Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

Appendix 9O, Criteria and Standards for Cardiology Continuum of Care

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 9O, dated **August 12, 1992** (Change 11)

Transmittal sheets located at the end of the document:

Change 14, dated **January 28, 1993**
Change 11, dated **August 12, 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
Washington, DC 20420

July 26, 19[illegible]

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

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The following material is rescinded: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

CRITERIA AND STANDARDS FOR CARDIOLOGY CONTINUUM OF CARE

1. BACKGROUND

a. More than one in four Americans suffer from some form of cardiovascular disease including:

(1) High blood pressure,

(2) Coronary heart disease, and

(3) Rheumatic heart disease.

(4) Stroke, the number one killer disease in America.

b. Death rates for heart attacks, strokes and other cardiovascular diseases are declining. Millions of people still die from cardiovascular diseases despite:

(1) Advances in medical treatment, and

(2) The trend toward healthier lifestyles in recent years .

2. PURPOSE

a. This appendix provides planning guidelines for VA (Department of Veterans Affairs) Cardiology Programs. It includes a definition of a Cardiology Continuum of Care and the services that must or should be available at various VA medical centers.

b. "Continuum of Care" is an integrated system of care that guides and tracks patients over time through a comprehensive array of physical health, mental health, and social services, spanning all levels and intensities of care. It is comprised of services and of integrating mechanisms.

NOTE: *The term* **must** *is used throughout the appendix to indicate what is mandatory. The term* **should** *is used to reflect preferred practice, yet allows effective alternatives to be used. Staffing guidelines are intended to represent the best current judgment of health care professionals regarding safe and clinically effective levels; they are not mandatory.*

NOTE: *Guidelines on Cardiac Surgery are addressed in M-9, chapter 9, appendix 9E, "Criteria and Standards for Cardiac (Open Heart) Surgery."*

3. GOAL

The goal of a continuum of care is to make available the array of health care and related services that a patient needs over time, through periods of both sickness and health. A single organization does not need to offer all services directly; rather, it must facilitate access to comprehensive services through a consortium or network. The services encompass a wide range, from acute hospital emergency room care to health education classes to rehabilitation.

4. DEFINITIONS

a. **Angioplasty.** A procedure sometimes used to dilate (widen) narrowed arteries. A catheter with a deflated balloon on its tip is passed into the narrowed artery segment, the balloon inflated, and the narrowed segment widened.

b. **Arrhythmia (or Dysrhythmia).** An abnormal rhythm of the heart.

c. **AICD (Automatic Implantable Cardioverter Defibrillator).** An implantable device to restore normal heart rhythm.

d. **Cardiac.** Pertaining to the heart.

e. **Cardiac Rehabilitation.** Cardiac rehabilitation involves physical and psychological restoration of patients with heart disease to enjoyable and productive life, as efficiently as possible. This includes:

(a) Education of patients and families in the recognition, prevention, and treatment of cardiovascular disease;

(b) Correction of risk factors;

(c) Improvement of psycho-social factors influencing the development of and recovery from heart disease;

(d) Structured progressive physical activity program; and

(e) Vocational counseling.

f. **Cardiology.** The study of the heart and its functions in health and disease.

g. **Cardiovascular.** Pertaining to the heart and blood vessels. ("Cardio" means the heart; "vascular" means blood vessels.) The circulatory system of the heart and blood vessels is the cardiovascular system.

h. **Catheterization.** The process of examining the heart by introducing a thin tube (catheter) into a vein or artery and passing it into the heart.

i. **CCU (Coronary Care Unit).** A specialized facility in a hospital that's equipped with monitoring devices and staffed with trained personnel designed specifically to treat coronary patients.

j. **Defibrillator.** An electronic device that helps reestablish normal contraction rhythms in a malfunctioning heart.

h. **ECHO (Echocardiography).** A diagnostic method in which pulses of sound are transmitted into the body and the echoes returning from the surfaces of the heart and other structures are electronically plotted and recorded.

i. **ECG or EKG (Electrocardiogram).** A graphic record of electrical impulses produced by the heart.

j. **EEG (Electroencephalogram).** A graphic record of the electrical impulses produced by the brain.

k. **EPS** (Electrophysiology Studies). They evaluate heart rhythms to see if the rhythms is dangerous to the patient, and to see if drugs or devices will help a condition.

l. **Exercise Testing, Prescription, and Training.** Monitored, multilevel cardiovascular fitness testing by treadmill or bicycle ergometry, which, when taken in context with a subject's historical, laboratory, and physical findings and activity requirements allows prescription of a training program to develop optimum physical ability in his/her daily living, work, and recreation.

m. **Levels of Risk Stratification**

(1) The type and duration of supervision and frequency of monitoring should be guided by the level of risk (low, moderate, or high) in which the patient has been placed.

(2) Categorization need not be limited to nor include every characteristic.

(3) The levels of risk are determined by using data obtained from the patient's:

(a) Medical history,

(b) Clinical course,

(c) Physiological variables, and

(d) Other test results.

(4) The levels of risk are regarded as minimal guidelines for risk stratification.

(5) The levels of risk are stratified as follows:

(a) **Low Risk Cardiac Patient.** A low risk cardiac patient had:

1. An uncomplicated hospital course;

2. Good cardiac function (EF (ejection fraction) over 50 percent));

3. Good physical work capacity (able to achieve 7 mets (metabolic equivalent) on a stress test); and

4. No significant heart rhythm disturbances or compromised blood supply to heart (e.g., no angina, ST displacement on EKG).

(b) **Intermediate (moderate) risk. A moderate risk** cardiac patient has:

1. Moderate to good cardiac function (EF 35 to 49 percent);

2. Evidence of reduced blood supply to heart (2mm ST displacement);

3. Reversible defects on thallium exercise test; and

4. New or changing pattern of angina.

(c) **High Risk.** A high risk cardiac patient had:

1. A large myocardial infarction (more than 35 percent of left ventricle).

2. Experienced heart failure during hospitalization.

3. Depressed cardiac function (EF less than 35 percent).

4. Poor physical work capacity (less than 5 mets on stress test with less than 1mm ST depression or low blood pressure response).

