

**Manual M-9, Strategic Planning**

**(Veterans Health Administration)**

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

**Appendix 9G, Criteria and Standards for New Outpatient Services  
Remote from VA Medical Centers**

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# Strategic Planning

July 26, 1991

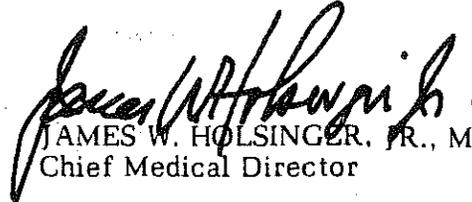
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CONTENTS

CHAPTERS

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

## RESCISSIONS

The following material is rescinded:

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

CONTENTS

CHAPTER 9. CRITERIA AND STANDARDS AND PROGRAM PLANNING FACTORS

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

**CRITERIA AND STANDARDS FOR NEW OUTPATIENT SERVICES  
REMOTE FROM VA MEDICAL CENTERS**

**1. INTRODUCTION**

a. Criteria and Standards for new outpatient services remote from VA (Department of Veterans Affairs) medical centers have been developed to meet the program planning needs of the VA facilities, regional divisions, and regions and for use by VA Central Office in the uniform review of planning proposals.

b. A criterion is defined as "a measurable characteristic of a health service."

c. 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."

d. These criteria and standards, along with the associated needs assessment methodology, will be reviewed by VA Central Office periodically, at least every 2 years, and revised as necessary based upon further analyses and experiences with their use.

**2. SCOPE, RATIONALE AND DEFINITIONS**

a. **Scope.** The following criteria and standards apply only to freestanding SOC (Satellite Outpatient Clinic) and CBC (Community Based Clinic) proposals. Independent clinics, although also freestanding outpatient facilities, will be considered separately. A discussion of outreach programs is included only as a means of differentiating such programs from SOCs and CBCs.

b. **Rationale.** Independent clinics have a wide range of primary, secondary and tertiary health care services similar to ambulatory care services in hospital-based outpatient clinics. SOCs and CBCs are similar in respect to being physically separated from VA medical centers, but administratively managed by them. Both types of clinics operate on a full-time basis, and although the kinds of services may vary, each offer at least basic primary health care. Outreach programs, in contrast, operate on a smaller scale and vary widely in purpose and service delivery.

**c. Definitions**

(1) **Freestanding Clinic.** A Freestanding Clinic is an outpatient facility that is physically separate from a VA medical center.

(2) **Independent Clinic.** An Independent Clinic is a full-time, self-contained, freestanding ambulatory care clinic which has no management, program, or fiscal relationships to a VA medical center.

(3) **SOC**

(a) A SOC is a full-time, freestanding ambulatory care facility that is physically separated but administratively attached to a VA medical center. It is usually located in a highly populated area so that a large concentration of veterans may obtain primary and secondary (in some cases, tertiary) outpatient health care services.

(b) Clinical services are delivered under the direction of a Chief Medical Officer who is located at the satellite clinic. Regular staff interaction and sharing of services should occur between the clinic and parent facility.

(4) CBC

(a) A CBC is a full-time ambulatory care facility that is physically separated but administratively attached to a VA medical center. It is usually located in a small town or rural area where special access problems prevent eligible veterans from obtaining needed:

1. Primary care,
2. Post-hospital follow-up, or
3. Referrals for secondary and/or tertiary health care.

(b) Responsibility for the clinic rests with either an Associate Chief of Staff for Ambulatory Care, a Chief of Staff, or a designated clinical bed service chief at the parent facility. Supervisory personnel from the parent facility make periodic site visits to the clinic, and at least one community physician is available for consultation.

(5) **Outreach Program.** An Outreach Program is a program designed primarily to solve a specific, unique problem of access to health care services. VA medical center staff travel to provide services to veterans in their own communities. Types of services vary depending upon local circumstances and veteran needs. Scheduling may be flexible, with no fixed base of operation. Such a program is usually part-time, often innovative in form, and can originate from various professional services, e.g., medicine, nursing, social service, psychiatry.

(6) **Primary, Secondary, Tertiary Care.** Functionally, health care in an outpatient setting can be divided into primary, secondary and tertiary care.

Source: A Glossary of HealthCare Delivery and Planning Terms, Institute for Health Planning.

(a) **Primary Care.** Primary care provides a point of entry into the health care system for non-emergency care. Providers of primary care maintain an ongoing relationship with patients for a wide range of health problems and arrange for referral to more specialized services when greater depth of expertise in a particular area of care is needed. The usual site for care is a hospital-based ambulatory care department, SOC or CBC, doctor's office, or group practice.

(b) **Secondary Care.** Secondary care deals with less frequently occurring conditions, or more unstable conditions for which specialized personnel, facilities, and services are needed to treat the patient. Most secondary care is inpatient care, but some secondary-level care for patients whose disease persists may be carried out in either specialists' offices or specialized clinics and in hospital emergency departments.

(c) **Tertiary Care.** Tertiary care deals with unusual and/or highly unstable conditions that require specialized health service personnel and a complex supporting technology. It is usually dispensed from major medical centers that are affiliated with medical schools

which serve a whole population or region. Most tertiary care is inpatient care, but some tertiary-level care may be carried out in highly specialized clinics or medical specialists' offices.

