

Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

Appendix 9M, Program Planning Factors for Domiciliary-Based Homeless 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 9M, dated **May 14, 1992** (Change 5)

Transmittal sheets located at the end of the document:

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

Change 5, dated **May 14, 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

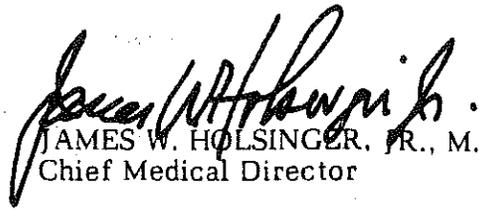
Veterans Health Administration
Washington DC 20420

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The following material is rescinded: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 DOMICILIARY-BASED HOMELESS PROGRAM

1. GOAL

The goal of the planning protocol for DCHV (Domiciliary Care for Homeless Veterans) is to achieve comprehensive integration of strategic and operational planning (including construction), budgeting and operational management of the VA (Department of Veterans Affairs) health care system consistent with the VA NHCP (National Health Care Plan).

2. BACKGROUND

a. Homelessness in America has emerged, especially within the last decade, as a social problem of considerable depth and magnitude. Estimates of the size of America's homeless population have been difficult to make. The best available estimates indicate that there are between 450,000 and 750,000 homeless persons in the United States on any given day, with perhaps twice as many experiencing homelessness at some point during the year. Studies indicate that approximately 110,000 to 250,000, or about one-third of the adult homeless are veterans.

b. As a response to the large numbers of veterans in the homeless population, VA was authorized by the "Urgent Relief for the Homeless Supplemental Appropriations Act of 1987," (Public Law 100-71) to implement the DCHV Program.

c. Studies of the health care status of the homeless have consistently discovered high prevalences of substance abuse, psychiatric illness and chronic medical illnesses.

(1) It has been estimated that perhaps 25 percent of the homeless have problems in two or more of these areas.

(2) Although many homeless veterans do not require hospitalization, their health care problems and social disabilities cannot be adequately treated while they continue to live in shelters or on the streets.

d. The DCHV Program differs from other residential programs for the homeless in that:

(1) It maintains a strongly goal-directed, clinical emphasis.

(2) It provides a five phase program of outreach, assessment, treatment, aftercare, and case management services specifically designed for the treatment of homeless veterans.

e. For many homeless veterans, the VA's DCHV Program has provided an important setting from which to receive desperately needed services.

3. PROGRAM PLANNING FACTORS

a. Referral Patterns of Patients and Geographic Area Served

(1) Medical centers experiencing significant demand for homeless veteran services and considering a DCHV Program should identify and provide a demographic analysis of the area to be served by the DCHV Program.

Chapter 9
APPENDIX 9M
Change 5

(a) The analysis should describe the homeless population in that geographic area and the subgroup of homeless veterans (homeless chronically mentally ill, substance abusers, transients, etc.).

(b) The analysis should also include any unique geographic or transportation limitations which limit access to the medical center to receive treatment.

(c) Homeless people congregate in the inner city where few VA medical centers are located; therefore, the medical center should be accessible from such areas that contain the largest concentrations of homeless. Every effort should be made to establish domiciliaries in urban medical centers in larger metropolitan areas.

(2) In rural areas where the homeless population is much more widely dispersed, reasonable access to transportation systems should be available to enhance referrals.

b. Present and Projected Need

(1) Thirteen VA medical centers located near major urban centers have new domiciliaries established under the DCHV Program.

(a) Thirteen existing VA domiciliaries now have DCHV Programs.

1. As of March, 1991, the DCHV Program had created 1,179 beds for the treatment of homeless veterans, and

2. Between November, 1987, and March, 1991, over 8,000 veterans were admitted to the DCHV Program and over 7,000 were discharged.

