

Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

**Appendix 9C, Program Guidelines for Hospital-Based
Ambulatory Care Programs**

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 9C, dated **May 24, 1991** (Change 1)

Transmittal sheets located at the end of the document:

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

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

Change 1, dated **May 24, 1991**

Sheet dated **October 2, 1989**

Transmittal sheets for changes prior to 1989 also located at the end of the document:

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

Memorandum dated **April 3, 1984**



Department of
Veterans Affairs

Strategic Planning

July 26, 1991

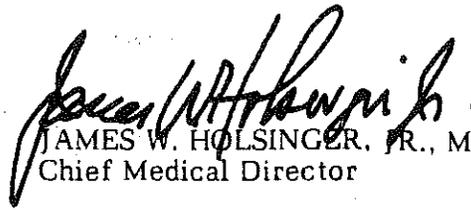
Veterans Health Administration
Washington DC 20420

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

CONTENTS

CHAPTERS

1. STRATEGIC PLANNING
2. STRATEGIC PLANNING CONSTITUENCY AWARENESS
3. STRATEGIC PLANNING CONFIDENTIALITY POLICY
4. OFF-CYCLE SUBMISSIONS
5. STRATEGIC PLANNING MODELS
6. MISSION REVIEW
7. STRATEGIC PLANNING DATA TABLE INSTRUCTIONS
8. ACTION DETAIL SHEET INSTRUCTIONS
9. CRITERIA AND STANDARDS AND PROGRAM PLANNING FACTORS
10. NURSING HOME NEEDS ASSESSMENT
11. STRATEGIC PLANNING, CONSTRUCTION, AND FDP (FACILITY DEVELOPMENT PLANS)
12. NATIONAL HEALTH CARE PLAN

RESCISSIONS

The following material is rescinded:

Complete rescissions:

Circulars

10-87-113 and Supplement No. 1
10-87-147
10-88-3
10-88-150
10-89-31
10-89-132
10-90-124

CONTENTS

CHAPTER 9. CRITERIA AND STANDARDS AND PROGRAM PLANNING FACTORS

PARAGRAPH	PAGE
9.01 Purpose	9-1
9.02 Overview	9-1
9.03 Content of Criteria and Standards	9-1
9.04 Definitions of Criteria and Standards	9-2
9.05 Contents of Program Planning Factors	9-2
 APPENDIXES	
9A Criteria and Standards for VA Domiciliary Program	9A-1
9B Criteria and Standards for the Spinal Cord Injury Program	9B-1
9C Program Guidelines for Hospital-based Ambulatory Care Programs	9C-1
9D Criteria and Standards for VA Oncology Programs	9D-1
9E Criteria and Standards for Cardiac Surgery (Open Heart)	9E-1
9F Criteria and Standards for GRECCs	9F-1
9G Criteria and Standards for New Outpatient Services Remote from VA Medical Centers	9G-1
9H Planning Guidelines and Criteria and Standards for VA Intermediate Care Programs	9H-1
9I Criteria and Standards for Traumatic Brain Injury Rehabilitation Program	9I-1
9J Program Procedures for HBHC (Hospital Based Home Care)	9J-1
9K Program Planning Factors for Blind Rehabilitation Service	9K-1
9L Program Planning Factors for Spinal Cord Injury Program	9L-1
9M Program Planning Factors for Domiciliary-Based Homeless Program	9M-1
9N Program Planning Factors for PTSD (Post-Traumatic Stress Disorder) Program	9N-1
9O Criteria and Standards for Cardiology Continuum of Care	9O-1
9P Mental Health Criteria and Standards	9P-1
9Q Criteria and Standards for GEM (Geriatric Evaluation and Management) Program	9Q-1

PROGRAM GUIDELINES FOR HOSPITAL-BASED AMBULATORY CARE PROGRAMS

1. INTRODUCTION

a. The delivery of health care in the outpatient setting has grown considerably in the United States due to developments in technology and the rising cost of inpatient care. Medications, diagnostic techniques (including imaging), and ambulatory surgery have all contributed to improvements in managing patients in the ambulatory setting. These same elements, however, require close and specific monitoring for safety and effectiveness. These can only be provided in a well-managed ambulatory setting.

b. Reflecting this trend, VA (Department of Veterans Affairs) Ambulatory Care Program has expanded from 6 million outpatient visits recorded in 1970 to over 21 million in 1989.

2. BACKGROUND

a. In October 1917, Congress enacted Public Law 65-90 which provided hospital and follow-up care to honorably discharged veterans of any war for injuries or diseases acquired or aggravated during active duty. VA was established and assumed responsibility for medical care of eligible veterans in 1930. Through a series of additional legislative actions, hospital care was extended to all veterans, subject to the availability of facilities.

b. Until 1960, outpatient or ambulatory care was authorized by law only for those conditions which were service-connected. In July 1960, Congress passed Public Law 86-639 which authorized outpatient treatment for nonservice-connected conditions when, in the professional judgment of the treating physician, such treatment was necessary for pre-bed or post-hospital care.

c. During the next 16 years, eligibility for ambulatory care was extended through various laws. In 1969, Public Law 91-102 authorized outpatient treatment for any condition for veterans suffering total and permanent disability as a result of a service-connected condition. Dental care was not included unless related to the service-connected disability. Veterans in receipt of special aid and attendance or housebound benefits received the same entitlement to outpatient care by virtue of Public Law 91-500, 1970.

