

Manual M-9, Strategic Planning

(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

Appendix 9J, Program Procedures for Hospital Based Home Care Program

This document includes:

Title page and p. ii for M-9, dated **July 26, 1991**

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Change 7, dated **June 1, 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

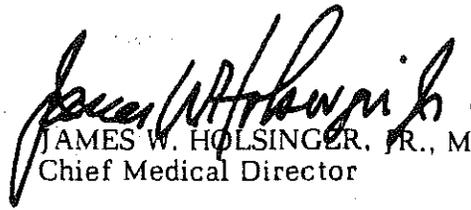
Veterans Health Administration
Washington DC 20420

Department of Veterans Affairs
Veterans Health Administration

Department of Veterans Affairs
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The following material is rescinded: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
10-88-3
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PROGRAM PROCEDURES FOR HOSPITAL BASED HOME CARE PROGRAM

1. INTRODUCTION

a. Program procedures for the HBHC (Hospital Based Home Care) Program have been developed to meet the strategic planning needs of the VA (Department of Veterans Affairs) facilities and regions, and for use by VA Central Office in the uniform review of HBHC program proposals.

b. The program procedures and the associated needs assessment methodology for the HBHC Program will be reviewed by VA Central Office periodically, or at least every 2 years, and revised as necessary based upon further analyses and experiences with their use.

c. It is recognized that in certain circumstances local conditions may exist which justify an adjustment to these standards. Such adjustments will be reviewed by VA Central Office on a case by case basis when accompanied by supportive information justifying the need for the proposed adjustment.

d. In conjunction with the program procedures and needs assessment methodology, VA VHA (Veterans Health Administration) Manual, M-5, "Geriatrics and Extended Care," Part V, "Hospital Based Home Care," provides information and direction specific to HBHC.

2. SCOPE

Each region should plan for the development of HBHC services at all medical centers which have a justifiable need.

3. DEFINITIONS

a. HBHC is a program which delivers primary health care in the home, through a VA hospital based interdisciplinary team, to homebound and often bedridden eligible veterans whose caregivers are willing and able to assist in their care.

(1) The program is administered from a VA health care facility using VA personnel and resources.

(2) HBHC is an outpatient program which provides medical services to individuals who require professional care and for whom return to an outpatient clinic on a recurring basis is not feasible.

b. Homebound is considered to be the normal inability to leave home because of any one of the following situations:

(1) The patient requires the assistance of another individual.

(2) The patient requires the aid of a supportive device.

(3) It is medically contraindicated for the patient to leave home.

(4) Leaving home requires a considerable and taxing effort.

(5) The patient leaves home only for a short duration and infrequently.

(6) The patient leaves home only for medical care.

c. A caregiver is defined as a person related to or associated with the veteran who performs, assists and/or lends support in the care of the patient.

4. OBJECTIVES

The six major objectives of the HBHC program are:

a. To provide primary health care services to homebound and often bedridden patients who reside in the community. This primary health care should be accessible, comprehensive, coordinated, continual, accountable and acceptable as described in the following:

(1) **Accessibility.** The HBHC patient/caregiver should have access to the providers of care. Explicit provisions have been made for emergencies during the night, on weekends, and on holidays.

(2) **Comprehensiveness.** The HBHC team should be able to treat and manage the majority of health problems arising in the HBHC population and provide preventive maintenance services.

(3) **Coordination.** The HBHC team should coordinate the patients' care by referring patients to the appropriate specialists, providing pertinent information to and seeking opinions from these specialists, and explaining diagnoses and teaching treatment to the patients and caregivers.

(4) **Continuity.** There should be regular visits from the HBHC team and complete medical records which are regularly reviewed and used in planning care.

(5) **Accountability.** There should be regularly scheduled patient care reviews as well as ongoing monitoring and evaluation of important aspects of care to ensure a high quality of health care.

(6) **Acceptability.** The HBHC patient and home caregiver should agree to receive HBHC services and participate in the development of the treatment plan.

b. To create a therapeutic, comfortable and safe environment in the home.

c. To support the home caregiver in the care of the patient.

d. To reduce the need for, and provide an acceptable alternative to hospitalization, nursing home care or other outpatient clinic visits.

e. To promote timely discharge from the hospital or nursing home.

f. To provide an academic and clinical setting for students of the health professions in the interdisciplinary delivery of primary care to a chronically ill, long-term care population.

