

**Manual M-9, Strategic Planning**

**(Veterans Health Administration)**

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

**Appendix 9A, Criteria and Standards for VA Domiciliary Program  
Annotated to reflect Change 2, dated July 26, 1991**

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)

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Text for Appendix 9A, dated **October 2, 1989**

Transmittal sheets located at the end of the document:

Change 14, dated **January 28, 1993**  
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Transmittal sheets for changes prior to 1989 also located at the end of the document:

Reference Slip, dated **January 27, 1986**  
Memorandum dated **April 3, 1984**



Department of  
Veterans Affairs

# Strategic Planning

July 26, 1991

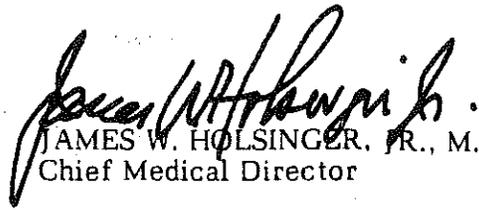
Veterans Health Administration  
Washington DC 20420

Department of Veterans Affairs  
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Veterans Health Administration  
Washington, DC 20420

July 26, 1991

Department of Veterans Affairs, Veterans Health Administration Manual M-9, "Strategic Planning," is published for the information and compliance of all concerned.

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

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## RESCISSIONS

The following material is rescinded:

Complete rescissions:

### Circulars

10-87-113 and Supplement No. 1  
10-87-147  
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## CRITERIA AND STANDARDS FOR VA DOMICILIARY PROGRAM

### 1. BACKGROUND

Historically, the domiciliary program is the oldest of VA's health care programs. Initiated through legislation passed in the late 1860's to provide a home for disabled volunteer soldiers of the Civil War, domiciliary care has undergone many changes. It has evolved from a "Home" to VA's least intensive clinical care inpatient program providing a range of rehabilitative services planned to maximize the independent functioning of each veteran to the extent possible. Most accurately described today as a clinically appropriate, multi-dimensional, cost-effective alternative to the unwarranted utilization of more intensive and more costly levels of inpatient care, the domiciliary is certainly no "Old Soldier's Home" anymore.

### 2. INTRODUCTION

a. Criteria and standards for VA domiciliary program have been developed to meet the program planning needs of VA facilities, districts, and regions and for use by VA Central Office in the uniform review of VA domiciliary program MEDIPP proposals. A criterion is defined as "a measurable characteristic of a health service." A standard is defined as "a quantitative and/or qualitative value or level of achievement with respect to a specific criterion which represents acceptable performance."

b. The criteria and standards for VA domiciliaries will be reviewed by VA Central Office periodically and revised as necessary based upon further analysis and experience with their use. It is recognized that in certain circumstances local conditions may exist which justify deviations from these standards. Such deviations will be reviewed by VA Central Office on a case-by-case basis when accompanied by quantitative information justifying the need for the proposed MEDIPP action.

NOTE: The term "must" is used throughout the document to indicate what is mandatory. The term "should" is used to reflect preferred practice, yet allows effective alternatives to be used.

### 3. SYSTEMWIDE AVAILABILITY

a. When planning for VA domiciliary programs, domiciliaries are to be considered a district resource, i.e., every district must plan to have a VA domiciliary within its district or assure that its patients have access to one in an adjacent medical district.

b. The proposed rehabilitative component as described in the criteria and standards is an upgrade of the existing VA domiciliary program. Medical centers and regions are permitted to fund the upgraded rehabilitation component at their discretion from within local resources or to seek additional funding through MEDIPP in competition with other proposals.

### 4. DEFINITIONS

a. **VA Domiciliary Program.** Represents that segment of VA health care continuum which provides rehabilitative and long-term health maintenance care for veterans who require minimal medical care. The domiciliary is also viewed as being an ideal setting for the provision of health care and related services to eligible homeless veterans.

Domiciliary patients are most often found to be ambulatory and do not require the level of clinical intervention or observation routinely provided to nursing home patients. It provides a full range of rehabilitation services for patients who do not require bedside nursing care. It provides a semi-structured, therapeutic environment, while providing optimal opportunities for community interaction both inside and outside the institution.

b. **Minimal Medical Care.** That level of care which offers a degree of clinical intervention and therapeutic structure that is greater than community residential care but less than nursing home or extended hospital based psychiatric care. VA domiciliary care has often been described as the least intensive level of VA inpatient care. For medical and legal criteria for admission to VA Domiciliary refer to VA Domiciliary Care Program Extended Care Manual, M-5, part IV, chapter 5, paragraph 5.03.

c. **Rehabilitation.** Physical, psychosocial, vocational, and behavioral interventions or activities required to bring the patient to optimal levels of functional independence and health while seeking to provide an optimal quality of life.

d. The domiciliary provides two distinct types of rehabilitation care:

(1) **Active Biopsychosocial Rehabilitation.** Those clinical interventions and services required to effect, to the extent possible, remediation of physical, mental health, and social impairments essential to the restoration of the patient to an optimal level of functional independence and health.

