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**(Veterans Health Administration)**

**Chapter 9, Criteria and Standards and Program Planning Factors**

**Appendix 9P, Mental Health Criteria and Standards**

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Department of  
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# Strategic Planning

July 26, 1991

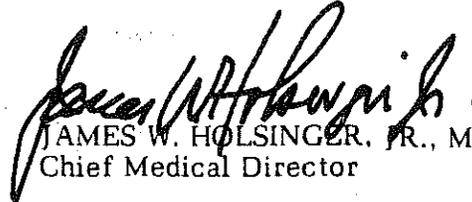
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## RESCISSIONS

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## MENTAL HEALTH CRITERIA AND STANDARDS

### 1. HIGH INTENSITY PSYCHIATRIC CARE

#### a. PICU (Psychiatric Intensive Care Unit)

(1) **Patient Description.** Patients admitted to this level of care will have the most severe behavioral problems including high suicide risk, assaultiveness, severe agitation, and disorganized behavior secondary to psychosis, confusion, or other severe psychiatric disorders.

#### (2) Program Description

(a) In response to the increasing numbers and acuity of patients seeking psychiatric care, today's psychiatric hospital needs the increased staffing, increased security (safe quiet/seclusion rooms), and expertise characterized by the PICU.

(b) A PICU may be physically within or adjacent to a traditional 20 to 30 bed (open or closed) admitting or general psychiatric ward. Psychiatric patients presenting with severe symptoms may be rapidly stabilized on such a unit, obviating the need for transfer to a long-term or more secure facility often some distance away.

(3) **Program Goal.** The primary goal of the treatment provided on a PICU is to quickly manage and treat the acute psychiatric disorders so that patients can be safely transferred to a less intensive level of care.

#### (4) Admission Standards

**Standard.** The patient must:

(a) Need rapid intensive assessment, management and treatment for severe psychiatric symptoms.

(b) Require close and constant monitoring and interventions.

#### (5) Treatment Standards

(a) **Standard.** PICU staff should be experienced in the evaluation, diagnosis, treatment and management of patients with severe psychiatric disorders.

(b) **Standard.** All PICUs must have available, but are not limited to, the following diagnostic and treatment modalities:

1. Medical and psychiatric assessment.
2. Psychopharmacology.
3. ECT (electroconvulsive therapy).
4. Psychological and social assessments.
5. Individual/group and family psychotherapies.

6. Seclusion rooms.
7. Restraints.
8. Quiet rooms.
9. Occupational therapy assessment and treatment.
10. Day-room with supportive/diversional activities.
11. Therapeutic exercise and recreational activities.

(c) **Standard.** The PICU must have the resources to provide one-on-one and constant observation for specific patients.

(d) **Standard.** Each patient must have a current, thorough evaluation and interdisciplinary treatment plan that clearly defines the criteria for continued treatment on the PICU pending transfer to a less intensive level of care.

**(6) Discharge and Transfer Criteria**

(a) **Standard.** High risk behaviors have decreased and treatments for such behaviors are no longer necessary. Current behaviors can be controlled at a less intensive level of care, e.g., a general psychiatric unit.

(b) **Standard.** Levels of patient behavioral control are manageable on the accepting unit.

**NOTE:** *LOS (length(s) of stay) in the PICU is a function of the intensity of symptoms and patient's response to treatment. Ordinarily, the LOS should be a matter of days before discharge or transfer to a less intensive level of care.*

**(7) Space Standards**

(a) **Standard.** VA (Department of Veterans Affairs) construction standards should be flexible to permit the option of both general psychiatric and PICU beds on one unit. PICUs must not exceed ten beds.

(b) **Standard.** Seclusion and quiet rooms to which patients may be directly admitted will be counted in the bed census unless they are configured and used exclusively for control of disturbed patients already assigned a hospital bed.

1. Seclusion and quiet rooms must have sound attenuated ceiling and walls.
2. Seclusion and quiet rooms must have outside windows wherever possible to counteract the sense of confinement.
3. Seclusion and quiet rooms must be adaptable for the needs of female as well as male veterans.

(c) **Standard.** VA guidelines for patient privacy must be followed. This includes provisions to meet the unique needs of female patients.

(d) **Standard.** Agitated and disturbed patients require substantial interpersonal space; thus, sufficient communal space must exist so that patients have adequate room to move about without impinging on the activities or privacy of other patients.

(e) **Standard.** Nursing stations and observation areas must be arranged in a way that staff can observe patients in an efficient manner.

(f) **Standard.** Space for staff computer terminals and a room for computerized patient interviews and tests must be available.

(g) **Standard.** For those affiliated programs where active training of mental health professionals occurs (psychiatry residents, psychology interns, social work and nursing students, etc.), adequate office, conference, and classroom space must be taken into account.

#### (8) Staffing Guidelines

(a) **Standard.** There must be sufficient staff with appropriate expertise to manage severely disturbed patients.

1. The level of staffing must permit close monitoring and intensive treatment of each patient.

2. The number and type of nursing staff must be adjusted to a level appropriate to provide care for a patient mix consisting of primary category III and IV cases as described in the Staffing Guidelines for Nursing in Psychiatric Units (M-2, pt V).

**NOTE:** *Staffing may be integrated within a larger ward program; and staffing ratios may vary depending upon local circumstances*

(b) The following staffing mix should be provided for a ten bed PICU:

1. Psychiatrist.

2. Physician assistant or nurse practitioner.

3. R.N. (Registered Nurse).

4. L.P.N. (Licensed Practical Nurse).

5. Nursing assistant.

6. Social worker.

7. Psychologist.

8. Occupational therapist and/or kinesiotherapist and/or recreation therapist.

9. Clerk.

(9) **Special Equipment for PICUs.** Special equipment for PICUs must include:

(a) Closed circuit TV (television) system, where the architecture does not permit direct patient observation.