d. In 1973, Congress enacted Public Law 93-82 which was by far the most liberal legislation in the extension of ambulatory care for nonservice-connected conditions. This law authorized ambulatory care for any veteran eligible for hospital care when outpatient treatment would obviate the need for hospitalization. At the same time, eligibility for treatment of any non-dental condition was extended to service-connected veterans with a disability rated at 80 percent or more (instead of the previous 100 percent requirement).

e. A VA Preventive Medicine Program has been operational since FY (fiscal year) 1985. The program requires VA provide at least one preventive service to each veteran receiving care for a service-connected disability and to each veteran with a disability rating of at least 50 percent receiving VA care for any purpose.

f. In 1986 and 1988 various levels of outpatient care were mandated by law for certain service-connected, low income, and special category veterans. For nonservice-connected

and higher income veterans, outpatient services depend upon the availability of resources and in some cases co-payments by veterans according to Public Law 99-272 and Public Law 100-322.

3. DEFINITION AND SCOPE

a. Ambulatory care is the coordinated provision of health care to eligible outpatients. This includes emergency care, scheduled, and unscheduled primary and specialty care, preventive services, and patient education programs for outpatients. It is part of a continuum of integrated health care which includes hospitalization and extended care.

b. The scope of ambulatory care services provided at each medical center must be related to the mission of the hospital, the availability of community health resources, and veterans' needs in the PSA (Primary Service Area). Not all veterans eligible for care may be entitled to receive care. In view of limited resources, an important distinction is made between patients' entitlement to care versus patients' eligibility for care.

c. This appendix covers planning guidelines for Hospital-based Ambulatory Care Programs. For guidelines of several mental health programs see paragraph 17. The outpatient planning model is described in chapter 5.

d. The terms "must" and "will" are used to indicate what is mandatory. The terms "should" and "may" are used to reflect preferred practice, yet allow effective alternatives to be used.

4. GOALS AND OBJECTIVES

The VA Ambulatory Care Program will provide a supportive setting for the integration of outpatient care, education, and research.

a. **Patient Care.** To deliver the highest quality outpatient health care to the greatest number of eligible veterans in a compassionate and cost-effective manner.

b. **Education.** To provide patient education and health counseling, continuing medical education to staff, and the education of graduate and undergraduate health care students where appropriate. Faculty should be encouraged to participate in teaching and be given opportunities to advance academically. The ACOS/AC (Associate Chief of Staff for Ambulatory Care) or the Coordinator of the Ambulatory Care Program will work with appropriate medical center staff to provide an environment conducive to teaching.

c. **Research.** To support research in all health care disciplines including management, quality assurance, education, rehabilitation, health services, and biomedical sciences.

5. SYSTEMWIDE AVAILABILITY

Every medical center must provide basic ambulatory care services. These would include, at a minimum, primary care services, such as screening, prevention, and continuing care. Every primary care facility must have one or more designated tertiary care facilities to which patients can be referred for definitive treatment. Definitions of primary and tertiary care are provided in paragraph 16. j and m.

6. ORGANIZATION

a. The Ambulatory Care Program is represented in VA Central Office by the DACMD/AC (Deputy Assistant Chief Medical Director for Ambulatory Care). The DACMD/AC is organizationally part of the Office of ACMD (Associate Chief Medical Director) for Clinical Affairs and has appropriate support staff.

b. Administrative coordination of ambulatory care activities at the medical center will be provided by a responsible physician, named by the Medical Center Director, whose qualifications, duties, and authority must be defined in writing.

(1) The coordinator for ambulatory care at medical centers with fewer than 50,000 annual visits is usually an assistant chief of a clinical service (at least 5/8 time VA) who can spend the majority of duty hours in ambulatory care.

(2) At medical centers with more than 50,000 annual visits, the Ambulatory Care Program responsibilities may be vested in the ACOS/AC who is at least 7/8 time VA. The ACOS/AC should participate and have input to various hospital-based committees including, Clinical Executive Board, Resource Management, Position Management, Space, and Dean's Committee.

c. Ambulatory Care is a multidisciplinary program. Since many services and disciplines are involved, lines of responsibility and authority must be clearly defined. There are dual lines of authority for staff working in ambulatory care. There is a professional line of authority from the service chief(s) or supervisor(s), and there is an administrative line of authority from the ACOS/AC or coordinator of the Ambulatory Care program. While there are variations of the matrix model, the basic element is that a program manager (i. e., the ACOS/AC) and the service chiefs jointly supervise personnel assigned. Supervision includes position management, recruitment, selection, performance appraisal, assignment of duties, training, coordination of leave, and discipline. Matrix management seeks the concurrence and ensures the input of the Ambulatory Care manager in all decisions related to ambulatory care. As care is provided by many services and full organizational integration is necessary, a multidisciplinary committee must be established to advise the Ambulatory Care manager and guide the provision of care.

7. SERVICES

The mission of the medical center will determine the scope of services provided by the Ambulatory Care program. The services provided will consist of some or all the following:

a. **Evaluation/Screening.** Each medical center will provide for:

(1) The processing of applicants for care and unscheduled visits, registration and determination of eligibility for care; and

(2) The expeditious clinical screening of applicants to determine needed level of care.

b. **Emergency Services**

(1) Basic emergency medical services must be provided and consist of services necessary to render prompt diagnosis, resuscitative life support, and the initial treatment

necessary to preserve life and reduce morbidity from acute illness or injury.

