

**Manual M-9, Strategic Planning**

**(Veterans Health Administration)**

**Chapter 9, Criteria and Standards and Program Planning Factors**

**Appendix 9K, Program Planning Factors for Blind Rehabilitation Service**

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# Strategic Planning

July 26, 1991

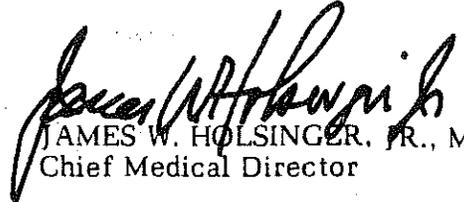
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## RESCISSIONS

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## PROGRAM PLANNING FACTORS FOR BLIND REHABILITATION SERVICE

### 1. BACKGROUND

a. The primary mission of Blind Rehabilitation Centers/Clinics is to engage veterans in skill acquisitions aimed at independence of action and the development of adjustment skills which result in the return of the veteran to community life.

b. Blind Rehabilitation consists of two major components: inpatient services provided by BRC (Blind Rehabilitation Centers) and Clinics; and outpatient services provided by VIST (Visual Impairment Service Team(s)). The various components of the Blind Rehabilitation Program receive support from all medical and professional disciplines within the VA (Department of Veterans Affairs) appropriate to the care and treatment of blinded veterans.

c. To meet the demands of increasing numbers of blinded veterans, BRCs were strategically located throughout the U. S. (United States), at VA Medical Center, Hines, IL in 1948; VA Medical Center, Palo Alto, CA, in 1967; VA Medical Center, West Haven, CT, in 1969; and VA Medical Center Birmingham, AL, in 1982. Most recently a BRC service was opened at VA Medical Center, San Juan, PR.

d. In addition to the BRCs, VA established smaller Blind Rehabilitation Clinics at five VA facilities starting in 1969 through 1973. Presently, there are three Blind Rehabilitation Clinics located at VA Medical Center, West Haven, CT; VA Medical Center, Waco, TX; and VA Medical Center, American Lake, Tacoma, WA.

e. The VIST is VA's front line diagnostic and treatment agent whose help can prevent blindness from becoming an all enveloping disability. The VIST members attempt to assist eligible veterans in maximizing their remaining vision and other sensorium through the provision of medical care and referral for blind rehabilitation training. To accomplish this, eligible blinded veterans are offered a VIST Review, generally consisting of complete eye, physical, audiometric, and psycho-social evaluations.

f. Providing support to the full and part-time VIST Coordinators are the four Regional Consultants. Specifically, the Blind Rehabilitation Regional Consultants are responsible for assisting the Director of BRS (Blind Rehabilitation Service) with planning, developing, implementing, directing, evaluating, troubleshooting, and controlling a strategy of service provision to blinded veterans within each BRS Region.

### 2. GOAL

The goal of the planning protocol for the BRS (Blind Rehabilitation Service) is to achieve comprehensive integration of strategic and operational planning (including construction), budgeting and operational management of the VA health care system consistent with the VA National Health Care Plan.

### 3. PROGRAM PLANNING FACTORS

a. Referral Patterns of Patients and Geographic Area Served

(1) The distribution of the blinded veteran population is of interest both in terms of its geographic and aging distributions (this information is detailed in par. 4). The geographic distribution of blinded veterans, for the years 1990, 1995, 2000, and 2005, indicates a relatively constant distribution. Region 2 has the greatest number of veterans (in all years) followed by Regions 1, 4 and 3 respectively. While this distribution among regions is constant, the number of blinded veterans in each region will dramatically increase with each region projected to have a growth rate of at least 66 percent in the number of blinded veterans between the years 1990 and 2005.

(2) Nine states account for over 50 percent of the estimated legally blind veteran population. These states are California (11 percent), New York (7 percent), Florida (7 percent), Texas (6 percent), Pennsylvania (6 percent), Ohio (5 percent), Illinois (4.5 percent), Michigan (3.5 percent), and New Jersey (3.5 percent). Table 1 in paragraph 4 provides a state by state breakdown of the estimated blinded veteran population for 1990.

(3) The incidence of blindness in veterans is heavily influenced by the aging trend of the veteran population.

(a) The majority of conditions causing legal blindness are age related.

1. Currently, about 25 percent of legally blind veterans are in their working years, between the ages of 20 and 54.

2. Almost 50 percent are between 55 and 75, and about 30 percent are age 75 and over.

(b) Blind rehabilitation services must provide for the needs of workers, newly retired individuals seeking to maintain their independence, and elderly individuals faced with multiple handicaps and/or the prospect of lengthy stays in long-term care facilities.