5. Complex cardiac ventricular rhythms.

n. **Pacemaker**

(1) The "natural" pacemaker of the heart is called the sinoatrial node. It is a small mass of specialized cells in the top of the right atrium of the heart that produces the electrical impulses that travel to ventricular muscle, causing the heart to contract.

(2) The term "artificial pacemaker" is applied to an electrical device that can substitute for a defective natural pacemaker or conduction pathway. The artificial pacemaker controls the heart's beating by emitting a series of rhythmic electrical discharges.

o. **MICU** (Medical Intensive Care Unit). A general intensive care unit for all types of medical illnesses requiring the highest level of care.

p. **Peripheral Vascular Disease.** Diseases of the arteries and veins primarily in the arms and legs.

q. **PTCA.** Perctaneous transluminal coronary angioplasty called angioplasty.

r. **SICU** (Surgical Intensive Care Unit). A general intensive care unit for all types of surgical illnesses (including post-operative care, patients with complications of surgery, and patients requiring surgery) requiring the highest level of care.

s. **Risk.** A factor, element or course involving certain hazard or danger. When referring to the heart and blood vessels, a risk factor is associated with an increased chance of developing cardiovascular disease including stroke.

t. **Vascular.** Pertaining to the blood vessels.

5. CATEGORIZATION OF VA MEDICAL CENTERS

a. **Categories.** For planning purposes medical/surgical VA medical centers have been categorized according to type of cardiac care services provided at the facility. Categories are:

(1) **Level 1:** VA medical centers with diagnostic and urgent cardiac care programs only.

(2) **Level 2:** VA medical centers performing cardiac catheterization procedures without an in-house Cardiovascular Surgery Program.

(3) **Level 3:** VA medical centers with an in-house Cardiovascular Surgery Program but no Heart Transplantation Program.

(4) **Level 3T:** VA medical centers with Cardiovascular Surgery and Heart Transplantation Programs.

b. **Cardiac Referral Centers.** VA medical centers with Heart Transplantation Programs (Level 3T) and VA medical centers with Cardiac Surgery Programs but no Heart Transplantation Program (Level 3) will serve as Cardiac Referral Centers.

6. SERVICES REQUIRED FOR CARDIAC CARE

a. **Prevention**

(1) **Goal.** The goal of the Preventive Medicine Program is to reduce the occurrence of preventable diseases by reduction of known risk factors and to detect and treat patients with asymptomatic disease to improve outcomes.

(2) **Guidance.** Formal program guidance/direction is contained in M-2, part IV, Chapter 9, "Preventive Medicine," which contains the goals and guidelines, both clinical and administrative, for directing, controlling and reporting on the program.

(3) **Risk Factors.** The Preventive Medicine Program, operational since 1985, focuses on eleven risk factor interventions/services which represent diseases having high mortality and morbidity in the VA patient population. Of the eleven, the following are cardiovascular risk factor interventions:

(a) **Screening Tests.** Hypertension and Cholesterol

(b) **Inquiry/Counseling.** Smoking cessation, nutritional/weight control, physical fitness/exercise, stress management, and medication.

(4) **Outpatient Clinics.** Most preventive services may be provided in the ambulatory care setting, via the following clinics:

(a) General internal medicine, preventive medicine, or primary care clinics;

(b) Mental health;

(c) Cardiology;

(d) Hypertension; and

(e) Dietetics.

(5) **Policy.** Every VA medical center should have a Preventive Medicine Program and a PMFC (Preventive Medicine Facility Coordinator) who monitors the program.

(a) All VA medical centers, at a minimum, should have:

1. A Hypertension Program,

2. A Smoking Cessation Program, and

3. A Lipid Program.

NOTE: *These programs may be part of a larger clinic.*

(b) Most preventive services may be performed by the following staff:

1. Physicians, including Internists, General Practitioners, and Cardiologists.

2. Other Health care professionals as:

a. Physician assistants,

b. Nurse Practitioners,

c. Clinical nurses,

d. Specialist R.N.s (Registered Nurse),

e. Psychologists,

f. Social workers, and

g. Dietitians.

(6) **Quality Management.** Issues of access to care, efficiency of delivery, and outcome measures should be considered.

b. **Diagnosis**

(1) **Laboratory**

(a) Level 1 facilities would require availability of many laboratory tests, but some would be sent off-station.

(b) A full-range of laboratories such as hematology/chemistry (including cardiac enzymes), lipid/cholesterol, X-ray, and blood gases must be available to the medical centers at Level 2 and higher.

(c) Level 3T may require an in-house Transplant Laboratory (Immunotyping), or may obtain these services via a sharing agreement or contract.

(2) **Non-invasive**

(a) **ECG.** Electrocardiography services should be available 24 hours a day and Level 3/3T VA medical centers. There should be one ECG technician per 6,000 ECGs conducted every year. ECG must be available at all VA medical centers.

(b) **ECHO (Echocardiography).** Echocardiography must be available at all VA medical centers Level 2 and higher. Color doppler is restricted to Level 3 VA medical centers although exceptions may be made for other VA medical centers if appropriate cardiology expertise is available. There should be one full-time echocardiography technician available for every 1,800 echocardiographs per year.

1. **Vascular (peripheral vascular administratively under medicine, surgery or radiology).** Vascular echocardiography services must be available at all Level 2 and higher VA medical centers. There should be one part-time Vascular Echocardiography technician available for every 450 procedures per year, or one full-time technician for every 1800 studies per year.

2. **Transesophageal.** Transesophageal equipment should be available at Level 3 VA medical centers.

(c) **Radiology.** Chest X-ray capability must be available at all VA medical centers. Level 2 and 3 VA medical centers must have access to a full array of radiology services.

(d) **Stress Tests (Routine).** At Level 2 and higher VA medical centers, there should be one full time technician available for approximately every 600 stress tests and Holter tests performed per year. Stress tests should be available locally for all VA patients, whether in-house or via sharing agreement.

(e) **Stress Tests (Nuclear).** Requires the presence of appropriately trained personnel and may not be available at Level 1 VA medical centers. Levels 2, 3 and 3T must have nuclear medicine.