### 3. GOAL AND OBJECTIVES

a. **Goal.** The basic overall goal of both SOC's and CBC's is to provide high quality, comprehensive, cost-effective outpatient care in a dignified manner to eligible veterans at reasonably convenient locations.

#### b. Objectives

(1) To provide high quality, compassionate, outpatient health care in accordance with principles of professional practice.

(2) To improve the availability and convenience of access to outpatient services.

(3) To provide timely, efficient delivery of health care.

(4) To demonstrate effective utilization of human, material, and financial resources.

(5) To provide or arrange for emergency services as needed.

(6) To maintain collaborative professional relationships between designated staff at the clinic and the parent facility.

### 4. REQUIREMENTS FOR ESTABLISHING "NEW" PROGRAMS

#### a. Criteria for Establishing an SOC

(1) Because establishing a new SOC requires considerable allocation of resources, including funding for leasing or construction, two sets of criteria must be applied.

(a) First, threshold (minimum) requirements must be met for a clinic site to be considered. These screening criteria are applied locally. If the minimum requirements are met, a request to establish an SOC may be submitted to VA Central Office for review and approval.

(b) The second set of criteria are applied at the national level with the intent of prioritizing all proposed clinic sites, thereby ensuring that limited resources are allocated to areas of greatest need. (See pp. 9G-10 through 9G-17 for details of the Needs Assessment Methodology.)

#### (2) Standards

##### (a) Threshold (Minimum) Requirements

1. Clinic site located in MSA (Metropolitan Statistical Areas) of 100,000 or more population (veteran and non-veteran) with the DPPB (Distributed Population Planning Base) formed around the MSA location.

2. Projected outpatient visits of 25,000 or more.

3. Distance from a VA facility of 75 miles or more.

4. Backup facility available for emergency care within 20 minutes travel time.

5. Alternative arrangements for outpatient care, have been considered and determined not to be feasible or to be more costly than operating a VA SOC. Some of these arrangements are:

- a. Sharing arrangements with DOD (Department of Defense) or other federal facilities,
- b. Contracting for services, or
- c. Fee-basis care.

**(b) Rationale**

1. The threshold requirements provide an objective means of identifying locations where a large portion of eligible veterans are likely to reside but have no comparable alternatives to VA outpatient care. An MSA population of 100,000 or more is likely to generate enough workload and available staff to establish and maintain an SOC. Also, a non-VA hospital with emergency backup service is likely to be present in the area.

2. The minimum distance of 75 miles from a VA facility was chosen for several reasons:

a. A significantly greater number of veterans live within 100 miles of a VA facility. The number of veterans who use VA outpatient services drops from 455 per 1000 within 25 miles of a VA facility to 136 per 1000 at a distance of 50 miles, followed by a gradual decline as distance increases.

b. Face-to-face interaction is required on a regular basis between staff at the SOC and the parent facility, necessitating staff travel which is time consuming and costly. The distance of 75 miles is considered reasonable as a maximum distance for staff to travel, as well as being far enough away from another VA facility to improve access for a significant number of veterans. (Refer to the Study of Health Care Services to Veterans Living in Geographically Remote Areas; M-2, pt. I, ch. 7, par. 7.04, "Administrative Coordination of Outpatient Activities.")

3. A workload of 25,000 outpatient visits is considered to be the minimum amount necessary to provide a full range of services to a substantial number of veterans. Approximately 59 percent of SOCs now have workloads of 25,000 or more visits.

**(c) Ranking Measures.** The following criteria are used to rank clinic sites across the VA system which have met the minimum requirements for consideration:

1. Projected Number of Outpatient Visits

**Rationale.** The greater the projected workload, the greater the need for services, and the more likely an efficient clinic can be maintained.

2. Number of Veterans Living in HMSAs (Health Manpower Shortage Areas) Within the DPPB.

**Rationale.** Shortages of primary care physicians, other health professionals, and generally poor health in a population provide evidence of greater need for a VA presence.

**3. Distance (Miles) from a VA Medical Center**

**Rationale.** As distance increases, access will be improved for a greater number of veterans.

**4. Percentage of Veterans with Service Connected Disabilities**

**Rationale.** The utilization rate is considerably higher for service connected veterans.

**5. Percentage of General Population Living Below Poverty**

**Rationale.** Veterans with low incomes are most likely to lack insurance and to use VA services. This indicator is a surrogate measure for veteran income.

**b. Criteria for Establishing a CBC.** The criteria for establishing a CBC include consideration of alternative arrangements, amount of workload, distance or travel time, how under served an area is, and whether emergency backup services are available.

**(1) Standards (Minimum Requirements)**

(a) Projected workload of at least 3,000 outpatient visits in targeted DPPB.

(b) Distance of 100 miles or 3 hours travel time from clinic site to nearest VA facility.

(c) More than one-half of counties in targeted DPPB designated HMSAs, or more than 50 percent of veteran population living in one or more HMSAs.

(d) Emergency backup services available within 20 minutes travel time.

(e) Alternative arrangements for outpatient care, have been considered and determined not to be feasible or to be more costly than operating a CBC. Some of these arrangements are:

1. Sharing arrangements with DOD or other federal facilities,

2. Contracting for services, or

3. Fee-basis care.

**(2) Rationale**

(a) Workload of 3,000 or more outpatient visits requires a full-time staff; a smaller workload would be considered an outreach program of the parent VA medical center.

