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(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

**Appendix 9N, Program Planning Factors for PTSD
(Post-Traumatic Stress Disorder)**

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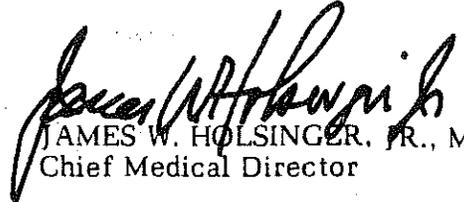
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CONTENTS

CHAPTERS

1. STRATEGIC PLANNING
2. STRATEGIC PLANNING CONSTITUENCY AWARENESS
3. STRATEGIC PLANNING CONFIDENTIALITY POLICY
4. OFF-CYCLE SUBMISSIONS
5. STRATEGIC PLANNING MODELS
6. MISSION REVIEW
7. STRATEGIC PLANNING DATA TABLE INSTRUCTIONS
8. ACTION DETAIL SHEET INSTRUCTIONS
9. CRITERIA AND STANDARDS AND PROGRAM PLANNING FACTORS
10. NURSING HOME NEEDS ASSESSMENT
11. STRATEGIC PLANNING, CONSTRUCTION, AND FDP (FACILITY DEVELOPMENT PLANS)
12. NATIONAL HEALTH CARE PLAN

RESCISSIONS

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10-88-150
10-89-31
10-89-132
10-90-124

CONTENTS

CHAPTER 9. CRITERIA AND STANDARDS AND PROGRAM PLANNING FACTORS

PARAGRAPH	PAGE
9.01 Purpose	9-1
9.02 Overview	9-1
9.03 Content of Criteria and Standards	9-1
9.04 Definitions of Criteria and Standards	9-2
9.05 Contents of Program Planning Factors	9-2
 APPENDIXES	
9A Criteria and Standards for VA Domiciliary Program	9A-1
9B Criteria and Standards for the Spinal Cord Injury Program	9B-1
9C Program Guidelines for Hospital-based Ambulatory Care Programs	9C-1
9D Criteria and Standards for VA Oncology Programs	9D-1
9E Criteria and Standards for Cardiac Surgery (Open Heart)	9E-1
9F Criteria and Standards for GRECCs	9F-1
9G Criteria and Standards for New Outpatient Services Remote from VA Medical Centers	9G-1
9H Planning Guidelines and Criteria and Standards for VA Intermediate Care Programs	9H-1
9I Criteria and Standards for Traumatic Brain Injury Rehabilitation Program	9I-1
9J Program Procedures for HBHC (Hospital Based Home Care)	9J-1
9K Program Planning Factors for Blind Rehabilitation Service	9K-1
9L Program Planning Factors for Spinal Cord Injury Program	9L-1
9M Program Planning Factors for Domiciliary-Based Homeless Program	9M-1
9N Program Planning Factors for PTSD (Post-Traumatic Stress Disorder) Program	9N-1
9O Criteria and Standards for Cardiology Continuum of Care	9O-1
9P Mental Health Criteria and Standards	9P-1
9Q Criteria and Standards for GEM (Geriatric Evaluation and Management) Program	9Q-1

PROGRAM PLANNING FACTORS FOR PTSD (POST-TRAUMATIC STRESS DISORDER)

1. PURPOSE

The purpose of the planning protocol for PTSD is two-pronged.

a. It is to achieve comprehensive integration of strategic and operational planning (including construction), budgeting and operational management of PTSD care in the field and VA (Department of Veterans Affairs) Central Office consistent with the VA NHCP (National Health Care Plan).

b. Equally important, the goal is to integrate all strategic and operational planning with an existing system in VHA (Veterans Health Administration) of research, planning, program funding, and program review begun by Congressional mandate in 1984 aimed at providing care for veterans with PTSD. This should produce at least five desirable outcomes as follows:

(1) Increased field awareness of the enormous data bases related to PTSD generated under VA auspices.

(2) Impetus to the field to utilize those data bases to improve planning for patient care and to improve daily operational patient care.

(3) A standardized needs assessment approach, fair to and known by the VA medical centers competing for scarce resources.

(4) Impetus to the field medical centers to form cooperative alliances to plan for special inpatient units or other program configurations which serve multiple primary service areas.

