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REGIONALIZATION OF VETERANS ADMINISTRATION'S HEALTH CARE SYSTEM

NOVEMBER 30, 1971

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FOREWORD

Regionalization of the country's health care systems is more and more coming to be regarded as one of the most exciting and potentially valuable concepts for providing greater availability of the highest quality of care for all Americans.

In hearings before the Senate Veterans' Affairs Committee, testimony has been developed to indicate that the Department of Medicine and Surgery of the Veterans' Administration is not only involved in such regionalization in concert with other elements of the private sector of the country's health care systems, but is planning and implementing its own regionalization process in the direct interest of the Nation's veterans it has been mandated by the Congress to serve.

This publication has been prepared to reflect not only the concept as it applies to all health care systems, but as an interim report on the progress of the Department of Medicine and Surgery toward this goal.

The Senate Veterans' Affairs Committee believes that by these efforts the Veterans' Administration's Department of Medicine and Surgery, under the administration of Mr. Donald E. Johnson, has demonstrated a capacity not only to keep pace with its counterparts in the public sector, but to assume a leadership role in insuring better health care to veterans and nonveterans alike.

The Senate committee is indebted to Dr. A. Wendell Musser, Assistant Chief Medical Director for Planning and Evaluation, and Mr. Adam Shuman, Director, Planning Service, for the preparation of this material. It also acknowledges its appreciation to Dr. Marc J. Musser, the Chief Medical Director of the Department of Medicine and Surgery, and other members of his staff for its final editing and preparation for publication.

VANCE HARTKE, *Chairman.*

PREFACE

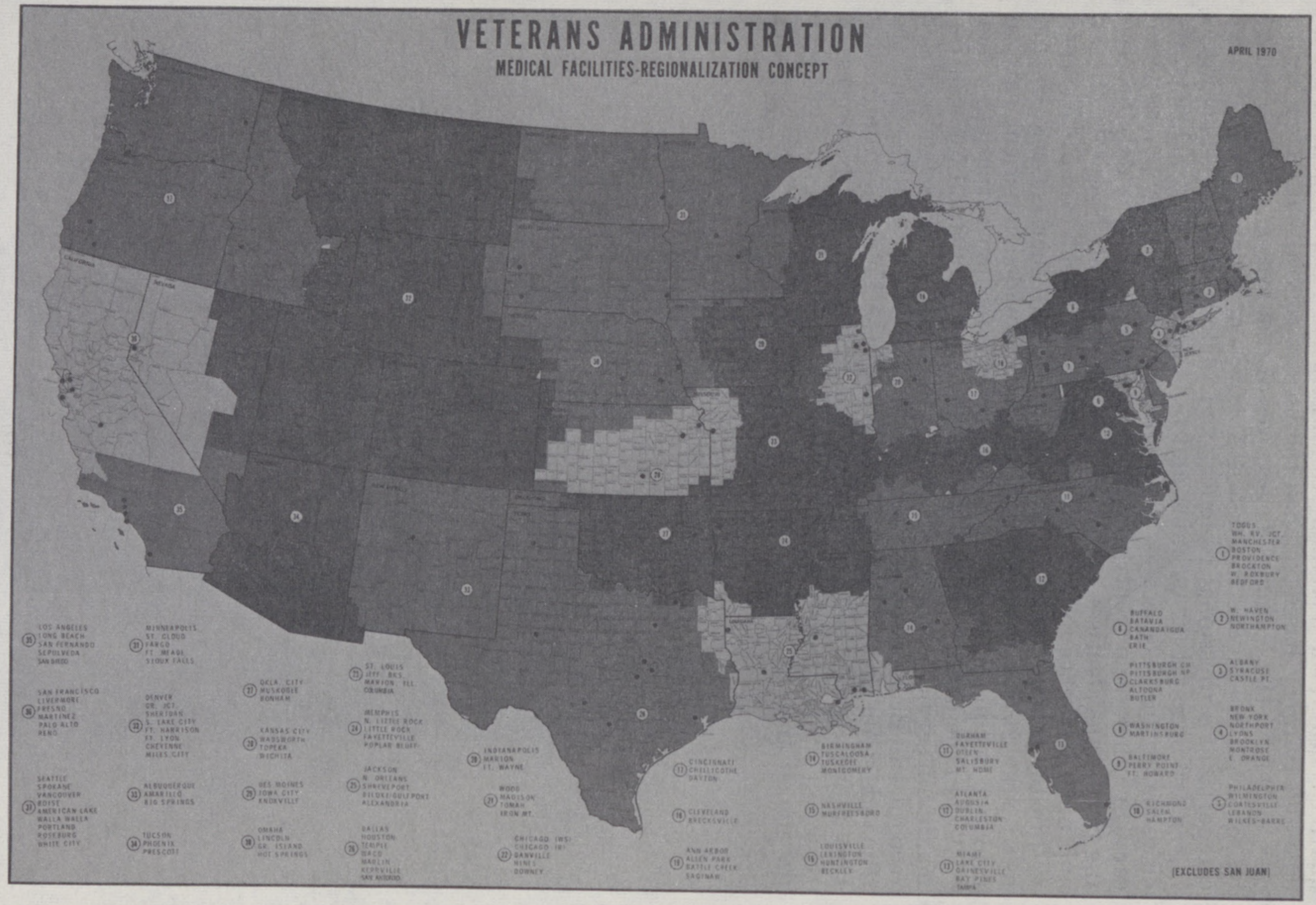
In fulfilling the mission assigned to it by the Congress over the past quarter century, the Veterans' Administration's Department of Medicine and Surgery has developed the largest centrally directed health care system in the Nation. The services of that system are represented by some 150,000 physicians, dentists, nurses, and members of all other categories of professional, technical, and related health personnel working in 166 hospitals, 200 clinics, and 73 nursing homes in 171 separate cities and towns in 50 States. These services are supplemented, as necessary, by other fee or contractual arrangements with privately practicing physicians, dentists, and other public and private hospitals, clinics, and nursing homes to care for veteran patients who cannot be served within the system for various geographical or other reasons. During fiscal year 1971 this health care system provided inpatient care in nearly 1 million cases and provided over 8 million outpatient visits.

Within the last few years the need to develop a method for insuring maximum service, utilization, and cost benefits of that system has been recognized. Because of the magnitude of both its facilities and the demands upon them, it was the decision of the Veterans' Administration and its Department of Medicine and Surgery that the process of regionalization can help achieve this goal. As a result, a plan has been developed and is now underway to regionalize the system.

VETERANS ADMINISTRATION

MEDICAL FACILITIES-REGIONALIZATION CONCEPT

APRIL 1970



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Regionalization for Health Care

Regionalization is a concept already in operation nationally in such areas as transportation, marketing, and communications. Its application to health care gained national understanding and acceptance and is being implemented as a result of two legislative measures enacted into law by the 89th Congress. The first was Public Law 89–239 passed in 1965 which provided for the establishment of regional medical programs as a functional effort in regionalization; the other, passed in 1966, was Public Law 89–749 which authorized the creation of comprehensive health planning organizations at both the State and local levels. Both laws, in effect, called for the establishment of cooperative community, State and/or regional efforts to not only identify health care needs, but to develop and implement plans to meet those needs in the most effective, equitable, efficient, and economic way.

To date, such efforts have helped to demonstrate how cooperative arrangements can achieve maximum utilization of institutional, professional, and financial resources. They have also served to show how expensive and wasteful duplication of equipment and personnel can be avoided, and how the all-too-prevalent selfish autonomy of various health care institutions and those who direct their services can be approached and altered.

Involvement of VA in Regionalization

First by voluntary action and subsequently by legislation, the Department of Medicine and Surgery of the Veterans' Administration has become actively involved in this effort on the national level, and the elements of its system have done likewise at the regional and community level.

The initial voluntary effort was represented by the involvement of VA hospitals in the early development of regional medical programs in regions where those hospitals had already established themselves as an integral part of the local health care system. Further official involvement was provided for in Public Law 91–515 which amended and extended the original regional medical programs and comprehensive health planning legislation. Under those amendments, the Chief Medical Director was directed to sit ex officio on the National Advisory Council of Regional Medical Programs Service, and each regional medical program was called upon to include a representative from local VA hospitals on its Regional Advisory Group. Similarly, State comprehensive health planning agencies with VA hospitals located therein were called upon to include VA representatives on their councils.

Another piece of legislation, also passed in 1966 as Public Law 89–785, made possible a whole series of additional cooperative activities between elements of the VA health care system and those of the pri-

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vate sector at the community and regional level. Called the "sharing law" it provided that selected specialized VA medical resources might be made available to the nonveteran population of a community in which such health benefits were not otherwise provided by their own institutions, or were in too short supply to meet the community's total needs. Conversely, facilities or specialized services provided by medical schools or community hospitals in the private sector which might not be found in the local VA hospitals could also be made available to them. Thus, in effect, the new law permitted, and indeed encouraged, the institutions of the Federal and private sector of any community of functional health care region to exchange or share services as an alternative to the expense of duplicating them, or the dangers of going without them.

Within the framework of the VA hospital-medical school affiliations developed over the preceding 25 years, such sharing arrangements were quickly put into operation in highly specialized surgery, nuclear medicine, X-ray therapy, and other new, expensive, and complex areas. However, the sharing concept has taken longer to implement in nonmedical center areas where other VA hospitals also are found.

This entire concept of total regionalization, including the Federal-private mix, is best described by Dr. David Rutstein, professor and chairman of the Department of Preventive Medicine at Harvard Medical School, in his book "The Coming Revolution in Medicine" MIT Press 1967). He writes:

> The plan [regionalization] is in no sense a fixed blueprint of a medical care system—it may not predict what will happen. Instead it indicates what could happen if we took full advantage of our resources, knowledge and skills. Whether or not this plan, or details of it, be implemented, one thing is clear. The consequences of not planning well for the future of medicine are too grave to contemplate. Let me give you a simple outline of the plan. We shall emphasize the need for the regional structure of medical care programs, propose a more effective use of medical manpower, indicate ways in which the physicians' time may be more strategically applied, take advantage of rapidly advancing automation and technology, suggest added dimensions for medical research, and recommend a system of medical education to meet future needs. Not every hospital will be able to provide what every patient needs for the prevention and treatment of his disease. If this dilemma is to be resolved, we cannot build the medical system of the future around self-centered individual hospitals as we do today. Instead, through careful planning and efficient transportation and communications systems we have to weave together all medical facilities and personnel into regional medical service areas centered upon large technical hospitals that are affiliated with medical schools.

VA Regionalization—A Beginning and Its Goals

The catalyst for effecting regionalization within the Veterans' Administration's health care system was the appointment by the Administrator of Veterans' Affairs, Mr. Donald E. Johnson, of Dr. Marc J. Musser as Chief Medical Director of the Veterans' Administration's Department of Medicine and Surgery in January 1970. The selection by the Administrator of Dr. Musser as his Chief Medical Director brought an experienced medical leader to the Veterans' Administration. Five years prior to that time, Dr. Musser accepted the responsibility for regionalizing the health services of North Carolina when he became coordinator of that State's regional medical program, established under Public Law 89–239. During those 5 years Dr. Musser

became one of the Nation's leaders in developing mechanisms for implementing health care regionalization. With the support and encouragement of Mr. Donald E. Johnson, Administrator, Dr. Musser proceeded to apply these concepts of regionalization to the U.S.-wide Veterans' Administration's health care system.

By January of 1970 many VA hospitals, clinics, nursing homes, and other facilities and services were already included in some of the long-range plans of regional medical programs and comprehensive health planning agencies. Indeed, many had become active participants in early projects being carried out by some of the country's 55 regional medical programs then in operation. However, because of its specialized mission and the magnitude of the VA system, it was agreed that the VA had to develop its own blueprint for regionalizing, to the extent compatible with the fulfillment of the overall mission of the VA, its own facilities and services to achieve the two major goals of—

- Insuring the availability of a maximum range of health services to its veteran patients as close as possible to their homes, and do so with the highest possible professional quality, organizational efficiency, and the lowest possible cost.
- Maintaining a system that had come to provide the single greatest potential for the development of not only its own physician and allied health manpower, but a resource for training and supplying such critical personnel to the private sector; an unequalled base for cooperative clinical research; and a community resource for services, as necessary, under the sharing concept.

Criteria of VA Regional Districts

For planning purposes, the criteria for VA regional districts were established as functional geographical areas wherein—

- The veteran population would be sufficiently large to produce a demand for VA medical care to support all general medical, surgical, and psychiatric services, as well as a full spectrum of special services to be found in any major medical area in the private sector.
- Conversely, sufficient VA facilities and resources must be available to provide such services for the population to be served.
- Two or more VA hospitals must be included with at least one of the hospitals having a full affiliation with a university medical center, or with a major accredited private practice clinic.

While it was agreed that each regional district would be planned and operated as a comprehensive self-sufficient health care system, certain exceptions were recognized.

- There could be inter-Regional District services where the population base of one or more provide only limited demand on certain areas of specialization such as organ transplantation, stereotactic surgery, blind rehabilitation, renal dialysis and care of spinal cord injuries.
- Sharing or exchange arrangements or contract services could be negotiated with other Federal institutions or those in the private sector where VA facilities themselves cannot provide all of the services, or are not adequate to meet the demands.

- Conversely, where an excess of VA capabilities may exist, full consideration should be given to utilizing them to complement or supplement the needs of nonveteran patients by similar arrangements.

It was also decided that the selection of hospitals to form a regional district would be primarily functional, and not necessarily be limited to geographical or political boundaries. As indicated, in making such decisions, factors relevant to the demands of patients, available services and the quality of the care to be provided will take precedence over administrative expediency or undue considerations of cost. Also, the established lines of patient flow and professional referrals will be encouraged within the regional districts so that each can be operated essentially as self-contained health care delivery system.

Role of VA Facilities in Regionalization

Under regionalization, the mission of each VA hospital, clinic, and other facilities is being identified to emphasize their strengths so that they can contribute in the most efficient way possible to the total health care system of the regional district. No facility's mission will be proscribed as an expedient to place it in a primary or secondary position to its colleagues. However, it is recognized that the hospitals affiliated with medical schools will generally represent the base of the regional district. The services of the general and specialized hospitals and other facilities relative to those base hospitals will be revised and strengthened as necessary to supplement or complement each other. A hospital, for example, to be truly supportive to the other cooperating hospitals may be expanded and its mission redefined as a modern chronic disease hospital. As such it could be further staffed and equipped to provide additional professional capabilities for providing care for arthritic, cardiac and pulmonary patients.

Distribution of Resources and Utilization

As indicated, it is expected that regionalization will provide the framework for appropriate distribution of resources among all of the facilities within each self-contained regional district to include and effectively coordinate all specialized medical services. Decisions of how much services are to be distributed will take into account a number of critical factors including those involved with ease of access for patients, availability of necessary skills, and volume of utilization. In effecting such a distribution, regionalization must continue to be recognized as a method for the improvement of patient care through more effective utilization of resources within a health care system.

The desired results of regionalization in the form of proper and adequate utilization can be realized through the development and use of cooperative and mutually shared programs between and among all of the institutions of the regional district, but only if regionalization in each regional district provides—

- *Easier access to the system* to enable patients to be admitted initially to any hospital or ambulatory care clinic.

- *Increased patient mobility* to improve transfer procedures that are immediately responsive to the needs of the patients in terms of placing them in the proper facilities where appropriate diagnosis and/or treatment consistent with their needs is available.
- *Increased staff mobility* to insure that consultative services are continuously and readily available between and among all facilities.
- *Optimum and efficient use of specialized services* to insure that they are operated at the critical level of demand to keep them at the necessary level of proficiency.
- *Improved data collection and transmission* to provide standardized patient records and their rapid transmission to support clinical needs among all facilities.
- *Adequate peer review within the regional district* designed to involve the representative staff and faculty of the cooperating hospitals and the medical schools utilizing their diverse professional skills.

Education and Exchange of Medical Information

Regionalization interrelates not only the institutions in a given regional district, but the professional and technical staffs working in or associated with them. Therefore, it follows that a common level of competence must exist in each of them. Such interdependence and collaboration makes the establishment of such standards a more easily achieved goal in each regional district as a result of—

- A single system which facilitates the mobility, wide utilization of clinical staff, consultants, faculty, and technical personnel to transmit new knowledge.
- Utilization of such teaching skills throughout the system which relieves each institution of maintaining its own educational programs, and allows it to take advantage of what is commonly available and concentrate its own efforts in training those needed for its own mission.
- Development of teachers, and training programs in the various specialties and disciplines on a regional basis utilizing those sites and personnel best suited to provide training to meet total identified regional needs.
- Permitting the application of the principles of scale economy in the purchase and use of highly qualified teachers and sophisticated training devices that could not be justified for a single hospital.
- By the same logic, allowing for development and maintenance of programs for the exchange of medical information which utilize computer oriented data base, closed circuit television networks, telephone consultation service, and other new modes and electronic media.

Research

The growing shortage of available Federal and private funds for biomedical research is causing an increasing level of concern in the country's medical community. In seeking ways of coordinating and

consolidating such activities, the type of collaborative research developed within the VA system over the past 25 years has gained prominence.

In effect, the VA research effort has been regionalized for years in that it has encouraged the coordination of such activities in its facilities and among its own staff in collaboration with the country's medical schools. As a result, these efforts are regionalized not geographically, but professionally and scientifically.

Under the regionalization plan, this type of effort will not only continue to be developed, but have the potential for operating within and between regional districts as considered appropriate by those directing and involved with this effort within the system.

Cost Control

After utilization, a major objective of regionalization is the control of the cost of medical care within the regional district to achieve not only a realistic cost benefit level. but to permit adequate funding allocations to those program areas that are most supportive of each hospital's mission and thereby the total delivery system within the regional district.

This objective can only be realized through the evolutionary development and refinement of each regionalization process. However, it can be established that the management matrix must include—

- *Health system benefits* related to availability of improved services and quality of care to more patients at a lower total and per patient cost resulting from increased demands; more rapid turnover rates; decreased length of stay; and increased occupancy rates.
- *Cost avoidance* which will depend upon the proper assignment and maximum utilization of not only physicians, nurses, and other categories of health manpower, but employment of the most modern medical techniques including automated equipment and the use of computers and other technologies to replace obsolete equipment and methodologies, less effective techniques, and costly duplication of services.
- *Cost reduction* which is closely related to cost avoidance, but reflects actual monetary savings through reduced costs of personnel services, equipment and materials, and the use of contractual services when saving can be realized with no effect on quality.

Development of Community Relationships and Involvement

Regionalization will enhance the interaction between VA facilities and other public and private institutions and organizations and the communities they serve. Thus, over and above the increased and more efficient use of VA facilities for their own patients, regionalization provides the means for developing better community relationships by identifying all resources in the regional district, both of the public and private sectors. Then, through sharing arrangements made possible by Public Law 89–785, all health resources can be utilized to the maximum advantage of veterans living in that area.

Administration

Successful operation of a regionalization program depends heavily upon the strength and quality of the administrative and professional leadership which exists and the firmness of the commitment of the several component institutions. To generate and maintain these, there must be appropriate involvement of each participating institution in planning, policy determination, and evaluation.

Based upon these principles, each regional district has attempted to develop an organizational structure consistent with its local resources and needs. In general, this has followed the pattern of cooperative effort that has been so effective in regional medical programs over the past 6 years. In most instances, each region's cooperative group has identified and designated its functional leadership. Also, in their developmental activities, regional districts have emphasized three basic requirements:

- *Flexibility* to vary any initial plan over time to provide the most functionally effective ultimate model consistent with the local goals and objectives.
- *Accountability*, in this case to the Department of Medicine and Surgery, in terms of meeting all of the national goals and objectives set by the criteria of regionalization, and by the continued implementation of the congressional mandate to the Department.
- *Evaluation* to establish a baseline and mechanisms to measure the development and progress of the regionalization effort in terms of increased quality and availability of medical care.

Overall operational responsibility is vested in the designated leadership, as the regional district director, and various cooperative groups serve in effect as a "board of directors" or "executive and planning committees," and other advisory and developmental components. This organizational structure also provides for the necessary liaison with other community and areawide health interests.

Thus far a number of organizational models have been developed. As these are evaluated over time, the most effective organizational structure will be identified.

The Regionalization Plan

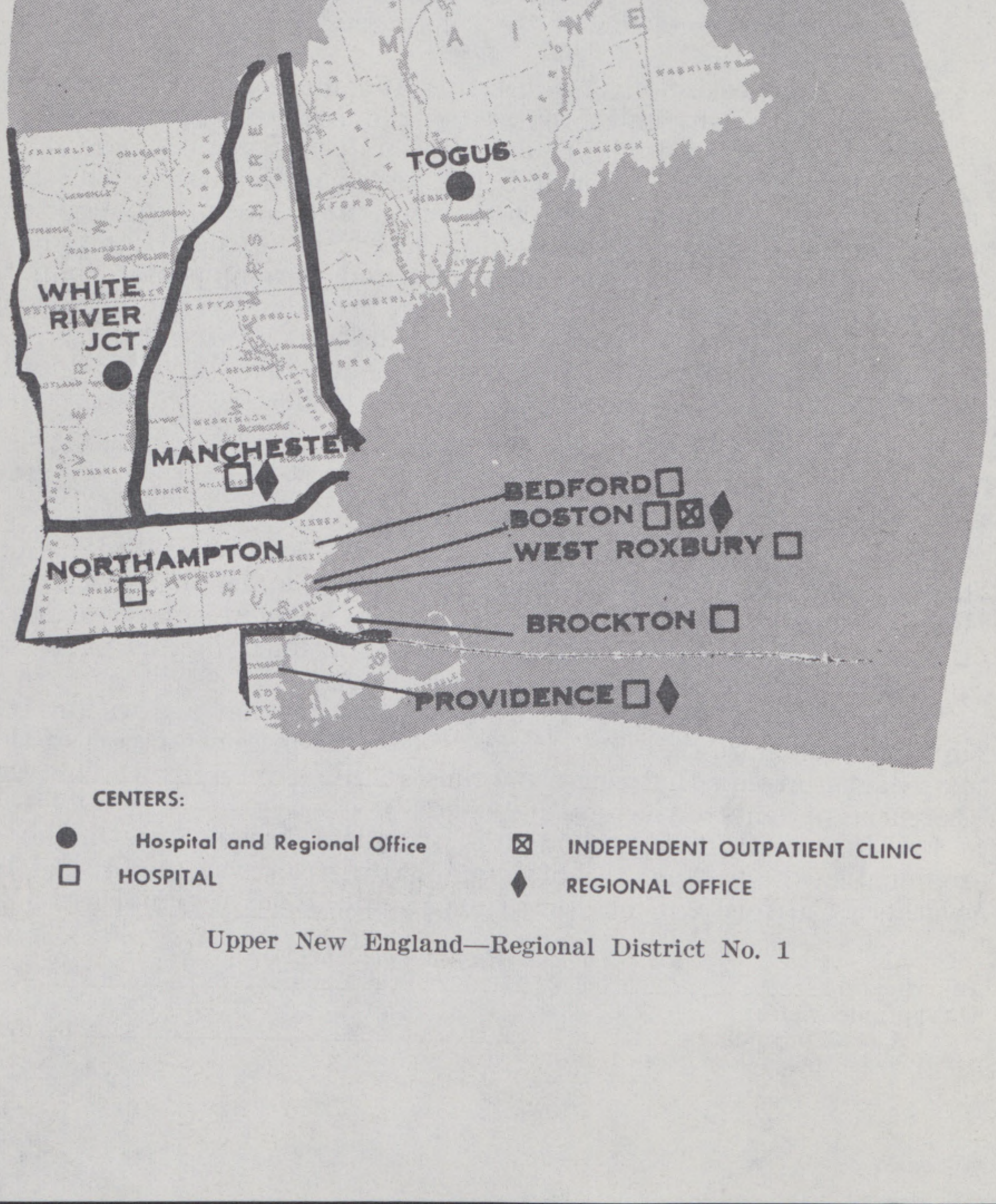
Having applied the concept, criteria, and goals described herein to the total VA health care system, the decision was made to establish 37 regional districts. Under the plan, each would embody or have the potential for fulfilling the objectives outlined in this paper to provide a total health care system for veterans.