(b) The distance criterion was chosen because outpatient visit rates drop by one-third at a distance of 75-100 miles from a VA facility, and continue to drop as distance increases. Since CBCs are designated for both distant, sparsely populated areas (e.g., great plains of Mid-West), as well as the less distant rural areas that have geographical

access barriers (e.g., mountainous areas), both distance (miles) and travel time are appropriate criteria, depending on local conditions. A distance of 100 miles, rather than the 75 miles designated for urban SOCs, is likely to improve access for a greater number of veterans located in DPPBs with small populations dispersed across large geographical areas.

(c) Use of telecommunications linked to the parent facility can provide for regular staff contact and consultation, rather than frequent face-to-face interaction.

(d) Designated HMSAs provide evidence of greater need for a VA presence.

(e) The most appropriate, cost-effective way of delivering health care to small populations of veterans must be determined by evaluating all potential alternatives before making a decision to establish a CBC.

## 5. NEEDS ASSESSMENT METHODOLOGY

a. All requests to VA Central Office to establish either type of clinic must be accompanied by a summary of the information requested in the methodology.

b. **Rationale.** A uniform assessment methodology is needed by planners and administrators at each level of the planning process. The results of the methodology can be used to objectively evaluate the need for outpatient services in both urban and rural, remote areas across the VA system.

c. An assessment methodology to determine the need for an SOC or CBC is presented beginning on page 9G-10.

## 6. PLANS FOR SYSTEM-WIDE AVAILABILITY

a. **Statement of Plans.** System-wide availability exists within the limits of the criteria and standards. To establish any new program, the criteria and standards are intended for application to under served areas that are geographically remote from VA health care facilities.

b. **Rationale.** It is important that a system-wide assessment be made to determine unusually under served areas where VA outpatient health care services are needed. With limited resources, priorities must be given to areas where there is evidence of the greatest need.

## 7. LEVELS OF PROGRAMS AND THEIR MINIMUM REQUIREMENTS FOR WORKLOAD, STAFFING, AGE OF SERVICES, AND HOURS OF OPERATION

Several levels of health care delivery need to be considered in formulating plans for outpatient care services in areas remote from VA medical centers. These levels include SOCs, CBCs, and outreach programs.

a. **Criteria.** Minimum requirements for workload, staffing, range of services and hours of operation are necessary to support and maintain the program levels for SOCs and CBCs.

b. **Standards for SOCs**

(1) **Workload:** 25,000 outpatient visits/year.

(2) **Staffing.** The minimum staffing level of 38 FTEE would be adequate for an increase in outpatient visits to 30,000 per year. For clinics having higher workloads, staffing would need to be increased proportionately, depending upon the types of services and staff mix needed to provide those services.

(3) **Range of Services.** The range of services include: General Medical, Surgical, Psychiatric Primary Care, and some optional specialty care. Specialty services are considered optional only in the sense that they could be made available if there were a demonstrated need for such services and veterans' access to the services of a VA medical center are problematic.

(4) **Hours of Operation.** The hours of operation are 5 days a week, 8.5 hours per day with arrangements for emergency services.

**c. Standards for CBCs**

(1) **Workload:** 3,000 outpatient visits per year.

(2) **Staffing:** 2.5 FTEE. The minimum staffing level would be adequate for an increase in outpatient visits to 3,500, but would need to be increased proportionately for workloads above 3,500.

(3) **Range of Services:** Medical and/or Psychiatric Follow-up, Primary Care, Referral for Secondary and Tertiary Care.

(4) **Hours of Operation:** 5 days a week, 8.5 hours per day with arrangements for emergency services.

**d. Outreach Programs.** Specific criteria and standards for outreach programs will be developed in the future. Workloads are generally fewer than 3,000 staff visits per year and vary by program area and structure of health care delivery. Hours of operation are less than full-time, services are usually focused, rather than broad in range.

**e. Rationale.** The provisions for three levels of outpatient care take into account both urban and rural areas where veterans reside, and allow for flexibility in service delivery.

**8. STAFFING GUIDELINES**

The staffing guidelines provided here are "suggestive" only, and were derived by consensus of a panel of clinical, administrative, and planning staff who were considered particularly knowledgeable of ambulatory care programs.

**a. Guidelines for SOCs**

(1) The minimum suggested staffing for an SOC is 38 FTEE for an initial workload of 25,000 outpatient visits which could increase to 30,000, including the following types of personnel:

Personnel	Number of FTEE
(a) Chief Medical Officer	1
(b) Administrative Assistant	1

Personnel	Number of FTEE
(c) Secretary	1
(d) Clerk	1
(e) Physician	6
(f) Nurse Practitioners,	7
(g) Staff RNs (Registered Nurse); LPN (Licensed Practical Nurse)	4
(h) Psychologist	1
(i) MSW (Masters Degree in Social Work)	2
(j) Social Work Associate	1
(k) Pharmacist	2
(l) Pharmacy Technician	1
(m) X-Ray Technician	1
(n) Clerical Support:	9
<u>1.</u> Supervisor, Scheduling Clerk,	
<u>2.</u> Medical Records Clerk, Mail/Supply	
<u>3.</u> Clerk, Steno-typist, and (4)	
<u>4.</u> Ambulatory Care Clerks	
Total	38

(2) This staffing includes a medical/surgical team of professional staff, as well as a psychiatric team.

(a) A professional direct care provider generally can be expected to handle 3,000 outpatient visits per year for primary or medical/surgical services.

(b) A professional mental health care provider can be expected to handle a minimum of 1,000 outpatient visits per year, based upon a 50-minute time period per visit.

