

Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

**Appendix 9Q, Criteria and Standards for GEM
(Geriatric Evaluation and Management) 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 9Q, dated **December 29, 1992** (Change 13)

Transmittal sheets located at the end of the document:

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

Change 13, dated **December 29, 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

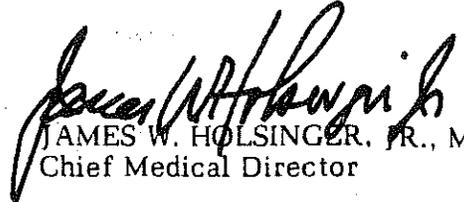
Veterans Health Administration
Washington DC 20420

Department of Veterans Affairs
Veterans Health Administration

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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The following material is rescinded: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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CRITERIA AND STANDARDS FOR GEM (GERIATRIC EVALUATION AND MANAGEMENT) PROGRAM

1. BACKGROUND

Because elderly persons have, on an average, more medical problems than younger persons and their need for health care services, especially long-term care, is much higher, the projected increase in the elderly population over the next 3 to 4 decades will likely create new, formidable health care delivery problems in the United States. The challenge that this aging trend poses for the VA (Department of Veterans Affairs) and the nation's health care system has stimulated increased interest in the degenerative processes associated with aging and the resulting disabilities specific to older persons.

2. PURPOSE

a. To meet this health care challenge, VA, using an innovative approach, has developed comprehensive geriatric evaluation and specialized GEM (Geriatric Evaluation and Management) Programs.

b. GEM is a specialized program of services in an inpatient or outpatient setting where an interdisciplinary health care team performs multidimensional assessments (evaluations) on a targeted (patients 65 years, or older, with multiple medical problems) group of elderly patients who will most likely benefit from these services. This team approach to assessment of the patient is followed by an interdisciplinary plan of care (management), including treatment, rehabilitation, health promotion and social service interventions.

c. The GEM Program assists in improving quality of care, reducing unnecessary use of hospital services, and avoiding inappropriate use of nursing homes and other long-term care services.

d. These criteria and standards will assist VA medical centers in the process of establishing new GEM Programs, and with modifying existing GEM Programs.

3. POLICY

a. The Under Secretary for Health has mandated that all VA medical facilities establish a GEM Program by 1997. The GEM Program can be inpatient, outpatient or a combined inpatient/outpatient program.

b. Patient Selection Criteria

(1) An important part of optional GEM function is to select those patients most likely to benefit. The development of inclusionary and exclusionary selection criteria should include consideration of such factors as available staff, unit size, and hospital setting.

NOTE: Inpatient GEMs should use special care in targeting patient selection to those who will benefit most because of the relatively greater cost of performing evaluation and management in the inpatient setting relative to the outpatient setting.

(2) The following selection criteria should be viewed as suggestive.

(a) **Inclusionary Criteria.** Those who might best benefit from a GEM are:

1. Patients age 65 years and older.
2. Patients with multiple medical, functional and/or psychosocial problems, who could benefit from an interdisciplinary team approach.
3. Patients with particular "geriatric" problems, as:
 - a. Dementia,
 - b. Urinary incontinence,
 - c. Elder abuse,
 - d. Unsteady gait/falls,
 - e. Malnutrition, and
 - f. Depression.

(b) **Exclusionary Criteria.** Patients who might best be excluded from the GEM are those who:

1. Need an intensive care unit.
2. Have a well-documented terminal illness with a life expectancy less than 6 months (e.g., metastatic malignancy, end-stage congestive heart failure or end-stage cirrhosis).
3. Need total care (e.g., severe irreversible dementia, brain-stem CVA (Cerebral Vascular Accident)) and either:
 - a. Have an inadequate social support network to allow for eventual return home, or
 - b. Lack suitable rehabilitation potential to allow for permanent discharge to other than a nursing home setting.
4. Exhibit persistent, major behavioral difficulties and require constant supervision (e.g. suicidal, abusive).
5. Have a high probability of poor cooperation with the team evaluation and management recommendations (e.g., alcoholics, patients with a severe personality disorder).

