

Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

Appendix 9B, Criteria and Standards for the Spinal Cord Injury 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)

Contents page for Chapter 9, dated **January 28, 1993** (Change 14)
Text for Appendix 9B, dated **October 2, 1989**

Transmittal sheets located at the end of the document:

Change 14, dated **January 28, 1993**
Change 2, dated **July 26, 1991**
Sheet dated **October 2, 1989**

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

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



Department of
Veterans Affairs

Strategic Planning

July 26, 1991

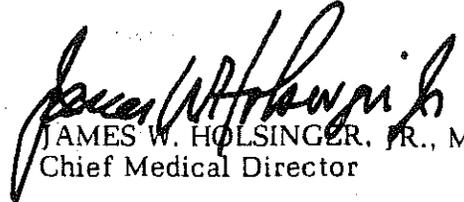
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Veterans Health Administration

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Washington, DC 20420

July 26, 1991

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


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Distribution: RPC: 1318
FD

Printing Date: 7/91

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RESCISSIONS

The following material is rescinded:

Complete rescissions:

Circulars

10-87-113 and Supplement No. 1

10-87-147

10-88-3

10-88-150

10-89-31

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CRITERIA AND STANDARDS FOR THE SPINAL CORD INJURY PROGRAM

1. BACKGROUND

a. In the United States, traumatic SCI (Spinal Cord Injury) claims approximately 10,000 victims each year and produces devastating, permanent neurological deficits. Whereas the types of trauma that cause spinal cord injury are many, the most frequent cause is related to motor vehicle accidents. Although spinal cord injury occurs most frequently in the civilian population, it is also a significant problem for the military, a population which is composed primarily of young men.

b. During the last decades, there have been major improvements in the medical management of patients with spinal cord injury. Thus survival has increased from less than 10 percent to over 85 percent, and the life expectancy of victims of spinal cord injury, although shorter than their age-matched controls, has also increased significantly. Despite improvement in mortality, there has been little change in morbidity of the spinal cord injured. Thus, there are between 250,000 and 500,000 victims of spinal cord injury now alive in the United States.

c. VA's system of specialized care for SCI patients is the largest such system in the world. The Department of Veterans Affairs has 19 SCI centers with a total of 1,350 beds serving approximately 19,000 patients. Forty-seven percent of the patients are quadriplegic and 53 percent are paraplegic.

d. The special services and care that these individuals require are great, and the need for care continues throughout the remainder of their lives. Some of the specialized programs within SCI include HBHC (Hospital Based Home Care), Urodynamic Laboratories, Independent Living Programs, and Outpatient Clinics.

2. INTRODUCTION

a. Criteria and standards for VA SCI 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 MEDIPP (Medical District Initiated Program Planning) proposals involving SCI services. 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 the SCI Program 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 on a case-by-case basis when accompanied by supportive information justifying the need for the proposed MEDIPP action.

NOTE: The terms "must" and "will" are 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

Each medical district must assure comprehensive care to all eligible SCI veterans, i.e., extend its services from the acute/critical phase through intensive rehabilitation management, and continuing care. The capabilities to treat SCI patients should be available within the medical district or by referral through inter-district planning.

4. SCOPE

The scope of this manual is limited to requirements of establishing a SCI center and SCI support service located at a VA medical center with no SCI center. The SCI inpatient care provided at a VA medical center with no SCI center or SCI support service, nursing home, and by home care programs, etc., will only be referenced as appropriate. The staffing requirements and the SCI Planning Model for estimating bed need have been addressed separately and are not included in this manual. SCI Planning Model is provided in chapter 5.

5. DEFINITION OF A SCI PATIENT

a. A SCI patient is an individual with trauma and/or dysfunction of the spinal cord or cauda equina, resulting in neurological deficits. The diagnostic categories of patients who should have access to VA SCI services include patients with:

- (1) Traumatic lesions of the spinal cord and cauda equina, resulting in neurologic deficits.
- (2) Intraspinal, non-malignant neoplasm, resulting in neurologic deficit of a stable nature.
- (3) Vascular insults to the spinal cord or cauda equina of thromboembolic, hemorrhagic or ischemic nature, producing neurologic deficit.
- (4) Inflammatory disease of the spine, spinal cord or cauda equina resulting in non-progressive neurologic deficit.
- (5) Demyelinating disease limited to the spinal cord and of a stable nature.

b. VA will provide care for active duty military personnel who sustain spinal cord injuries. A sequence of events and responsibilities has been detailed in M-2, part I, chapter 19.