As constituted, facilities of each regional district are within 100 miles or not more than 2 hours away from 88 percent of each of the population groups that constitute the 28 million veterans who are the potential patients of the total system.

On July 1, 1970, only 6 months after the decision was made to regionalize the system, the first regional district was established in southern California. Since that time 13 additional regional districts

have been activated. The current plan is to put the remaining 23 regional districts into operation during 1972.

A summary of the regional districts, currently operating or planned, has been prepared on the following pages to indicate the identity and geography of each, and to reflect some measure of the VA facilities, their resources, the potential demand, and the service provided by them.



Upper New England—Regional District No. 1

UPPER NEW ENGLAND—REGIONAL DISTRICT NO. 1

Service Area

The entire States of Maine, New Hampshire, Vermont, Rhode Island and all but three western counties of Massachusetts.

Veteran Population

1969	1,157,000
1980 (projected)	1,215,000

VA facilities

Bedford VA Hospital
Boston VA Hospital
Boston Out-Patient Clinic
Lowell, Mass. (sub-clinic)
Springfield, Mass. (sub-clinic)
Worcester, Mass. (sub-clinic)
Brockton VA Hospital
Manchester VA Hospital
Providence VA Hospital
New Bedford, Mass. (sub-clinic)
Togus VA Hospital
West Roxbury VA Hospital
White River Junction VA Hospital

Medical school affiliation

Dartmouth Medical School
Harvard Medical School
Tufts University School of Medicine
Boston University School of Medicine

Full-time staff (Apr. 1, 1971)

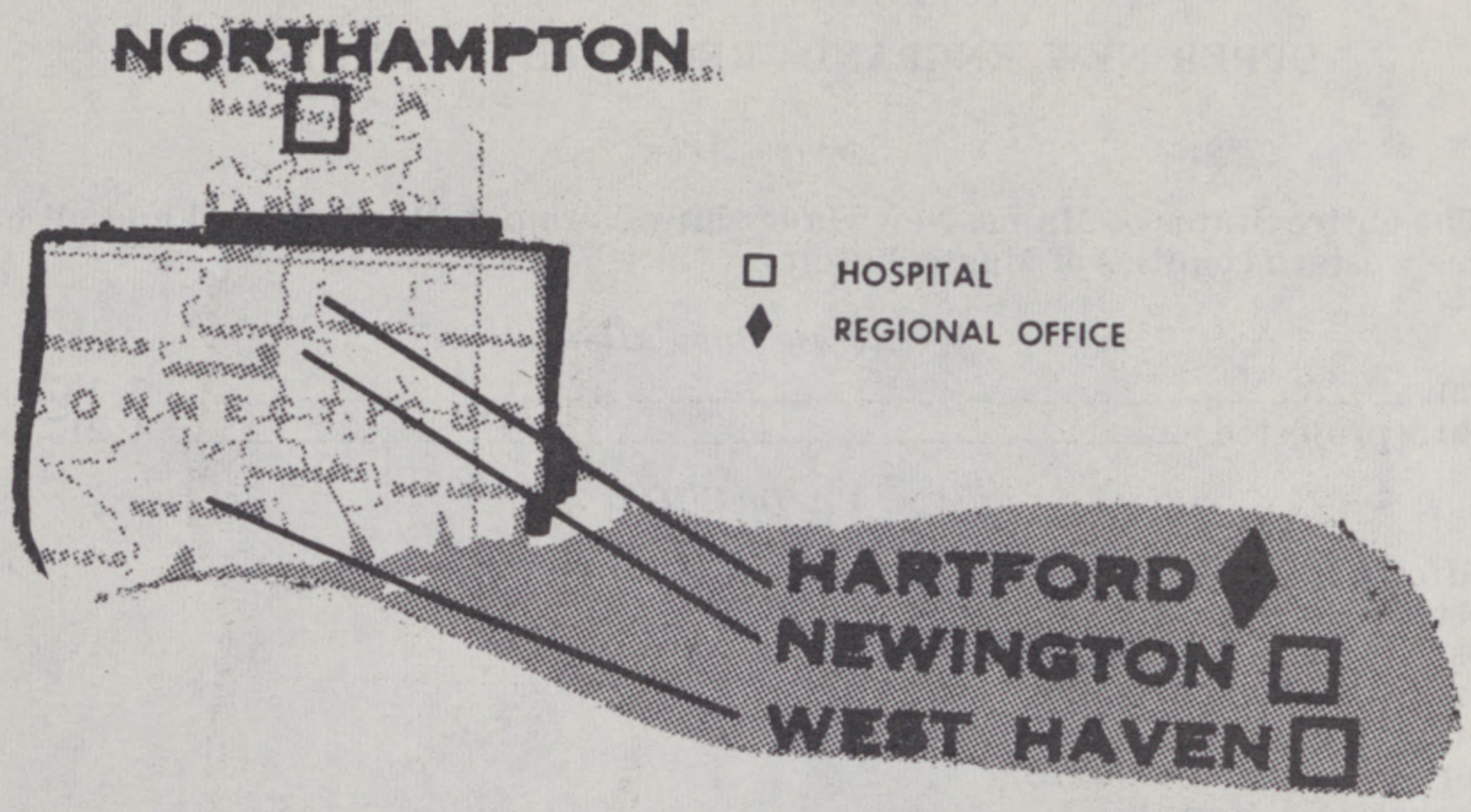
Physicians	202	Nurses	696
Dentists	27	All other	4,268

Operating beds (September 1, 1971)

Medical	1,462	Psychiatric	2,182
Surgical	705	Nursing home	360

Services delivered (fiscal year 1971)

In-patients	34,350
Out-patient visits:	
VA staff physicians	439,839
Private physicians (fee basis)	64,794



Connecticut—Regional District No. 2

CONNECTICUT—REGIONAL DISTRICT NO. 2

Service area

This district includes the entire State of Connecticut, plus Hampshire and Hampden Counties in Massachusetts.

Veteran population

1969	495,000
1980 (projected)	554,000

VA facilities

Newington VA Hospital
Northampton VA Hospital
West Haven VA Hospital

Medical school affiliation

University of Connecticut School of Medicine
Yale University School of Medicine
Albany Medical College of Union University

Full-time staff (Apr. 1, 1971)

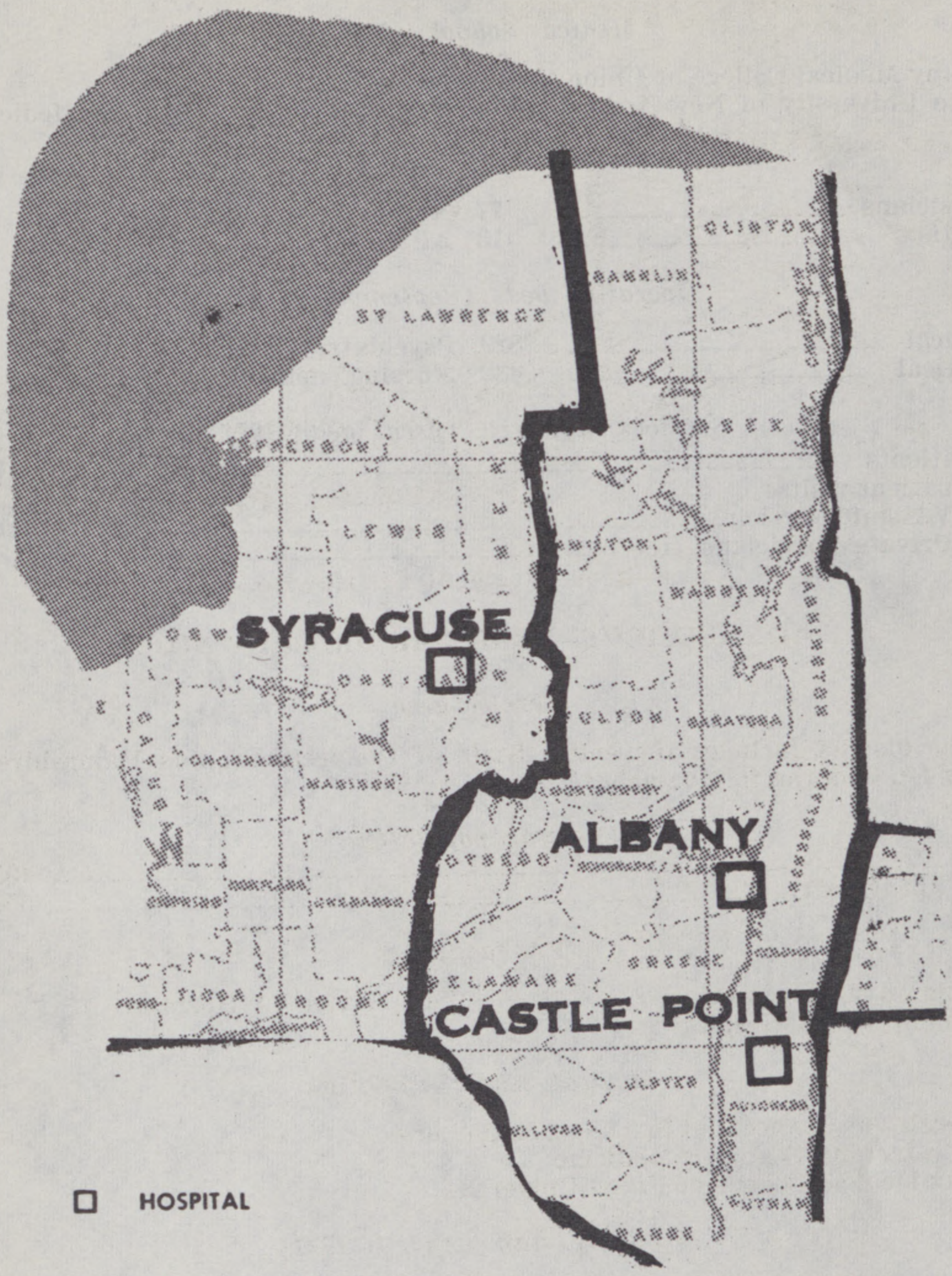
Physicians	69	Nurses	262
Dentists	10	All other	1,962

Operating beds (September 1971)

Medical	531	Psychiatric	818
Surgical	298	Nursing home	45

Services delivered (fiscal year 1971)

In-patients	10,718
Out-patient visits:	
VA staff physicians	119,710
Private physicians (fee basis)	8,917



Eastern New York State—Regional District No. 3

EASTERN NEW YORK STATE—REGIONAL DISTRICT NO. 3

Service area

This regional district includes all of eastern New York State except for the eight counties in the New York City metropolitan area. The district boundaries extend westward to include Wayne, Seneca, Tompkins, and Tioga Counties. Berkshire County in Massachusetts is also included.

Veteran population

1969	546,000
1980 (projected)	550,000

VA facilities

Albany VA Hospital
Castle Point VA Hospital
Syracuse VA Hospital

Medical school affiliation

Albany Medical College of Union University
State University of New York, Upstate Medical Center, College of Medicine

Full-time staff (Apr. 1, 1971)

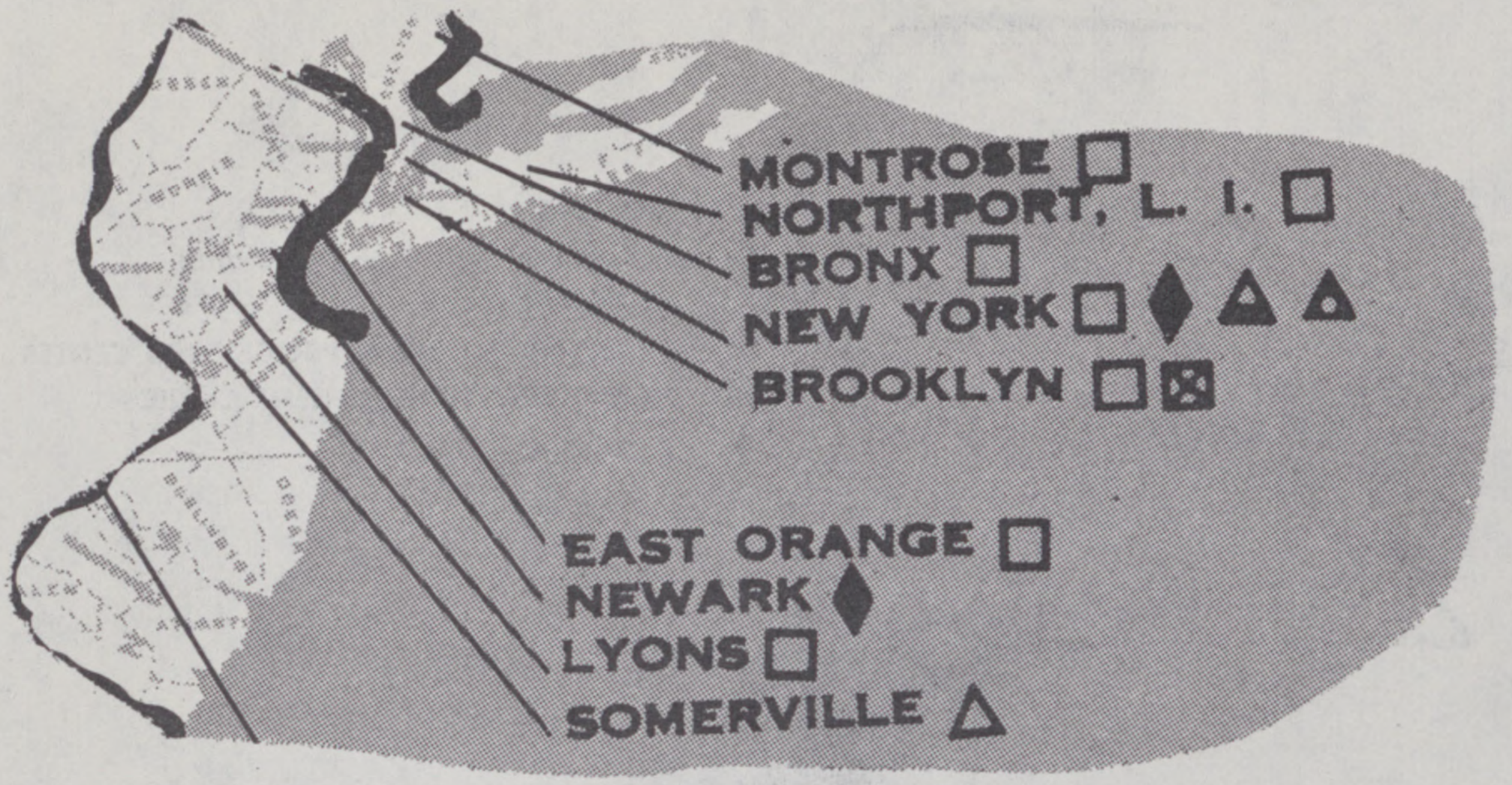
Physicians	77	Nurses	276
Dentists	13	All other	1,740

Operating beds (September 1971)

Medical	829	Psychiatric	206
Surgical	432	Nursing home	166

Services delivered (fiscal year 1971)

In-patients	13,606
Out-patient visits:	
VA staff physicians	115,805
Private physicians (fee basis)	36,685



New York City and surrounding area—Regional District No. 4

NEW YORK CITY AND SURROUNDING AREA—REGIONAL DISTRICT NO. 4

Service area

This district includes New York City, Long Island, and 14 northern New Jersey counties.

Veteran population

1969	2,476,000
1980 (projected)	2,668,000

VA facilities

Bronx, N.Y., VA Hospital
Brooklyn, N.Y., VA Hospital
Brooklyn, N.Y., Out-Patient Clinic
East Orange, N.J., VA Hospital
Lyons, N.J., VA Hospital
Montrose, N.Y., VA Hospital
Newark, N.J., Out-Patient Clinic
New York City, VA Hospital
New York City Out-Patient Clinic
Northport, N.Y., VA Hospital

Medical school affiliation

Mount Sinai School of Medicine
State University of New York, Downstate Medical Center, College of Medicine
College of Medicine and Dentistry of New Jersey
New York University School of Medicine
State University of New York at Stony Brook
New York Medical College
Rutgers Medical School

Full-time staff (Apr. 1 1971)

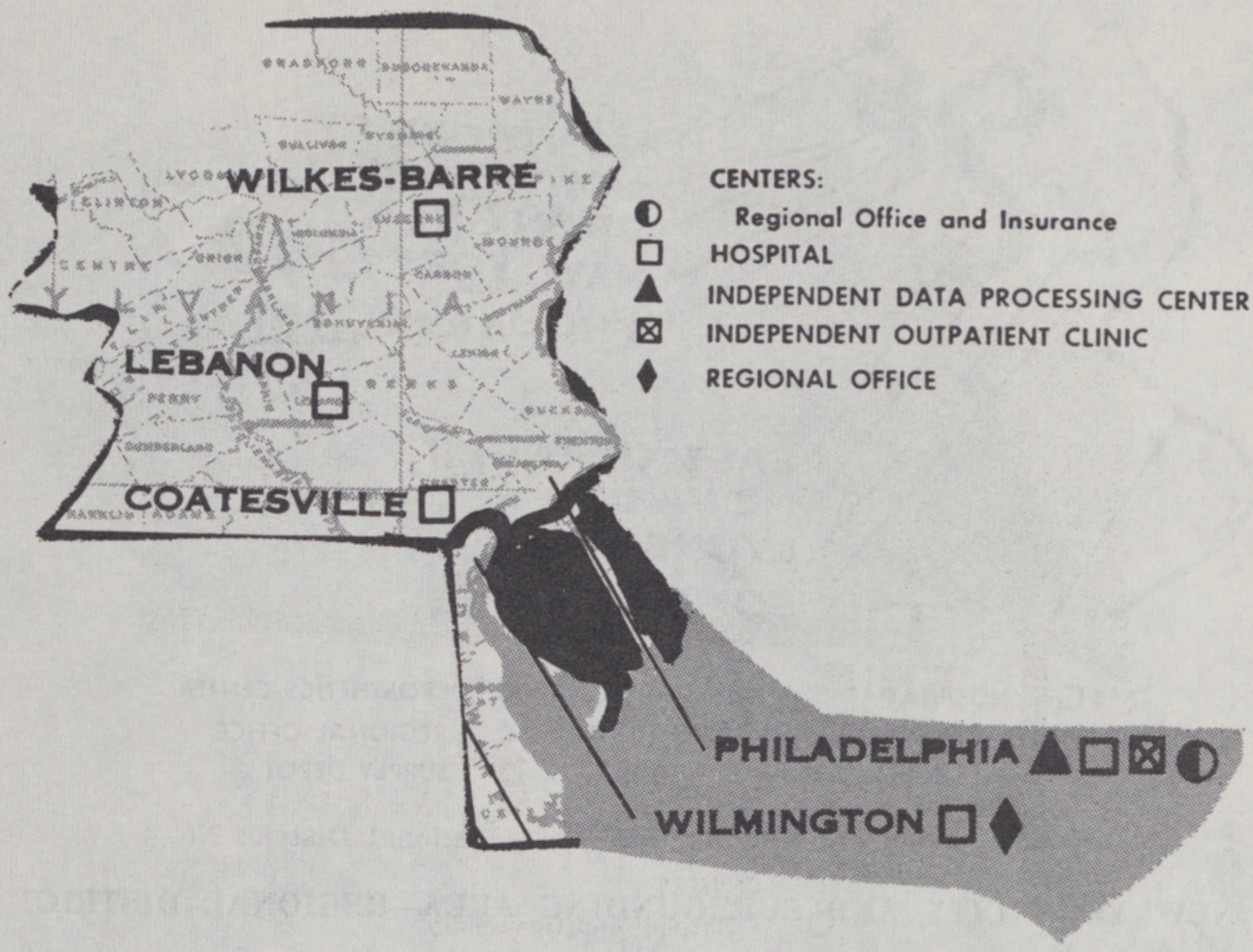
Physicians	396	Nurses	903
Dentists	50	All other	7,889

Operating beds (September 1971)

Medical	2,850	Psychiatric	3,930
Surgical	1,354	Nursing home	114

Services delivered (fiscal year 1971)

In-patients	49,999
Out-patient visits:	
VA staff physicians	646,033
Private physicians (fee basis)	52,040



Eastern Pennsylvania/Delaware—Regional District No. 5

EASTERN PENNSYLVANIA/DELAWARE—REGIONAL DISTRICT NO. 5

Service area

This regional district includes the eastern half of Pennsylvania and the entire State of Delaware.