(f) **Transtelephonic Event Recorders and Holter Monitors.** Twenty-four hour Holter monitoring must be available at all Level 2 and higher VA medical centers, although this may be via sharing agreement or by referral (of tapes) to a Level 3 or 3T VA medical center. Due to requirements for a high volume of tapes to maintain quality standards, Level 1 and many Level 2 VA medical centers should not perform this service in-house.

(g) **Imaging.** Imaging may include:

1. **CAT (Computerized Axial Tomography) Scanner.** CAT scans with contrast are done in Radiology only. CAT Scans are available at most VA medical centers.

2. **MRI (Magnetic Resonance Imaging).** MRI should be available at Levels 3 and 3T VA medical centers, either in-house or through sharing agreement.

(3) **Quality Management.** Diagnostic services should meet quality control and quality assurance standards as recommended by external organizations such as JCAHO (Joint Commission on Accreditation of Healthcare Organizations) and CAP (College of American Pathologists).

c. **Acute Care Inpatient Treatment**

(1) **CCU.** There should be a separate CCU where workload justifies it (requires an average 70 percent occupancy). A CCU is highly desirable for any Level 3 or 3T referral center treating cardiac patients. A CCU is desirable for all level 2 VA medical centers.

(2) **MICU**

(a) Level 2 VA medical centers should have MICUs.

(b) If there is no separate CCU at Levels 3 and 3T, coronary care patients often are treated in an MICU. This is undesirable for many reasons, as MICU patients tend to have more infections and the environment is noisy.

(3) **SICU**

(a) Levels 3 and 3T VA medical centers should have Surgical Intensive Care Units for cardiac surgery patients.

(b) Transplant centers will require separate units or isolation beds within regular units.

(4) **Telemetry/Step Down.** Levels 3 and 3T VA medical centers should have a separate Telemetry/Step Down Unit.

(5) **OR (Operating Room) Services.**

(a) The following operating services must be available:

1. Cardiopulmonary bypass machines,

2. Cardiac assist devices, and

3. Intraoperative blood gas and laboratory testing capability.

(2) Intra-aortic balloon pumps must be available to the Levels 3 and 3T medical centers.

(a) A cardiac surgical team must have two (can be part-time) board certified cardiac surgeons on service, at least one of whom participates in each cardiac (open heart) operation.

(b) A separate team assigned to provide coverage for the patients on the CCU and Step Down Units is preferred. Some affiliates still use ward teams to manage ICU patients but VA prefers exclusive ICU team coverage.

(6) **Quality Management.** Acute care inpatient treatment should meet standards of general medical staff monitoring and evaluation as well as overall quality of care standards of JCAHO.

d. **Acute Care Outpatient Treatment**

(1) **Cardiology Clinic**

(a) Patients with complex cardiovascular diagnostic and management problems are followed in the cardiology clinic.

1. Patients' post myocardial infarctions or interventional therapy should be followed in cardiology clinics for at least 1 year.

2. PTCA patients are generally seen in this clinic.

3. Many Level 3 and 3T VA medical centers may require two to three 1/2 day clinics per week.

(b) **Staff**

1. Designated to this clinic should be a minimum staff of:

a. One attending cardiologist and several fellows,

b. One ECG technician,

c. One R.N. or L.P.N. (Licensed Practical Nurse), and

d. Medical students and residents, if available.

2. Expansion of accessibility to a cardiology (subspecialty) clinic is preferable to having cardiology patients followed at a GMC (general medical clinic).

(2) **Cardiothoracic Surgery Clinic.** All VA medical centers with in-house cardiovascular surgery (Level 3/3T) will require an outpatient clinic, at least 1/2 day per week.

(a) A thoracic surgery clinic will be justified if there is a minimum workload of five to six patients per day or follow-up from an in-house cardiovascular surgery program.

(b) Necessary staff consists of one R.N. and one staff surgeon as well as trainees.

(3) **Cardiac Transplant/Congestive Heart Failure Clinic.**

(a) There should be a post transplant clinic available at the Levels 3 and 3T VA medical centers or via sharing agreement.

(b) Biopsy of veteran patients can be performed at VA or via sharing agreement.

(c) The VA medical center should have one full-time secretary, and one nurse transplant coordinator designated for transplant patients.

(4) **Pacemaker Clinic**

(a) Levels 3 and 3T VA medical centers should have a Pacemaker Clinic.

(b) For a pacemaker clinic to operate 1/2 day to 1 day per month, a staff is needed of:

1. One cardiologist,

2. One R.N.,

3. One pacemaker technician, and

4. One ECG (Electrocardiograph) technician are needed.

(c) Staff is supplemented by telephone surveillance by either the Eastern (Washington, DC) or Western (San Francisco, CA) Pacemaker Surveillance Center.

(d) Level 3 or 3T VA medical centers with many implanted devices may require a full clinic day each week.

(5) **Arrhythmia/Automatic Implantable Cardioverter Defibrillator/Drug Protocol Clinic.** A combined clinic of arrhythmia, pacemaker, and defibrillators may be required at Levels 3 and 3T VA medical centers.

(a) A 1/2 day clinic would require a minimum workload of five to six patients.

(b) There should be:

1. One staff physician,

2. One EP (Electrophysiology) R.N. or technician or physician assistant, and

3. One ECG technician.

(6) **Anticoagulation Clinic.**

(a) One R.N. and one technician can follow up to ten to fifteen patients per 1/2 day.

(b) All Level 1 and higher VA medical centers with outpatient clinics must have a mechanism in place to follow anticoagulated patients. This could be a separate anticoagulatic clinic or part of another clinic.

(7) **Vascular (Surgical/Medical) Clinic.** Levels 2 and higher should have a Vascular Clinic. This clinic may be administratively under cardiology, cardiovascular surgery or general surgery. This clinic should follow-up patients with symptomatic peripheral vascular diseases, especially those who have undergone some type of surgery.

(8) **Cardiac Risk Factors, i.e., Lipid Clinic.** All Level 1 and higher VA medical centers should have Cardiac Risk Factor Clinics. This clinic may be administratively, under cardiology, endocrinology, preventive medicine or a separate clinic for behavioral and pharmacologic treatment of lipid disorders.