(5) Ultimately, equitable distribution of resources to improve the equity of access to care for PTSD.

2. BACKGROUND

a. In the past, actions, initiatives or programs were developed based on facility, district, or regional needs and projected growth in areas such as:

(1) Special programs, i.e., HBHC (Hospital Based Home Care), ADHC (Adult Day Health Care), Spinal Cord Injury,

(2) Disease entities, i.e., AIDS (Acquired Immunodeficiency Syndrome), PTSD, stroke, etc.,

(3) High technology equipment, i.e., MRI (Magnetic Resonance Imaging), PET (Position Electron Transformation), Lithotripsy, etc., and

(4) Workload changes, i.e., beds, visits, patients treated, etc.

b. Although local needs assessment methodologies have been developed for PTSD, the Strategic Planning and Policy Office has not previously developed projection models, needs assessments, or planning protocols for standard system-wide application.

c. There has been extensive and thorough work by the CMD (Chief Medical Director)'s Special Committee on PTSD in conjunction with the Great Lakes' HSR&D (Health Services Research and Development) Field Program. The contractual report of findings from the NVVRS (National Vietnam Veterans Readjustment Study) has also provided previously unavailable data bases which contain valuable prevalence information. These important efforts were the direct result of a Congressional mandate that was met outside of the formal VHA planning process.

d. Although the CMD's Special Committee on PTSD did not produce formal planning protocols, it was involved in program planning and evaluation.

(1) Special programs for PTSD were developed in conjunction with the VA Central Office, MH&BSS (Mental Health and Behavioral Sciences Service) in the form of:

- (a) A National Center,
- (b) Special Inpatient Units,
- (c) Outpatient PTSD Programs,
- (d) Dual diagnosis treatment programs, and
- (e) Contract programs.

(2) These programs were planned centrally, utilizing demographic/geographic data in conjunction with requests for proposals, and funded from special Congressional appropriations.

(3) The only field planning involvement was some initial prioritization of programs by the regions.

(4) Program evaluation continues to be a function of the CMD's Special Committee on PTSD, and MH&BSS through the NEPEC (Northeast Program Evaluation Center) at VA Medical Center, West Haven, CT.

3. DEFINITIONS

a. The **PTSD Planning Protocols** are general characteristics which are applied in order to evaluate the need for programs. These protocols will be used to complete program assessments and determine the priority for the development of programs applicable to PTSD. A program assessment is a quantitative narrative analysis of need. Programs planned for PTSD must take into consideration several important factors about the disorder and its treatment.

(1) PTSD is a chronic, major war related mental health problem frequently accompanied by comorbidities.

(2) The occurrence of the disorder as a problem related to war experiences by the veteran is unpredictable.

(3) The treatment of the disorder requires new, different, and often complex methods and programs.

b. The programs anticipated as needed system-wide are as follows:

(1) **National Center for PTSD.** The National Center for PTSD includes VA medical centers involved not only in patient care but also funded to be leaders in VA research and education in the field of PTSD.

(2) **Special Inpatient Units.** Special Inpatient Units are located in specific medical centers where they provide specialized treatment with multi-disciplinary treatment teams for refractory PTSD patients who often need specialized or longer term inpatient care.

(3) **PCTs (PTSD Clinical Teams).** A PCT is a multi-disciplinary team at the medical center level which identifies PTSD patients, provides and coordinates consultations to other services and professions and collects data on these patients.

(4) **EBTPUs (Evaluation/Brief Treatment PTSD Units).** EBTPUs are designed as a component of an existing inpatient psychiatry unit which provide short term inpatient care for patients close to their homes.

(5) **PRRPs (PTSD Residential Rehabilitation Programs).** PRRPs are based in domiciliaries. These semi-structured therapeutic environments provide further care to veterans with previous PTSD treatment prior to their release to more independent functioning in the community.

(6) **Vet Centers.** Vet Centers are an important part of PTSD care; they provide initial screening services, counseling, and referrals to VHA facilities.

(a) Vet Centers do not serve veterans with PTSD exclusively and are not funded through the same mechanisms as VHA facilities,

(b) Vet Centers are funded separately from VHA and maintain a separate data collection system.