Veteran population

1969		1,344,000
1980	(projected)	1,451,000

VA facilities

Coatesville, Pa., VA Hospital
Lebanon, Pa., VA Hospital
Harrisburg, Pa. (sub-clinic)
Philadelphia, Pa., VA Hospital
Philadelphia, Pa., Out-Patient Clinic
Wilkes-Barre, Pa., VA Hospital
Wilmington, Del., VA Hospital

Medical school affiliation

University of Pennsylvania School of Medicine
The Medical College of Pennsylvania
Jefferson Medical College of Philadelphia

Full-time staff (Apr. 1, 1971)

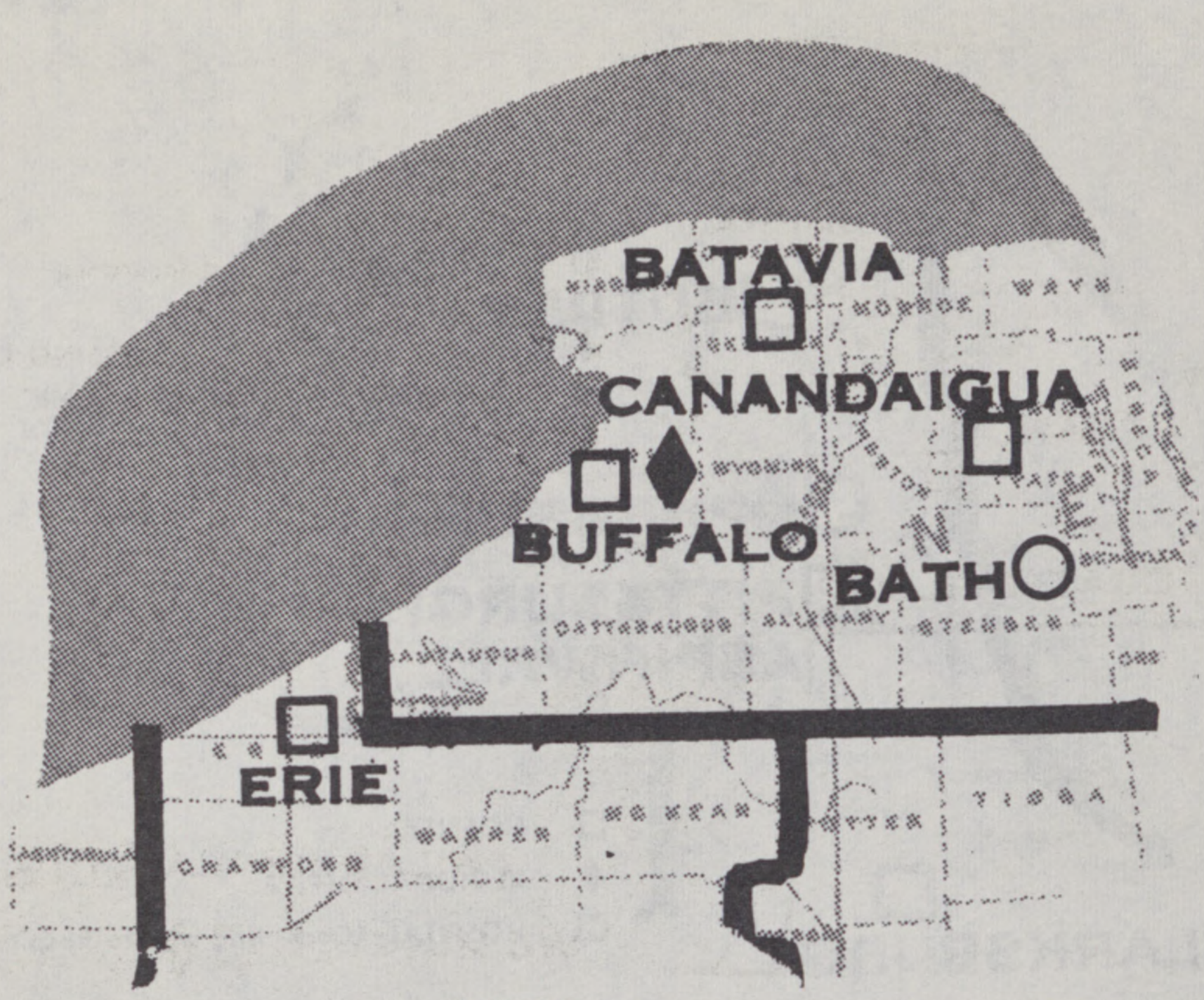
Physicians	130	Nurses	500
Dentists	20	All other	3,041

Operating beds (September 1971)

Medical	1,120	Psychiatric	2,117
Surgical	531	Nursing home	147

Services delivered (fiscal year 1971)

In-patients	22,105
Out-patient visits:	
VA staff physicians	279,900
Private physicians (fee basis)	64,556



Western New York and northwestern Pennsylvania—Regional District No. 6

WESTERN NEW YORK AND NORTHWESTERN PENNSYLVANIA—REGIONAL DISTRICT NO. 6

Service area

This district includes the 15 western counties of New York, 10 northwestern counties of Pennsylvania, and Ashtabula County in Ohio.

Veteran population

1969	487,000
1980 (projected)	506,000

VA facilities

Batavia, N.Y., VA Hospital
Bath, N.Y., VA Hospital and Domiciliary
Buffalo, N.Y., VA Hospital
Canandaigua, N.Y., VA Hospital
Rochester, N.Y. (sub-clinic)

Medical school affiliation

University of Rochester, School of Medicine and Denistry
State University of New York at Buffalo School of Medicine

Full-time staff (Apr. 1, 1971)

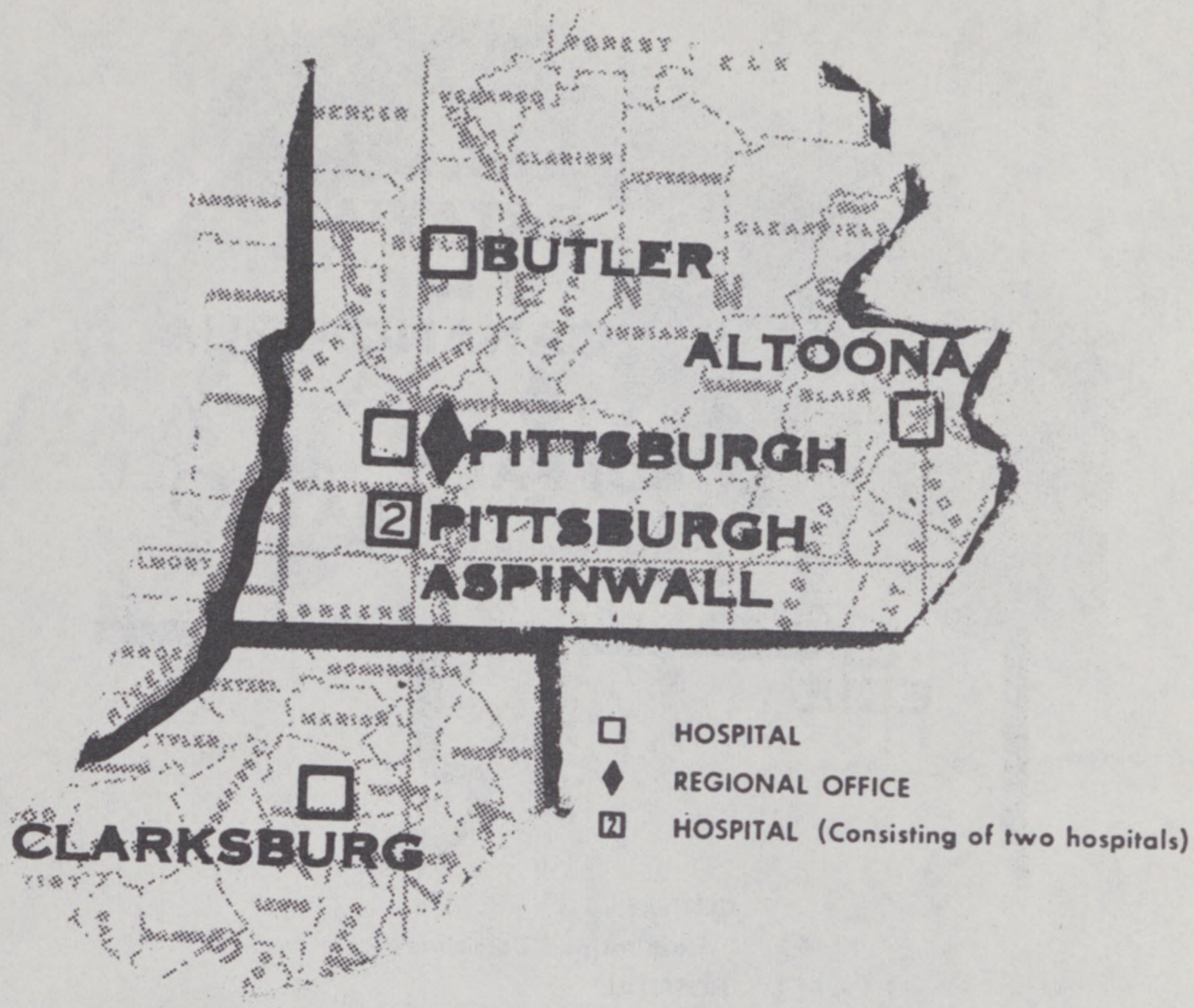
Physicians	84	Nurses	319
Dentists	19	All other	2,409

Operating beds (September 1971)

Medical	1,037	Psychiatric	1,146
Surgical	376	Nursing home	216

Services delivered (fiscal year 1971)

In-patients	14,230
Out-patient visits:	
VA staff physicians	143,029
Private physicians (fee basis)	10,014



Western Pennsylvania/eastern Ohio and northwestern West Virginia—Regional District No. 7

WESTERN PENNSYLVANIA/EASTERN OHIO AND NORTHWESTERN WEST VIRGINIA—REGIONAL DISTRICT NO. 7

Service area

This district includes 22 western counties of Pennsylvania, 23 northwestern counties of West Virginia, and 10 east-central counties of Ohio.

Veteran population

1969	805,000
1980 (projected)	886,000

VA facilities

Altoona, Pa., VA Hospital
Butler, Pa., VA Hospital
Clarksburg, W. Va., VA Hospital
Pittsburgh, Pa. (University Dr.), VA Hospital
Pittsburgh, Pa. (Leech Farm Rd.), VA Hospital
Wheeling, W. Va. (sub-clinic)

Medical school affiliation

West Virginia University School of Medicine
University of Pittsburgh School of Medicine

Full-time staff (Apr. 1, 1971)

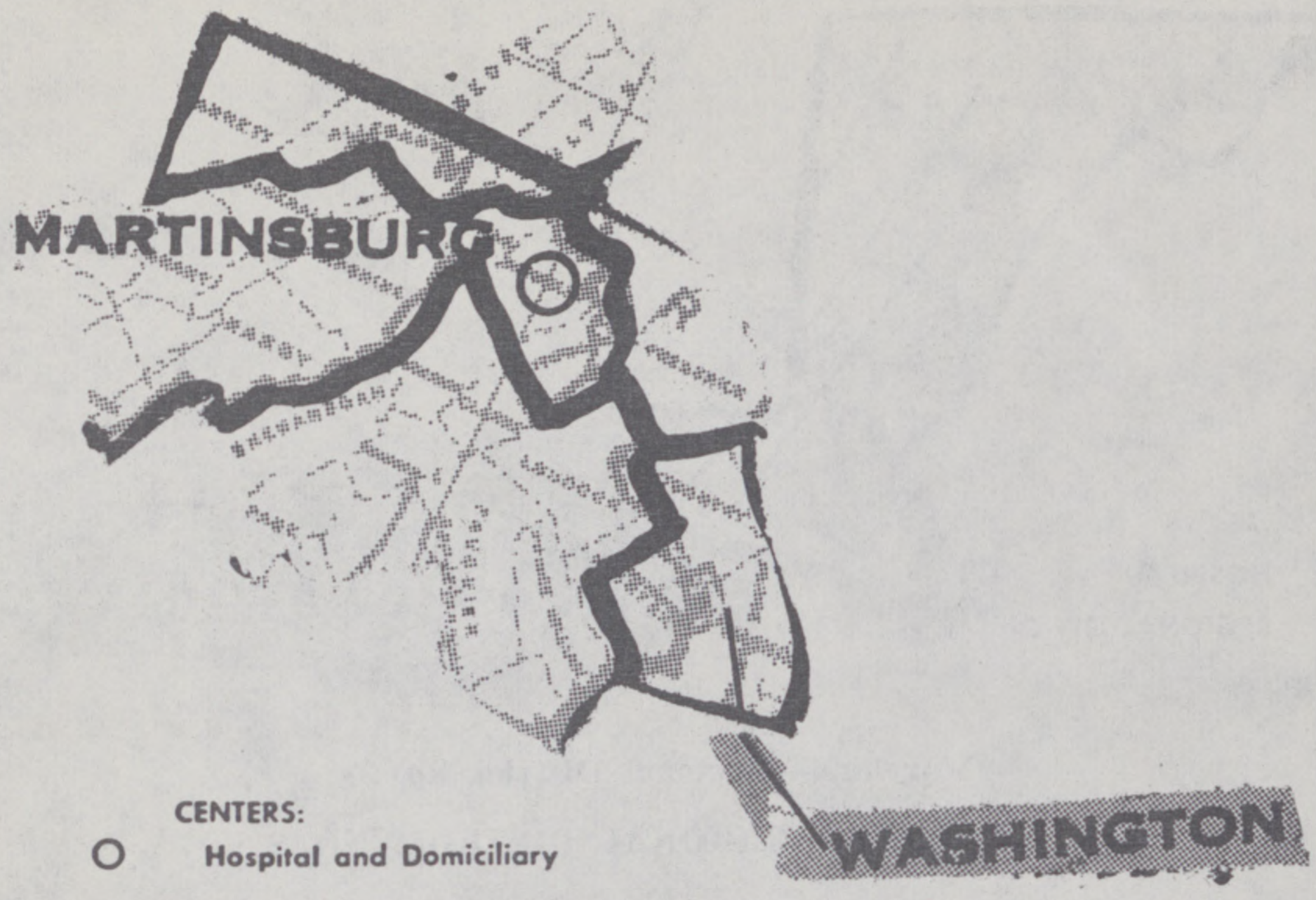
Physicians	86	Nurses	450
Dentists	21	All other	2,581

Operating beds (September 1971)

Medical	1,076	Psychiatric	883
Surgical	449	Nursing home	272

Services delivered (fiscal year 1971)

In-patients	16,522
Out-patient visits:	
VA staff physicians	132,190
Private physicians (fee basis)	20,405



Washington, D.C., metropolitan area/northern West Virginia—Regional District No. 8

WASHINGTON, D.C., METROPOLITAN AREA/NORTHERN WEST VIRGINIA—REGIONAL DISTRICT NO. 8

Service area

This district includes the District of Columbia, 15 independent cities and/or counties in northern Virginia, eight counties in northern West Virginia, eight counties in Maryland, and two counties in south central Pennsylvania.

Veteran population

1969	503,000
1980 (projected)	518,000

VA facilities

Martinsburg, W. Va., VA Hospital and Domiciliary
Washington, D.C., VA Hospital

Medical school affiliation

George Washington University School of Medicine
Georgetown University School of Medicine
Howard University School of Medicine

Full-time staff (Apr. 1, 1971)

Physicians	74	Nurses	263
Dentists	16	All other	1,719

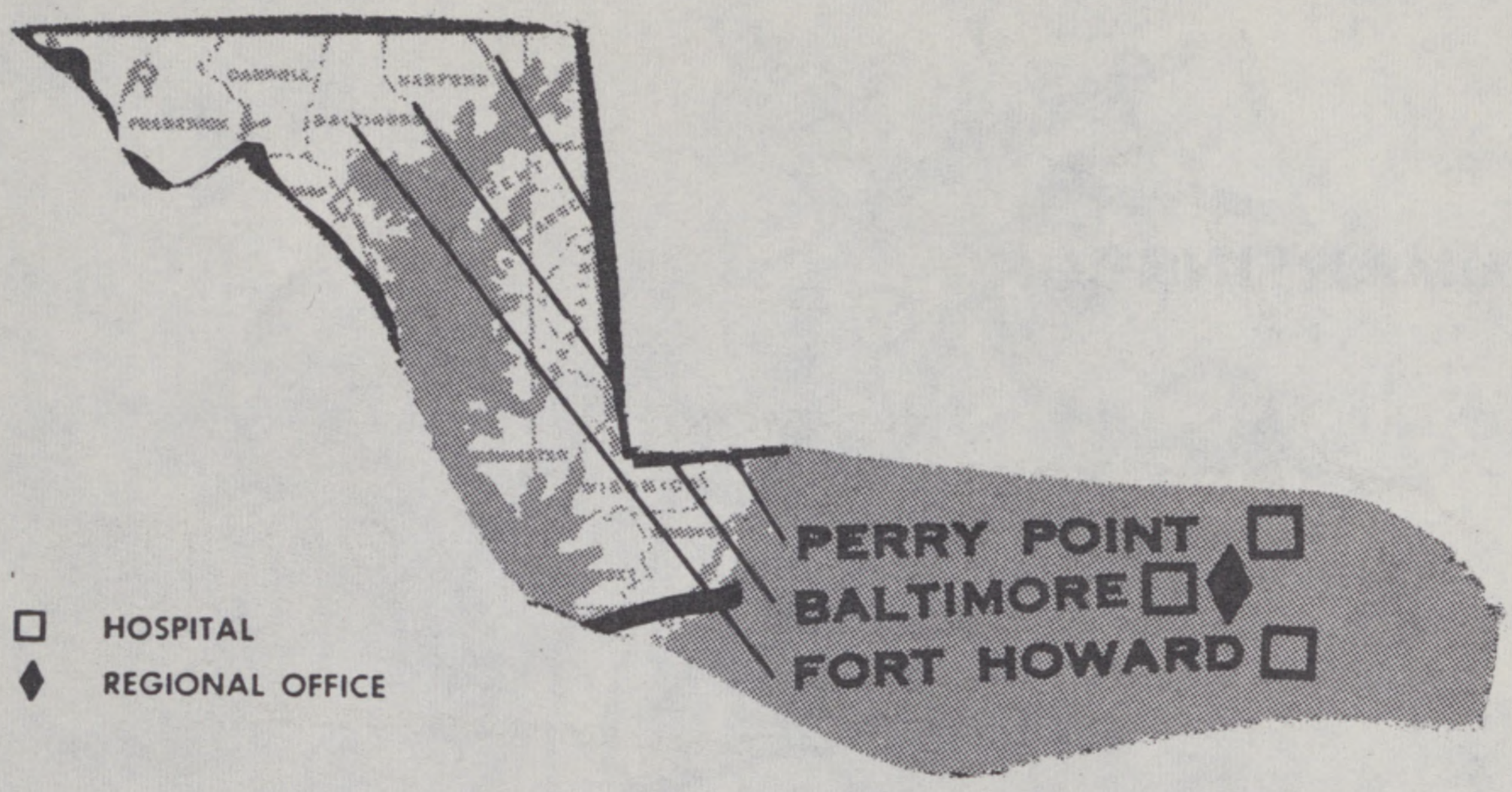
Operating beds (September 1971)

Medical	818	Psychiatric	220
Surgical	336		

Services delivered (fiscal year 1971)

In-patients	13,928
Out-patient visits:	
VA staff physicians	118,691
Private physicians (fee basis)	6,442

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Maryland—Regional District No. 9

MARYLAND—REGIONAL DISTRICT NO. 9

Service area

This district includes the city of Baltimore, plus 12 counties in central and eastern Maryland.

Veteran population

1969	305,000
1980 (projected)	342,000

VA facilities

Baltimore VA Hospital
Baltimore Out-Patient Clinic
Fort Howard, Md., VA Hospital
Perry Point, Md., VA Hospital

Medical school affiliation

University of Maryland School of Medicine
Johns Hopkins University School of Medicine

Full-time staff (Apr. 1, 1971)

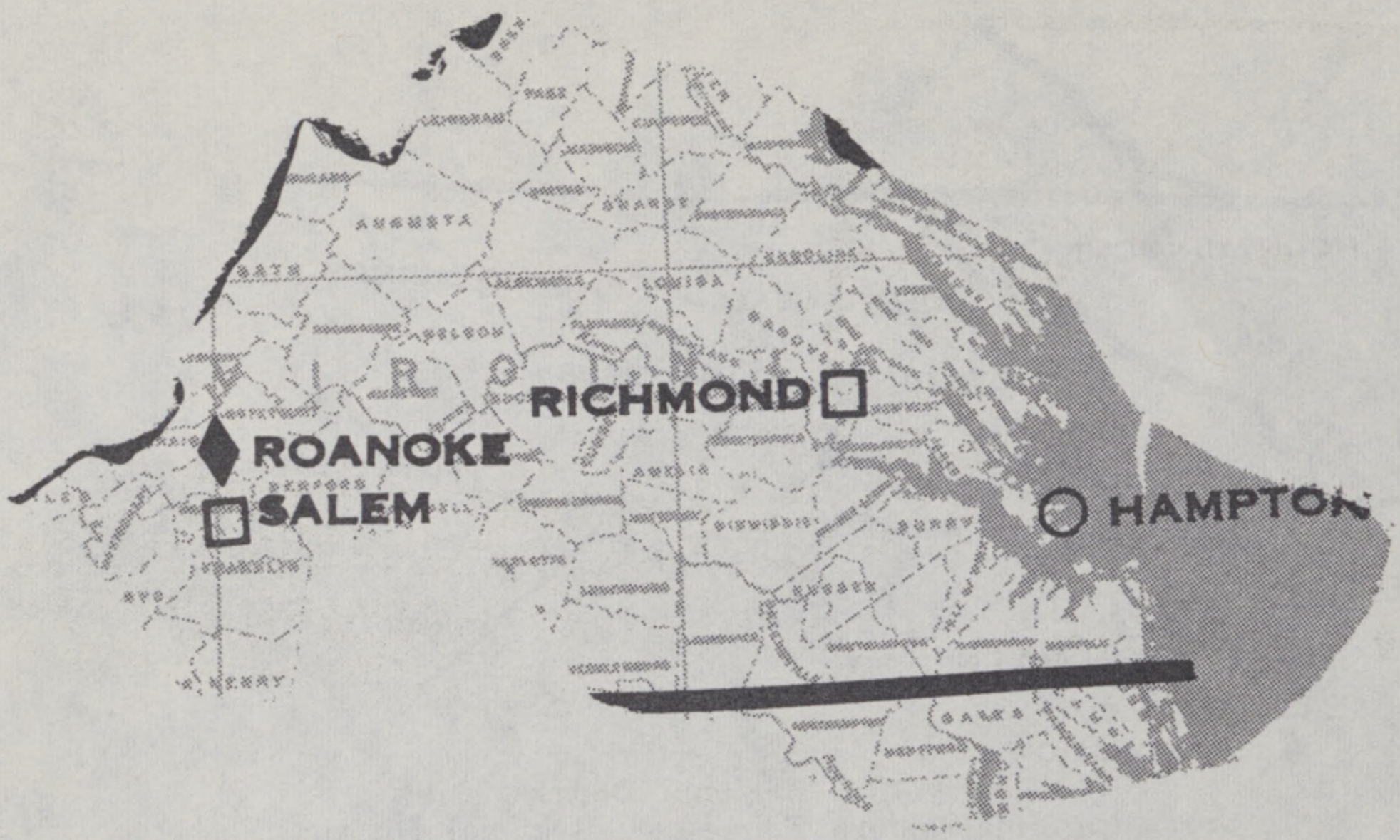
Physicians	63	Nurses	200
Dentists	11	All other	1,684

Operating beds (September 1971)

Medical	500	Psychiatric	956
Surgical	132	Nursing home	97

Services delivered (fiscal year 1971)

In-patients	10,671
Out-patient visits:	
VA staff physicians	90,384
Private physicians (fee basis)	5,589



Virginia—Regional District No. 10

VIRGINIA—REGIONAL DISTRICT NO. 10

Service area

This district includes all of Virginia except 11 northern and two southern central counties, plus 11 northeastern counties in North Carolina.