Non-veterans may be admitted to VA acute SCI services if the needed specialized resources for SCI care are not available in the area, provided certain conditions are met. Other policies regarding admission of non-veterans are listed in M-2, part I, chapter 19. In admitting non-veterans, the quality of care provided to veterans will not be diminished. Admission of a non-veteran to a SCI service must be approved by the medical center Director or designee.

6. VA SCI CENTER

a. Definition. After MEDIPP approval, SCI centers will be designated by the Chief Medical Director or designee. The SCI center will be organized as an independent service under the chief of staff. The SCI center will provide both inpatient and outpatient care.

There are four major types of inpatient care needed by SCI patients, i.e., acute, initial rehabilitation, sustaining, and long-term care. The SCI center may provide any one or more types of care.

b. Mission/Goal

(1) The mission of a SCI center is to provide comprehensive care to all eligible veterans who have sustained spinal cord injury or have other conditions as defined in the "Definition of a SCI patient." The rehabilitation mission of the program emphasizes a greater use of innovative medical technology for specialized programs to meet the needs of SCI patients. The SCI center has the responsibility for establishing programs for education and follow-up care to improve quality of life in the community and decrease the need for hospitalization. It is the responsibility of the SCI center to ensure that SCI patients receive continuing care.

(2) The goal of a SCI center is to meet the extensive medical, psychological, social, and vocational needs of spinal cord injured patients and enable them to resume a place in the community functioning at their maximum physical and psychosocial potential.

c. Criterion: Acute Injury Care

(1) Definition: It is the phase of treatment from time of injury to stabilization.

(2) Standard: Acute injury care should be provided in a VA SCI center. However, acute care may be provided in an appropriately staffed non-SCI service VA medical center only until such time when the patient is medically stable and can be safely transferred to a SCI center.

d. Criterion: Initial Rehabilitation Care

(1) Definition: Initial rehabilitation care is designed for newly injured patients whose injuries occurred less than 6 months prior to admission to a VA SCI center. Initial care may also be needed by SCI patients if their current admission is their first visit to a VA SCI center.

These patients may have received some medical care in a civilian hospital or a non-SCI center VA facility, but would not have been given rehabilitative care for their injuries.

(2) Standard: Initial rehabilitation care must be provided by SCI centers only.

e. Criterion: Sustaining Hospital Care

(1) Definition: Sustaining care includes treatment for intercurrent illnesses and follow-up care following initial rehabilitation.

(2) Standard: Care requiring hospitalization for greater than 10 days or elective surgery must be provided by a SCI center or a SCI support service only. (For definition of SCI support service refer to Item 7).

f. Criterion: Long-Term SCI Care

(1) Definition: Long-term care includes care of all patients that have received maximum acute and rehabilitation hospital benefits but require institutional maintenance of their achieved level or have psychosocial problems that prevent discharge to the community.

(2) Standard: Long-term units should be special SCI units offering maintenance rehabilitation services (e.g., corrective therapy, occupational therapy, recreation therapy, physical therapy), bowel and genitourinary care, pulmonary (including ventilator dependent) and plastic surgery supports, and a wide range of psychosocial support preparing the SCI patient for some sort of independent living. Outplacement efforts should continue for all long-term patients when appropriate.

g. Criterion: Outpatient care

(1) Standard: All SCI centers must have an SCI clinic to provide outpatient care which will be an integral element of the continuum of care.

(2) Standard: All SCI centers must provide the opportunity for regular follow-up care for all SCI patients in their catchment area through an effective recall system.

h. Criterion: SCI Home Care

(1) Definition: The SCI Home Care program is designed to assist newly injured patients and their families in their adjustment when released from the hospital to the community. The program also aids SCI patients already in the community with counseling, educational activities, and medical care. Services provided may include, but are not limited to, the following:

- Activities of daily living
- Assessment of equipment needs
- Case management
- Direct nursing care
- Education and support to patients, families, and caregivers
- Establishment of a therapeutic regimen in the home
- Home evaluation
- Leisure counseling and training
- Medical management and care
- Nutritional services
- Psychosocial support
- Referral to community agencies
- Support for vocational follow-up

(2) Standard: All SCI centers will provide follow-up through SCI home care programs consisting of an interdisciplinary team under the supervision of the Chief, SCI Service.

