

**Manual M-9, Strategic Planning**

**(Veterans Health Administration)**

**Chapter 10, Nursing Home Needs Assessment**

**(Paragraphs 10.01 through 10.05; Appendix 10A through Appendix 10C)**

**Revises Chapter 10 dated October 2, 1989 through Change 2 dated June 26, 1991**

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Department of  
Veterans Affairs

# Strategic Planning

July 26, 1991

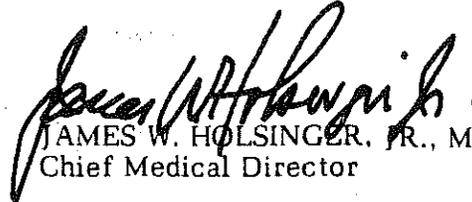
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July 26, 1991

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

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## RESCISSIONS

The following material is rescinded:

Complete rescissions:

### Circulars

10-87-113 and Supplement No. 1  
10-87-147  
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CHAPTER 10. NURSING HOME NEEDS ASSESSMENT

10.01 INTRODUCTION

a. Long range projections of future nursing home care needs for veterans are based in part on data derived from the NCHS' (National Center for Health Statistics) National Nursing Home Survey.

b. By assuming that veterans utilize NHC (nursing home care) at a rate comparable to male civilians, the future needs for NHC by veterans can be projected. The equation is both age and census region-specific.

$$\text{Veteran Utilization} = \frac{\text{Male Civilians in Nursing Homes}}{\text{Male Civilians in Population}}$$

c. The census region rates are refined into medical facility-specific rates by weighting the proportion of a facility's population that overlaps into more than one census region. All facilities which fall into one census region have the same utilization rates.

10.02 PLANNING STANDARDS

a. Current policy for NHC requires that establishment of additional nursing home care beds be accomplished through maximum utilization of CNH (Community Nursing Home) and SH (State Home) nursing home beds or conversion of excess hospital capacity wherever possible before constructing new VA (Department of Veterans Affairs) nursing home beds.

b. All proposals for additional VA NHCU (Nursing Home Care Unit) beds acquired via conversion with major renovation or through construction must be validated by accounting for all suitable and available CNH/SH NHC beds.

c. Before proposing new construction of VA NHCU beds, the potential for conversion of excess hospital capacity must be evaluated.

d. The projected veteran demand for a future year for a facility is equal to "Veteran Utilization Rate X Veteran Population."

e. The market share is defined as the percentage of the veteran demand treated under VA auspices in VA, community, or state nursing home beds.

(1) The number of veterans treated under VA auspices is:

$$\text{VA Sponsored Demand} = \text{Veteran Demand} \times \text{Market Share}$$

(2) The general market share to be used for planning purposes is 16 percent.

f. The percentages of veterans to be treated under VA auspices (i.e., program mix) in VA beds, CNH beds, and state home beds are 30 percent, 40 percent, and 30 percent, respectively.

g. The projected future size of each program is

$$\text{(a) VA Census} = \frac{\text{Total VA}}{\text{Sponsored Demand}} \times 30 \text{ percent}$$

(b) Community Nursing Census = Total VA  
Sponsored X 40 percent  
Demand

(c) State Home Census = Total VA  
Sponsored X 30 percent  
Demand

h. This national goal may not be achieved in some VA medical centers and regions because of the absence of state home nursing home care beds or a constrained CNH bed supply. Nevertheless, VA medical centers and regions are expected to work towards the program mix guideline through comprehensive inter-facility planning efforts. Inter-facility planning is necessary for allocating SH and CNH beds whenever there is an overlap in two or more facilities' DPPBs (Distributed Planning Population Bases).

### 10.03 PLANNING DOCUMENTS

a. Planners will each have a computer disk which contains an updated listing of age, facility, and DPPB-specific utilization rates.

b. Current program planning guidance for each of the three nursing home programs (i.e., VA, CNH, SH) is contained in the Program Guide, G-1, M-9, Part I.

c. M-9, chapter 10, Appendix 10A, "Procedures for Validating Planned Increases in VA NHCUs Beds."