(c) Planning for Vet Centers based on traditional VA workload measures is not included in the planning protocols.

(d) The existence of Vet Centers is pertinent to the issues of accessibility and sharing.

(7) Programs Involving Construction or Redesignation

(a) Many PTSD patients are treated in established VA medical center programs such as:

1. Inpatient psychiatry,
2. Alcohol treatment,
3. Substance abuse,
4. Medicine or domiciliary beds, and
5. Outpatient Mental Hygiene Clinics and Day Hospital programs.

(b) These patients may need less intensive treatment than those treated on Special Inpatient Units, or they may need treatment for concurrent problems or comorbidities.

(c) Current and future documented unmet needs for PTSD care, which can be provided through additional hospital beds or outpatient visits, may have a significant impact on individual construction projects.

(d) The planning protocols may also be used to evaluate the need for construction projects, or the sizing of construction projects, based on the need to provide PTSD care.

(e) In some cases minimal or no construction will be needed to redesignate beds from some current usage to PTSD usage.

(8) PTSD Contract Program

(a) The PTSD Contract Program is administered by VA Central Office, RCS (Readjustment Counseling Service), which provides funds to contract with private sector health care providers. Contracts are let to purchase aftercare for veterans with PTSD who live in areas remote from VA facilities, or in areas with a high concentration of veterans with PTSD, to the extent that nearby VA facilities cannot provide sufficient staff for aftercare.

(b) Any PTSD program assessment should be as detailed as possible to ensure appropriate consideration by regional and VA Central Office reviewers. Information contained in the protocol should be from various sources, such as:

1. Local data contained in the:
 - a. PTF (Patient Treatment File),
 - b. Staff Outpatient File,
 - c. CDR (Cost Distribution Report),
 - d. Veteran Population File, and
 - e. AMIS (Automated Management Information System) reports.
2. Other federal agencies such as the Census Bureau.
3. Other internal VA sources such as the NVVRS and reports of the CMD's special committee on PTSD, or any other pertinent data bases.

4. PROGRAM PLANNING FACTORS

The following factors should be considered, and where applicable, included in any analysis for submission of actions, initiatives, or programs for PTSD care:

a. Referral Patterns of Patients and Geographic Area Served

(1) In planning for PTSD extensive data bases exist which may be utilized to ascertain where patients in need of services are located and where patients are located who are currently receiving VA services for PTSD.

(2) These data bases can be utilized specifically to develop disorder prevalence rates, treatment rates, and ratios which can be used to compare veterans' relative access to care in specific geographic areas. That information can be utilized to plan additional services for areas that have some treatment services but are not satisfying veterans' needs, or to plan for services in areas that have no PTSD treatment services within a reasonable distance.

(a) The NVVRS contains sample data on the number of Vietnam veterans nation-wide and those with PTSD. Follow-up information has been developed for the CMD's Special Committee on PTSD based on the NVVRS.

(b) The PTF contains zip code level and data as described in the previous paragraphs on inpatients treated by VA medical centers.

(c) The VA Mental Health Outpatient and Vet Center Survey contains Social Security level data on veterans treated for PTSD that can be matched with PTF data to provide outpatient origin data.

(3) In general, PTSD patients should have geographic access equal to other patients utilizing the VA health care system. For that reason, the existing planning guidelines for the establishment of outpatient clinics may be used in determining reasonable time and travel distances for PTSD patients seeking health care under VA auspices.

(4) In areas remote from any present or planned VA facilities with substantial numbers of veterans with PTSD, a PTSD Contract Program may be planned in lieu of a PTSD program at a community-based clinic. All existing and planned medical centers, free-standing outpatient clinics, and satellite outpatient clinics should be capable of providing PTSD services.

(5) Some areas of the country currently experience a large potential or present demand for bed services, but have a small supply of beds. Demand for treatment may be affected by:

(a) The acceptance of psychiatry in the locale, and

(b) Patient characteristics such as:

1. Income,

2. Race, or

3. National origin.

(6) The CMD's Special Committee on PTSD has addressed these problems in an attempt to provide more equity of access. These problems should also be addressed by the regions, consortiums of individual medical centers, and Vet Centers planning for PTSD care together. The result should be Special Inpatient Units in strategically located medical centers with feeder medical centers referring refractory patients. However, at times this ideal is modified by a lack of professionals available to provide services in a given geographic area.