1. The number of blinded veterans under age 74 can be expected to remain relatively constant or decrease slightly over the next 15 years.

2. In the over 75 population, substantial increases will occur which will result in an overall increase of some 140 percent in the total blinded veteran population between the years 1990 and 2005.

(4) Access refers to the ability of veterans in various locations to obtain Blind Rehabilitation Services when compared to a set standard such as the national rate.

(a) The national rate is obtained by establishing a ratio of workload accomplished at a specific point in time with the veteran population.

(b) In cases where workloads are very small as in the case of Blind Rehabilitation, the workload is shown per hundred thousand veterans.

(c) Two analyses were conducted, one focusing on Blind Rehabilitation Center/Clinic admissions, with the second concentrating on blinded veterans discharged from all VA medical centers.

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(d) The complete access analysis may be found in paragraph 4, with major findings as follows:

1. Under both access analyses, the Eastern Region has the largest number of states falling below the national rate. The state of New Hampshire is the only state exceeding the national rate for both admissions and discharges.

2. For both analyses, the Western Region is the only other Region showing a majority of states below the national rate. Only the state of Arizona exceeds the national rate for both analyses.

3. The Central Region shows a slight majority of states below the national rate for admissions, while a slim majority of states in that Region are above the national rate in terms of discharges.

4. The Southern Region is the only Region showing a large majority of states exceeding the national rate for both analyses. The states of Texas, Mississippi, Alabama, South Carolina, and Florida exceed the national rate under both analyses.

#### b. Present and Projected Need

##### (1) Inpatient Programs

(a) A waiting time for entry to a Blind Rehabilitation Center/Clinic of 120 days or less is appropriate.

(b) BRS has determined that a ratio of 1.6 staff per bed is necessary to provide maximum rehabilitation in the least amount of time.

(c) The most ideal configuration would be to establish two 30 bed BRCs and four 15 bed Clinics.

1. These program expansions could be accomplished either through bed conversions or new construction. Beds can be activated much sooner via conversion than through construction and possibly at significant cost savings.

2. Potential sites for construction and/or conversion should be identified based upon geographic and demographic considerations. (Refer to par. 3 f.)

(d) If only current resources are considered (154 operating beds), VA market share for treating blinded veterans in centers and clinics is only 0.8 percent. *NOTE: This percentage is derived by dividing the FY 1990 Blind Rehabilitation Center/Clinic workload of 725 patients by the 93,274 estimated blinded veterans in FY 1990.*

1. If this low market share is applied to the projected blinded veteran population for the year 2005, 66 additional beds would be required.

2. This figure is obtained by multiplying the year 2005 projection of 137,439 blinded veterans by the 0.8 percent market share and dividing by the standard 5 patients treated per bed per year. The current operating beds are then subtracted from this result (i.e.,  $220 - 154 = 66$ ). To meet a 1.6 percent market share 286 more beds would be required.

(e) The incidence of legal blindness in the veteran population is based upon incidence rate data gathered by the National Center for Health Statistics as reported by the National Society for the Prevention of Blindness (1980) and the American Foundation for the Blind (Nelson, 1987).

1. The veteran population data used to estimate the number of legally blind veterans was extracted from the Projected Veteran Population File at the Austin Data Processing Center for the years 1990 through 2005.

a. The incidence of legal blindness in the population up to age 44 is 0.00011 per thousand.

b. After age 44 the incidence rate increases gradually to age 75 where it is 0.013 per thousand.

c. At age 85 and over the incidence rate increases dramatically to 0.048 per thousand (4.8 percent).

d. Due to the large number of World War II veterans the largest number of legally blind veterans is in the 55 to 74 age range. This will remain true for the next decade as well due to mortality in the World War II population and the aging of the Korean and Viet Nam veteran populations.

2. The net effect of these aging trends is that the total number of legally blind veterans will increase by 140 percent between the years 1990 and 2005. Paragraph 4 provides a more detailed analysis.

## (2) Outpatient Programs

(a) Although VISTs established at 97 VA medical centers and outpatient clinics provide coordinated services to blinded veterans at the local level, these services include little or no training in the acquisition of skills which enable blind individuals to achieve independence in their daily lives.

1. Blinded veterans who do not attend a BRC or Clinic Program receive little or no blind rehabilitation training.

2. Further complicating this issue is the fact that high quality non-VA community based rehabilitation training is typically unavailable in most U.S. communities.

3. When community based services of suitable quality are available, they are utilized by VISTs to provide services to blinded veterans at the local level, but the demand for these services by the civilian blind often limit the type and extent of services which can be drawn upon by the blinded veteran population.