Veteran population

1969	372,000
1980 (projected)	403,000

VA facilities

Hampton, Va., VA Hospital and Domiciliary
Richmond, Va., VA Hospital
Salem, Va., VA Hospital

Medical school affiliations

Medical College of Virginia

Full-time staff (Apr. 1, 1971)

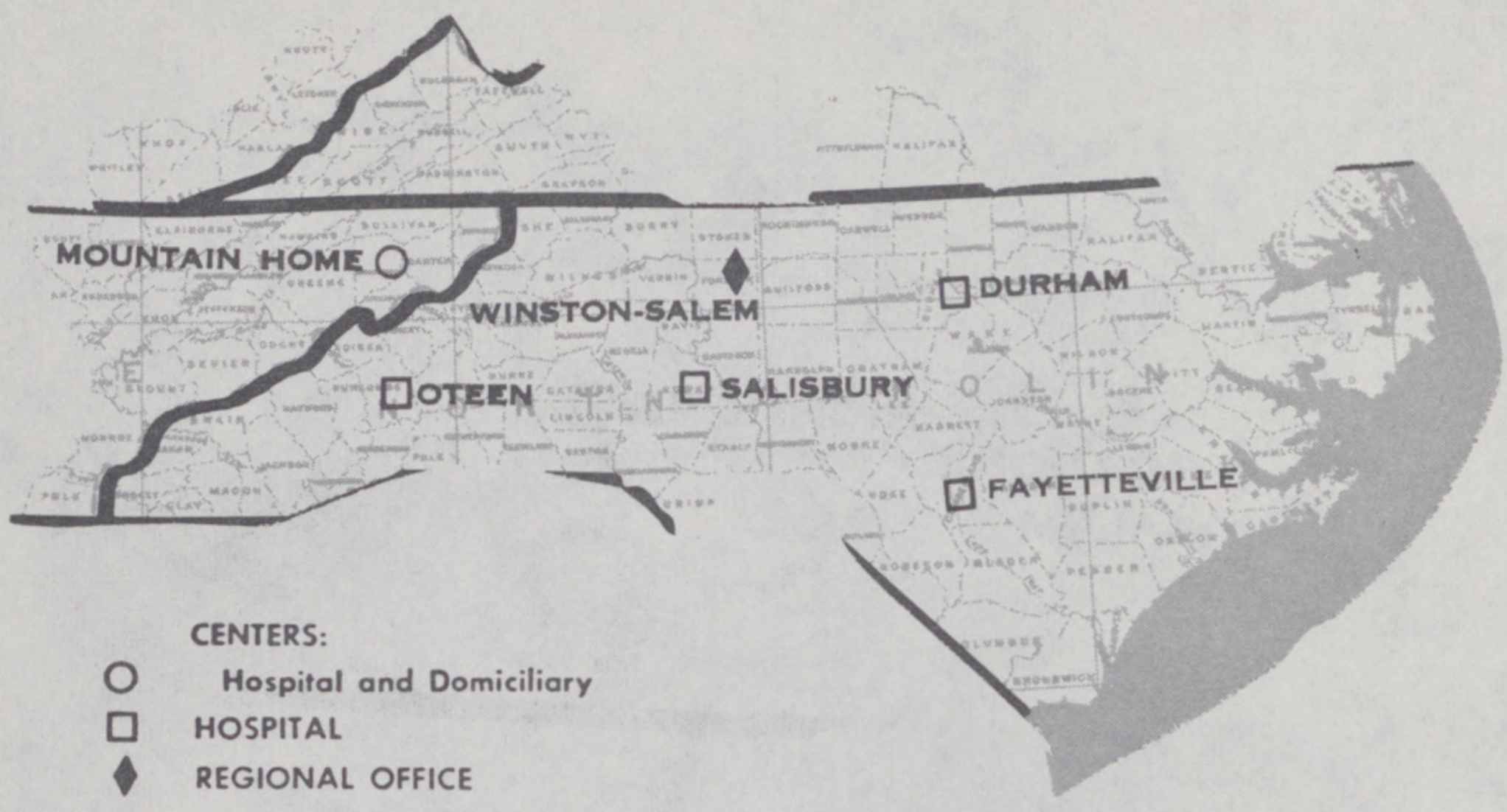
Physicians	119	Nurses	385
Dentists	16	All other	2,848

Operating beds (September 1971)

Medical	1,342	Psychiatric	933
Surgical	403	Nursing home	141

Services delivered (fiscal year 1971)

In-patients	20,454
Out-patient visits:	
VA staff physicians	126,428
Private physicians (fee basis)	21,135



North Carolina/eastern Tennessee—Regional District No. 11

NORTH CAROLINA/EASTERN TENNESSEE—REGIONAL DISTRICT NO. 11

Service area

This district includes all of North Carolina except 10 northeastern counties, 22 counties in eastern Tennessee, 12 counties in southwestern Virginia.

Veteran population

1969	663,000
1980 (projected)	734,000

VA facilities

Durham, N.C., VA Hospital
Fayetteville, N.C., VA Hospital
Mountain Home, Tenn., VA Hospital and Domiciliary
Oteen, N.C., VA Hospital
Salisbury, N.C., VA Hospital
Winston-Salem, N.C., Out-Patient Clinic

Medical school affiliation

Duke University School of Medicine

Full-time staff (Apr. 1, 1971)

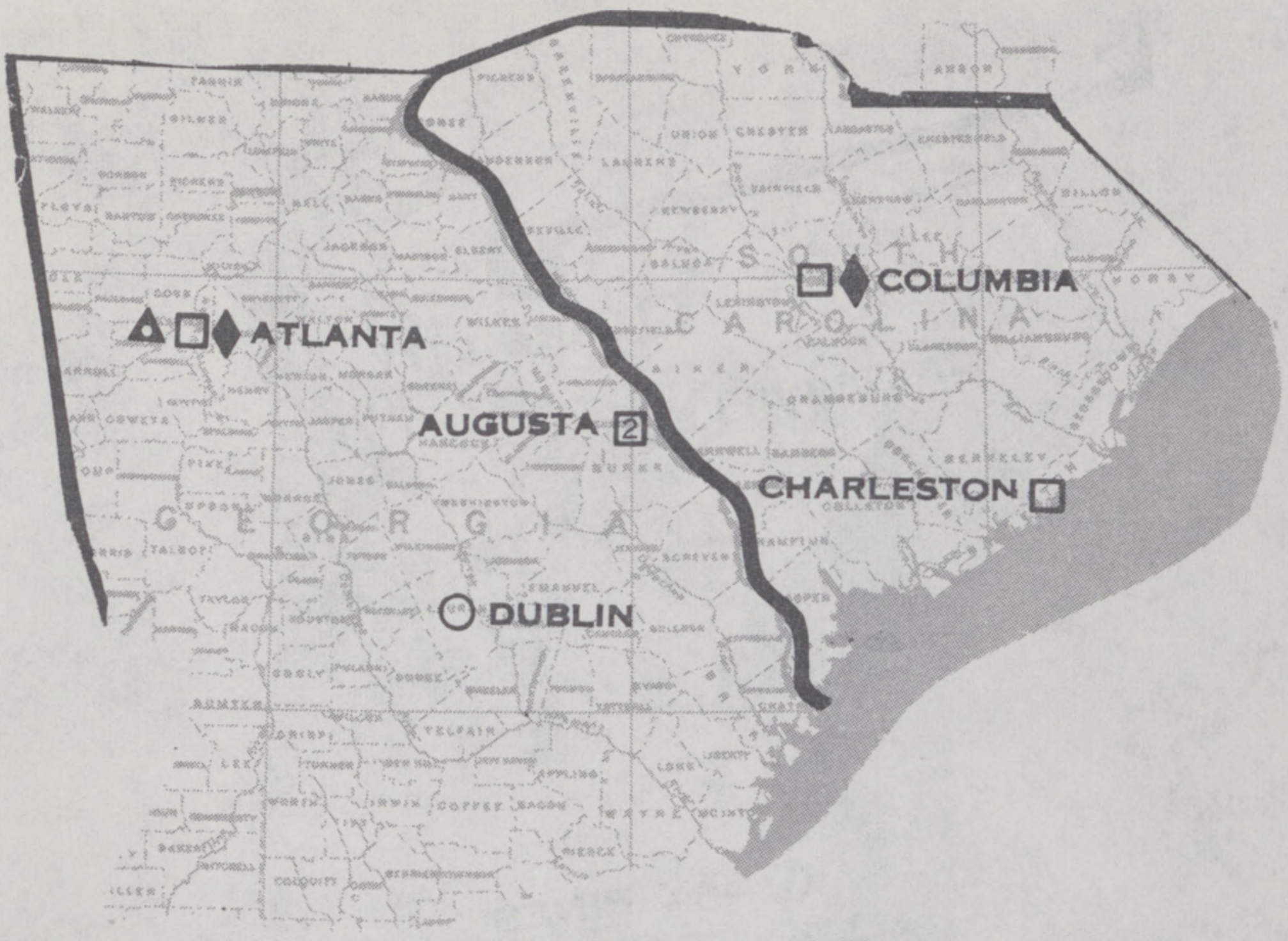
Physicians	139	Nurses	554
Dentists	22	All other	3,088

Operating beds (September 1971)

Medical	1,298	Psychiatric	852
Surgical	650	Nursing home	237

Services delivered (fiscal year 1971)

In-patients	28,784
Out-patient visits:	
VA staff physicians	135,577
Private physicians (fee basis)	36,169



CENTERS:

○ Hospital and Domiciliary

□ HOSPITAL

2 HOSPITAL (Consisting of two hospitals)

△ MARKETING CENTER

♦ REGIONAL OFFICE

Georgia/South Carolina—Regional District No. 12

GEORGIA/SOUTH CAROLINA—REGIONAL DISTRICT NO. 12

Service Area

This district includes all of South Carolina except for three northeastern counties; the State of Georgia except for 30 southern counties; two counties in North Carolina and one county in southeastern Tennessee.

Veteran Population

1969	736,000
1980 (projected)	783,000

VA Facilities

Atlanta, Ga., VA Hospital
Augusta, Ga., VA Hospital
Charleston, S.C., VA Hospital
Columbia, S.C., VA Hospital
Columbia, S.C., Out-Patient Clinic
Dublin, Ga. VA, Hospital and Domiciliary

Medical School affiliation

Emory University School of Medicine
Medical College of Georgia School of Medicine
Medical College of South Carolina

Full-time staff (Apr. 1, 1971)

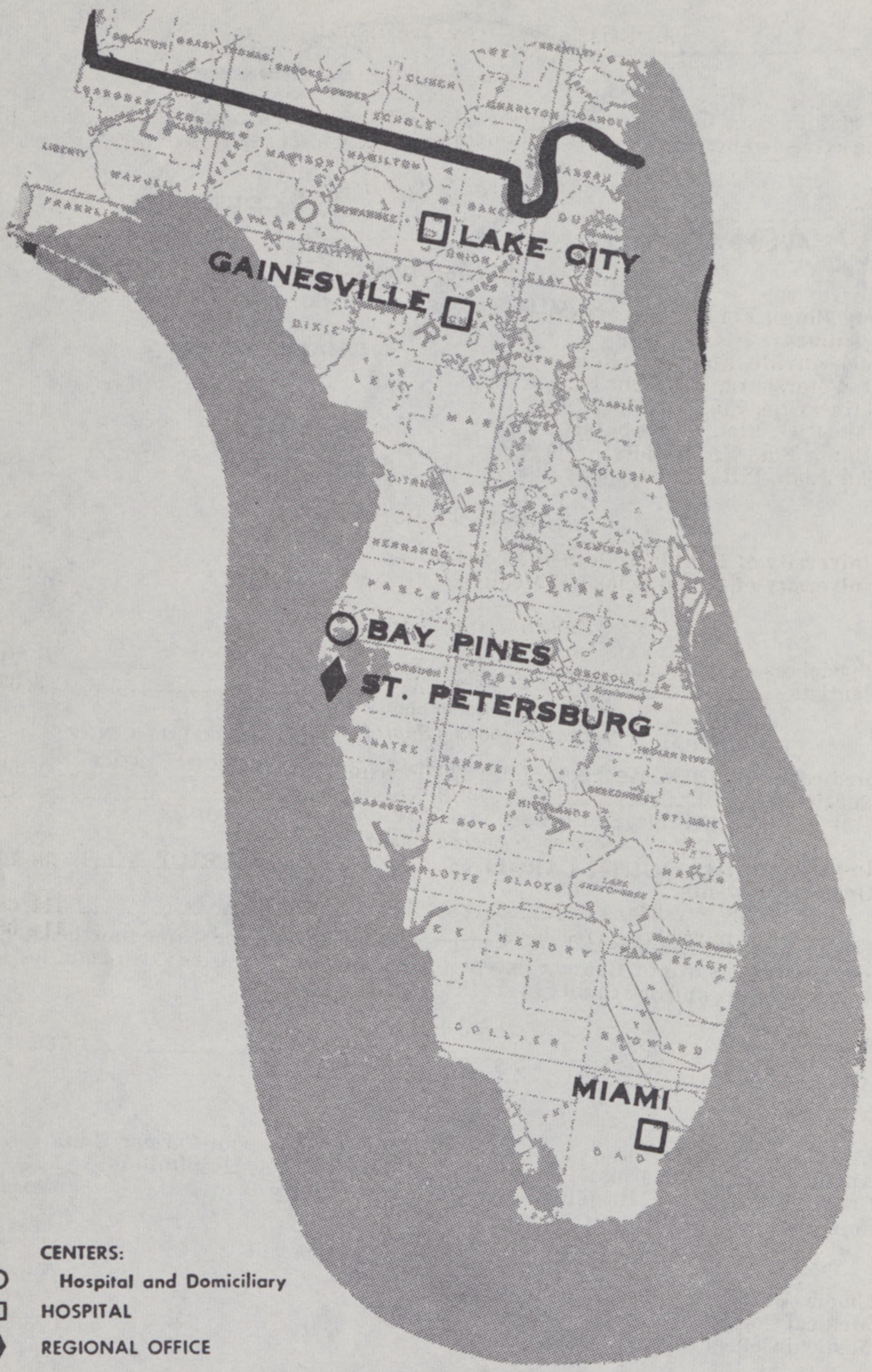
Physicians	137	Nurses	524
Dentists	24	All other	3,090

Operating beds (September 1971)

Medical	1,393	Psychiatric	821
Surgical	796	Nursing home	168

Services delivered (fiscal year 1971)

In-patients	29,770
Out-patient visits:	
VA staff physicians	160,289
Private physicians (fee basis)	48,172



Florida—Regional District No. 13

FLORIDA—REGIONAL DISTRICT NO. 13

Service area

This district includes the entire State of Florida except for eight counties in the extreme northwestern section, plus 19 counties in southern Georgia.

Veteran population

1969	908,000
1980 (projected)	1,280,000

VA facilities

Bay Pines, Fla., VA Hospital and Domiciliary
Jacksonville, Fla. (sub-clinic)
St. Petersburg, Fla., Out-Patient Clinic
Gainesville, Fla., VA Hospital
Lake City, Fla., VA Hospital
Miami, Fla., VA Hospital
San Juan, P.R., VA Hospital

Medical school affiliation

University of Florida College of Medicine
University of Miami School of Medicine

Full-time staff (Apr. 1, 1971)

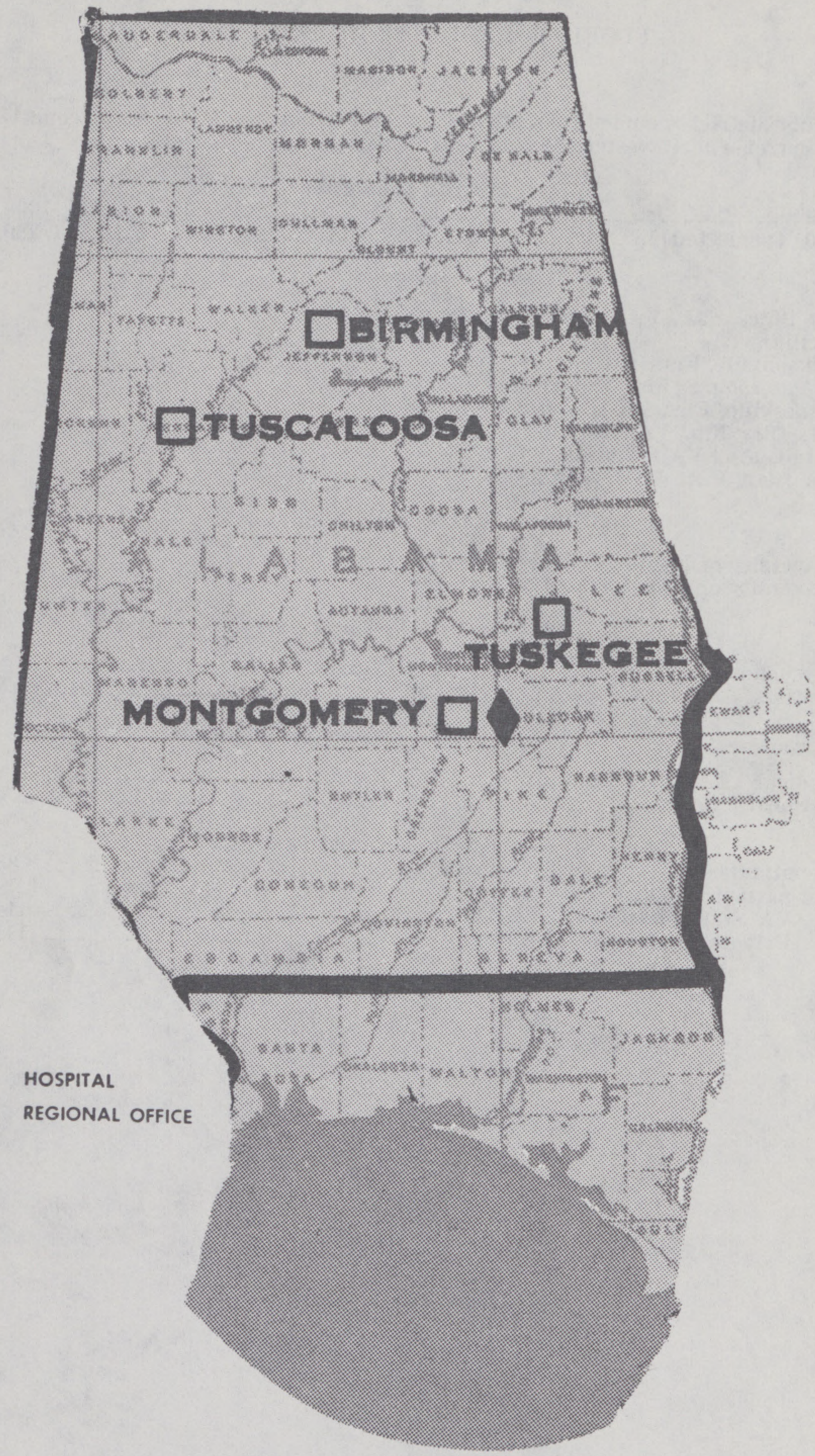
Physicians	214	Nurses	714
Dentists	32	All other	3,634

Operating beds (September 1971)

Medical	1,579	Psychiatric	560
Surgical	843	Nursing home	120

Services delivered (fiscal year 1971)

In-patients	38,762
Out-patient visits:	
VA staff physicians	414,682
Private physicians (fee basis)	114,684



Alabama—Regional District No. 14

ALABAMA—REGIONAL DISTRICT NO. 14

Service area

This district includes the entire State of Alabama except for one county in the northwestern corner and three counties in the southwestern corner, plus 11 southwestern counties of Georgia and six western counties of Florida.

Veteran population

1969	389,000
1980 (projected)	447,000

VA facilities

Birmingham, Ala., VA Hospital
Montgomery, Ala., VA Hospital
Tuscaloosa, Ala., VA Hospital
Tuskegee, Ala., VA Hospital

Medical school affiliation

Medical College of Alabama

Full-time staff (Apr. 1, 1971)

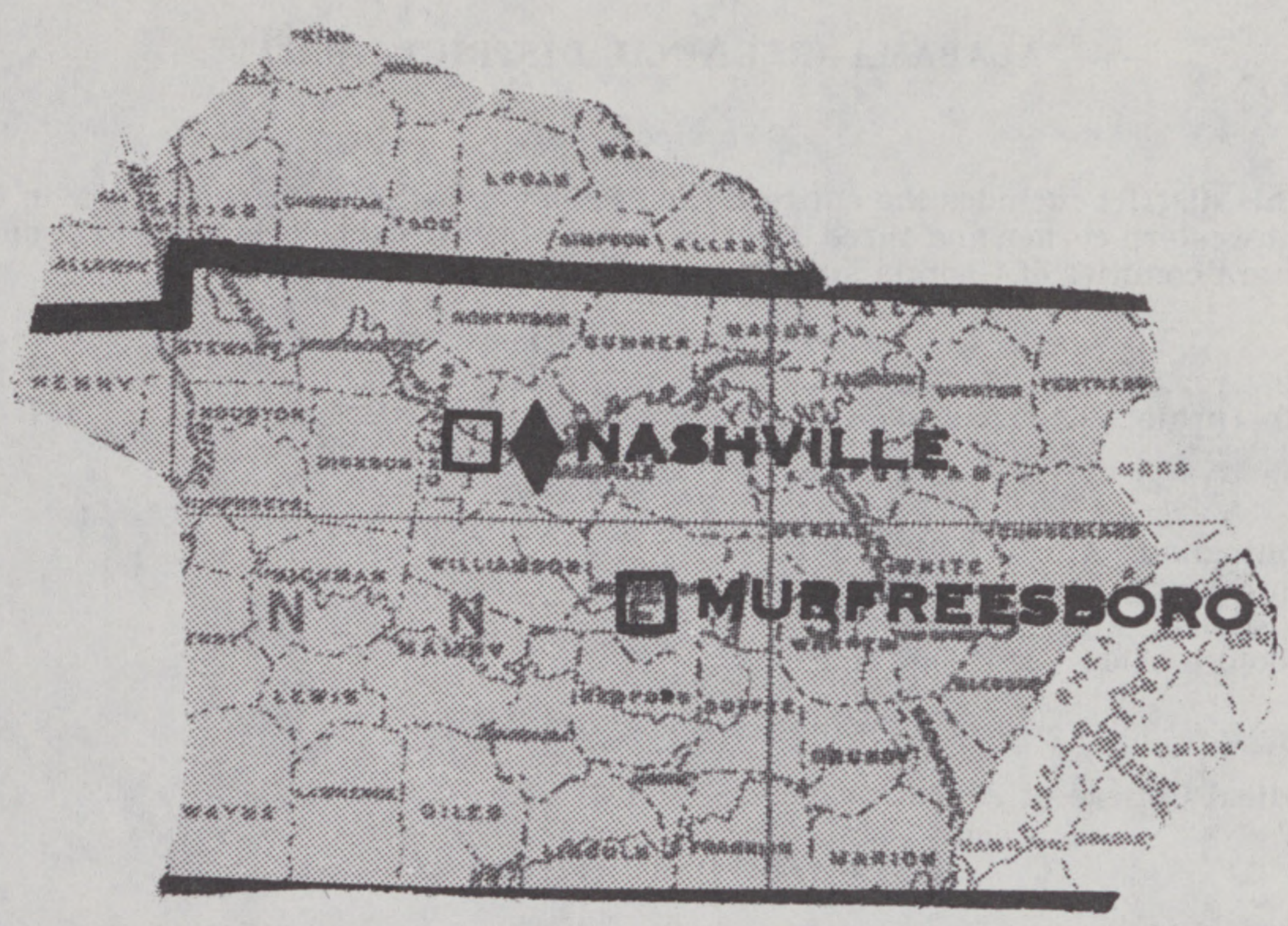
Physicians	74	Nurses	356
Dentists	18	All other	2,499

Operating beds (September 1971)

Medical	633	Psychiatric	1,545
Surgical	411	Nursing home	120

Services delivered (fiscal year 1971)

In-patients	20,945
Out-patient visits:	
VA staff physicians	97,237
Private physicians (fee basis)	23,385



Tennessee—Regional District No. 15

TENNESSEE—REGIONAL DISTRICT NO. 15

Service area

This district includes 53 counties in central Tennessee and 13 counties in southern Kentucky.