(7) These same consortiums should assess the quantity and quality of care needed in terms of beds, visits, and programs to care for those patients who can be cared for locally

without referral to a Special Inpatient Unit. If these needs assessments result in additional construction needs, then projects should be included in construction plans.

b. Current and Projected Need

(1) Planning for services and programs to meet the health care needs of veterans has traditionally been based on models (VA/GAO (General Accounting Office) bed sizing and outpatient models) which project past service usage by age forward according to the change in veteran population by age. This methodology assumes the incidence of the diseases or medical problems causing the health care problems will remain constant and that the past amount of services provided actually met the needs of the veteran population.

(2) Utilization of this methodology is invalid for PTSD planning for at least two important reasons:

(a) First, during the 1980's there were only two "new diseases" causing any major VA-wide impact on workload and cost which were unpredictable based on past incidence and service usage patterns. Those "new diseases" were AIDS and PTSD. Although we know PTSD has been in existence for a long while, it was not formally recognized and named by the American Psychiatric Association until 1980, and it continued to be relatively unknown and poorly understood for several years. Although veterans from previous wars experienced PTSD and may have been treated for problems caused by the disorder in VA and elsewhere, it was the return of the Vietnam veterans which brought attention to the disorder. Problems suffered by Vietnam veterans gave impetus to Congress to mandate care; these problems began bringing new workload to the VA, 5 to 15 years post-Vietnam.

(b) The second reason the methodology is invalid is:

1. Information gathered by the CMD's Special Committee on PTSD indicates that although PTSD symptoms became evident to many returning Vietnam veterans quite soon, the realization by those veterans that the symptoms were war-related often came years later and the time of this realization was not predictable.

2. This is underscored by the fact that VA clinicians still identify some new PTSD cases among World War II and Korean Conflict veterans.

3. The NVVRS has provided an incidence of PTSD among Vietnam veterans, and there is no current data which indicates when a veteran will make the connection between his symptoms and war experiences and seek help at the VA or elsewhere for PTSD.

(c) Traditional VA projection methodology is invalid due to:

1. The lack of predictability,

2. The large numbers of Vietnam veterans with current PTSD (479,000 individuals) or symptoms (an additional 350,000 individuals), and

3. The small number thus far treated by VA (20 percent).

NOTE: In an effort to improve the accuracy of workload estimates for the development

(5) **Projection methodology**

(a) Data sources for the numbers to be used in the PTSD Projection Methodology can be obtained from:

1. The NVVRS,
2. The Mental Health Outpatient and Vet Center Survey,
3. The PTF,
4. The Staff Outpatient File, and
5. The NEPEC Reports.

(b) This methodology affords creativity and adjustment to local planning activities in addition to providing some nation-wide standardization. An example of how it can be used is contained in paragraph 6.

c. **Appropriate Type and Size of the Program**

(1) Projections under current and projected need were expressed in terms of beds and visits because they are used as the basic building blocks for program planning and costing. Other useful tools in planning the appropriate type and size of PTSD programs include:

- (a) Established criteria and standards,
- (b) Data from the VA's Cost Distribution Report,

(c) Data presented in the CMD's Special Committee on PTSD reports comparing FTEE (Full-time Employee Equivalent)/bed, physician FTEE/bed and funding of special inpatient units and PCTs,

(d) The Long Journey Home: The First Progress Report on the Department of Veterans Affairs PTSD Clinical Teams Program, and

(e) The Mental Health Outpatient and Vet Center Survey.

(2) In all stages of PTSD planning there should be clinical input and this is particularly true in determining the type of programs and the volume to be served in each program.

(a) For example, after the needed outpatient visits are projected for a medical center's DPPB (Distributed Planning Population Base), it will be important to look at historical data and utilize clinical judgment to determine how many visits should be planned and costed in programs such as:

1. Mental Hygiene Clinic,
2. Day Hospital, or
3. a PTSD Contract Program.

(b) Judgments need to be made on the relative benefits versus the costs of augmenting an existing program such as Mental Hygiene or starting up a new Day Hospital.

