

**Manual M-9, Strategic Planning**

**(Veterans Health Administration)**

**Chapter 9, Criteria and Standards and Program Planning Factors  
(Paragraphs 9.01 through 9.05)**

**Rescinds/Revises Chapter 9 dated October 2, 1989**

**Appendix 9A through Appendix 9Q do not appear in this document.  
They have been handled as separate documents.**

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 Chapter 9, dated **May 4, 1992** (Change 4)

Transmittal sheets located at the end of the document:

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

Change 4, dated **May 4, 1992**

Transmittal sheets for changes prior to 1992 also located at the end of the document:

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

Sheet dated **October 2, 1989**

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

Memorandum dated **April 3, 1984**



Department of  
Veterans Affairs

# Strategic Planning

July 26, 1991

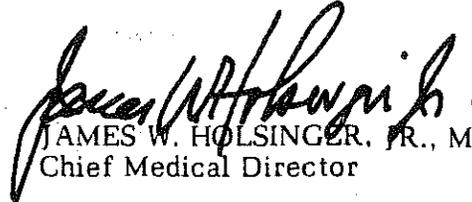
Veterans Health Administration  
Washington DC 20420

Department of Veterans Affairs  
Veterans Health Administration

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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.

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

Distribution: RPC: 1318  
FD

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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The following material is rescinded: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

10-89-132

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**CHAPTER 9. CRITERIA AND STANDARDS AND PROGRAM PLANNING FACTORS****9.01 PURPOSE**

a. Criteria and standards for various programs have been developed to meet the program planning needs of VA (Department of Veterans Affairs) facilities, regions and Central Office in the uniform review of program proposals. These criteria and standards are reviewed by VA Central Office periodically and revised, as necessary, based upon further analysis and experience with their use.

b. Where criteria and standards do not exist, PPFs (Program Planning Factors) are intended to provide a systematic manner for analyzing available and needed services. The development of PPFs address:

- (1) The goal of performing system-wide analyses of certain program areas and determining the need for additional programs,
- (2) The overlap of existing programs and services, and
- (3) Facilitating the decision-making process relative to those programs.

**9.02 POLICY**

A key component in the development of the VHA (Veterans Health Administration) NHCP (National Health Care Plan) is the assessment of need for particular programs. In the VHA planning process, criteria and standards and PPFs represent the general protocols that are to be applied to accomplish this quantitative assessment of programmatic need. In an effort to improve access to care and minimize health care costs, a broader assessment of the need for selected programs is required. Future planning, at a minimum, will include broad-based program assessments to insure that maximum benefits are derived from VA expenditures. As an outcome, the application of PPFs and consideration of other pertinent indicators and influences (legislative mandates, budgetary constraints, etc.) will be reviewed by VA Central Office program officials, and recommendations made to the CMD (Chief Medical Director) to indicate where program changes are necessary to implement the NHCP. PPFs will be created as the need arises and the selection of programs for which PPFs will be developed will be based on the goals and objectives of the Secretary of Veterans Affairs and the CMD.

**9.03 CONTENT OF CRITERIA AND STANDARDS**

- a. Each program-specific set of criteria and standards covers the following topics:
- (1) Definitions.
  - (2) Goals and objectives.
  - (3) Optimal minimum size and/or workload of the program.
  - (4) High technology equipment requirements, if any.
  - (5) Other program services that are to be available at the VA medical centers and/or in the community.

- (6) Criteria/standards/rationale.
- (7) Staffing and space guidelines.
- (8) Protocols for submission.
- (9) Needs assessment methodology (optional).
- (10) Quality Management.
- (11) Any other special requirements of the program.

b. The criteria and standards are developed by task groups with representation from:

- (1) The respective program office(s),
- (2) VA Central Office,
- (3) Field representatives, and
- (4) Private sector consultants.

c. It is recognized that in certain circumstances local conditions may exist which justify deviations from the standards. Such deviations are reviewed by VA Central Office on a case-by-case basis when accompanied by quantitative information.

#### 9.04 DEFINITIONS OF CRITERIA AND STANDARDS

a. A **criterion** is a measurable characteristic of a health service.

b. A **standard** is a quantitative and/or qualitative value of achievement with respect to a specific criterion which represents acceptable performance.

c. Whenever the term "**must**" is used it is mandatory to meet the requirements of the standard. The term "**should**" is used to reflect a preferred practice.

#### 9.05 CONTENTS OF PPFs

a. The application of PPFs and analyses of existing services and programs will be primary tools for determining the need for establishing new units, and determining service gaps and overlaps among programs in VHA. Each PPF is a quantitative analysis of need accompanied by a detailed, narrative description of the assessment and supported by information obtained from various sources (internal VA; national, regional and local health care entities; other Federal agencies, etc.). The following factors should be considered, where applicable, and included in any analysis that is used to support VHA programmatic actions/initiatives:

##### (1) Referral Patterns of Patients and Geographic Area Served

(a) A major factor to be determined is what is a reasonable distance to require patients to travel to receive care. Each program will need to be addressed on an individual basis with consideration given to the type of care provided. For example, one

would not expect a patient to travel long distances three times a week to receive dialysis treatment. However, a patient receiving a kidney transplant may have to travel a considerable distance for services related to such care. The referral patterns reflected in the planning networks, must be considered.

(b) Each assessment should include an analysis of the geographic area served and a study of patient origin.

1. The analysis should include data from existing workload with application to the total veteran population within the DPPB (Distributed Population Planning Base). For example, those facilities with existing programs may want to enhance or expand services. One way to illustrate potential workload would be to apply the existing applicable utilization rate to the total veteran population in the DPPB.

2. A patient origin study from the PTF (Patient Treatment File) will identify geographic distribution by county and/or zip code. County and/or zip code information can then be used to determine distance from medical centers.