(c) The ratio of outpatient visits to direct care provider would be greater for programs that utilize group therapy and/or other group teaching activities.

(d) Some services, if found to be cost-effective, could be contracted for, e.g., dental, security, and housekeeping. Permanent personnel, then, would not be necessary. Personnel for other services, such as supply, personnel, fiscal and engineering, could be shared with the parent medical center.

**b. Guidelines for CBCs**

(1) The minimum suggested staffing for a CBC is 2.5 FTEE for an outpatient workload of 3,000 visits, using the following types of personnel:

Personnel	Number of FTEE
(a) Physician	0.5 (or 1.0)
(b) Nurse Practitioner or Physician Assistant	1.0 (or 0.5)
(c) Administrative Clerk	1.0 (or 0.5)
Total	2.5

(2) Arrangements can be developed for community physician consultants and/or contracting for various secondary and tertiary care services as needed.

**c. Rationale**

(1) Considerations that were taken into account in these recommended staffing levels were:

(a) Alternative ways of providing high quality outpatient care, including:

1. Preventive care through teaching activities,
2. Episodic care,
3. Triage,
4. Post-hospital follow-up, and
5. Management of chronic illness.

(b) Efficiency and cost-effectiveness in regard to clinic management, staff mix, and patient workload.

(2) Although the total recommended staffing for an SOC approximates the average (see M-9, ch. 9, app. 9G, subpar. 8a.), fewer physicians with several additional nurses are suggested to provide optimum balance while maintaining quality at a reduced cost.

(3) Use of a physician's assistant or nurse practitioner under the supervision of a part-time community physician for a CBC could also provide quality service at a minimum cost. However, a full-time physician is preferable, and in instances where this is not feasible, a telecommunications link with the parent facility is necessary to ensure appropriate guidance and consultation, as well as a community based physician on call.

**9. SPACE REQUIREMENTS**

The spatial structure for SOCs must meet all related JCAHO (Joint Commission on Accreditation of Healthcare Organizations) standards and VA Central Office, facility planning requirements.

## 10. QUALITY ASSURANCE

### a. Criteria

(1) There must be an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of outpatient care in SOC's and CBC's.

(2) There must be a written plan for the quality assurance program's objectives, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities.

(3) The quality assurance process should ensure the establishment and application of clinical criteria in the monitoring and evaluation process.

(4) The responsibility for implementation of the quality assurance program must be assigned to a particular individual or group. The Chief Medical Officer has that responsibility in each SOC. A designated professional must be assigned similar responsibility in each CBC.

(5) The scope of the quality assurance program must include evaluation of:

(a) The quality and appropriateness of diagnostic and treatment procedures.

(b) The quality, content, and completeness of medical records.

(c) Use of medications.

(d) Patient satisfaction.

(e) Quality control in pathology, laboratory, and radiology services.

b. **Standard.** Specific standards for ambulatory health care are presented in the 1986 edition of the Ambulatory Health Care Standards Manual, published by the JCAHO. A five point rating scale for self-assessment is presented in the manual and can be used to evaluate the degree of compliance with each standard.

## 11. UNIFORMITY OF APPLICATION

a. The criteria and standards, along with the associated needs assessment methodology, have been developed to assure a rational, objective approach to establishing new outpatient services which are remote from VA medical centers.

b. Any exception to applying the criteria and standards for establishing either type of new clinic will require "specific" justification with detailed documentation of measures used to arrive at decisions related to establishing a clinic. An exception can be requested through a written proposal to VA Central Office, and will be reviewed along with other proposals which meet the criteria and standards as presented.

## 12. APPLICATION OF THE NEEDS ASSESSMENT METHODOLOGY FOR SATELLITE AND COMMUNITY-BASED OUTPATIENT CLINICS

*NOTE: This Needs Assessment Methodology for SOC's is a revision of the former methodology; the changes involve the threshold criteria as well as the criteria for prioritizing potential SOC sites.*

**a. Satellite Outpatient Clinics**

(1) Threshold criteria and criteria for prioritizing potential SOC sites were made with the following objectives in mind:

(a) To build into the methodology a national, as well as local, level assessment for determining potential SOC locations;

(b) To provide an objective system for selecting and prioritizing clinic locations; and

(c) To make the prioritization methodology for SOCs compatible with the methodology for prioritizing major construction projects.

(2) The threshold criteria are minimum requirements that must be met before a clinic location can be considered a viable candidate. These criteria:

(a) Provide an objective means of identifying locations where a large portion of eligible veterans are likely to reside but a VA health care facility is not in close proximity, and where alternative arrangements for outpatient care have been found to be unavailable or too costly.

(b) Include the requirement of an MSA location where there is likely to be enough workload and available staff to establish and maintain an SOC, as well as a community hospital for emergency backup services.

(3) The revised criteria are as follows:

**(a) Threshold Criteria**

1. Population Requirement for Site Location: MSA of 100,000 or more, with DPPB formed around MSA location.

2. Projected Outpatient Visits: 25,000 or more.

3. Distance from VA medical center: 75 miles or more.

4. Backup facility available for emergency care within 20 minutes travel time.

5. Alternative arrangements for outpatient care, i.e., sharing agreements with DOD or other federal facilities, contracting for services and/or fee-basis care have been considered and determined not to be feasible or to be more costly than operating a VA SOC.