(2) **Long-Term Health Maintenance Care.** Those clinical interventions and services required to prevent or delay, to the extent possible, those degradations in functional status that would, if unchecked, be expected to result from the progression of chronic disease. In this type of care, patients are permitted and encouraged to live in noninstitutional settings during periods of remission. It is important to note that long-term health maintenance must involve active, ongoing health service delivery. Each long-term patient must be assigned to a treatment team and must have appropriately developed treatment and discharge plans.

## 5. GOALS AND OBJECTIVES

Goals and objectives of the two models of VA domiciliaries:

a. **Rehabilitation Model (40-100 beds).** A minimum size of 40 beds is considered appropriate for this model, fewer than 40 beds would not be cost-effective based on the need for certain core staffing. These VA domiciliaries should concentrate on the provision of active biopsychosocial (see Definitions) and vocational rehabilitation care. To the extent possible, long-term health maintenance patients should be referred to the larger multi-purpose domiciliaries.

The primary objective of this domiciliary program is to identify all treatment needs, provide treatment of relatively short-term duration, transfer patients for health maintenance care or outplace them with necessary support networks for successful community integration.

b. **Rehabilitation and Health Maintenance Model (over 100 beds).** Based on professional judgment and past experience with existing domiciliaries, a size of over 100 beds is considered appropriate for this model. These VA domiciliaries should provide both active biopsychosocial and vocational rehabilitation care and long-term health maintenance care.

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

*NOTE: As evidenced by Public Law 100-71, Congress has recognized a need to care for homeless veterans and to ameliorate the causes of their homelessness. Both domiciliary models are considered appropriate for the homeless veterans.*

#### 6. CRITERION - LOCATION OF VA DOMICILIARIES (BOTH MODELS)

a. Standard: Consistent with projected need, domiciliary care services when possible should be established at urban medical centers where:

(1) Patients would have ready access to a full range of ambulatory and consultative hospital-based programs (in-house or community) as identified in *SERVICES*.

(2) More than one of the services (e.g., residential care, boarding homes, low income housing, halfway houses, or similar referral resources) are available in the community with demonstrated capability to accommodate outplacements from the domiciliaries, and

(3) Reasonable access to transportation systems is available to enhance referrals from other VA facilities within the district and outside the district.

b. Rationale. Domiciliary patients require ready access to a full range of clinical and supportive services.

#### 7. CRITERION -- AVERAGE OCCUPANCY/TURNOVER RATE FOR PLANNING PURPOSES

a. Standard. VA domiciliaries (both models) should be planned with the assumption of an average occupancy rate of at least 85 percent for short-term or 95 percent for long-term.

b. Standard. The average patient turnover for two different levels, i.e., Active Biopsychosocial Rehabilitation and Long-Term Health Maintenance Rehabilitation should range between 15 to 20 percent and 5 to 8 percent per month, respectively.

c. Rationale. A higher turnover rate than the current rate of approximately 10 percent (due to decreasing average length of stay of patients) in VA domiciliaries would increase the dynamic capacity of current and future facilities.

#### 8. CRITERION -- THERAPEUTIC PROGRAMS

a. Standard. VA domiciliaries (both models) must utilize a broad range of therapeutic modalities, professional disciplines and experience drawn from specialized clinical care programs. Program activities must include, but not necessarily be limited to:

(1) Outreach. Identification and development of effective linkages between domiciliary staff, medical center personnel and community-based services and programs.

(2) Screening. Screening for appropriate placement.

(3) Biopsychosocial Services. To develop patients' social, vocational, and daily living skills essential to successful transition to community living while achieving medical or behavioral stabilization of illness.

(4) Outplacement. Coordination and utilization of community-based social and health support services, housing, employment, education and training, supplementation of income, etc.

(5) Aftercare. Provision of VA services (such as VA outpatient care, VA residential care, etc.) are essential to the success of community living arrangements where needed services are not available through community-based organizations. Provision of crisis intervention services where indicated.