SCI home care should provide similar services as traditional Hospital Based Home Care Program but with speciality focus on SCI under the direction of Chief, SCI Service.

i. Criterion: Emergency Care

(1) Definition: Emergency care is care provided to spinal cord injured persons for acute illnesses requiring immediate treatment.

(2) Standard: Patients with spinal cord injury requiring immediate care should receive care in a designated SCI center if possible. If urgency requires treatment at non-SCI centers, coordination with the Chief of the nearest SCI center is imperative and patients will be retained only until they can be safely transferred to an appropriate SCI center.

j. Criterion: Urological Care - Urinary Tract Surgery

(1) Standard: Any procedure on the urinary tract of SCI veterans should be performed only at VA SCI centers, unless an emergency situation contraindicates transportation of the patient.

(2) Standard: Urinary diversion surgery will not be performed on SCI patients without prior approval of the ACMD for Clinical Affairs (128), VA Central Office, except in case of emergency or bladder malignancy.

(3) Rationale: Experience derived from long-term follow-up of SCI patients indicates that urinary diversion is rarely necessary; it should only be done under very specific conditions.

k. Criterion: Urological Care - Open Urolithiasis Surgery

(1) Standard: All patients considered for open urolithiasis surgery will be referred to SCI centers. No open urolithiasis surgery will be performed on SCI patients without prior approval of the ACMD for Clinical Affairs (128), VA Central Office, except in cases of emergency.

(2) Rationale: Urolithiasis occurs frequently in SCI patients. Recurrent urinary lithiasis has led to multiple surgical interventions in which scarring has led to increasing difficulty in performing surgery and increased occurrence of complications.

l. Criterion: Catchment Area Requirement

(1) Definition: Catchment area is defined as the group of counties surrounding each VA medical center that contains a SCI center. In general, constructing a catchment area involves grouping counties which are closer to a particular VA SCI center than to other VA SCI centers. (Refer to SCI Planning Model provided in chapter 5.)

(2) Standard: There must be an established catchment area for each SCI center.

(3) Rationale: It is important to identify which VA medical centers (with no SCI services) will be referring patients to VA SCI centers. Defining the catchment area will also help in identifying the SCI support services (located at VA medical centers with no SCI centers) for which the SCI center will be designated as the lead SCI center. Definition of SCI support services is provided in Item 7.

m. Criterion: Location (Site and distance requirements for establishing a new SCI center)

(1) Standard: The SCI center will be established within an existing VA medical center.

(2) Standard: The "new" SCI center should be at least 200 miles from an existing VA SCI center. Exceptions will be made based upon population density and current/projected utilization of nearest VA SCI centers.

(3) Rationale: It is important that a SCI center be located in an area where workload would justify establishment of such center. Minimum size of a SCI center is provided in Item 6u.

n. Criterion: Community Resources

(1) Standard: The availability of the following community resources should be considered in selecting a site for a SCI center:

- (a) Community Nursing Home
- (b) Employment Opportunities
- (c) Home Health Services
- (d) Medical/Educational Facilities
- (e) Recreational Facilities
- (f) Vocational Rehabilitation
- (g) Transportation Services

(2) Rationale: The above resources are desirable and necessary for the proper care of SCI patients.

o. Criterion: Accessibility

(1) Standard: New site location should promote optimal access to veterans in the catchment area.

(2) Rationale: Patients have difficulty in traveling long distances because of being wheelchair bound. It is also preferable for the patient to remain as close to family and community support as possible.

p. Criterion: Referral Patterns

Standard: Patients with spinal cord injuries should be referred to the designated SCI center which is most convenient to the patients' homes. If the most convenient SCI center does not have appropriate bed/service available, that SCI center must locate appropriate care. Location of appropriate care is not the responsibility of the non-SCI center referral hospital.