(b) The VIST Coordinator system provides a vehicle for improving the delivery of outpatient rehabilitation services to blinded veterans. Adding a rehabilitation training component to the VIST through the assignment of blind rehabilitation specialists to the VIST would enable VA to enhance the delivery of rehabilitation services through the following contributions:

1. Provide basic skills training to blinded veterans who have been accepted at a center or clinic but are awaiting admission.

2. Provide follow-up services to BRC graduates who are in receipt of prosthetic equipment and/or who are considered to be at risk for not transferring their newly acquired skills to their local environments.

3. Provide rehabilitation training to veterans who need services, but are unable or unwilling to attend an inpatient program.

a. In particular, it would be effective for VA to have the capability of providing training to blinded veterans who need extensive skill acquisition in one area such as low vision, but do not need or cannot tolerate the full panoply of services offered by a BRC.

b. This would be particularly effective when addressing the needs of elderly veterans who may be experiencing multiple medical impairments or cognitive difficulties.

(c) The ability to provide training at the veteran's home would better enable family members to care for dependent veterans and would frequently obviate the need for placement of the veteran in a nursing home at great expense to VA or other governmental agencies.

1. Providing initial assessment and training for blinded veterans prior to attending an inpatient program would be cost effective in that it would give these veterans a "head start" in the rehabilitation process and thereby shorten their length of stay.

2. Since it is estimated that the provision of outpatient services prior to an inpatient stay would reduce the length of stay by 1 to 2 weeks, a savings would be realized. This savings would be partially offset by the expense of providing the preadmission training.

3. This outpatient capability would provide VA with early intervention capability to assist our veterans in their adjustment to a sudden and disabling onset of blindness.

4. Reducing the length of stay in the inpatient programs would have a positive impact on the exceedingly long "waiting list" for inpatient programs.

5. The availability of post discharge follow-up services would ensure that blinded veterans have successfully transferred the skills they acquired at a BRC to their home environment and would enable them to achieve the highest possible degree of independence.

(d) Blind rehabilitation specialists should be assigned to VIST Programs to provide pre/post evaluation and training to blinded veterans waiting for admission to a Blind Rehabilitation Program and evaluation/training to blinded veterans not able to participate in a VA Blind Rehabilitation Program.

(3) Nursing Home Programs. Presently the incidence of severe visual impairment in the nursing home population is extremely high, yet there are no public, private, or VA Blind Rehabilitation Program services for these individuals.

(a) Most of these severely visually impaired patients, due to complex medical conditions, will not be candidates to attend Blind Rehabilitation Centers/Clinics, but could benefit from limited services. A coordinated outpatient program targeted at providing direct services to blinded veterans in these settings is needed.

(b) A second level of services would be directed at teaching the nursing home staff sufficient skills to enable them to properly care for blinded veterans. In many cases, this training would provide a high level of patient independence and require less staff time and expense, in addition to improving the quality of the veteran's life.

(c) Resources to accomplish this needed program could be combined with other outpatient services provided by a blind rehabilitation specialist attached to full-time VISTs.

#### (4) Technological Impact on Bed Need

(a) The impact of new technology may be speculative but based on experience, it is inevitable that additional stress will be placed on the system to meet increases in demands. Questions to be considered at this time are:

1. The increase in prosthetic equipment budget.
2. The workload to Blind Rehabilitation Centers/Clinics.
3. The ability of VA to provide training services within a reasonable time.
  - a. These last two points translate into the need for dedicated teaching staff.

b. Currently two to three beds at each participating Blind Rehabilitation Center are dedicated to training for the various new technological devices, with a waiting list of 12 to 16 months for computer training. This detracts from existing beds available for veterans requesting basic blind rehabilitation.

(b) Training for new technology could account for 10 percent to 14 percent of current workload.

1. This would include veterans already at the BRCs undergoing rehabilitation training to some extent, but predominantly would require former Blind Rehabilitation Center/Clinic graduates to return for additional sophisticated training.

2. Serious consideration should be given to providing outpatient technological services through placement of qualified personnel in the field, possibly attached to key VISTs in large population centers possessing adequate support.

(c) Blind rehabilitation is a relatively new discipline with graduate studies having been initiated in the 1960's.

1. Information in the field is increasing at a very rapid rate.
2. The average number of publications per year has doubled each decade since 1950.
3. Technology has also become a key ingredient with a corresponding increase in the rate at which rehabilitation professionals must absorb new knowledge.

(d) Nationally, there is a shortage of blind rehabilitation professionals.

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1. This shortage coupled with a dramatically increasing body of knowledge, and VA's need to expand services to its blinded veteran population, will increasingly challenge VA's ability to deliver services.