(b) ECT equipment (if in a treatment room fully equipped for maintaining an airway and CPR (Cardiopulmonary Resuscitation) and if ECT will be performed on the ward).

(c) Computer terminals.

(d) Appropriate restraint devices.

(e) Panic alarm system.

(f) Exercise equipment.

(g) Recreation therapy equipment.

**b. Psychiatric Evaluation and Treatment Program on a General Psychiatric Ward**

**(1) Patient Description**

(a) Patients require hospitalization because their symptoms are so severe that they cannot be treated safely at a less intensive level of care, or they need evaluative, diagnostic services and treatment that can only be provided in an inpatient setting.

(b) Because of the severity of illness or the type and intensity of treatment required, patients eligible for admission to these units require an inpatient level of care which may be unrelated to their diagnostic category. As many as a third of chronic VA psychiatric patients currently treated in a other settings need periods of care in high intensity settings, such as a general psychiatric ward.

(2) **Program Description.** This multipurpose Psychiatric Evaluation and Treatment Program offers a brief period of hospital care for new patients as well as for those experiencing episodes of decompensation, or who develop new symptoms currently unmanageable at a lesser level of care. Psychiatric Evaluation and Treatment Units are capable of doing the necessary careful comprehensive medical and psychosocial assessments required for these and all other patients. They must be securable and be able, at least, to provide a time-limited (2 to 3 days) safe treatment environment for patients exhibiting disturbed behavior thus, avoiding the need to transfer patients to another facility.

(3) **Objectives.** The primary objectives of this multipurpose unit are to:

(a) Identify and evaluate the treatment needs of the patient.

(b) Provide this treatment in a relatively short duration, ordinarily 5 to 20 days and occasionally up to 30 or 40 days.

(c) Assist in identification and placement of appropriate follow-up needed for successful community reintegration or supervision, treatment and/or rehabilitation at a less intensive level of care.

**(4) Admission Standards**

(a) **Standard.** Failure of treatment at a less intensive level of care or unavailability of alternative care must be established.

(b) **Standard.** The patient must demonstrate one or more of the following:

1. A potential danger to self, others, or property.
2. Impaired reality testing accompanied by disordered behavior.
3. A need for continuous skilled observation, ECT, high dose medication, or therapeutic milieu.
4. Impaired social, family, or occupational functioning.
5. Legally mandated admission.

**(5) Treatment Standards**

(a) **Standard.** These patients must have available a broad range of therapeutic modalities available from a interdisciplinary treatment team.

(b) **Standard.** These patients must have available the following modalities which may include, but not be limited to:

1. Physical and psychiatric assessment, including chemical substance abuse assessment.
2. Access to appropriate medical/surgical consultation and treatment.
3. Neuropsychological evaluation.
4. Psychological and social assessments.
5. Vocational assessment and counseling.
6. Occupational therapy assessment and activities.
7. Psychopharmacologic treatments.
8. Individual counseling and/or psychotherapy.
9. Group psychotherapy.
10. Couples and/or family therapy.
11. Nutritional assessment.

(c) Other modalities which may be implemented when appropriate are:

1. ECT.
2. Behavior modification.

3. Pastoral counseling.
4. Health education.
5. Treatment based on Recreation Therapy Database and Leisure Assessment.

**(6) Discharge and Transfer Standards**

(a) **Standard.** Patients must be stable enough to be discharged or transferred to an available less intensive level of care.

(b) **Standard.** Patients must have attained maximum treatment program benefit.

(c) **Standard.** Patients must be transferred if another program better meets their treatment needs.

**(7) Space Criteria**

(a) **Standard.** All guidelines for patient privacy must be observed and be adequate to meet the needs of female as well as male patients.

(b) **Standard.** New or renovated nursing units must not exceed 30 beds in size.

(c) **Standard.** New construction and renovation of existing bed space must be based on no more than two beds per room.

(d) **Standard.** A unit should be composed of the following:

1. Day room.

**NOTE:** *A separate exercise KT (kinesiotherapy) clinic is an option.*

2. Examination room(s).

3. Office space on the ward to accommodate assigned staff.

4. A classroom, plus group and conference rooms (some of which may have multiple uses).

5. Nurses' station.

6. Two to four computer support spaces, depending upon staff needs, including terminals for patient interviews and testing.

7. Seclusion and/or quiet rooms (minimum 1).

8. Four to six single rooms.

9. Occupational therapy clinic. **NOTE:** *Due to safety and infection control standards, it is not recommended to use the clinic for multiple purposes.*

10. Environmental Management space.

11. Dirty and clean utility rooms.

12. Patient laundry facilities.
13. Recreation therapy clinic and kitchen.
14. Baggage storage.
15. Shaving room, lavatory, toilets, and showers.
16. Dining facilities.
17. Staff rest room and/or lounge.
18. Patient and/or family visiting area affording adequate privacy.

(e) **Standard.** Seclusion and quiet rooms to which patients may be directly admitted will be counted in the bed census. Those configured and used exclusively for control of disturbed patients already assigned a hospital bed shall not be counted in bed capacities.

(f) **Standard.** Nursing stations and observation areas must be arranged in a way that staff can observe patients in an efficient manner, preferably without glass or other physical barriers intervening that hinders communication with patients. **NOTE:** *Newly constructed nursing stations must not be completely enclosed by glass or other physical barriers.*

(g) **Standard.** Nurses must have adjacent, enclosed space for undisturbed charting, preparation of medications, or confidential conversations.

(8) **Staffing Guidelines.** The following staffing mix should be provided for a 30-bed unit.

- (a) Psychiatrist.
- (b) Internist, or physicians assistant, or nurse practitioner.
- (c) Social worker with a Master's Degree in Social Work.
- (d) Psychologist.
- (e) Recreation therapist.
- (f) Occupational therapist.
- (g) Kinesiotherapist.
- (h) Ward clerk.
- (i) Nurse specialist.
- (j) Chaplain.
- (k) Dietitian.
- (l) Substance abuse counselor.

(m) Nursing staff.