(2) The level of emergency care services provided by the medical center will be based on patient needs, the mission of the medical center, and the availability of alternative community services. Levels of care provided may be defined using JCAHO (Joint Commission for Accreditation of Health Care Organizations) guidelines. At a minimum, every VA medical center will meet Level IV guidelines of JCAHO requirements. The JCAHO requirements for Level III and IV have been changed to reflect VA requirements. The levels of care are as follows:

(a) **Level I** (Trauma Center) is not provided in VA medical centers.

(b) **Level II** provides emergency care 24-hours a day. At least one physician experienced in emergency care is on duty in the emergency care area and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Initial consultation through two-way voice communication is acceptable. The hospital's scope of services includes in-house capabilities for managing physical and emotional problems, with provision for patient transfer to another facility when needed.

(c) **Level III** offers emergency care 24-hours a day. At least one in-house physician is available to respond to the emergency care area. A medical staff call roster is available to provide sub-specialty care within 30 minutes (approximately). Initial consultation through two-way voice communication is acceptable. Specialty consult should be available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

(d) **Level IV** offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest facilities that have the capability of providing needed services.

c. Primary General Medical Services

(1) Every medical center must provide primary general medical services; this includes a defined plan for detection of non-symptomatic conditions, and continuing care. Primary general medicine is the foundation for all medical care provided by the medical center. Most VA medical centers have recognized this need and are providing primary care services. The most common setting is a general medical or primary care clinic. Subspecialty medical clinics may also provide primary care to patients who require continuing expert intervention. Primary care providers serve as advocates, case managers, and providers of health care (For definitions of case management and provider refer to paragraph 16. c and k. Primary care should consist of the following elements:

(a) An access to needed services,

(b) A mechanism to assure long-term continuity of care,

(c) A defined plan for preventive care, and

(d) A mechanism of referral for consultation and return of the patient to the primary provider when the consultation has been completed. Consultants should only be used for consultation and management of those patients whose conditions require continuing expert intervention.

(2) There are variations of the basic model of primary care. One common model is the team approach used to provide care to patients with multiple chronic medical and psychosocial problems common to aging and disability. The team may consist of physicians, nurses, nurse practitioners, physician assistants, social workers, pharmacists, dietitians, rehabilitation therapists, mental health specialists, and medical administration staff. Two examples of the possible composition of a multidisciplinary team are provided under paragraph 8. l. The team approach is also conducive to ambulatory care education and research.

d. Consultant Services

(1) Each medical center will provide consultant services (specialty and sub-specialty care) commensurate with the mission of the hospital and the needs of veterans receiving care. Many programs have published "Program Guides" for the provision of speciality services such as: Mental Health Clinic, Day Hospital, Day Treatment Center, Dialysis, Drug and Alcohol Rehabilitation programs; see paragraph 17. h through k.

(2) The scope of consultant care is broad. The following is an outline of the services which may be commonly provided in a large Ambulatory Care Program in a tertiary care medical center. Regional distribution of some of these services is common and requires efficient referral and transfer processes among VA medical centers. This should be coordinated by the Office of the ACOS/AC.

(a) Services provided by Medical Service may include:

1. Consultation, or specialty clinics, with limited engagement (expert management when needed and referral back to a primary care provider),
2. Primary care for those patients who require continuing expert intervention,
3. Ambulatory care special procedures such as endoscopies and cardiac procedures,
4. Dialysis, and
5. Certain diagnostic services such as, EKG (Electrocardiograph) and pulmonary function.

(b) Care provided by Surgery Service may include pre-operative and post-operative care:

1. General Surgery Clinic,
2. Consultant or specialty clinics,
3. Ambulatory Surgery, and
4. Diagnostic services, such as, vascular laboratory.

(c) Care provided by Neurology Service may include:

1. Neurology consultation and management, and
2. Diagnostic procedures, such as, EMG (Electromyograph) and EEG (Electroencephalograph).

(d) **Care provided by Radiology Service.** Care provided by Radiology Service may include Radiation oncology (radiation therapy) services and/or treatments.

(e) **Care provided by Psychiatry Service may include:**

1. MHCs (Mental Health Clinics)
2. Day Hospitals
3. Day Treatment Centers
4. Specialized Mental Health Clinics:
 - a. PTSD (Post-Traumatic Stress Disorder) Clinical Teams,
 - b. Substance Abuse Clinics,
 - c. Consultation/Liaison Programs, and
 - d. Geriatric Psychiatry Clinics.
5. Psychiatric Residential Treatment
6. Intensive Psychiatric Community Care
7. Community Residential Care, and the
8. HCMI (Homeless Chronically Mentally Ill).

(f) **Care provided by Rehabilitation Medicine Service may include:**

1. Psychiatrist consultation
2. Recreation services
3. Audiology
4. Speech Pathology
5. Rehabilitation Therapy:
 - a. PT (Physical Therapy),
 - b. OT (Occupational Therapy), and
 - c. KT (Kinesiotherapy).
6. Incentive therapy
7. Compensated Work Therapy, collaboratively with Psychology
8. VIS (Visual Impairment Services) Team follow-up
9. Spinal Cord Injury follow-up, and
10. Vocational Rehabilitation, collaboratively with Psychology.