The SCI coordinators at non-SCI center VA medical centers are responsible for initiating referrals to appropriate SCI centers and coordinating arrangements for transfers.

q. Criterion: Services (Site Selection Requirements)

(1) Standard: VA medical center being considered for a SCI center providing acute, initial rehabilitation, and/or sustaining care must be a full service tertiary care hospital. (For definition of tertiary care hospital refer to Item 13c.

(2) Rationale: A full range of services is needed for patients in SCI centers, including vocational counseling and psychosocial support to orient the SCI patients toward community rather than institutional living. Other support services will be utilized as necessary.

r. Criterion: Medical Technology (Site Selection Requirements)

Standard: The medical center being considered as a potential site for a SCI center must have access to the following types of medical technology (at the medical center or in the community):

- (1) CT Scanning
- (2) Magnetic Resonance Imaging

- (3) Non-invasive Stone Therapy
- (4) Neurophysiological testing
- (5) Prosthetic Services
- (6) Sonography
- (7) Tomography
- (8) Urodynamics
- (9) Driving Simulator/Training Van/Car

s. Criterion: Space (Site Selection Requirements)

(1) Guidelines: The following space availability should be considered for establishing a SCI center:

- (a) Availability of space for new construction
- (b) Land for parking
- (c) Space for recreation
- (d) Ground floor location
- (e) Close proximity of existing space to support services, e.g., x-ray, laboratory, intensive care units, etc.
- (f) Space for outdoor rehabilitation/recreation

(2) Guidelines: The following space guidelines should be adhered to at all SCI centers:

Chapter 104, Office of Facilities, Planning Criteria for VA Facilities, Manual, H-08-9. Also available is a SCI Design Guide, Office of VA Facilities, Oct. 1987.

t. Criterion: Staff

Guidelines: Staffing guidelines have been developed for seven of the services that provide care (treatment) to spinal cord injured patients at VA facilities designated as spinal cord injury centers. These services are:

- (1) Dietetic Service
- (2) Nursing Service
- (3) Prosthetic Service
- (4) Psychology Service
- (5) Recreation Service
- (6) Rehabilitation Medicine Service
- (7) Social Work Service

Time and budgetary constraints precluded a study of manpower requirements for SCI outpatients.

u. Criterion: Size of a "New" SCI center

(1) Standard: The SCI center offering acute, initial rehabilitation, and/or sustaining care must have a minimum mix of 30 beds. The SCI center offering long-term care must have a minimum of 30 beds. Neither model should exceed 60 beds.

(2) Rationale: A minimum size of 30 beds is needed to ensure optimum quality of care. Fewer than 30 beds would not be cost-effective based on the need for certain core staffing. Based on the experience with existing units it has been noted that large units become difficult for the Chief, SCI Service, to effectively administer.

(3) Standard: Acute care, initial rehabilitation, and sustaining care beds may be located on the same ward. Long-term care beds must not be located on the same ward as acute and sustaining care beds.

(4) Rationale: It is preferable to separate acute and sustaining care patients from long-term care patients who may have become institutionalized.

v. Criterion: Education and Training (SCI Staff)

(1) Standard: Inservice training programs in SCI special skills should be provided for all personnel newly assigned to the SCI Service. The Chief, SCI Service, shall encourage continuing training for all members of the SCI staff. Continuing education shall include but not be limited to topics that are identified through the quality assurance process such as missed diagnoses, complicated cases, morbidity-mortality conferences, etc.

(2) Standard: The Chief of SCI Service will document the continuing education of SCI staff, which will be a factor in the yearly evaluation reports and credentialing actions.

(3) Rationale: SCI medicine is an interdisciplinary practice which requires specialized training in SCI.

w. Criterion: Research

Standard: Research in all areas of SCI care should be encouraged. Guidance regarding research activities should be sought from the ACOS or coordinator for Research and Development in each facility. Relevant information can also be found in Research and Development in Medicine (M-3, Part I) Medical Research, Merit Review or corresponding circulars for Rehabilitation, Research and Development or Health Services Research and Development. Active interaction with the academic affiliate is strongly recommended.

x. Criterion: Quality Assurance

(1) Standard: All SCI centers must plan and implement a quality assurance program to monitor the quality and appropriateness of services provided. SCI specific outcome criteria and occurrence screens shall be developed separately for each level of care and for departmental SCI quality assurance purposes. SCI Service at each medical center will take part in VA medical center's mandated HSRO (Health Services Review Organization) quality assurance program. SCI Home Care quality assurance will also be an integral part of the SCI quality assurance program. However, SCI Home Care quality assurance review activities currently are not confidential and protected under 38 U.S.C. Section 3305.