NOTE: *Staffing ratios may vary depending upon local circumstances.*

**c. Brief Stay Medical-Psychiatric Programs**

**(1) Patient Description**

(a) Most patients with combined medical and psychiatric problems can be treated on traditional psychiatric or medical wards using consultation as needed. The occasional patient who presents both acute medical and acute psychiatric illness creates special problems because neither the physicians nor nursing staffs in one setting are generally cross-trained sufficiently to be comfortable with both specialties nor is the physical setting appropriate.

(b) Examples of such patients are:

1. The suicidal psychiatric patient with a life threatening overdose problem.
2. The severely ill cancer patient who has become depressed and agitated.
3. The patient with a severe post-surgical psychosis.
4. The agitated patient with an organic brain disorder requiring rapid neuropsychological assessment.
5. The chronic schizophrenic in a psychotic exacerbation who has coexisting chronic pulmonary disease, diabetes mellitus or congestive heart disease.
6. The manic patient requiring medical treatment for sleep apnea.

(c) Other examples include psychiatric patients with medical conditions requiring intensive nursing care, such as:

1. Dependence upon nurses for feeding, transfers, and ambulation.
2. Time consuming treatments such as foot soaks.
3. Need for cleanup from frequent and unpredictable urinary and fecal incontinence.
4. Need for intravenous antibiotics.

(d) Another category is patients whose active psychosis, mania or paranoia is of such intensity that they must have psychotherapeutic and psychopharmacologic interventions to effect needed adequate medical treatment.

(e) A final category is patients with stable medical or neurologic residual and a reactive (or additional primary) psychiatric disorder whose special medical or neurological needs exceed the standard ward procedures on a psychiatric unit.

1. All these patients become most difficult on single specialty wards and are appropriate for this specialized program.

2. Examples are:

a. Aphasia.

b. Severe cognitive impairment.

c. AIDS (Acquired Immunodeficiency Syndrome) dementia.

d. Partial complex seizures with primarily psychiatric symptom presentation.

e. Higher rancho score traumatic brain injury patients.

### **(2) Program Description**

(a) The presence of significant numbers of patients presenting combined acute medical and psychiatric conditions suggest the establishment of a specialized Brief Medical-Psychiatric Treatment Unit. Recent literature suggests that such programs often function best when led by a psychiatrist working in close collaboration with internists or preferably by someone boarded in both specialties. A head nurse on such a unit should have interest, skills, and experience in both medicine and psychiatry. Such programs should select patients carefully and have discharge/transfer plans worked out ahead of time so that patients do not stay unnecessarily long on this intensive level of care.

(b) Consistent with projected need, Brief Medical-Psychiatric Treatment Units may be established at moderate to large medical centers capable of providing tertiary medical care consistent with the goals of this program. These units are also needed in predominantly psychiatric medical centers where patients are chronically and/or acutely psychiatrically ill, and at the same time have acute medical conditions requiring specialized care, such as trauma, CVA (Cardio Vascular Accident), diabetic crisis, or extended post-surgical care because of the patient's inability to participate or cooperate with care.

(c) As chronic mentally ill patients age, these exacerbations of chronic medical conditions or onset of new ones are expected to become more frequent. Smaller Psychiatric Services will also face the same needs and may need to combine the PICU, medical-psychiatric, and general psychiatric programs into one nursing unit.

### **(3) Goal and Objectives**

(a) The goal of this Brief Stay Medical-Psychiatric Program is to provide a setting for high quality care in selected VA medical centers to veterans with combined medical and psychiatric problems who are not able to be managed appropriately in existing settings. The program may be a resource for nearby VA medical centers as well as for the medical center itself.

(b) The primary objective of such a setting is to provide quality care using staff who have skills in both medical and psychiatric areas.

(c) The secondary objective is to maintain a brief stay philosophy with tight control over both admissions and discharge placements so that beds will be available for severely ill patients at all times.

(4) Admission Standards

(a) Standard. Patients must have medical problems sufficient to require medical hospitalization along with current psychiatric problems of sufficient severity to require close psychiatric supervision and treatment.

(b) Standard. Discharge options for applicants must be adequately developed prior to admission to the extent that placement problems do not threaten the short-term mission of the program.

(5) Treatment Standard

Standard. All treatment modalities and resources usually provided to and needed by patients treated on acute medical and acute psychiatric wards must be made available to patients on these units.

(6) Discharge and Transfer Standards

(a) Standard. Amelioration of medical and/or psychiatric condition must be achieved so that the patient can be treated on a general medical or psychiatric ward, or discharged to a less intensive level of care.

(b) Standard. The patient and/or patient's caregivers must understand both the medical and psychiatric follow-up plans and regimen.

*NOTE: The LOS on this unit should be under 21 days with transfers to psychiatric, medical or less intensive care settings as appropriate.*

(7) Space Standards

(a) Standard. All guidelines for patient privacy applicable on acute medical and acute psychiatric wards must be observed.

1. No unit should be operated in excess of 20 beds.

2. If unit is established by new construction, the number of beds per room must be limited to two.

3. For the occasional confused, wandering, or involuntary patients, the unit must be able to be secured.

(b) Standard. Except for rooms equipped for acute medical care, Brief Medical-Psychiatric units must have the physical and architectural features of a general psychiatric ward. A unit should include:

1. Rooms for patient groups including a day room.

2. Space and facilities for occupational and recreational therapy.

3. Conference space.

4. Group dining for patients.

5. A minimum of two examination rooms.

6. A minimum of two seclusion and/or quiet rooms.
7. Recreation therapy clinic space.

(c) **Standard.** Facilities must be adequate to support the care of bedridden, incontinent, and physically debilitated individuals. The following room features must be present:

1. Adjustable hospital beds.
2. Outlet for oxygen and suction and call buttons in at least 20 percent of beds.
3. Outlet for oxygen and suction in seclusion rooms, if they can be made tamper-proof.
4. Ability to support IV therapy or hyperalimentation.
5. Hand rails and handicap access for all areas.
6. Electronic arm or leg alarm bands, or similiar technology to notify staff if the confused patient attempts to leave the unit.
7. Call buttons in selected rooms.
8. One to three medical isolation rooms (can function as quiet room).
9. Female care capability.
10. Sinks for handwashing available in all bedrooms.