2. VA will need to improve the level of staff professionalism through the creation of a comprehensive staff training program. Such programs will improve the quality of service and help ensure retention of critically needed staff.

3. VA should work closely with appropriate university programs to ensure a flow of competently trained professionals equipped with the skills needed to serve the blinded veteran population.

(e) During the late 1960s, the Chief Medical Director directed that two FTEE (Full-Time Employee Equivalents) be assigned to clinical research within each BRC.

1. Researchers so assigned have played leadership roles leading to:

- a. The development of electronic travel aid programs.
- b. The introduction of computer technology in blind rehabilitation.
- c. The development of innovative service delivery programs.
- d. The development and definition of low vision services.
- e. Providing demographic and program evaluation services.

2. It is recommended this research effort be maintained.

(f) The dramatic increase in new knowledge and technology in blind rehabilitation, as well as the changing veteran population, present clinical concerns which need timely answers:

1. What are the evolving needs of the aging blinded veteran population?
2. What services must be developed?
3. What technology is beneficial?
4. How can independence and quality of life best be restored?

These questions can best be answered by research staff dedicated to supporting clinical services. Such research programs provide expertise in evaluation of technology and programs, and continue VA's leadership in developing new rehabilitation strategies. These research programs cooperate with existing VA research activities (i.e., Rehabilitation Research and Development Service).

4. Clinical research programs are often not deemed appropriate for funding via existing VA research mechanisms and it is recommended that each BRS research program be provided with core funding for equipment, supplies, and travel.

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c. **Appropriate size of program.** The recommended optimum bed size of 30 for BRCs would greatly enhance the therapeutic benefit of a residential program. Any larger size would certainly diminish the beneficial effects achievable with smaller units. The recommended optimum bed size for Blind Rehabilitation Clinics would remain at 15.

d. **Opportunities for consolidation, sharing or contracting of programs**

(1) Most blinded veterans are currently being referred to all available non-VA blind rehabilitation agencies in their home area. Unfortunately, most of the state, community, and private agencies in the U.S. serving the blind are not able to provide the high level of evaluation, training and prosthetic support that is currently available through VA Blind Rehabilitation Programs.

(2) The non-VA agencies rely on VA to provide evaluation and training to veterans so that scarce resources can be used to serve the non-veteran blinded population.

e. **Available resources**

(1) The inpatient component of BRS currently consists of 175 authorized beds situated at seven separate VHA (Veterans Health Administration) facilities located throughout the four Regions. Their locations and respective numbers of operating beds are as follows:

- (a) VA Medical Center West Haven, CT, has 45 beds.
- (b) VA Medical Center Birmingham, AL, has 30 beds.
- (c) VA Medical Center Hines, IL, 30 has beds.
- (d) VA Medical Center Tacoma, WA, has 15 beds.
- (e) VA Medical Center Palo Alto, CA, has 30 beds.
- (f) VA Medical Center Waco, TX, has 15 beds.
- (g) VA Medical Center San Juan, PR, has 10 beds.

(2) As of the end of FY 1990, BRS had 1,248 applications on file for admission to the various inpatient programs. These comprehensive inpatient programs have experienced a national average length of stay of 62 days.

(3) Regional BRS consultants work directly with the VIST Programs by providing:

- (a) Education and training to coordinators and VIST members.
- (b) Site reviews.
- (c) Recommendations for program improvement.

(4) Some VISTs function with full-time Coordinators while other VISTs have part-time Coordinators who carry out other assignments.

(a) Facilities without a recognized VIST designate a Coordinator as a contact person from whom local blinded veterans can obtain necessary services.

(b) VISTs are generally established at VA facilities having 100 or more eligible blinded veterans.

**f. Other Considerations**

(1) A proposed BRC or Clinic site must possess a full range of medical, surgical and rehabilitative services including such program essentials as:

- (a) Audiology.
- (b) Optometry.
- (c) Ophthalmology.
- (d) Recreation.
- (e) Social Work.
- (d) Psychology.

(2) In order to accomplish the mission of Blind Rehabilitation, a minimum staffing level of 1.6 staff per bed is recommended for BRCs and Clinics. Adequate funding should be provided to assure full staffing for the delivery of the highest quality Blind Rehabilitation services.

(3) Proposed BRC or Clinic sites should possess:

- (a) Medical and supportive services specific to an increasingly geriatric population.
- (b) The ability to provide necessary general medical and surgical care services.
- (c) A prosthetic service with a sufficient range of services to support the specific needs of a Blind Rehabilitation Program.

(4) Quality assessment methodologies should be developed and used in order to maintain a high quality level of care.

(5) A proposed BRC or Clinic should be located in a geographical area having convenient access to interstate air, train, bus and local public transportation.