5. TYPES OF PATIENTS APPROPRIATE FOR HBHC SERVICES AND THE RELATED PURPOSES OF THIS CARE

a. Long-term care patients (i.e., patients with multiple interacting medical/psychosocial problems). The purposes of care are:

- (1) To offer families an alternative to nursing home placement.
- (2) To prevent premature admissions to long-term care institutions.
- (3) To maintain optimal physical, mental and social functioning.

b. Hospice care patients (i.e., patients with terminal illnesses). The purposes of care are:

- (1) To offer the patient the option of death in the patient's home rather than in an institution.
- (2) To help the patient and family cope with imminent death.
- (3) To manage pain and other symptoms.

c. Post-acute care patients (i.e., patients needing post-hospital care). The purposes of care are:

- (1) To assist in the transition from hospital to home.
- (2) To minimize the amount of formal follow-up by ambulatory care services and programs.
- (3) To optimize rehabilitation.

6. TWO LEVELS OF HBHC PROGRAMS

Currently there are two levels of HBHC programs, Level A and Level B. Planning activities should include an evaluation of the need for the appropriate level of HBHC program.

a. Level A HBHC Programs: Programs that have a projected HBHC workload of at least 50 ADC (average daily census) and require a minimum staff of at least 8 FTEE (Full-time Employee Equivalent).

b. Level B HBHC Programs: Programs that cannot meet the minimum projected workload requirements of a Level A program (50 ADC) but which have sufficient projected workload to support an HBHC Program of at least 35 ADC and an HBHC staff of at least 5.5 FTEE.

7. MINIMUM UTILIZATION REQUIREMENTS

a. Level A Program

A minimum projected utilization of at least 50 ADC is required to establish and support a Level A HBHC Program (staffed at the 8 FTEE level). This level of utilization should be achieved by the second year of operation of an HBHC Program and maintained

or increased thereafter. Level A HBHC Programs should also perform a minimum of at least 350 home visits per month.

b. Level B HBHC Program

A minimum projected utilization of at least 35 ADC is required to establish and support a Level B HBHC Program (staffed at the 5.5 FTEE level). This level should be achieved by the second year of operation of an HBHC Program. Level B HBHC Programs should perform a minimum of at least 210 home visits per month.

8. SATELLITE HBHC Program REQUIREMENTS

Existing HBHC Programs may develop one or more satellite HBHC Programs for funding consideration. Each proposed satellite program must be able to meet the following minimum requirements:

a. Project a workload similar to a Level B HBHC Program, of at least 35 ADC and 210 home visits per month. This workload should be documented by utilizing the HBHC Needs Assessment Methodology. (See M-9, ch. 9, app. 9J, par. 11.)

b. Demonstrate that the proposed site of an HBHC satellite is within a reasonable travel time from the core HBHC Program's medical center site to provide for needed hospital. Generally, Satellite HBHC Programs should be located within a maximum of 2 hours driving time from the core HBHC Program's medical center site.

c. Staffing for a satellite HBHC Program shall take into consideration the amount of core HBHC staff assistance available to the satellite and the projected workload of the satellite.

d. Satellite outpatient clinics may develop free-standing satellite outpatient clinic based home care programs for funding consideration. The minimum requirements are stated in M-9, chapter 9, appendix 9J, paragraphs 8 a. and b.

9. EXPANSION OF EXISTING HBHC PROGRAMS

Plans for HBHC expansion should be based on increasing the program's ADC in an increment of at least 25 ADC (at a minimum). Documentation supporting the need for the increase should be consistent with the methodology required of new program requests.

10. STAFFING GUIDELINES

A Level A HBHC Program should have a minimum total of 8 FTEE staff and Level B HBHC Program should have a minimum total of 5.5 FTEE staff to include the following types of personnel categories:

- a. Physician.
- b. Nurse.
- c. Social Worker.
- d. Dietitian.

- e. Rehabilitation Medicine Therapist.
- f. Pharmacist.
- g. HBHC Program Director
- h. Secretary.