### 10.04 ANALYSIS REQUIREMENTS

Planners must:

a. Reassess current nursing home care plans in view of market share percentages and current utilization rates.

b. Complete an analysis on the availability and suitability of CNH and SH nursing home beds if new construction or conversion requiring major renovation is being proposed (see M-9, ch. 10, app. 10A).

c. Complete an analysis of the SH nursing home care program, including a patient origin study, indicating in which counties the patients reside. This data can be found in the PTF (Patient Treatment File) for patients discharged from a VA facility, or from the SH records. Allocations of state nursing home census, for the purposes of planning, should be by facility based on patient origin studies. The VA medical center which is the clinic of jurisdiction still remains responsible for related operational resources.

d. Complete an analysis of the potential for conversion of excess hospital capacity prior to proposing new construction.

e. Assess impact on currently funded construction projects and planned conversions to nursing home care beds.

### 10.05 SUBMISSION REQUIREMENTS

a. Submission of NHC plans should be as a result of the application of criteria and standards which determines need. Requests for additional VA NHCUs beds should be

included with Regional submissions for the NHCP (National Health Care Plan).

b. Planned census levels, program mix and market share information for specified FYs (Fiscal Year) (e.g., FY 1991 through FY 1995).

c. Supporting documentation for use in the technical review including:

(1) Projections of total nursing home care by age groups for specified FYs.

(2) SH and CNH care survey analyses including a narrative describing the impact of present and planned community/state supply on specific, proposed/planned VA NHCU bed increases, e.g. through construction/conversion. Supporting documentation should accompany survey analyses.

(3) Projection of CNH beds for all planning years (e.g., FY 1991 through FY 1995).

(4) Quantitative justification for departures (+, -) from market share and program mix guidelines, and census levels.

(5) Details of inter-facility planning for SH including patient origin studies.

(6) Details of overall inter-facility planning. This must describe not only who intends to address the demand outside the facility, but the recipient facility should also report in their narrative that they intend to absorb XX percent from medical center XX, etc.

(7) Analysis of potential for conversion of excess hospital capacity.

## PROCEDURES FOR VALIDATING PLANNED INCREASES IN VA NHCU (NURSING HOME CARE UNIT) BEDS

### 1. INTRODUCTION

a. The purpose of these procedures is to obtain information on the availability and suitability of SH (state home) and CNH (community nursing home) beds. This information is needed in order to determine whether new VA (Department of Veterans Affairs) NHCU beds are needed or whether NHC (Nursing Home Care) needs can be met by CNHs and SHs.

b. VA NHCU construction projects are specific to DPPB (Distributed Planning Population Bases), therefore, all analyses are DPPB-specific. The procedures do not mandate a minimum or maximum set of analyses; rather, the amount of analysis required will be dictated by the number of DPPBs which project a future increase in VA NHCU beds. VA planners must be prepared to defend the increase with an appropriate array of analyses. Because the analyses are DPPB-specific and, thus, no set of procedures could capture all factors unique to the wide varieties of DPPBs within the VA medical care spectrum, planners should employ unique analyses, as appropriate, when defending planned increases in VA NHCU beds.

c. Data should be gathered on a CNH-by-CNH basis. Due to the wide variation of data available from State Health Departments, etc., it may not be possible to obtain some of the individual CNH data without directly contacting each CNH. Planners and other staff involved in the process should make the nursing home staffs aware that the purpose of the inquiry is the assessment of the potential of available and suitable beds -- not an evaluation or inspection of the nursing home.

d. To provide consistency in determining the availability and suitability of CNH beds, certain critical data must be collected (see M-9, ch. 10, app. 10C). Other elements, locally developed, may be considered when there is compelling justification for their use and this is well documented.