**(b) Application of the Threshold Criteria**

1. MSA of 100,000 or more population, with DPPB formed around selected site in MSA. For each potential SOC, the theoretical DPPB is defined as those counties where the population centroids (center of mass) are closer to the planned clinic site than to an existing or planned VA health care facility. For purposes of constructing the theoretical DPPB, state and regional boundaries may be ignored, as veterans will tend to go to the nearest available facility regardless of jurisdiction. If, however, regional boundaries are crossed, their needs to be inter-regional coordination to insure that there is no double counting of veterans.

**2. Projected Outpatient Visits of 25,000 or More**

a. Historically, visit projections for potential SOC's have been based upon observed specific visit rates for VA SOC's during the years 1972-1977. The procedure consisted of multiplying the veteran population of the targeted theoretical DPPB within a given distance range by the appropriate visit rate.

b. The SOC visit rates have now been revised to incorporate FY 1991 data and enhanced to include consideration of the impact not only of distance, but also of age on utilization. The new procedure consists of multiplying the veteran population by age in the SOC's DPPB, and then by the appropriate age and distance-specific visit rate as follows:

(1) Visits = 2005 Veteran Population(ijk) X Visit Rate(jk)

i = counties in theoretical DPPB  
 j = distance range  
 k = age group

(2) Table 1. **SATELLITE OUTPATIENT CLINIC VISITS  
 PER 1000 VETERANS BY AGE AND DISTANCE, FY 1991**

DISTANCE (MILES)	AGE GROUP								Overall
	0-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
25	299	230	363	311	419	718	732	593	455
25-49	111	60	129	121	171	306	239	186	179
50-74	92	40	79	83	134	231	215	193	136
*75-99	54	18	22	22	26	57	74	158	34

\* 100 or more miles - use rates for the 75-99 mile category.

(3) Table 1 displays the age and distance-specific visit rates for existing VA SOC's that were considered to be similar to those most likely to be activated in the future, considering size of population and remoteness, as specified in this methodology.

(4) The SOC utilization rates in Table 1 are likely to fit most situations since data from all SOC's was used to calculate visit rates and therefore is likely to represent those established in the future.

(c) Unusual circumstances may not be addressed using this methodology. If additional analyses indicate that existing outpatient utilization rates for a targeted theoretical DPPB are considerably greater than those used in the methodology, such utilization rates may be substituted for the SOC rates. However, if this alternative is used, an adjustment must be made to take into account the outpatient workload likely to be retained by one or more VA facilities other than the proposed clinic. (See page 9G-17 for alternate method.)

(d) **Distance From a VA medical center of 75 Miles or More.** A standard mileage guide should be used to compute distance. The number of miles from the proposed SOC site to the nearest VA facility needs to be specified.

(e) **Backup facility in Area for Emergency Care.** To meet the criterion, the name of the hospital for backup emergency care, evidence of availability and willingness to provide services, and travel time/distance from the proposed SOC site to the backup hospital must be provided.

**(f) Consideration of Alternative Arrangements for Outpatient Care**

1. Alternative arrangements for outpatient care, including sharing arrangements with DOD or other federal facilities, contracting for services, or fee-basis care, must have been considered on the basis of:

a. **Availability.** Whether services were available within distance of 75 miles of the proposed site or nearest VA facility.

b. **Comparability.** Whether services were similar to VA outpatient care in respect to type of services needed, quality of care.

c. **Cost.** Whether the outpatient visit cost of one or more alternative arrangements was comparable or less costly than the estimated cost for an SOC visit.

2. Any alternative for outpatient care meeting the preceding conditions should be given priority, rather than incurring the expense of a VA SOC. Full documentation of alternatives and comparisons of the cost of each alternative with the proposed SOC must be presented to meet this criterion.

3. After the basic requirements (threshold criteria and standards) are met for determining the need to establish an SOC, the proposal for such a clinic is submitted to VA Central Office where ranking criteria are applied at a national level to prioritize proposed clinic locations.

**(4) Ranking Criteria and Their Application**

(a) The kinds of information required for ranking purposes, along with their data sources and a description of their application, are as follows:

Criteria	Data Source
1. Projected number of outpatient visits.	VA veteran population projections for the year 2005 by county.  FY 1991 SOC age and distance-specific visit rates. (p. 9G-12)
2. Number of veterans living in HMSAs within DPPB	Federal Register, Vol. 52:221, November 17, 1987; and yearly updates of HMSAs published in the Federal Register. VA veteran population estimates by County (VA Central Office 172B).
3. Distance (miles) from a VA facility.	Standard mileage guide.

Criteria	Data Source
4. Percentage of veterans with service connected disabilities.	VA estimates of service-connected veteran population by county (available at VA Central Office 172B)
5. Percentage of population below poverty level.	<u>County and City Data Book</u> , Bureau of Census, 1988

(b) Although these criteria will be applied in VA Central Office, the following process outlined may prove helpful to field planners in developing their recommendations to the regional divisions and regional offices.