(b) In a December 1989, study of the DCHV Program by the NEPEC (Northeast Program Evaluation Center), VA Medical Center, West Haven, CT, it was determined that:

1. The FY 1988 ALOS (average length of stay) for new DCHV domiciliaries was 94 days, and

2. The FY 1988 ALOS was 79 days for DCHV programs established in existing domiciliaries.

(2) Any evaluation of homeless veteran needs, both present and projected, should be based, in part, on current and projected Year 2005 veteran population statistics, by age. Veterans, who make up 29 percent of the adult male population, constitute a roughly similar percentage of the overall homeless population. Historical data indicate that the majority of veterans receiving DCHV assessments have been Vietnam era veterans.

(3) Information obtained through communication with existing local homeless coalitions, public agencies and volunteer organizations should be an integral element of the evaluation of need. Such groups can be a valuable source for gauging the prevalence of homelessness as well as providing a measure of the homeless resources that are currently in place or planned.

(4) Facilities that plan to draw upon the resources of, or meet the DCHV needs of, other facilities must fully delineate the scope and nature of such plans.

c. Appropriate Size of Program

There are two models of VA domiciliaries that are appropriate for homeless veterans:

(1) Rehabilitation Model

(a) A minimum size of 40 beds is considered appropriate for this model; fewer than 40 beds would not be cost-effective from a program operations perspective.

1. It is intended that small domiciliaries (40-100 beds) focus their resources and efforts primarily on the provision of active biopsychosocial rehabilitation services.

2. To the extent possible, long-term health maintenance patients should be referred to the larger multi-purpose domiciliaries.

(b) The primary objective of this domiciliary program is to:

1. Identify all treatment needs,

2. Provide treatment of relatively short-term duration,

3. Transfer patients for health maintenance care, or

4. Outplace them with necessary support networks for successful community integration.

(c) Specialized programs within smaller domiciliaries often include substance abuse rehabilitation, vocational rehabilitation, group therapies, resocialization, etc.

(2) Rehabilitation and Health Maintenance Model

(a) Based on professional judgment and past experience with existing domiciliaries, a size of 100 beds or more is considered appropriate for this model. These VA domiciliaries provide:

1. Active biopsychosocial, vocational rehabilitation care, and

2. Long-term health maintenance care.

(b) The primary objective of this domiciliary program is to assist the patient in achieving the maximum level of functional independence. Some, including a nucleus of current patients, may require continuing care for an extended period, but the ultimate goal is the return of the veteran to independent functioning in the community.

(c) A full range of services is needed in order to support the DCHV patient population. M-5, Part IV, "Domiciliary Care Program," provides a listing of services that must be available in-house, community, or from nearby VA medical centers to VA domiciliaries.

(d) Larger domiciliaries, by design, often house a broad range of specialized clinical programs intended to address sub-acute treatment and rehabilitation needs of a varying array of patients as:

1. Traumatic brain injury,
2. Substance abuse,
3. Long-term psychiatric rehabilitation,
4. PTSD (post-traumatic stress disorder),
5. AIDS-HIV (Acquired Immunodeficiency Syndrome - Human Immunodeficiency Virus) disease, and
6. Cardiac rehabilitation, etc.

(e) It is expected that each VA domiciliary will offer programs necessary to the satisfaction of identified health care needs of the patients. Services and programs may vary in accordance with domiciliary patient treatment needs. A comprehensive listing of therapeutic programs and activities is presented in M-5, part IV.

(f) Facilities proposing a DCHV Program must meet the existing space requirements found in H-08-9, chapter 312. Additionally, the domiciliary must conform to the Uniform Federal Accessibility Standards and provide appropriate privacy for female veterans.

d. Opportunities for Consolidation, Sharing or Contracting of Programs

Comprehensive assessments of homeless veteran need involve exploring alternative resources and opportunities. The potential for collaboration with Federal, state and local entities involved in the provision of service to the homeless should be described.

e. Available Resources

(1) All DCHV Programs are designed, established, staffed, equipped and operated in a manner fully consistent with requirements, standards and criteria set forth in M-5, part IV; and M-9, chapter 9, appendix 9A.