### 2. ASSUMPTIONS

a. Justification for constructing new VA NHCU beds stems from the 30-40-30 program mix guideline (see M-9, ch. 10, par. 1.02), whereby the national goal for VA NHCU beds was set at 30 percent of the total NHC market share. It has been an implicit planning practice that as long as the VA NHCU program mix did not exceed 30 percent, the VA NHCU allocation was "defensible." This assumption removes that implicit practice from the planning spectrum. The basic planning strategy will be to defend additional VA NHCU beds by accounting for all suitable and available CNH and SH NHC beds and demonstrating that there is not a sufficient number of beds available to meet the selected market share.

b. Planners must further assume that 70 percent of the nursing home workload will be outside the VA.

c. A key assumption necessary to conduct the analyses is that current occupancy rates and suitability status for CNH and SH NHC will be same in future years as today and that the current situation will prevail. For example, if an analysis shows an occupancy rate of 93 percent, the same occupancy rate will be assumed in the future target year. This

assumption is consistent with the NHC Needs Assessment Methodology which utilizes a straightline basis to project rates.

d. To account for future demand, the following analysis utilizes a change factor based upon the increase in the age 65+ veteran population for the target year.

(1) The change factor is computed as follows:

$$\frac{\text{Civilian Male Population Aged 65+ (2005) by DPPB}}{\text{Civilian Male Population Aged 65+ (1990) by DPPB}}$$

(2) For example, if the age 65+ veteran population doubles by the Year 2005, then needed CNH beds will double. In a sense, therefore, the age 65+ change factor functions as a "projection" of CNH beds..

(3) If specific data are available to planners which suggest otherwise, those data could be used in place of the age 65+ change factor.

*NOTE: If civilian population is unavailable, state-specific ratios may be used. If neither civilian or state population is available, veteran population ratios may be used. Planners should also indicate the ratio used.*

### 3. OVERVIEW OF PROCEDURE

The following procedures are displayed in a hierarchical-type arrangement whereby increasingly detailed data is required as the relative availability of CNH and SH NHC beds increases. Procedures for assessing the CNH market are developed first followed by procedures for assessing the SH NHC market. Planners should not consider themselves bound to the tasks and data sources but rather should use whatever data are available from whatever sources to strengthen the defensibility of proposed VA NHCU construction projects or conversions.

### 4. COMMUNITY NURSING HOME CARE

a. How many CNH beds currently exist in the DPPB?

(1) Data Sources

(a) State Departments of Health Care/Planning/Licensing for Health Care;

(b) State Nursing Home Associations; and

(c) HSA (Health Systems Agency) -- NOTE: *HSAs are not active in all states.*

(2) Include only state-licensed NHC beds. Some states will include boarding homes, community care homes, etc., in their licensing programs. Such homes do not meet minimum definitions of NHC (see M-5, pt. III, ch. 3) and should not be included; residential care and personal care beds should not be included.

b. What is the current availability of CNH beds in the DPPB?

(1) Data Sources

- (a) State Departments of Health Care/Planning/Licensing for Health Care;
- (b) State Nursing Home Associations; and
- (c) HSA.

(2) "Availability" here means empty (i.e., there is not a patient currently occupying the bed) bed available for occupancy. (At this point, the "suitability" of any empty beds will not have been assessed.)

(a) For planning purposes, a 95 percent occupancy rate will be considered full occupancy. This guideline is the same as that used for VA NHCU beds. Some data sources will show availability in whole numbers of beds; others will show occupancy rates which can then be used to compute the number of empty (available) beds.

(b) It is important to note that even if a DPPB in the aggregate shows a 95 percent occupancy rate, many individual CNHs may experience less than 95 percent. The available beds in CNHs with less than 95 percent occupancy should be assessed for suitability because they represent opportunities to expand the VA's penetration into the CNH market. Nursing homes which have recently opened and have not reached their optimal planned occupancy rate should be noted in the analysis.