**(8) Staffing Guidelines**

(a) **Standard.** The basic nursing knowledge and skills needed for medical-psychiatric care must be present.

(b) Staffing for a 20 bed unit should include:

1. Psychiatrist
2. Internist.
3. Psychologist.
4. Occupational therapist.
5. Physical therapist.
6. Recreational therapist.
7. Ward clerk.
8. Social worker.
9. Nursing staff.

NOTE: *Staffing ratios may vary, depending upon local circumstances.*

d. **CEPC (Continued Extensive Psychiatric Care).** The CEPC, a long-term specialized high intensity psychiatric care program, is established for a relatively small but persistent group of psychiatric patients found primarily in the larger, predominately psychiatric medical centers who require a high intensity level of staffing and are too disruptive and unresponsive to remain for long on a general psychiatric ward, psychiatric intensive care unit.

**(1) Patient Description**

(a) Patients appropriate for CEPC are primarily those who require ongoing hospital level psychiatric care because their major psychiatric disorder has been refractory to treatment in the past, e.g., psychotic patients who continue to exhibit active assaultive, obstreperous and/or suicidal behavior despite extensive and varied therapeutic approaches.

(b) Appropriate patients also include those who have serious loss of control secondary to combined organic brain syndromes and psychoses, with or without other medical problems. Many of these patients can benefit from:

1. New therapeutic trials.
2. Attempts at resocialization.
3. Behavior therapies.
4. Rehabilitation.

(2) **Program Description.** CEPCs are specialized psychiatric programs designed to control targeted behaviors that are obstacles to placement in less intensive levels of care. They offer improved self-care, further therapeutic trials, and work toward more compliant social adjustment. CEPCs should be conceived of as referral programs for patients who have proved unmanageable or poorly responsive to treatment in other psychiatric treatment settings and may serve as a regional resource.

(3) **Goals and Objectives.** The goals and objectives of the CEPC are to provide a specialized, therapeutic environment for psychiatric patients who present with some of the most difficult, chronically disruptive behaviors.

(a) The goal is to provide care for these patients in a protected environment where a interdisciplinary treatment staff with special expertise can be assembled and where the physical environment can be appropriately structured to ensure the safety of staff and patients, while restricting these patients to the minimal degree necessary to manage their symptoms.

(b) The primary objective of the CEPC is to provide intensive monitoring and intervention, often over a protracted period, which will allow the patient to progress to the point where he or she can be returned to a less restrictive environment.

(c) The CEPC also contributes to the overall safety of the inpatient psychiatric environment at the facility, by segregating patients who are out of control from other patients who may be potential victims.

**(4) Admission Standards**

(a) **Standard.** Patients admitted to CEPC units must have failed to respond to treatment on general psychiatric programs.

(b) **Standard.** Patients admitted to CEPC Programs will be medically stable and not bedridden.

(c) **Standard.** Patients' behavioral state must preclude placement on less intensive long-term units. The behaviors may include assaultive and self destructive elements, as well as severe impairment of ADL (activities of daily living) skills.

**(5) Treatment Standards**

(a) **Standard.** Active treatment planning and interventions must be an integral part of the CEPC Program.

(b) **Standard.** Each patient must have a current written treatment plan which includes objectives for increased self-care and the reduction of inappropriate or disruptive behaviors.

(c) **Standard.** A interdisciplinary staff must provide a full-range of interventions including:

1. Psychopharmacologic treatment.
2. Group and targeted behavioral approaches, as appropriate.
3. Occupational, kinesiotherapy, and recreation therapy.
4. Other innovative approaches appropriate to this difficult patient population.

**(6) Discharge and Transfer Standards**

(a) **Standard.** Patients whose behavioral problem or psychiatric condition improves to a point where the environment of the CEPC Program is no longer necessary must be transferred to a less intensive or restrictive level of care, including community care.

(b) **Standard.** Patients who become medically unstable must be transferred to an appropriate medical or medical-psychiatric program.

(7) **LOS Planning Standard.** The range of LOS on CEPC units will vary considerably due to the treatment resistant nature of the patients' illnesses.

(a) **Standard.** LOS must be a function of the intensity and persistence of the patient's symptoms and will not be arbitrarily limited.

(b) **Standard.** Patients' potential for transfer to a less intensive level of care will be reviewed at least every 30 days.

(8) Space Standard

**Standard.** The space requirements prescribed for the general (acute) psychiatric units must be applied to CEPC wards.

(9) Staffing Guidelines

(a) **Standard.** There must be sufficient staffing of the proper mix to ensure that the expected behavioral disruptions can be safely and adequately managed.

(b) **Standard.** All staff must have training or specialized experience in the evaluation, treatment, management and control of the chronically disturbed and disruptive patients (e.g., management of assaultive behavior training).

(c) **Standard.** The level of staffing must permit close monitoring and intensive intervention for each patient on the unit.

(d) **Standard.** Staffing must include:

1. Psychiatrist.
2. Internist, physician's assistant, or nurse practitioner.
3. Psychologist and/or psychology technician.
4. Social worker.
6. Clinical nurse specialist.
7. Nursing staff.
8. Occupational therapist.
9. Kinesiotherapist.
10. Recreation therapist.
11. Ward clerk.

**NOTE:** *Staffing ratios may vary depending on local circumstances.*

**2. STAR (SUSTAINED TREATMENT AND REHABILITATION) UNITS**

The essence of this level of care is its emphasis on sustained treatment and rehabilitation for varied groups of patients who have failed to achieve sufficient recovery in 90 days to be discharged but who still require a higher level of staffing and support than found in nursing homes, domiciliaries, or other residential or treatment resources. Staffing levels within this new level of care vary considerably but are generally not as resource intensive as required in a high intensity setting. Education of staff and caregivers regarding appropriate and realistic expectations of the patients' abilities, and practical suggestions for modifying the environment to maximize patients' functioning must be a prominent component of the STAR patient education effort.