(a) Travel to a BRC or Clinic should generally not exceed 1 day of surface travel time (i.e., 8 hours) or 3 hours flying time.

(b) The physical plant, hospital grounds and surrounding community should be adequate in size and conducive to the creation of a comprehensive rehabilitative milieu. This element is especially critical in assuring that blind veterans will be challenged with a wide variety of travel learning experiences in orientation and mobility.

(c) Dedicated blind rehabilitation space should be consolidated and contiguous, yet set apart from the main hospital wards.

(6) BRCs should also endeavor to establish new programs and tap emerging technologies in order to remain on the cutting edge of their specialty.

(a) Clearly, the presence of a strong Blind Rehabilitation Research Program at each Center would significantly contribute towards meeting this important goal.

(b) In addition to providing basic Blind Rehabilitation Programs, BRCs should consider adding the following programs:

1. Family Program;
2. Independent Living Program;
3. Electronic Travel Aides Program; and
4. Computer Training Program.

(7) Planned blind rehabilitation services must geographically augment existing Blind Rehabilitation Centers/Clinics and reflect the demographic evolution of the projected veteran population.

#### 4. ACCESS ANALYSIS

##### a. Introduction

(1) An analysis has been conducted to determine the level of access blind veterans experience in obtaining needed health care services. In order to obtain a clearer picture, two data sources were used.

(a) The FY 1990 semi-annual reports issued by the BRCs were examined to monitor admissions.

(b) The PTF (Patient Treatment File) at the Data Processing Center at Austin, TX, provided data regarding the discharges of all veterans treated during FY 1990 with blindness included as part of their diagnosis (ICD-9-CM (International Classification of Diseases, 9th revision, Clinical Modifications) Code 369).

(2) A state by state comparison to the national rate was completed.

(3) Accompanying tables contain the supportive data.

(4) Because of the relatively low numbers of admissions and discharges compared to the state and national veteran populations (extracted from the VETPOP File at Austin) admission and discharge rates have been calculated per hundred thousand veterans.

(5) While the blind rehabilitation admission data offer a detailed look at the availability of these specialized services, the PTF discharge data provide a broader perspective as to the access blinded veterans experience in obtaining health care services, particularly in areas remote from existing BRCs and Clinics.

b. **Blind Rehabilitation Admissions.** An examination of the FY 1990 Blind Rehabilitation admissions data suggests the following observations:

(1) The vast majority of states in the Southern Region exhibit admission rates at or above the national rate. Only three states (Arkansas, Georgia, and Oklahoma) are found below the national rate.

(2) Slightly more than half of the states in the Western Region show admission rates below the national rate. These states which are clustered along the Pacific coast and the Northern section of the Region include the states of California, Oregon, Washington, Idaho, Montana, and Wyoming. The states clustered in the Southern portion of the Region, including Nevada, Utah, Arizona, Colorado, and New Mexico, have admission rates at or above the national rate.

(3) In the Central Region, a slim majority of the states (North Dakota, Minnesota, Wisconsin, Michigan, Kansas, Iowa, and Ohio) experience admission rates below the national rate, while South Dakota, Nebraska, Missouri, Illinois, Indiana, and Kentucky have rates exceeding the national rate.

(4) In the Eastern Region, the vast majority of states demonstrate admission rates below the national rate. Of the thirteen states in this Region, only two (New Hampshire and Connecticut) are at or exceed the national rate for admissions to Blind Rehabilitation Centers/Clinics.

c. **Blind Veteran Discharges.** The following observations are based upon FY 1990 PTF blind discharge data:

(1) The vast majority of states in the Southern Region have discharge rates at or above the national rate. Only four states (Oklahoma, Louisiana, Tennessee, and North Carolina) fall below the national rate.

(2) In the Western Region, the vast majority of states exhibit rates below the national rate. Only three states (Montana, Wyoming, and Arizona) exceed the national rate.

(3) In the Central Region, a slim majority of seven states exceeds the national blind discharge rate. The states of North Dakota, Minnesota, Wisconsin, Michigan, Indiana, and Ohio fall below the national rate.

(4) The vast majority of states in the Eastern Region fall below the national rate. Only the states of New York, New Hampshire, and West Virginia meet or exceed the national rate.

d. **Findings:**

(1) Under both Access analyses, the Eastern Region has the largest number of states falling below the national rate. The state of New Hampshire is the only state exceeding the national rate for both admissions and discharges.

(2) For both analyses, the Western Region is the only other Region showing a majority of states below the national rate. Only the state of Arizona exceeds the national rate for both analyses.