(c) Planners may encounter some CNHs for which an occupancy rate of less than 95 percent is considered by the home as "full." These situations can exist because of patient mix/staffing patterns in the CNH and such CNHs with apparently available beds may even have waiting lists. For example, a CNH may have several available and suitable beds but will admit only specific light care patients. Whenever such situations are encountered, the facts need to be carefully documented because, for planning purposes, such apparently available and suitable beds will be considered unavailable.

**c. What is the suitability of currently available CNH beds in the DPPB?**

**(1) Data Sources**

(a) Social Work, Acquisitions and Materiel Management, and Medical Administration Services at VA medical centers;

(b) State Departments of Health Care/Planning/Licensing for Health Care;

(c) State Nursing Home Care Associations; and

(d) RCS 10-0168, Community Nursing Home Report

(2) An available bed must also be suitable before it can be used by the VA. Thus, the available supply in most instances will be reduced by the number of available, but unsuitable, beds. Suitability can be a very difficult concept to quantify; however, it is critical that it be quantified in order to adequately assess the viability of CNH beds for use by the VA. The analysis of suitability should be done on a CNH-by-CNH basis. For planning purposes, "suitable" CNH beds will be the end result of an analysis of the following:

(a) An available CNH bed, certified for Medicare/Medicaid, is generally considered "suitable" for planning purposes. The vast majority of veterans convert to Medicaid following placement at VA expense.

1. Some certified homes constructed before 1984 may not meet current Life Safety Codes or FSES (Fire Safety Equivalency System); and in some areas this may be an important factor in assessing suitability of CNH beds.

2. VA requires a CNH to meet current Life Safety Codes or FSES.

3. Some CNHs, which are "certifiable," may not be certified because they choose not to be. In these cases, an on-site survey would be required to determine suitability.

(b) CNHs which are currently under contract with the VA are considered suitable unless action is underway to terminate the contract (e.g., lack of use or inaccessibility of beds to patients being discharged from the VA medical center, or unresolved quality of care issues). By using the analysis of available beds above, planners can compute the number of suitable beds by counting beds included in existing contracts.

(c) CNHs which have been inspected for purposes of establishing a contract and have been denied a contract are considered unsuitable.

(d) CNHs which the VA has solicited but which have declined to participate in the VA's CNH program are considered unsuitable for planning purposes.

(e) CNHs which restrict admission to specific clientele (e.g., specific religious, social, or professional groups) are generally considered unsuitable for VA purposes.

1. CNHs which fall under a category commonly known as "life care communities" (i.e., communities which provide multiple levels of care from single family dwellings to skilled nursing care and normally require a significant enrollment fee) are considered unsuitable for VA purposes.

2. VA contracting language tends to prohibit contracts with facilities that are restrictive. It is important that any assessment of CNHs include an assessment of CNHs that restrict membership because:

a. Most of these CNH beds are not readily available for VA use;

b. The number of CNH beds in these categories has been increasing, especially, the "life care community" NHC beds; and

c. It is likely that such homes are counted in state totals and may be considered available by oversight organizations.

(3) **Conclusion of analysis of CNH beds.** Planners should have information about not only the number of available and suitable NHC beds in the DPPB but also where these beds are located. It is important to address the "unknown" beds through special studies and initiatives for suitability; otherwise, for planning purposes, these beds must be considered suitable.

d. **What factors inhibit use of the identified available and suitable CNH beds?**

(1) **Data Sources.** Variable. Specify in analyses. Any number of factors can interact to prevent VA's use of otherwise available and suitable CNH beds. The objective in the following assessments is to analyze data such that the available pool of CNH beds should be changed based on these factors. The changes may appear artificial, but for the sake of quantitative analysis, they must be made consistently.

**(a) Accessibility**

1. It was the intent of the Congress, when the legislation establishing the VA's contract NHC program was enacted, to have veterans placed in geographic proximity to their homes. The legislation, of course, did not define "geographic proximity"; nevertheless, a reasonable definition would suggest that geographic proximity would entail, at a minimum, placement within one's county of origin if not within one's own local community. Such a definition, of course, needs to be tempered by local conditions (i.e., distance, in and of itself, may not be as compelling a factor as travel time and travel conditions). For example, a trip on public transportation across a large metropolitan area can be as significant a barrier as a 100-mile trip across country on a good road network.