(c) The ranking criteria have been weighted in importance, using an average weight computed from scores provided by a designated panel of VA health care professionals, and measured on a continuum which is converted to a 10 point scale. A composite score is obtained for a particular clinic site by summing the scores for each weighted criterion, so that comparisons can be made among sites. The formula for computation of the weighted scores on each criterion for a given clinic site are:

1. Workload =  $\frac{\text{Projected Visits to SOC}}{\text{Maximum Projected Visits for Any Competing SOC}} \times 10 \times \text{Importance Weight}$
2. Under served Score =  $\frac{\text{Number of Veterans in HMSAs}}{\text{Maximum No. Veterans in HMSAs for any competing SOC}} \times 10 \times \text{Importance Weight}$
3. Distance Score =  $\frac{\text{Distance from Proposed SOC to Nearest VA Facility}}{\text{Maximum Distance for any Competing SOC}} \times 10 \times \text{Importance Weight}$
4. SC (Service Connected) Score =  $\frac{\% \text{ SC Veterans}}{\text{Maximum \% SC Vets for any Competing SOC}} \times 10 \times \text{Importance Weight}$
5. Poverty Level Score =  $\frac{\% \text{ Below Poverty Level in DPPB}}{\text{Maximum \% Below Poverty for Competing SOC}} \times 10 \times \text{Importance Weight}$

(b) The importance weights for each criterion are:

<u>Criteria</u>	<u>Importance Weight</u>
1. Under served Areas (HMSAs)	8
2. Workload (Projected Outpatient Visits)	8

<u>Criteria</u>	<u>Importance Weight</u>
3. Poverty Level	7
4. Distance From A VA Facility	6
5. SC Veterans	6

(c) After a weighted score is computed for each criterion, then a composite score can be obtained by summing each of the weighted scores:

1. Composite Score =  $\frac{\text{Workload Score}}{\text{Workload Score}} + \frac{\text{Under served Score}}{\text{Under served Score}} + \frac{\text{Distance Score}}{\text{Distance Score}} + \frac{\text{SC Score}}{\text{SC Score}} + \frac{\text{Poverty Score}}{\text{Poverty Score}}$

2. The following example illustrates how the ranking methodology is applied to several competing clinic locations:

a. Example: Assume there are three proposed SOC's with the following characteristics:

<u>SOC</u>	<u>Projected Visits</u>	<u>Distance</u>	<u>Vets in HMSAs (000s)</u>	<u>%SC</u>	<u>% Poverty</u>
A	40,000	75	10	15	14
B	25,000	120	3	20	15
C	30,000	90	6	10	8
Workload Score	= $\frac{40,000}{40,000}$	X	10	X	8 = 80
Distance Score	= $\frac{75}{120}$	X	10	X	6 = 37
Under served Score	= $\frac{10}{10}$	X	10	X	8 = 80
SC Score	= $\frac{15}{20}$	X	10	X	6 = 45
Poverty Score	= $\frac{14}{15}$	X	10	X	7 = 65
Composite Score					307

b. Weighted Scores for B and C would be similarly computed, and the three proposed SOC's would be ranked in priority using the Composite Scores:

<u>SOC</u>	<u>Composite Score</u>	<u>Rank</u>
A	307	1
B	264	2

<u>SOC</u>	<u>Composite Score</u>	<u>Rank</u>
C.	220	3

\* This methodology is compatible with the prioritization methodology for major construction projects. To be considered along with other construction projects, the composite scores are standardized by dividing the sum of criteria weights into each composite score. As a result, all scores are on a 10 point scale and can be compared and prioritized.

## b. Community-based Clinics

### (1) Design

(a) Since CBCs are outpatient programs designed for less populated urban and rural areas, considerably fewer resources are required for initiation and operational expenses, compared to SOCs:

1. Funds are not required for building construction;
2. Clinics may be set up in space donated by veterans service organizations; and
3. Rental space within local communities, or through various other arrangements.

(b) With small patient workloads, staffing resources are relatively minimal. Rather than competing with SOCs on a national level, resources for CBCs are determined at the VA medical center, and regional planning levels through the establishment of priorities and, when necessary, reallocation of resources. Therefore, only one set of threshold criteria (minimum requirements) must be met to establish the need for a CBC.

### (2) Threshold Criteria (Minimum Requirements)

- (a) Projected workload of at least 3,000 outpatient visits in targeted DPPB.
- (b) Distance of 100 miles or 3 hours travel time from clinic site to nearest VA facility.
- (c) More than one-half of counties in targeted DPPB designated HMSAs, or more than 50 percent of veteran population living in one or more HMSAs.
- (d) Emergency backup services available within 20 minutes travel time.
- (e) Alternative arrangements for outpatient care, i.e., sharing arrangements with DOD or other federal facilities, contracting for services, or fee-basis care have been considered and determined not to be feasible or to be more costly than operating a CBC.

### (3) Application of the Threshold Criteria

(a) Projected workload of at least 3,000 outpatient visits. Computation of the projected outpatient visits for the target theoretical DPPB is based upon the updated FY 1991 SOC visit rates which take into account the impact of distance and age. The

procedure is the same as for establishing SOCs which was previously discussed. See Table 1 for distance and age-specific visit rates.

(b) **Distance of 100 miles or 3 hours travel time.** A standard mileage guide should be used to compute distance. The number of miles from the proposed CBC site to the nearest VA medical center needs to be specified. If the distance is less than 100 miles, but the travel time is 3 hours or more, verification of the travel time (e.g., American Automobile Association estimates) and documentation of travel conditions are necessary.

(c) **More than one-half of counties in the DPPB designated as HMSAs, or more than 50 percent of veteran population living in one or more HMSAs.** HMSAs are federally designated as geographical areas where populations experience shortages of personal health services. The Public Health Service Act gives such populations priority for Federal assistance. See the Federal Register, Vol. 52:221, November 17, 1987, for a listing of HMSAs by county. A listing of the counties in the targeted DPPB, those cited as federally designated HMSAs and the veteran population for each, should be presented as evidence of meeting the criterion.