(3) The Central Region shows a slight majority of states below the national rate for admissions, while a slim majority of states in that Region are above the national rate in terms of discharges.

(4) The Southern Region is the only Region showing a large majority of states exceeding the national rate for both analyses. The states of Texas, Mississippi, Alabama, South Carolina, and Florida exceed the national rate under both analyses.

e. Table I. Estimated legally blind veteran population by age range and state for 1990.

<u>STATE</u>	<u>AGE TO 44</u>	<u>45 TO 64</u>	<u>65 TO 74</u>	<u>75 TO 84</u>	<u>85 &amp; OVER</u>	<u>TOTAL</u>
Alabama	133	451	408	244	154	1390
Alaska	29	71	38	17	6	161
Arizona	147	435	477	280	155	1494
Arkansas	39	260	260	169	115	894
California	898	3144	2940	1773	1132	9888
Colorado	157	430	329	184	109	1209
Connecticut	114	434	423	248	146	1366
Delaware	29	86	80	44	22	260
Florida	447	1556	2033	1296	837	6169
Georgia	265	715	585	343	180	2088
Hawaii	35	112	96	53	25	321
Idaho	39	118	101	55	35	350
Illinois	395	1350	1252	730	442	4169
Indiana	242	683	574	339	210	2047
Iowa	124	339	295	172	143	1073
Kansas	93	306	291	171	127	988
Kentucky	119	399	352	203	140	1213
Louisiana	143	441	435	253	135	1406
Maine	55	163	155	90	57	520
Maryland	186	599	544	304	159	1793
Massachusetts	195	721	773	459	289	2437
Michigan	386	1092	931	520	314	3242
Minnesota	180	543	446	263	195	1627
Mississippi	74	249	251	154	95	821
Missouri	216	682	633	379	244	2153
Montana	37	107	95	52	33	324
Nebraska	62	195	171	100	71	600
Nevada	50	168	142	78	32	471
New Hampshire	56	157	135	78	49	474
New Jersey	242	984	1026	593	333	3177
New Mexico	67	176	165	93	51	551
New York	542	1946	2015	1230	749	6482
North Carolina	227	744	734	411	208	2324
North Dakota	22	70	56	34	23	205
Ohio	457	1372	1301	739	426	4295
Oklahoma	130	408	378	223	157	1297
Oregon	131	372	343	208	149	1202
Pennsylvania	462	1629	1718	991	553	5354
Puerto Rico	45	145	110	49	28	376
Rhode Island	36	126	140	82	48	432
South Carolina	125	384	361	203	105	1177
South Dakota	26	87	73	42	36	263
Tennessee	192	568	515	307	180	1761
Texas	659	1872	1631	966	551	5678
Utah	46	158	141	76	46	466
Vermont	25	68	59	34	26	211

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<u>STATE</u>	<u>AGE TO 44</u>	<u>45 TO 64</u>	<u>65 TO 74</u>	<u>75 TO 84</u>	<u>85 &amp; OVER</u>	<u>TOTAL</u>
Virginia	232	733	651	377	203	2195
Washington	225	649	541	316	203	1933
Washington, DC	17	59	62	42	32	213
West Virginia	73	221	237	144	88	763
Wisconsin	20	611	517	279	196	1810
Wyoming	22	58	40	25	18	163

f. Table 2. Access by Blind Rehabilitation Centers and Clinic Admissions FY 90

	<u>Total Admissions</u>	<u>FY90 Vet Pop in Hundred Thousands</u>	<u>BRC Admissions per Hundred Thousand</u>
Alabama	12	4.02	2.99
Alaska	0	.63	0
Arizona	23	4.24	5.42
Arkansas	4	2.50	1.60
California	66	27.97	2.36
Colorado	19	3.93	4.83
Connecticut	21	3.81	5.51
Delaware	0	.79	0
Washington, DC	13	.55	23.64
Florida	69	15.40	4.48
Georgia	15	6.68	2.25
Hawaii	0	.99	0
Idaho	1	1.07	.93
Illinois	34	12.04	2.82
Indiana	21	6.32	3.32
Iowa	3	3.21	.93
Kansas	4	2.79	1.43
Kentucky	11	3.53	3.12
Louisiana	14	4.12	3.40
Maine	1	1.53	.65
Maryland	6	5.39	1.11
Massachusetts	13	6.55	1.98
Michigan	12	10.11	1.19
Minnesota	9	4.90	1.84
Mississippi	6	2.28	2.63
Missouri	18	6.24	2.88
Montana	0	.99	0
Nebraska	5	1.76	2.84
Nevada	10	1.47	6.80
New Hampshire	10	1.46	6.85
New Jersey	0	8.63	0
New Mexico	7	1.71	4.09
New York	31	17.68	1.75
North Carolina	8	6.81	1.17
North Dakota	0	.61	0
Ohio	31	12.79	2.42
Oklahoma	5	3.74	1.34