(9) **Quality Management.** Acute care outpatient treatment should meet standards of general medical staff monitoring and evaluation as well as overall quality of care standards of JCAHO.

e. **Cardiovascular Laboratory**

(1) **Policy**

(a) Cardiac catheterization laboratories should be available to perform:

1. Cardiac catheterization,

2. Angioplasty,

3. Valvuloplasty,

4. Temporary and permanent pacemaker insertions, and

5. Electrophysiologic studies and treatments.

(b) All Levels 3 and 3T VA medical centers must have a Cardiovascular Laboratory. Existing cardiac catheterization laboratories which are not located in facilities where there is an active cardiovascular surgery program must have a formal transfer agreement with a nearby (preferably adjacent) cardiovascular surgical facility, for emergency referrals.

(2) **Minimum Workload Requirements**

(a) The minimum number of total procedures for a catheterization laboratory is 300 per year; the minimum number of left heart procedures is 250 per year.

(b) No new laboratories will be opened unless nearby VA and other Federal laboratories are performing an average of 500 cases annually.

(3) **Closure.** Closure of a cardiac catheterization laboratory will be considered if there is:

(a) Failure to achieve minimum performance standards;

(b) Failure to retain or recruit appropriately trained and credentialed staff;

(c) An unduly high morbidity or mortality;

(d) Failure to report as required; and

(e) A change in the mission of a VA medical center.

(4) **Staff**

(a) Invasive cardiovascular procedures will only be performed by appropriately experienced, credentialed and privileged staff.

(b) Approximately five clinical FTE (full-time employee) are required to operate a catheterization laboratory performing the minimum of 300 procedures. This would include 1 chief catheterization laboratory physician, two R.N.s, and two catheterization technicians.

(c) Qualifications of staff involved include:

1. The director of the unit should be board-certified in Internal Medicine, Radiology, or Cardiovascular Disease, with consultation available from specialists in areas as:

a. Cardiovascular anesthesiology,

b. Cardiovascular surgery,

c. Radiology, and

d. Surgery other than cardiovascular.

NOTE: *Trainees must be directly supervised by a fully qualified staff member.*

2. A R.N. should have special training in:

a. Critical care with or without coronary care unit experience;

b. Cardiac catheterization procedures and equipment use;

c. Cardiovascular medications;

d. Cardiopulmonary resuscitation; and

e. Psychological care and support of cardiac patients.

3. A radiologic technologist should have experience in:

a. Angiographic principles,

b. Cardiac catheterization procedural techniques, and

c. Cardiac catheterization equipment, operation, and care.

4. A cardiopulmonary technician should have experience in:

a. Blood gas evaluation;

b. Calculations, including dye dilution curves;

c. Principles of hemodynamics;

d. Pressure wave form recording;

e. Arrhythmia recognition;

f. Determination of cardiac output;

g. Patient monitoring;

h. Recording of physiologic data; and

i. Cardiopulmonary resuscitation.

5. The catheterization unit should also include technical support personnel which should be available as needed, either in-house or via contract:

a. An electronic and radiologic repair technician with skills in:

(1) Tests,

(2) Calibration,

(3) Maintenance of radiologic equipment, and

(4) Proper adjustment and maintenance of recording instrumentation;

b. A radiologic-electronics engineer; and

c. A radiation physicist.

(5) **Equipment.** VA medical centers performing 1,000 total procedures annually could justify two fully equipped rooms. Resuscitation equipment and supplies are to be available at all times for immediate use in the laboratory.

(6) **Space.** For space criteria for Cardiovascular Laboratories refer to Planning Criteria for VA Facilities, H-08-9, Chapter 210.

(7) **Quality Management.** Some aspects of quality which should be considered are:

(a) Technical equipment function,

(b) Appropriateness of procedures selection,

(c) Access to care, and

(d) Functional outcome measures.

f. **Major Invasive Cardiology Procedures**

(1) **Cardiac Catheterization Procedure**

(a) **Purpose**

1. Cardiac catheterization is used for a variety of purposes, including, but not limited to:

a. Examination of the blood vessels supplying the heart and the four heart chambers;

b. Implantation of electrodes for a pacemaker; and

c. Insertion of a device which will assist in the circulation of blood.

2. Examination of the heart's blood vessels and the heart chambers are the most definitive means for deciding whether a patient is a candidate for cardiovascular surgery.

3. Cardiac catheterization in the veteran population generally requires an inpatient stay because most VA patients are elderly and have complicated medical problems.

4. Cardiac catheterization should be available at Levels 3 and 3T VA medical centers.

(b) **Travel Time.** Maximum travel time for outpatients to get to facilities providing cardiac catheterization should be no more than 3 hours for 75 percent of the population.

(c) **Minimum Workload Requirements.** A physician should perform a minimum total of 150 cardiac catheterizations per year (including outside cases) to remain proficient.

(d) **ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modifications).** For consistency and accuracy of records it is suggested that all VA medical centers use the following ICD-9-CM codes to indicate cardiac catheterization procedures:

PROCEDURES	ICD-9-CM
1. Right heart cardiac catheterization	3721
2. Left heart cardiac catheterization	3722
3. Combined right and left heart cardiac catheterization	3723
4. Biopsy of heart	3725

(e) **Multidisciplinary Team.** Cardiac Catheterization requires highly developed teamwork; the team must work together in the evaluation of the patient and in making decisions on diagnosis and therapy. The team may include:

1. An angiographer,

2. A medical cardiologist,

3. A cardiovascular surgeon,

4. An anesthesiologist,

5. A radiologist,

6. A R.N., and

7. Members of allied services.

(f) **Quality Management Mechanisms.** Medical centers performing cardiac catheterization should maintain a program of review of deaths and complications resulting from the procedure as well as a program of peer review. Complications resulting from a cardiac catheterization procedure and reporting requirements are found in M-2, part IV, chapter 2, section I, paragraph 2.01j.

NOTE: *For quality care IABP (Intra Aortic Balloon Pulsation) pump should be available (in-house) at all catheterization laboratories.*

(2) **PTCA**

(a) **Procedure.** Angioplasty involves using small balloons to open narrowed or closed coronary arteries. Cardiovascular surgery backup must be available in order to perform angioplasty. An angioplasty procedure requires an in-patient stay of 1 to 3 days post-procedure; total hospitalization takes 2 to 5 days. Angioplasty capability should be available at Level 3 and 3T VA medical centers.

