [1]	*Number* [1]
Total admissions to hospital	1,123	1,480	1,183	2,124
Unsuitable for PBC ¡total	1,003	1,405	1,083	1,843
Distance	50	229	119	293
Emergency or requiring immediate hospitalization	751	930	844	1,235
Psychiatric cases	51	85	16	33
Admissions from PHC status	124	119	83	212
Reevaluation (observation)	2	6	4	10
All other reasons	25	36	17	60
Suitable for PBC but not placed on PBC total	32	31	92	120
Beds available	6	17	44	74
Physician preferred hospitalization to PBC	1	3	19	30
Patient refused	15	0	0	0
Work-up tests may have required repetition following admission	0	0	8	0
Service connected	1	2	3	0
All other reasons	9	9	18	16
Suitable for PBC and placed on PBC total	88	44	8	161
	Percent	*Percent*	*Percent*	*Percent*
Total admissions to hospital	100.0	100.0	100.0	100.0
Unsuitable for PBC, total	89.4	94.9	91.5	86.8
Distance	4.5	15.5	10.1	13.8
Emergency or requiring immediate hospitalization	66.9	62.9	71.3	58.1
Psychiatric cases	4.6	5.7	1.4	1.6
Admissions from PHC status	11.0	8.0	7.0	10.0
Reevaluation (observation)	.2	.4	.3	.5
All other reasons	2.2	2.4	1.4	2.8
Suitable for PBC but not placed on PBC, total	2.8	2.1	7.8	5.6
Beds available	.5	1.1	3.7	3.4
Physician preferred hospitalization to PBC	.1	.2	1.6	1.4
Patient refused	1.3	0	0	0
Workup tests may have required repetition following admission	0	0	.7	0
Service connected	.1	.1	.3	0
All other reasons	.8	.6	1.5	.8
Suitable for PBC and placed on PBC, total	7.8	3.0	.7	7.6

[1] During the period Oct. 18 to Nov. 16, 1965.

TABLE 4.—*Study hospitals with high PBC rates*

	Total	Altoona, Pa.	Chicago (West Side), Ill.	Coral Gables, Fla.	Dearborn, Mich.	Fresno, Calif.	New York, N.Y.
	Number [1]	*Number* [1]	*Number* [1]	*Number* [1]	*Number* [1]	*Number* [1]	*Number* [1]
Total admissions to hospital	1,123	126	197	200	200	200	200
Unsuitable for PBC, total	1,003	126	169	196	192	175	145
Distance	50	32		2		16	
Emergency or requiring immediate hospitalization	751	94	109	163	139	119	127
Psychiatric cases	51		12		6	19	14
Admissions from PHC status	124		45	31	36	10	2
Reevaluation (observation)	2					2	
All other reasons	25		3		11	9	2
Suitable for PBC but not placed on PBC, total	32	0	5	2	0	7	18
Beds available	6		2			4	
Physician preferred hospitalization to PBC	1		1				
Patient refused	15						15
Workup tests may have required repetition following admission							
Service connected	1			1			
All other reasons	9		2	1		3	3
Suitable for PBC and placed on PBC, total	88	0	23	2	8	18	37
	Percent	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*
Total admissions to hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unsuitable for PBC, total	89.4	100.0	85.8	98.0	96.0	87.5	72.5
Distance	4.5	25.4		1.0		8.0	
Emergency or requiring immediate hospitalization	66.9	74.6	55.3	81.5	69.5	59.5	63.5
Psychiatric cases	4.6		6.1		3.0	9.5	7.0
Admissions from PHC status	11.0		22.9	15.5	18.0	5.0	1.0
Reevaluation (observation)	.2					1.0	
All other reasons	2.2		1.5		5.5	4.5	1.0
Suitable for PBC but not placed on PBC, total	2.8	0	2.5	1.0	0	3.5	9.0
Beds available	.5		1.0			2.0	
Physician preferred hospitalization to PBC	.1		.5				
Patient refused	1.3						7.5
Workup tests may have required repetition following admission							
Service connected	.1			.5			
All other reasons	.8		1.0	.5		1.5	1.5
Suitable for PBC and placed on PBC, total	7.8	0	11.7	1.0	4.0	9.0	18.5

[1] During the period Oct. 18 to Nov. 16, 1965.

