

**Manual M-9, Strategic Planning**

**(Veterans Health Administration)**

**Chapter 9, Criteria and Standards and Program Planning Factors**

**Appendix 9D, Criteria and Standards for VA Oncology Programs**

This document includes:

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

Contents page for M-9, dated **June 5, 1992** (Change 9)

Rescissions page for M-9, dated **May 4, 1992** (Change 4)

Contents page for Chapter 9, dated **January 28, 1993** (Change 14)

Text for Appendix 9D, dated **December 29, 1992** (Change 12)

Transmittal sheets located at the end of the document:

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

Change 12, dated **December 29, 1992**

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

Change 3, dated **September 9, 1991**

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

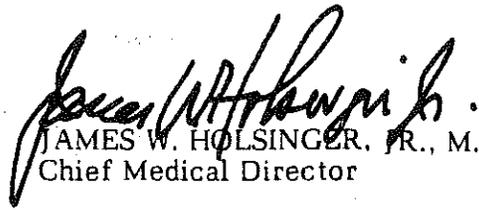
Veterans Health Administration  
Washington DC 20420

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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

Distribution: RPC: 1318  
FD

Printing Date: 7/91

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## RESCISSIONS

The following material is rescinded:

Complete rescissions:

### Circulars

10-87-113 and Supplement No. 1  
10-87-147  
10-88-3  
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## CRITERIA AND STANDARDS FOR VA ONCOLOGY PROGRAMS

### 1. PURPOSE AND SCOPE

a. Criteria and Standards for VA (Department of Veterans Affairs) Oncology Programs have been developed to meet the program planning needs of VHA (Veterans Health Administration) facilities, and regions.

(1) A criterion is defined as "a measurable characteristic of a health service."

(2) A standard is defined as "a quantitative and/or qualitative value or level of achievement with respect to a specific criterion which represents acceptable performance."

b. Since all VA medical centers provide some type of cancer care, oncology criteria and standards are intended to assist the planners in assessing the existing capabilities of cancer care and in the planning for appropriate levels of care. The purpose of this effort is to improve patient treatment and referral mechanisms.

c. This appendix addresses the major requirements for surgical, medical, and radiation oncology. Treatment of superficial skin cancer and dermatology resource requirements are not addressed, and references in this appendix to required numbers of cancer cases exclude superficial skin cancers. Primary cancer disease sites are provided in paragraph 23.

### 2. BACKGROUND

a. Cancer is the second leading cause of death in the United States and has been estimated to affect one out of four Americans. The disease is not a single entity but includes more than 100 different types of malignancies. Within VA, approximately 43 percent of hospital deaths during FY (Fiscal Year) 1988 occurred in patients who had been treated for neoplasms. Neoplasms accounted for approximately 10 percent of principal discharge diagnoses during FY 1988; 11 percent of discharges had associated diagnoses of neoplasms. Since cancer is largely a disease of older individuals (with about 50 percent of cancer occurring in individuals 65 and older and almost 60 percent of deaths occurring after 65) VA's responsibility for providing care for cancer patients can be expected to increase as the veteran population ages. Women veterans appear to have a higher rate for some cancers than the general female adult population (1985 Survey of Female Veterans). The incidence of some malignancies is increased after exposure to radiation and certain toxic materials which may occur during military service. VA has accepted an association between service in Vietnam and the development of non-Hodgkins' Lymphoma, as well as the association between exposure to dioxin-containing herbicides and the development of soft tissue sarcomas. In light of these considerations, cancer care must be considered one of VA's highest medical care priorities.

b. Surgery, chemotherapy, and radiation therapy are the three major modalities of cancer treatment. The primary curative treatment for a number of common types of cancer is surgery. About 60 percent of all cancer patients will require radiation therapy during their course of disease either for cure, palliation, or as a component of combined modality therapy (Source: Criteria for Radiation Oncology in Multidisciplinary Cancer Management: Report to the Director of the National Cancer Institute, National Institutes of Health). Combined modality treatment has been successful for improving the results in a number of types of cancer while initial treatment of certain malignancies such as acute leukemia is chemotherapy alone.

c. Provision of cancer treatment within VA has been predominantly at the discretion of the individual VA health care facilities. The development of increasingly sophisticated diagnostic techniques and treatment modalities offers potential for successfully treating certain otherwise refractory malignancies. VA Central Office Medical Service has determined that a coordinated approach is needed in planning for oncology care in the VA system.

d. In order to plan for the effective delivery of health care, some qualitative and quantitative guidelines are needed to assess existing capabilities of clinical programs and to plan for the future. These criteria and standards were developed with the assistance of an ad hoc multidisciplinary oncology advisory group, with consideration given to prior oncology efforts within VA.

e. It is recognized that in certain circumstances, local conditions may exist that justify deviations from these standards. Such deviations will be reviewed by Central Office on a case-by-case basis.

f. References to resources such as staff, space, and equipment, are intended to include resources that are readily available at affiliated institutions as well as "in-house" resources, unless otherwise specified. Staffing guides are intended to represent safe and clinically effective levels but are not mandatory. They are provided to assist in program development and evaluation.

g. The term "must" when used in this appendix indicates that item or element is mandatory. The term "should", will be used to reflect preferred practice, yet allow effective alternatives to be used.

### 3. DEFINITIONS

a. **Autologous BMT (Bone Marrow Transplant).** Autologous BMT refers to the infusion of the patient's own stored bone marrow after intensive treatment for cancer.

b. **Cancer Committee.** A committee of individuals with special interest and expertise in cancer that provides leadership and organizational structure to a facility's oncology care effort.

c. **Cases.** Cases are unique primary tumors or malignancies whether occurring in the same or different patients.

d. **Neoplasms.** Neoplasms refer to new growths, including malignant and benign tumors.

e. **Network.** For the purpose of this appendix, a network represents an organized geographic grouping or referral pattern of VHA facilities as established and approved by the AsCMD (Associate Chief Medical Director) for Operations.

f. **Oncology.** Oncology is defined as the study or science dealing with malignancies or cancer. For purposes of this appendix, this term is intended to encompass the multidisciplinary treatment of patients with cancer. Components of oncology care include:

(1) Prevention

- (2) Screening
- (3) Diagnosis
- (4) Pretreatment evaluation (including staging)
- (5) Treatment
- (6) Rehabilitation
- (7) Continuing care (including terminal care).

g. **Regional Advisory Committee.** An advisory committee organized by the Regional Director to provide leadership and recommendations for strengthening cancer care.

h. **TAG (Technical Advisory Group).** TAG is an alternate name for the regional advisory committee.

i. **Tissue Committee.** The committee that assesses appropriateness of care by reviewing the pre-operative and post-operative diagnosis and substantiates these diagnoses by the tissue report and other findings.

j. **Transfusion Committee.** Committee reviewing transfusion practices (such as indications, whole blood versus blood component administration, and adverse occurrences) for appropriateness and cost-effectiveness.

k. **Tumor Board.** A tumor board is a scheduled conference in which specialists representing the major disciplines involved in cancer diagnosis and treatment review individual cancer cases and offer recommendations to the patient's primary physician.

l. **Tumor Registry.** A tumor registry is an organized system for entering and maintaining relevant information on individual cancer patients for such purposes as facilitating follow-up, outcome evaluation, and program assessment.

m. **Unique Cancer Patients/Individuals.** Unique cancer patients/individuals are those with different social security numbers.

n. **Unique Primary Tumors.** Unique primary tumors are independent primary malignancies whether occurring in the same patient or different patients. The term cases refers to independent primaries not patients.