(b) **Staff.** The minimum staff for angioplasty should include a cardiologist fully trained in angioplasty (if a trainee is involved, this would reflect a need for another cardiologist).

1. It is advisable to have two physicians present for most angioplasties, except when the procedure is in the most experienced of hands. A second physician is often a fellow in training.

2. Angioplasty also requires a R.N. with coronary care unit expertise.

NOTE: *In some of the catheterization laboratories where the x-ray controls are set away from the physician, an x-ray technician is required.*

(c) **Minimum Workload Requirements.** VA has accepted the guidelines of the American Heart Association and the American College of Cardiology, setting the minimum workload necessary to maintain skills in angioplasty at 50 angioplasties per year per operator.

1. Fully trained angioplasters performing fewer than 50 angioplasties per year (in terms of volume) must be accompanied by a more active angioplasty attending physician.

2. Failure to conform to minimum requirements can result in laboratory closure.

(d) **Data.** For consistency and accuracy of records it is suggested that all VA medical centers use the following ICD-9-CM codes to indicate angioplasty procedures:

PROCEDURES	ICD-9-CM
1. Single vessel PTCA without mention of thrombolytic agent	3601
2. Single vessel PTCA with thrombolytic agent	3602
3. Open chest coronary artery angioplasty	3603
4. Multiple vessel PTCA performed during single operative episode	3605

(e) **Quality Management Mechanisms.** Quality assurance indicators for angioplasty should include:

1. The number of patients who die during that specific hospital admission, either directly or indirectly as a result of their angioplasty;

2. The number of patients with "failed" angioplasties;

3. The number of patients with dissections or other complications who require emergency surgery; and

4. All other major complications.

NOTE: *For all other reporting requirements refer to M-2, part IV, chapter 2, section I, paragraph 2.01j(1)(2).*

(3) **EP Studies**

(a) **Procedure.** EP involves putting wires into the heart to assess electrical activity and determine why heart rhythm is abnormal.

1. The procedure may take 2 to 8 hours and often has to be repeated on different dates.

2. If extensive drug trials are needed, the procedure requires 3 days to 6 weeks of hospitalization.

3. EP study capability should be available at Level 3 and 3T VA medical centers.

(b) **Staff.** Minimum number of personnel required for an EP study include the presence of one registered nurse, preferably a nurse who has had experience in critical care, and an electrophysiology technician for an EP study. Therapeutic procedures (such as catheter ablation) require the presence of two attending electrophysiologists or one attending and one fellow.

(c) **Training Requirements.** All physicians performing electrophysiology studies at a minimum should have completed a 1-year training fellowship in electrophysiology, or performed a minimum of 75 electrophysiology studies as the primary operator.

(d) **Minimum workload Requirements.** To maintain proficiency and experience with this technique, physicians should perform 75 procedures per year which may include both VT (Ventricular Tachycardia) and SVT (Supra Ventricular Tachycardia.)

(e) **Data.** For consistency and accuracy of records it is suggested that all VA medical centers use the following ICD-9-CM codes to indicate EP studies:

EP STUDIES	ICD-9-CM CODE
1. Cardiac electrophysiologic stimulation and recording studies.	3726
2. Implantation or replacement of automatic cardioverter and/or defibrillator total system.	3794
3. Insertion of permanent pacemaker, initial or replacement type of device not specified.	3780

(f) **Quality Management Mechanisms.** Quality assurance indicators should include a record of whether the patient had any complications (which include groin hematomas or perforation of the heart or pneumothorax).

(4) **AICD**

(a) If drug therapy does not work to protect against lethal heart rhythms detected at EPS, then a small defibrillator is inserted into the patient.

(b) When the rhythm becomes dangerous, it shocks the heart back to pumping.

(c) AICD capability may be available at certain Level 3 and 3T VA medical centers.

(d) Specific questions regarding the AICD program should be referred to: Chief, Cardiovascular Diseases, Medical Service, VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420.

(5) **Pacemaker Implantation**

(a) **Policy**

1. A pacemaker is an electronic device to sustain the patient's heart rhythm regardless of the underlying heart disease.

2. The pacemaker implantation procedure takes approximately 45 minutes to 3 hours.

3. Pacemaker implantation capability should be available at Level 3 and 3T VA medical centers.

(b) **Staff.** The minimum staff required for a permanent pacemaker implantation is:

1. One physician with training in pacemaker implantation;

2. One experienced R.N.; and

3. One technician.

(c) **Training Requirements**

1. The training requirement for a person implanting pacemakers should include either:

a. A 1-year fellowship in electrophysiology, or

b. Implantation of at least 25 permanent pacemakers during a cardiology or cardiovascular surgery training program, or

c. A minimum of a 6-month fellowship in pacemaker implantation.

2. If a physician has been performing pacemaker implantation for a prolonged period of time in private practice, or in another academic medical center, and has adequate records of these implants as well as complication rates, the physician may be given privileges to implant pacemakers.

(d) **Minimum Workload Requirements.** Physicians implanting permanent pacemakers should be performing a minimum of 15 new pacemaker implants per year.

(e) **Data.** For consistency and accuracy of records it is suggested that all VA medical centers use the following ICD-9-CM codes to indicate implantation of permanent pacemakers.

IMPLANTATION	ICD-9-CM CODE
1. Insertion of permanent Pacemaker initial/replace type of device	3780
2. Initial insertion of single-chamber device, not specified as rate responsive	3781
3. Initial insertion of single chamber device	3782

IMPLANTATION Continued	ICD-9-CM CODE
4. Initial insertion of dual chamber device	3783
5. Replacement pacemaker device with single chamber device	3785
6. Replace pacemaker with single chamber device	3786
7. Replace pacemaker with dual chamber device	3787
8. Revision or removal pacemaker device	3789

(f) **Quality Management Mechanisms.** Quality Assurance indicators should include:

1. The volume of pacemaker implantation, and

2. Complications, primarily:

a. Pneumothorax,

b. Perforation, and

c. Infection.

(6) **Cardiac (Open Heart) Surgery**

(a) **Procedure.** Cardiac (Open Heart) surgery includes operations on the heart and thoracic great vessels requiring use of a heart-lung machine. Cardiac surgery is a requirement of Level 3 and 3T VA medical centers.