**a. Long-Term Medical-Psychiatric Unit (STAR I)**

**(1) Patient Description**

(a) Patients include many of those currently on intermediate medicine wards, those formerly designated PMI (Psychiatric and Medically Infirm), and those who may require indefinite LOS with the goal of enhancing quality of life and augmenting acceptable levels of behavior rather than that of rapid discharge to the community. These patients have medical, neurological, and psychiatric disorders that interact in such a way as to make care in traditional long-term psychiatric or medical programs (including traditional nursing homes) difficult or impossible. This difficulty occurs because these patients need more intensive medical care than personnel on long-term psychiatric wards are trained and staffed to provide and because they are so disruptive or psychiatrically disturbed that they cannot be maintained in long-term programs for the medically infirm.

(b) Placement may have failed in VA domiciliaries, psychiatric nursing homes, shelter homes, half way houses, etc., because the patient's medical condition has deteriorated. Alternatively, placement may have failed in more medically oriented programs such as intermediate care, traditional nursing homes, intensive outpatient medical follow-up, etc., because of the patient's behavioral and/or psychiatric disturbance.

*NOTE: Psychogeriatric patients may be appropriate.*

**(2) Program Description**

(a) STAR I Programs will provide care for patients with various combinations of chronic psychiatric and medical illnesses. Because of the broad range of medical and psychiatric needs, the units must have the capability to provide treatment, care, and safety for both moderately physically active, psychotic patients and those who are semi-bedridden and/or confused.

(b) STAR I units must have the capacity to manage involuntary patients and protect them from harming themselves and others while they are receiving medical and psychiatric treatments. Transfers of patients from existing intermediate care or long-term psychiatric wards as well as admissions from higher intensity wards is anticipated.

(c) The unit may be part of a psychogeriatric program.

**(3) Goals and Objectives.** The goals and objectives are to:

(a) Provide a setting for patients with mixed, chronic, medical and psychiatric problems who do not need high intensity medical or psychiatric care.

(b) Provide a safe, supportive environment for patients who are unable to cooperate with needed voluntary medical treatment because of their severe psychiatric disturbance.

(c) Provide an emphasis on "quality of life" rather than rapid symptom amelioration and discharge.

(d) Provide a safe, appropriate, long-term placement for patients with degenerative neurological disorders such as Huntington's or Alzheimer's disease during the phase of active wandering and/or belligerence.

**(4) Admission Standards**

(a) **Standard.** Patients admitted to long-term medical-psychiatric units must have:

1. Significant medical problems where treatment is complicated by psychiatric and/or behavioral disturbances such as severe COPD (chronic obstructive pulmonary disease) with a psychosis poorly responsive to treatment.
2. Post-stroke patients with debilitating, non-responsive depression.
3. Deteriorating Huntington's disease patients.
4. Alzheimer's patients with significant medical and behavioral problems.

(b) **Standard.** To be accepted, patients must have been thoroughly assessed both medically and psychiatrically by the referring facility or unit. This assessment will contain specific recommendations for goals and objectives in both the medical and psychiatric treatment of these patients.

1. Interdisciplinary assessment and planning will include development of both medical and psychiatric treatment goals.
2. The treatment plan should contain specific measurable goals and objectives in medicine and psychiatry toward which treatment is directed.

**(5) Treatment Standards**

(a) **Standard.** Initial assessment by a interdisciplinary team (including medical, rehabilitative, and psychiatric evaluations) will occur on admission to establish or review treatment plans and goals addressing the patients' psychiatric and medical problems.

(b) **Standard.** Regular review of the medical and psychiatric components of the treatment plan and patients progress will occur as appropriate to maintain quality of care.

(c) **Standard.** Innovative approaches to promote quality of life and as much autonomy and self esteem as feasible for these patients will be pursued vigorously. Patients will be treated in the least restrictive manner as permitted by their ability to cooperate and participate in their care.

**(6) Discharge and Transfer Standards**

(a) **Standard.** If stability of the medical and/or psychiatric condition has been achieved, patients must be discharged or transferred to a less restrictive environment or a setting with a lower intensity of care.

(b) **Standard.** If necessary, due to acute medical or psychiatric decompensation, patients must be transferred to a more intensive medical or psychiatric level of care.

NOTE: *No predefined lengths of stay standards are appropriate for these units.*

**(7) Space Standard**

**Standard.** Space will have to be in full compliance with VA, JCAHO (Joint Commission on Accreditation of Healthcare Organizations), and MHM (Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services) standards for long-term psychiatric wards.

**(8) Staffing Guidelines**

**(a) Standard.** The intensity of nursing care may be less than expected in the CEPC Program but higher than other STAR units. Nursing care must be based:

1. On patient requirements for nursing care.
2. Patient and family needs for education.
2. Activities of daily living skills training.
4. Education for self medication.
5. The need for supportive psychotherapy.

**(b) Standard.** Nursing staffing levels must be based on the VA Nursing Staffing Guidelines and staff must be required to have skill in both psychiatric and medical nursing.

**(c) Standard.** Interdisciplinary team work must be standard practice for staff who work with these multiply disabled patients.

1. Active involvement of physicians representing psychiatry and medicine (and other specialties as appropriate) will be established at a level appropriate to the numbers of patients treated and the complexity and type of disorders treated such that quality care is delivered.

2. Professionals such as psychologists, social workers, specialists and therapists in the various aspects of rehabilitative medicine will be involved as dictated by the needs of the patients treated.

3. Staffing levels necessary for assessment, treatment, and evaluation in recreation therapy will be provided at a level consistent with identified patient needs and requirements of the JCAHO.