TABLE 5.—*Study hospitals with average PBC rates*

	Total	Columbia, S.C.	Houston, Tex.	Madison, Wis.	Martinez, Calif.	Omaha, Neb.	Sioux Falls, S. Dak.	Tucson, Ariz.	West Roxbury, Mass.
Total admissions to hospital	*Number* [1] 1,480	*Number* [1] 200	*Number* [1] 200	*Number* [1] 171	*Number* [1] 200	*Number* [1] 200	*Number* [1] 116	*Number* [1] 194	*Number* [1] 199
Unsuitable for PBC, total	1,405	193	184	164	191	193	107	178	195
Distance	229	52	26	37	15	31	31	28	9
Emergency or requiring immediate hospitalization	930	102	108	119	122	113	58	123	185
Psychiatric cases	85	----	30	----	22	19	2	12	----
Admissions from PHC status	119	29	10	1	29	24	16	10	----
Reevaluation (observation)	6	----	----	2	----	4	----	----	----
All other reasons	36	10	10	5	3	2	----	5	1
Suitable for PBC but not placed on PBC, total	31	2	13	2	5	5	0	4	0
Beds available	17	2	12	----	3	----	----	----	----
Physician preferred hospitalization to PBC	3	----	----	----	----	2	----	1	----
Patient refused	----	----	----	----	----	----	----	----	----
Workup tests may have required repetition following admission	----	----	----	----	----	----	----	----	----
Service connected	2	----	----	----	1	----	----	1	----
All other reasons	9	----	1	2	1	3	----	2	----
Suitable for PBC and placed on PBC, total	44	5	3	5	4	2	9	12	4

[1] During the period Oct. 18 to Nov. 16, 1965.

TABLE 5.—*Study hospitals with average PBC rates*—Continued

	Total	Columbia, S.C.	Houston, Tex.	Madison, Wis.	Martinez, Calif.	Omaha, Nebr.	Sioux Falls, S. Dak.	Tucson, Ariz.	West Roxbury, Mass.
	Percent	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*
Total admissions to hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unsuitable for PBC, total	94.9	96.5	92.0	95.9	95.5	96.5	92.2	91.8	98.0
Distance	15.5	26.0	13.0	21.6	7.5	15.5	26.7	14.4	4.5
Emergency or requiring immediate hospitalization	62.9	51.0	54.0	69.6	61.0	56.5	50.0	63.4	93.0
Psychiatric cases	5.7	----	15.0	----	11.0	9.5	1.7	6.2	----
Admissions from PMC status	8.0	14.5	5.0	.6	14.5	12.0	13.8	5.2	----
Reevalution (observation)	.4	----	----	1.2	----	2.0	----	----	----
All other reasons	2.4	5.0	5.0	2.9	1.5	1.0	----	2.6	.5
Suitable for PBC but not placed on PBC, total	2.1	1.0	6.5	1.2	2.5	2.5	0	2.0	----
Beds available	1.1	1.0	6.0	----	1.5	----	----	----	----
Physician preferred hospitalization to PBC	.2	----	----	----	----	1.0	----	.5	----
Patient refused	----	----	----	----	----	----	----	----	----
Workup tests may have required repetition following admission	----	----	----	----	----	----	----	----	----
Service connected	.1	----	----	----	.5	----	----	.5	----
All other reasons	.6	----	.5	1.0	.5	1.5	----	1.0	----
Suitable for PBC and placed on PBC, total	3.0	2.5	1.5	2.9	2.0	1.0	7.8	6.2	2.0