1. In the case of contract programs, clinical judgment needs to determine whether there is sufficient expertise in PTSD treatment in the private sector in the locale to be served.

2. In the case of planning for inpatient services, there must be joint efforts among prospective feeder medical centers, and those existing or proposed to contain Special Inpatient Units, in order to provide the proper mix of services.

(3) In general, the steps for determining the appropriate types and sizes of programs for PTSD care are as follows:

(a) Distribute the workload as determined in paragraph 4.b., Current and Projected Need, in terms of beds and visits to the appropriate programs utilizing historical data and clinical judgment.

(b) Budget the FTEE, salaries, equipment, and all other dollars for each program.

(c) Issues of cost and treatment effectiveness on an inpatient basis are still being debated in the medical community.

1. Compare the relative costs and clinical efficacy of the programs as a check on the decisions made.

2. Costs should be compared to comparable community programs if available.

3. The minimum workload necessary to maintain clinical competence as well as cost efficiencies should also be considered.

d. Opportunities for Consolidation, Sharing or Contracting of Programs. Since the major causes of PTSD are war related, the VA has a special responsibility in this area and through Congressional mandate has become the leading health care provider in the field.

(1) Since much of the responsibility and expertise lies with the VA, the opportunities for community sharing may be limited but should be explored in order to provide increased access to care and cut costs through joint ventures. Since a diagnosis of PTSD may negatively affect the career of active-duty military personnel, some interest and opportunities for VA/DOD (Department of Defense) sharing may also be limited.

(a) Joint pre-discharge screening mechanisms involving PCTs and DOD personnel would be highly desirable.

(b) Potential VA patients could be identified early, resulting in more beneficial treatment for veterans and an eventual savings to the VA years later.

(c) In light of current volatile foreign situations in which the United States is embroiled, pre-discharge programs should be explored at both the VA Central Office and local levels.

(2) PTSD Contract Programs should be explored, especially in underserved and remote areas. Again, care must be taken to ensure that the services contracted stem from professionals with experience and expertise in the field of PTSD treatment.

e. **Available Resources.** Planning for PTSD should consider whether existing resources would be available for the program planned.

(1) A particular facility may have a high degree of demonstrated need for a program to address PTSD, but be unable to recruit the personnel qualified to staff the program. In the case of affiliated medical centers, the role the affiliation would be willing to play in providing staff, recruiting efforts, space, administrative support and equipment should be explored and considered in program planning.

(2) Existing medical center resources that would negate the need to receive additional resources to start or expand a program should be addressed. Examples include:

(a) Conversion of closed surgical beds to psychiatry, substance abuse, or special PTSD inpatient unit beds, or

(b) Conversion of an under-utilized ADHC Center to a Day Hospital Program aimed at PTSD patients.

5. CONCLUSION

The planning protocol for PTSD is not intended to be all inclusive. Rather, the protocol is intended to provide a consistent form for developing proposals and stimulate planning based on need regardless of the existence or absence of an RFP (Request for Proposal) from MH&BSS.

a. In some instances, the establishment of need will stimulate reallocation of resources to programs with higher priorities at the medical center, regional and VA Central Office levels.

b. If each needs assessment for PTSD includes the program planning factors as a minimum requirement, a mechanism will exist at any level to help judge the feasibility of establishing or expanding PTSD programs.

c. The assessments will provide medical center specific documentation to develop budget and operational goals and objectives at the VA Central Office level.

6. SAMPLE ANALYSIS PTSD PLANNING

a. VA Medical Center Rural began providing psychiatry services to veterans in 1988. Since that time, the Psychiatry Service and Psychology Service staffs have noticed a large influx of patients with PTSD who demanded considerable staff time and resources.

(1) This was discussed with the Chief of Staff who in turn discussed the matter with the medical center Director and the FPC (Facility Planning Coordinator).

(2) The Director charged the FPC with coordinating the tasks of gathering data on PTSD, performing a needs assessment for services, and suggesting potential implementation resources.