(6) In addition to the services listed above the long-term health maintenance services must be provided at the large (over 100 bed) domiciliary unit.

b. Standard: It is expected that each VA domiciliary will offer programs necessary to the satisfaction of identified health care needs of the patients. Services and programs may vary in accordance with domiciliary patient treatment needs. The therapeutic programs listed below are examples of a range of clinical activities that are offered at existing domiciliaries:

- Audiologic/Speech Rehabilitation
- Cardiac Rehabilitation
- Pulmonary Disease Rehabilitation
- Head Trauma Rehabilitation
- Patient Health Education
- Physical Fitness
- Therapeutic Recreation
- Vocational Assessment, Training, Placement
- Pharmacologic Therapy (covers medications prescribed by Internal Medicine for COPD, Diabetes Mellitus, etc., as well as psychotropic medications).
- Prosthetic Rehabilitation
- Psychiatric/Psychosocial Behavioral Treatment and Rehabilitation
  - Programs, including:
    - Behavior Modification
    - Biofeedback
    - Compensated Work Therapy
    - Educational Therapy
    - Incentive Therapy/Compensated Work Therapy
    - Independent Living Skills
    - Individual and Group Psychotherapy
    - Resocialization Therapy
    - Sobriety Maintenance
    - Stress Management
- Substance Abuse Rehabilitation
- Validation Therapy
- Neurological Rehabilitation Programs, e.g., Stroke Recovery

c. Some domiciliaries have experienced significant success in the development of innovative, domiciliary based programs designed to meet specialized needs of some patient population subgroups. Some examples are: lithotripsy patients, oncology patients, and patients requiring institutional support during periods of pre-hospitalization, evaluation, and assessment as well as post-hospital treatment and rehabilitation.

d. A more comprehensive listing of therapeutic programs and activities is presented in the Domiciliary Care Program Guide, G-1, M-5, Part IV, June 13, 1985.

e. Rationale: Therapeutic programs are needed to restore patients to the highest level of functional independence.

## 9. SERVICES

a. Standard: Consistent with the Domiciliary Care Program Extended Care Manual M-5, part IV, chapter 5.07, the following comprehensive range of services must be available (in-house, community, or from nearby VA medical centers) to VA domiciliaries:

- Ambulatory Care Services
- Audiology and Speech Pathology Service
- Chaplain Service
- Dental Service
- Dietetic Service
- Laboratory Service
- Library Service
- Medical Administration Service
- Medical Service
- Neurology Service
- Nuclear Medicine Service
- Nursing Service
- Optometry Service
- Pharmacy Service
- Podiatry Service
- Prosthetic Service
- Psychiatry Service
- Psychology Service
- Radiology Service
- Recreation Service
- Rehabilitation Medicine Service
- Social Work Service
- Surgical Service
- Voluntary Service
- Indirect services such as Building Management, Engineering,  
Canteen Service, etc.

b. Rationale: From past experience with VA domiciliaries it has been noted that the services listed above are most often needed for comprehensive domiciliary care.

## 10. CRITERION -- STAFFING GUIDELINES

a. Standard: Every VA domiciliary (both 40-100 bed and over-100 bed models) must use an interdisciplinary team approach to treating patients. Treatment team members

should represent Medicine, Recreation, Psychiatry, Nursing, Social Work, Psychology, Rehabilitative Medicine, Chaplain, Dietetics, Medical Administration, Domiciliary Operations, and consultants based on the individual needs of the patient. The team composition may vary from patient to patient.

b. For details of team philosophy and its approach refer to the Domiciliary Care Program Guide, G-1, M-5, part IV, paragraph IV-A & B.

c. Rationale: The successful identification, selection and treatment of patients in the domiciliary program and their return to independent community living is largely dependent upon the knowledge, skills, and abilities of an interdisciplinary team of health care professionals who base their treatment decisions on a thorough understanding and evaluation of the needs, abilities, and resources of each individual patient.

d. Guidelines: The following represents minimal direct care staffing requirements for a 40-60 bed VA domiciliary:

*Physician e.g., internist, neurologist, psychiatrist, etc. ....	1.00 FTEE
Dentist .....	0.25 FTEE
**Nurse (NP/PA) (RN/LPN) .....	2.00 FTEE
Rehabilitation Medicine Therapist .....	6.40 FTEE
Rehabilitation Technician .....	1.00 FTEE
Psychologist .....	2.00 FTEE
Social Worker .....	1.00 FTEE
Drug/Alcohol Counselor .....	0.40 FTEE
Recreation Therapist .....	0.75 FTEE
Vocational Rehab. Therapist .....	0.50 FTEE
Dietitian .....	1.00 FTEE
Domiciliary Chief .....	1.00 FTEE
Secretary .....	1.00 FTEE
Clerk .....	0.50 FTEE
Pharmacy .....	0.10 FTEE
Volunteer .....	0.25 FTEE
Audiology/Speech Pathology .....	0.25 FTEE
	Total = 19.15 FTEE

