

Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

Appendix 9L, Program Planning Factors for Spinal Cord Injury Program

This document includes:

Title page and p. ii for M-9, dated **July 26, 1991**

Contents page for M-9, dated **June 5, 1992** (Change 9)

Rescissions page for M-9, dated **May 4, 1992** (Change 4)

Contents page for Chapter 9, dated **January 28, 1993** (Change 14)

Text for Appendix 9L, dated **July 10, 1992** (Change 10)

Transmittal sheets located at the end of the document:

Change 14, dated **January 28, 1993**

Change 10, dated **July 10, 1992**

Transmittal sheets for changes prior to 1992 also located at the end of the document:

Change 2, dated **July 26, 1991**

Sheet dated **October 2, 1989**

Reference Slip, dated **January 27, 1986**

Memorandum dated **April 3, 1984**



Department of
Veterans Affairs

Strategic Planning

July 26, 1991

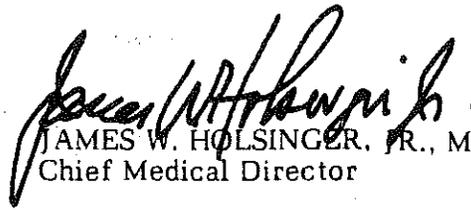
Veterans Health Administration
Washington DC 20420

Department of Veterans Affairs
Veterans Health Administration

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

July 26, 1991

Department of Veterans Affairs, Veterans Health Administration Manual M-9, "Strategic Planning," is published for the information and compliance of all concerned.


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

Distribution: RPC: 1318
FD

Printing Date: 7/91

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RESCISSIONS

The following material is rescinded:

Complete rescissions:

Circulars

10-87-113 and Supplement No. 1
10-87-147
10-88-3
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PROGRAM PLANNING FACTORS FOR SPINAL CORD INJURY PROGRAM

1. BACKGROUND

a. In the U.S. (United States), traumatic SCI (Spinal Cord Injury) claims approximately 8,000 victims each year and produces devastating, permanent neurological deficits. The most frequent cause of spinal cord injury is motor vehicle accidents. Although spinal cord injury occurs most frequently in the civilian population, it is also a significant problem for the military, a population composed primarily of young men.

b. During the last decades, there have been major improvements in the medical management of patients with spinal cord injury.

(1) Survival has increased from less than 10 percent to over 85 percent, and the life expectancy of the spinal cord injured has also increased significantly.

(2) Despite improvement in mortality, there has been little change in morbidity of the spinal cord injured. There are now over 250,000 spinal cord injured in the U.S.

c. VA's (Department of Veterans Affairs) system of specialized care for SCI patients is the largest such system in the world.

(1) There are currently 21 SCI centers with a total of 1,396 beds serving approximately 19,000 patients.

(2) Forty-seven percent are quadriplegic and 53 percent are paraplegic. The special services and care that these individuals require are great, and the need for care continues throughout the remainder of their lives.

(3) Some of the specialized programs include:

(a) SCI Home Care.

(b) Urodynamic Laboratories.

(c) Independent Living Programs.

(d) Outpatient Clinics.

(e) Outpatient Support Clinics.

2. GOAL

The goal of the planning protocol for the SCI Program 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. DEFINITIONS

a. The SCI patient is an individual with trauma and/or dysfunction of the spinal cord or cauda equina, resulting in neurological deficits.

b. The diagnostic categories of patients who should have access to VA SCI services include patients with:

(1) Traumatic lesions of the spinal cord and cauda equina, resulting in neurologic deficits.

(2) Intraspinal, non-malignant neoplasm, resulting in neurologic deficit of a stable nature.

(3) Vascular insults to the spinal cord or cauda equina of thromboembolic, hemorrhagic or ischemic nature, producing neurologic deficit.

(4) Inflammatory disease of the spine, spinal cord or cauda equina resulting in non-progressive neurologic deficit.

(5) Demyelinating disease limited to the spinal cord and of a stable nature.

c. Programs established for the inpatient and outpatient care of SCI patients include SCI Centers, SCI Support Clinics, and SCI Support Units.

(1) VA SCI Centers

(a) SCI Centers are designated by the CMD (Chief Medical Director) or designee and will provide both inpatient and outpatient care.

(b) The mission of the SCI Center is to meet the extensive medical, psychological, social and vocational needs of spinal cord injured patients to enable them to return to the community functioning at their maximum potential.

(c) The SCI Center has the responsibility for establishing programs for education and follow-up care, particularly a SCI Preventive Medicine Program to improve the patient's quality of life in the community and decrease the need for hospitalization.

(d) It is the responsibility of the Center to ensure that SCI patients receive continuing care and health maintenance. The SCI Center will provide one or more of the following types of inpatient care:

1. Acute injury care is the phase of treatment from time of injury to stabilization. This may be provided in a non-SCI Center VA medical center only until such time as the patient is medically stable and can be safely transferred to an SCI Center.