Results from surveys conducted by JCAHO (Joint Commission on Accreditation of Healthcare Organizations), PVA (Paralyzed Veterans Of America), patient satisfaction surveys, etc. should be considered in the quality assurance process of the SCI Service at the medical center. The districts should also monitor quality through the MEDIPRO (Medical District Initiated Peer Review Organization) program.

(2) Standard: The SCI Service Chiefs should make sure that reviewers at the medical center have the knowledge and expertise to review the SCI services.

(3) Rationale: The continuous monitoring of the elements of care is the best tool for improvement of the quality of care, provided each action or correction recommended is followed.

7. SCI SUPPORT SERVICE

Recognizing the difficulty of transportation and need to provide an alternative to inpatient care provided at a SCI center, SCI support clinics and/or services may be established at non-SCI VA medical centers.

a. Definition: A VA medical center which has both a SCI support inpatient unit and a SCI support outpatient clinic will be considered as having a SCI Support Service. Detailed requirements for establishing SCI support clinics and SCI support bed units are provided in Items 8 and 9 respectively.

(1) Standard: Each VA medical center with a SCI support unit must have a SCI support clinic. However, a VA medical center with a SCI support clinic may not need a SCI support unit.

(2) Rationale: Patients discharged from the SCI support unit need continuity of care through the SCI support clinic.

8. SCI SUPPORT CLINIC

a. Criterion: Definitions

A SCI support clinic is a designated clinic that is located in a VA medical center without a SCI center (host medical center) and staffed by the host medical center's staff. The SCI support clinic provides basic SCI ambulatory and screening services to SCI veterans residing in its catchment area. (A SCI outpatient clinic is a clinic in a medical center with a SCI center. A SCI satellite clinic is a clinic remote from a medical center that has a SCI center but is staffed by the SCI center.)

(1) Standard: Every SCI support clinic must be associated with a designated lead SCI center through formal written agreement. The lead SCI center must provide routine professional consultation and admit any SCI patients referred from the SCI support clinic who comply with established admission criteria. Close communication must be maintained between the SCI support clinic and the lead SCI center. The lead SCI center must supply relevant SCI patient data to the SCI support clinic.

(2) Rationale: The SCI center has the qualified and experienced staff to provide professional consultation as needed by the SCI support clinics.

b. Criterion: Functions

Standard: SCI support clinics must provide the following:

- (1) Annual evaluations (in coordination with the lead SCI center);
- (2) Diagnosis and outpatient treatment of SCI and non-SCI related (sustaining) problems;
- (3) Emergency assessment of illness or trauma to determine whether to admit to the host medical center or the designated lead SCI center;
- (4) Provision of prescription medications and supplies; and minor low cost prosthetic equipment and repairs;

(5) Supplying the lead SCI center with copies of all SCI patients' relevant outpatient data on a monthly basis.

c. Criterion: Location of a "New" SCI Support Clinic

(1) Standard: A proposed SCI support clinic should be at least 100 miles or 2 hours ground travel time away from an existing SCI center or another SCI support clinic.

(2) Rationale: It is important that a support clinic be located in an area where workload would justify establishment of such a clinic.

d. Criterion: Utilization Requirement

(1) Standard: The projected workload for a proposed clinic must be at least 20 visits per month. Need for a SCI Support Clinic can be determined by using the Outpatient Model provided in chapter 5.

If there is a need for SCI support clinic functions and activities and the projected workload is less than 20 per month, the establishment of a "satellite" clinic staffed by the SCI center staff should be considered.