4. GOALS AND OBJECTIVES

The goals and objectives of a GEM are to:

- a. Improve the process and outcome of clinical care.
- b. Provide geriatric education for health professionals and trainees.
- c. Ensure efficient use of hospital and community resources.

- d. Encourage geriatric research.

5. PROGRAM COMPONENTS

Each GEM shall consist primarily of clinical and teaching activities; research in clinical and health services is encouraged.

a. **Clinical.** The primary function is comprehensive geriatric assessment and management of a targeted population by an interdisciplinary team with expertise in Geriatrics.

b. **Education.** The GEM Program should be utilized as an education/training resource for GEM staff, other facility staff, staff of other VA facilities, non-VA staff as appropriate, and trainees.

c. **Research.** Staff of the GEM Program should be encouraged to include a clinical or health services research component directed at improving the quality of care of patients and the overall health care delivery to older veterans.

6. INPATIENT GEM PROGRAM

Each VA medical center should assess their targeted veteran population and determine the need for a GEM inpatient program.

a. **Minimum size of the Unit.** A GEM Program should consist of a minimum of 10 beds. *NOTE: A program with less than 10 beds will not utilize maximally the core team manpower; more than 25 beds will require significantly more resources.*

b. **Location.** The preferable location of the beds for the GEM Program is in an acute care or intermediate medicine setting. A NHCU (Nursing Home Care Unit) should not be used unless it is justified that this unit is the only feasible site for a GEM Program and that it can provide all the necessary care to GEM patients (including increased diagnostic studies, acute or emergency care, daily treatments, pharmacy, laboratory and radiology). Location in a NHCU must not impinge on NHCU patient care. If such justification is made and approved, the number of NHCU beds will be reduced by the number of GEM beds through a bed change request.

c. **Primary Core Team.** The primary core team must consist (at a minimum) of a physician, registered nurse (nurse practitioner or clinical nurse specialist), and social worker. The primary core team must have expertise or interest in Geriatrics. (If the core team members have interest but no expertise in Geriatrics, the VA facility should provide assurance that those individuals will receive support for participation in Geriatric courses and/or training programs). The medical center director must identify a medical director for the GEM Program. (The medical director can be the primary core team physician.)

NOTE: See G-2, M-5, part IV, GEM Program Guide, for roles and responsibilities of primary core team.

d. **Interdisciplinary Team.** The facility should designate members of specific disciplines as GEM expanded team (e.g., psychiatry, dietary, pharmacy, psychology, rehabilitation, and other services as appropriate). *NOTE: Assurance of support is necessary from all service chiefs within the facility.*

e. Support Services

(1) VA facility support must include 24-hour medical and nursing coverage. **NOTE:** *The core nurse should be a nurse practitioner or clinical specialist and not assigned as a staff nurse.*

(2) Facility support must include necessary laboratory and radiological services.

(3) Administrative support (e.g., secretary) must be provided for the core GEM staff.

f. Staffing Guidelines. Personnel must be designated as primary or support staff to the GEM Program. The primary core team for a 10 bed inpatient GEM Program must consist (at a minimum) of 0.5 physician, 1.0 nurse, 0.75 social worker. Determination of staff size should take into consideration the number of beds, level of care, and severity of illness of the target population of veterans. The range determined by a sample of GEM Programs was 1 to 2.5 FTEE (Full-time Employee Equivalent) physicians for 10 to 25 beds (this does not include Fellows and/Residents), the range for Clinical Nurse Specialist or Nurse Practitioner for 10 to 25 beds was one to two FTEE, and the range for social workers was .7 to 1.7 FTEE for 10 to 25 beds. The medical center director is responsible for the assignment of other professional and support personnel (e.g., 24 hour nursing coverage, pharmacy, psychiatry, psychology, physical therapy, occupational therapy, secretary, etc.) for consultation and assessment.

g. Space. Office space must be provided for the core GEM staff.