**b. Community Reentry Rehabilitation Care (STAR II)**

**(1) Patient Description**

**(a)** STAR II level of care is appropriate for chronically ill psychiatric patients who are judged to have potential for discharge following an intensive psychological, social, and vocational evaluation, and functional skills training program.

(b) These patients may have adjusted to the hospital environment but have marked deficits in social-functional skills and poor judgement. These patients have accrued sufficiently long LOS in institutions such that skills training cannot be completed within a 90 day period and may take up to a year. These patients should have no significant medical problems that would prevent outplacement and have low projected risk of dangerous behavior in the community.

**(2) Program Description**

(a) STAR II Programs must provide an intensive psychosocial, vocational, and functional skills training program for chronically ill psychiatric patients who are judged to have the potential for discharge. The treatment emphasis of the STAR II Programs should be on providing various learning experiences adequate to prepare patients for reentry as community residents.

(b) The STAR II Program should be guided by the major principle that patients can learn to exercise personal responsibility towards achieving the highest level of functioning possible in a mutually supportive atmosphere. The emphasis should be on patient self-help and self-care as opposed to staff caregiving.

(c) The STAR II Program must be characterized by maximum patient participation in:

1. Patient government.
2. Self maintenance of the living area.
3. Decision making about goal achievement.
4. Progress within the unit and movement to other levels of care.

(d) Other models may be developed to fit local conditions directed towards the same therapeutic goals.

(3) **Goal.** The goal of STAR II programs is to provide a treatment, rehabilitation, and training program that will increase the possibility for selected long-term psychiatric patients to move to a lower level of care in community settings.

**(4) Admission Standards**

(a) **Standard.** Patients admitted to STAR II programs must require care or treatment within the scope of the program's goals and objectives.

1. Patients must have a history of continuous hospitalization or repeated readmission to acute psychiatric care within the preceding 2 years, or failure to achieve treatment goals within the time limits of psychiatric intermediate care.

2. The patients' conditions must be characterized by deficits in social-functional skills and/or poor judgment which at the time of referral requires an active program of treatment and monitoring.

3. Patients' medical and behavioral problems must be stabilized to the extent that patients could participate in program activities without requiring care or treatment beyond the scope of the program.

4. Patients must be assessed to have potential for management in the community or in a less restrictive environment.

(b) **Standard.** To be accepted for STAR II Programs, patients must have been thoroughly assessed medically, psychiatrically, socially, and psychologically by the referring facility or unit.

1. This assessment must contain specific recommendations for the further treatment of these patients and demonstrate some reasonable evidence that these patients will be able to progress in the accepting program.

2. These patients must have demonstrated capacity to participate in developing and implementing their treatment plans.

(5) **Treatment Standards**

(a) **Standard.** Patients must receive sufficient treatment, education and training directed toward living in a less restrictive environment or facilitating reentry into the community.

1. A written interdisciplinary assessment of the patient must document the patient's potential for discharge or management in a less restrictive environment after an intensive social-functional skills treatment and training program.

2. The treatment plan will include criteria for evaluating patient progress as a result of participating in education and treatment activities.

3. The treatment plan will reflect the patient's participation and agreement.

4. Patient treatment must include education and training in behavioral and social skills.

5. Patients must receive ongoing evaluation and training in performing specified tasks, such as vocational skills, when appropriate.

6. Patients must receive evaluation and treatment directed toward improving functional, self-care living skills.

7. Patient treatment must include a leisure skills development and community reentry component.

(b) **Standard.** The STAR II unit must have the capacity to conduct home and work-site evaluation in the community.

(c) **Standard.** The STAR II unit must have available, but not be limited to, the following treatment modalities:

1. Psychopharmacological treatment with emphasis on self-medication and compliance.

2. Training in self-care skills as dressing, cleaning, and self-medication.
3. Group therapy on focused problem solving.
4. Social skills training.
5. Individual and/or family therapy.
6. Occupational therapy.
7. Incentive therapy.
8. Prevocational and vocational assessment of aptitudes, interests, and personality.
9. Vocational counseling.
10. Vocational skills training (i.e., job seeking, job applications completion, job interviews, task performance evaluation, etc.).
11. Recreation Therapy, including leisure education.
12. Kinesiotherapy including counseling in the maintenance of good physical conditioning before and after community reentry.

(d) Modalities of treatment which may be implemented when appropriate are:

1. Vocational rehabilitation therapy (formerly manual arts therapy) by therapists with certain talents in:

- a. Vocational skills evaluation.
  - b. Prevocational training and guidance.
  - c. Expertise in home maintenance skills for independent living and community reentry.
2. CWT (Compensated Work Therapy).
  3. Educational therapy.

**(6) Discharge and Transfer Standards**

(a) **Standard.** Discharge planning must be an integral part of the initial and ongoing treatment plan. Assessment of the readiness for discharge should include but is not limited to the following:

1. The degree to which the patient has achieved the goals and objectives established by the treatment plan.
2. The nature, extent, and availability of after care services required.
3. The availability of a community living environment appropriate to the patient's functional level.

4. The availability of financial resources sufficient to defray the cost of the plan.

(b) **Standard.** The patients must be discharged or transferred when treatment goals have been achieved. This will ordinarily occur in less than 1 year.

(c) **Standard.** Patients must be transferred to an appropriate level of care when medical and/or behavioral status plateaus at a level which does not permit discharge.

(d) **Standard.** Patients developing medical or psychiatric problems too severe for management on the STAR II unit must be transferred to appropriate other programs for treatment.

**(7) LOS Standards**

(a) **Standard.** LOS on STAR II units, except in documented unusual circumstances, will be limited to 1 year.

(b) **Standard.** LOS will be reviewed at a minimum of every 90 days.

(c) **Standard.** LOS extension beyond 1 year will be in 30 day increments, each of which must be justified in writing by the attending physician.

**(8) Space Standards**

(a) **Standard.** The STAR II unit should be limited to 30 beds.