11. NEEDS ASSESSMENT METHODOLOGY

a. The HBHC Needs Assessment Methodology is intended to provide a facility with an indication of whether it has sufficient hospital discharges to qualify for either a Level A or Level B HBHC Program.

b. A Level "A" HBHC Program is staffed at an 8 FTEE or greater level, serves a minimum HBHC need of at least 50 ADC, and should perform a minimum of at least 350 home visits per month. A Level "B" HBHC Program is staffed with a minimum of 5.5 FTEE, serves a minimum HBHC need of 35 ADC, and should perform a minimum of at least 210 home visits per month.

c. The HBHC Needs Assessment requires an extensive hospital discharge analysis relating patient characteristics to primary diagnoses, which have been previously determined to be good indicators of the need for HBHC services.

d. The HBHC Needs Assessment Methodology is intended to provide a facility with an indicator of whether it has sufficient hospital discharges to justify:

- (1) Expanding its existing Level "A" or "B" HBHC Program, or
- (2) Adding a satellite HBHC Program to serve an additional catchment area.

e. The three steps of the Needs Assessment Methodology:

(1) Step 1. Identify all discharges to the potential HBHC Catchment area

(a) For the previous full fiscal year identify all discharges to the potential HBHC catchment area which is defined, for the purpose of this methodology, as a 50 mile radius of the facility.

1. This step requires a zip code analysis.

2. A computer printout of the latest full fiscal year PTF (Patient Treatment File) data for the primary facility and any other facility (e.g., at tertiary facility) which returns patients to the catchment area, should be obtained from the medical center or Region Office.

(b) To determine potential workload for a satellite HBHC Program, conduct a zip code analysis of the proposed satellite catchment area. For the purpose of this methodology, the radius of the satellite program may be up to 50 miles from the satellite office.

(c) To determine the potential workload increase for existing HBHC Programs which seek expansion, all discharges to the catchment area should be analyzed.

1. Plans for HBHC expansion should be based on the addition of personnel to enable an incremental expansion of at least 25 ADC.

2. At a minimum this incremental unit of expansion would require the addition of one RN (Registered Nurse). Other program staff, such as FTEE for physician and social work time, should be proportionally increased.

(d) When the determination of the number of discharges within the specified diagnostic categories to the proposed catchment area is made, the aggregated total should meet the number of ADC required for program expansion.

(2) Step 2. Further analyses, of the discharges in the HBHC catchment area, utilizing the most recent fiscal year data, determine the number of discharges who meet at least one of the criteria outlined in the following:

(a) Eighty-five years of age or older.

(b) NSC (Nonservice-connected) patients in receipt of Housebound or Aid and Attendance.

(c) Fifty percent SC (Service-connected) patients in receipt of Aid and Attendance.

(d) The presence of one of the following primary discharge diagnoses:

Primary Discharge Diagnosis	ICD-9-CM
1. Motor Neuron Disease..... (includes Amyotrophic Lateral Sclerosis)	335.20 thru 335.29
2. Chronic Obstructive Pulmonary Diseases..... (includes chronic bronchitis,..... Emphysema, and excludes Asthma)	491.0 thru 492.8, 494, 496
3. Diseases of Arteries, Arterioles and..... Capillaries	440.0 thru 443.9
4. Congestive Heart Failure.....	415.0, 416.9, 428.0 thru 428.9, 402.00 thru 402.91
5. Dementia (which includes specific..... diseases such as Alzheimer's..... Disease, and non-specific..... category such as Organic Brain Syndrome)	290.0 thru 290.43, 294.0, 294.1, 310.9, 331.0, 331.1
6. Diabetes Mellitus.....	250.00 thru 250.91
7. Fracture of Hip.....	820.00 thru 820.9
8. Ischemic Heart Disease.....	410.0 thru 414.9
9. Malignant Neoplasms.....	140.0 thru 172.9, 174.0 thru 208.9
10. Multiple Sclerosis.....	340

Primary Discharge Diagnosis Continued	ICD-9-CM
<u>11.</u> Parkinson's Disease.....	332.0,332.1
<u>12.</u> Rheumatoid Arthritis.....	714.0
<u>13.</u> Cerebrovascular Disease.....	430 thru 438
<u>14.</u> Traumatic Brain Injury.....	V15.5
<u>15.</u> HIV (Human Immunodeficiency Virus)..... HIV Infection	042 thru 043.9
<u>16.</u> Respite.....	V60.5

(3) Step 3 (optional). Include any other needs assessment activities which indicated need at the medical center.