(3) The Director also instructed the FPC to contact VA Medical Center Referral Center and discuss the potential impact of VA Medical Center Rural's planning for PTSD on VA Medical Center Referral Center and the need for joint planning.

b. VA Medical Center Referral Center had been dealing with PTSD for over 5 years through its Special Inpatient Unit and was glad to see the interest by VA Medical Center Rural in the problem. However, VA Medical Center Referral Center knew that any joint planning should also include VA Medical Center Affiliated, another major source of PTSD patients for VA Medical Center Referral Center.

c. A planning meeting was held at VA Medical Center Referral Center which included the FPCs from each medical center and selected members from the Psychology and Psychiatry staffs.

(1) At the meeting the PTSD Planning Protocol was discussed and initially it was decided to plan for PTSD services for the veteran population contained in all three primary service areas as a unit.

(2) Data collection was divided so that VA Medical Center Referral Center collected prevalence data utilizing data specific to the area containing the three VA medical centers.

(3) Since VA Medical Center Affiliated employed a programmer capable of accessing the PTF, it collected historic length of stay and bed usage data.

(4) VA Medical Center Rural provided visit rate data from the Mental Health Outpatient Survey.

(5) VA Medical Center Affiliated disagreed with the Mental Health Outpatient Survey data, so it decided to provide its own locally collected data covering a full year. Further, VA Medical Center Rural agreed to provide costing data based on facility specific CDR costs for each facility after workload projections and program planning were complete.

d. The PTSD Planning Protocol formulas were applied as follows:

(1) **Bed Projections**

(a) Area Served Vietnam era Vets with PTSD in thousands	X	Current rate treated as inpatients by area served per thousand	=	Number needing inpatient care
VA Medical Center Rural	3.5 (1000's)	X 45 (per 1000)	=	157.5 Needing inpatient care
VA Medical Center Referral Center	10.0 (1000's)	X 50 (per 1000)	=	500 Needing inpatient care
VA Medical Center Affiliated	10.0 (1000's)	X 18 (per 1000)	=	180 Needing inpatient care

(b) At this point, using historical discharge and patient origin data from the PTF of VA Medical Center Referral Center, it was determined that the number of patients displayed in the following equation, which are a portion of the total inpatients needing care, would need care on a Special Inpatient Unit:

VA Medical Center Rural		20	
VA Medical Center Referral Center		75	
VA Medical Center Affiliated		50	
<u>Total</u>		=	145 inpatients needing Special Inpatient Unit

$$\text{Inpatients} \times \text{Planned LOS (Length of Stay)} = \text{Total BDOC (Bed Days of Care) Needed}$$

NOTE: Determined on the basis of historical clinical judgment to be 120 days.

$$145 \times 120 \text{ days} = 17,400 \text{ BDOC needed}$$

(c) At this point the BDOC already provided were calculated by using PTF data from VA Medical Center Referral Source to determine the BDOC provided on the Special Inpatient Unit annually.

$$\text{BDOC needed} - \text{BDOC already available} = \text{new BDOC needed}$$

$$17,400 - 9,855 = 7,545 \text{ new BDOC needed}$$

$$\text{New BDOC needed} / 365 / \text{Standard Occupancy Rate} = \text{New Special Inpatient Unit Beds Needed}$$

NOTE: The standard occupancy rate for Psychiatry is 90 percent.

$$7,545 / 365 / .90 = 23 \text{ New Special Inpatient Unit Beds needed in the catchment area equivalent to the DPPBs of all three medical centers}$$

(d) At this point, using historical discharge and patient origin data from the PTF it was determined that the number of inpatients displayed in the application of the following formula, which are the remainder of the total inpatients needing care, would need care on beds other than Special Inpatient Unit Beds. This can be calculated on a bedsection basis but for brevity this has been done on a VA medical center basis.

$$\text{Remaining Inpatients} \times \text{Projected LOS} = \text{Total BDOC needed}$$

NOTE: Historical LOS can be national average, local average or other quantifiably justified average. Source can be PTF.

$$\text{VA Medical Center Rural} \quad 137.5 \times 10 \text{ days} = 1,375 \text{ BDOC needed}$$

$$\text{VA Medical Center Referral Center} \quad 425 \times 21 \text{ days} = 8,925 \text{ BDOC needed}$$

$$\text{VA Medical Center Affiliated} \quad 130 \times 7 \text{ days} = 910 \text{ BDOC needed}$$

2. The projections show an excess of beds that are not Special Inpatient Unit beds

a. Further patient origin studies showed the "excess" beds were being used by veterans from other areas that come directly to VA Medical Center Referral Center.

b. This data showed the need to look at referral patterns to insure all patients are served within the three catchment areas without any additional beds that are not Special Inpatient Unit beds.