(g) **Care provided by geriatrics and extended care.** Care provided by geriatrics and extended care may include outpatient care programs that are alternatives to institutional care:

1. Outpatient Geriatric Evaluation and Management Unit,
2. Hospital Based Home Care,
3. Adult Day Health Care, and
- 4 Residential care.

e. **Care provided by Administrative Medicine**

- (1) C&P (Compensation and Pension)
- (2) Environmental Programs
- (3) Ex-prisoner of War Program
- (4) Blind Rehabilitation Program, and
- (5) Vocational Rehabilitation Programs.

f. **Care provided by Dental Service.** Each medical center will deliver dental services to eligible veterans.

g. **Care provided by Diagnostic Services.** Each medical center will provide diagnostic services commensurate with the mission of the VA medical center and the needs of the patients, such as: Laboratory, Pathology, Radiology and Nuclear Medicine services.

h. **Preventive health services.** Preventive health services as mandated by Public Law 98-160, such as hypertension screening, breast cancer screening, and smoking cessation classes will be provided.

i. **Fee-basis.** Under the Fee-basis program, community health care providers deliver medical care dispensed at VA expense. Decisions to place eligible veterans on fee-basis are made on a case-by-case basis, and generally depend on the beneficiary's geographical non-accessibility to VA care and/or the non-availability of needed services at a VA facility. For the basic policy on Fee-basis refer to M-1, part I, chapter 18.

j. **Employee Health Program.** The employee health program will provide treatment of on-the-job illnesses and injuries, conducting medical surveillance on employees exposed to chemical, physical and biological hazards in conformity with CDC (Center for Disease Control), OSHA (Occupation and Safety Health Administration), JCAHO, and NIOSH (National Institute Occupational Safety and Health) Standards, and the standard of care in occupational medicine, immunization and infection control. Employee health provides significant recordkeeping services for the administration of OWCP (Office of Workmen Compensation and Pension) and OSHA as well as administration of the light duty program. The employee health program will also perform pre-employment physicals, and storage/administration of employees' personal medications (allergy shots, insulin injections, etc.) for all VA medical center employees and employees of other VA facilities (regional office, data processing center, etc.) served by the medical center.

8. STAFFING

The Ambulatory Care Program should be staffed commensurate with the anticipated volume of patients, the needs of patients, the mission of the medical center and the scope of services offered. The staffing must be determined for all the services provided by the Ambulatory Care Program and should be adequate to support the mission of the VA medical center. The following staffing is recommended based on clinical judgement and are not considered standards:

a. **The Coordinator of the Ambulatory Care Program Staff.** The Coordinator of the Ambulatory Care Program at medical centers with fewer than 50,000 annual visits will be supported by a secretary, and a program assistant, and nursing supervisor/coordinator.

b. **The ACOS/AC Staff.** The ACOS/AC at medical centers with more than 50,000 visits per year will be supported by a Health Systems Specialist, a secretary and an associate Chief Nurse or nursing supervisor/coordinator. The minimum qualifications of an ACOS/AC are as follows:

- (1) Doctor of Medicine or Osteopathy
- (2) Board-certified in a medical specialty
- (3) Recognized by peers for clinical competence
- (4) Extensive clinical experience
- (5) A good understanding of the relationships among the various patient-care providers
- (6) A history of increasingly successful accomplishments, and
- (7) A reasonably high academic rank and be an acceptable teacher for medical students and physician-residents where the facility has an academic affiliation.

c. **Administrative Personnel, MAS (Medical Administration Service).** Clerical and administrative services should include:

- (1) Supervisory clerical staff
- (2) Ambulatory care clinic clerks
- (3) Administrative coordinators for POW (Prisoner of War) and Environmental Programs
- (4) Staff for admission and processing functions
- (5) Staff for medical records room activities
- (6) Staff for documenting information on management workload, and
- (7) Staff for fee-service programs (non-VA care supported by VA medical center budget).

d. **Nursing Service.** Nursing Service should provide adequate staffing to accomplish the following:

- (1) Comprehensive health assessment and management
- (2) Ongoing monitoring of progress
- (3) Preventive health care
- (4) Health counseling and education of patients, families, and other staff, and
- (5) Coordination of patient care.

e. **Dietetic Service.** There should be adequate staff to provide both group and individual nutritional counseling.

f. **Ambulatory Care Pharmacy Services.** The pharmacy should provide adequate staff to provide clinical consultations, prescription refills, dispensing of medication and support drug utilization review studies.

g. **Prosthetics and Sensory Aids Service.** Prosthetics and Sensory Aids services should be available as part of the Ambulatory Care Program.

h. **Psychology Service.** There should be adequate staffing to provide:

- (1) Individual/group psychotherapy.
- (2) Substance abuse counseling.
- (3) Psychological testing for personality and intelligence.
- (4) Neuropsychological evaluation for brain damage.
- (5) Vocational assessment, counseling and job placement.
- (6) Family therapy.
- (7) Sexual dysfunction counseling.
- (8) Health Psychology Clinic (Preventive Health), for smoking cessation, weight reduction, stress management, biofeedback, and
- (9) Consultation.