(2) Rationale: A minimum workload of 20 visits per month will keep the SCI staff up to date on current SCI practices.

e. Criterion: Types of Staff

Standard: The SCI support clinic must have a minimum of the following types of staff:

Physician, Registered Nurse, and SCI Coordinator. (For responsibilities of an SCI Coordinator, refer to M-2, part XII, chapter 2 and M-2, part I, chapter 19).

A workload of 20 visits per month would be equivalent to approximately 1 day's work per week for each discipline. FTEE for each category of staff will vary according to workload and program responsibility.

f. Criterion: Education and Training (SCI staff)

Standard: The designated lead SCI center will function as the primary resource for SCI staff education. The SCI coordinators should have at least 2 weeks of training in SCI, preferably at their lead SCI center. The minimum training for the physician and nurse must be 3 months in SCI, preferably at their lead SCI center. This training does not have to be for 3 consecutive months. Also, training at a local private sector SCI Service, completion of SCI-related courses and/or attendance at seminars, conferences, etc., may be substituted for part of the training requirement.

g. Criterion: Quality Assurance

Standard: Quality assurance will be conducted by the SCI support clinic staff as part of the medical center's mandated HSRO program. The Chief of the lead SCI center will be given privileges at the center with the support clinic. Their participation in the quality assurance process will be the same as any other health care professional in the medical center with the support clinic.

9. SCI SUPPORT UNIT**a. Definition**

A SCI support unit is an inpatient bed unit designated for SCI sustaining care patients. It is intended to support the inpatient needs of the SCI support clinic and other local needs. (*Not all VA medical centers with SCI support clinics would need SCI support units.*) If anticipated length of stay of patients in SCI support units is more than 30 days, then the patients should be transferred to a SCI center. The SCI support units are not intended for acute, initial rehabilitation, and long-term care patients.

(1) Standard: Every SCI support unit must be associated with a designated lead SCI center through formal written agreement. The physician in charge of a SCI support clinic would also be in charge of the SCI support unit as a Section Chief, and maintain close consultation with the lead SCI center.

(2) Rationale: SCI support units will promote continuity of care and improve patient accessibility to specialized care.

b. Criterion: Minimum size

(1) Standard: The SCI support units should have at least 15 beds.

(2) Rationale: A minimum of 15 beds will allow sufficient volume necessary to maintain staff skills.

c. Criterion: Education and Training (SCI Staff)

Standard: Education and training requirements of the SCI support unit staff are the same as the SCI support clinic except the physician in charge should have at least 6 months of training in SCI care, preferably at the lead SCI center (refer to Item 8f).

d. Criterion: Quality Assurance

Standard: Quality assurance will be conducted by the SCI support unit staff as part of the medical center's mandated HSRO program. The Chief of the lead SCI center will be given privileges at the center with the support unit. Their participation in the quality assurance process will be the same as any other health care professional in the medical center with the support unit.

10. SCI PATIENT CARE AT VA MEDICAL CENTERS WITHOUT SCI CENTERS OR SCI SUPPORT SERVICES**a. Criterion: Types of care at non-SCI centers**

SCI veterans often use VA medical centers without SCI services to receive medical and nursing care, usually because those facilities are closest to their homes. However, if possible, inpatient care and elective surgery should be provided at SCI centers.

(1) Standard: Sustaining care should not be provided at VA medical centers with no SCI centers or SCI support units if the anticipated length of stay will be more than 10 days unless approved by the Chief of SCI Service at the lead SCI center.

(2) Standard: Outpatient care (in VA medical centers with no SCI centers or SCI support services) should be provided in various clinics, e.g., medicine, surgery, as appropriate, if visits are few (less than 20 per month). If SCI related visits by SCI patients average more than 20 per month, the SCI coordinator will advise the medical center Director, for appropriate action such as designation of an "SCI Support Clinic," as described in Item 8.

(3) Rationale: The SCI patient needs to be attended by an interdisciplinary team on a daily basis and not just by consultation. The treating physician needs to be trained to deal with problems peculiar to spinal cord injured patients since many disease entities are present under different symptoms in SCI patients and require different treatment modalities.