Veteran population

1969	242,000
1980 (projected)	263,000

VA facilities

Murfreesboro, Tenn., VA Hospital
Nashville, Tenn., VA Hospital
Knoxville, Tenn. (sub-clinic)

Medical school affiliation

Vanderbilt University School of Medicine
Meharry Medical College School of Medicine

Full-time staff (Apr. 1, 1971)

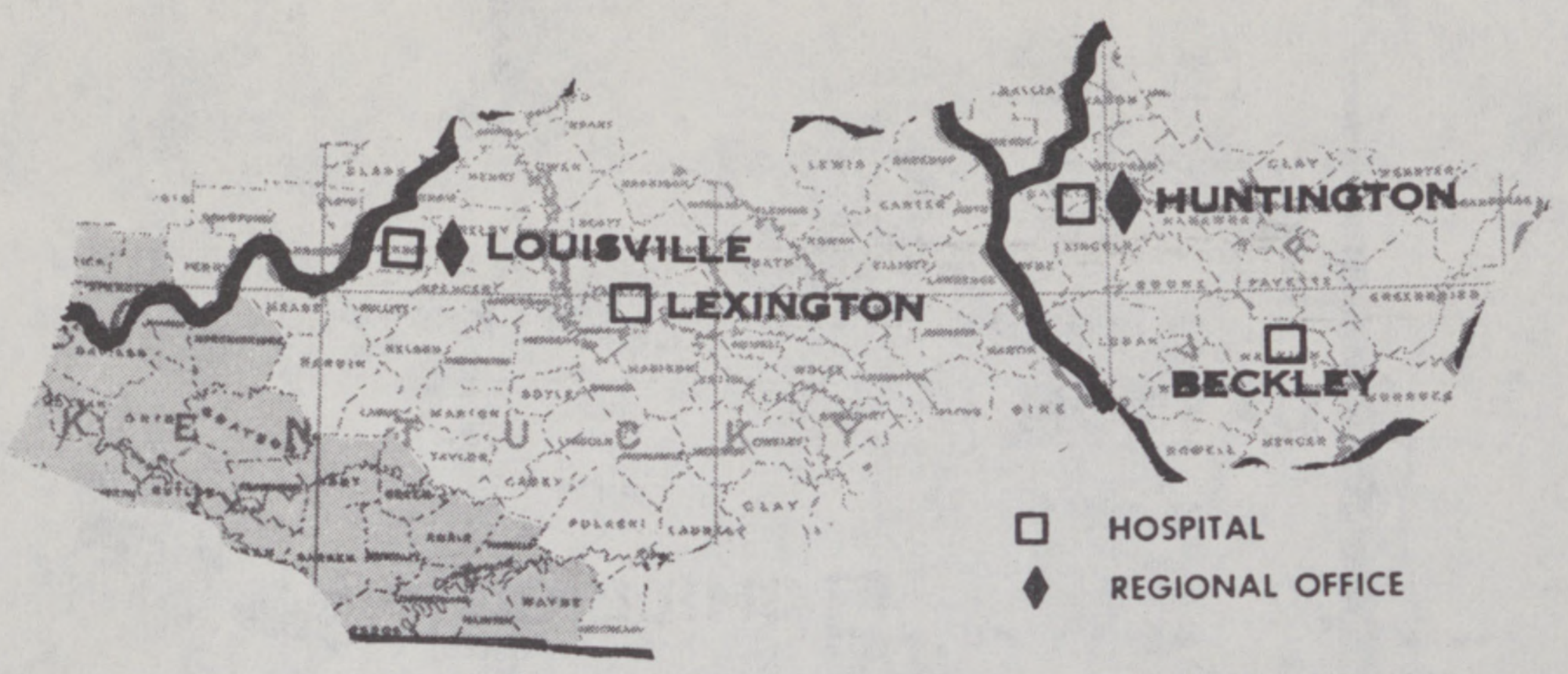
Physicians	37	Nurses	194
Dentists	6	All other	1,284

Operating beds (September 1971)

Medical	503	Psychiatric	826
Surgical	204	Nursing home	48

Services delivered (fiscal year 1971)

In-patients	11,167
Out-patient visits:	
VA staff physicians	73,024
Private physicians (fee basis)	8,972



Kentucky/West Virginia—Regional District No. 16

KENTUCKY/WEST VIRGINIA—REGIONAL DISTRICT NO. 16

Service Area

This district includes the entire State of Kentucky except for 27 southwestern counties and eight southeastern counties; 19 southwestern counties of West Virginia, 11 southern counties of Indiana, and three southeastern counties of Ohio.

Veteran population

1969	447,000
1980 (projected)	482,000

VA facilities

Beckley, W. Va., VA Hospital
Huntington, W. Va., VA Hospital
Lexington, Ky., VA Hospital
Louisville, Ky., VA Hospital
Louisville, Ky., Out-Patient Clinic

Medical school affiliation

University of Kentucky College of Medicine
University of Louisville School of Medicine

Full-time staff (Apr. 1, 1971)

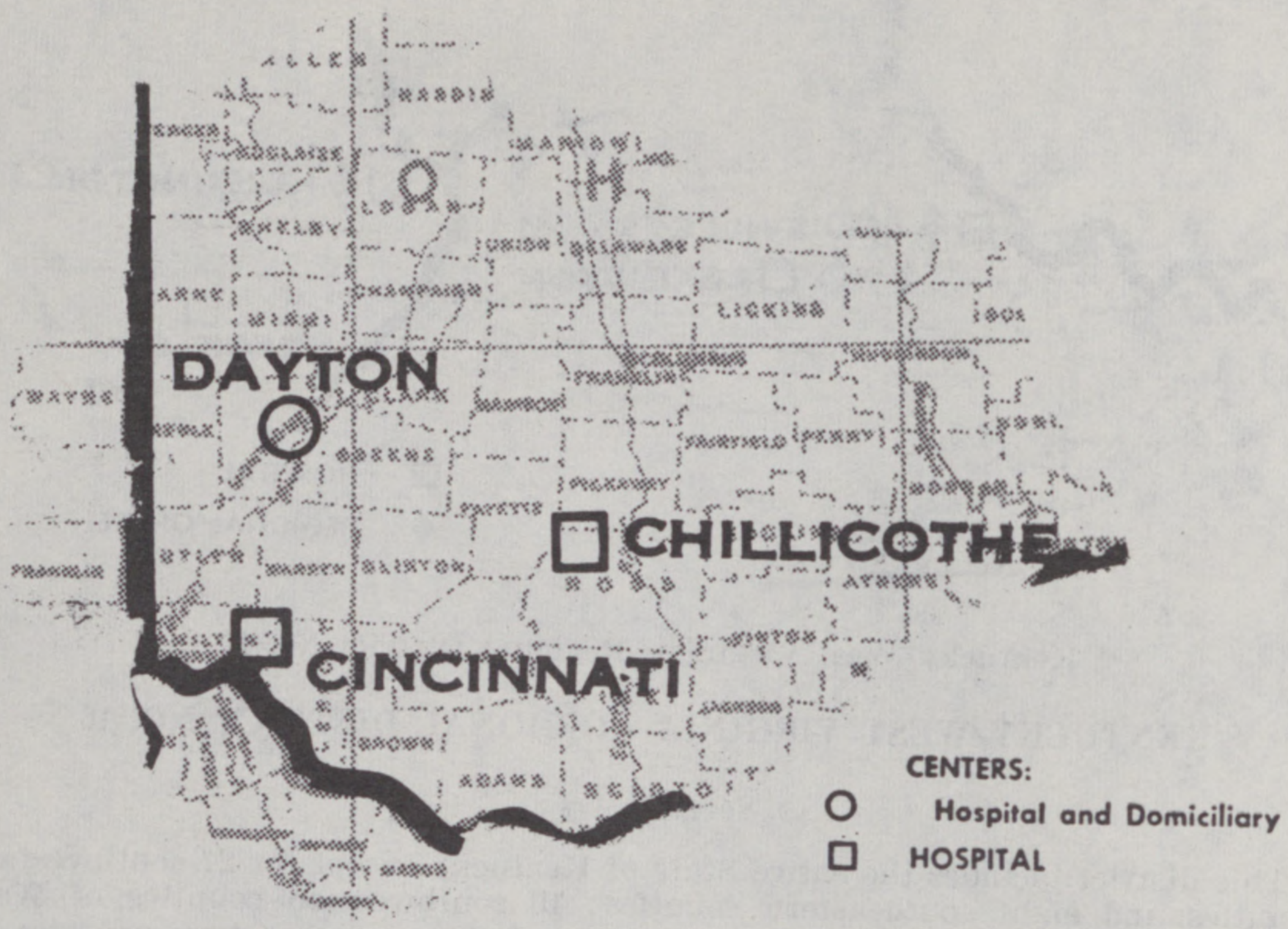
Physicians	84	Nurses	300
Dentists	8	All other	1,675

Operating beds (September 1971)

Medical	614	Psychiatric	584
Surgical	423	Nursing home	143

Services delivered (fiscal year 1971)

In-patients	20,255
Out-patient visits:	
VA staff physicians	124,945
Private physicians (fee basis)	23,758



Southwestern Ohio—Regional District No. 17

SOUTHWESTERN OHIO—REGIONAL DISTRICT NO. 17

Service area

This district includes 34 counties in southwestern Ohio, nine northern counties in Kentucky, and six southwestern counties in Indiana.

Veteran population

1969	683,000
1980 (projected)	752,000

VA facilities

Chillicothe, Ohio, VA Hospital
Cincinnati, Ohio, VA Hospital
Columbus, Ohio (sub-clinic)
Dayton, Ohio, VA Hospital and Domiciliary

Medical school affiliation

University of Cincinnati College of Medicine
Ohio State University College of Medicine

Full-time staff (Apr. 1, 1971)

Physicians	93	Nurses	306
Dentists	18	All other	2,954

Operating beds (September 1971)

Medical	1,139	Psychiatric	1,217
Surgical	421	Nursing home	388

Services delivered (fiscal year 1971)

In-patients	16,331
Out-patient visits:	
VA staff physicians	99,925
Private physicians (fee basis)	22,065



Northeastern Ohio—Regional District No. 18

NORTHEASTERN OHIO—REGIONAL DISTRICT NO. 18

Service area

This district includes 25 counties in northeastern Ohio.

Veteran population

1969	647,000
1980 (projected)	717,000

VA facilities

Cleveland, Ohio, VA Hospital

Brecksville, Ohio, VA Hospital

Medical school affiliation

Case Western Science University School of Medicine

Full-time staff (Apr. 1, 1971)

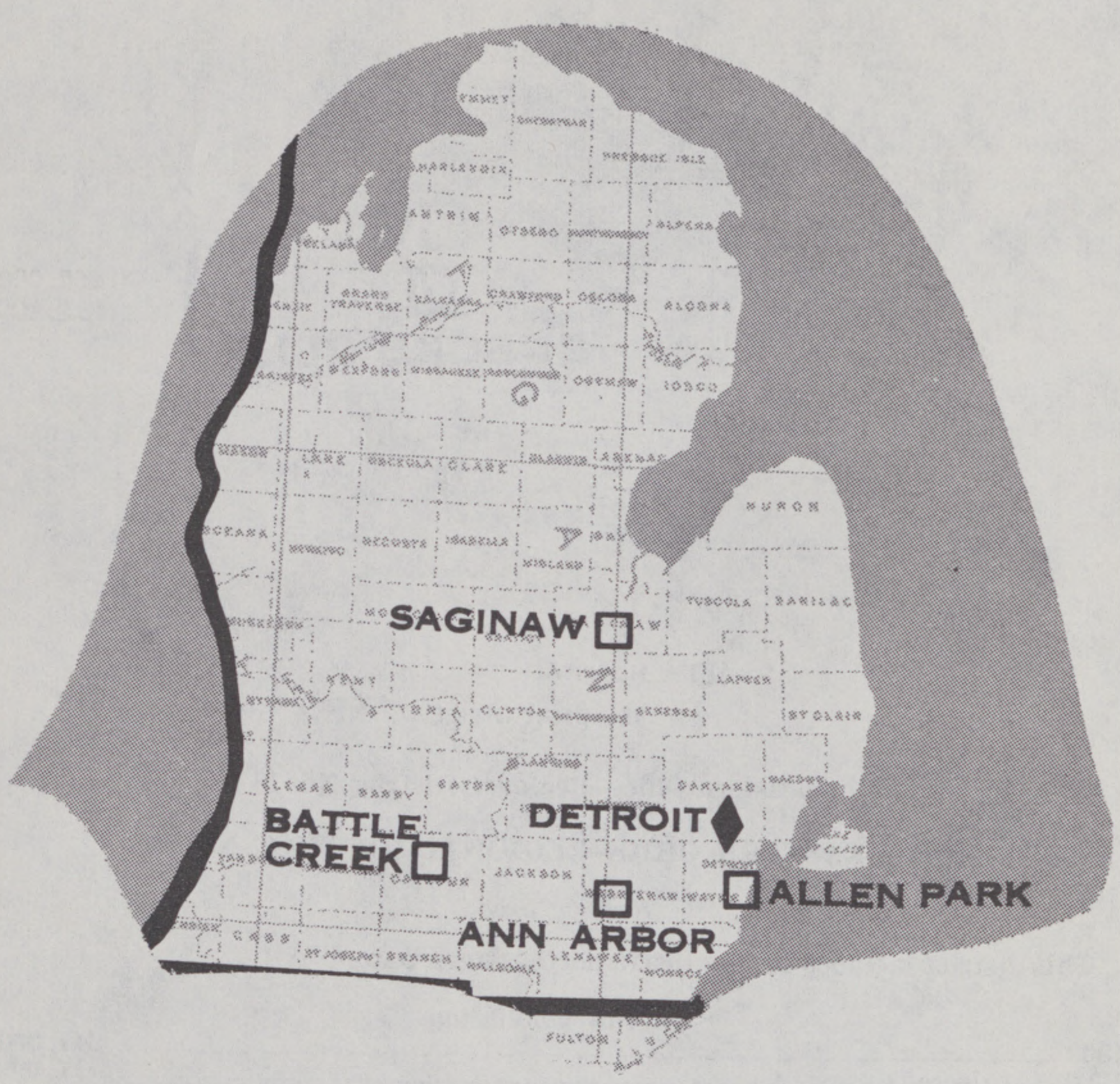
Physicians	66	Nurses	237
Dentists	11	All other	1,757

Operating beds (September 1971)

Medical	618	Psychiatric	738
Surgical	323	Nursing home	100

Services delivered (fiscal year 1971)

In-patients	13,063
Out-patient visits:	
VA staff physicians	116,795
Private physicians (fee basis)	43,832



Michigan lower peninsula—Regional District No. 19

MICHIGAN LOWER PENINSULA—REGIONAL DISTRICT NO. 19

Service area

This district includes the entire lower peninsula area of Michigan, plus three northwestern counties of Ohio.

Veteran population

1969	1,203,000
1980 (projected)	1,328,000

VA facilities

Allen Park, Mich., VA Hospital
Ann Arbor, Mich., VA Hospital
Battle Creek, Mich., VA Hospital
Saginaw, Mich., VA Hospital

Medical school affiliation

Wayne State University School of Medicine
University of Michigan Medical School

Full-time staff (Apr. 1, 1971)

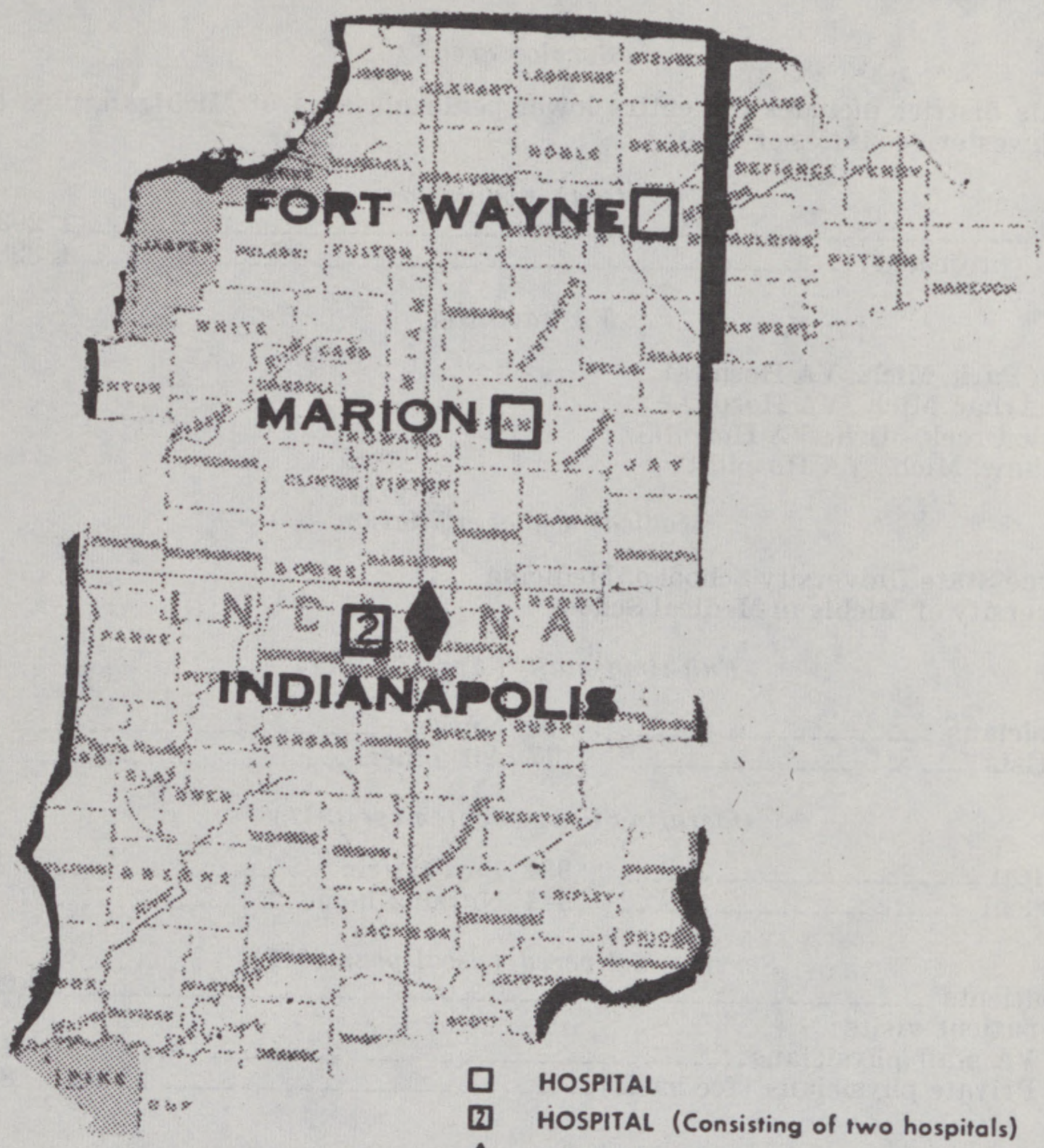
Physicians	94	Nurses	311
Dentists	17	All other	2,697

Operating beds (September 1971)

Medical	934	Psychiatric	1,131
Surgical	444	Nursing home	252

Services delivered (fiscal year 1971)

In-patients	20,594
Out-patient visits:	
VA staff physicians	145,128
Private physicians (fee basis)	84,837



Indiana—Regional District No. 20

INDIANA—REGIONAL DISTRICT NO. 20

Service area

This district includes the State of Indiana, plus seven northwestern counties of Ohio.

Veteran population

1969	511,000
1980 (projected)	582,000

VA facilities

Fort Wayne, Ind., VA Hospital
Indianapolis, Ind., VA Hospital
Indianapolis, Ind., Out-Patient Clinic
Marion, Ind., VA Hospital

Medical school affiliation

Indiana University School of Medicine.

Full-time staff (Apr. 1, 1971)

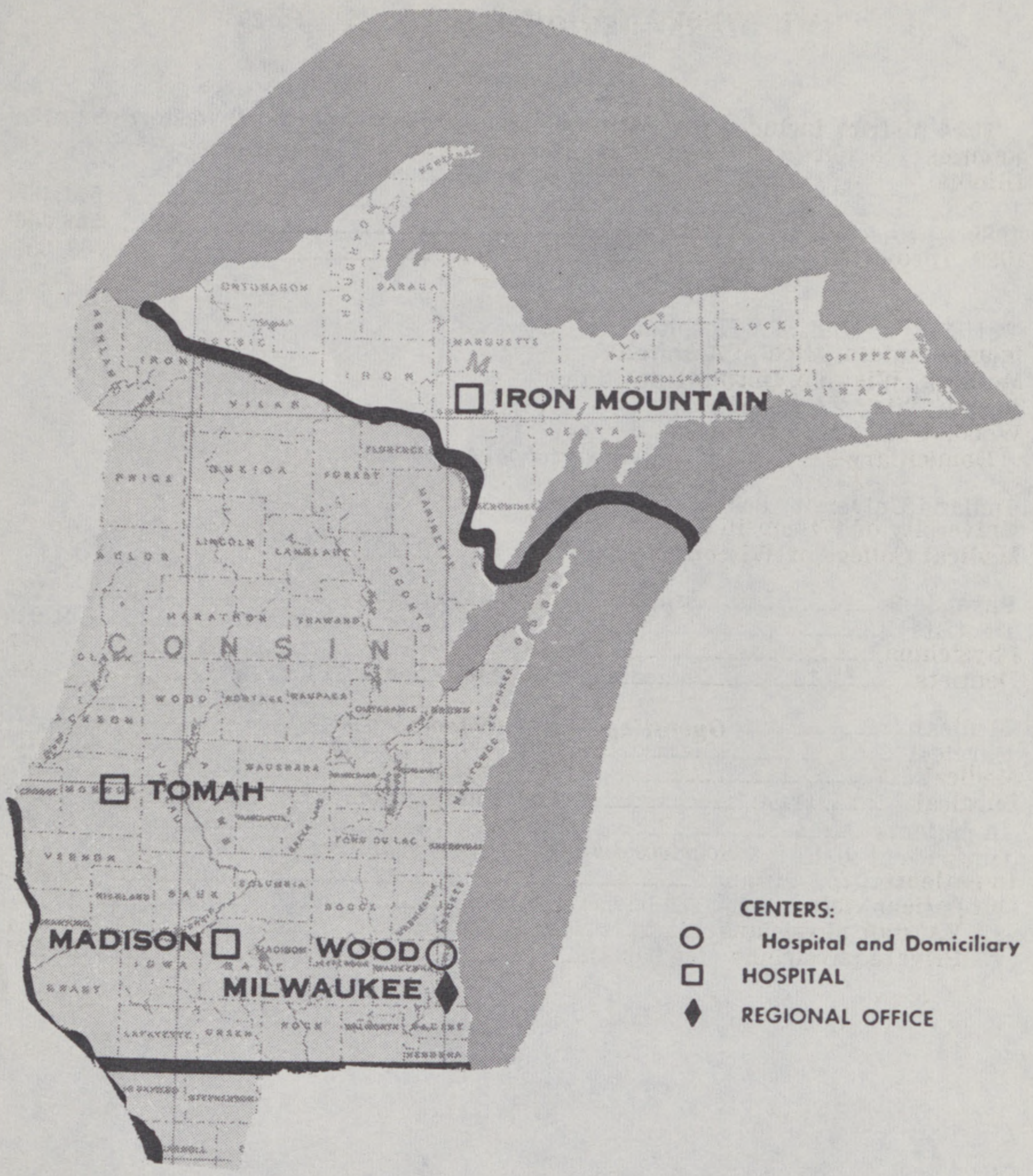
Physicians	70	Nurses	253
Dentists	13	All other	2,013

Operating beds (September 1971)

Medical	683	Psychiatric	1,178
Surgical	262	Nursing home	155

Services delivered (fiscal year 1971)

In-patients	13,965
Out-patient visits:	
VA staff physicians	85,125
Private physicians (fee basis)	18,651



Wisconsin—Regional District No. 21

WISCONSIN—REGIONAL DISTRICT NO. 21

Service area

This district includes the entire State of Wisconsin, except 16 northwestern counties; 15 northern counties in Michigan and five northwestern counties in Illinois.