i. **Social Work Service.** There should be adequate staffing to provide psychosocial evaluation, treatment and case management.

j. **Security Service.** There should be provisions to insure adequate security services.

k. **Employee Health.** There should be adequate staffing to deal with employee accident and illness and support the medical surveillance program.

l. **Master Multidisciplinary Staffing Plan.** A master multidisciplinary staffing plan for a primary general medical care clinic as defined in paragraph 7. c., is as follows:

(1) For primary general medical care services, the following chart provides examples of the composition of an Interdisciplinary Core Team, as suggested by the VA PACE (Pilot Ambulatory Care and Education Center) model being implemented at Sepulveda, CA, and another used by a HMO (Health Maintenance Organization) located in the midwest. Such a plan should be developed, based on patient need, mission and workload for each clinic service/program in the outpatient area.

(2) In these models, the core team is responsible for a panel of 5500-6000 patients and see 120-160 patients per day. FTEE refers to full-time employee equivalent. The suggested composition of the team is:

Type of Staff	PACE Model FTEE	HMO Model FTEE
(a) Physician (General internists or family practitioners)	3.0	2.0
(b) Physician Assistants or Nurse Practitioners	2.0	8.0
(c) Medicine Interns	4.0	—
(d) Medicine Residents	2.0	—
(e) Psychiatry Resident	1.0	—
(f) Psychiatrist	1.0	—
(g) Social Worker	2.0	1.0
(h) Pharmacists (including clinical pharmacist)	2.0	3.0
(i) Clinical Nurse Specialist	1.0	—
(j) RNs	2.0	3.0
(k) Nursing Assistants	2.0	—
(l) LPNs	—	10.0
(m) Radiologists	—	1.4
(n) Laboratory Technicians	—	2.8
(o) Clerical Support (Includes data entry personnel, appointment and file clerks, and receptionists.)	6.0	8.0
(p) Dietitian	0.5	—
Total FTEE	28.5	39.2

9. FACILITIES

a. Adequate facilities will be provided for the Ambulatory Care Program. They will be designed or renovated to:

- (1) Eliminate physical barriers for the physically, visually, hearing, or speech impaired.
- (2) Give patients visual and auditory privacy, as appropriate, without compromising patient care.

b. An ambulatory care (examination/treatment) module for the provision of care should contain the following components, appropriate to the size and mission of the Ambulatory Care Program areas:

- (1) Clean utility room
- (2) Consultation room,
- (3) Exam rooms (2 exam rooms per provider)
- (4) MAS reception/control
- (5) Nurses station/medication room
- (6) Public toilets marked "Visitors" and "Patients"
- (7) Soiled utility room
- (8) Staff/patient multipurpose conference/classroom
- (9) Staff toilet
- (10) Storage (medical equipment)
- (11) Storage for stretcher(s)
- (12) Wheelchair toilet, and
- (13) Waiting area.

c. Modules accommodating the following sub-specialty clinics may require special procedure/treatment facilities:

- (1) Audiology
- (2) Dental
- (3) Dermatology
- (4) Emergency
- (5) Gastroenterology
- (6) Gynecology

- (7) Oncology
- (8) Ophthalmology
- (9) Orthopedics
- (10) Podiatry
- (11) Psychiatry
- (12) Rehabilitation
- (13) Surgery, and
- (14) Urology.

c. For additional information refer to VA Handbook H-08-9, "Space Planning Criteria for Ambulatory Care," chapters 204, 222, 232, 233, 260, 262, 270, and 286.

10. EQUIPMENT

a. VA Handbook H-08-5, "Equipment Guide List," chapter 262, has been developed as a planning guide for VA facilities. It provides a ready reference for planning and developing the equipment requirements for construction projects. The guide may be used to evaluate and to plan equipment requirements for new as well as existing facilities.

b. Procedures, including operative procedures, that require the use of special equipment should be performed only when appropriate resources are available.

11. EDUCATION AND TRAINING

a. Ambulatory care educational activities can be broken down into three major categories:

(1) Inservice and continuing education for individuals who provide and support ambulatory care services. Material developed will be based on the findings from monitoring and evaluating the quality and appropriateness of care. They will also include safety, infection control and CPR (Cardiopulmonary Resuscitation).

(2) Ambulatory care education of medical, nursing, and allied health students.

(3) Outpatient educational programs, which should be developed in collaboration with the hospital patient education committee, to meet the needs of outpatients.

b. Effective ambulatory care education requires adequate space, appropriate support services, and ample faculty time. Ambulatory care physician managers are in an ideal position to coordinate efforts, shift resources and collaborate with colleagues at academic centers.

c. Affiliated hospitals should establish appropriate joint medical school and VA committees in ambulatory care to define objectives, expand educational programs, and

develop effective teaching and evaluation techniques at the undergraduate and graduate levels. A specific curriculum for outpatient care should be developed.

12. RESEARCH

Research should be an integral part of the ambulatory care program whenever possible. It should be encouraged especially in the areas of health services research, clinical sciences, quality assurance, basic research and psychosocial education in the ambulatory care setting.

13. INFORMATION SYSTEMS

a. A medical record must be maintained for every patient. The content and format of the medical record in the Ambulatory Care Programs are described in M-1, part I, chapter 5, Section V. In order to enhance access to information, medical centers should implement elements of the electronic record as soon as they become available.