3. Since the total historical inpatient usage of veterans at VA Medical Center Affiliated is much lower than the other two medical centers, a committee was formed to study that issue in the future.

(b) Outpatient

1. There is a need to plan additional outpatient visits.

2. Since the visit rate is much higher at VA Medical Center Affiliated than the other two medical centers, the same committee formed to study the low inpatient usage was also asked to study this issue.

(2) The multi-disciplinary team proceeded to plan the following programs and recommended sources of funding:

(a) Special Inpatient Unit

1. Although 23 beds were projected, only ten additional were planned at VA Medical Center Referral Center because:

a. It would be difficult to recruit staff for more than 10 additional beds according to VA Medical Center Referral Center.

b. It would be not be difficult to recruit staff to VA Medical Center Rural and the remaining 13 beds could easily be included in a construction project already planned (see par. 3 (7), Programs Involving Construction or Redesignation).

2. Cost Estimates

a. These ten beds were costed utilizing average FTEE and all other costs already established historically in the CDR of VA Medical Center Referral Center. No indirect costs were added because the increase in beds was less than one ward.

b. VA Medical Center Referral Center estimated the minimal equipment costs (which were minimal because the recommended funding source was funds from VA Medical Center Referral Center through conversion of beds and staff from surgery due to declining occupancy rates).

(b) PCTS (PTSD Clinical Teams). Since none of the medical centers had a PCT, it was felt that both VA Medical Center Rural and VA Medical Center Affiliated needed a PCT, particularly to deal with the volume of outpatient visits projected.

1. Since the volume at VA Medical Center Rural was much less, a two person team consisting of a psychiatrist and a social worker was planned.

a. VA Medical Center Rural felt according to past experience these disciplines could be recruited whereas nursing personnel would be difficult to recruit.

b. Costing was based on VA Medical Center Rural's CDR average costs for the positions.

2. VA Medical Center Affiliated felt a team of at least four was needed including a psychologist, social worker, counselor, and a LPN (licensed practical nurse).

a. According to VA Medical Center Affiliated's past experiences, psychiatrists were extremely difficult to recruit as were RNs (Registered Nurses).

b. Costing was based on VA Medical Center Affiliated's CDR average costs for the positions.

3. The source of funds for the positions was determined to be the VA Central Office MH&BSS which has distributed RFPs for PCTs in the past. Any other costs would be borne by the medical centers.

(c) **Vet Centers.** There was only one Vet Center in all three areas and it was located in the same city as VA Medical Center Affiliated.

1. Through additional data provided by the Vet Center it was determined that through a very active staff they were providing the equivalent of 10,000 visits per year to veterans in the VA Medical Center Affiliated's area.

2. This number was subtracted from the new visits needed at VA Medical Center Affiliated.

(d) Programs Involving Construction or Redesignation

1. In addition to the conversion of 10 surgery beds at VA Medical Center Referral Center, an additional 13 bed unit was planned at VA Medical Center Rural, which already has a construction project in its 5 Year Facility Plan to convert under utilized space in an outlying domiciliary building to additional psychiatry beds.

a. The space available was sufficient to add the 13 beds to the project.

b. Because of its setting and the low cost of living, VA Medical Center Rural is able to recruit Psychiatry, Psychology, and Social Work staff.

c. Therefore, a 13 bed Special Inpatient Unit was planned at VA Medical Center Rural.

d. The sources of funds expected for the unit were the funds for construction and activation normally associated with any VA construction project, plus some funds to augment the staffing needed for a Special Inpatient Unit from MH&BSS in VA Central Office.