2. Initial rehabilitation care is designed for newly injured patients whose injuries occurred less than 6 months prior to admission. Initial care may also be needed by SCI patients on their first admission to a VA SCI Center.

3. Sustaining hospital care is treatment for follow-up care and illnesses, whether resulting from SCI or not.

4. Long-term care includes care of all patients who have received maximum acute and rehabilitation hospital benefits but require institutional maintenance of their achieved level or have psychosocial problems that prevent discharge to the community.

(f) All SCI Centers will also provide outpatient care and in-home care through outpatient SCI clinics and SCI Home Care Programs.

1. Home care is designed to assist patients and their families in adjusting to discharge from the hospital, and aid patients already in the community with counseling, educational activities, and medical care. SCI home care should provide services similar to those provided in traditional Hospital Based Home Care Programs, but with a special focus on spinal cord injury.

2. SCI Preventive Medicine Program includes a complete yearly physical which forms the basis of a well-planned system to promote wellness and prevent the multiple complications of SCI.

(2) VA SCI Support Services. SCI Support Services consist of an inpatient support unit and an outpatient support clinic at a non-SCI Center. They will function only after documented VA Central Office approved training for the staff and after formal designation by the CMD.

(a) SCI Support Unit - an inpatient bed unit designated for sustaining care patients.

1. It is intended to support the inpatient needs of the SCI support clinic and other local needs.

2. Patients with an anticipated length of stay of more than 30 days should be transferred to an SCI Center.

3. Support units are not intended for acute, initial rehabilitation, or long-term care patients.

(b) SCI Support Clinic is a clinic that provides basic ambulatory and screening services at a VA medical center without an SCI Center. Each medical center with an inpatient support unit must have an outpatient support clinic.

4. PROGRAM PLANNING FACTORS

a. Comprehensive Care. Comprehensive care should be available to all eligible SCI veterans within each Regional Division Office area.

(1) VA medical centers with existing designated SCI Centers are as follows:

(a) Region One

Brockton/West Roxbury
Bronx
Castle Point
East Orange
Hampton
Richmond

(b) Region Two

Cleveland
Hines
Milwaukee
St. Louis

(c) Region Three

Augusta
Houston
Memphis
Miami
San Juan
Tampa

(d) Region Four

Albuquerque
Long Beach
Palo Alto
San Diego
Seattle

(2) **SCI Centers.** Proposed SCI Centers should be at least 200 miles or 4 hours driving time from an existing VA SCI Center.

(a) Exceptions may be made based on population density and current/projected utilization of the nearest SCI Centers.

(b) VA medical centers must be full-service tertiary care hospitals.

(c) The medical center must have access, at the medical center or in the community, to the following types of technology:

1. State-of-the-art imaging technology.
2. Non-invasive Stone Therapy.
3. Neurophysiological testing.
4. Prosthetic services.
5. Urodynamic laboratories.
6. Driving simulator/training in a van/car.

(d) **Community Resources.** The following community resources should be considered in site selection:

1. Community nursing homes.
2. Employment opportunities.
3. Home health services.
4. Educational and recreational facilities.
5. Vocational rehabilitation.
6. Transportation services.

(e) **Space Requirements.** Space requirements should consider:

1. Availability of space for new construction.

2. Land for parking.
3. Indoor and outdoor recreation space.
4. Ground floor location.
5. Close proximity to support services such as X-ray and laboratory.

NOTE: *Space requirements for SCI centers, which can be extrapolated for SCI Support Units, are contained in "SCI Center Design Guide", published by the Office of Facilities in July, 1990.*

(3) **Establishment of an SCI Support Clinic.** A support clinic should be at least 100 miles or 2 hours ground travel time from an existing SCI Center or another SCI support clinic with a projected workload of at least twenty patients monthly. Staff should be formally trained through a VA Central Office approved educational program.

b. Current and Projected Need

(1) The SCI Planning Model, part of the Hospital Planning Model, projects future need for SCI beds based on historical utilization.

(a) The four major input variables to the model are:

1. Actual discharges from the SCI unit by age and type of care (short term or long term).
2. SCI veteran population data by:
 - a. Age and year, and
 - b. Lengths of stay by type of care.
3. Target occupancy rates.

(b) The SCI veteran population associated with a VA medical center corresponds to the SCI veteran population of the Region in which the VA medical center is located. Regional SCI veteran population is projected using incidence and prevalence rates, accounting for the aging of the population.

(2) National projections show an increased need for SCI beds for 2005, particularly for the age groups over 55. The planning model results may be used as the first step in analyzing the need for SCI units.

(3) Not all of the existing SCI centers provide a full range of acute, rehabilitation, sustaining and long term care. This must be taken into consideration in determining not only the numbers of additional beds needed, but also the mix and location.

(4) In the absence of a national historic database providing outpatient visits by veterans with spinal cord injuries, outpatient visits should be projected by multiplying the SCI veteran population currently on a facility's SCI Coordinator's patient roster times a quantifiably established annual visit rate.