#### 4. GOALS

The goals of an Oncology Program are to:

- a. Provide state-of-the-art multidisciplinary comprehensive and humane cancer care delivered in a cost-effective manner to eligible veterans, including women and elderly veterans.
- b. Improve patient access to comprehensive oncology care.
- c. Ensure use of a coordinated approach in planning for oncology activities.

d. Provide cost-effective alternatives to inpatient oncology treatment that is consistent with high quality care.

#### **5. THREE LEVELS OF VA CANCER PROGRAM**

a. Although eight categories of cancer programs have been approved by the ACoSCC (American College of Surgeons Commission on Cancer), for planning purposes, VA uses three levels:

- (1) CCC (Comprehensive Cancer Center) (Tertiary Level),
- (2) Secondary Level Cancer Program (termed "Specialized" in one former Region), and
- (3) Primary Level Cancer Program.

b. Aspects of the three levels of the VA Cancer Program (such as utilization requirements, services, and staff) are provided in paragraphs 10 through 22.

c. Deficiencies in services, facilities, staffing, equipment or other criteria must be corrected before a facility receives full or unconditional designation for its oncology program (see par. 6).

d. With major input from the network and Regional Oncology Advisory Committee or TAG, the Regional Director, with the concurrence of the Office of Clinical Programs, designates each facility's oncology program level. Initial designation will be accomplished within 1 year from the date of this revision of the manual. Oncology program level designations previously made should be reviewed for appropriateness and changed if necessary. Subsequent redesignations may be made as necessary.

#### **6. APPROVAL BY THE ACoSCC**

Each VA medical center that wishes to be designated as a CCC must obtain approval from the ACoSCC. If a facility lacks ACoSCC approval it may be given conditional designation as a CCC for a defined time period while it seeks ACoSCC approval. All VA medical centers are encouraged to seek ACoSCC approval.

#### **7. SYSTEM-WIDE AVAILABILITY**

a. **Standard.** Every network must have access to a VA CCC. Each CCC must be located at a VA medical center closely affiliated with a medical school that has all major services and specialties necessary to treat complicated malignancies.

b. A Regional Oncology Advisory Committee or TAG (Technical Advisory Group) must be established to assist in planning for optimal oncology care delivery, see subparagraphs 9a and 9b.

c. As noted in subparagraph 5e, initial designation of each facility's oncology program level will be accomplished by December 1, 1993.

## 8. REFERRAL PATTERN

a. **Rationale.** Networking among VHA facilities providing various levels of oncology care should assist in providing a coordinated approach to comprehensive cancer treatment and improve patient quality of care.

b. Each VA network should develop appropriate arrangements to facilitate referrals among various levels of cancer programs. It should be the responsibility of the CCC to readily accept appropriate patient referral from Secondary and Primary Level programs ensuring prompt high quality care. Other facilities should readily accept patients referred from CCCs for continued care by qualified staff. Among the considerations that should be addressed to improve networking are:

- (1) Maintaining an updated inventory of services.
- (2) Facilitating the flow of records and data among facilities.
- (3) Encouraging professional to professional communication.
- (4) Resolving problems with transportation.
- (5) Developing innovative arrangements to house patients and families, if possible.

## 9. ROLES OF VARIOUS COMMITTEES

### a. The Role of Regional Oncology Advisory Committee or TAG

(1) **Standard.** Each VHA region will establish a Regional Oncology Advisory Committee or TAG.

(2) Such a group can be valuable for considering issues that may be better addressed at the larger regional level than on a smaller scale such as network. These may include:

- (a) Providing overall leadership.
- (b) Organization of regional cancer care conferences.
- (c) Site visits to facilities emphasizing non-resource-intensive suggestions for strengthening oncology programs.
- (d) Development of uniform tumor registries.
- (e) Development of inventories of specialized oncology services.
- (f) Consideration of collaborative oncology research.
- (g) Encouragement of oncology health services research and evaluation.

(3) This group should be multidisciplinary and predominantly clinical including representatives from:

- (a) Medical,

- (b) Surgical,
- (c) Radiation oncology,
- (d) Nursing, and
- (e) Tumor registry staff.

**b. Role of Network Oncology Advisory Committee**

(1) **Recommendation:** Each network is encouraged (but not required) to establish a Network Oncology Advisory Committee. This committee should meet at least once a year and be supplemented by conference calls as necessary.

(2) It is recommended that this committee include representatives from all individual VA medical centers in the network, preferably of individuals active in local cancer programs or on the Tumor Board.

(3) The composition of the committee should be multidisciplinary, and predominantly clinical.

(4) Suggested functions include:

(a) Reviewing the resources available at each facility and being responsible for the development and maintenance of a clinical inventory of the oncology services offered by the network.

(b) Offering recommendations regarding oncology program levels.

(c) Providing guidance as to which types of cancer a VA health care facility could appropriately treat (including which diagnostic procedures and components of the cancer care spectrum should be offered).

(d) Recommending policies and procedures to facilitate transfer of oncology patients among various levels of cancer care programs.

(e) Assessing cost-effectiveness and patient care treatment options and proposals.

(f) Assisting in the coordination of oncology quality assurance efforts at the individual facility, and ensuring that appropriate quality assurance indicators will be used to evaluate the quality of care delivered.

(g) Facilitating and serving as a resource for oncology education in the network.

(h) Submitting a quarterly report with recommendations as appropriate to the Regional Oncology TAG.

(5) It should be emphasized that this committee is intended to provide broad guidance relating to oncology. Referral and other aspects of managing individual patients would continue to be the responsibility of the involved clinicians and not require involvement of the Network Oncology Advisory Committee.

**(6) Rationale**

(a) Oncology planning must consider the specific characteristics of VA facilities in each area in terms of such factors as:

1. Workload,
2. VA and community resources and expertise,
3. Geography, and
4. Referral patterns, etc.

(b) A multidisciplinary Network Oncology Advisory Committee with representation from all VA medical centers can provide valuable recommendations for coordinating and optimizing care for cancer patients.

**c. VA Medical Center Cancer Committee**

- (1) Each VA medical center designated as a CCC must have a Cancer Committee.
- (2) Other levels of VA cancer programs are encouraged to have such a committee.
- (3) For organizational requirements, objectives, and required duties of the Cancer Committee, refer to part I of the "Cancer Program Manual" published by the ACoSCC.

**10. MINIMUM UTILIZATION REQUIREMENTS FOR ESTABLISHING VA CANCER PROGRAM**

a. **Standard.** A CCC must treat over 300 new cancer cases (unique primary tumors/malignancies) per year.

b. **Standard.** A VA Secondary Level Cancer Program must treat over 100 new cancer cases (unique primary tumors/malignancies) per year.

c. There are no minimum utilization requirements for a Primary Level VA Cancer program. VA facilities that do not qualify for designation as CCCs or VA Secondary Level Cancer Programs must provide services identified for VA Primary Level Cancer Programs.

d. **Source.** Professional judgment of Ad Hoc Advisory Group for VA Oncology Programs based on VA experience, and the ACoSCC Cancer Program Manual.