12. SUBMISSION REQUIREMENTS

The following items must be discussed as part of HBHC Program proposal:

a. Needs Assessment

M-9, chapter 9, appendix 9J, paragraph 11, outlines procedures for a needs assessment which is designed to provide the medical center, the Regional Office and VA Central Office with an indicator of need for HBHC services. In addition to this assessment, the medical center can provide any other data or studies reflecting need for HBHC.

b. Organization

Organizational placement of the proposed HBHC Program should be identified and discussed. HBHC is an outpatient program which is frequently organized under the Associate Chief of Staff for Extended Care. At some medical centers, HBHC is organizationally under the Associate Chief of Staff for Ambulatory Care. The reasoning behind the medical center's choice of organization should be explained from the standpoint of benefit to the HBHC's mission and integration with existing services and programs.

c. Staffing

(1) The proposed staffing for an HBHC Program should discuss the potential for staff recruitment and retention, especially in hard to recruit categories such as rehabilitation therapists. The levels of nursing practice planned should be explained as well as the experience and discipline of the HBHC director and the specialty of the HBHC physician.

(2) HBHC is a VA program which is interdisciplinary in its delivery of patient care. Team training and leadership are very important to both the process and positive outcomes of care rendered by the program.

d. Medical Center Resources

(1) The facility's ability to support the operation of an HBHC Program should be addressed. Issues of concern include:

(a) The availability of space which is accessible to ancillary services such as Laboratory and Pharmacy.

(b) The availability of General Services Administration vehicles and accessible parking.

(c) A direct phone line.

(2) Questions to be investigated are:

(a) Is the proposed HBHC catchment area considered generally safe for staff?

(b) Is the flow of patients from the hospital to various outpatient programs in a particular medical center without major barriers?

(3) It would be helpful to describe the effectiveness of the discharge planning process of the facility.

e. Community Resources

Communities differ widely in the resources available to chronic and terminally ill individuals.

(a) Will HBHC fill needed gaps or enhance existing resources?

(b) To what extent can veterans access existing community services?

(c) Are there any plans to integrate services (especially Extended Care services) with community services?

f. Budget

(a) The need for non-recurring start up funds should be addressed.

(b) A first year budget should be prepared which outlines salary requirements and estimates utilization of ancillary services as travel costs, etc.

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**

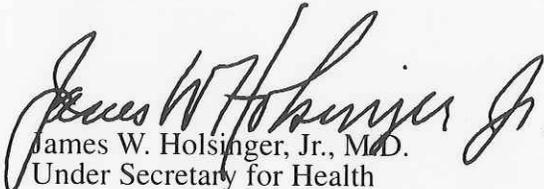
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9P-1 through 9P-26 ✓

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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June 1, 1992

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

2. Principal change is to add Appendix 9J, "Program Procedures for the Hospital Based Home Care Program."

3. Filing Instructions

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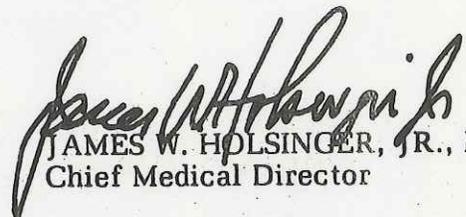
9-i

Insert pages

9-i

9J-1 through 9J-8

4. RESCISSION: None.


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

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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

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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.

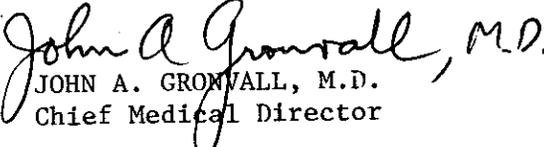
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

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

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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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6/1/84
JAN 27 1986

FROM

Marjorie R. Quandt
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications

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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