(b) **Minimum Workload Requirements.** VA guidelines state that all programs should perform at a level of 150 cases per year to provide adequate experience and work volume for training programs and support personnel.

(c) **Staff.** A surgical team of ten FTEE (full-time equivalent employees) is suggested as the minimum estimated staffing needed to perform a total volume of 150 cardiac surgery procedures annually at a VA medical center. The surgical team should consist of:

1. Surgeons;

2. Physician's assistants;

3. Anesthesiologist and/or anesthetist;

4. Scrub nurse and/or technician;

5. Circulating nurse; and

6. Perfusionists.

(d) SICU. At least four surgical intensive care unit beds should be available for

a Cardiac Surgery Program that performs a minimum of 150 procedures annually. It is recommended that the ratio of nurses be at least one to one for the care of cardiac surgery patients for the first 24 hours post-operatively.

(e) **Quality Management Mechanisms**

1. The Cardiac Surgery Consultants Committee has a defined review schedule and set of standards by which the reported results are evaluated. It may be obtained from Director, Surgery Service (111B), VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420.

2. Paper audits are required if:

a. The overall mortality for CABG (Coronary Artery Bypass Graft) procedures equals or exceeds 10 percent, or

b. The operative mortality is twice the national VA average for 6 month periods, or

c. The operative mortality for primary CABG procedures exceeds 5 percent for a 2 year period.

3. Site visits are initiated if there are paper audits in two 6 month periods of 2 consecutive years, or volume less than 100. Findings of audits and requests from VA Central Office, regional or facility directors may also be reasons for performing site visits.

4. Programs may be put on probation or even discontinued if serious problems are present and problems are not corrected.

5. A site visit is required after the deficiencies have been corrected, or at the end of the probationary period. For details refer to M-9, chapter 9, Appendix 9E, "Criteria and Standards for Cardiac (Open Heart) Surgery Program."

(7) **TX (Transplant Program)**

(a) **Policy.** Each VA Heart Transplantation Center must perform at least 12 heart transplants annually.

(b) Specific questions should be referred to the Director, Surgical Service, (111B), VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420.

g. **Cardiac Rehabilitation Program**

(1) **Definition.** Cardiac rehabilitation involves the physical, psychosocial, and vocational restoration of patients with heart disease to enjoyable and productive life as efficiently as possible.

(a) An inpatient Cardiac Rehabilitation Program should be provided by Level 2 VA medical centers and must be provided by VA medical centers higher than Level 2.

(b) Outpatient cardiac rehabilitation should be provided by Level 3 and higher VA medical centers.

(c) Cardiac rehabilitation interventions may be prescribed in the following phases of rehabilitation:

1. **Phase I.** Phase I corresponds to the acute inpatient length of stay (7 to 14 days) following an acute myocardial infarction or cardiovascular surgery. The interventions during this phase include:

a. Supervised exercise and structured activity progression (to recondition and prevent deliterious effects of bed rest).

b. Patient and/or family education regarding:

(1) Disease process,

(2) Treatment,

(3) Diet,

(4) Risk factors,

(5) Activity guidelines,

(6) Sexual activity,

(7) Medications,

(8) Return to work, and

(9) Follow-up;

c. Psycho-social assessment and interventions as needed;

d. Discharge planning; and

e. A submaximal exercise test is recommended prior to discharge to determine:

(1) Risk,

(2) Response to medical therapy, and

(3) Functional capacity.

2. **Phase II**

a. Phase II corresponds to the convalescent stage following a hospital discharge. It starts immediately after the acute stay and includes monitored exercise.

b. The outpatient phase may last for 16 weeks during which time the following occur:

(1) Home-based walking program and/or hospital-based telemetry monitored exercise training,

(2) Education,

(3) Risk factor management,

(4) Lifestyle and leisure counseling,

(5) Psychological counseling,

(6) Social and vocational assessment and referral as needed,

(7) Smoking cessation,

(8) Diet and/or lipid management,

(9) Weight reduction,

(10) Stress management,

(11) Management of blood pressure and diabetes,

(12) Exercise testing and risk stratification, and

(13) Medical management.

3. **Phase III.** Phase III corresponds to an extended supervised outpatient program which lasts from 4 to 6 or more months. This involves:

a. Continuing exercise training;

b. Therapeutic fitness outings;

c. Risk factor modification;

d. Health promotion activities;

e. Exercise prescription based on initial and periodic graded exercise testing;

f. Electrocardiographic or telemetry monitoring for intermediate or high risk patients, if indicated;

g. Occupational evaluation, if indicated;

h. Vocational counseling, if indicated; and

i. Simulated work evaluation testing, if indicated.

4. **Phase IV.** Phase IV corresponds to the maintenance phase which includes:

a. A continuing exercise program,

b. Control of risk factors, and

c. Follow-up visits which serve as a guide for progression of activity to include:

(1) Repeat exercise testing, and

(2) Measurement of exercise training intensity.

NOTE: *Referral to community facilities for exercise maintenance can be considered.*

(2) **Interdisciplinary Team.** Cardiac rehabilitation is a critical phase of total cardiac care. A comprehensive approach that utilizes an Interdisciplinary Team is mandatory.

(a) **Minimal staffing guidelines** (not mandatory) Minimal staffing guidelines for an Interdisciplinary Team are:

Position	FTEE
1. Cardiologist/Physiatrist	0.125 to 0.25 FTEE
2. Exercise Therapist	0.5 to 1.0 FTEE
3. Clinical Nurse Specialist (also serves as case manager/program coordinator)	0.5 to 1.0 FTEE
4. Dietitian	0.25 to 0.5 FTEE
5. Psychologist/Social worker	0.25 FTEE
6. Vocational Counselor	As needed
7. The following therapists may also serve as an exercise therapist:	
a. Exercise Physiologists	As needed
b. Kinesiotherapists	As needed
c. Physical Therapists	As needed
d. Recreation Therapists	As needed
e. Occupational Therapists	As needed

(b) **Staffing Ratios (not mandatory)**

1. For intermediate or high risk patients while in the phase II and phase III program, a ratio of one therapist to four patients with a physician in the immediate vicinity is generally sufficient.