3. For centers which do not have a particular program, station specific data, if available, may be used to track referrals to other VA medical centers, community programs, or non-VA sources.

4. The assessment should include any unique geographic or transportation limitations which limit access to a medical center to receive treatment.

(c) The assessment should include the impact a change in referral patterns would have on affiliation agreements.

(2) **Present and Projected Need.** The current and projected veteran population, by age, must be used in evaluating present and projected need.

(a) Where appropriate, relevant diagnoses or other determining factors must be included in any assessment. For example, admission to a HBHC (Hospital Based Home Care) program requires the presence of a spouse or other care-giver; candidates for transplants will be limited by age and diagnosis.

(b) For programs related to specific diagnoses, the incidence (number of new cases) and prevalence (number of cases at a given point in time) must be considered.

(c) Constraints on the program by policy decisions, such as market share or eligibility must also be considered and addressed.

(3) **Appropriate Size of Program.** Many programs currently address appropriate size through criteria and standards. PPFs should be used in concert with existing criteria, standards and other guidelines.

(a) Criteria and standards should be used as guides, and not as justification for establishing new or altering existing programs. For example, while it may be desirable to start a mental hygiene program with 5,000 visits, the actual number of projected visits should be calculated based on historical utilization data.

(b) Each assessment should include an evaluation and comparison of costs, both start-up and recurring.

1. Data from the CDR (Cost Distribution Report) must be considered to facilitate comparison of costs per unit (procedure, visit, etc.) in each VA medical center, region, and nationally.

2. The costs of specific follow-up care must be included, where appropriate, such as the cost of immunosuppressants in renal transplants.

3. All costs should be compared to similar non-VA programs, if available.

(c) The minimum number of procedures necessary to maintain clinical competence as well as cost efficiencies should be included.

(4) **Opportunities for Consolidation, Sharing or Contracting of Programs.** In some cases, medical services can be obtained at lower costs through contractual arrangements with local community facilities or other providers.

(a) Each assessment should evaluate the availability of unused capacity in the community, sharing opportunities with DOD (Department of Defense) and community facilities, and the contracting out of programs that are not cost-effective.

(b) Consolidation of nearby under-utilized programs should also be considered.

(c) Every effort should be made to develop programs that will provide access to the greatest number of veterans in the most cost-effective manner.

(5) **Available Resources.** The following factors, to be applied in program assessments are not all inclusive, but are provided to ensure a consistent, quantitative approach for analyzing programmatic need.

(a) Each program assessment employing the planning factors will provide a basis upon which to gauge the feasibility of establishing or modifying major VHA programs.

1. Each assessment should consider what resources would be needed to achieve the desired goal of the action/initiative. For example, a facility may have demonstrated a need for a certain program but may not have the capability to hire the appropriate staff to adequately administer the program.

2. The assessment should address:

a. Affiliation agreements in place and what role the affiliated entity might play in providing services; and

b. Existing available resources (including space, staff, support functions and equipment) that would negate the need to expend additional resources to establish or expand a program.

(b) The assessments will provide documentation to develop budget and operational goals and objectives at the VA Central Office level.

b. The level (national, regional, network or medical center) at which PPFs are to be applied are to be specified with each issuance.

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**

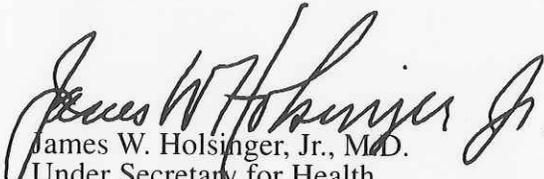
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9-i ✓

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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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STAFF (101E)

May 4, 1992

1. Transmitted is a change to the Department of Veterans Affairs, Veterans Health Administration Manual M-9, "Strategic Planning", Chapter 9, "Criteria and Standards and Program Planning Factors."

2. Principal changes are:

a. The inclusion of Program Planning Factors into Chapter 9.

b. The addition of:

(1) Appendix 9F: "Criteria and Standards for Geriatric Research, Education and Clinical Centers," which provides guidance concerning VA GRECC programs.

(2) Appendix 9G: "Criteria and Standards for New Outpatient Services Remote from VA Medical Centers," which provides guidance for establishing VA outpatient services which are remote from VA medical centers.

(3) Appendix 9H: "Criteria and Standards for VA Intermediate Care Programs," which provides guidance for VA intermediate care programs.

3. Filing Instructions

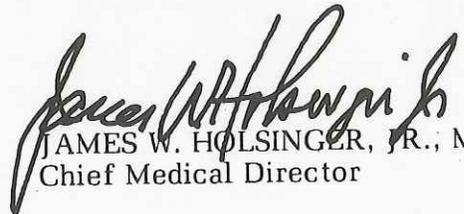
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9-i through 9-1

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iii-iv  
9-i through 9-4  
9F-1 through 9H-17

4. RESCISSIONS: Circular 10-88-150, dated December 9, 1988; Circular 10-89-132, dated December 8, 1989; and Circular 10-90-124, dated September 27, 1990.

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

Distribution: RPC: 1318  
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Printing Date: 5/92

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STAFF (161E)

July 26, 1991

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

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

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

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

3. Filing Instructions:

Remove pages

Insert pages

Cover page through iv

Cover page through iv

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

Distribution: RPC: 1318  
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Printing Date: 7/91

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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.

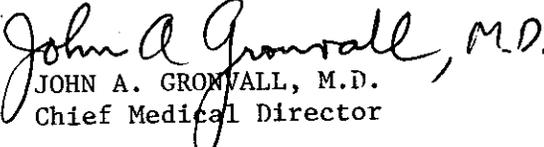
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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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

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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)

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3331

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MAY 1980

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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.

*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