2. As a result of this policy, ALL CNHs in the DPPB must be assessed for availability and suitability of beds. It may be appropriate, however, to consider patient origin as a source of justification for not including all CNH beds determined to be available and suitable in a given DPPB.

3. Assessing available and suitable CNH beds CNH-by-CNH will allow planners to determine the impact of accessibility on these beds. Clearly, if there is a large number of CNH beds available and suitable, but far removed from the targeted population, the beds become less usable.

4. For purposes of analysis, a patient who cannot be placed in a CNH and who is an appropriate candidate for a VA NHCU can be used to reduce the number of available and suitable CNH beds.

**(b) Six-month Limitation on Contract NHC.** This is an especially delicate issue and is cited here for information. It involves a practice by some CNH providers who, in effect, refuse to accept a veteran because the VA will not guarantee to take the patient back at the end of the 6-month contract period. Some may wish to use this issue as an argument for more VA NHCU beds. Planners should approach this issue with extreme caution, however, because it involves many questions such as the adequacy of discharge planning and the intent of the law which limits NSC (nonservice-connected) veterans to 6-month contracts.

**(2) Limited Services.** CNHs may be limited to the services they can provide.

(a) The contract language states that the CNH will provide "routine" NHC needs of veterans placed under VA contract; however, in actual practice, there may be a limit to the services. This pragmatic limitation on services can be a defensible justification for use of a VA NHCU bed in lieu of a CNH bed for particular patients.

(b) CNH providers evaluate prospective patients and tend to refuse to accept those who have extensive rehabilitation or medical needs. Care must be taken to assure that patients are being considered for possible placement in facilities known to accept patients with the respective disabilities, problems, diagnoses. In addition, if a facility has a minimal number of discharges for patients with a certain diagnosis(es), it is not appropriate to discount beds at a facility which will not accept patients with that diagnosis(es) e.g., AIDS (Acquired Immunodeficiency Syndrome).

**(3) Special Needs.** The basic approach is to identify a patient population with special rehabilitation needs or special medical needs who have been refused placement or who cannot be placed in a CNH.

## 5. SH NURSING HOME CARE BEDS

a. How many SH NHC beds are available to the DPPB? Different residency restrictions may affect this analysis.

(1) Data Sources

(a) Office of Geriatrics and Extended Care (114), VA Central Office.

(b) State Office of Veterans' Affairs.

(c) Directors of State Homes.

(2) Planners should use 75 percent or the actual percentage of veterans in existing SH NHC beds, whichever is larger. NOTE: A few State Veterans Homes were constructed without VA grant funding. By law, therefore, only 50 percent + of the beds in such homes must be occupied by veterans. Again, the actual percent of veteran usage should be used if it exceeds this limitation.

(3) Use of a patient-origin study will allow planners to apportion the available beds to appropriate DPPBs.

b. How many SH NHC beds will be added (or deleted) to the currently available supply in the future?

(1) Data Sources

(a) Office of Geriatrics and Extended Care (114), VA Central Office.

(b) State Office of Veterans' Affairs.

(c) Directors of State Homes.

NOTE: *Planners should consult the identified sources to determine future change(s) in the SH NHC bed supply, and these sources should be thoroughly documented.*

(2) **Identifying change(s).** Identifying the change(s) is a relatively straightforward task. Apportioning the changed beds to a DPPB(s), however, will require special analyses. If there are existing SH beds in the State, patient origin data could be used to overlay the changed beds -- if there is a proposed site. If there is not yet a proposed site, the only approach is "best judgment."