TABLE 6.—*Study hospitals with low PBC rates, not using special test procedures*

	Total	Buffalo, N.Y.	Denver, Colo.	Erie, Pa.	Hines, Ill.	Los Angeles, Calif.	Phoenix, Ariz.
Total admissions to hospital	*Number*[1] 1,183	*Number*[1] 199	*Number*[1] 200	*Number*[1] 193	*Number*[1] 200	*Number*[1] 191	*Number*[1] 200
Unsuitable for PBC, total	1,083	197	180	181	198	166	161
Distance	119	69	21	19	----	10	----
Emergency or requiring immediate hospitalization	844	107	141	143	193	109	151
Psychiatric cases	16	6	1	----	5	----	4
Admissions from PBC status	83	13	12	14	----	42	2
Reevaluation (observation)	4	1	1	----	----	2	----
All other reasons	17	1	4	5	----	3	4
Suitabl for PBC but not placed on PBC, total	92	2	15	12	1	23	39
Beds available	44	----	3	1	1	1	38
Physician preferred hospitalization to PBC	19	2	3	5	----	8	1
Patient refused	----	----	----	----	----	----	----
Workup tests may have required repetition following admission	8	----	----	----	----	8	----
Service connected	3	----	3	----	----	----	----
All other reasons	18	----	6	6	----	6	----
Suitable for PBC and placed on PBC, total	8	0	5	0	1	2	0
Total admission to hospital	*Percent* 100.0	*Percent* 100.0	*Percent* 100.0	*Percent* 100.0	*Percent* 100.0	*Percent* 100.0	*Percent* 100.0
Unsuitable for PBC, total	9.15	99.0	90.0	93.8	99.0	87.0	80.5
Distance	10.1	34.7	10.5	9.8	----	5.2	----
Emergency or requiring immediate hospitalization	71.3	53.8	70.5	74.1	96.5	57.2	75.
Psychiatric cases	1.4	3.0	.5	----	2.5	----	2.0
Admissions from PHC status	7.0	6.5	6.0	7.3	----	22.0	1.0
Reevaluation (observation)	.3	.5	.5	----	----	1.0	----
All other reasons	1.4	.5	2.0	2.6	----	1.6	2.0
Suitable for PBC but not placed on PBC, total	7.8	1.0	7.5	6.2	.5	12.0	19.5
Beds available	3.7	----	1.5	.5	.5	.5	10.9
Physician preferred hospitalization to PBC	1.6	1.0	1.5	2.6	----	4.2	.5
Patient refused	----	----	----	----	----	----	----
Workup tests may have required repetition following admission	.7	----	----	----	----	4.2	----
Service connected	.3	----	1.5	----	----	----	----
All other reasons	1.5	----	3.0	3.1	----	3.1	----
Suitable for PBC and placed on PBC, total	.7	0	2.5	0	.5	1.0	0

[1] During the period Oct. 18 to Nov. 16, 1965.

TABLE 7.—*Study hospitals with low PBC rates, using special test procedures*

	Total	Amarillo, Tex.	Beckley, W. Va.	Boston, Mass.	Brooklyn, N.Y.	Dublin, Ga.	Marion, Ill.	Minneapolis, Minn.	Pittsburgh, Pa. (general)	San Francisco, Calif.	St. Louis, Mo.	White River Junction, Vt.
Total admissions to hospital	*Number* [1] 2,124	*Number* [1] 181	*Number* [1] 200	*Number* [1] 200	*Number* [1] 196	*Number* [1] 197	*Number* [1] 195	*Number* [1] 198	*Number* [1] 199	*Number* [1] 197	*Number* [1] 199	*Number* [1] 162
Unsuitable for PBC, total	1,843	175	180	158	130	190	143	197	174	193	146	157
Distance	293	39	19	6	8	101	4	28	17	33	1	37
Emergency or requiring immediate hospitalization	1,235	121	136	126	69	86	85	127	149	117	102	117
Psychiatric cases	33	----	----	----	8	----	2	17	1	----	3	2
Admissions from PHC status	212	10	22	26	44	3	24	----	1	42	40	----
Transfers in	----	----	----	----	----	----	----	----	----	----	----	----
Reevaluation (observation)	10	2	3	----	----	----	3	----	1	1	----	----
All other reasons	60	3	----	----	1	----	25	25	5	----	----	1
Suitable for PBC but not placed on PBC, total	120	2	19	0	12	2	23	1	23	2	36	0
Beds available	74	----	12	----	----	----	1	1	22	2	36	----
Physician preferred hospitalization to PBC	30	2	7	----	----	1	20	----	----	----	----	----
Patient refused	----	----	----	----	----	----	----	----	----	----	----	----
Workup tests may have required repetition following admission	----	----	----	----	----	----	----	----	----	----	----	----
Service connected	----	----	----	----	----	----	----	----	----	----	----	----
All other reasons	16	----	----	----	12	1	2	----	1	----	----	----
Suitable for PBC and placed on PBC, total	161	4	1	42	54	5	29	0	2	2	17	5
Total admissions to hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Unsuitable for PBC, total	86.8	96.7	90.0	79.0	66.3	96.5	73.3	99.5	87.4	98.0	73.4	96.9
Distance	13.8	21.5	9.5	3.0	4.1	51.3	2.1	14.1	8.5	16.8	.5	22.8
Emergency or requiring immediate hospitalization	58.1	66.9	68.0	63.0	35.2	43.7	43.6	64.2	74.9	59.4	51.3	72.3
Psychiatric cases	1.6				4.1		1.0	8.6	.5		1.5	1.2
Admissions from PHC status	10.0	5.5	11.0	13.0	22.4	1.5	12.3		.5	21.3	20.1	
Transfers in												
Reevaluation (observation)	.5	1.1	1.5				1.5		.5	.5		
All other reasons	2.8	1.7			.5		12.8	12.6	2.5			.6
Suitable for PBC but not placed on PBC, total	5.6	1.1	9.5	0	6.1	1.0	11.8	.5	11.6	1.0	18.1	0
Beds available	3.4		6.0				.5				18.1	
Physician preferred hospitalization to PBC	1.4	1.1	3.5			.5	10.3					
Patient refused												
Workup tests may have required repetition following admission												
Service connected												
All other means	.8				6.1	.5	1.0					
Suitable for PBC and placed on PBC, total	7.6	2.2	.5	21.0	27.6	2.5	14.9	0	1.0	1.0	8.5	3.1