(1) For a minimum of 98 percent of the scheduled outpatients, the medical record should be available when the patient is seen in the clinic.

(2) Outpatient chart dividers (color-coded if possible) may be used to facilitate ease of reference to various clinics, inpatient reports, and laboratory reports.

b. VA Forms 10-2875-1 and 10-2875-2, Outpatient Routing and Statistical Activity Records, must be completed for each outpatient service, primarily as source documents for accumulating statistical information about outpatient workload. These forms may be completed manually or computerized. They also serve as a source of information about which specific clinics (also called clinic stops) were visited.

c. There should be ready access to terminals, either in or close proximity to examination rooms. Ambulatory Care Program personnel should have ready access to various automated programs including:

(1) Registration and eligibility determination.

(2) Scheduling appointments.

(3) Medication profiles.

(4) Laboratory requests and reports.

(5) Radiology requests and reports.

(6) Nuclear Medicine requests and reports.

(7) Diagnostic Data Base.

(8) Mental Health Package.

(9) Health Summary Package, and

(10) Adequate data processing equipment to service the Quality Assurance Program.

d. Each medical center will provide the education necessary for care providers to use the automated programs relevant to the provision of care.

e. Employee medical records should be maintained in accordance with OPM (Office of Personnel Management) regulations appearing in 5 CFR (Code of Federal Regulations) 293 and OSHA regulation appearing in 29 CFR 1910.20 which also provide for employee access to these records.

14. QUALITY ASSURANCE MECHANISMS

The evaluation of outpatient services must be fully integrated into the facility's overall quality assurance program. The ACOS/AC or coordinator for Ambulatory Care will be responsible for the effective implementation of the Ambulatory Care Quality Assurance Program. Each service engaged in ambulatory care activities will be responsible for quality assurance in its area, and for participating in multidisciplinary quality assurance studies.

a. As part of the medical center's Quality Assurance Program, the quality and appropriateness of patient care provided in the Ambulatory Care Program will be monitored and evaluated.

b. The Ambulatory Care Program will have a written Quality Assurance Plan. The objectives of the plan should be:

(1) To objectively and systematically monitor and evaluate the quality and appropriateness of outpatient care, the administration of OWCP and OSHA recordkeeping, the administration of light duty and medical surveillance programs, and compliance with the medical surveillance elements of JCAHO, NRC (Nuclear Regulatory Commission) and OSHA,

(2) To pursue opportunities to improve patient care, and

(3) To resolve identified problems.

c. The monitoring and evaluation process should be based on the JCAHO 10-step process (see par. 17. a.).

d. Each clinical service will participate by following the JCAHO 10 step process for monitoring and evaluation of the quality and appropriateness of the services they provide in Ambulatory Care. The 10 step process is as follows:

(1) Assign responsibility for monitoring and evaluation activities.

(2) Delineate the scope of care provided by the service in Ambulatory Care.

(3) Identify the most important aspects of care.

(4) Identify indicators for monitoring the important aspects of care.

(5) Establish thresholds for the indicators that trigger evaluation of the care.

(6) Monitor the important aspects of care by collecting and organizing the data for each indicator.

- (7) Evaluate care when thresholds are reached in order to identify either opportunities to improve care , or problems.
- (8) Take actions to improve care or to correct identified problems.
- (9) Assess the effectiveness of the actions and document the improvement in care.
- (10) Communicate the results of the monitoring and evaluation process to relevant individuals, departments or services and to the organization quality assurance program.
 - e. The process will be ongoing and continuous.
 - f. The effectiveness of the Quality Assurance Plan will be evaluated annually.
 - g. In order to assess outpatient satisfaction, the Outpatient Satisfaction Questionnaire is available as part of the Patient Satisfaction Survey.

15. POLICIES AND PROCEDURES

- a. The provision for ambulatory care services is guided by written policies and procedures that address the scope and conduct of patient care to be provided in the ambulatory care setting.
- b. These policies should be approved by the clinical staff through its designated mechanism and by the medical center Director.
- c. These policies and procedures should be reviewed at least annually, revised as necessary, dated, and enforced.
- d. Each medical center should have a policy and procedural manual for the Ambulatory Care Program which will address the requirements of JCAHO, OWCP, OSHA and other issues listed:
 - (1) Attention to and respect for each patient 's dignity and rights.
 - (2) Appointment and scheduling system.
 - (3) Mechanism to inform a patient of the practitioner(s) responsible for the patient 's care.
 - (4) Mechanism to contact patients when diagnostic test results require immediate follow up.
 - (5) Confidentiality of patient information.
 - (6) Safeguarding of records.
 - (7) Release of information to authorized individuals.
 - (8) Any required consent for treatment.
 - (9) Location, storage, and procurement of medications, supplies, and equipment.
 - (10) Dispensing of medications in accordance with legal requirements.