7. OUTPATIENT GEM PROGRAM

a. An outpatient GEM Program should consist of at least 3 half-day sessions per week. The range of patients, 2 to 4 new and 6 to 24 follow-up visits is dependent upon physician staffing (i.e., attending physicians, residents, fellow, etc.).

b. Primary core team should consist of a physician, registered nurse (nurse practitioner or clinical nurse specialist), and social worker.

NOTE: *Office space and administrative support must be provided for the core staff.*

c. The primary core team should have expertise or interest in Geriatrics. (If the core team members have interest but no expertise in Geriatrics, the VA facility must provide assurance that those individuals will receive support for participation in Geriatric courses and/or training programs.)

d. The medical center Director must identify a medical director for the GEM program. (The medical director of the GEM Program can be the primary core team physician.)

e. VA facility support would include clinic space, support personnel such as clinic nurse, clerk, etc. Ancillary services (laboratory, radiology, pharmacy, etc.) must be readily available.

f. Staffing Guidelines. The primary core team for an outpatient program must consist (at a minimum) of 0.4 physician, 0.4 nurse, 0.4 social worker for three half

days a week. The medical center Director should provide support personnel, clinic and office space for the program. Workload (number of patients treated) should determine the appropriate staffing levels.

8. INPATIENT/OUTPATIENT GEM PROGRAM

a. When establishing an inpatient and outpatient GEM program concurrently, each should be developed as related to the previous information for both programs. The outpatient program should complement the inpatient program (follow-up of patients) as well as admitting a limited number of new patients for outpatient evaluation and for ongoing primary care of frail elderly patients.

b. A combined program should limit the inpatient program to 10 to 15 beds, and meet 2 half days per week in the outpatient GEM Program. A core team member/members from the inpatient unit should also be assigned to the GEM clinic for continuity of care.

c. **Staffing Guidelines.** If the facility establishes a combined inpatient/outpatient program then the minimum staff for both inpatient/outpatient programs (based on a 10 bed unit and at least 2 half days of clinic/week) must be adhered to. Again, staffing levels would depend on workload, level of care, and severity of illness of targeted population.

9. GEM CONSULTATION TEAM

a. If a GEM Program includes, as part of their program, geriatric consultation services for the VA medical center, members of the primary core team should allocate time to be available for assessment and treatment if requested. Other professional staff from the GEM expanded team should also be available as needed (e.g., pharmacy, dietary, psychology, rehabilitation, etc.).

b. **Staffing Guidelines.** If consultation services are included in the program the number of consultations/week and the average length of time of each consultation should be considered in determining staffing levels needed.

10. CONTINUITY OF CARE

A member of the primary core team should follow patients in the geriatric or medical clinic for continuity of care.

11. QUALITY ASSURANCE

a. Each GEM Program must establish and document a process by which it evaluates the accomplishments of their clinical, educational and research activities. Measurable objectives should be used for each activity of the GEM program. (See G-2, M-5, part IV, GEM Program Guide.)

b. Specific clinical indicators should be identified and monitored in a prospective and systematic manner and focus on outcomes of care. Each GEM must coordinate quality assurance studies with the overall quality assurance program at the facility.

12. PROTOCOL FOR SUBMISSION FOR ESTABLISHING GEM

To justify the establishment of a GEM Program, a VA facility must meet the following requirements:

- a. There must be documentation of current and projected demographic data in order to estimate potential demand for GEM services.
- b. There must be assurance of support from appropriate service chiefs.
- c. There must be identification of personnel and physical resources needed to operate the program.
- d. There must be identification of interested and enthusiastic potential GEM staff, preferably with expertise in Geriatrics, from appropriate disciplines. (See G-2, M-5, part IV, GEM Program Guide.)