[1] During the period Oct. 18 to Nov. 16, 1965.

TABLE 8.—*Attitude toward PBC program of patients who were placed on PBC*

Patients' attitude	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
All patients	100.0	100.0	100.0	100.0
Acceptable	98.0	96.3	97.6	98.8
Not acceptable	2.0	3.7	2.4	1.2

TABLE 9.—*Employment status of patients at time of admission to hospital*

Employment status	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
All patients	100.0	100.0	100.0	100.0
Employed	32.4	39.9	34.4	31.5
Unemployed	65.9	60.0	60.8	68.1
Unknown	1.7	.1	4.8	.4

TABLE 10.—*Distance of patients' residence from hospital*

Number of miles	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
All patients	100.0	100.0	100.0	100.0
Less than 10 miles	36.0	46.4	31.4	34.7
10 to 19 miles	15.0	24.0	8.7	14.8
20 miles or more	49.0	29.6	59.9	50.5

TABLE 11.—*Marital status of patients*

Marital status	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
All patients	100.0	100.0	100.0	100.0
Single	13.9	15.7	13.1	13.6
Married	66.4	64.9	67.7	66.3
Widowed	8.0	7.1	8.0	8.3
Divorced	11.7	12.3	11.2	11.8

TABLE 12.—*Eligibility status of patients*

Eligibility status	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
All patients	100.0	100.0	100.0	100.0
Service connected	12.2	13.2	11.9	12.0
Service connected with non-service-connected disabilities	18.2	19.1	18.1	18.0
Non-service-connected	69.6	67.7	70.0	70.0

TABLE 13.—*Bed serivce to which patients were assigned*

Bed service	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
Total	100.0	100.0	100.0	100.0
Surgical	40.3	45.3	37.5	39.9
Medical	51.5	46.3	53.1	52.5
Other	8.2	8.5	9.4	7.6

TABLE 14.—*Age distribution of patients*

Age group	Percent			
	All study hospitals	Study hospitals with PBC rates that were—		
		High	Average	Low
All patients	100.0	100.0	100.0	100.0
Under 45	27.6	29.5	26.2	27.6
45 to 54	24.8	24.0	24.1	25.3
55 to 64	12.5	15.7	11.6	12.0
65 and older	35.1	30.8	38.1	35.1

TABLE 15.—*Number and percent of patients discharged to PHC status and requiring medication*