Veteran population

1969	630,000
1980 (projected)	708,000

VA facilities

Iron Mountain, Mich., VA Hospital
Madison, Wis., VA Hospital
Tomah, Wis., VA Hospital
Wood, Wis., VA Hospital and
Domiciliary

Medical school affiliation

University of Wisconsin Medical School
Medical College of Wisconsin

Full-time staff (Apr. 1, 1971)

Physicians	118	Nurses	327
Dentists	24	All other	2,664

Operating beds (September 1971)

Medical	1,057	Psychiatric	697
Surgical	499	Nursing home	232

Services delivered (fiscal year 1971)

In-patients	20,483
Out-patient visits:	
VA staff physicians	129,754
Private physicians (fee basis)	38,683



Northeastern Illinois—Regional District No. 22

NORTHEASTERN ILLINOIS—REGIONAL DISTRICT NO. 22

Service area

This district includes 33 northeastern counties in Illinois and six counties in western Indiana.

Veteran population

1969	1,293,000
1980 (projected)	1,427,000

VA facilities

Chicago, Ill., West Side VA Hospital
Chicago, Ill., VA Research Hospital
Danville, Ill., VA Hospital
Downey, Ill., VA Hospital
Hines, Ill., VA Hospital

Medical school affiliation

University of Illinois College of Medicine
Northwestern University Medical School
Chicago Medical School
Loyola University Stritch School of Medicine

Full-time staff (Apr. 1, 1971)

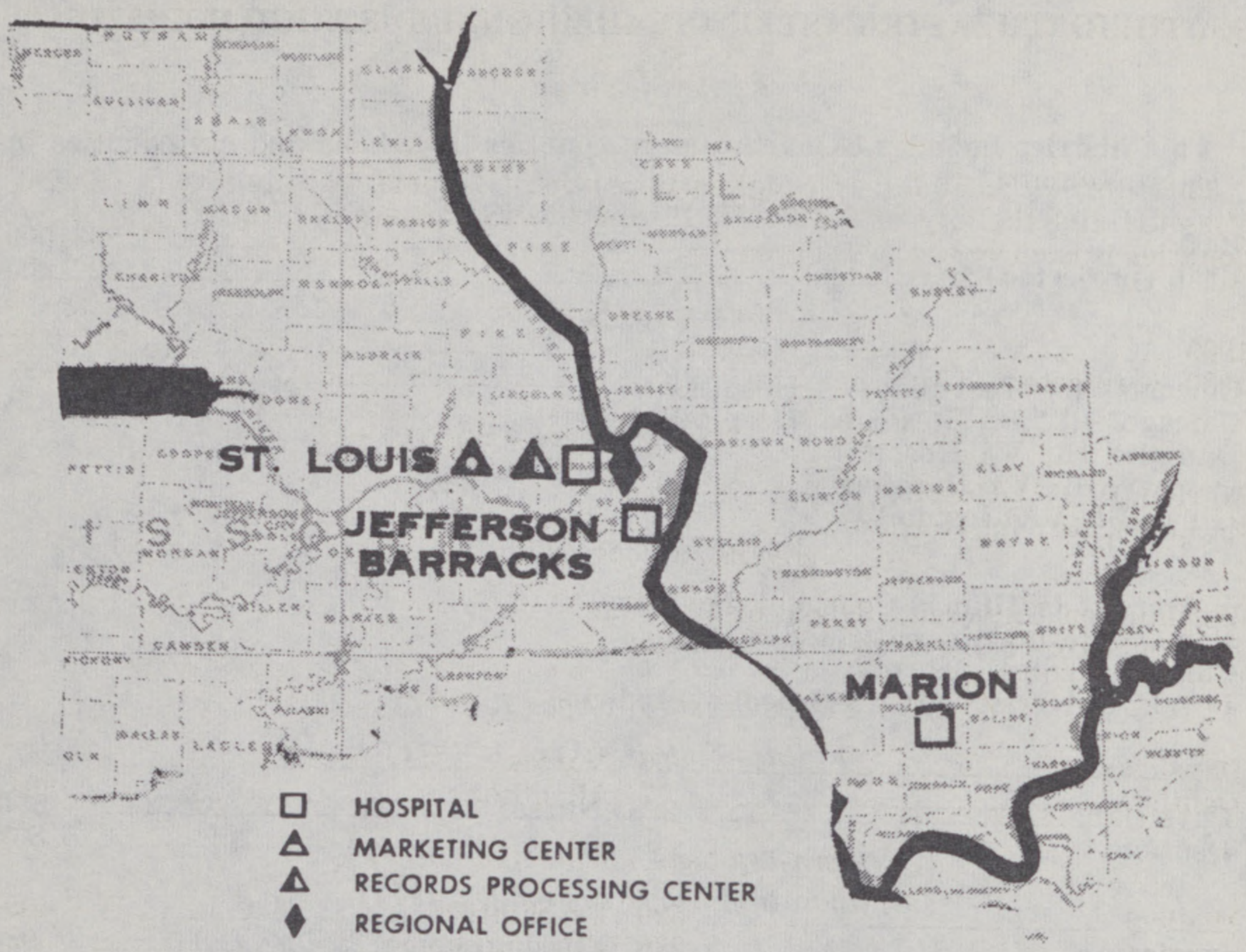
Physicians	228	Nurses	805
Dentists	32	All other	5,862

Operating beds (September 1971)

Medical	2,268	Psychiatric	2,671
Surgical	1,009	Nursing home	310

Services delivered (fiscal year 1971)

In-patients	40,743
Out-patient visits:	
VA staff physicians	312,691
Private physicians (fee basis)	14,947



Southern Illinois/east central Missouri—Regional District No. 23

SOUTHERN ILLINOIS/EAST CENTRAL MISSOURI—REGIONAL DISTRICT NO. 23

Service area

This district includes 47 counties in southern Illinois, 51 counties in central Missouri and the city of St. Louis, 12 counties in western Kentucky, and three counties in southwestern Indiana.

Veteran population

1969	637,000
1980 (projected)	698,000

VA facilities

Marion, Ill., VA Hospital
St. Louis, Mo., VA Hospital

Medical school affiliation

Washington University School of Medicine
St. Louis University School of Medicine

Full-time staff (Apr. 1, 1971)

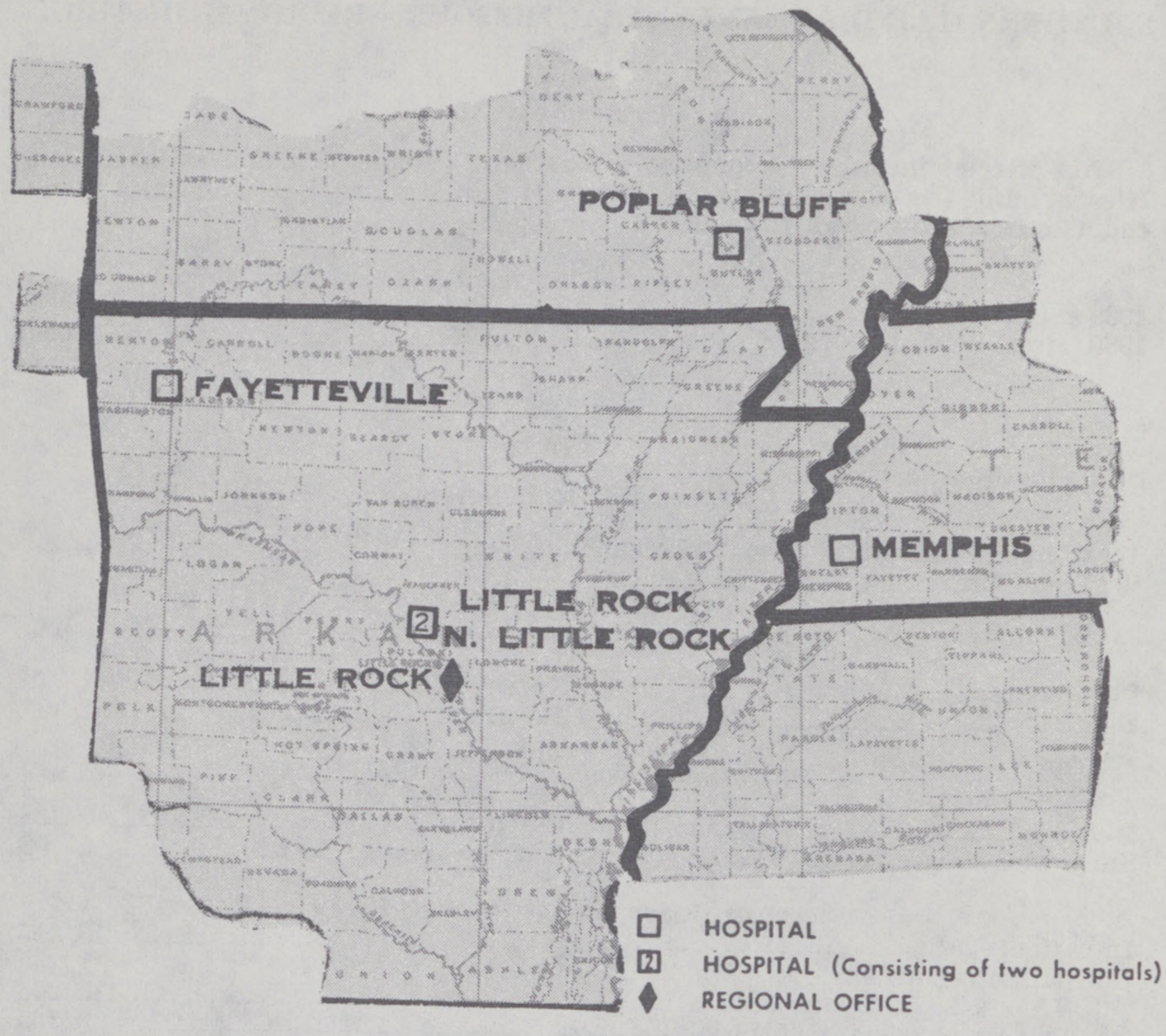
Physicians	56	Nurses	225
Dentists	7	All other	1,364

Operating beds (September 1971)

Medical	520	Psychiatric	468
Surgical	276	Nursing home	93

Services delivered (fiscal year 1971)

In-patients	13,435
Out-patient visits:	
VA staff physicians	112,293
Private physicians (fee basis)	6,785



Arkansas, southern Missouri, western Tennessee, and northern Mississippi—
Regional District No. 24

ARKANSAS, SOUTHERN MISSOURI, WESTERN TENNESSEE, AND NORTHERN MISSISSIPPI—REGIONAL DISTRICT NO. 24

Service area

This district includes 70 counties in Arkansas, 35 counties in Missouri, 25 counties in Mississippi, 19 counties in Tennessee, two counties each in Kentucky, Oklahoma, and Kansas, and one county in Alabama.

Veteran population

1969	491,000
1980 (projected)	544,000

VA facilities

Fayetteville, Ark., VA Hospital
Little Rock, Ark., VA Hospital
Memphis, Tenn., VA Hospital
Poplar Bluff, Mo., VA Hospital

Medical school affiliation

University of Arkansas School of Medicine
University of Tennessee College of Medicine

Full-time staff (Apr. 1, 1971)

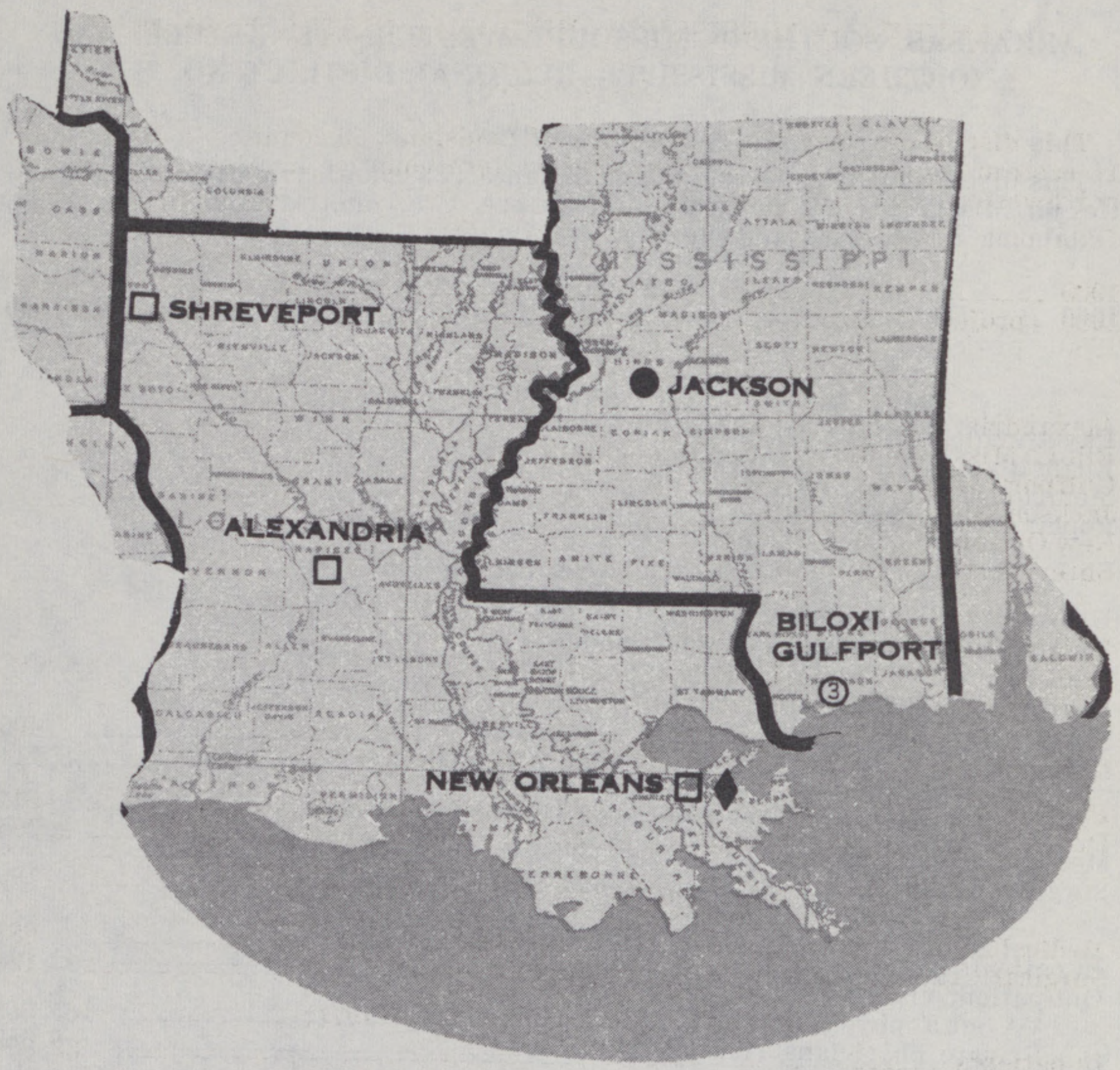
Physicians	135	Nurses	496
Dentists	18	All other	3,114

Operating beds (September 1971)

Medical	1,349	Psychiatric	964
Surgical	596	Nursing home	199

Services delivered (fiscal year 1971)

In-patients	34,019
Out-patient visits:	
VA staff physicians	185,503
Private physicians (fee basis)	8,989



CENTERS:

③ Hospital and Domiciliary (Consisting of two hospitals and a domiciliary)

● Hospital and Regional Office

□ HOSPITAL

♦ REGIONAL OFFICE

Louisiana/Mississippi—Regional District No. 25

LOUISIANA/MISSISSIPPI—REGIONAL DISTRICT NO. 25

Service Area

This district includes the entire State of Louisiana, 49 counties in Mississippi, 14 eastern counties in Texas, five southwestern counties in Alabama, and two northwestern counties in Florida.

Veterans population

1969	728,000
1980 (projected)	825,000

VA facilities

Alexandria, La., VA Hospital
Biloxi, Miss., VA Hospital and Domiciliary
Gulfport, Miss., VA Hospital
Jackson Miss., VA Hospital
New Orleans, La., VA Hospital
Shreveport, La., Hospital

Medical school affiliation

Tulane University School of Medicine
Louisiana State University School of Medicine
University of Mississippi School of Medicine

Full-time staff (Apr. 1, 1971)

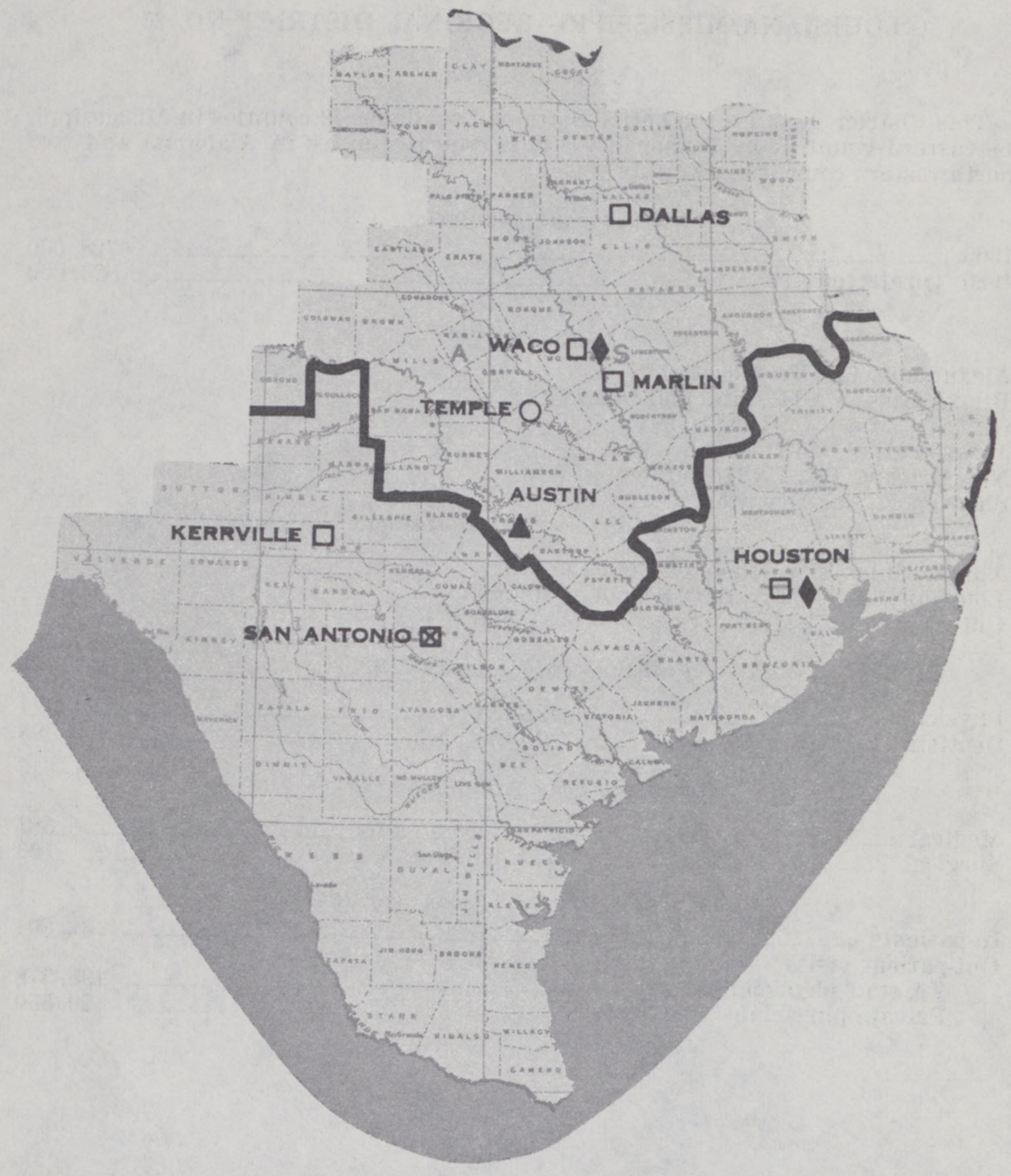
Physicians	138	Nurses	511
Dentists	20	All other	2,995

Operating beds (September 1971)

Medical	1,280	Psychiatric	687
Surgical	770	Nursing home	166

Services delivered (fiscal year 1971)

In-patients	32,804
Out-patient visits:	
VA staff physicians	195,378
Private physicians (fee basis)	29,550



East central Texas—Regional District No. 26

EAST CENTRAL TEXAS—REGIONAL DISTRICT NO. 26

Service area

This district includes 46 counties of the eastern half of the State of Texas.

Veteran population

1969	1,064,000
1980 (projected)	1,140,000

VA facilities

Dallas, Tex., VA Hospital
Houston, Tex., VA Hospital
Kerrville, Tex., VA Hospital
Marlin, Tex., VA Hospital
Temple, Tex., VA Hospital and Domiciliary
Waco, Tex., VA Hospital
San Antonio, Tex., Out-Patient Clinic

Medical school affiliation

University of Texas Southwestern Medical School
Baylor University College of Medicine

Full-time staff (Apr. 1, 1971)

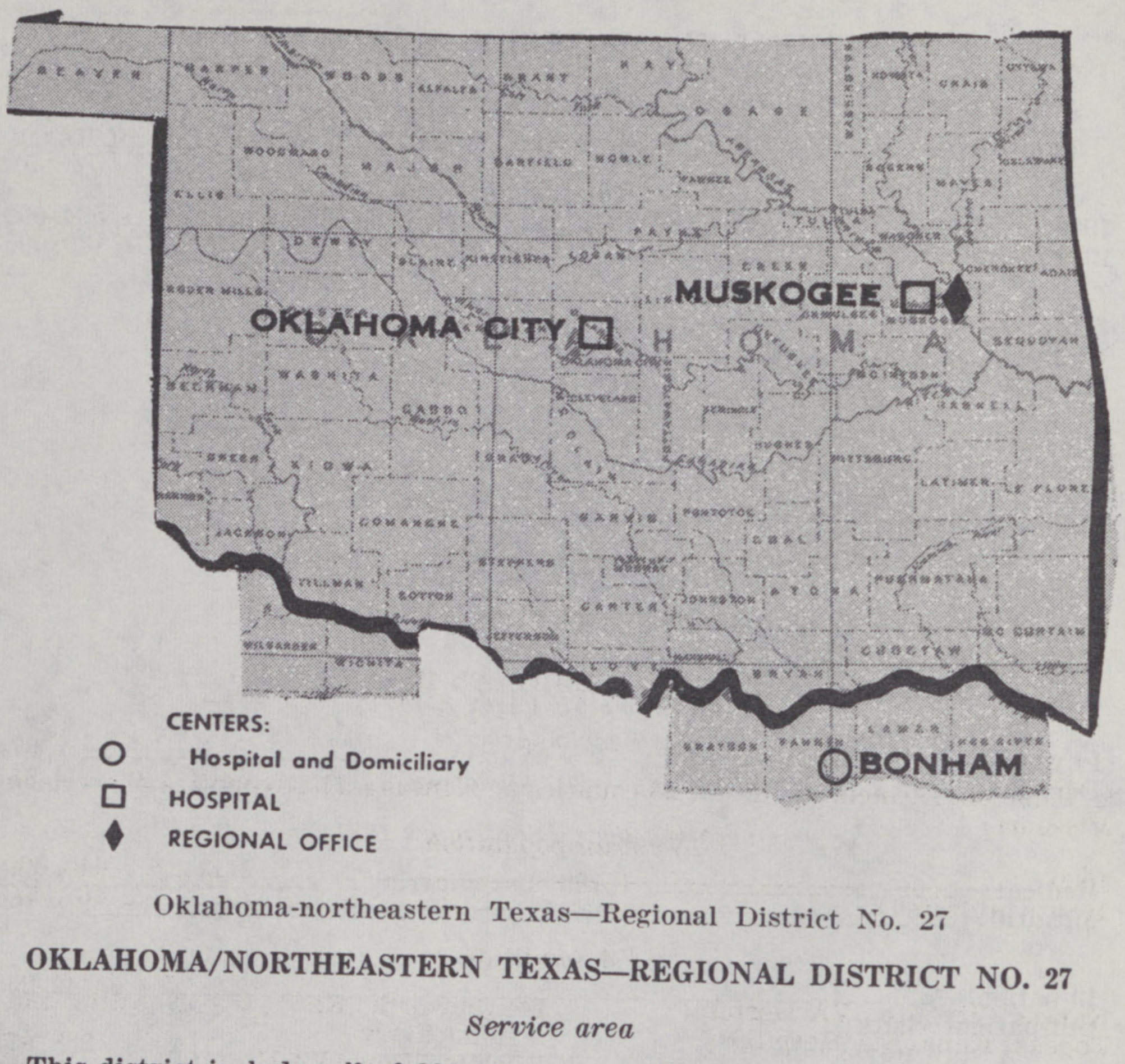
Physicians	224	Nurses	674
Dentists	28	All other	4,517

Operating beds (September 1971)

Medical	1,783	Psychiatric	1,854
Surgical	854	Nursing home	198

Services delivered (fiscal year 1971)

In-patients	42,259
Out-patient visits:	
VA staff physicians	268,971
Private physicians (fee basis)	43,711



Oklahoma-northeastern Texas—Regional District No. 27

OKLAHOMA/NORTHEASTERN TEXAS—REGIONAL DISTRICT NO. 27

Service area

This district includes all of Oklahoma except for two western and two eastern counties, six counties in Texas and one county in Kansas.