**11. SERVICES/FACILITIES REQUIREMENTS**

a. **Minimum Services Required for Establishing CCC.** CCCs must provide a broad range of services for cancer patients including prevention, screening, diagnosis, treatment, follow-up rehabilitation, and continuing care. At a minimum, a VA CCC must provide the following services or have access to these services through a VA-affiliated medical school or hospital. If all services are not available "in-house," patient transportation and travel require major consideration in planning for utilization of resources from other institutions.

(1) **Prevention.** Smoking cessation program in cooperation with Mental Health and Behavioral Sciences Service. Furthermore, the VA facility should seek to become totally smoke-free and ban the sale of tobacco products in accordance with VA policies.

(2) **Screening**

(a) Oral soft tissue screening by Dental Service

(b) Access to mammography and pap testing.

(c) Other screening programs as recommended by VA's Preventive Medicine Program are encouraged.

(3) **Diagnosis**

(a) Complete clinical laboratory including state-of-the-art pathology such as immunologic techniques, cytogenetic, and HLA (Human Leukocyte Antigens/histocompatibility) testing.

(b) Diagnostic invasive and non-invasive radiology [this includes adequate CT (Computerized Tomography) scan capabilities, mammography, ultrasound, and the availability of MRI (Magnetic Resonance Imaging).

(c) Nuclear Medicine Service with availability of monoclonal antibodies and SPET (Single Proton Emission Tomography) encouraged.

(d) Gynecology.

(4) **Treatment Services**

(a) Complete Blood Bank.

(b) Chemotherapy including access to "state-of-the-art" antineoplastic agents.

(c) Dermatology.

(d) Full complement of internal medicine subspecialty support including endoscopy, ICU (Intensive Care Unit), and dialysis.

(e) Nuclear medicine including radiopharmaceutical therapy.

(f) Surgery and surgical subspecialties.

(g) Complete pharmacy service including clinical specialist support and chemotherapy preparation.

(h) Comprehensive Social Work Services.

(i) Psychological counseling.

(j) Nutritional Support Services. A fully functioning NST (Nutrition Support Team) must be available to provide parenteral and enteral nutrition for inpatients and outpatients.

(k) Radiation Therapy

1. Standard. For definitive treatment for cure, palliation, or as part of planned combined modality treatment, the following radiation therapy services must be readily available either "in-house" or by utilization of resources at another institution, such as the affiliated university hospital.

- a. Radiation oncology consultation.
- b. Treatment planning using computerized dosimetry.
- c. Administration of RT (Radiation Therapy), Teletherapy and Brachytherapy.
- d. Follow-up Radiation Oncology Clinic.
- e. Maintenance of RT records and registry.
- f. Teaching program available for all residents, staff, and other personnel in radiation oncology.
- g. Participation in clinical trials and research.
- h. Representation at Tumor Board and Cancer Committee.
- i. Radiation Safety Program and participation on Radiation Safety Committee.
- j. Radiation Physics Program.
- k. Participation in Tumor Registry.

2. A QA (Quality Assurance) Program using the guidelines in "Criteria for Radiation Oncology in Multidisciplinary Cancer Management Report for National Cancer Institute," should be in place.

(5) **Rehabilitation Services.** Rehabilitation Services should be available to provide inpatient and outpatient rehabilitation care. These services can be provided by physical therapy, occupational therapy, kinesiotherapy, recreation therapy and speech therapy. As a minimum, physical and occupational therapy should be available. Development of a special comprehensive rehabilitation program is strongly encouraged.

(6) Continuing Care

(a) VA HBHC (Hospital Based Home Care), formally designated and/or locally developed programs.

(b) Bereavement counseling.

(c) Case management.

(d) Hospice and/or Palliative Care Programs, or an arrangement with local community Hospice and/or other providers is encouraged.

(e) Establish support groups for patients and families or encourage and provide referrals to non-VA support groups.

(f) Efforts to facilitate use of appropriate community resources for VA patients should be considered.

**(7) Other Programs**

(a) Residency training program in specialties/subspecialties including internal medicine, surgery, and at least two of the following:

1. Gynecology,
2. Pathology,
3. Diagnostic radiology,
4. Radiology oncology, or
5. Medical oncology.

**NOTE:** *A clinical pharmacy specialty residency in oncology is also encouraged.*

(b) Oncology Research Program, see paragraph 21.

(c) QA Program, see paragraph 19.

(d) Consultative advice to other VA medical centers regarding referred patients

(e) Tumor Registry Program, see subparagraph 20a.

**(8) BMT (Bone Marrow Transplantation)**

(a) Standard. No facility will initiate a BMT program without approval from the Regional Director and concurrence of the Office of Clinical Programs.

(b) Follow-up of VA patients who have received BMT, either within a VA or at a non-VA BMT program, should be provided at a CCC rather than at a Secondary or Primary Level Cancer Care Program.

**b. Services Required for Secondary Level Cancer Program**

(1) Standard. A Secondary Level Cancer Program treatment center need not have all the resources which are available in a CCC, but must have the capability and expertise to do some chemotherapy and oncologic surgery.

(2) Standard. The following services must be provided by a Secondary Level Cancer Program:

(a) **Prevention.** Smoking cessation program in cooperation with Mental Health and Behavioral Sciences Service. Furthermore, the VA facility should seek to become totally smoke-free and ban the sale of tobacco products in accordance with VA policies.

**(b) Screening**

1. Oral soft tissue screening by Dental Service.

2. Access to mammography and pap testing.

3. Other screening programs, as recommended by VA's Preventive Medicine Program, are encouraged.

(c) **Diagnosis.** Radiology, Nuclear Medicine, and Pathology Services able to perform all routine types of tests and procedures including standard surgical pathology, and clinical laboratories.

(d) **Treatment**

1. Chemotherapy,

2. Oncologic surgery, and

3. Radiation therapy or access to radiation therapy.

a. **Standard.** A Secondary Level Cancer Program is required to make radiation therapy available to treat all patients who need that modality. This may be by referral to a VA CCC, by contract or sharing agreement with another institution that has adequate capability; or, "in-house" when determined by number of patients receiving treatment. Access to palliative radiation therapy should be available locally and not require referral to a distant CCC.

b. Each Radiation Oncology Program should include the following services to provide palliative radiation and adjuvant or multi-modal phase of radiation therapy:

(1) Radiation Oncology consultation.

(2) Administration of RT, including Teletherapy (Brachytherapy is optional).

(3) Treatment planning program with access to Computerized Dosimetry.

(4) Follow-up Radiation Oncology Clinic.

(5) Maintenance of RT records.

(6) Representation on Tumor Board and Cancer Committee, if applicable.

(7) Participation in educational and training programs.

(8) Radiation Safety Program.

(9) Radiation Physics Program.

(10) Participation in Tumor Registry.