- (11) Responsibility for maintaining the integrity of the emergency drug supply.
- (12) Infection control measures.
- (13) Pertinent safety practices.
- (14) Reporting of communicable diseases to appropriate authorities.
- (15) Impact on the Ambulatory Care Program of the medical center emergency preparedness plan.
- (16) Use of standing orders.
- (17) Handling and safekeeping of patients' valuables.
- (18) Telephone advice.
- (19) Waiting time for a scheduled appointment as appropriate for the type of care to be provided.
- (20) Reduction of cultural and social barriers.
- (21) Mechanisms for internal and external referral.
- (22) Access to the medical records.
- (23) Research activities involving patients in the Ambulatory Care Program.
- (24) Teaching activities.
- (25) Enrolling veterans who make unscheduled visits to the medical center.
- (26) Procurement and use of blood and blood components.
- (27) Short and long-term planning, addressing:
 - (a) Space needs,
 - (b) Needs assessment,
 - (c) Clinic availability,
 - (d) AHIS (Automated Hospital Information System) needs, and
 - (e) New programs,
- (28) Allocation of resources.
- (29) Organizational structure of the Ambulatory Care Program.
- (30) Rape treatment, procedure and reporting.
- (31) Unconscious/unaccompanied patients.

May 24, 1991

M-9
Chapter 9
Change 1
APPENDIX 9C

- (32) Minor patients.
- (33) Reporting requirements.
- (34) Security.
- (35) Broken appointments.
- (36) Patient participation in the development of a "plan of care."
- (37) Emergency Room staffing and specialty care and POD (Physician of the Day)s coverage.
- (38) Humanitarian treatment for non-VA patients.
- (39) Transfer of patients.
- (40) VA and DOD (Department of Defense) contingency planning and sharing as it relates to ambulatory care.
- (41) Maintenance and transfer of employee medical records provided in accordance with OPM and OSHA regulations, 5 CFR 293, 29 CFR 1910.20, and
- (42) Medical Surveillance conducted as mandated by OSHA and NRC and as recommended by CDC and NIOSH.

16. GLOSSARY

a. **Ambulatory Surgery.** Surgery, either diagnostic or therapeutic, that can be performed under local, topical, regional, or general anesthesia, and which can be safely performed without the need for hospitalization. Instructions and guidelines for performance of ambulatory surgery, including recognized surgery procedures, space and equipment requirements, restrictions on use of anesthesia, staff qualifications, etc., are described in a circular on "Instructions and Guidelines for Performance of Ambulatory Surgery."

b. **Application for Medical Benefits (VA Form 10-10).** The form completed for patients examined to determine their need for hospital, outpatient, or domiciliary care.

c. **Case Management.** The term is defined as a process that includes three essential steps:

- (1) Multidisciplinary patient assessment,
- (2) Follow-up with patient and services, and
- (3) Re-assessment and revision of care plan.

d. **Clinic Stop.** A clinic stop is identified as a particular patient-provider encounter during the course of a visit to a facility.

e. **C&P (Compensation and Pension).** Under the C&P Program, veterans are examined to determine the existence and/or extent of any disability that may have occurred during military service. The results of these examinations are then forwarded to the Regional Office of the Veterans Benefits Administration where the determination of

service-connection and/or degree of compensable disability is made. Exams may be done either by VA physicians or on a fee-basis by non-VA physicians.

f. **Independent Clinic.** Independent clinic is a full-time, self-contained, free standing, ambulatory care clinic which has no management, program, or fiscal relationships to a VA medical center.

g. **Obviate Care.** Care provided to prevent the need for hospitalization.

h. **Outpatient Visit.** An outpatient visit is the physical presence of a person in the outpatient area who has obtained outpatient services during a single 24-hour period. Services provided may be diagnostic, therapeutic, educational or all of these. They may be provided by physicians or, at their direction and supervision, by other personnel. There may be one or more clinic stops during an outpatient visit (see subpar. d).

i. **Pre-bed Care.** Medical examination or treatment provided on an outpatient basis in preparation for admission to the hospital.

j. **Primary Care.** Primary care provides a point of entry into the health care system for non-emergency care. Providers of primary care maintain an ongoing relationship with patients for a wide-range of health problems and arrange for referral to more specialized services when greater depth of expertise in a particular area of care is needed.

k. **Provider.** A provider is anyone capable by training and licensure to care for patients' medical or psychosocial needs either independently or under supervision. Provider generally refers to physicians, dentists, psychologists, nurses, physician assistants, social workers, pharmacists, and some specially trained technicians who deliver defined, limited care with direct supervision.

l. Satellite Clinics

(1) Satellite clinic is a full-time, freestanding ambulatory care facility that is physically separated but administratively attached to a VA medical center. It is usually located in a highly populated area so that a large number of veterans may obtain primary and secondary (in some cases, tertiary) outpatient health care services.

(2) Clinical services are delivered under the direction of a Chief Medical Officer who is located at the satellite clinic. Regular staff interaction and sharing of services should occur between the clinic and parent facility.

m. **Tertiary Care.** Tertiary care deals with unusual and/or highly unstable conditions that require specialized health service personnel and a complex supporting technology. It is usually dispensed from major medical centers that are affiliated with medical schools. Most tertiary care is inpatient care, but some tertiary-level care may be carried out in highly specialized clinics or medical specialists' offices.

n. **Triage/Screening.** Triage is an initial examination of a patient to determine the priority of medical need and proper referral for treatment.

o. **Walk-In.** A person who reports to a medical facility without an appointment.