(d) **Emergency backup services available.** To meet this criterion, the name of the facility for backup emergency care, evidence of availability and willingness to provide services, and travel time/distance from the proposed clinic site to the backup hospital must be provided.

**(e) Consideration of Alternative Arrangements for Outpatient Care**

1. Alternative arrangements for outpatient care, including sharing arrangements with DOD or other federal facilities, contracting for services, or fee-basis care, must have been considered on the basis of:

a. **Availability.** Whether services were available within distance of 100 miles or 3 hours travel time to the proposed site or nearest VA facility.

b. **Comparability.** Whether services were similar to VA outpatient care in respect to type of services needed, quality of care.

c. **Cost.** Whether the outpatient visit cost of one or more alternative arrangements was comparable or less costly than the estimated cost for a community based outpatient visit.

2. Any alternative for outpatient care meeting the preceding conditions should be given priority, rather than incurring the expense of a CBC. Full documentation of alternatives and comparisons of the cost of each alternative with the proposed CBC must be presented to meet this criterion.

3. After the basic requirements (threshold criteria and standards) are met for determining the need to establish a CBC, the proposal for such a clinic is submitted to VA Central Office.

**13. ALTERNATE METHOD FOR ESTIMATING SOC WORKLOAD**

a. **Introduction.** Planners may use an alternate method for establishing projected outpatient visits for a proposed SOC.

(1) This alternate method utilizes visit rates derived from an analysis of actual visits

experienced rather than the prescribed DSVR (Distance - Specific Visit Rates) in Table 1.

(2) Indications for such use could be anticipation of an unusually high rate of visits in an area whereby use of DSVRs might understate the need for services.

(3) Use of the alternate method will require calculation of visit rates based on actual experience and projection of visits in the conventional manner using the calculated visit rates.

**b. Calculating Visit Rates**

(1) The formula to be used to compute existing outpatient visit utilization rates is as follows:

$$\text{Visit Rate} = \frac{\text{Current Outpatient Visits}}{\text{Veteran Population}}$$

(2) This formula must be computed for each county in the identified DPPB. Current visits can be obtained from the Staff Outpatient File. The outpatient visits identified in the Staff Outpatient File may include extraneous visits to distant VA facilities (e.g., a veteran from Lamar County, Texas, may conceivably receive outpatient treatment at the Phoenix, Arizona VA Medical Center); and such visits should not be included in the totals used to compute utilization rates.

(3) Visits should be counted only when they are to adjacent VA facilities.

**c. Projecting Visits**

(1) The formula for calculating projected visits is as follows:

$$\text{Projected Visits} = \text{Visit rate for each county in DPPB} \times \text{Projected veteran population of each county - Year 2005}$$

(2) To calculate projected visits, multiply visit rates by veteran population for the Year 2005 for each county separately.

(3) The sum of the visits for all counties included in the theoretical DPPB must then be adjusted to take into account the outpatient workload likely to be retained by one or more VA facilities other than the proposed clinic. This is done by multiplying the total workload obtained by a factor of 70 percent, which is the percentage of workload, on the average, that existing remote outpatient clinics generate from their theoretical DPPBs; with 30 percent of the workload continuing at one or more VA medical center-based outpatient clinics.

**(4) Example, Using Alternate Method**

<u>DPPB</u>	<u>CURRENT OP VISITS</u>	<u>VET POP</u>	<u>VISIT RATE</u>	<u>2005 YR. PROJECTED VET POP</u>	<u>2005 YR. PROJECTED OP VISITS</u>
County A	6200	60,000	.103	65,000	6695
County B	950	25,000	.038	24,500	931

<u>DPPB</u>	<u>CURRENT OP VISITS</u>	<u>VET POP</u>	<u>VISIT RATE</u>	<u>2005 YR. PROJECTED VET POP</u>	<u>2005 YR. PROJECTED OP VISITS</u>
County C	2060	31,000	.066	30,000	<u>1980</u>
Total Projected Visits in DPPB =					9606

(a) Adjustment of Workload (Year 2005) = DPPB Projected OP Visits x .70

(b) Projected Workload Year 2005 = 9606 x .70 = 6724

**14. PROTOCOLS FOR SUBMISSION**

Requests for establishing new SOCs and Community-based Outpatient Clinics must include a summary of the findings of the Needs Assessment Methodology, using the following format:

**a. Proposed SOC**

(1) Region.

(2) Parent Facility.

(3) Evidence of Meeting the Threshold Criteria.

(a) Satellite clinic site (City and State)

(b) MSA (Name and Size)

(c) Counties in DPPB (Names)

(d) Distance from proposed site to nearest VA facility (miles, name of facility)

(e) Backup hospital (travel time, name of hospital)

(f) Projected workload (number of outpatient visits)

(g) Alternative arrangements considered: Describe each in terms of availability, comparability of services, and cost.

(h) Other supporting information and/or documentation

(4) Information Needed for Ranking Sites (after they have met the threshold criteria):

(a) Projected number of outpatient visits.

(b) List of counties in DPPB that are HMSAs; veteran population in each HMSA.

(c) Distance (miles) from site to nearest VA facility.

(d) Percentage of veterans with service connected disabilities in DPPB.

(e) Percentage of general population below poverty level in DPPB.