Veteran population

1969	363,000
1980 (projected)	383,000

VA facilities

Bonham, Tex., VA Hospital and Domiciliary
Muskogee, Okla., VA Hospital
Oklahoma City, Okla., VA Hospital

Medical school affiliation

University of Oklahoma School of Medicine

Full-time staff (Apr. 1, 1971)

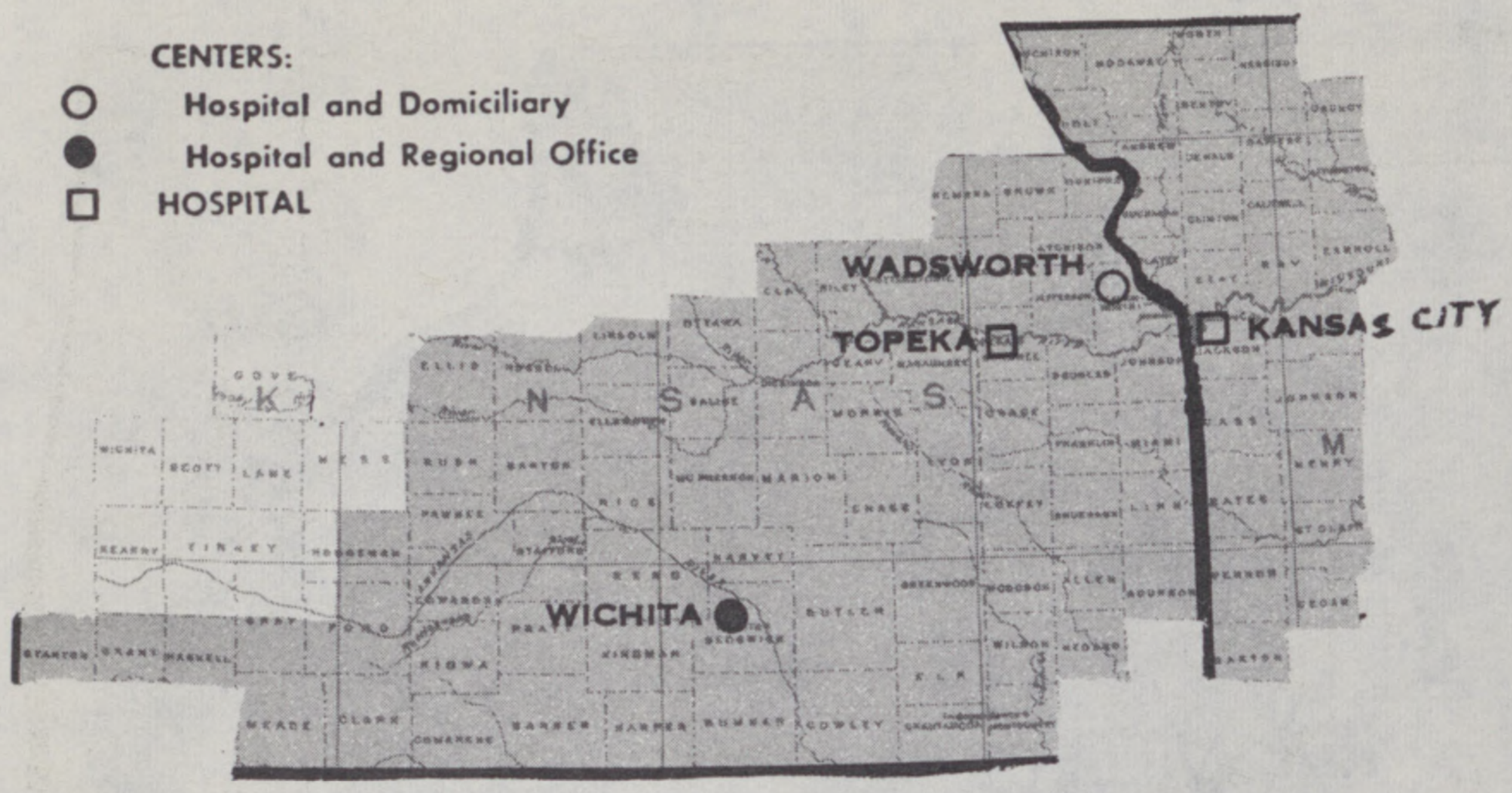
Physicians	57	Nurses	195
Dentists	8	All other	1,027

Operating beds (September 1971)

Medical	387	Psychiatric	88
Surgical	282	Nursing home	38

Services delivered (fiscal year 1971)

In-patients	12,708
Out-patient visits:	
VA staff physicians	89,260
Private physicians (fee basis)	11,452



Kansas/Missouri—Regional District No. 28

KANSAS/MISSOURI—REGIONAL DISTRICT NO. 28

Service area

This district includes all but 28 counties of Kansas and 27 counties of western Missouri.

Veteran population

1969	446,000
1980 (projected)	464,000

VA facilities

Kansas City, Mo., VA Hospital
Topeka, Kans., VA Hospital
Leavenworth, Kans., VA Hospital and Domiciliary
Wichita, Kans., VA Hospital

Medical school affiliation

University of Kansas School of Medicine

Full-time staff (Apr. 1, 1971)

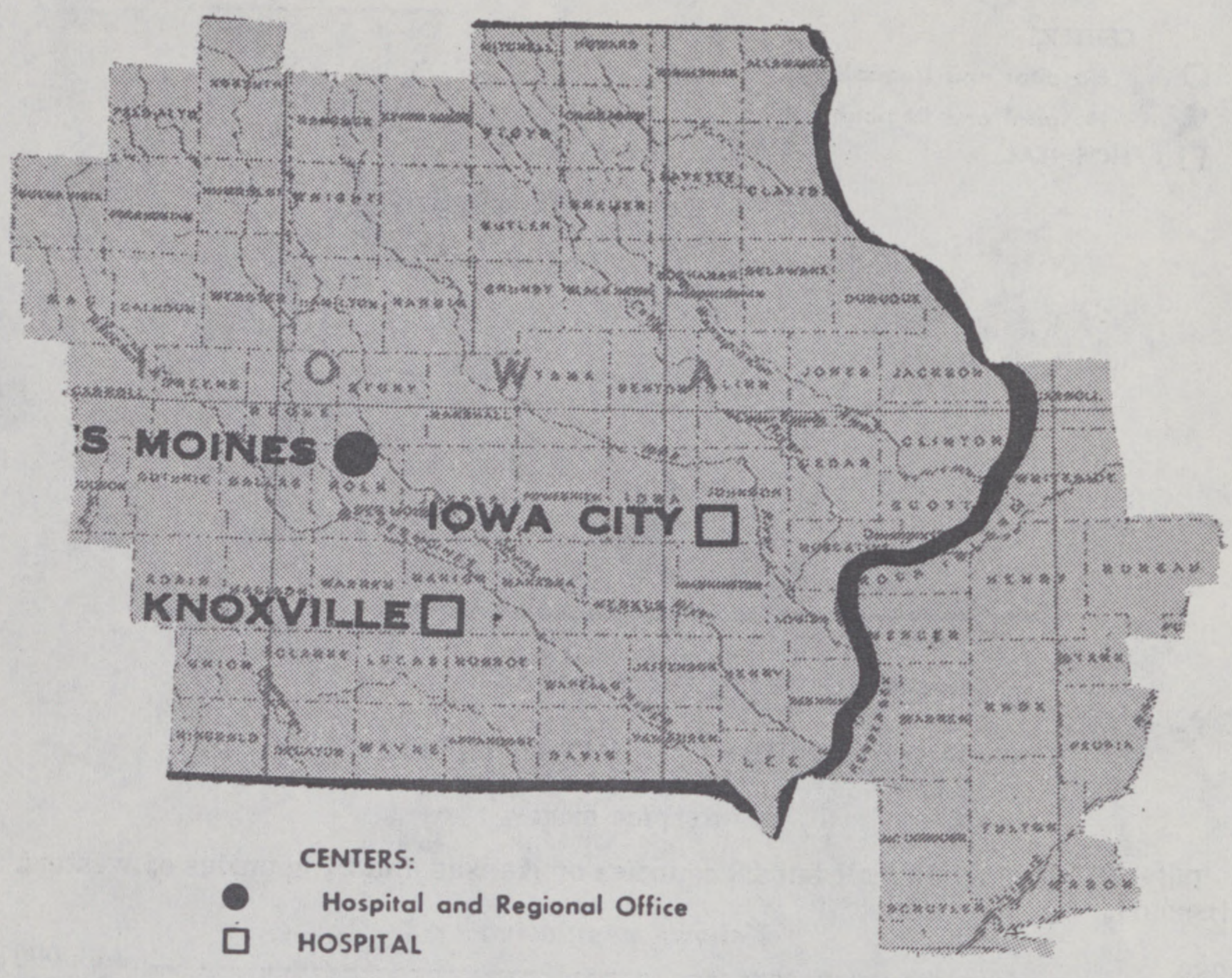
Physicians	109	Nurses	334
Dentists	21	All other	2,447

Operating beds (September 1971)

Medical	941	Psychiatric	709
Surgical	485	Nursing home	124

Services delivered (fiscal year 1971)

In-patients	21,225
Out-patient visits:	
VA staff physicians	156,181
Private physicians (fee basis)	24,642



Iowa—Regional District No. 29

IOWA—REGIONAL DISTRICT NO. 29

Service area

This district includes the entire State of Iowa except for 25 western counties and 16 northwestern counties of Illinois.

Veteran population

1969	411,000
1980 (projected)	448,000

VA facilities

Des Moines VA Hospital
Iowa City VA Hospital
Knoxville VA Hospital

Medical school affiliation

University of Iowa College of Medicine

Full-time staff (Apr. 1, 1971)

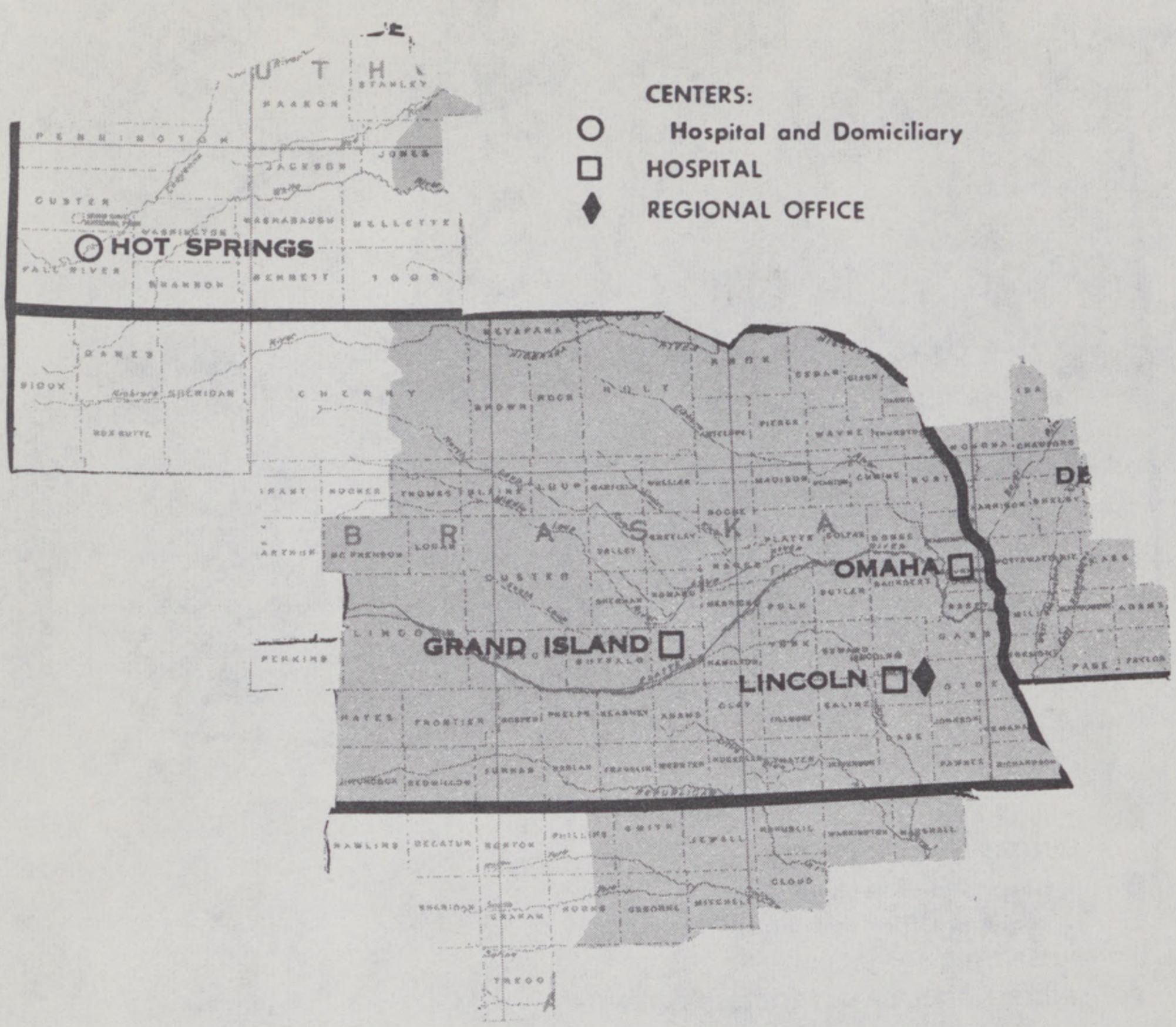
Physicians	63	Nurses	265
Dentists	9	All other	1,716

Operating beds (September 1971)

Medical	550	Psychiatric	702
Surgical	329	Nursing home	200

Services delivered (fiscal year 1971)

In-patients	13,157
Out-patient visits:	
VA staff physicians	92,229
Private physicians (fee basis)	17,036



Nebraska/South Dakota—Regional District No. 30

NEBRASKA/SOUTH DAKOTA—REGIONAL DISTRICT NO. 30

Service area

This district includes all of Nebraska except 10 western counties; 14 southwestern counties in Iowa, 15 northern counties in Kansas, 12 southwestern counties in south Dakota, and three northeast counties in Wyoming.

Veteran population

1969	231,000
1980 (projected)	241,000

VA facilities

Grand Island, Nebr., VA Hospital
Hot Springs, S. Dak., VA Hospital and Domicilary
Lincoln, Nebr., VA Hospital
Omaha, Nebr., VA Hospital

Medical school affiliation

Creighton University School of Medicine
University of Nebraska College of Medicine

Full-time staff (Apr. 1, 1971)

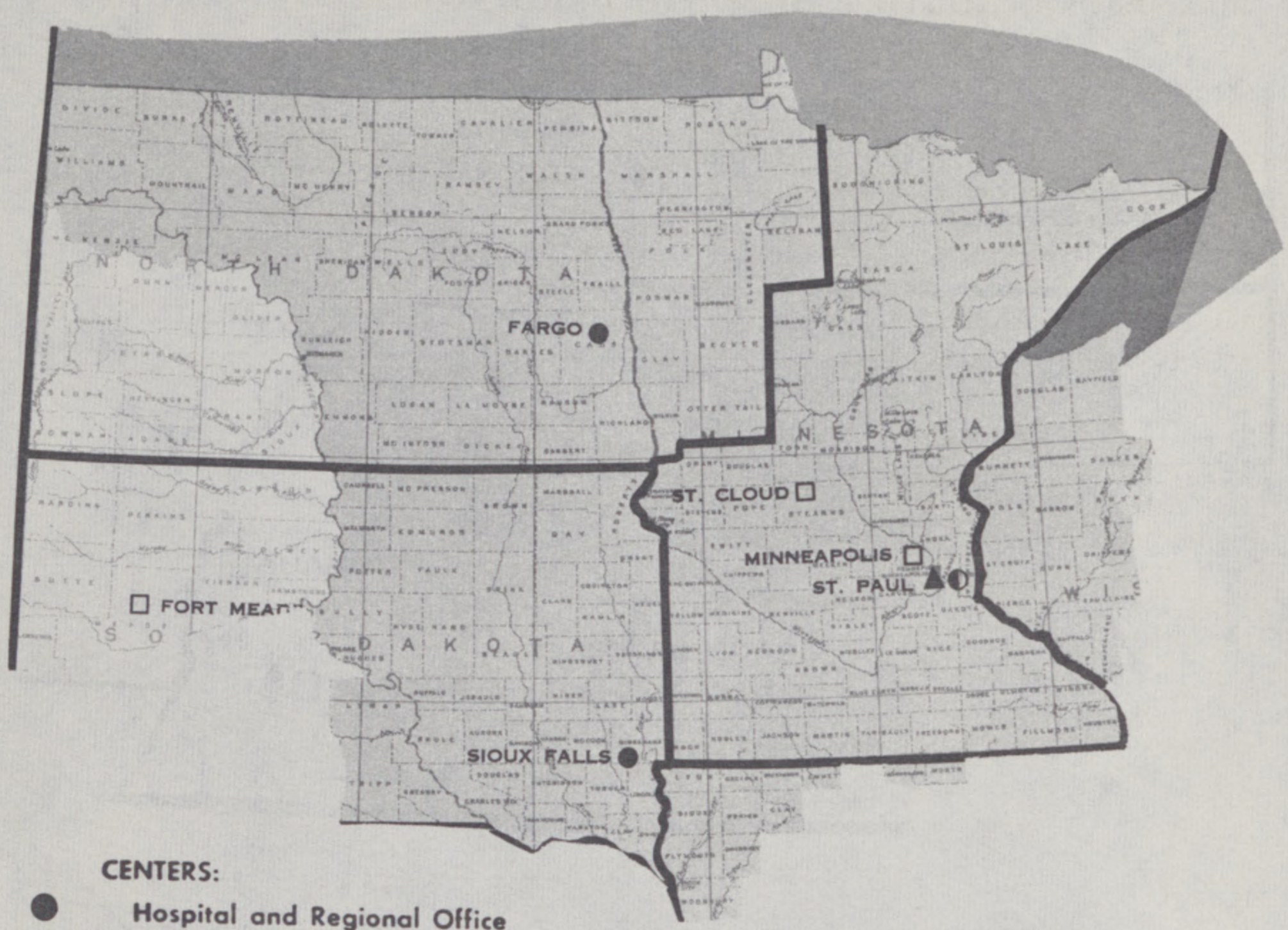
Physicians	56	Nurses	224
Dentists	10	All other	1,250

Operating beds (September 1971)

Medical	611	Psychiatric	122
Surgical	281	Nursing home	40

Services delivered (fiscal year 1971)

In-patients	12,485
Out-patients visits:	
VA staff physicians	64,672
Private physicians (fee basis)	11,449



Minnesota, North and South Dakota—Regional District No. 31

MINNESOTA, NORTH AND SOUTH DAKOTA—REGIONAL DISTRICT NO. 31

Service area

This district includes the entire States of Minnesota, North Dakota, all but 12 southwestern counties in South Dakota, 16 western counties of Wisconsin, and 12 northwestern counties of Iowa.

Veteran population

1969	738,000
1980 (projected)	821,000

VA facilities

Fargo, N. Dak., VA Hospital
Fort Meade, S. Dak., VA Hospital
Minneapolis, Minn., VA Hospital
St. Cloud, Minn., VA Hospital
Sioux Falls, S. Dak., VA Hospital
St. Paul, Minn., Out-Patient Clinic

Medical school affiliation

University of Minnesota Medical School

Full-time staff (Apr. 1, 1971)

Physicians	136	Nurses	462
Dentists	18	All other	2,825

Operating beds (September 1971)

Medical	1,216	Psychiatric	1,052
Surgical	566	Nursing home	169

Services delivered (fiscal year 1971)

In-patients	31,810
Out-patient visits:	
VA staff physicians	159,830
Private physicians (fee basis)	27,114



CENTERS:

● Hospital and Regional Office

□ HOSPITAL

♦ REGIONAL OFFICE

Colorado/Montana/Utah/Wyoming—Regional District No. 32

COLORADO/MONTANA/UTAH/WYOMING—REGIONAL DISTRICT NO. 32

Service area

This district includes the entire States of Colorado, Montana, Utah, 12 southeastern counties in Idaho, and all but three counties of Wyoming.