2. Those patients should be electrocardiographically or telemetry-monitored.

3. For the low risk and Phase IV maintenance patients, a ratio of one therapist to five to six patients is adequate.

(3) **Provisions.** The following equipment and supplies should be available to a Cardiac Rehabilitation Program:

(a) Equipment, to include:

1. EKG Machine,

2. Defibrillator,

3. Treadmill,

4. Bicycle ergometers,

5. A two arm ergometer or rowing machine, and

6. Telemetry.

(b) Supplies, to include, but not limited to:

1. Electrodes,

2. Educational materials,

3. Sphygmomanometers, and

4. Stethoscopes.

(4) **Safety**

(a) A crash cart should be in the exercise area and updated to avoid expiration.

(b) At least one member of the interdisciplinary team should be Advance Cardiac Life Support-certified.

(c) A Code Team (resuscitation team) should be immediately available.

(d) Only those professionals licensed in a state administer IV drugs and/or defibrillate may do so.

(e) All members of the team should have a Basic Cardiac Life Support certification.

(f) Ongoing continuing education in cardiac rehabilitation issues and updates should be provided to the members of the team.

(5) **Types of Patients Treated in Cardiac Rehabilitation Program**

(a) Not all patients require supervised rehabilitation to return to an optimum level of function or to modify their risk factors.

1. Patients should be selected based on their physical and psychological conditions.

2. All patients should receive education and risk factor counseling.

3. Patients who have not returned to an optimum lifestyle or are psychologically impaired generally benefit from a structured program.

4. Patients who are stable, but at high risk and low functional capacity are likely to benefit most from cardiac rehabilitation.

5. Low risk patients with higher functional capacity may benefit from a period of time in a supervised setting to enhance their confidence in performing physical activities or in preparing to return to work.

(b) Services provided by Cardiac Rehabilitation Programs can benefit patients with other chronic disease diagnoses.

(c) According to a VHA (Veterans Health Administration) Cardiopulmonary Rehabilitation Survey in Fiscal Year 1990, the types of patients seen at VA Cardiac Rehabilitation Programs include:

Diagnosis	Occurrence
1. Post MI (Myocardial Infarction)	20 to 93 percent
2. Post CABG	20 to 64 percent
3. Post PTCA	2 to 25 percent
4. Stable angina	8 to 20 percent
5. High cardiac risk	2 to 25 percent
6. Pulmonary	1 to 7 percent
7. Diabetic	3 to 10 percent
8. Other (mental hygiene)	2 percent

(d) Cardiac Rehabilitation programs may also include patients with:

1. Cardiac transplantation.

2. Pacemakers.

3. AICD.

4. PVD (Peripheral vascular disease) and/or claudication.

5. COPD (Chronic Obstructive Pulmonary Disease).

NOTE: *PVD patients respond well to structured exercise and share the same risk factors as coronary patients and therefore benefit from the same preventive medicine interventions.*

(e) For consistency and accuracy of records it is suggested that all VA medical centers use the following ICD-9-CM codes to indicate type of patients treated in a Cardiac Rehabilitation Program:

Diagnosis	ICD-9-CM Codes
1. Coronary Angioplasty	36.0

Diagnosis Continued	ICD-9-CM Codes
2. Coronary artery bypass surgery	36.1
3. Acute myocardial infarction	410
4. Other acute or subacute forms of ischemic heart disease	411
5. Old myocardial infarction	412
6. Valvular diseases	424
7. Cardiomyopathy	425.4
8. Cardiovascular disease, unspecified	429.2
9. Heart transplantation	37.5
10. Cardiac pacemakers	3780
11. AICD	3794
12. PVD	443.9
13. COPD	496
14. Angina pectoris	413
15. Cardiac surgery (Valve)	35.2

e. **Follow-up**

(1) Close follow-up in Cardiac Rehabilitation Programs can serve to detect early evidence of decompensation providing:

a. An opportunity for early intervention; and

b. The potential for preventing re-hospitalization.

(2) Examples of appropriate follow-up are:

(a) Patients should be sent back to the referring or primary care physician for continued care while being seen on an interim basis by Cardiac Rehabilitation Service.

(b) Providing cardiac rehabilitation services for patients who do not live in close proximity to a facility is difficult. Innovations might include:

1. Transtelephonic monitoring during home exercise.

2. Telephone follow-up.

f. **Quality Management.** Aspects of quality management which should be considered are:

(1) Access to care,

(2) Efficiency of delivery, and

(3) Functional outcome measures.

7. COST EFFECTIVE ALTERNATIVES

a. Many VA medical centers have close institutional relationships with affiliated hospitals and/or medical schools to which VA patients can be referred for special treatment requiring high technology. This is fine as long as quality medical care is provided in a cost-effective manner. For many cardiac procedures, affiliates simply cannot provide price schedules as low as the federal government's, due to cost discounting to the government, e.g., the price of items as pacemakers.

b. Most cardiac services should be provided through the VA's referral system.

(1) As a system, referral patterns permit adequate case loads at referral centers.

(2) Exceptions should be made for emergency cases.

(3) For example, a VA medical center that does not provide angioplasty may identify several patients each year that require emergency angioplasty or cardiovascular surgery.

c. To facilitate use of the VA system's resources, patient transfers between VA facilities are necessary.

(1) Patient transfers from one facility to non-VA facilities are required in urgent and emergent situations.

(3) There is a fixed, and sometimes considerable, cost of the transfer itself which should be taken into account in any cost effectiveness survey.

d. Whenever possible contracts should be negotiated annually, on a competitive bid basis. The VA medical center may have a primary affiliation but in some instances competitive bidding will still be required.

8. CONTINUITY OF CARE, THE INTEGRATING MECHANISMS

There should be a dedicated FTEE of either a specialized nurse or a physician assistant responsible for coordinating cardiac care activities at all Level 3 and 3T VA medical centers, to include the following:

a. Coordinating cardiac care activities between departments of Cardiovascular Surgery and Cardiology. Such communication is important with the increased use of PTCA, which requires follow-up on all patients, and possible PTCA repetition in up to one-third of the patients.

b. Follow-up of patients as those:

(1) On anticoagulants,

(2) In post angioplasty,

(3) In post-cardiovascular surgery, and

(4) In post electrophysiology testing or treatment.

c. Maintaining a tracking system for patients that are waiting for surgery, angioplasty or electrophysiology in order to schedule them.

d. Filling in operative and post-operative information:

(1) On the Nationwide VA Risk in Cardiothoracic Assessment Study, and

(2) Filling in Pacemaker and AICD registry forms.

e. Educating patient and family.

f. Involving the social worker and other members of treatment team for discharge planning.

g. Facilitating patient transfers from Level 1 and 2 facilities to Level 3/3T facilities.