(11) Quality Assurance Program.

c. **Guidelines.** A Radiation Oncology Residency Training Program or participation in national clinical cooperative trials is encouraged.

d. A RT program at a VA Secondary Level Cancer Programs differs from an RT program at a VA CCC in the following ways:

- (1) No primary RT with curative intent,
- (2) No isotope implant program,
- (3) No electron beam capability, and
- (4) No training programs for radiation oncology residents, radiation therapy technologists, or dosimetrists.

e. The RT Program at a VA Secondary Level Cancer Program should be active in providing medical center staff, residents, and students with education in radiation oncology and safety.

(e) Continuing care

1. VA HBHC, formally designated and/or locally developed programs.
2. Bereavement counseling.
3. Case management.
4. Hospice and/or Palliative Care Programs, or an arrangement with local community Hospice and/or other providers is encouraged.
5. Establish support groups for patients and families or encourage and provide referrals to non-VA support groups.
6. Efforts to facilitate use of appropriate community resources for VA patients should be considered.

(f) Psychological and social work services.

(g) Nutrition support services. A fully functioning NST must be available if TPN (Total Parenteral Nutrition) is provided.

(3) Additional functions may be added to facilities with Secondary and Primary Level Cancer Programs based on resources, expertise available, and local circumstances. If additional functions are performed, space and staffing should be provided as appropriate.

c. **Primary Level Cancer Program.** The following services must be provided by a Primary Level Cancer Program:

(1) **Prevention.** Smoking cessation program in cooperation with Mental Health and Behavioral Sciences Service. Furthermore, the VA facility should seek to become totally smoke-free and ban the sale of tobacco products in accordance with VA policies.

(2) **Screening**

(a) Oral soft tissue screening by Dental Service.

(b) Access to mammography and pap testing.

(c) Other screening programs as recommended by VA's Preventive Medicine Program are encouraged.

**(3) Treatment**

(a) A Primary Level Cancer Program provides basic internal medicine care, access to surgical care (in-house, referral or consultation), and access to radiation therapy.

(b) A Primary Level Cancer Program is not required to offer in-house radiation therapy services. However, there should be appropriate methods for referring patients for RT consultation and treatment to other facilities, either VA or non-VA, having the necessary programs/services. Access to palliative RT should be available locally.

**(4) Continuing Care**

(a) VA HBHC, formally designated and/or locally developed programs.

(b) Bereavement counseling.

(c) Case management.

(d) Hospice and/or Palliative Care Programs, or an arrangement with local community Hospice and/or other providers is encouraged.

(e) Establish support groups for patients and families or encourage and provide referrals to non-VA support groups.

(f) Efforts to facilitate use of appropriate community resources for VA patients should be considered.

*NOTE: Based on available resources and expertise, additional functions may be added to facilities with Secondary and Primary Level Cancer Programs. Additional space and staffing should be provided as appropriate.*

**12. INPATIENT TREATMENT MODALITY**

a. Each CCC is strongly encouraged to designate a specialized oncology unit area or group of beds within the Medical Service bed section. A core group of oncology beds may be supplemented by contiguous beds (swing beds) that may be used for oncology patients, if necessary, to improve efficiency.

b. A specialized oncology unit can promote high quality care to selected cancer patients requiring specialized nursing skills, such as those actively receiving chemotherapy, and those with complications.

(1) Such a unit facilitates multidisciplinary team care, continuity of nursing care, and the availability of specially trained staff to administer and monitor therapy.

(2) This results in:

(a) Increased patient safety,

(b) Improved treatment efficiency,

(c) Provision of patient and staff support,

- (d) Patient advocacy,
  - (e) Improved data collection, and
  - (f) Improved compliance with OSHA (Occupational Safety and Health Administration) guidelines.
- c. It is not intended for all patients with cancer to be treated in such a unit. Some may be better managed on a surgery or surgical subspecialty ward, in a hospice program, etc.

d. Secondary and Primary Level Cancer Programs may propose oncology bed units if justified by local circumstances (e.g., patient workload, local expertise, etc.) Treatment of certain oncology patients in a designated area should improve the care that can be provided.

### 13. OUTPATIENT TREATMENT MODALITY

a. A CCC must have a dedicated chemotherapy/transfusion center as part of the oncology clinic function. It must be available for outpatient cancer care at least 5-days per week, 8-hours per day. This is to provide follow-up care to cancer patients without unnecessary admission for inpatient treatment. Additional clinic space should also be provided as needed, see subparagraph 15b.

b. Secondary and Primary Level Cancer Programs may also have an oncology clinic, including space for chemotherapy administration as needed.

c. Special housing arrangements such as the use of self-care wards, motels, and rental housing, should be made available for ambulatory patients receiving extended treatment such as radiation therapy. This will prevent unnecessary retention of these patients in acute beds, and avoid placement of patients in types of units having an adverse effect on their morale and quality of life.

d. Problems relating to transportation should be addressed to facilitate outpatient care.

e. Social Work Service should be available for consultation and assistance concerning the special residential and transportation needs of patients/families.

### 14. STAFFING GUIDELINES

a. **Staffing Guidelines for CCC.** These guidelines suggest types of personnel for staffing a VA CCC. They are optimal staffing levels and are not to be considered as standards. Staff coordination of inpatient and outpatient oncology treatment is essential to ensure continuity of care. A multidisciplinary team approach to cancer treatment can be valuable for assuring high quality care and is strongly recommended.

#### (1) Physicians

(a) VA surgical oncologist (strongly encouraged) or board certified general surgeon performing oncologic surgery.

- (b) VA board certified medical oncologist and VA board certified hematologist.
- (c) VA board certified pathologist specializing in tumor pathology.
- (d) VA board certified diagnostic radiologist trained in CT and special procedures.
- (e) VA board certified nuclear medicine specialist.
- (f) VA head/neck surgeon.
- (g) VA otolaryngologist.
- (h) VA thoracic surgeon.
- (i) VA psychiatrist or psychologist with training and interest relative to the needs of cancer patients.
- (j) Board certified physicians available on the staff or obtained on consultation basis in the following areas:
  - 1. Gynecology,
  - 2. Ophthalmology,
  - 3. Other internal medicine subspecialties,
  - 4. Prosthodontics,
  - 5. Maxillofacial, prosthetics, and plastic surgery,
  - 6. Orthopedic surgery,
  - 7. Physiatry (rehabilitation medicine),
  - 8. Neurosurgery, and
  - 9. Urology.
- (k) Optional - physician's assistant
- (2) Nurses
  - (a) Oncology clinical nurse specialist.
  - (b) Skilled personnel, R.N.s (registered nurses) or N.P.s (nurse practitioners), available for inpatient and outpatient chemotherapy administration.
  - (c) Appropriately trained and skilled R.N.s and L.P.N.s (licensed practical nurses).
  - (d) Nurse coordinator for patient education and liaison services.
  - (e) Enterostomal therapist/nurse.

(f) It should be recognized that a designated oncology unit will require increased R.N. staffing, particularly during the day shift. For the nursing requirement on an Oncology unit refer to M-2, part V, chapter 9, appendix A, "Staffing Guidelines for Medical/Surgical Patients."