*\*Depending on the type of patient mix, the physician FTEE can be divided among the internist, neurologist, psychiatrist, etc., but there should be no less than 0.25 FTEE of each type. One will be designated as the Medical Director of the unit.*

*\*\*Nursing Staffing Guidelines have not been established.*

e. The total staffing need for more than 60 and up to 100 beds can be estimated proportionately.

f. Guidelines: For planning purposes it has been assumed that a 200-bed VA domiciliary would serve a patient population where approximately half the patients would require active rehabilitation and the other half would require long-term health maintenance care. The following represents minimal direct care staffing requirements for 200-bed VA domiciliary units:

*Physician, e.g., Internist, Neurologist, and Psychiatrist, etc. . . . .	3.50 FTEE
**Nurses (PA/NP) (LPN/RN) . . . . .	2.00 FTEE
Psychologist . . . . .	2.00 FTEE

*\*Depending on the type of patient mix, the physician FTEE can be divided among the internist, neurologist, and psychiatrist, etc., but there should be no less than 1.00 FTEE of each type. One will be designated as the Medical Director of the unit.*

*\*\*Nursing Staffing Guidelines have not been established.*

Social Worker . . . . .	4.00 FTEE
Rehabilitation Medicine Therapist (including 0.5 FTEE Occupational & 0.5 FTEE Physical Therapist) . . . . .	5.00 FTEE
Rehabilitation Technician . . . . .	9.50 FTEE
Drug/Alcohol Counselor . . . . .	2.00 FTEE
Audiology/Speech Pathology . . . . .	1.00 FTEE
Recreation Therapist . . . . .	1.50 FTEE
Dietitian . . . . .	2.00 FTEE
Dentist . . . . .	2.50 FTEE
Chaplain . . . . .	0.50 FTEE
Pharmacy . . . . .	2.00 FTEE
Voluntary Service Staff . . . . .	1.00 FTEE
Vocational Rehabilitation Therapist . . . . .	2.00 FTEE

Total = 38.50 FTEE

g. It is recognized that the precise staffing mix will vary from program to program depending upon the needs of the patient population served by the program.

h. The staffing need for less than or more than 200 beds can be estimated proportionately.

i. It is also recognized that in most instances existing domiciliary care programs are staffed at levels below recommended level. Consideration must be given to improving domiciliary staffing through the reallocation of staffing resources that may become available as a result of bed reductions in other services.

**NOTE:** For both Active Biopsychosocial Rehabilitation and Rehabilitation and Long-Term Maintenance Models:

(1) The indirect care FTEE, e.g., building management, engineering, food service, medical administration, fiscal, and supply requirements should be determined at the individual facilities taking into consideration program operational requirements and staffing guidelines of involved services.

(2) *Highly specialized programs, e.g., Traumatic Brain Injury, Alcohol/Drug Treatment Programs, Community Transitional Units, need to be staffed separately in addition to the domiciliary staffing guidelines.*

(3) *The Office of Strategic Planning is planning to study nurse staffing needs as these VA Domiciliary models are established. In the interim, the Chief, Domiciliary Programs should provide around-the-clock nursing coverage for those domiciliary patients that need active biopsychosocial rehabilitation.*

#### 11. CRITERION -- SPACE GUIDELINES

a. Standard: Domiciliaries of size 40-100 beds will be established through redesignation of existing space, and space must be available for contiguous beds.

b. Standard: Space planned for redesignation from other uses must, as closely as possible, conform to space criteria and functional relationships set forth in Domiciliary Space Planning Criteria presented in H-08-9, chapter 312.

c. Standard: Space utilized in the provision of domiciliary care must also conform to the UFAS (Uniform Federal Accessibility Standards) and provide appropriate privacy for female veterans.

d. In addition, the following must be available to the domiciliary:

- (1) Clinical examination/treatment area
- (2) Ambulatory care services area
- (3) Adequate staff offices space (based on staff assigned as per Standard 10).
- (4) Staff restrooms and lounges
- (5) Classroom/conference room/group therapy room areas
- (6) Computer support space - ADP support and equipment room
- (7) Quiet room
- (8) Storage for building management equipment/supplies
- (9) Storage for clinical equipment/supplies

e. The patient must also have access to the following:

- (1) Recreational activity area
- (2) Laundry facilities
- (3) Vending area
- (4) Multipurpose room with kitchenette
- (5) Appropriate dining facilities
- (6) Canteen
- (7) Baggage storage room
- (8) Chapel

#### 12. CRITERION -- RESEARCH AND EDUCATION

a. Standard. Similar to those in VA medical centers, domiciliary personnel are encouraged to submit innovative research and education need proposals through their local R&D/Academic Affairs offices. Additional information may be obtained by contacting Medical Research Service (151) and Academic Affairs (14), VA Central Office.

b. Rationale. An excellent potential for long-term and longitudinal studies exists in domiciliaries due to its relatively stable population.