(b) **Standard.** The physical environment of STAR II programs must meet all applicable VA and JCAHO standards for psychiatric ward areas.

1. The physical environment for STAR II units must be organized to contribute to the long-range goal of deinstitutionalization.

2. The environment must approximate a community living situation as much as possible, given the building structure and the need to maintain psychiatric care standards.

3. Ample recreational space and space where patients can be quietly reading and doing other solitary activities must be incorporated into the space plan.

4. Sleeping rooms must allow for personalization of the area by the patient.

(c) **Standard.** Sufficient space for program elements, such as community meetings, interview rooms, group therapy and/or other group activities, staff meetings, teaching/classroom space, etc., must be provided.

(d) **Standard.** For affiliated programs where active training of mental health professionals occurs (psychiatric residents, psychology interns, social work and occupational therapy students, etc.), adequate office and classroom space must be provided.

**(9) Staffing Standards**

(a) **Standard.** Staffing must be adequately represented by the core mental health professionals to care for the number of patients.

(b) **Standard.** There must be adequate program staffing or sufficient resources available at the medical center to provide services listed under Treatment Standards.

(c) **Standard.** Staffing levels must reflect the severity of patients' psychiatric symptoms and behavioral disorders. In general, these patients are currently less severely psychiatrically disturbed than those cared for in intensive or intermediate care psychiatric units, but more so than those in nursing homes or Domiciliary Programs.

(d) **Standard.** Program leadership must be selected on an interdisciplinary basis among the core mental health professions. Selection must be made based on best available skill, experience and talent.

**c. Skilled Psychiatric Nursing Unit (STAR III)**

(1) **Patient Description.** Patients are admitted to this unit with chronic, refractory, partially stabilized, major psychiatric or organic brain disorders. Characteristically, these patients:

(a) No longer can use intensive treatment and are not actively suicidal or chronically assaultive.

(b) Are medically stable.

(c) Have impaired judgment and disruptive and uncooperative behaviors which make them unsuitable for placement in VA or community nursing homes or other programs within the community mental health systems.

(d) Are often unable to remain safely in an open or unrestricted setting.

**(2) Program Description**

(a) STAR III units provide ongoing care and rehabilitation for patients with chronic psychiatric illness. First admission to these units generally follows at least 90 continuous days in a more intensive treatment setting. Many are admitted under an involuntary legal status because of their unwillingness or inability to remain in treatment voluntarily, and the settings are generally securable.

(b) The distinction between STAR II and STAR III is the option in STAR III for a securable setting, a lower expectation for discharge and higher emphasis on psychiatric nursing rather than rehabilitation care. Unlike the CEPC, the STAR III unit is not designed to treat patients who are actively suicidal or chronically assaultive. The STAR III Programs do not offer the medical expertise present in STAR I.

(3) **Goals and Objectives.** The goals and objectives of the STAR III unit are to provide long-term care for chronic, refractory patients in a secure and therapeutic environment.

(a) The goal for all patients is to improve their quality of life and their general level of functioning. This includes rehabilitation objectives directed towards increased self-care and a reduction of inappropriate behaviors.

(b) An objective of the unit is to continue the patient's treatment and rehabilitation, with the long-term goal of placement into a less restrictive setting including community residential care or community living.

**NOTE:** *Originally uncooperative patients may decide to participate in more active treatment and be transferred to an intensive, intermediate, or STAR II level of care.*

**(4) Admission Standards**

(a) **Standard.** Patients must be medically stable and not bedridden.

(b) **Standard.** Patients must have chronic, refractory, partially stabilized major psychiatric or organic brain disorders.

(c) **Standard.** Patients must not currently exhibit significant assaultive or self-destructive behavior.

(d) **Standard.** Patients must currently exhibit only minimal discharge potential.

**(5) Treatment Standards**

(a) **Standard.** Each patient shall have a current written treatment plan which includes objectives for increased self-care and reduction of inappropriate behaviors.

(b) **Standard.** An interdisciplinary staff must provide a full range of interventions including:

1. Psycho-pharmacological treatment.

2. Psychological and social assessment.

3. Group and individual rehabilitative approaches as appropriate to this patient population in a low demand environment.

4. Skilled psychiatric nursing care.

5. Other innovative approaches appropriate to a chronic, refractory patient population.

(c) **Standard.** Treatment planning must address the positive improvement of the quality of life for the patients.

**(6) Discharge or Transfer Standards**

(a) **Standard.** Patients who become medically unstable must be transferred to an appropriate medical unit or Medical-Psychiatric Program.

(b) **Standard.** Patients whose behavioral problem or psychiatric condition improves to the point where STAR III level of care is no longer necessary should be transferred to a less intensive or restrictive level of care (e.g., STAR II, Domiciliary, Nursing Home Care Unit, Community Residential Care).

(c) **Standard.** Patients whose psychiatric condition deteriorates to the point where they cannot be safely or effectively managed on the STAR III unit must be transferred to a psychiatric program with a higher intensity of care.

(7) **LOS Standards**

(a) **Standard.** The LOS on STAR III units will be reviewed, at a minimum, every 90 days.

(b) **Standard.** Appropriate patients must be returned to a general treatment setting annually for reevaluation of treatment potential.

(8) **Space Standards**

(a) **Standard.** The unit size should be limited to 30 beds.

(b) **Standard.** The physical environment of STAR III programs must meet all applicable VA and JCAHO standards for long-term psychiatric ward areas.

(c) **Standard.** The physical environment for STAR III units must be organized to contribute to the long-range goal of deinstitutionalization.

1. The environment must approximate a community living situation as much as is possible, given the building structure and the need to maintain full psychiatric care facilities.

2. Ample recreational space and space where patients can be quietly reading and doing other solitary activities must be incorporated into the space plan.

3. Sleeping rooms must allow for personalization of the area by the patient.

(d) **Standard.** Sufficient space for program elements such as community meetings, group therapy and/or other group activities, staff meetings, teaching/classroom space, etc., must be provided.