17. REFERENCES

- a. Accreditation Manual for Hospitals, JCAHO, most recent issue.
- b. Accreditation Manual for Hospitals, JCAHO, chapter PL 1, "Plant Technology and Safety Management."
- c. Alcohol Dependence Treatment Program, G-11, M-2, part X.
- d. Ambulatory Health Care Standards Manual, JCAHO, most recent issue.
- e. Criteria and Standards for New Outpatient Services Remote from VA Medical Centers.
- f. Criteria and Standards for Hospital Based Home Care Program.
- g. Criteria and Standards for Ambulatory Surgery Program.
- h. Day Hospital Program Guide, G-9, M-2, part X.
- i. Day Treatment Center Program Guide, G-10, M-2, part X.
- j. Drug Dependence Treatment, G-1, M-2, part XXI.
- k. Mental Health Clinic Program Guide, G-11, M-2, part X.
- l. OPM Regulations 5 CFR 293, Maintenance and Transfer of Employee Medical Records.
- m. OSHA Regulations 29 CFR (includes Medical Surveillance and Environmental Screening).
- n. OSHA Publication 2014, Recordkeeping and Reporting Guidelines for Federal Agencies.
- o. Overview of Mental Health Treatment Programs, G-19, M-2, part X.
- p. Pilot Ambulatory Care and Education Center, Department of Veterans Affairs Medical Center, Sepulveda, CA Report, July 27, 1989.
- q. Planning Space Criteria for the Ambulatory Care Program (Draft), chapters 260, 262, and 286.
- r. VHA Manual M-1, Part I, Chapter 4, "Admissions;" Chapter 5, "Medical Records;" Chapter 15, "Emergency Medical Care;" Chapter 16, "Outpatient Care - General;" Chapter 17, "Outpatient Care - Staff;" Chapter 18, "Outpatient Care - Fee;" Chapter 19, "Outpatient Dental Treatment;" and Chapter 20, "Outpatient Examinations, C&P/other."
- s. VHA Manual M-2, Part I, Chapter 7, "Outpatient Diagnosis and Treatment;" Chapter 19, "Spinal Cord Injury," Chapter 20, "Community Placement Programs;" Chapter 23, "Informed Consent," Chapter 26, "Supervision of Physician Residents."

- t. VHA Manual M-2, Part VI, "Standard Procedures for Blood Transfusions."
- u. VHA Manual, M-10, Part I, Chapters 1 and 2, "Environmental Program (Agent Orange Exposure)."

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**

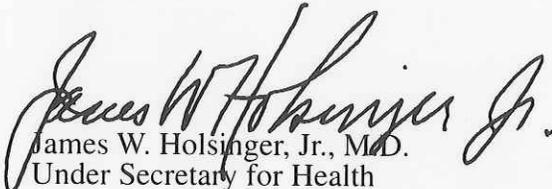
Remove

9-i ✓

Insert

9-i ✓
9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.


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

Distribution: **RPC 1318**
FD

Printing Date: 2/93

RECEIVED
MAR 31 7 19 AM '93
PUBLICATIONS AND
DIRECTIVES MANAGEMENT
STAFF (101E)

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

Insert pages

Cover page through iv

Cover page through iv


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

Distribution: RPC: 1318
FD

Printing Date: 7/91

PUBLICATIONS AND
DIRECTIVES MANAGEMENT
STAFF (161E)

SEP 12 1 27 PM '91

RECEIVED

May 24, 1991

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-9, "MEDIPP," Chapter 9, "Criteria and Standards."

2. Principal change is to add Appendix 9C, "Program Guidelines for Hospital-based Ambulatory Care Programs," which provides guidance concerning VA Hospital-Based Ambulatory Care Programs.

3. Filing Instructions

Remove

Insert

9-i

9-i

Appendix 9C-1 through 9C-20

4. RESCISSIONS: None.

Holsinger, Jr., M.D.

James W.

Chief

Medical Director

Distribution: RPC: 1318

FD

Printing Date: 6/91

DEC 20 1989

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.

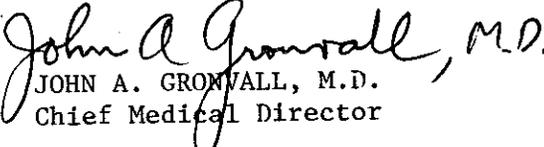
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

Insert pages

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

Distribution: RPC: 1318 is assigned
FD

Printing Date: 10/89



Veterans Administration

REFERENCE SLIP

TO (Name or title—Mail routing symbol)	INITIALS-DATE
1. Director, Regulations & Publications Management Staff (10A1B) <i>PA 4/28/86</i>	
2. (10)	
3. (10A1B)	
4. (17A) <i>(Copy forwarded) 2/4/86</i>	
5.	

REASON FOR REFERENCE

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> AS REQUESTED | <input type="checkbox"/> FOR YOUR FILES | <input type="checkbox"/> NOTE AND RETURN |
| <input type="checkbox"/> COMMENTS | <input type="checkbox"/> INFORMATION | <input type="checkbox"/> PER CONVERSATION |
| <input type="checkbox"/> CONCURRENCE | <input type="checkbox"/> NECESSARY ACTION | <input type="checkbox"/> SIGNATURE |

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

RECEIVED

611/134
JAN 27 1986

FROM

Marjorie R. Quandt
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications
Management Staff (10A1B)

TEL. EXT.
3331

VA FORM
MAY 1980 3230

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