13. NEEDS ASSESSMENT METHODOLOGY

- a. Patients 65 and over with multiple diagnosis, but not diagnosed as terminally ill, may require GEM inpatient admission. These patients are further screened based on Selection Criteria provided in paragraph 2b. It is difficult to determine the number of patients that would require GEM inpatient program until selection criteria has been applied at the admission.
- b. In order to be cost-effective and efficient a GEM inpatient program should consist of a minimum of 10 beds. The following provides a methodology to estimate number of patients that would be expected to be treated in a 10 bed GEM inpatient unit:
 - (1) Based on the resources available and location of GEM beds (such as, intermediate or acute care) determine length of stay of patients.
 - (2) Assuming that the average length of stay of GEM a patient is 25 days then $365/25 = 14.6$ patients would use one bed per year.
 - (3) Assuming the occupancy rate of 90 percent in a 10 bed unit, then $14.6 \times 9 \text{ beds} = 131$ targeted patients per year would require a 10 bed unit.
 - (4) Beds will be increased in increments of 5 beds. The number of patients treated will be expected to increase proportionately. For example, if it is 15 bed unit, assuming the same average length of stay of 25 days and occupancy rate of 90 percent, the following formula applies:
 - (a) $15 \text{ bed unit} \times 0.9 \text{ occupancy rate} = 13.5$ patients per bed per year.
 - (b) $14.6 \times 13.5 = 197$ targeted patients per year would be expected to be treated in a 15 bed unit.

NOTE: Over 10 beds, if there is not a 90 percent occupancy, the facility should reevaluate the number of beds used for the GEM Program.

- c. For establishing an outpatient GEM Program, consider the following for possible sources of workload:

(1) **Inpatient GEM.** From experience it is seen that from a 10 bed unit, out of 131 inpatients approximately 105 patients (80 percent) would need follow-up. Each follow-up would need 1/2 hour per visit.

(2) **New Patients.** Any new patient would need a 2 to 3 hour visit, and 2 to 3 visits.

(3) **Referrals.** Based on the referral pattern, determine the number of patients that would require GEM outpatient care.

(4) **Other.** Determine the number of patients 65 and older that are seen in Geriatric Primary Care Clinic or any other clinics at the VA medical center.

d. In order to determine the number of clinic hours needed use the following formula:

(1) **Inpatient GEM Patient.** From a 10 bed GEM unit approximately 105 (80 percent) patients would require follow-up. Each follow-up patient requires about 1/2 hour clinic time.

(2) **New Patient.** Each new patient would require 2 to 3 hours per visit. For example:

(a) $52 \text{ weeks} \times 2 = 104 \text{ hours per year, or}$

(b) $52 \text{ weeks} \times 3 = 156 \text{ hours per year.}$

(3) **Follow-up Patient.** Each follow-up patient would require 1/2 hour per week. For example:

$105 \text{ patients} \times 1/2 \text{ hour} = 52.5 \text{ hours per year}$

(4) **Total Clinic Hours Needed.** For example:

(a) $104 + 52.5 = 156.5 \text{ hours per year, or}$

(b) $156 + 52.5 = 208.5 \text{ hours per year.}$

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**

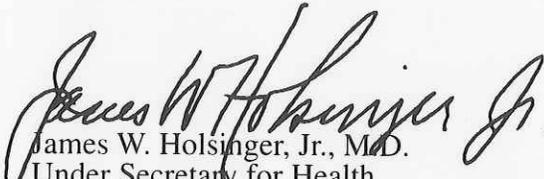
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9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.


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

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December 29, 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 to add Appendix 9Q, "Criteria and Standards for GEM (Geriatric Evaluation and Management) Program," which provides guidance concerning GEM Programs.

3. **Filing Instructions**

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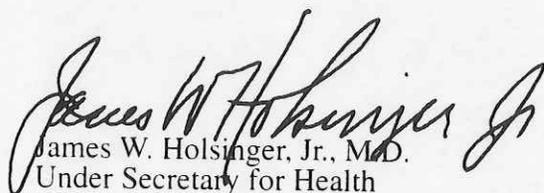
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4. **RESCISSIONS:** None.


James W. Holsinger, Jr., M.D.
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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.

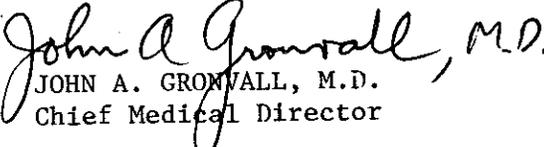
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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Cover page through v
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

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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
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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