**(3) Radiation Therapy Staffing**

1. Staffing guidelines are based on radiation therapy equipment and workload. The following personnel list provides staffing guidelines for planning "in-house" radiation therapy services.

a. One FTE (full-time employee) board certified staff radiation oncologist.

b. One FTE radiation physicist "qualified expert." A "qualified expert" is a radiological physicist who holds a degree in the physical sciences and who:

(1) Is certified by the American Board of Radiology in either radiological physics or therapeutic radiological physics; or

(2) Is eligible for such certification; or

(3) Has a Bachelors Degree in the physical sciences and 3 years full-time experience in clinical radiation therapy physics working under the direction of a physicist certified (or board eligible) by the American Board of Radiology, or has a Doctorate or Masters Degree in Physical Sciences and 2 years such experience; or

(4) Has a Doctorate or Masters Degree in radiological or medical physics and 2 years of post-graduate clinical therapeutic physics experience.

c. One FTE dosimetrist or junior physicist.

d. Three FTE radiation therapy technologists.

e. One FTE nurse oncologist or R.N.

f. One FTE secretary/typist.

2. If a second treatment unit (Linear Accelerator) is included, three additional FTE are required:

a. One radiation oncologist, board certified, and

b. Two radiation therapy technologists.

(4) NST (Nutrition Support Team). The NST should include a:

(a) Physician,

(b) Dietitian,

(c) Nurse, and

(d) Pharmacist.

(5) Other

(a) Dentist(s) experienced in oncologic care. Board certification in oral and maxillofacial surgery, periodontics or prosthodontics is highly desirable.

(b) Clinical pharmacist specialist(s) in oncology.

(c) Secretarial/administrative support.

(d) Speech, physical, occupational, and other RMS (Rehabilitation Medicine Service) therapists as is indicated.

(e) Social Workers experienced in working with the terminally ill patients and their families.

(f) Adequate tumor registry staff.

(g) Appropriate staff support from Dietetic Service, HBHC, hospice, and/or palliative care type activities.

(6) **Staffing Ratios.** The following staffing ratios are suggested (Source: Based on the personal experience of the advisory group participants, comments from other oncologists and VA Central Office staff):

(a) One FTE physician hematologist and/or medical oncologist per 150 cancer cases (unique primary tumors/malignancies) per year.

(b) One FTE nurse oncology specialist per 400 cancer cases per year.

(c) One FTE oncology administrative assistant per 800 cancer cases per year.

(d) One FTE oncology secretary per 500 cancer cases per year.

(e) One FTE tumor registrar per 250 new cases per year (this is approximately the average new cases per registry FTE ratio found in the National Tumor Registrars Association/ACoSCC Registry Staffing Manual, 1989).

(f) One FTE clinical pharmacist specialist.

(g) **Dietetic Staffing.** Standards of the Association of Community Cancer Centers recommend:

1. One full-time Registered Dietitian for a 50-bed oncology unit, or

2. One full-time Dietitian per 100 beds as staffing approximations.

(h) Need for other support personnel should be determined based on facility requirements.

**b. Staffing Guidelines for Secondary Level Cancer Program.** The following types of personnel are to be available at a Secondary Level Cancer Program:

(1) A board certified Internist with additional specialized training in chemotherapy, preferably board-eligible or board-certified medical oncologist.

(2) A board certified general surgeon with significant interest and expertise in oncologic surgery.

(3) An oncology nurse specialist, and other nursing staff.

(4) A social worker.

(5) A Nutrition Support Team including a physician, dietitian, nurse, and pharmacist is to be available if total parenteral nutrition is provided.

(6) Secretarial/administrative support.

(7) Staffing in other disciplines as appropriate such as Pharmacy, Radiology, Nuclear Medicine, Pathology and Dental Services.

c. **Staffing Guidelines for Primary Level Cancer Program.** At a minimum, in a Primary Level Cancer Program, adequate staff able to provide routine types of services, are to be available in the following areas:

(1) Basic internal medicine care,

(2) Radiology,

(3) Nuclear medicine,

(4) Pathology (laboratory),

(5) Dental Service,

(6) Surgery (access to surgical care, in-house, referral or consultation),

(7) Nursing, and

(8) Other disciplines.

## 15. SPACE GUIDELINES

a. **Inpatient at a CCC.** The guidelines should conform to Office of Facilities, Planning Criteria for VA Facilities, Handbook H-08-9, chapter 100 with the following modifications:

(1) The Oncology Unit should be designed to provide treatment to such patients as those with granulocytopenia. It is desirable to have 25 percent of the special oncology beds in single-bed rooms (including the isolation rooms) and the remaining 75 percent in two-bed rooms. All rooms should have separate bathrooms.

(2) Approximately two to four isolation beds should be provided per 30 bed oncology unit. These isolation rooms should be equipped with HEPA (High Efficiency Particulate Air) filters, but laminar flow is not necessary.

(3) **Rationale.** This approach is needed to facilitate reverse isolation procedures and recognizes that cancer patients frequently have symptoms such as nausea, vomiting, and diarrhea as well as psycho-social problems including depression. Also, single-bed rooms will facilitate isolation of patients who have radioactive implants.

(4) These space allocation figures are suggested guidelines only and must be coordinated with Office of Facilities for the development of final architectural plan figures appropriate to a VA medical center's particular circumstances. The space guidelines provide an estimation of space required to plan for in-house radiation therapy services. Refer to Office of Facilities, Planning Criteria for VA Facilities, Handbook H-08-9, chapter 277.

(5) Space Requirements

(a) Staff Offices (preferably next to ward areas)

Function	Space Guidelines
<u>1.</u> Section Chief (each)	150 NSF (Net Square Feet)
<u>2.</u> Other Professional Staff (each)	120 NSF
<u>3.</u> Pharmacy	240 NSF

**NOTE:** *A dedicated area necessary for chemotherapy preparation may be located in main Pharmacy or satellite location.*

(b) Other space requirements contiguous to Oncology Bed Unit

Function	Space Guidelines
<u>1.</u> Procedure Room	200 NSF
<u>2.</u> Patient Education/Support Group Room	200 NSF
<u>3.</u> Family Consultation Room	150 NSF
<u>4.</u> Staff Conference Room (if other conference space not available)	300 NSF

(c) Secondary and Primary Levels should plan for space requirements based on their specific functions.

b. **Outpatient at a CCC.** The space guidelines provide an estimate of space required to plan for in-house chemotherapy services. For space criteria refer to Office of Facilities, Planning Criteria for VA Facilities, Handbook H-08-9, chapter 262.

(1) An Oncology Clinic should be located adjacent to the inpatient Oncology Unit or in the outpatient area. There should be a dedicated area available for chemotherapy, transfusion therapy, and supplemented with additional outpatient space as needed (swing space).

(2) For housing ambulatory patients receiving continuing therapy, see subparagraph 13c.

c. **Secondary and Primary Levels Cancer programs.** Secondary and Primary Level Cancer programs should plan for space requirements based on their specific activities and workload.

## 16. RADIATION THERAPY EQUIPMENT

Utilization guidelines of equipment items have been adopted from a report to the Director of the National Cancer Institute by the Committee for Radiation Oncology Studies.

### a. CCC

**Standard.** The following equipment and services must be available in-house or accessible on a contract basis to provide comprehensive cancer care: **NOTE:** *If radiation therapy is contracted to another facility it should be in close proximity, within 10 to 15 minutes travel time. The other institution should provide similar services and fulfill the requirements specified for VA CCC. For additional equipment requirements refer to Office of Facilities, Planning Criteria for VA Facilities, Handbook H-08-5, chapter 276.*

#### (1) One Megavoltage Therapy Unit

(a) Four to six Megavoltage X-ray Linear Accelerator or Cobalt 60 Unit (80 cm SAD, isocentric).