2. Patient origin data

a. In planning for the projected visits, patient origin data was gathered which indicated that the following percentages of visits could be expected within the commuting areas:

VA Medical Center Rural	40%
VA Medical Center Referral Center	60%
VA Medical Center Affiliated	80%

b. Therefore, the following new visits were planned at each VA Medical Center:

VA Medical Center Rural	16,000 X .40 = 6,400 visits
VA Medical Center Referral Center	48,000 X .60 = 28,800 visits
VA Medical Center Affiliated	30,000 X .80 = 24,000 visits

NOTE: VA Medical Center Affiliated subtracted 10,000 visits provided at the Vet Center.

3. Space

a. Since VA Medical Center Rural had just completed an outpatient clinical addition, there was adequate space and staff from activation funding in conjunction with the planned PCT to accommodate the new 6,400 visits.

b. VA Medical Center Referral Center also had adequate space but not adequate staff to provide an additional 28,800 visits for PTSD. The only funding source considered was a future item in the VA budget placed there through the VHA planning, budgeting and resources process.

c. VA Medical Center Affiliated had an approved outpatient clinical addition construction project in the design phase. The contractor took the additional 24,000 visits into consideration when space was designed, and staffing was built into activation funding.

d. The only costing necessary was for the visits planned at VA Medical Center Referral Center which utilized the costs attributable to PTSD on a per visit basis from their own CDR.

(e) PTSD Contract Program. The remaining visits were planned to be provided and funded through the PTSD Contract Program when a demand sufficient to support a contract arose in any particular geographic area.

1. The following numbers were planned for this program at each VA medical center:

VA Medical Center Rural	16,000 X .60 = 9,600 contract visits
VA Medical Center Referral Center	48,000 X .40 = 19,200 contract visits
VA Medical Center Affiliated	30,000 X .20 = 6,000 contract visits

NOTE: VA Medical Center Affiliated subtracted 10,000 visits provided at the Vet Center.

2. The costs would be negotiated by the Acquisition and Materiel Management Service at each medical center with significant input by the Psychiatry and Psychology staffs.

May 14, 1992

M-9
Chapter 9
APPENDIX 9N
Change 5

(f) Conclusion

The multi-disciplinary team presented this plan to the medical center Directors who approved them. The proper forms and proposals were sent to the Regional Director and the proper VA Central Office offices to set the plans in motion. The medical center Directors maintained the multi-disciplinary team and charged them with monitoring progress and implementation and providing any updated plans or data needed.

January 28, 1993

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

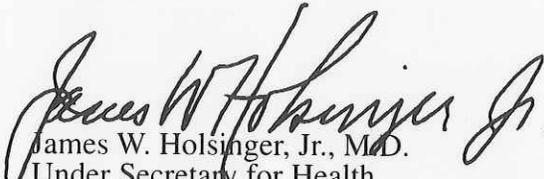
Remove

9-i ✓

Insert

9-i ✓
9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.


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

Distribution: **RPC 1318**
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May 14, 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 the addition of the following appendices to Chapter 9:

a. Appendix 9M: Program Planning Factors for Domiciliary-Based Homeless Program.

b. Appendix 9N: Program Planning Factors for PTSD (Post-traumatic Stress Disorder) Program.

3. Filing Instructions

Remove Pages

9-i ✓

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9M-1 through 9N-17 ✓


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

Distribution: RPC: 1318
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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

Cover page through iv


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

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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.

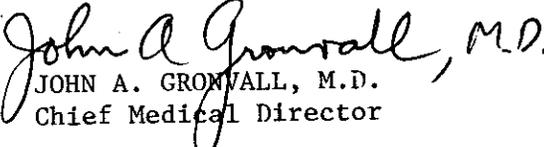
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

Insert pages

Cover page through v
1-1 through 11-3

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


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

Distribution: RPC: 1318 is assigned
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Printing Date: 10/89



Veterans Administration

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REMARKS

SUBJ: Departmental Manual M-9

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

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

"Planning and Evaluation and Systems Development"

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

3. Thank you for your assistance.

Approved Disapproved

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

2-3-86
Date

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611/134
JAN 27 1986

FROM

Marjorie R. Quandt
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications
Management Staff (10A1B)

TEL. EXT.
3331

VA FORM 3230
MAY 1980

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



Veterans
Administration

Memorandum

APR 03 1984

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

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

Subj: Establishment of M9-MEDIPP

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

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

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

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

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

Approve
~~Disapprove~~

4/17/84
Date