(1) Patient safety should be the main determinant of the mode of transfer.

(2) Operative reports and discharge summaries need to accompany the patient to the patient's home VA medical center, so that continuity of care can be maintained.

8. VA CARDIOLOGY RESEARCH

a. A wide-range of clinical and basic research in cardiology is being conducted in VA medical centers.

(1) This research, being performed by physicians and other scientists, is being supported by:

(a) Medical Research Service;

(b) Other Federal agencies (e.g., National Institutes of Health); and

(c) Pharmaceutical and other private sector firms.

(2) Some VA staff conduct research in cardiology without any special research funding.

b. In Fiscal Year 1990, approximately $13.6 million or 6.9 percent of the total Medical Research Service allocation was used to support research relevant to cardiology.

(1) These funds are awarded competitively to physicians and other scientists in VA medical centers.

(2) Such awards are made to applicants whose proposals have been appraised as being scientifically excellent by scientific peer review groups.

NOTE: *Only VA employees (at least 5/8 time) are eligible to receive research support.*

c. In Fiscal Year 1990, VA investigators received approximately $18 million from other federal agencies and private sector firms to support research related to cardiology.

d. The funds expended on cardiology research are intended to:

(1) Promote substantive scientific goals regarding the prevention, diagnosis, and treatment of disease.

(2) Contribute to the recruitment and retention of physicians to treat veteran patients served by VA medical centers and outpatient clinics.

10. REQUIREMENTS FOR ESTABLISHING NEW CARDIOLOGY PROGRAM

a. To establish a "new" Level 3 or 3T cardiology program, the VA medical center should be able to provide all the services provided in paragraph 5.

b. New programs should project minimum workload requirements of major cardiology and surgery procedures to be attained within 3 years of initiation.

c. A new cardiac surgery program must have an affiliation with an approved residency training program in cardio-thoracic surgery.

d. VA medical centers planning to set up a cardiac rehabilitation program should consider collaborating with a facility with an established program. This collaboration could provide assistance with staff training and program development.

11. CARDIOLOGY LEVELS 1-3 SERVICES

	LEVELS		
SERVICE	1	2	3/3T
a. Prevention	Exception	Yes	Yes
b. Diagnosis			
Laboratory	Yes	Yes	Yes
ECG	Yes	Yes	Yes
ECHO		Yes	Yes
Vascular		Exception	Yes
Transesophageal		Exception	Yes
X-Ray	Yes	Yes	Yes
Stress Test - Routine	Yes	Yes	Yes
Stress Test - Nuclear	No	Yes	Yes
Signal Averaging	No	Exception	Yes
Holter	No	Yes	Yes
Cat Scans	Yes	Yes	Yes
MRI	No	Exception	Optional
c. Acute Care Inpatient Treatment			
AICD	No	No	Yes
CCU	No	Desirable	Yes
Cardiac Surgery	No	No	Yes

LEVELS Continued

SERVICE	1	2	3/3T
MICU	Optional	Yes	Yes
SICU	Optional	Yes	Yes
Telemetry/Step	Optional	Yes	Yes
Operating Room	Optional	Optional	Yes
d. Clinics			
Cardiology	No	Optional	Yes
Cardiothoracic	No	No	Yes
Transplant/Heart Failure	No	No	Yes
Pacemaker	No	Yes	Yes
Arrhythmia	No	No	Yes
Anticoagulation	Yes	Yes	Yes
Vascular	Maybe	Yes	Yes
Cardiac Risk	Yes	Yes	Yes
e. Cardiac Catheterization Lab			
Cardiac Catheterization	No	Optional	Yes
Angioplasty	No	No	Yes
EPS Studies	No	Optional	Yes
Pacemaker Implantation	No	Optional	Yes
f. Transplant Program	No	No	Yes
g. Cardiac Rehab Program	Optional	Yes	Yes

NOTE: *Exception means by exception only, e.g., may be approved depending on available local expertise.*

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-9
Chapter 9
Change 14

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	Insert
9-i	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

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-9
Chapter 9
Change 11

August 12, 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," Appendix 9O, "Criteria and Standards for Cardiology Continuum of Care."

2. Principal change is to add Appendix 9O, "Criteria and Standards for Cardiology Continuum of Care."

3. **Filing Instructions**

Remove pages	Insert pages
9-i	9-i 9O-1 through 9O-29

4. **RESCISSION:** None

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

Distribution: **RPC: 1318**
FD

Printing Date: 9/92

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-9
Change 2

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

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

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.
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)	1/28/86
2. ~~(10)~~	
3. ~~(10A1B)~~	
4. (17A) (Copy forwarded 2/4/86)	
5.	

REASON FOR REFERENCE

- ☐ AS REQUESTED
- ☐ COMMENTS
- ☐ CONCURRENCE
- ☐ FOR YOUR FILES
- ☐ INFORMATION
- ☐ NECESSARY ACTION
- ☐ NOTE AND RETURN
- ☐ PER CONVERSATION
- ☐ 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 X Disapproved ___

JOHN W. DITZLER, M.D. (for)
Chief Medical Director
2-3-86
Date

RECEIVED
61/134
JAN 27 1986
Regulations and Publications
Management Staff (10A1B)

FROM

MARJORIE R. QUANDT
ACMD for Planning Coordination (17A)

1/23/86
TEL. EXT. 3331

VA FORM MAY 1980 3230 EXISTING STOCKS OF VA FORM 3230, AUG 1976, WILL BE USED. ☆ U.S. G.P.O. 1984-709-228

Veterans Administration

Memorandum

DATE: 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, M.D.
Chief Medical Director (10)

Approve ✓
Disapprove ___

4/17/84
Date

VA FORM 2105
DEC 1981