**NOTE:** For those affiliated programs where active training of mental health professionals occurs (psychiatry residents, psychology interns, social work students, etc.), adequate office and classroom space will need to be taken into account.

(9) **Staffing Standards**

(a) **Standard.** Staffing for STAR III units must be adequate to conduct an active treatment and rehabilitation program for the patient population. Staffing ratios are generally less than other STAR programs.

(b) **Standard.** The interdisciplinary staff servicing the STAR III unit should include:

1. Adequate psychiatric and nursing care to meet the needs of the patient mix.
2. Occupational therapists necessary to maintain an active therapeutic program.
3. Sufficient recreation therapists to maintain a therapeutic recreation program.
4. Social work staff to meet the patient and family needs.

### 3. GENERAL PROGRAM STANDARDS

#### a. Program Evaluation

**Standard.** Program evaluation must be an integral part of the management of all psychiatric care activities.

#### b. Quality Management

(1) **Standard.** The monitoring of the quality of patient care must be an integral part of all psychiatric care activities.

(2) **Standard.** A qualified person must organize and manage the Psychiatric Care Quality Management Program.

(3) **Standard.** The care provided in this program must meet the standards of JCAHO.

(4) **Standard.** The quality assessment activities of the Integrated Psychiatric Care Program must be included within the overall quality management plan of the psychiatric service.

#### c. Education

**Standard.** Education activities for all psychiatric care workers must be integrated with the facility's educational efforts for professional staff.

**NOTE:** *In affiliated medical centers, appropriate clinical staff should have faculty appointments.*

d. **Research.** All units on the psychiatric continuum of care are encouraged to participate in research, with particular emphasis on the development of innovative treatment approaches specific to the patient population defined by their program and mission.

### 4. OTHER LEVELS OF CARE

a. Other levels of care are described in M-2, part X, chapter 3. They are:

- (1) Brief Stay Psychogeriatric Programs.
- (2) Brief Substance Abuse Treatment Programs.
- (3) Brief Stay and/or Respite Psychiatric Care Programs.

- (4) Intermediate Psychiatric Care Programs.
  - (5) Mental Health Sections in VA Nursing Home Care Units.
  - (6) Mental Health Programs in VA Domiciliaries.
  - (7) Residential Bed Care Programs.
  - (8) Outpatient and Community-Based Care Programs.
  - (9) Psychogeriatric Programs.
- b. Currently, there are no standards and criteria for these programs.

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**

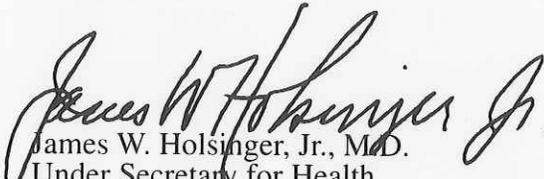
**Remove**

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

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PUBLICATIONS AND  
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July 26, 1991

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-9, "MEDIPP," which is changed to M-9, "Strategic Planning."

2. Principal reason for this manual change is to delete the term "MEDIPP":

a. In chapters 1 through 11, delete the term "MEDIPP" and replace it with "Strategic Planning."

b. Changes to all M-9 chapters are in process to update to current procedures.

3. Filing Instructions:

Remove pages

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Cover page through iv

Cover page through iv

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

Distribution: RPC: 1318  
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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.

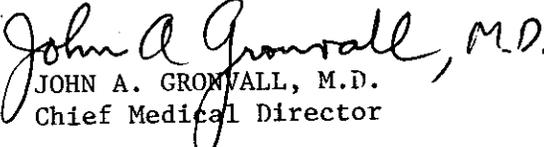
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

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  
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Printing Date: 10/89



Veterans Administration

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REMARKS

SUBJ: Departmental Manual M-9

1. In DM&S Supplement MP-1, Part II, Changes 35 dated November 13, 1984, the title of M-9 is "Medical District Initiated Program Planning."

2. This is to request that the title of this manual be changed to:

*"Planning and Evaluation and Systems Development"*

We expect to be submitting a number of items to be included in this manual during the coming year.

3. Thank you for your assistance.

Approved  Disapproved

*John W. Ditzler*  
JOHN W. DITZLER, M.D.  
Chief Medical Director

*2-3-86*  
Date

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FROM

*Marjorie R. Quandt*  
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications  
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3331

VA FORM 3230  
MAY 1980

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



Veterans  
Administration

# Memorandum

APR 03 1984

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

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

Subj: Establishment of M9-MEDIPP

1. Request permission to establish a new manual (M9-MEDIPP) to formalize MEDIPP (Medical District Initiated Program Planning) as a permanent DM&S Policy.
2. MEDIPP has in its two year cycle become an effective mechanism for DM&S planning purposes. MEDIPP has become the management tool providing comprehensive information directly from the medical districts. This allows prudent decision making in order to meet the health care veterans needs of the 1990's and beyond.
3. The '84 MEDIPP Planning Guidance has been reviewed and concurred in by appropriate program offices, therefore, in order to expedite the process, I would recommend that Volume I: Medipp Purpose, Structure, and Process and Volume II: Plan Development, of the '84 MEDIPP Planning Guidance be accepted as the M9-MEDIPP Manual without further circulation. (Appropriate formatting would be instituted.) I anticipate no changes to these two volumes in the near future.

Volume III: Needs Assessment Methodology and Volume IV: MEDIPP Reference Documents will by necessity be revised annually and will therefore have to be issued annually as a CMD Circular.

4. It is timely that M9-MEDIPP be developed in order to firmly establish its important place in DM&S as a consistent, and permanent policy.

*Murray G. Mitts M.D.*  
MURRAY G. MITTS, M.D.

*Donald L. Custis*  
DONALD L. CUSTIS, M.D.  
Chief Medical Director (10)

Approve   
~~Disapprove~~

*4/17/84*  
Date