(b) Existing cobalt machines are usually replaced with a 6 Megavoltage Linear Accelerator.

(c) Per 300 cancer cases (unique primary malignancies) per year and/or 6,000 treatment/visits per year or 25 treatment/visits per day.

#### (2) One High Energy Therapy Unit

(a) Ten Megavoltage or over Linear Accelerator with electron beams.

(b) Adding a second unit. The existing unit should be performing in excess of 6,000 patient procedures per year before consideration is given to adding a second unit. When the second unit is an extra high energy machine, it is not required to perform 6,000 treatments per year. That is, a facility may have two machines even though their combined workload may only be expected to be 8,000 or 9,000 treatments per year according to the Federal Register.

(3) **One Superficial/Ortho X-ray Therapy Unit.** One Superficial/Ortho X-ray Therapy Unit with accessories for treatment of skin cancer and intracavitary lesions, (optional, not required if similar capability with electron beams and brachytherapy is available).

#### (4) One Hyperthermia Unit (optional)

(5) **One Radiation Therapy Simulator.** A Radiation Therapy Simulator (X-ray Unit) including X-ray film processor for treatment planning.

(6) **One Treatment Planning Program.** A Treatment Planning Program with computerized dosimetry.

(7) **Brachytherapy Services.** Brachytherapy services to include superficial interstitial and intracavitary use of sealed sources, systemic and intracavitary use of unsealed radioactive material. Remote afterloading facilities should be made available for use in the appropriate clinical settings.

(8) **Fabricating Equipment.** Equipment and tools to fabricate customized shadow blocks and other treatment accessories.

(9) **Physics Equipment and Services.** Physics equipment and services including current calibration certificates where applicable, to assure mechanical, optical and dosimetry calibration of all treatment and simulation units, and dosimeters, with appropriate phantoms, to measure or adequately infer dose distributions within patients.

(10) **CT Scanner and/or Ultrasound.** Availability of CT Scanner and/or Ultrasound in Diagnostic Radiology Department or in-service dedicated radiation therapy CT Scan and/or Ultrasound Unit.

**b. Secondary Level Cancer Program**

**Standard**

(1) A Secondary Level Cancer Program is required to provide access to radiation therapy services. Radiation therapy can be referred to the VA CCC if close by, or contracted out to private institutions. The non-VA institution should provide similar services and fulfill the same requirements specified for VA CCC. Also, patient transportation and travel time must be considered in planning for utilization of non-VA institutions.

(2) The following equipment must be available if an in-house program is utilized:  
**NOTE:** *Patients must be able to receive palliative treatment locally.*

(a) **Megavoltage Therapy Unit.** A 4-6 Megavoltage linear accelerator or a dual-beam accelerator with electron beam capability or a current model Cobalt 60 Unit with workload of 4000 treatments/visits per year.

(b) **Electron Beam Treatment, Superficial X-ray and Brachytherapy.** Electron beam treatment, superficial X-ray and brachytherapy are optional, but should be provided in the VA CCC or obtained on a contract basis.

(c) **Radiation Therapy.** Radiation therapy simulator or X-ray Unit, including X-ray film processor to be used for simulation for treatment planning.

(d) **Computerized Dosimetry.** Computerized dosimetry for treatment planning program unit, with the equipment, tools, and accessories to provide customized shadow blocks.

(e) **Physics Equipment and Services.** Physics equipment and services to monitor and measure radiation.

(f) **CT Scans and Ultrasound Unit.** CT Scans, and Ultrasound Unit should be available.

## 17. CANCER CARE FOR FEMALE VETERANS

a. The 1985 Survey of Female Veterans suggests that women veterans may have higher rates for certain forms of cancer than the general adult female population. Consequently female veterans should have access to generally accepted modalities of gender-specific cancer screening, including:

- (1) Mammography,
- (2) Pap smears,
- (3) Complete physical examinations including pelvic and breast examinations,
- (4) Education in breast self-examination, and
- (5) Treatment using in-house or consultant staff including board certified gynecologists, gynecologic oncologists, and surgeons experienced in breast cancer and reconstructive surgery.

b. Facilities for examining female patients are required at all levels of cancer programs. All VA facilities should have provision for the privacy necessary to treat female veterans with non gender-specific cancers.

## 18. COST-EFFECTIVE ALTERNATIVES

a. **In-house therapy versus contract costs.** Costs and impacts on patients of providing oncology treatment services in non-VA facilities versus in-house care should be compared during proposal development; for example, the cost of in-house radiation therapy or home nutrition support provided by an in-house NST compared to obtaining such services by contract.

(1) **Standard.** Any strategic plan proposal should be the most cost-effective alternative consistent with high quality care.

(2) Use of standardized nomenclature of the American College of Radiology will facilitate comparison of contract radiation therapy versus in-house costs.

b. **Selecting the most cost-efficient site for CCC.** VA medical centers considered as potential sites for a CCC should be compared for additional costs involved in bringing them to the CCC level.

(1) **Standard.** Any strategic plan proposal for establishing a CCC within a network must be the most cost-effective alternative consistent with high quality care.

(2) Compare additional staff, equipment, services, space requirements, and costs at each VA medical center based on the requirements specified for a CCC. Existing resources should be utilized to the greatest extent possible.

(3) In addition to providing the greatest cost advantages, a CCC site must be appropriately located to serve as an area-wide resource for other facilities within the network.

**19. QA (QUALITY ASSURANCE)**

a. **Standard.** The quality and appropriateness of care provided by oncology programs should be routinely reviewed and evaluated as part of the VA medical center's overall QA Program. Compliance with relevant standards of the ACoSCC, JCAHO (Joint Commission on Accreditation of Healthcare Organizations) and other accrediting bodies, will help ensure that oncology services are adequately monitored.

b. The Regional Oncology Advisory Committee or TAG and the Network Oncology Advisory Committee should assist the local oncology quality assurance efforts where possible. Consideration should be given to development of indicators for facility Quality Improvement Programs so that patients with potentially curable malignancies are properly identified and promptly referred for appropriate treatment and to prevent premature or inappropriate placement of patients in Palliative Care or Hospice Programs in lieu of consideration for definitive cancer treatment. When formulating recommendations regarding oncology program levels and the functions to be assigned to individual VA medical centers results of oncology quality assurance activities, including but not limited to audits, monitors, and studies, should be considered.

c. Approaches to quality assurance in oncology may include the following:

- (1) Quality and appropriateness of care monitors and audits.
- (2) Reviews of incidents, especially iatrogenic complications due to antineoplastic drugs and invasive procedures for cancer diagnosis and treatment.
- (3) Unexpected deaths in cancer patients.
- (4) Antineoplastic drug use evaluation.
- (5) Findings of Surgical Case (Tissue) Committees.
- (6) Findings of Transfusion Committees.
- (7) Mortality and morbidity case conference presentations.
- (8) Tumor Registry findings.
- (9) Tumor Board findings.
- (10) Complaint letters.
- (11) Litigation.

d. QA for radiation oncology should consider clinical aspects including:

- (1) Documentation of diagnosis.
- (2) Strategy.
- (3) Indications for radiation therapy.