	<u>Total Admissions</u>	<u>FY90 Vet Pop in Hundred Thousands</u>	<u>BRC Admissions per Hundred Thousand</u>
Oregon	4	3.52	1.14
Pennsylvania	28	14.91	1.88
Puerto Rico	56	1.24	45.16
Rhode Island	0	1.16	0
South Carolina	14	3.54	3.95
South Dakota	2	.76	2.63
Tennessee	22	5.27	4.17
Texas	54	17.45	3.09
Utah	9	1.39	6.47
Vermont	0	.63	0
Virginia	8	6.62	1.21
Washington	2	5.95	.34
West Virginia	2	2.14	.93
Wisconsin	8	5.56	1.44
Wyoming	0	.53	0
<b>NATIONAL</b>	<b>711</b>	<b>270.00</b>	<b>2.63</b>

Source: BRC Annual Reports and Vetpop File at the Data Processing Center in Austin, TX.

g. Table 3. Access By Blind (ICD-9-CM) Code 369 Discharges FY 1990

	<u>Total FY90 Discharges</u>	<u>FY 90 Vet Pop in Hundred Thousands</u>	<u>PTF Discharges per Hundred Thousand</u>
Alabama	101	4.02	25.10
Alaska	1	.63	1.60
Arizona	86	4.24	20.30
Arkansas	76	2.50	30.40
California	375	27.97	13.40
Colorado	73	3.93	18.80
Connecticut	67	3.81	17.50
Delaware	14	.79	17.70
Washington, DC	38	.55	69.00
Florida	358	15.40	23.20
Georgia	165	6.68	24.70
Hawaii	0	.99	0
Idaho	16	1.07	14.90
Illinois	280	12.04	23.3
Indiana	103	6.32	16.30
Iowa	96	3.21	29.90
Kansas	114	2.79	40.90
Kentucky	94	3.53	26.60
Louisiana	84	4.12	20.30
Maine	18	1.53	11.80
Maryland	74	5.39	13.70
Massachusetts	105	6.55	16.00
Michigan	125	10.11	12.40

July 10, 1992

M-9  
Chapter 9  
change 10  
APPENDIX 9K

	<u>Total FY90 Discharges</u>	<u>FY 90 Vet Pop in Hundred Thousands</u>	<u>PTF Discharges per Hundred Thousand</u>
Minnesota	62	4.90	12.60
Mississippi	70	2.28	30.70
Missouri	184	6.24	29.50
Montana	48	.99	48.40
Nebraska	99	1.76	56.30
Nevada	22	1.47	14.90
New Hampshire	45	1.46	30.80
New Jersey	76	8.63	8.80
New Mexico	29	1.71	16.90
New York	512	17.68	28.90
North Carolina	136	6.81	19.90
North Dakota	10	.61	16.30
Ohio	220	12.79	17.20
Oklahoma	58	3.74	15.50
Oregon	69	3.52	19.60
Pennsylvania	292	14.91	19.60
Puerto Rico	97	1.24	78.20
Rhode Island	15	1.16	12.90
South Carolina	117	3.54	33.10
South Dakota	64	.76	84.20
Tennessee	112	5.27	21.30
Texas	518	17.45	29.60
Utah	32	1.39	23.00
Vermont	4	.63	6.30
Virginia	121	6.62	18.30
Washington	100	5.95	16.80
West Virginia	65	2.14	30.40
Wisconsin	94	5.56	16.90
Wyoming	15	.53	28.30
NATIONAL	5,751	270.00	21.30

Source: VETPOP File and PTF File at the Data Processing Center in Austin, TX.

January 28, 1993

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-9, "Strategic Planning," Chapter 9, "Criteria and Standards and Program Planning Factors."
2. Principal change is to add Appendix 9P, "Mental Health Criteria and Standards."
3. **Filing Instructions**

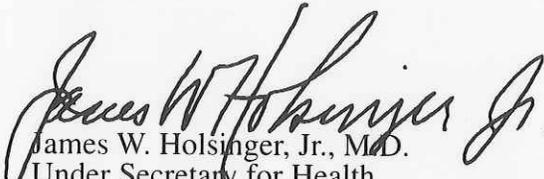
**Remove**

9-i ✓

**Insert**

9-i ✓  
9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.

  
James W. Holsinger, Jr., M.D.  
Under Secretary for Health

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Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

M-9  
Chapter 9  
Change 10

July 10, 1992

1. Transmitted is a change to the Department of Veterans Affairs, Veterans Health Administration, Manual M-9, "Strategic Planning", Chapter 9, "Criteria and Standards and Program Planning Factors."