Veteran population

1969	604,000
1980 (projected)	665,000

VA facilities

Cheyenne, Wyo., VA Hospital
Denver, Colo., VA Hospital
Fort Harison, Mont., VA Hospital
Fort Lyon, Colo., VA Hospital
Grand Junction, Colo., VA Hosiptal
Miles City, Mont., VA Hospital
Salt Lake City, Utah, VA Hospital
Sheridan, Wyo., VA Hospital

Medical school affiliation

University of Colorado School of Medicine
University of Utah College of Medicine

Full-time staff (Apr. 1, 1971)

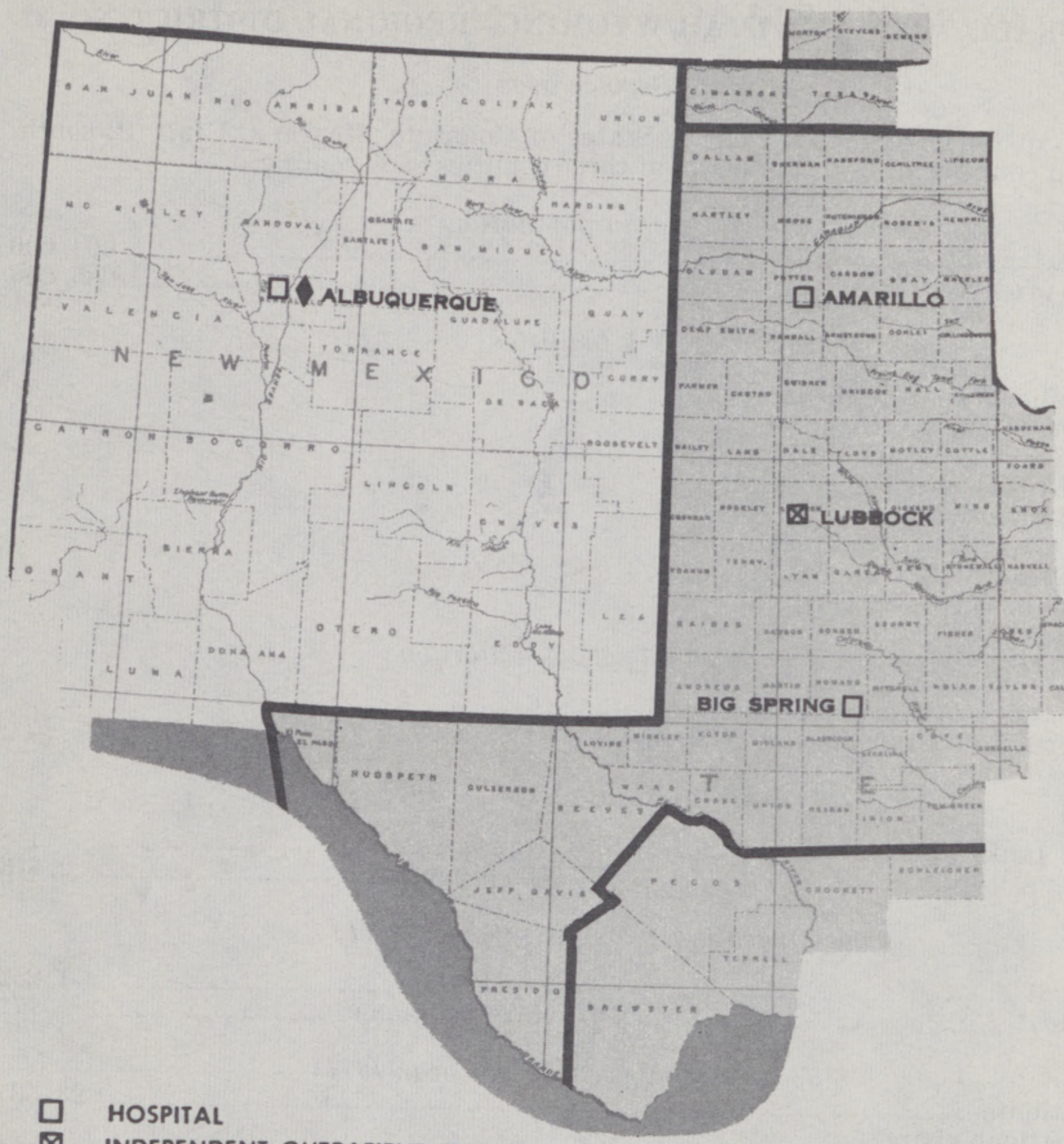
Physicians	102	Nurses	418
Dentists	17	All other	2,573

Operating Beds (September 1971)

Medical	628	Psychiatric	1,257
Surgical	507	Nursing home	172

Services delivered (fiscal year 1971)

In-patients	23,537
Out-patient visits:	
VA staff physicians	142,191
Private physicians (fee basis)	30,169



HOSPITAL
INDEPENDENT OUTPATIENT CLINIC
REGIONAL OFFICE

New Mexico/west Texas—Regional District No. 33

NEW MEXICO/WEST TEXAS—REGIONAL DISTRICT NO. 33

Service area

This district includes the entire State of New Mexico except one southwestern county; plus 87 western counties in Texas, three southwestern counties in Kansas, and two western counties in Oklahoma.

Veteran population

1969	357,000
1980 (projected)	407,000

VA facilities

Albuquerque, N. Mex.
Amarillo, Tex.
Big Spring, Tex.
Lubbock, Tex., Out-Patient Clinic

Medical school affiliation

University of New Mexico School of Medicine

Full-time staff (Apr. 1, 1971)

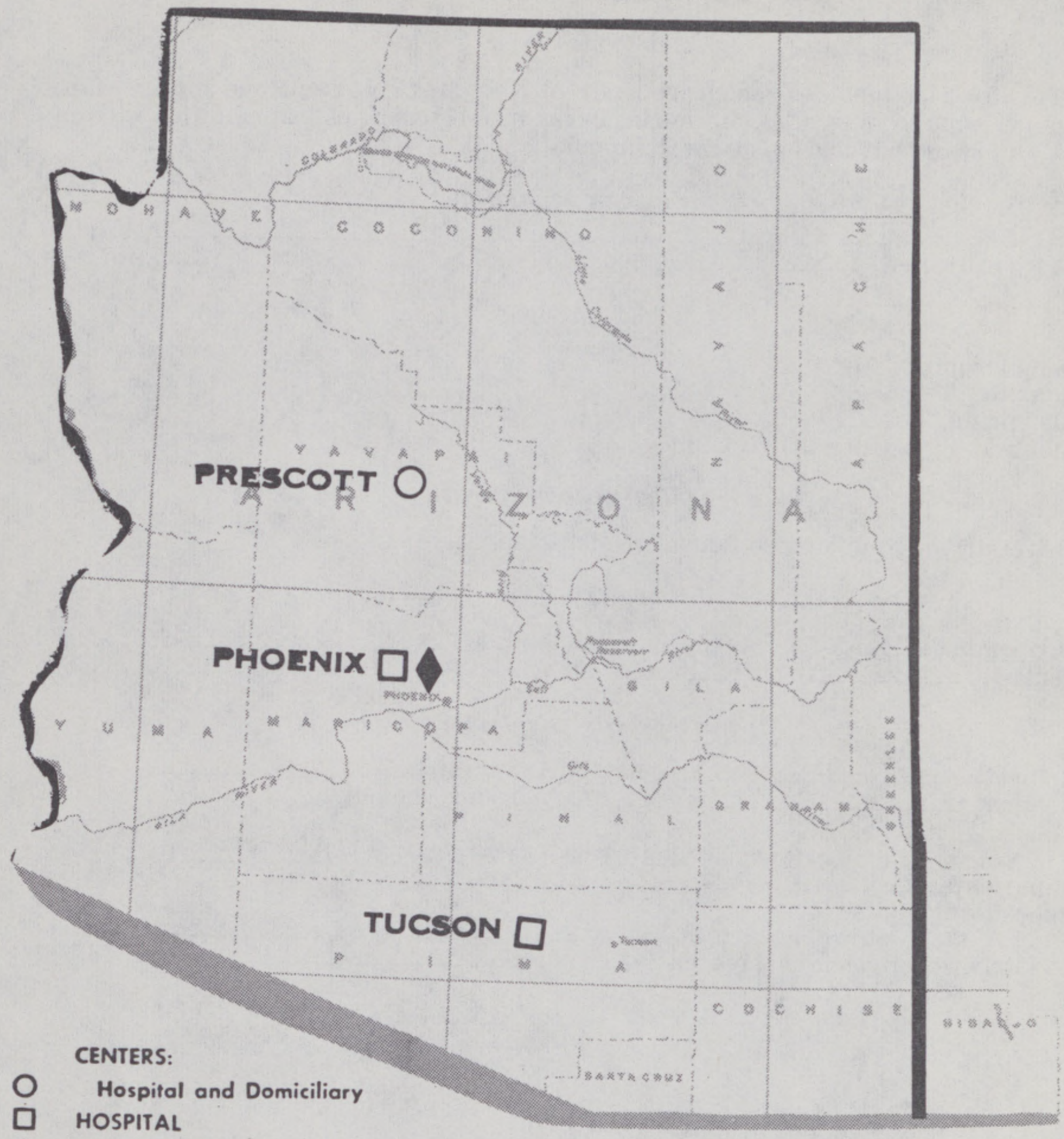
Physicians	65	Nurses	166
Dentists	7	All other	908

Operating beds (September 1971)

Medical	389	Psychiatric	73
Surgical	323	Nursing home	72

Services delivered (fiscal year 1971)

In-patients	12,580
Out-patient visits:	
VA staff physicians	76,177
Private physicians (fee basis)	18,711



Arizona—Regional District No. 34

ARIZONA—REGIONAL DISTRICT NO. 34

Service area

This district includes the entire State of Arizona plus one county in New Mexico.

Veteran population

1969	229,000
1980 (projected)	296,000

VA facilities

Phoenix, Ariz., VA Hospital
Prescott, Ariz., VA Hospital and Domiciliary
Tucson, Ariz., VA Hospital

Medical school affiliation

University of Arizona College of Medicine

Full-time staff (April 1, 1971)

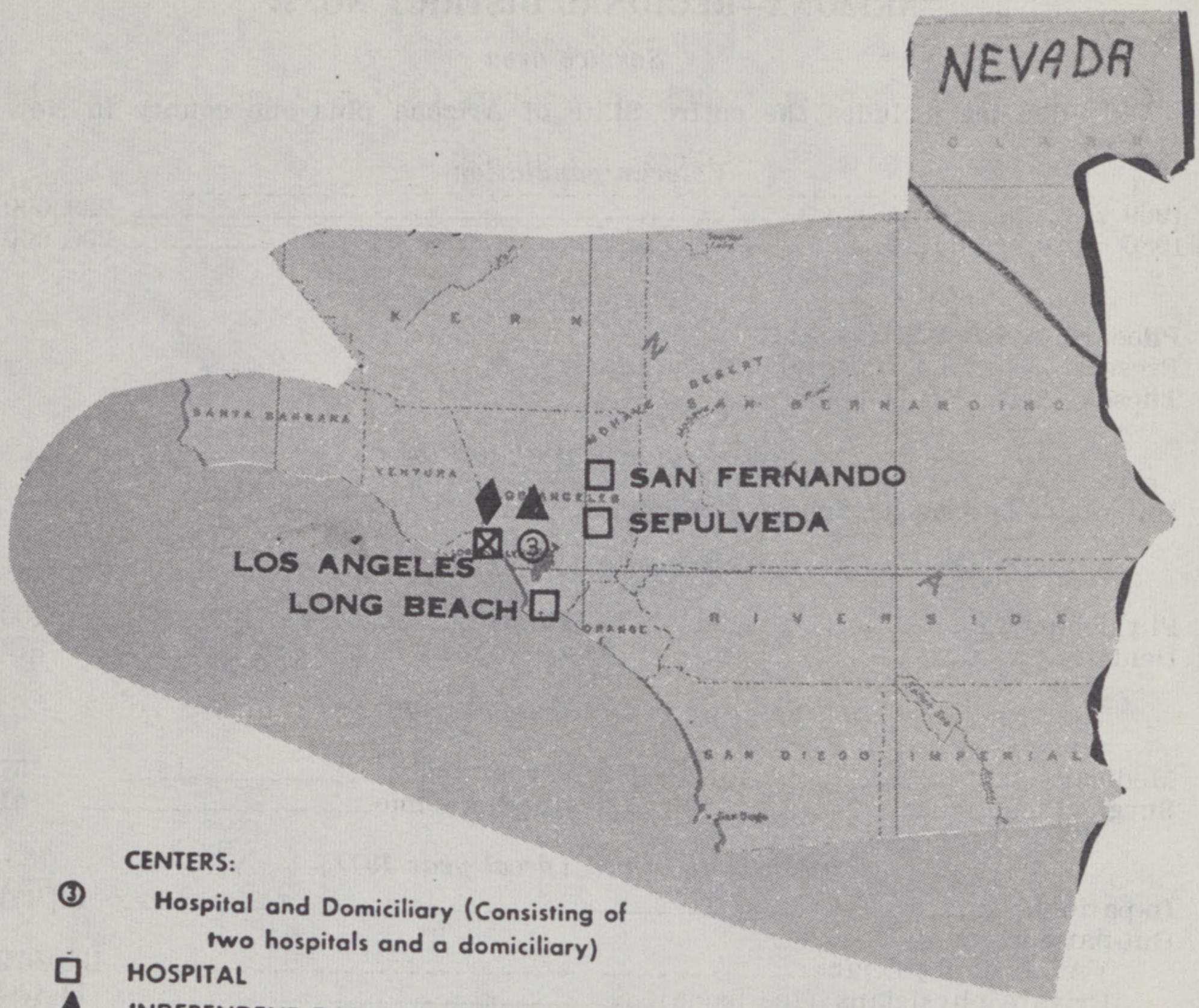
Physicians	75	Nurses	200
Dentists	10	All other	972

Operating beds (September 1971)

Medical	459	Psychiatric	57
Surgical	225	Nursing home	41

Services delivered (fiscal year 1971)

In-patients	11,451
Out-patient visits:	
VA staff physicians	105,979
Private physicians (fee basis)	11,687



Southern California—Regional District No. 35

SOUTHERN CALIFORNIA—REGIONAL DISTRICT NO. 35

Service area

This district includes nine counties in southern California and one county in Nevada.

Veteran population

1969	1,821,000
1980 (projected)	2,171,000

VA facilities

Long Beach VA Hospital
Los Angeles:
  Extended Care Hospital
  Brentwood VA Hospital
  Wadsworth VA Hospital
  VA Domiciliary
  Out-patient Clinic
Sepulveda VA Hospital
San Diego, Calif. (sub-clinic)

Medical school affiliation

University of Southern California School of Medicine
University of California, Irving, College of Medicine
University of California at Los Angeles School of Medicine

Full-time staff (April 1, 1971)

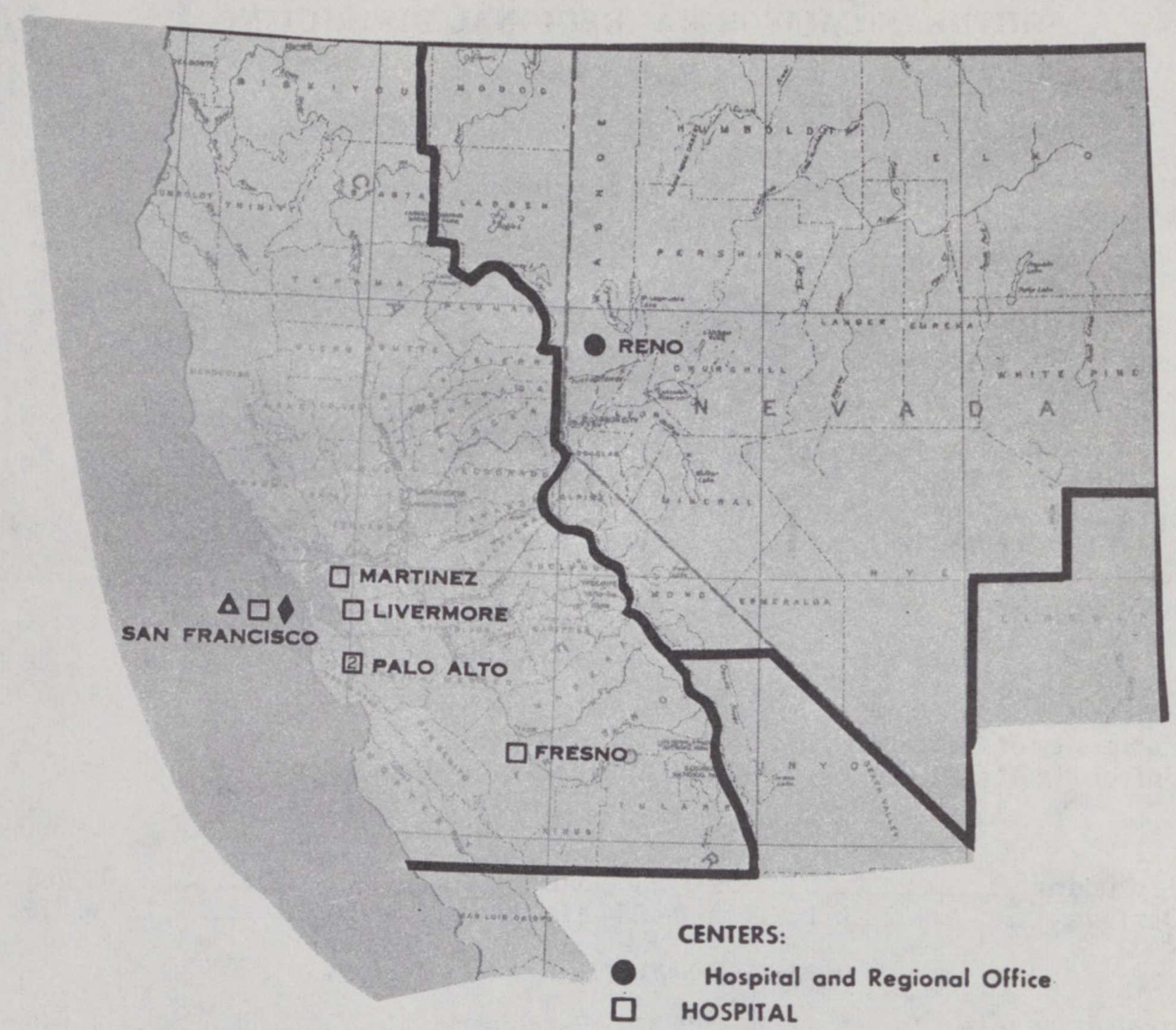
Physicians	230	Nurses	785
Dentists	33	All other	4,379

Operating beds (September 1971)

Medical	2,374	Psychiatric	1,049
Surgical	862	Nursing home	338

Services delivered (fiscal year 1971)

In-patients	40,904
Out-patient visits:	
VA staff physicians	496,044
Private physicians (fee basis)	70,974



Northern California/western Nevada—Regional District No. 36

NORTHERN CALIFORNIA/WESTERN NEVADA—REGIONAL DISTRICT NO. 36

Service area

This district includes 49 north-central counties in California and 12 western counties in Nevada.

Veteran population

1969	1,189,000
1980 (projected)	1,414,000

VA facilities

Fresno, Calif., VA Hospital
Livermore Calif., VA Hospital
Martinez, Calif., VA Hospital
Palo Alto, Calif., VA Hospital
Reno, Nev., VA Hospital
Oakland, Calif., Out-Patient Clinic
San Francisco, Calif., VA Hospital

Medical school affiliation

Stanford University School of Medicine
University of California School of Medicine

Full-time staff (Apr. 1, 1971)

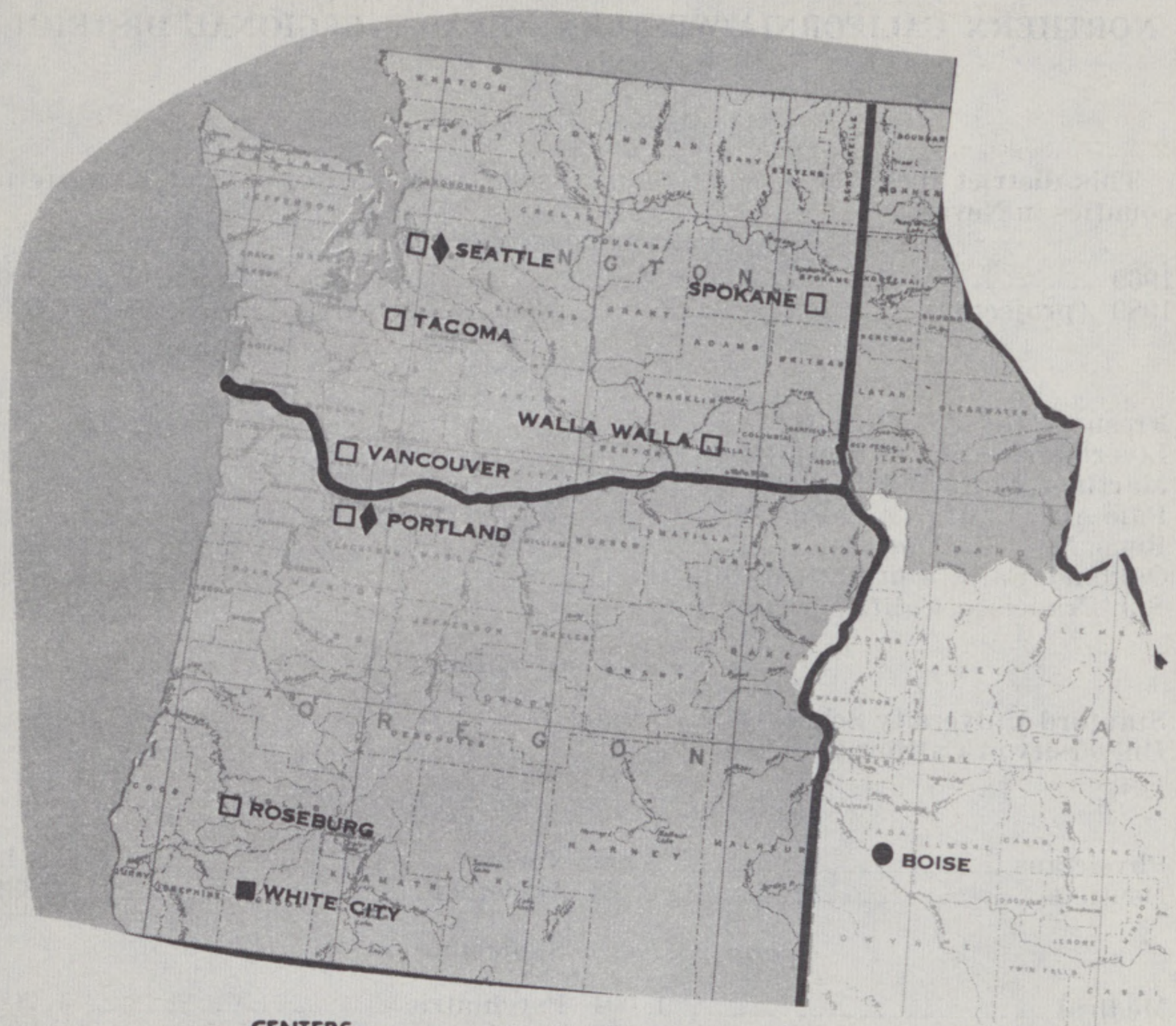
Physicians	212	Nurses	649
Dentists	23	All other	3,336

Operating beds (September 1971)

Medical	1,004	Psychiatric	1,205
Surgical	799	Nursing Home	208

Services delivered (fiscal year 1971)

In-patients	33,035
Out-patient visits:	
VA staff physicians	278,722
Private physicians (fee basis)	51,227



CENTERS:

- ● Hospital and Regional Office
- ■ DOMICILIARY
- □ HOSPITAL
- ♦ REGIONAL OFFICE

Pacific Northwest—Regional District No. 37

PACIFIC NORTHWEST—REGIONAL DISTRICT NO. 37

Service area

This district includes the entire States of Washington and Oregon and all but 12 southwestern counties in Idaho.

Veteran population

1969	844,000
1980 (projected)	938,000

VA facilities

American Lake, Wash., VA Hospital
Boise, Idaho, VA Hospital
Portland, Oreg., VA Hospital
Roseburg, Oreg., VA Hospital
Seattle, Wash., VA Hospital
Spokane, Wash., VA Hospital
Vancouver, Wash., VA Hospital
Walla Walla, Wash., VA Hospital
White City, Oreg., VA Domiciliary
Portland, Oreg., Out-Patient Clinic

Medical school affiliation

University of Oregon Medical School
University of Washington School of Medicine

Full-time staff (Apr. 1, 1971)

Physicians	153	Nurses	514
Dentists	24	All other	2,668

Operating beds (September 1971)

Medical	1,024	Psychiatric	1,167
Surgical	668	Nursing home	121

Services delivered (fiscal year 1971)

In-patients	30,324
Out-patient visits:	
VA staff physicians	205,993
Private physicians (fee basis)	24,771

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