- (4) Consent.
- (5) Treatment records and reports.
- (6) Statistical reports and records.
- (7) Assessment of treatment results.
- (8) Complications and follow-up.

e. QA for radiation oncology also should consider physics aspects including:

- (1) Dosimetry.
- (2) Treatment planning.
- (3) Treatment machines and simulators.
- (4) Radiation safety.

f. Any apparent problems or deficiencies identified by the various QA approaches should be brought to the attention of the responsible professionals such as the VA medical center Cancer Committee, see subparagraph 9c, for appropriate action.

## 20. TUMOR REGISTRIES AND COMPUTERIZED DATA SYSTEMS

a. **Tumor registries.** A tumor registry may be defined as an organized system for entering and maintaining relevant information on cancer patients and individual primary malignancies for such purposes as facilitating follow-up, outcome evaluation, and program assessment.

(1) **Standard.** Each Comprehensive Cancer Program is required to have a local tumor registry program in conformity to ACoSCC. Other level cancer care programs are also encouraged to participate in tumor registries. Development of a uniform tumor registry system throughout a network or Region offers a number of advantages and should be considered.

(2) VA facilities are encouraged to participate in and support comprehensive automated tumor registries such as the VA's Oncology software package now available.

(3) The tumor registry and registrar should be assigned to a clinical service actually utilizing the data. Recommended registrar staffing ratio is 1 FTE per 250 new cancer cases per year (this is approximately the average new cases per registry FTE ratio found in the National Tumor Registrars Association/ACoSCC Registry Staffing Manual, 1989).

(4) The registrar position should be upgraded to a program assistant level, GS 7-9, so that individuals capable of functioning as sophisticated data managers may be more easily recruited and retained.

(5) **Rationale.** Accurate information contained in a Tumor Registry is vital to proper patient management, program assessment, planning and strengthening of oncology care.

**b. Other Computerized Data Systems**

(1) **Recommendation.** VA facilities are encouraged to utilize national oncology data systems such as the National Cancer Institute's PDQ (Physicians Data Query) System.

(2) **Rationale.** The PDQ system provides computerized information on treatment recommendations for various types and stages of cancer as well as information on current experimental treatment protocols, and names of professionals and organizations active in oncology care. All VA medical centers now have access to the PDQ system via electronic mail and telefax.

**21. RESEARCH**

a. **Standard.** VA participation in oncology research is encouraged for all levels of cancer programs consistent with applicable VA regulations, including those relevant to approval of research studies, protection of human subjects, and informed consent. Especially encouraged are:

- (1) Investigations capitalizing on unique research opportunities in the VA system.
- (2) Clinical and laboratory research on malignancies that are commonly seen in VA patients (e.g., GI (gastrointestinal), head and neck, lung and GU (genitourinary) tumors).
- (3) Cooperative and collaborative studies among VA facilities.
- (4) Participation in cooperative cancer treatment protocols.

b. Entry of VA research protocols into the PDQ system is also recommended.

c. Participation in oncology research is a requirement for VA CCCs in conformity to ACoSCC guidelines for NCI (National Cancer Institute) comprehensive cancer programs and teaching hospital cancer programs.

d. **Rationale.** The VA facilities' participation in oncology research can enhance patient care and is consistent with the VA's health care mission which includes educational and research mandates.

**22. EDUCATION**

a. **Standard.** Regional oncology advisory committees or oncology technical advisory groups are encouraged to organize regional cancer care conferences in collaboration with their RMECs (Regional Medical Education Centers). Such conferences may be more efficiently presented at the regional level and could include:

- (1) Presentations on major scientific advances in oncology,
- (2) Practical sessions on such topics as tumor registries and oncology quality assurance, and
- (3) Discipline-specific and network-specific breakout sessions.

b. Oncology staff of VA CCCs and the Network Oncology Advisory Committee should assume responsibility for:

- (1) Assisting in education efforts at the Secondary and Primary Level VA Cancer Programs.
- (2) Participating in oncology education programs at their individual facilities.
- (3) Seeking support for oncology education programs from their RMECs.

### 23. LIST OF CANCER DIAGNOSES BY PRIMARY DISEASE SITES

Primary Disease Site	ICD-9-CM (International Classification of Diseases 9th revision Clinical Modification)
a. Lip, Oral Cavity and Pharynx	140-149, 230.0
b. Esophagus	150-150.9, 230.1
c. Stomach	151-151.9, 230.2
d. Pancreas	157-157.9
e. Colon, Rectum, Rectosigmoid Junction and Anus	153-154.8, 230.3-230.6
f. Other Digestive Organs and Peritoneum	152-152.9, 155-156.9 158-159.9, 230.7-230.9
g. Bronchus and Lung	162-162.9, 231.2
h. Other Respiratory and Intra-thoracic Organs	160-161.9, 163-165.9, 231.0-231.1, 231.8-231.9
i. Melanoma Skin	172-172.9
j. Other Skin	173-173.9, 232-232.9
k. Breast (Male and Female)	174-175.9, 233.0
l. Female Genital Organs	179-184.9, 233.1-233.3
m. Prostate	185, 233.4
n. Other Male Genital Organs	186-187.9, 233.5-233.6
o. Kidney	189.0-189.1
p. Urinary Bladder and Other	188-188.9, 233.7
q. Other Urinary Organs	189.2-189.9, 233.9
r. Brain and Nervous System	191-192.9

Primary Disease Site	ICD-9-CM (International Classification of Diseases 9th revision Clinical Modification)
s. Lymphatic and Hematopoietic	200.0-208.9
t. Other, unspecified, ill-defined and secondary neoplasms	193-199.1; 190-190.9; 234.0-234.9
u. Malignant neoplasms of connection and other soft tissue	171-171.9
v. Neoplasms of uncertain behavior	235-238.9
w. Neoplasms of unspecified nature	239-239.9

**24. NEEDS ASSESSMENT METHODOLOGY**

a. The needs assessment methodology will be used to project future workloads. Proposals for each level of the cancer program must be based on the results of this methodology and must meet the requirements provided in the criteria and standards. This methodology will assist in projecting cancer discharges/workload, identifying the appropriate level of cancer program for each site, projecting inpatient bed needs and outpatient clinic needs.

**b. Application of Cancer/Oncology Program Planning Factors**

(1) **Methodology.** Fiscal Year 1995, 2000 and 2005, workload by Network and Region was projected by applying the mean 1989-1991 number of cancer cases treated to the projected veteran population. If any one patient had identifiers for more than one type of cancer, each type was counted as a separate case.

(a) All projections were based upon age-specific rates. In addition, the number of new cancer cases for FY 1991 was identified by using 1991 as the index year and subtracting patients who were seen with the same diagnosis during any of the prior 2 years.

(b) The number of new cases will be used to assure compliance with the ACoSCC requirement of 300 new cases per year.

(c) Workload projections by Region are provided in paragraph 24 (2). Medical center and network specific projections can be obtained from the Office of Strategic Planning and Policy (172B).