11. SCI CARE IN NURSING HOMES

a. Criterion: SCI Care Nursing Homes

(1) Standard: An SCI patient should be discharged to a nursing home only if the patient's condition, irrespective of the spinal cord injury, warrants such an admission. SCI patients in nursing homes should be regularly followed by SCI center, SCI support clinic, or SCI support service. SCI long-term care patients may be placed in a nursing home at the patients' request in order to be close to family and friends. These nursing homes should have facilities proven suitable to care for SCI patients. This includes staff trained in SCI patient care as well as physical facilities appropriate for the care of SCI patients.

(2) Rationale: The special care required for SCI patients is often not available in a nursing home. Moreover, patients with a spinal cord injury who have Alzheimer's Disease and/or mental impairment should not be mixed with patients who are mentally alert.

12. RESIDENTIAL CARE

Definition

Residential care is provided in private homes selected by VA at the veteran's own expense. Veterans receive monthly follow-up visits from VA social workers and other health care professionals and are outpatients of the local VA facilities.

Standard: SCI veterans may be discharged, when necessary and appropriate, to private homes. It is the responsibility of the Chief, SCI Service, to ensure that the private home is appropriate for SCI patients. All SCI patients must be enrolled in an outpatient follow-up program.

13. GLOSSARY

For the purpose of this manual, VA facilities have been categorized based on the three levels of care provided at various facilities. Definitions of these three categories are:

a. Primary Care facilities (Level I) provide primary diagnosis and treatment services staffed by personnel capable of providing relatively simple but essential patient services. These services are used to diagnose and treat common and uncomplicated illnesses, ambulatory surgery, and to stabilize major emergencies before transfer to a higher level facility.

b. Secondary Care facilities (Level II) provide all Level I services as well as common and uncomplicated medical, surgical, and psychiatry inpatient treatment which constitutes vast majority of such care. Patients with complex care needs for illnesses requiring highly specialized professional teams or equipment will be referred to Level III facilities.

c. Tertiary Care facilities (Level III) provide highly specialized diagnostic and treatment services for patients referred from Level I and Level II facilities, or directly from the community. These facilities are designed to treat complex cases, relatively rare diseases and emergencies for all categories of critically ill people, and would also perform Level I and Level II functions.

REFERENCES:

- a. VHS&RA Manual M-2, part I, chapter 19; VHS&RA Manual, M-1, part I, chapter 4.
- b. Interagency Committee on Spinal Cord Injury Report, Department of Health and Human Services, Public Health Service, National Institutes of Health. April 1987.

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**

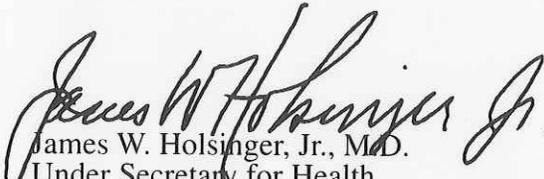
Remove

9-i ✓

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9-i ✓
9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.


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

Distribution: **RPC 1318**
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Printing Date: 2/93

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July 26, 1991

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

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

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

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

3. Filing Instructions:

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Cover page through iv

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

Distribution: RPC: 1318
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Printing Date: 7/91

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DIRECTIVES MANAGEMENT
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October 2, 1989

1. Transmitted is a new Veterans Health Services and Research Administration Manual M-9, "MEDIPP," chapter 1 through chapter 11. Changes will be made to incorporate the recent reorganization in the near future.

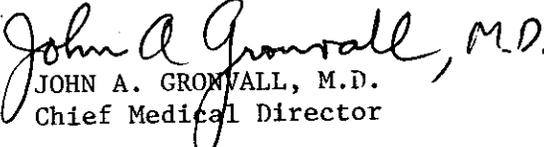
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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1-1 through 11-3

4. RESCISSIONS: Circular 10-87-113, dated October 10, 1987 and Supplement No. 1 dated April 4, 1988; Circular 10-87-147, dated December 30, 1987; Circular 10-88-3, dated January 13, 1988; Circular 10-88-150, dated December 9, 1988; and Circular 10-89-31, dated March 23, 1989.


JOHN A. GRONVALL, M.D.
Chief Medical Director

Distribution: RPC: 1318 is assigned
FD

Printing Date: 10/89



Veterans Administration

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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
Management Staff (10A1B)

TEL. EXT.
3331



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