(3) **"Tentatively planned" SH NHC beds.** Planners may also experience some difficulty in reporting "tentatively planned" SH NHC beds. This category is reserved for "planned" beds for which application for a grant has been made to VA Central Office. Such beds should be treated as planned beds and apportioned as appropriate. The rationale for including such beds, which may never actually be constructed and operated, is that it could be concluded that VA NHCU beds should not be constructed until the question of whether the SH NHC beds will or will not be built has been answered.

**6. TABLE 1 Sample Format for SUMMARY OF NHC BED\* NEEDS FOR \_\_\_\_\_ DPPB (2005)**

- 1. Total model projection of veterans requiring NHC . . . . . \_\_\_\_\_
- 2. Total CNH beds in DPPB . . . . . \_\_\_\_\_
- 3. Total Empty CNH beds in DPPB . . . . . \_\_\_\_\_
- 4. Currently available CNH beds in DPPB . . . . . \_\_\_\_\_
- 5. Changes to suitable beds based on:
  - (a) Accessibility [p. 10A-4] . . . (\_\_\_\_)
  - (b) Limit on # of vets placed in a single CNH [p. 10A-5] . . . . . (\_\_\_\_)
  - (c) Patients with special needs [p. 10A-5]) . . . . . (\_\_\_\_)
  - (d) Other \_\_\_\_\_ (\_\_\_\_)  
(Specify)
- Total changes . . . . . (\_\_\_\_)
- 6. Total suitable CNH beds (Line 4 - Sum Line 5) . . . . . \_\_\_\_\_
- 7. Total suitable future CNH beds (Line 6. X  
    Adjustment Factor for civilian males age 65+) . . . . . \_\_\_\_\_
- 8. Projected change in SH NHC beds (+/-). . . . . \_\_\_\_\_
- 9. Total projected non-VA beds (Line 7 + Line 8). . . . . \_\_\_\_\_
- 10. Current VA-supported NHC Census in DPPB:
  - (a) CNH census . . . . . \_\_\_\_\_
  - (b) State census of Vets in DPPB. . . \_\_\_\_\_
- Total . . . . . \_\_\_\_\_
- 11. Current supportable VA NHCU census  
    (Authorized Beds X .95) . . . . . \_\_\_\_\_
- 12. Additional VA NHCU census need [Line 1. -  
    (Lines 9 + 10 + 11)] . . . . . \_\_\_\_\_
- 13. Additional VA NHCU Bed Need (Line 12 X 1.05) . . . . . \_\_\_\_\_

\*The conversion factor for beds to census is 95 percent and for census to beds is 105 percent.

\*\*NHC Needs Assessment proposes 16 percent market share.



**REQUIRED DATA ELEMENTS  
FOR THE NURSING HOME NEEDS ASSESSMENT**

1. NAME OF NURSING HOME
2. CITY/COUNTY/STATE
3. STATE LICENSURE STATUS AND LICENSED BED LEVELS
4. OCCUPANCY RATES
5. MEDICAID CERTIFIED
6. LIFE SAFETY CODE STATUS
7. ADMISSION RESTRICTIONS
8. WILLINGNESS TO CONTRACT WITH THE VA
9. STAFFED BED LEVELS

May 18, 1992

1. Transmitted is a revision to the Department of Veterans Affairs Veterans Health Administration Manual M-9, "Strategic Planning", Chapter 10, "Nursing Home Needs Assessment."

2. Principal changes are deletion of all references to MEDIPP and changes to procedures for validating planned increases in VA nursing home care unit beds.

**3. Filing Instructions**

**Remove page**

10-i through 10C-1

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

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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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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.

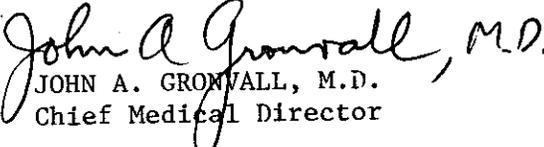
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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REMARKS

SUBJ: Departmental Manual M-9

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

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

*"Planning and Evaluation and Systems Development"*

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

3. Thank you for your assistance.

Approved  Disapproved

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

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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