**(2) Distribution and Analysis of Cancer Cases Per Region**

**(a) Number of Cancer Cases: Current and Projected**

	MEAN 89-91	1995	2000	2005
National	102,828	110,668	114,281	115,378
Region 1	23,060	24,452	24,840	24,381
Region 2	25,408	26,874	27,504	27,559

	MEAN 89-91	1995	2000	2005
Region 3	36,940	40,261	41,784	42,539
Region 4	17,420	19,081	20,152	20,899

(b) The FY (Fiscal Year) 2005 projected rate of cancer cases treated per 1,000 veteran population for medical/surgical services:

1. Western Region: Projected rate of 4.22 per 1,000 veteran population.
2. Central Region: Projected rate of 4.92 per 1,000 veteran population.
3. Southern Region: Projected rate of 6.60 per 1,000 veteran population.
4. Western Region: Projected rate of 4.62 per 1,000 veteran population.
5. Projected National Rate: 5.16 per 1,000 veteran population.

(c) The total number of cancer cases treated in VHA facilities is projected to increase 12 percent from the mean 1989-91 figure of 102,828 to the 2005 figure of 115,378. The increase in cancer cases will peak in FY 2000 for the Eastern Region and in FY 2005 for the Central, Southern and Western Regions. The Western Region will experience the largest percentage increase in cancer workload (20 percent) when comparing current workload with 2005 projections. The Southern Region, which treats the largest number of cancer patients, is projected to experience a 15 percent increase in workload by 2005, while the Eastern and Central regions will experience 6 percent and 8 percent increases in workload respectively.

**c. Outpatient Workload Projections**

(1) Review 3 years of data on pertinent age-specific outpatient clinic stops, and based on the average, estimate projected clinic stops for the years 1995, 2000, and 2005, by using the following formula:

(a) Current radiation therapy clinic stops (#903) (age-specific) = 3 years' average (1989, 1990, and 1991 age-specific data)

(b) Projected radiation therapy clinic stops (age-specific) =

$$\text{Current radiation therapy clinic stop (age-specific)} \times \frac{\text{1995 Veterans Population by DPPB (Distributed Population Planning Bases) (age-specific) or new Population Planning Base for outpatient care}}{\text{Current Veteran Population by DPPB (age-specific) or new Population Planning Base for Outpatient}}$$

(c) Similar projections can be made for years 2000 and 2005.

(d) Similar projections should be made for numbers of the following clinic stops: Oncology/Tumors (#316); Hematology (#308); Chemotherapy (#904); Oncological Nuclear Medicine (#111); Breast Cancer Screening (#131); Cervical Cancer Screening (#133); and Colorectal Cancer Screening (#135).

(2) If no age-specific data are available, an estimated age adjustment may still be made as follows:

Projected radiation therapy clinic stop =

$$\frac{\text{Current radiation therapy x clinic stops} \times \text{Projected TOTAL OP (outpatient) clinic stops in 1995 (from outpatient model available from the Regional Office Planner)}}{\text{Current TOTAL OP Clinic Stops}}$$

d. Services previously obtained on a fee-for-service, contract and/or sharing agreement basis as well as treatments provided directly in VA facilities should be considered in estimating future oncology related workload.

e. Projection of radiation therapy treatments can help in estimating specific radiation therapy equipment needs.

## 25. REPORTING

Each Region will submit an annual report summarizing its oncology activities and efforts to strengthen cancer care undertaken in accordance with this manual section. This report will be submitted to the AsCMD for Operations for forwarding to Medical Service, VA Central Office, within 3 months after the end of each fiscal year.

January 28, 1993

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

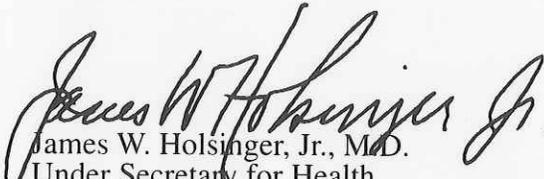
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9-i ✓

**Insert**

9-i ✓  
9P-1 through 9P-26 ✓

4. **RECISSIONS:** None.

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

Distribution: **RPC 1318**  
FD

Printing Date: 2/93

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December 29, 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," Appendix 9D, "Criteria and Standards for VA Oncology Programs."

2. Principal changes include:

- a. Substitution of VA Networks for Regional Division Offices.
- b. Establishing optional Network Oncology Advisory Committees.
- c. Extending the time period for implementation to December 1, 1993.
- d. Adding the requirement for annual report submission summarizing regional oncology activities.

3. Filing Instructions

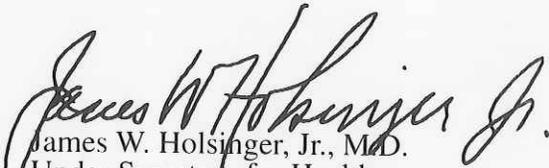
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9D-1 through 9D-33

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9D-1 through 9D-29

4. RESCISSION: M-9, chapter 9, appendix 9D, dated September 9, 1991.

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

Distribution: RPC: 1318  
FD

Printing Date: 1/93

September 9, 1991

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-9, "Strategic Planning" 9, "Criteria and Standards," Appendix 9D, "Criteria and Standards for VA Oncology Programs."

2. Principal change is to add Appendix 9D, "Criteria and Standards for VA Oncology Programs," which provides guidance concerning VA Oncology Programs.

3. **Filing Instructions**

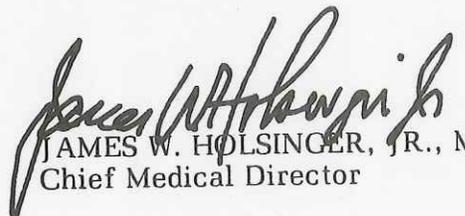
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9D-1 through 9D-32

4. **RESCISSION:** Circular 10-87-37, dated April 23, 1987.

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

Distribution: **RPC: 1318**  
FD

Printing Date: 9/91

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DIRECTIVES MANAGEMENT  
STAFF (101E)

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

Distribution: RPC: 1318  
FD

Printing Date: 7/91

PUBLICATIONS AND  
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SEP 12 1 27 PM '91

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DEC 20 1989

October 2, 1989

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

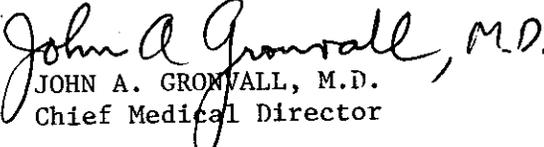
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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Cover page through v  
1-1 through 11-3

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

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

Distribution: RPC: 1318 is assigned  
FD

Printing Date: 10/89



Veterans Administration

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REMARKS

SUBJ: Departmental Manual M-9

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

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

*"Planning and Evaluation and Systems Development"*

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

3. Thank you for your assistance.

Approved  Disapproved

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

*2-3-86*  
Date

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FROM

*Marjorie R. Quandt*  
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

Regulations and Publications  
Management Staff (10A1B)

TEL. EXT.  
3331



**Veterans  
Administration**

# Memorandum

APR 03 1984

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

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

Subj: Establishment of M9-MEDIPP

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

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

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

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

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

Approve  \_\_\_\_\_  
Disapprove  \_\_\_\_\_

*4/17/84*  
Date