VA hospital	Last 200 consecutive discharges prior to Sept. 30, 1965	Placed on PHC status							
		Number	Percent	Requiring medication					
				Number			Percent		
				Total	For less than 30 days	For more than 30 days	Total	For less than 30 days	For more than 30 days
All study hospitals, total	6,800	3,181	46.7	1,975	1,071	901	62.1	33.8	28.3
Affiliated, total	3,800	2,069	54.4	1,275	746	529	61.6	36.0	25.6
Baltimore (TB)	200	86	43.0	86	44	42	100.0	51.2	48.8
Boston	200	123	61.5	123	83	40	100.0	67.5	32.5
Brooklyn	200	114	57.0	114	114	----	100.0	100.0	0
Buffalo	200	94	47.0	67	51	16	71.3	54.3	17.0
Chicago (West Side)	200	129	64.5	57	24	33	44.2	18.6	25.6
Coral Gables	200	116	58.0	75	8	67	64.7	6.9	57.8
Dearborn	200	95	47.5	74	24	50	77.9	25.3	52.6
Denver	200	71	35.5	71	36	35	100.0	50.7	49.3
Hines	200	113	56.5	37	29	8	32.7	25.6	7.1
Houston	200	71	35.5	71	39	32	100.0	54.9	45.1
Los Angeles	200	109	54.5	49	28	21	45.0	25.7	19.3
Madison	200	80	40.0	38	14	24	47.5	17.5	30.0
Minneapolis	200	100	50.0	100	62	38	100.0	62.0	38.0
New York	200	125	62.5	44	34	10	35.2	27.2	8.0
Omaha	200	94	47.0	49	27	22	52.1	28.7	23.4
Pittsburgh (general)	200	108	54.0	56	10	46	51.9	9.3	42.6
St. Louis	200	151	75.5	73	41	32	48.3	27.2	21.2
San Francisco	200	149	74.5	32	32	----	21.5	21.5	0
West Roxbury	200	141	70.0	59	46	13	41.8	32.6	9.2

Nonaffiliated, total	3,000	1,112	37.0	700	325	375	62.9	29.2	33.7
Altoona	200	52	26.0	19	18	1	36.5	34.6	1.9
Amarillo	200	48	24.0	16	12	4	33.3	25.0	8.3
Beckley	200	57	28.5	41	35	6	71.9	61.4	10.5
Columbia	200	55	27.5	22	1	21	40.0	1.8	38.2
Dublin	200	63	31.5	17	3	14	27.0	4.8	22.2
Erie	200	56	28.0	56	33	23	100.0	58.9	41.1
Fresno	200	116	58.0	76	46	30	65.5	39.7	25.9
Grand Island	200	97	48.5	43	20	23	44.3	20.6	23.7
Marion, Ill	200	118	59.0	83	18	65	70.3	15.3	55.0
Martinez	200	93	46.5	93	67	26	100.0	72.0	28.0
Phoenix	200	58	29.0	35	24	11	60.3	41.4	18.9
Sioux Falls	200	46	23.0	26	14	12	56.5	30.4	26.1
Tucson	200	66	33.0	66	17	49	100.0	25.8	74.2
Tuskegee (psychiatric)	200	49	24.5	43	5	38	87.8	10.2	77.6
White River Junction	200	138	64.0	61	12	49	44.2	8.7	35.5

TABLE 16.—*PBC–PHC study—Patients discharged and patients readmitted to hospital within 48 hours following discharge during September 1965*

VA hospital	Patients discharged during September 1965	Patients readmitted to hospital within 48 hours following discharge during September 1965	
		Number	Percent
All study hospitals total	15,340	305	2.0
Affiliated total	11,564	212	1.8
Baltimore (TB)	85	----	----
Boston	836	25	3.0
Brooklyn	637	----	----
Buffalo	537	6	1.1
Chicago (West Side)	512	7	1.4
Coral Gables	507	1	.2
Dearborn	624	9	1.4
Denver	533	2	.4
Hines	1,292	27	2.1
Houston	874	9	1.0
Los Angeles (general)	1,003	15	1.5
Madison	415	10	2.4
Minneapolis	913	52	5.7
New York	795	15	1.9
Omaha	409	1	.2
Pittsburgh (general)	554	15	2.7
St. Louis	515	2	.4
San Francisco	335	4	1.2
West Roxbury	188	12	6.4
Nonaffiliated, total	3,776	93	2.5
Altoona	120	1	.8
Amarillo	173	1	.6
Beckley	212	----	----
Columbia	637	5	.8
Dublin	220	2	.9
Erie	143	1	.7
Fresno	332	14	4.2
Grand Island	144	9	6.3
Marion, Ill	198	3	1.5
Martinez	446	1	.2
Phoenix	230	8	3.5
Sioux Falls	216	4	1.9
Tucson	222	----	----
Tuskegee (psychiatric)	258	11	4.3
White River Junction	225	33	14.7

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