(2) The feasibility of renovation or redesignation/conversion of unused or under utilized inpatient care beds/buildings to a DCHV facility must be fully explored. Proposals for new construction must be made only if the potential for renovation or redesign is not available at a lower cost.

(3) All DCHV proposals should support and complement existing, expanded or newly created VA efforts targeted to homeless veteran populations and must be integrated with existing coalitions of public agencies and volunteer organizations working with the homeless.

(4) Resources needed to achieve the desired goals and objectives should be specified, outlining start-up and recurring costs, including transportation.

(5) Affiliations should be addressed as well as any prospective roles, including house staff availability, in the DCHV Program.

(6) Every VA domiciliary must use an interdisciplinary team approach to treating patients.

(a) Treatment teams should include, but not be limited to:

1. Medicine.
2. Recreation.
3. Psychiatry.
4. Nursing.
5. Social Work.
6. Psychology.
7. Rehabilitative Medicine.
8. Dentistry.
9. Chaplaincy.
10. Dietetics.
11. Medical Administration.
12. Domiciliary Operations.
13. Consultants based on the individual needs of the patient.

(b) The team composition may vary from patient to patient. Domiciliary Care Program staffing guidelines that appear in M-9, chapter 9, appendix 9A, should be consulted for appropriate staffing levels.

f. Other Considerations

(1) **Program Components.** Program activities must include, but are not necessarily limited to, the following:

(a) **Community Outreach and Referral.** Linkages should be developed with local homeless coalitions and with clinical programs and agencies that provide services to the homeless.

(b) **Admission Screening and Assessment.** Admission criteria are used to determine eligibility for the DCHV Program.

(c) **Medical and Psychiatric Evaluation.** A medical assessment and psychiatric diagnostic interview is conducted on all veterans admitted to the DCHV Program.

(d) **Medical Treatment, Social Rehabilitation and Discharge Planning.** DCHV staff work closely with veterans on their treatment needs and discharge plans in three core clinical areas:

1. Health care,
2. Housing, and
3. Employment.

May 14, 1992

(e) **Post-discharge community support.** Procedures for following veterans after discharge should be developed to provide continuity of care.

(2) **Quality Components**

(a) The DCHV Program will be included in the medical quality assurance program of the medical center.

1. There should be a written quality assurance program which is reviewed annually and updated as necessary.

2. There should be a continuous review of all services and programs for domiciliary patients which includes comment or retrospective review methods.

(b) All DCHV Programs are required to participate in ongoing program evaluation activities conducted by the NEPEC at the VA Medical Center, West Haven, CT.

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**

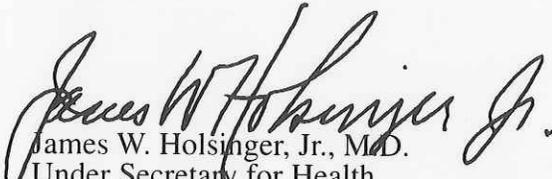
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9-i ✓

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9-i ✓
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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May 14, 1992

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 the addition of the following appendices to Chapter 9:

a. Appendix 9M: Program Planning Factors for Domiciliary-Based Homeless Program.

b. Appendix 9N: Program Planning Factors for PTSD (Post-traumatic Stress Disorder) Program.

3. Filing Instructions

Remove Pages

9-i ✓

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

Distribution: RPC: 1318
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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:

Remove pages

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Cover page through iv

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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.

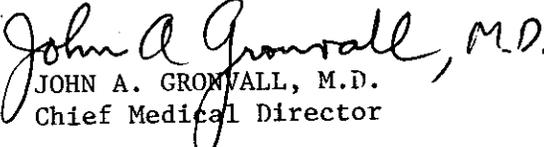
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

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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JAN 27 1986

FROM

Marjorie R. Quandt
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

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3331

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MAY 1980

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



Veterans
Administration

APR 03 1984

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

Memorandum

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

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