2. Principal change is the addition of the following appendices to Chapter 9:

a. Appendix 9K: Program Planning Factors for Blind Rehabilitation Service.

b. Appendix 9L: Program Planning Factors for Spinal Cord Injury Program.

3. Filing Instructions

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9-i

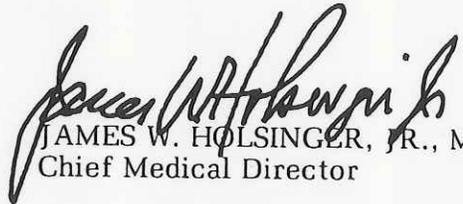
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9K-1 through 9K-15

9L-1 through 9L-7

4. RESCISSIONS: None.

  
JAMES W. HOLSINGER, JR., M.D.  
Chief Medical Director

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July 26, 1991

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-9, "MEDIPP," which is changed to M-9, "Strategic Planning."

2. Principal reason for this manual change is to delete the term "MEDIPP":

a. In chapters 1 through 11, delete the term "MEDIPP" and replace it with "Strategic Planning."

b. Changes to all M-9 chapters are in process to update to current procedures.

3. Filing Instructions:

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JAMES W. HOLSINGER, JR., M.D.  
Chief Medical Director

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October 2, 1989

1. Transmitted is a new Veterans Health Services and Research Administration Manual M-9, "MEDIPP," chapter 1 through chapter 11. Changes will be made to incorporate the recent reorganization in the near future.

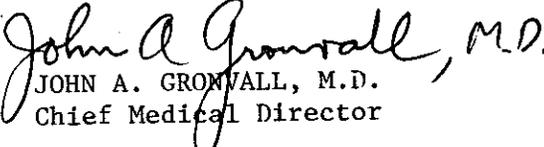
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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1-1 through 11-3

4. RESCISSIONS: Circular 10-87-113, dated October 10, 1987 and Supplement No. 1 dated April 4, 1988; Circular 10-87-147, dated December 30, 1987; Circular 10-88-3, dated January 13, 1988; Circular 10-88-150, dated December 9, 1988; and Circular 10-89-31, dated March 23, 1989.

  
JOHN A. GRONVALL, M.D.  
Chief Medical Director

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Veterans Administration

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REMARKS

SUBJ: Departmental Manual M-9

1. In DM&S Supplement MP-1, Part II, Changes 35 dated November 13, 1984, the title of M-9 is "Medical District Initiated Program Planning."

2. This is to request that the title of this manual be changed to:

*"Planning and Evaluation and Systems Development"*

We expect to be submitting a number of items to be included in this manual during the coming year.

3. Thank you for your assistance.

Approved  Disapproved

*John W. Ditzler*  
JOHN W. DITZLER, M.D.  
Chief Medical Director

*2-3-86*  
Date

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FROM

*Marjorie R. Quandt*  
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications  
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Veterans  
Administration

# Memorandum

APR 03 1984

From: Director, Program Analysis and  
Development (10C2B)

To: Chief Medical Director (10)  
Publications Control Officer (101B2)

Subj: Establishment of M9-MEDIPP

1. Request permission to establish a new manual (M9-MEDIPP) to formalize MEDIPP (Medical District Initiated Program Planning) as a permanent DM&S Policy.
2. MEDIPP has in its two year cycle become an effective mechanism for DM&S planning purposes. MEDIPP has become the management tool providing comprehensive information directly from the medical districts. This allows prudent decision making in order to meet the health care veterans needs of the 1990's and beyond.
3. The '84 MEDIPP Planning Guidance has been reviewed and concurred in by appropriate program offices, therefore, in order to expedite the process, I would recommend that Volume I: Medipp Purpose, Structure, and Process and Volume II: Plan Development, of the '84 MEDIPP Planning Guidance be accepted as the M9-MEDIPP Manual without further circulation. (Appropriate formatting would be instituted.) I anticipate no changes to these two volumes in the near future.

Volume III: Needs Assessment Methodology and Volume IV: MEDIPP Reference Documents will by necessity be revised annually and will therefore have to be issued annually as a CMD Circular.

4. It is timely that M9-MEDIPP be developed in order to firmly establish its important place in DM&S as a consistent, and permanent policy.

*Murray G. Mitts M.D.*  
MURRAY G. MITTS, M.D.

*Donald L. Custis*  
DONALD L. CUSTIS, M.D.  
Chief Medical Director (10)

Approve   
~~Disapprove~~

*4/17/84*  
Date