### 13. CRITERION -- COST EFFECTIVE ALTERNATIVES - PHYSICAL PLANT

a. Standard. The feasibility of renovation or redesignation of unused or under-utilized inpatient care buildings to domiciliary facilities must receive full consideration in planning for VA domiciliary programs. Proposals for new construction must be made only if the potential for renovation or redesign of space is not available at a lower cost.

b. Rationale. The renovation or redesignation of existing space may offer a timely, low cost alternative to the new construction of additional structures.

### 14. CRITERION -- QUALITY ASSURANCE MECHANISMS

a. Standard. Monitoring the quality of VA domiciliary care must be an integral part of VA medical center quality assurance program. Domiciliaries, other than independent domiciliaries, are part of the medical center for purposes of medical facility HSRO-SIR (Health Services Review Organization-Systematic Internal Review) program participation. Independent domiciliaries must have a medical quality assurance program which, at a minimum, is consistent with agency regulations implementing 38 U.S.C. Section 3305.

b. The responsibility for implementation of the quality assurance program must be formally assigned to the quality assurance coordinator.

c. Clinical privileges for the domiciliary based health care professionals will be assigned in a manner consistent with that utilized in the assignment of clinical privileges for similar professionals throughout the medical center.

d. The domiciliary program will be included in the medical quality assurance program of the medical center. There should be a written quality assurance program which is reviewed annually and updated as necessary. There should be a continuous review of all services and programs for domiciliary patients which includes concurrent or retrospective review methods. However, any such continuous reviews are confidential and protected only to the extent specified in the medical quality assurance records confidentiality regulations, 38 CFR Section 17.500 and following.

e. Domiciliary SCEM (Standards, Criteria, Evaluative Algorithm and Measuring Instruments) have been published and must be utilized in evaluating overall program operations during cyclical SERP (Systematic External Review Process) review activities.

f. Rationale. As is the case with all clinical care programs and activities, the scope and quality of services provided at VA domiciliary must be appropriately assessed.

### 15. PROTOCOLS FOR SUBMISSION

All proposed initiatives to establish, eliminate or modify VA domiciliary capability are subject to the Criteria and Standards stated herein and are to be submitted through the \*MEDIPP process.

\* Replace MEDIPP with Strategic Planning (Change 2, dated July 26, 1991).

16. GLOSSARY

a. **Community Residential Care Program.** The community residential program provides residential care, including room, board, personal care, and general health care supervision, to veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume independent living and have no suitable family resources to provide the needed care.

b. **VA Nursing Home Care.** The nursing home care units located in VA medical centers provide skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational, and spiritual activities. Nursing home patients typically require a prolonged period of nursing care and rehabilitation services to attain and/or maintain optimal functioning.

January 28, 1993

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-9, "Strategic Planning," Chapter 9, "Criteria and Standards and Program Planning Factors."
2. Principal change is to add Appendix 9P, "Mental Health Criteria and Standards."
3. **Filing Instructions**

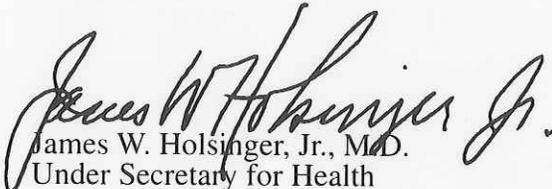
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4. **RECISSIONS:** None.

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

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PUBLICATIONS AND  
DIRECTIVES MANAGEMENT  
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July 26, 1991

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

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

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

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

3. Filing Instructions:

Remove pages

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Cover page through iv

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

Distribution: RPC: 1318  
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PUBLICATIONS AND  
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STAFF (161E)

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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.

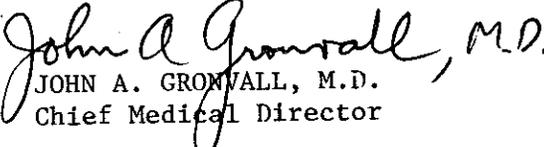
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

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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

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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.

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Chief Medical Director (10)

Approve   
~~Disapprove~~

*4/17/84*  
Date