(a) This annual visit rate may be obtained from local data kept by the facility or from other facilities who have already established a Support Clinic.

(b) If outpatient visits are being projected for an SCI Support Clinic, only those veterans on a facility's SCI Coordinator's patient roster who live in a logical service area surrounding the Satellite Outpatient Clinic should be used in the formula.

c. Appropriate Size of Program

(1) The SCI Center offering acute, initial rehabilitation, and/or sustaining care must have a minimum mix of 30 beds. The SCI Center offering long-term care must have a minimum of 30 beds. Neither model should exceed 60 beds.

(2) An SCI support unit should have a minimum of 15 beds.

(3) The projected workload for an SCI support clinic must be at least 20 visits per month. If there is need for support clinic functions and the projected workload is fewer than 20 per month, the establishment of a satellite clinic staffed by the SCI Center staff should be considered.

d. Opportunities for Consolidation, Sharing or Contracting of Programs

(1) VA provides SCI services for DOD (Department of Defense), which has no SCI services of its own. A VA/DOD agreement to that effect has been executed by the Secretary of Veterans Affairs and the Assistant Secretary of Defense.

(2) Any sharing of underutilized SCI resources is encouraged as long as variable costs are met, and sufficient flexibility is allowed to assure the provision of care to eligible veterans.

e. Available Resources. Although the private sector does have acute SCI rehabilitation facilities along with other support and clinical services available, they are usually located in major metropolitan areas inconvenient for many SCI veterans.

(1) Most of the facilities are on a fee-for-service basis which places them outside the financial means of most of the SCI veteran population and often beyond the means of the private citizen.

(2) No local or state-wide system provides such encompassing continuous care and support as VA provides for the spinal cord injured veteran.

(3) For VA PPF (Program Planning Factors) purposes, there is no comparable national system all encompassing in scope, other than VA for spinal cord injured individuals.

f. Other Considerations

(1) **Psychiatric SCI beds.** SCI patients who have an active psychiatric condition pose a difficult management problem, and should be taken into consideration for purposes of determining demand as well as necessary facilities. A psychiatric ward is not prepared to deal with the acute SCI injury or a past injury where there is a need to re-hospitalize the veteran due to deterioration of his psychiatric condition. Nor is an SCI unit appropriately prepared to address an acute psychiatric condition. An appropriate method of dealing with this issue needs to be explored.

(2) **Long-Term SCI Ventilator Beds.** A problem presented to a number of VA medical centers has been the cost of care and maintenance of long-term ventilator patients. This is further complicated when the patient is an SCI patient, because the care of the SCI ventilator patient is more complex, and successful outplacement of such patients is virtually unknown.

(a) Other alternatives need to be developed to address outplacement while at the same time assuring competent quality care for all patients receiving treatment.

(b) As the SCI veterans get older and as we are able to "save" the more acutely injured, there will be a slow but continual increase of the ventilator dependent patients.

(c) VA currently has less than 10 percent of its SCI beds designated as ventilator beds.

(3) **Criteria and Standards.** Additional detailed information relating to the planning of services for veterans with spinal cord injuries can be found in M-9, Chapter 9, Appendix 9B, "Criteria and Standards for the Spinal Cord Injury Program."

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**

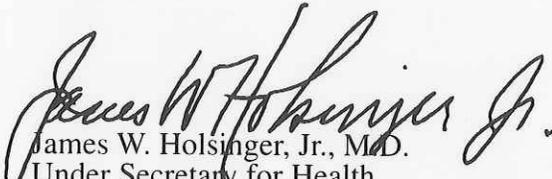
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9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.


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

Distribution: **RPC 1318**
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Printing Date: 2/93

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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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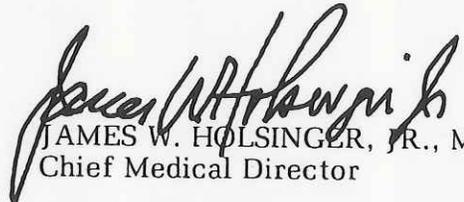
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9-i

9K-1 through 9K-15

9L-1 through 9L-7

4. RESCISSIONS: None.


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

Distribution: RPC: 1318
FD

Printing Date: 7/92

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.

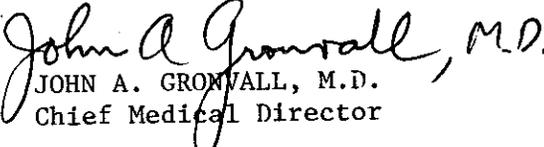
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

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

Distribution: RPC: 1318 is assigned
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Printing Date: 10/89



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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JAN 27 1986

FROM

Marjorie R. Quandt
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications
Management Staff (10A1B)
1/27/86

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VA FORM 3230
MAY 1980

EXISTING STOCKS OF VA FORM 3230, ★ U.S. G.P.O. 1984-709-228
AUG 1976, WILL BE USED.



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