(5) Name and FTS Number of Contact Person (to answer questions regarding ranking sites information).

**b. Proposed CBC**

(1) Region.

(2) Parent Facility.

(3) Evidence of Meeting the Threshold Criteria.

(a) Projected number of outpatient visits in targeted DPPB.

(b) Distance/travel time from clinic site to nearest VA facility.

(c) Counties in targeted DPPB (Names); veteran population in each County.

(d) Counties designated as HMSAs (Names); Percent of DPPB veteran population living in HMSAs.

(e) Name of backup hospital.

(f) Travel time to backup hospital.

(g) Alternative arrangements considered: Describe each in terms of availability, comparability of services, and cost.

(4) Other supporting Information and/or Documentation.

(5) Name and FTS Number of Contact Person (to answer questions regarding supporting information/documentation).

**15. TECHNICAL REVIEW OF NEW OUTPATIENT SERVICES**

**a. Name of VA Medical Center.**

**b. Question.** Does the proposed site meet the 25,000 visit threshold for an SOC or the 3,000 visit threshold for a Community-based Clinic as appropriate?

**c. Source Documents**

(1) Veteran population data provided by the Office of Information Management and Statistics.

(2) Distance-specific visit rates shown in Table 1.

(3) Map of geographic area surrounding the proposed location.

**d. Review Procedures**

(1) Spot-check veteran population and visit rates used (either distance-specific or actual) to insure accuracy (if actual rates are used instead of distance-specific rates,

make sure that total visits are discounted by 30 percent).

(2) Spot-check mileage used to insure that correct visit rates are used (distance-specific rates only).

(3) Spot-check calculations.

(4) Determine that the methodology generates at least 25,000 visits for an SOC or 3,000 for a CBC. The plan must contain appropriate justification if these threshold levels are not met.

## 16. TECHNICAL REVIEW OF NEW OUTPATIENT SERVICES

a. **Question.** Is the theoretical DPPB used in the analysis reasonable?

b. **Source Document.** Map of the geographic area surrounding the proposed SOC location.

c. **Review Procedures**

(1) Locate the names of the counties comprising the DPPB and the nearest existing VA medical centers on a map.

(2) Determine that the proposed site is at least 75 miles from any existing VA facility for an SOC and 100 miles away (or 3 hours) for a CBC.

(3) Locate the major population centers for each county on the map and determine that they are closer to the proposed clinic site than to any existing VA facilities. (While it is sometimes difficult to determine from a map, "closeness" should be evaluated more in terms of accessibility than distance; that is, 50 miles on an uncrowded interstate highway would be "closer" than 40 miles on a narrow country road.)

## 17. TECHNICAL REVIEW OF NEW OUTPATIENT SERVICES

a. **Name of VA Medical Center.**

b. **Question.** Does the submission for the proposed SOC or Community-based Clinic contain all the required information?

c. **Source Documents.** Proposal submission.

d. **Review Procedures.** Conduct a completeness check to ensure that all required elements are contained in the submission as follows:

(a) **SOC**

1. Name of clinic site (City and State).

2. MSA (name and size).

3. Counties in DPPB by name.

4. Distance from site to nearest VA facility (miles and name of facility).

5. Backup hospital (travel time and name).
6. Projected workload (number of outpatient visits).
7. Alternative arrangements considered by availability, comparability of service, and cost.

(b) CBC

1. Name of clinic site (city and state).
2. Counties designated as HMSAs (name and size).
3. Counties in DPPB by name.
4. Distance from site to nearest VA facility (miles and name of facility).
5. Backup hospital (travel time and name).
6. Projected workload (number of outpatient visits).
7. Alternative arrangements considered by availability, comparability of service, and cost.

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**

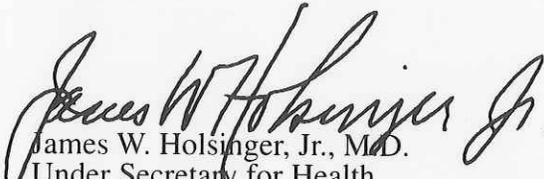
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9-i ✓

**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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May 4, 1992

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

2. Principal changes are:

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

b. The addition of:

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

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

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

3. Filing Instructions

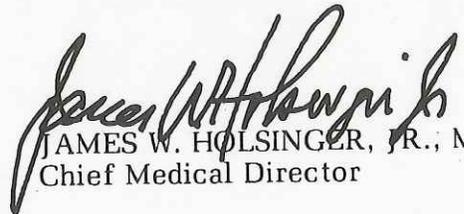
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iii-iv  
9-i through 9-1

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

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

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

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July 26, 1991

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

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

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

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

3. Filing Instructions:

Remove pages

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Cover page through iv

Cover page through iv

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

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October 2, 1989

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

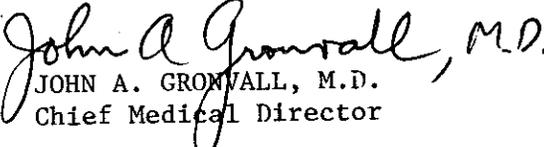
2. Principal reason for this manual is to provide a description of and issue guidance concerning VHS&RA planning process.

3. Filing Instructions:

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Cover page through v  
1-1 through 11-3

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

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

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Veterans Administration

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4. (17A) <i>(Copy forwarded) 2/4/86</i>	
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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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*Marjorie R. Quandt*  
MARJORIE R. QUANDT

ACMD for Planning Coordination (17A)

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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